Guiding Document

for the development of a roadmap towards achieving universal health coverage

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Disclaimer:

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List of abbreviations

ADP	Annual Development Plan
BHU	Basic Health Unit
BIA	Budget impact analysis
CEA	Cost-effectiveness analysis
CMIS	Central management information system
DFID	Department for International Development
DIB	Development impact bond
ESSI	Employment Social Security Institution
FTT	Financial transaction tax
G-BA	*Gemeinsamer Bundesausschuss*, Joint Federal Committee (Germany)
GDP	Gross domestic product
GIS	Geographic information system
HCC	Health Care Commission
HITAP	Health Intervention and Technology Assessment Program (Thailand)
HSA	Health Services Academy
HSRU	Health Sector Reform Unit
IDS	Integrated Development Strategy
IFMIS	Integrated Financial Management Information System
IHME	Institute for Health Metrics and Evaluation
IPD	Inverse population density
IQWiG	*Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen*, Institute for Quality and Efficiency in Healthcare (Germany)
KP	Khyber Pakhtunkhwa
LHW	Lady Health Worker
M&E	Monitoring and evaluation
MTBF	Medium Term Budgetary Framework
MTI	Medical Teaching Institution
NADRA	National Database and Registration Authority
NFC	National Finance Commission
NGO	Non-governmental organisation
NHI	National Health Insurance (Thailand)

NHIL	National Health Insurance Levy (Ghana)
NICE	National Institute for Health and Care Excellence (United Kingdom)
NIPS	National Institute of Population Studies
OBB	Output-based budgeting
OOPs	Out-of-pocket payments
PHC	Primary health care
PHEN	Pakistan Health Economic Network
PHIMC	Punjab Health Initiative Management Company
PIFRA	Pakistan Improvement to Financial Reporting and Auditing Project
PLSM	Pakistan Living Standards Measurement
PMNHP	Prime Minister's National Health Program
PMT	Proxy means test
PPP	Purchasing power parity
RHC	Rural Health Centre
RMNCH	Reproductive, maternal, newborn and child health
SDG	Sustainable Development Goal
SDPF	Strategic Development Partnership Framework
SHA	System of Health Accounts
SHPI	Social Health Protection Initiative
SIB	Social impact bond
SLIC	State Life Insurance Corporation of Pakistan
SPRU	Social Protection Reform Unit
THE	Total health expenditure
TRF(+)	Technical Resource Facility
UHC	Universal health coverage
UN	United Nations
VAT	Value-added tax
WHO	World Health Organization

Glossary

Ability to pay	The maximum price a consumer is able to pay for a product or service.
Actuarial science	The application of mathematical and statistical methods for the assessment of risks for insurance.
Adverse Selection	Adverse selection occurs when individuals use their inside information to accept or reject a contract, so that those who accept are not an average sample of the population.
Benefit incidence	The distribution of (public) services across different groups in society.
Equity in delivery	A fair distribution of health care benefits across different groups in society based on equal access.
Equity in financing	A fair distribution of the financing burden across different (socioeconomic) groups in society.
Financing incidence	The actual contribution of different groups in society towards health financing through taxes, direct payments or insurance fees.
Fiscal space	The budgetary room that allows a government to provide resources for public purposes without undermining fiscal sustainability and economic stability.
Out-of-pocket payments	Out-of-pocket payments are payments borne by the individual or household (often in cash at the point of service) that are not subsequently reimbursed by the government or by an insurer; they constitute the most inequitable form of health spending.
Output-based budgeting	Output-based budgeting is a process by which government agencies are funded on the basis of outputs delivered.
Public financial management	Public financial management describes the rules, systems and processes used by governments to mobilise revenue, allocate public funds, undertake public spending, and monitor and evaluate these activities.

Social determinants of health	Social determinants of health describe contextual conditions into which people are born, grow up in, live, work and age. These conditions are influenced by the distribution of resources on different geographic levels. They influence the distribution of health and sickness in society via economic mechanisms.
Social equity	Relative distribution of rights, opportunities and resources in society that is considered fair and equitable.
Social protection	Measures for prevention and reduction of risks that threaten the socio-economic well-being of individuals, households and society as a whole.
UHC roadmap	Overview of projects under the UHC strategy; describes concrete project goals, objectives and deliverables within a coherent framework; contains milestones and timelines; outlines risks and dependencies
UHC strategy	A country's high level plan to achieve universal health coverage; incorporates other specific strategies (HR, health financing, etc.)
Universal health coverage	Universal health coverage describes the goal that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while the use of these services does not expose the user to financial hardship.
Willingness to pay	Willingness to pay describes the (maximum) price a consumer is willing to pay for a product or service.

Foreword

Pakistan has prioritised the post-2015 development agenda known as "*Transforming our World: the 2030 Agenda for Sustainable Development"*, consisting of 17 Sustainable Development Goals (SDGs) and 169 targets distributed among them. The SDGs are well in line with the seven pillars of the Pakistan Vision 2025. In particular, the SDG target 3.8 that talks about achieving Universal Health Coverage (UHC) including financial protection and quality essential health services, has become a prime concern both at the national and provincial level.

The provincial Government of Khyber Pakhtunkhwa is committed to taking all necessary measures for improving the performance of the health care system and shaping it to achieve universal coverage. Concerning this, an integrated approach has been envisaged by engaging all the stakeholders in developing a comprehensive UHC strategy. This is also deemed an important methodology because attaining UHC by any stakeholder alone may not be easy.

The expectation from the current "*Guiding Document for the development of a roadmap towards achieving universal health coverage"* is that it will be of great value for all involved stakeholders in development of a UHC roadmap. With the support of GIZ Pakistan, the document is one of the first endeavours of its kind, which will provide stakeholders' an opportunity to work jointly and impart their respective expertise to the cause.

SHAHRAM KHAN TARAKI
Senior Minster Health
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Preface

In the recent past, health has become a central focus globally and also drawn immense attention in Pakistan; evident by the fact that it is placed at a higher priority when budgets and policies are developed at the national and provincial levels. Various aspects of health related matters are considered absolutely imperative and are frequently discussed at different forums, including continuous improvement in the service delivery, coverage and immunisation. It is also equally essential to focus on increasing financial protection for those availing health services. To achieve such a uniform and integrated health system where everyone has equal access to health care services without undue financial hardships, Pakistan is not behind and ready to embrace this Universal Health Coverage (UHC) concept whole heartedly.

The provincial Government of Khyber Pakhtunkhwa (GoKP) is also cognizant of the importance of UHC, considering it achievable for countries like Pakistan. However, it is further acknowledged that it requires a strong political commitment and without active government intervention, the transition to UHC will be lengthy. At the moment, initiation of Social Health Protection Initiative (SHPI) widely known as 'Sehat Sahulat Programme' in Khyber Pakhtunkhwa is one of the initial steps leading towards UHC. The SHPI insurance scheme is providing 69% of the poor population health coverage including maternity care, non-maternity hospitalisation and post-hospitalisation assistance. The Health Sector Reform Unit of Health Department GoKP is further committed to set the stage for UHC, which has also been mentioned in the Khyber Pakhtunkhwa Health Sector Strategy 2010 – 2017.

Keeping UHC in mind, Health Department GoKP deliberated whether an extension of the said policy would be feasible or otherwise. Hence, concluded with the proposal that instead of extension of the policy a comprehensive strategy/policy, pillared on UHC, be furnished which is to lead and achieve the provincial commitment towards UHC. In this regard, this *"Guiding Document for the development of a roadmap towards achieving universal health coverage"* can serve as a prerequisite for a more comprehensive strategy/policy. It may not only facilitate the Health Department GoKP in development of UHC roadmap in near future but also to track situational analysis in context of UHC.

Health Department GoKP duly recognises the efforts and cooperation of GIZ Pakistan in this area and looks forward to continued support in this regard.

MUHAMMAD ABID MAJEED
Secretary to Government of Khyber Pakhtunkhwa
Health Department

Purpose of the Guiding Document

This Guiding Document is intended to assist the Government of Khyber Pakhtunkhwa (KP) in the planning processes directed at the progressive realisation of universal health coverage (UHC). The Government of KP envisages a roadmap that describes the steps of the reform processes required to achieve universal access to quality health services. Such a UHC roadmap will

- Outline the pathway deemed feasible by the stakeholders,
- Address all health system building blocks and the design elements appropriate in the context of Pakistan in general and KP in particular,
- Provide concise descriptions of the projects and milestones that indicate progress towards set goals, and
- Be embedded in a strategy that ensures processes are aligned with other relevant provincial and national policies and that ensures risk mitigation is adopted as appropriate.

Ideally, under Pakistan's National Health Vision the UHC strategy will be aligned with the province's Health Sector Strategy that is due to be renewed in 2018.

The Guiding Document addresses the envisaged roadmap as a whole and highlights elements of key importance, as prioritised by stakeholders in preceding discussions. The Guiding Document outlines the necessary steps towards a coherent and effective design of the pathway towards UHC taking into account political and socio-economic context, the current state of the Pakistan's health system and stakeholder preferences.

Stakeholder interviews in August and September 2017 and a Round Table with key stakeholders in September 2017 have contributed to shaping the Guiding Document. Wherever sources have been used that are accessible to the public, these are appropriately referenced. Other sources of information comprise working documents from health reform contexts in different countries and are largely confidential.

Shortly before the 2018 elections in Pakistan, all political parties emphasise the importance of health, the topic commonly described as a top priority together with education. The time seems appropriate to initiate a joint effort of relevant stakeholders towards a coherent plan for progress towards UHC. Khyber Pakhtunkhwa provides a particularly suitable environment for taking the next steps, as the province has taken great steps towards improving access and service quality. The Sehat Insaf card, which provides access to inpatient care for poor households, has been expanded to all districts and will cover larger segments of the population in the future. Policy-makers envisage the programme to serve as a vehicle towards UHC.

1 Aim and objectives

The Guiding Document forms part of the output of a project that pursues the overarching aim to assist the Government of KP in the effective design of health reform towards UHC. The Guiding Document will support the Government of KP in formulating a roadmap towards UHC. It will also feed into and complement the provincial government's generic Health Sector Strategy.

The supporting **objectives** are

- To outline the elements of a governance approach for health sector reform in KP;
- To ensure the inclusion of all relevant elements in a future roadmap;
- To present options for a health financing strategy as one component of a comprehensive strategy towards UHC.

The **impact hypothesis** of this project can be formulated as follows: The co-ordinated development of a Guiding Document supports key stakeholders at the provincial level in developing a comprehensive UHC strategy that is based on a set of rigorous principles accepted by all parties concerned, that builds on inter-provincial exchange and cooperation with the federal level, and that reliably guides a **concrete and time-bound pathway** towards the achievement of universal access to affordable and needs-based health services in the form of a UHC roadmap.

2 Rationale and background of the project

2.1 Project rationale

2.1.1 Towards the realisation of universal access

Providing affordable and accessible healthcare for all has become one of the main priorities for many low- and middle-income countries over recent years with UHC, including financial risk protection, explicitly reflected as a target under the UN Sustainable Development Goals (SDGs). As there is no one-size-fits-all approach to providing healthcare for all, every country needs to develop its unique strategy, approaches and tools to achieve the goal.

An increasing number of countries are in the process of expanding health coverage of their population, particularly to people working in the informal sector and other vulnerable groups. In the pursuit of equity (both in delivery and financing), efficiency and sustainability of countries' health systems, health financing and healthcare provision are gradually being integrated into coherent and coordinated comprehensive systems designed to overcome fragmentation.

While policy-makers in Pakistan are clearly dedicated to increasing access to health service for poor people in the informal sector and the major political parties have

stated their commitment to universal access, a clear vision is lacking as to how a health system could be realised that would benefit all citizens of Pakistan and improve social equity.

Stakeholders in Pakistan highlight three barriers to successfully moving towards UHC:

- **Fiscal constraints**: Provincial health budgets are subject to pressures on the revenue and the expenditure side. Given current practice and expectations, there is little room to manoeuvre.
- **Political constraints**: Adding to the limiting circumstance of a partisan divide between the provincial and the national level, there is limited political capacity to engage in the full breadth of health reform topics across levels of government and across provinces.
- **Legal constraints:** Many stakeholders perceive the devolution of health to the provinces by the 18th Constitutional Amendment as a restraint, as the federal level's potential role in expediting provincial investments in priority sectors, such as health, have not been appropriately explored.

2.1.2 Characteristics of a roadmap

A roadmap is a living document. A UHC roadmap converts the policy directives of a UHC strategy into concrete projects and activities. The KP roadmap for health reform towards the achievement of UHC will provide an overview of the pattern of individual projects that are required in order to increase population coverage with quality health services, to broaden the benefit package and to ensure the reduction of out-of-pocket payments for health in the interest of reducing the financial burden of disease on households.

The roadmap will reflect a meaningful meta-structure of project management plans. It will therefore reflect the project scope, objective, steering structure, tasks and responsibilities, management approach, activities and time plan for each project and sub-project. It will describe technical and legal requirements for each of the projects. Interdependencies of projects will be analysed and the feasibility of each project and sub-project assessed in the light of scarce resources. Risks will be evaluated and risk mitigation plans and contingency plans developed.

Responsibilities will be assigned to stakeholders (ideally members of the Task Force, see section 6.5, or a sub-committee of the Task Force) to regularly update the roadmap, to ensure that it is used as a binding planning tool, and to communicate changes and progress. An approach to learning and innovation will have to be outlined.

The roadmap will reflect a meaningful **meta-structure of project management plans**. It will therefore reflect the project **scope**, **objective**, **steering structure**, **tasks** and **responsibilities**, **management approach**, **activities** and **time plan** for each project and sub-project. It will describe **technical** and **legal requirements** for each of the projects.

2.1.3 Elements of a prospective UHC strategy

UHC implies that the health system should provide all people with access to needed health services (including prevention, promotion, treatment and rehabilitation) of sufficient quality and should ensure that the use of these services does not expose the users to financial hardship.

A UHC strategy comprises of a number of components to be coordinated with (and reflected in national and provincial policies; see 2.2.5), including (but not limited to)

- Guiding principles;
- Health financing strategy (and priority setting principles and processes);
- HR strategy; skills development strategy;
- Quality strategy (levels of care, regulation, registration and licensing, certification, accreditation, norms and standards);
- Governance structures (including roles of the public and private sectors, processes and mechanisms);
- Other institutional arrangements;
- Legislative matters;
- Project and time plans (including transitional arrangements);
- Research, monitoring and evaluation (including costing of strategy).

Shape and format of the UHC strategy need to be developed in a consultative manner with appropriate stakeholder representation.

2.1.4 Stakeholders

The involvement of all important stakeholders in consultative processes is essential. The list of important stakeholders in health reform towards UHC would include[1]

- The Chief Minister's office, the provincial Departments of Health, Finance, Planning, Law, Establishment, and their relevant strategic, research and planning units, such as the Health Sector Reforms Unit (HSRU) within the Health Department or the Social Protection Reform Unit (SPRU) within KP's Planning and Development Department — as well as these institutions' counterparts at the federal level;

[1] This list of stakeholders was derived in an interactive associative exercise during the Round Table event with decision-makers in Islamabad on 28 September 2017.

- Other provincial government departments, e.g. Public Health Engineering, Social Welfare, Science & Technology and Information Technology;
- Public and private healthcare providers (or their representative organisations), including
    - Family physicians
    - Public hospitals
    - Private hospitals;
- Institutions/bodies currently involved in the implementation or management of health financing;
- Current and potential future providers of financial services for the health sector, including the insurance industry;
- Civil society, community voice, patients/vulnerable groups;
- Religious institutions;
- Research and academia;
- Media;
- Development partners (technical).

The steering structure for the process of designing and implementing the UHC strategy is indispensible. It is different from the steering structure envisaged for the future health system. Along the health reform process, it will be important to ensure a level playing field between stakeholders and interest groups.

2.1.5 Planning process

The planning phase of the policy process is crucial. Capacity requirements are very high, people familiar with the type of work need to plan the work. Experience shows that reform processes fail due to lack of planning capacity.

The planning process will be based on jointly agreed principles: principles for the target scenario as well as principles to guide the process (process governance principles). Governance principles envisaged for the target scenario in the main areas of governance - clinical governance, corporate governance, information governance, and research governance - should inform the governance principles along the development and implementation process.

Managing the different projects, e.g. design and implementation of a health financing strategy, will be very data intensive and require comprehensive financial, socio-demographic and health data. The planning process will benefit greatly from the detailed 2017 Census data. Different data management systems have been put in place and are being improved, prominently the District Health Information System that is being upgraded further.

The all-embracing policy process encompassing the various “projects” requires a sophisticated steering structure and an appropriate governance framework (section 6).

2.2 Background

2.2.1 Demography

KP demographic data reflect the fact that the province has a young population. Of a total population of approximately 30.5 million (Pakistan Bureau of Statistics, 2017), 49% of people are under 20 years old (Figure 1) Demographic data play an important role in designing and planning the health system. Demographic projections allow important conclusions across reform areas, e.g. the suitability of pay-as-you-go components for health financing, or the role of long-term care in benefit package design.

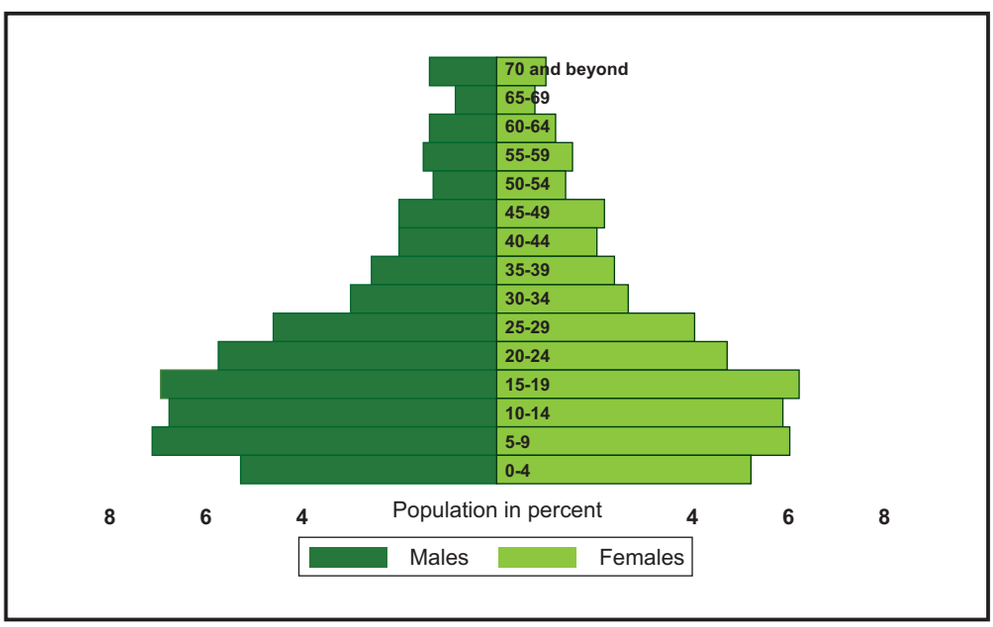

Figure 1: Population pyramid KP (Source: Frölich et al., 2016)

2.2.2 Disease burden

Pakistan's health indicators are still poor. According to the Demographic and Health Survey 2012-13, the under-five mortality rate stood at 89 (per 1,000 live births per year), the infant mortality rate at 74 (per 1,000 live births) (NIPS, 2013). Pakistan has the third highest burden of maternal, foetal and child mortality worldwide (Bhutta et al., 2013). The trend, however, is downwards (IHME, n.d.). In KP, maternal mortality persists as a major public health issue at an estimated 271 (per 100,000 live births) (Mir et al., 2016).

Non-communicable diseases are on the increase in Pakistan. The two most important causes of death in Pakistan are ischemic heart disease and cerebrovascular disease. Deaths from both these causes are rapidly increasing and they constitute a significantly higher burden on the Pakistani health system than on average in comparable countries (IHME, n.d.).

Even though progress has been made over recent years with respect to some health indicators, the health status of the Pakistani population falls behind other countries of similar levels of economic development.

2.2.3 Access to health services

Access to adequate preventive, curative and rehabilitative health services is lacking for a majority of the population. Among the determinants of access to quality services, lack of affordability stands out as the main access barrier. A recent study conducted in KP found that the most important reason by far for not seeking health care in case of illness was the unaffordability of services (Frölich et al., 2016).

A normative set of goals is embedded in the concept of UHC, including equity in utilisation or service use relative to need, equity in financing (according to ability to pay), financial protection, and quality. The planning process towards UHC requires the careful consideration of all potential barriers to accessing and utilising health services. These differ geographically and with socio-economic and socio-cultural status. A thorough understanding of determinants of access across the province or country will inform the design of the strategy for health reform towards UHC; it will enlighten the on-going discussion on health system strengthening and service quality.

Stakeholders complain that there is currently no trust in the public primary health care (PHC) services offered in KP. Patients would rather use outpatient services at secondary and tertiary hospitals or see a private qualified doctor. It is important to understand the determinants of provider choice across needs and socio-economic strata. A better understanding will guide the strategy directed at the improvement of service quality in the province. It may also help in the design of incentives and an efficient referral system.

An **analysis of provider choice** is advisable: Thorough understanding of the determinants of provider choice across needs and socio-economic strata should guide the strategy directed at the improvement of service quality in the province.

2.2.4 Social determinants of health

Social factors play an important role in determining the health status of the Pakistani population. Socio-economic status is strongly correlated to the achievement of good health. Living conditions differ widely across the country but also within provinces. An individual's health position is shaped by the household's economic or poverty status, by the person's sector of employment, by the characterization of the employment status as formal or informal and by several other factors determining an individual's vulnerability, including gender.

There are implications of this complex set of causes and effects that will affect the design of Pakistan's future health system in different areas, for example when it comes to principles for designing the benefit package.

2.2.5 National and provincial policies

The Pakistan National Health Vision 2016-2025 (The Vision) was launched in September 2016 after consultation with a broad range of stakeholders, including the public and private sectors, government entities, academia and civil society, and approval by the provinces. It aims at UHC as its ultimate goal (Government of Pakistan, 2016, p. 7). The Vision rests on eight thematic pillars:

1. Health financing
2. Health service delivery
3. Human resources for health
4. Health information systems
5. Governance
6. Essential medicines & technology
7. Cross-sectoral linkages
8. Global health responsibilities

The Vision builds on an analysis of the challenges. The identified challenges will be taken into account in this concept note and the subsequent roadmap towards UHC. They will be complemented with the KP provincial perspective.

The KP Health Department is mandated to ensure equitable access to quality health services in the province. Public health service providers include 89 Rural Health Centres (RHCs), 769 Basic Health Units (BHU[2]s), 429 other primary health centres and 190 hospitals, including eleven autonomous tertiary hospitals. KP's activities in the health sector have been guided by the province's Health Sector Strategy 2010-2017 (HLSP, 2010). This strategy was developed under the paradigm of the Millennium Development Goals. It emphasises the general goal of health status improvement through ensuring access to quality healthcare and mentions five outcomes, as budgeted in the Medium Term Budgetary Framework (MTBF):

Outcome 1: Enhancing coverage and access to essential health services especially for the poor and vulnerable.
Outcome 2: A measurable reduction in morbidity and mortality due to common diseases especially among vulnerable segments of the population.
Outcome 3: Improved human resource management.
Outcome 4: Improved governance and accountability.
Outcome 5: Improved regulation and quality assurance.

The outcomes are monitored through a set of indicators.

[2] Several BHUs are currently being upgraded to RHCs.

Thus the Health Sector Strategy has set a frame of reference that supports objectives that are in line with the UHC vision. A new Health Sector Strategy to succeed the current one will be developed, and a future UHC strategy should be aligned with and complement the new KP Health Sector Strategy.

2.2.6 Recent social health protection initiatives

Recently launched social health protection programmes have introduced the concept of social health protection with an initial focus on poor households and families. Policy-makers at the provincial and at the federal level consider the programmes as vehicles towards the achievement of UHC. These two health protection schemes, one by the provincial government of KP and one by the federal government, are rolled out concurrently.

SHPI / Sehat Sahulat Programme

The Social Health Protection Initiative (SHPI) started in February 2016 with support of the German government through KfW Development Bank in four districts of KP and in April 2016 in one district of Gilgit-Baltistan. The programme is targeted at poor households. It covers the household as a unit of reference (maximum of eight persons) and provides free access to secondary and tertiary level inpatient care (up to an annual cap). The premium that is paid by the province on behalf of the beneficiaries is 1,500 PKR per household per annum. The State Life Insurance Corporation of Pakistan (SLIC) has been contracted to implement the programme in KP with tasks including the enrolment of beneficiaries, contracting of providers, data management as well as monitoring and evaluation.

At the beginning of 2017, the provincial government in KP not only extended the programme to the whole province, but also significantly expanded the target group by raising the income limit and provided financial resources for expansion from its own budget. The Government of KP clearly expresses the intention to not only further increase the number of beneficiaries by raising the income threshold, but also to build on the programme, which is also called Sehat Sahulat Programme, to rapidly increase health coverage of KP citizens. Rapid expansion is politically desired and not based on an analysis of feasibility and risk.

Eligible households are identified based on their Proxy Means Test (PMT) score.[3] Phase I of the SHPI targeted households up to a PMT score of 16.71 (roughly corresponding to the group of people living on less than 1 USD PPP per day).

[3] The Pakistan PMT score has been assigned to every household based on information for variables included in the respective PMT formula (using a poverty scorecard), e.g. education level of the household, land owned by household, type of toilet used, number of rooms in relation to number of people in household, vehicle ownership. The score is a proxy of the household's welfare status (the lower the score, the poorer the household is considered to be). Pakistan has not undertaken a PMT survey since 2009. Targeting based on the PMT score has repeatedly been subject to methodological criticism (Cheema et al., 2015; Kidd et al., 2017).

Phase II of the programme started with the beginning of fiscal year 2017/18: The PMT cut-off score was raised up to 24.4, implying a coverage of approximately 51% of the population. Currently, another expansion is planned by increasing the PMT cut-off to 32.5 with a population coverage of about 69%.

The current set of benefits covers maternity care, non-maternity hospitalisation (about 500 medical procedures at empanelled hospitals), as well as post-hospitalisation assistance. The benefit limit is 30,000 PKR per individual per annum (implying an annual cap of 240,000 PKR per household). Furthermore, additional benefits of up to 300,000 PKR will be provided for tertiary level care.

The Sehat Insaf card is currently seen as a channel to expand social health protection towards UHC. Khyber-Pakhtunkhwa Chief Minister Pervez Khattak has already approved the extension of the Sehat Insaf card to all employees of public and autonomous bodies, including employees of universities and medical institutes, as well as lawyers and journalists. The respective groups of employees would then have to contribute an insurance premium. Only the poorest segments of society are eligible to a free Sehat Insaf card.

The extension of the scheme to government employees has been under discussion for a while. GIZ has provided technical support for concept development.

PMNHP

The Prime Minister's National Health Program (PMNHP), which - as the SHPI - targets low-income groups, has been implemented since January 2016. The poverty cut-off is set at 32.5 PMT (interpreted to approximate a daily income of 2 USD per day). The unit of insurance is the family (defined as a group composed of [a] husband, wife and unmarried children; [b] husband and wife without any children; [c] divorced or separated woman/man, widow/widower with or without unmarried children, living alone or with her parents/relatives; or [d] parents not included in family but will form a separate family unit if living in same household).

The roll-out plans originally foresaw the inclusion of 23 districts (four districts in each of the four provinces, two districts in each of the three regions and one in Islamabad Capital Territory). The plan was revised when KP and Sindh announced not to join the programme. In the meantime, however, the PMNHP has expanded into four KP districts (Abbottabad, Mardan, Kohat and Chitral). In these districts, PMNHP has moved in to cover the population above 24.4 PMT, the then-cut-off point of the SHPI, and the PMNHP threshold of 32.5.

In principle, PMNHP contributions are paid by provinces. The priority interventions are, however, subsidised by the federal level. In areas without their own budget, e.g. federally administered areas FATA and ICT, contributions are covered from the federal budget.

The benefit package covers inpatient care for a range of services at the secondary and tertiary levels at an annual premium of 1,500 PKR per family, which is paid by federal and provincial governments. Same as the SHPI in KP, the PMNHP is also being implemented by SLIC as a cashless scheme.[4]

Each family is insured up to an amount of 50,000 PKR per annum for secondary care treatment and up to 250,000 PKR for priority care treatment.[5] There is an understanding that admitted patients who have consumed their limits will be provided with additional limits by Bait-ul-Mal. Secondary care treatment is limited by means of an exclusion list. Among other diseases, the exclusion list mentions mental illness.

PMNHP provides a traveling allowance of 350 PKR per trip for a total of three trips from the patient's residence to the hospital and back.

[4] It is only the fact that both SHPI and PMNHP are being implemented by the same insurance company, SLIC, that ensures a certain degree of portability of PMNHP claims across the districts of KP as well as some degree of portability of SHPI claims from the occasional utilisation of services outside the province.

[5] Seven disease areas comprise the priority treatment package: Cardiovascular disease, diabetes mellitus-related complications requiring hospitalisation, emergency and trauma, end stage renal disease, organ failure management, complications of chronic infections, and oncological diseases.

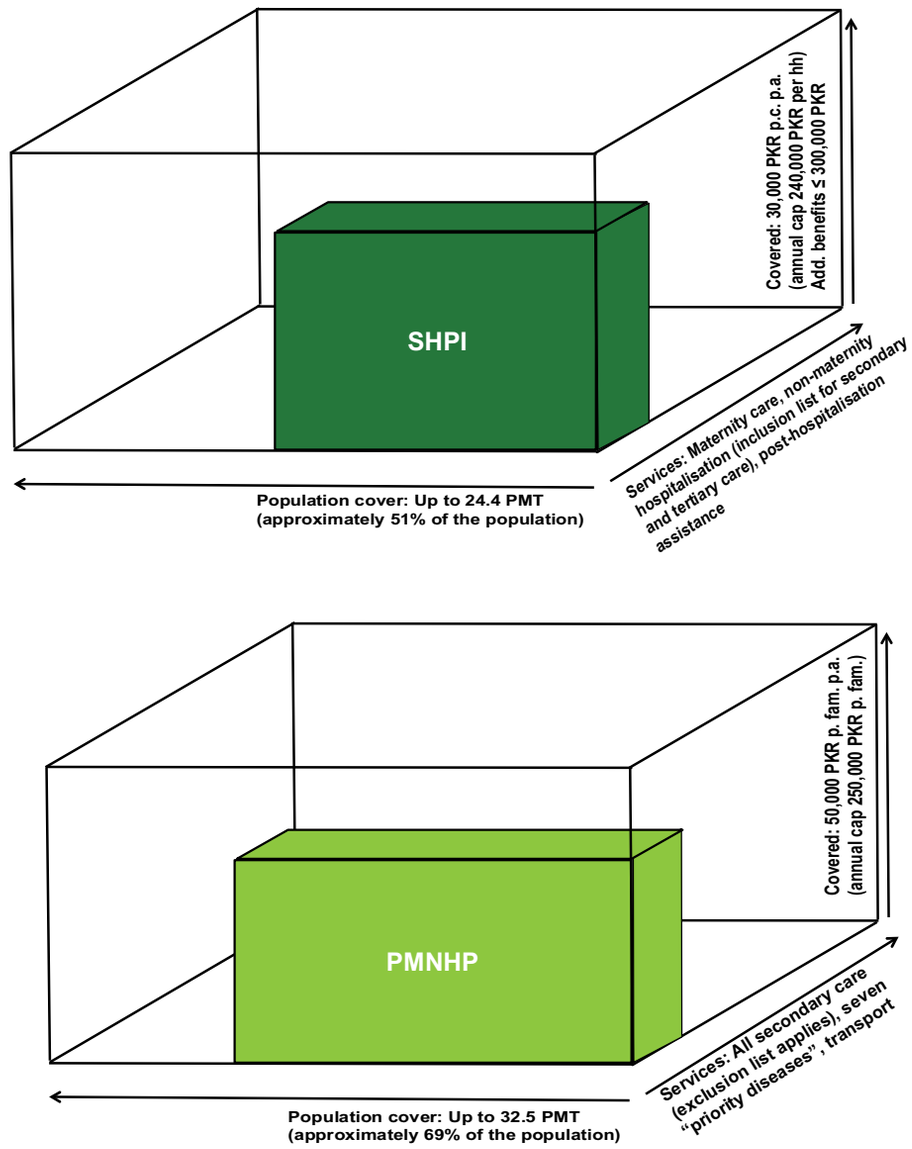

Figure 2: Two social health protection programmes compared

2.2.7 Covering employees

Government employees scheme

There are other initiatives that are currently being discussed and that need to be considered in the planning processes towards UHC. One is a scheme for government employees. Under the Medical Attendance Rules, government employees currently receive benefits in cash for outpatient treatment as medical allowances and are reimbursed for inpatient treatment in public and in private hospitals in Pakistan. There are currently around 470,000 employees under the Public Civil Servant Act with about 3.5 million dependents. GIZ has made the KP Government aware of the risk of skyrocketing costs under the current system. The integration of government employees into the (third-party payment) SHPI scheme has therefore been considered. The number of government employees would be

multiplied with the current premium in order to define the overall amount to be budgeted for coverage of this target group (including dependents). An option would be to ensure that premium payment is shared between the employer (the KP Government) and the employee. The SHPI would thus gain a contribution-financed arm that would ideally be compulsory (to avoid the negative effects of adverse selection).

There have already been discussions within the Department of Health on the inclusion of further population groups into social health protection, including certain groups of employees (e.g. television actors) and minorities (e.g. transgender people).

One coherent option to expand coverage on the basis of the recently introduced **social health protection scheme** would be to establish a **contribution-financed** arm with **compulsory membership** for employees. There could be a **succession** of population groups to be covered. The first group to join could be **government employees**.

Khyber Pakhtunkhwa Employment Social Security Institution (ESSI)

Currently employers provide funds for healthcare in three ways: either through occupancy health care, through group insurance, or through social security (which is managed by Employment Social Security Institutions, ESSI). ESSIs exist in all four provinces as autonomous bodies attached to the respective provincial Department of Labour. They basically act as agents and are funded through contributions. Contributions are based on gross income and are shared by employees (3%) and employers (3%). They cover sickness, maternity, work injury, invalidity and death benefits of employees and their dependents. Dependents include the employee's spouse, dependent parent and any unmarried children under age 21. ESSI's focus is on provision of healthcare to the employees of private industries and commercial establishments employing 5 to 10 or more employees (depending upon the province). Informal sector employees are excluded. In KP in 2016-17, 77,736 persons in employment were registered with ESSI (in 5,249 "units") (Government of KP, 2017a). The Khyber Pakhtunkhwa ESSI funds only a tiny share (approximately 0.2%) of total health expenditure in the province.

2.2.8 Vertical programmes

Vertical primary health care programmes were also devolved following the 18th Constitutional Amendment. KP has developed and approved an integrated service package comprising maternal, newborn and child health, immunisation, nutrition and population welfare programmes. In KP, approximately 13,500 lady health workers (LHW) provide primary healthcare services. Their services have only been regularised with effect from July 2014.

There are different vertical communicable disease programmes, e.g. the Polio Eradication Initiative (PEI)[6] or the Integrated HIV, Hepatitis and Thalassemia Control Program. Varying with perception, there are roughly 11 vertical programmes in health services provision in KP. There is an initiative to merge seven programmes, including the LHW programme, a nutrition programme, family planning, TB, HIV and hepatitis. A PC-1, the comprehensive project document for submission to Planning & Development, has been prepared for this purpose.

2.3 Data and system requirements

Discussions around an insurance management information system at the provincial level and beyond are ongoing. The National Database and Registration Authority (NADRA) and SLIC have developed and implemented a "central management information system" (CMIS) to serve as an ICT platform for the PMNHP and the SHPI. It is uncertain whether and to what degree the CMIS can be extended towards a system-wide ICT solution.

The architectural design for a future management information system needs to fit the future business requirements that include a range of processes and types of information, such as member administration, budgets and expenditures, provider relations and contracting, service utilisation, performance indicators, risks and fraud prevention. The system also needs to allow quick decision-making and communication of such decisions. In support of this, rapid feedback mechanisms and default reporting for various strategic and management tasks need to form key features. The routine analysis of claims data, for example, will be an important exercise to generate the evidence needed for steering and fine-tuning the components of the wider health system.

Given that the health system in KP and in Pakistan in general will see many changes over the years ahead, the management information system must be dynamic and amenable to change. In the development phases of the management information system, it is important to avoid the risk of supplier lock-in in order to allow for flexibility of future strategic decision, also with a view to system extensions to include further functions and capabilities. Interoperability is, of course, a key feature of the ICT system, as it will be important to keep the platform interoperable with other systems in the health and social sectors.

[6] Fewer children are being missed by vaccinators today, yet Pakistan's polio surveillance system is still detecting the virus in different parts of the country. 2017 has seen five cases across the whole country so far, one in KP.

The architectural design for a **future management information system** needs to fit the **future business requirements** that include a range of processes and types of information, such as **member administration**, **budgets** and **expenditures**, **provider relations** and **contracting**, **service utilisation**, **performance indicators**, **risks** and **fraud prevention**.

3 Towards a people-centred health system

Health reform discussions in Pakistan in general and in KP in particular have rarely emphasised a systemic approach. A broad spectrum of elements within the health system building blocks have been tackled separately. These include service quality and human resources for health, among others.

Striving for a health system that is responsive, i.e. people-centred, and that allows all people within Pakistani society to obtain the health services they need requires a different planning approach.

The planning approach should be based on an initial diagnosis of Pakistan's/KP's current health system performance vis-á-vis intermediate objectives and final health system goals. The focus should be on the entire population and the whole health system, rather than components thereof, such as single schemes. The participatory planning process towards a people-centred health system should take into account a spatial needs analysis and a complete and updated mapping of providers of all levels of care.

3.1 Population coverage

Pursuing the UHC goal implies that steps should be taken to cover the largest possible number of people within reasonable time according to a coherent plan. It will be important to address different socio-economic strata across the widely diverse lifeworlds of the province. Experience with similar processes shows that solidarity - or the idea to be tied into the same system with groups of different socio-economic or socio-cultural status - is not easily accepted by many. Solidarity, which involves the ideas of risk-related and income-related cross-subsidies, cannot be imposed on people, but needs to develop. Stepping up levels of the respective types of cross-subsidies involves meticulous policy-planning. Usually, the realisation of risk-related cross-subsidies, e.g. by enlarging the membership pool and/or introducing risk equalisation, does not automatically imply increased income-related cross-subsidies and vice versa. Health reform moves along a delicate trajectory (Figure 3).

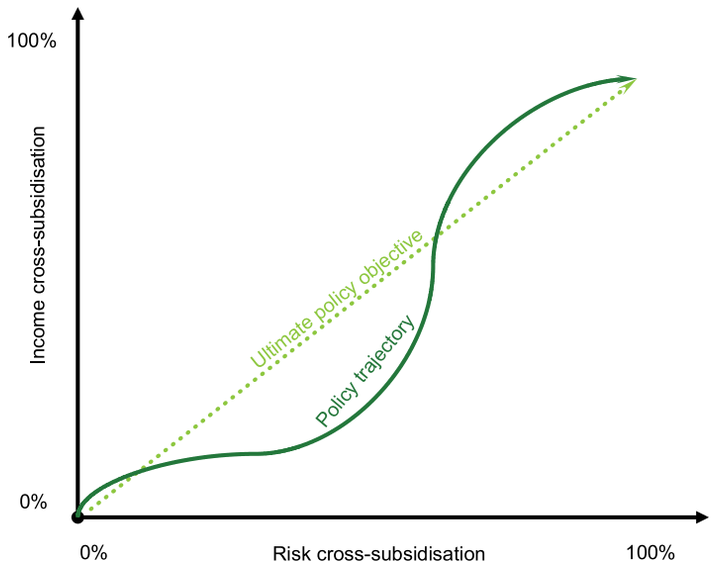

Figure 3: Mastering the tension between risk- and policy-related cross-subsidies

> Across the breadth of the diverse population covered, people should **contribute** according to their **ability to pay**. This implies that the **poor** ought to benefit from **free coverage** and the **better-off** should pay **contributions** in line with their **socio-economic position**.

The tension between the expansion of the population covered under a system of uniform principles and shared structures on the one hand and the need for solidarity to grow on the other hand constitutes the outstanding predicament that policy-makers need to manage. The "privileged" may not be prepared to find themselves covered under the same system with similar rights than the previously "underprivileged".

A decision seems to have been made to utilise the current approaches to social health protection as the basis of building up a system towards the achievement of UHC. With scarce resources (see section 4.3.2) and a large and diverse population to cover, it will be important to draw on different sources of funding as appears appropriate under the principles to be established under UHC. Across the breadth of the diverse population covered, people should contribute according to their ability to pay. This implies that the poor ought to benefit from free coverage and the better-off should pay contributions in line with their socio-economic position.

3.2 Portability of entitlements

As mentioned elsewhere, UHC is, by definition, a concept that does not end at the provincial borders. Ultimately, people should be able to use their health card to utilise health services across the whole country when needed. Currently, there is inter-district portability for both social health protection programmes, the SHPI and the

PMNHP: Using the health card, a resident of one district will be able to access empaneled health care facilities of another district where the respective programme is present.

In practice, people currently even benefit from a certain degree of inter-provincial portability, even if this has not been an explicit feature of any of the two programmes. It is made possible, as the CMIS, which is used by the two programmes' common insurer SLIC, creates one virtual pool of beneficiaries. Therefore a patient with a Sehat Insaf card will receive services covered in the SHPI benefit package in a hospital in Islamabad, for example. As this is owed to the early stage of the initiatives and the specific constellation at this point in time, there is urgent need for regulating the relationship of the two schemes and for carefully drafting a plan for portability of entitlements.

3.3 Integration

From a systems theory angle, integration merely describes the course of action of combining separate subsystems, so that they work together as a complete system; integration does not carry any value in itself. The integration of vertical programmes is not recommendable if the general health system is weak and any additional component would add to the administrative burden (Thiede & Baltes, 2017).

Even though integration has been formulated as an objective by stakeholders in Pakistan, it will be important to carefully analyse whether and how vertical programmes can be integrated.

The merits of integration, such as increased effectiveness, efficiency, equity or sustainability of the health system need to be argued for each individual case. The benefits of integration depend on the health system's preparedness, which can be assessed along different dimensions: Financing, delivery, coverage and governance.

4 Health financing in Pakistan and Khyber Pakhtunkhwa

4.1 Overview

Fiscal support for health has been traditionally low in Pakistan. Health has not been a political priority up to 2013 (Nishtar et al., 2013). Since then, the picture has been changing, albeit slowly. A comprehensive public debate has yet to follow.

Health expenditure per capita amounted to 36.16 USD (current USD) or 128.99 USD (constant 2011 international USD, PPP) according to the WHO Global Health Expenditure Database (2014 data; apps.who.int/nha/database). Government expenditure for health as share of total government expenditure is low at 4.7%. As general government expenditure as a percentage of GDP is low in comparison with other countries (a mere 19%), government health expenditure as a share of GDP appears particularly low (0.9%).[7]

Private health expenditure amounts to 1.7% of GDP, a share of 64.8% of total health expenditure (THE). 56.3% of THE is paid out of pocket.[8]

4.2 National Health Accounts 2013/14

The latest National Health Accounts data (Pakistan Bureau of Statistics, 2016) show a government share in KP of little over a fifth of THE in 2013/14 (Table 1).

This picture has been changing with the Government of KP's dedication towards funding social health protection. For example, according to the Annual Development Plan (ADP) 2017/18, the KP Government has allocated 5.3 billion PKR to Phase II of the Social Health Protection Initiative, 3.3 billion PKR in 2017-18 (Government of KP, 2017b), i.e. the Initiative's expansion to include less poor segments of the population as well as to cover all districts within the province (see 2.2.6).

[7] This level compares to Laos and Nigeria; the level reflects the second lowest in the world after Bangladesh (0.8%) (The average of low- and middle-income countries is 3.0%).

[8] NHA data (Pakistan Bureau of Statistics, 2016) indicate an even higher share of out-of-pocket payments for 2013-14, 60.2% of total health expenditure.

	Expenditure (million PKR)	Expenditure (%)
General Government	**22,548**	**21.3**
Federal Government*	2,103	2.0
Provincial Government	19,777	18.7
District/Tehsil Government	85	0.1
ESSI	223	0.2
Zakat Council	33	0.0
Bait ul Mal	205	0.2
Autonomous Bodies/Corp.	122	0.1
Private Sector	**82,460**	**77.8**
Private Health Insurance	-	0.0
OOPs	71,754	67.7
Local NGOs	10,706	10.1
International Donors	**1,020**	**1.0**
Total	**106,028**	

*here: Military

Table 1: Total health expenditure in Khyber Pakhtunkhwa 2013-14 (Source: Pakistan Bureau of Statistics, 2016)

As in many countries who are currently in the process of "consolidating" their health systems with a view to moving towards UHC, in Pakistan there are different competing or parallel health protection initiatives as well as vertical programmes, different mechanisms are targeted at different segments of the population and there is a need to overcome fragmentation.

4.3 Budgets

4.3.1 Federal budget

The total outlay of the 2017-18 federal budget is 5,103.8 billion PKR, reflecting an increase of 4.3% over the previous fiscal year (Government of Pakistan, 2017). The provincial share has increased over-proportionately: At 2,384.2 billion PKR, it exceeds the budget estimates for 2016-17 by 11.6%.

The fiscal goals, which include a significant decrease in current fiscal deficit, contribute to restricting 'fiscal space' and thereby limits the flow of additional resources into development activity, including health-related activities. Despite these pressures, the Government of Pakistan has undertaken significant efforts to ensure additional resources on a range of sectors including human development, reflected in projects for higher education and health sector service delivery.

Under the head of Health Affairs and Services, the federal budget allocates 12.8 billion PKR in 2017-18, 3.8% above the revised estimates for the fiscal year 2016-17.

4.3.2 Provincial (KP) budget

Revenue

The National Finance Commission (NFC) allocates the provincial shares of federal revenue according to a multiple-criteria formula based on the criteria population (82%), poverty and backwardness (10.3%), revenue collection/generation (5%) and inverse population density (IPD) (2.7%). Further, there is an allocation from the so-called Divisible Pool for the War on Terror. KP's share of the divisible pool, i.e. the total allocation of federal money to the provinces, is 16.42% in 2017-18.

General revenue receipts basically comprise the transfers from Federal Government and KP's own tax and non-tax revenue. Of total general revenue receipts reflected in KP's 2017-18 budget 470.8 billion PKR, 90.4% (425.4 billion PKR) reflect federal transfers.[9] Federal transfers comprise of shared taxes, straight transfers (revenue from oil and gas) and other grants including net profits from hydroelectric ("hydel") power generation and arrears.[10]

Over recent years, the provincial budget of KP has increased steadily. Only the 2016-17 budget saw a modest increase of just about 3% above the previous fiscal year. The 2017-18 budget is projected to reflect an increase of 19%.

The provinces' own receipts, composed of tax and non-tax receipts, are estimated to increase by 15% over the previous fiscal year, which may turn out to be optimistic given the government's inclination to maintain a policy of austerity. Overall, there is little elbowroom for the province to increase provincial revenue. Provincial own tax receipts stem from the following sources:

- Direct taxes
    - Taxes on income (agriculture)
    - Property tax (85% to be passed on to districts)
    - Land revenue
    - Taxes on professional trades and callings
    - Urban capital value tax

- Indirect taxes
    - Sales tax on services
    - Provincial excise

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[9] The actual transfers from Federal Government have tended to be significantly lower than the KP share communicated in the budget estimates. In the fiscal year 2016-17 the actual transfer was about 13% below the figure given in the budget estimate.

[10] Net profits earned by the Federal Government or any agency established or administered by the Federal Government, from power generation at a hydro-electric station are to be transferred to the Province in which the station is situated, according to Article 161(2) of the Constitution of Pakistan. Arrears result from previous differences between the Province and the Federal Government over the amount, which have largely been resolved in an arbitration process.

- Stamp duty
- Motor vehicles tax
- Other

Sources of provincial non-tax receipts are

- Income from property and enterprises
- Civil administration
- Community services
- Economic services
- Miscellaneous

What is the envisaged expenditure on health within the provincial budget?

On the expenditure side of the budget, current expenditure needs to be distinguished from development expenditure. The third largest budgetary allocation for any single service delivery area in the current expenditure section of KP's 2017-18 budget goes to health (26.9 billion PKR), after public order and safety affairs (49.8 billion PKR), and immediately following education (27.6 billion PKR) which, however, includes health education. A look at the relative position of the areas within current revenue expenditure shows changes over the years, e.g. based on the revised estimates of the previous two fiscal years, the relative positions of health and education were reversed.

The KP Government sees the provision of quality health services as a priority. Institutional reforms include the statutory autonomy of all major hospitals in the province under independent Boards of Directors. Payment of health professionals has been increased.

The sectoral analysis presented in the Finance Department's White Paper (Government of KP, 2017c) highlights the 39% increase in the allocation for the Health Department in the budget estimates 2017-18. The total budget earmarked for the Health Department (current revenue expenditure as well as development expenditure) is reflected in Table 2.

Expenditure (million PKR)	Budget estimates 2016-17	Revised estimates 2016-17	Budget estimates 2017-18
Current revenue expenditure	**25,521.645**	**31,670.624**	**35,496.385**
Salary	17,534.840	19,380.084	23,623.372
Non-salary	7,986.805	12,290.540	11,873.013
Development expenditure	**17,479.114**	**14,396.039**	**16,474.710**
Total	**43,000.759**	**46,066.663**	**51,971.095**

Table 2: Allocation to Health in Budget Estimates 2017-18 (Source: Government of KP, 2017c)

Table 2 reflects a 12% increase of the budget estimates 2017-18 for current revenue expenditure as compared to 2016-17. It also shows a 22% increase in salaries paid out of that amount. At 14%, the increase in development expenditure dedicated to health projects is worth noting. Yet the budgeted amount is lower than the original estimate for 2016-17.

The provincial health budget includes provincial health institutions but also grant-in-aid to medical teaching institutions. An estimated 13.8 billion PKR out of the province's health budget will be transferred to the district health offices.

The total Annual Development Programme (ADP) for KP sums up to 208 billion PKR, signifying an increase of 21% over the revised estimates for the previous fiscal year. Nearly 40% of the development portfolio will be financed through foreign assistance. The share of foreign assistance in the development expenditure reflected in Table 2 amounts to 27%. Over the last fiscal year, foreign aid increases by 127% to a total of 82.0 billion PKR, out of which 36% comes as grants and 64% as loans. A comparison of the original budget allocation and the revised estimates for the fiscal year 2016-17 shows that the expected share of foreign assistance was higher. It will also be crucial for the health sector that foreign assistance be made available in time and as per the agreements with the KP Government. Foreign assistance allocated to health projects amounts to 4.5 billion PKR in 2017-18.

The local funding for health projects within the ADP amounts to 12.0 billion PKR. Table 3 shows the allocation according to sub-sector.

Sub-sector	Allocation (million PKR)
Basic Health	4,012.724
General Hospitals	2,147.124
Medical Education & Training	1,211.897
Miscellaneous Health	0.001
Preventive Programme	1,560.246
Teaching Hospitals	3,067.008
Total	**12,000.000**

Table 3: Development expenditure (local) for health 2017-18 (Source: Government of KP, 2017a)

Apart from a range of projects focusing on the upgrading of primary care facilities, the sub-sector 'Basic Health' includes funding for the Financial Management Cell, the Planning Cell, the HSRU, and the strengthening of the District Health Information System (DHIS). Importantly, it also this sub-sector also includes funding for the SHPI.

'Miscellaneous Health' reflects a token local contribution to the USAID-funded Health Initiative with a focus on maternal, newborn and child health.

The ‘Preventive Programme’ comprises various vertical initiatives around immunisation and disease control (including the KfW-assisted project on safe blood transfusion).

Medium-term budget estimates

The Medium Term Budget Estimates for Service Delivery consider a time period of three years. The current version covers fiscal years 2017-18 to 2019-20 (Government of KP, 2017d). Within the health section of this framework, the Health Department’s policy emphasises the upgrading and optimal usage of health facilities. Yet the medium term budget also acknowledges SDG 3 and further highlights social protection for low income and vulnerable groups. Further focus areas are capacity building for evidence- and outcomes-based planning as well as a focus on community-led health programmes.

Medium-term budget planning in KP defines concrete outcomes and outputs. Among the outcomes, the goals of enhanced health coverage and access to essential health services complement the goal of reducing the burden of disease. The other listed outcomes constitute important preconditions for UHC: Improved human resource management, improved governance and accountability and improved health regulations.

Medium-term budget planning allocates funds to the pre-defined outcomes and outputs. The single largest outcome category across the upcoming fiscal years is the enhancement of coverage and access to essential health services. At 35.5 billion PKR, the allocation amounts to 68.3% of the total provincial health budget for 2017-18.

Planning capacity at the KP Health Department

According to stakeholders, capacity at the Health Department in preparing output-based budgets has increased in recent years. Units with thematic as well as managerial expertise have been established.

Across the province, the last decade has seen enormous progress in planning and public financial management capacity, to some degree owing to the introduction of the Integrated Financial Management Information System (IFMIS), implemented through the World Bank’s Pakistan Improvement to Financial Reporting and Auditing Project (PIFRA). Geographic information system (GIS) cells have been established in six districts (now expanding into eight more districts) that will help district administrations to improve monitoring and planning of health services as well as budgeting for service improvement.

Capacity for the design, planning and monitoring of the steps towards a health system in line with the principles of UHC is a core requirement of the government departments involved in health reform, particularly the Health Department.

Is there fiscal space for health in KP?

Fiscal space is commonly the term used for the possibility of creating room within the budget to allow government to provide resources for public purposes without undermining fiscal sustainability and economic stability. Given the high degree of dependence on transfers from the Federal Government, fiscal space is limited.

As highlighted in section 4.3.2, there is hardly any scope at provincial level to increase revenue from taxes given the current tax structures and the arrangement of transfers from the federal level. Given the structure of the country's economy, the tax ratio can be expected to grow steadily but slowly over the next decade, but the idea of tax-funding the larger share of the country's future health system is unrealistic.

Over recent years, the discussion of fiscal space for health has often been associated with the lively discussion of alternative or "innovative" financing sources. The World Bank has defined "innovative" financing as "financing...that helps to generate additional development funds...enhance the efficiency of financial flows...[or] make financial flows more results-oriented" (World Bank, n.d.).

An increase of indirect taxes to expand fiscal space has been seen with scepticism, given the latent regressivity of value-added tax (VAT), i.e. the fact that it may negatively impact low-income households. Ghana's National Health Insurance Levy (NHIL) is raised in the form of a 2.5% mark-up on VAT that is earmarked and finances approximately 70% of the National Health Insurance Scheme; the levy is "mildly progressive" (Akazili et al., 2011).

Simple further options to widen fiscal space include an increase in excise taxes such as "sin taxes" on tobacco. Earmarked financial transactions taxes (FTT) - occasionally known as "Robin Hood taxes" - have also been considered in health financing. FTTs have been subject to heated debate in high-income countries ever since they were first proposed by John Maynard Keynes in the wake of the Great Depression and later by fellow economist James Tobin as a tax on currency spot conversions. Some countries have earmarked revenue from FTT, e.g. Brazil, where FTT revenue supports local government to fund health programmes (Beitler, 2010). The potential of FTTs to raise revenue to protect key public services such as healthcare needs to be further analysed.

Development impact bonds (DIBs) and social impact bonds (SIBs) have been proposed as sources of revenue for the health sector. These resemble outcome-based contracts between donors or the public sector on the one hand and private counterparts, such as private sector firms or individuals, on the other. They are based on the assumption that certain programmes lead to considerable improvements in social outcomes, here: health outcomes. If health outcomes improve, government would repay investors for their initial investment plus a return for the financial risks; if the envisaged outcomes are not achieved, the investors may lose their investment (Social Finance, 2013). Private engagement would be socially motivated and cover the costs of a particular programme under the risk of under-performance, in the case of which investors would not get repaid.

Fiscal space is also jeopardised from the expenditure side: Health planning in KP suffers from a dilemma that is well known in resource poor settings. In order to tackle under-provision in terms of service availability and service quality, more medical staff is hired, but the additional HR expenditure poses an enormous burden on the budget and significant throw-forward liabilities, including an ever-increasing pension envelope.[11] The increasing number of health staff in KP will stand in the way of any attempt to move towards an output-oriented reimbursement system.

Yet in looking forward, the improved use and performance of KP's existing public resources need to be further scrutinised. In the international UHC discussion, there are voices who emphasise that relying on on earmarked mechanisms for the purpose of introducing or expanding social health insurance may be limiting. Such mechanisms should only be considered as one component within a range of domestic resource mobilisation strategies (Barroy, Kutzin et al., 2017). Thus, despite the tight frame, policy options on the revenue and on the expenditure side of the budget should be explored with rigour.

4.4 Health financing strategy - exploring pathways

Health financing will be a key topic for the development of a UHC strategy, and a health financing strategy will form an important component within the overarching strategy. The central elements or "chapter headings" of the health financing strategy are "fixed"; They will comprise the policies and arrangements for:

- Revenue sources and contribution mechanisms
- Pooling of funds
- Purchasing of services
- Policies on benefit design, rationing and the basis for entitlement
- Governance of these financing functions and policies (Kutzin et al., 2017)

Whereas the elements of a health financing strategy are consistent across countries, the actual shape and content of a future strategy will need to take into consideration Pakistan's/KP's health system performance relative to the UHC goals and objectives, which will need to be explicitly stated. Even though the exercise foresees the design of a strategy for KP as a first step, the fit with a future system within which the provincial approaches form parts of a coherent whole needs to be taken into account. The strategy needs to be designed with the entire population in mind and not specific components or individual schemes. As the comprehensive UHC strategy, the health financing strategy will be designed on the basis of a consistent timeline.

[11] Total salary expenditure in the KP budget shows an increase of about 13.6% per annum over the last 5 years. Over the same time, expenditure for pensions more than doubled.

4.5 Aligning PFM and health financing

Sustainable financing for UHC comprises sufficient financing, the equitable and efficient use of resources as well as financial management and accountability (Cashin, Bloom et al., 2017). In Pakistan/KP, public resources will be critical in ensuring efficient and equitable progress towards UHC.

Pakistan's public financial management (PFM) system (institutions, policies and processes) will play a critical role. PFM in Pakistan, as it has been developing in the years after the 18th Constitutional Amendment to devolve education, health, and substantial resources to the provinces, ought to be scrutinised and assessed with a view to health financing reform under the UHC objective. In some countries, fiscal decentralisation has been observed to be in conflict with the health financing objective to increase national pooling of health funds.

Devolution also means that the provinces are basically independent to develop their own approach to providing social health protection for their citizens. This has encouraged provinces in Pakistan to explore different approaches to social health protection, initially with a focus on the poor in the informal sector.

In KP, PFM has been high up on the agenda. In April 2017 KP formulated a PFM Reform Strategy 2017-2020 just to replace the Integrated PFM Strategy 2010 (Government of KP, 2017c). Under the overall aims of aggregate fiscal discipline, allocative efficiency and operational efficiency, the new PFM Strategy follows six key policy objectives:

1. Ensuring policy driven planning and budgeting;
2. Facilitation of a comprehensive, credible and transparent annual budget;
3. Improving predictability and control in budget execution;
4. Enabling resource mobilisation and enhancing provincial own-source revenues;
5. Improving asset and liability management; and
6. Fostering accountability for results.

Both the World Bank and DFID have committed to providing technical support to the Government of KP in implementing the PFM Strategy.

Under the heading of PFM, a Strategic Development Partnership Framework (SDPF) was adopted, establishing peer-to-peer relationships between the KP Government and its development partners around eight key thematic areas, including enhanced fiscal space, improved citizen participation, and improved transparency and accountability. The Integrated Development Strategy (IDS) was formulated to operationalise the SDPF and to realign government policies and priorities, including how these are reflected in the ADP (Government of KP, 2014).

Public financing plays a key role in progressing towards UHC (Barroy, Vaughan et al., 2017). Thus public commitments to the health sector in Pakistan should be safeguarded and further strengthened.

A systematic **analysis** of **fiscal space for health** is a **prerequisite** of the development of a **health financing strategy** for KP.

Pakistan still has rather low tax revenue-to-GDP ratio at 11.0% (Miller & Kim, 2017).[12] Fiscal space for health has not been assessed for Pakistan and its provinces. A systematic analysis is an important prerequisite of any exercise to develop a comprehensive health financing strategy.

There are many further associated questions. An example is the discussion as to whether and how revenue should be earmarked for health care. Earmarking is a political choice and it is often unclear on the basis of what information, economic or ethical justification the decision should be made. There is some evidence that may indicate a less pronounced relationship between earmarking, revenue generation for the health sector and the achievement of UHC goals (Cashin, Sparkes et al., 2017). In any case, earmarked taxes require strong PFM systems in place.

Among the achievements of the Health Department in 2016-17 were the establishment of a Financial Management Cell in the Health Secretariat as well as the establishment of a Procurement Cell at the DG Health Service's office, both funded from the development budget. Also the strengthening of the Health Department's Planning Cell, the Health Sector Reform Unit (HSRU) and the Independent Monitoring Unit (IMU) shape the preconditions for improving PFM in the province's health sector.

4.6 Budgeting for UHC

Output-based budgeting (OBB) is already reflected in KP's medium-term budget estimates. These constitute a prime tool for linking policy, planning and budgeting with a view to improving service delivery. Budget estimates have been prepared with reference to performance benchmarks for each administrative department.

UHC is a goal associated with a medium- to long-term perspective. Milestones must be defined for every activity area of health reform towards UHC in line with the policy or UHC strategy and will need to be converted into meaningful outcomes/outputs within OBB within the constraints of fiscal space. The links between policy and budget formulation should be worked out well and should be credible. Ultimately, political commitment is key.

The macro-fiscal realities as well as the ways in which resources are commonly allocated must be taken into account in the planning exercise. Sufficient and stable resources are necessary to reach the UHC-related objectives.

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[12] India's tax revenue-to-GDP ratio ranges only slightly higher at 16.6%. Turkey's tax burden, in contrast, equals 28.7% of total domestic income.

More often than not, practice shows that the timing of such reforms and the time required for the achievement of milestones are not fully predictable. Just as the overall set of project plans, the OBB framework needs to be designed such as to accommodate variations. However, this should not be interpreted as a relaxation of the rules that should apply to PFM.

4.7 A note on provider payment

The payment of providers lies at the heart of the vision of the realisation of UHC. If well designed, provider payment will significantly contribute to system efficiency. Provider payment relates to all the other design features of the health system, including the priorities. As is well understood among stakeholders in Pakistan, a purchaser-provider split is useful to ensure that any provider incentives through payment reform can be effective, for example, as providers would be free to make decisions on human resources.

Provider payment should reflect the principles and objectives of the reform effort. Yet provider payment is one of the functions that are linked to many other components of the system. Payment reform usually requires further changes in other areas of the system and is therefore difficult to plan and to implement. Substantial legal changes form one area that demands particular attention. Payment reform also requires considerable time for (phased) implementation and efforts to change behaviours.

Provider payment is also data intensive. The introduction of a comprehensive prospective payment system, for example, requires detailed patient/claims data as well as good quality cost data.

5 Benefit package design

5.1 Criteria for defining and expanding a benefit package

Aspects to be considered for **benefit package design** include the **direct cost associated with a disease**, different **health technologies** available, the **burden of disease** and its **development over time** (incidence, prevalence and duration of specific diseases in focus as well as their causes), as well as different **patient groups** and their **respective characteristics**, and the **political economy,** including different stakeholder perspectives.

On different occasions, stakeholders have expressed the wish to include “all needed care” in a “comprehensive” benefit package. Designing a coherent package that addresses people’s needs comprehensively and ensures quality is not a trivial task in the light of considerable resource constraints.

The benefit package needs to reflect the same principles that apply to the whole health system in the light of UHC. In order to ensure that services within the benefit package are adequate in the light of people's needs and also cost-effective, an explicit process of identification of health services to be included in the package needs to be in place. The inclusion criteria must be plausible and transparent.

Internationally, different approaches to setting priorities in benefit package design have been chosen, depending on historical as well as politico-economic context, fiscal and budgetary consideration and stakeholder influence (Glassman et al., 2017). It is not seldom that benefit package design starts with a list of services addressing priority diseases or treatment to address the greatest needs.

This has been the intention in the compilation of the original SHPI benefit package, which included specified maternity-related care and a list of 497 medical procedures in empaneled secondary hospitals. This benefit package is based more on the experience and intuition of its designers than on health economic criteria (including cost-effectiveness and equity), but it is generally regarded as successful, even if the view is often expressed that outpatient services need to be included.[13]

In KP, there is agreement among policy-makers that outpatient services should become part of the benefit package available with the Sehat Insaf card. The degree to which the benefit package should include services beyond the curative is unclear, however. Even if - according to the international discussion - UHC should comprise preventive, promotive, and palliative services apart from curative, the feasibility of achieving the desired breadth of the benefit package in the context of poor countries is limited.

Given the objective of UHC to reduce the incidence of impoverishment caused by ill health, the design of the benefit package should first and foremost ensure that the main health-related economic risks are covered. The way in which this is best achieved depends on the specific context. Aspects to be considered include the direct cost associated with a disease, different health technologies available, the burden of disease and its development over time (incidence, prevalence and duration of specific diseases in focus as well as their causes), as well as different patient groups and their respective characteristics, and the political economy, including different stakeholder perspectives. Depending on the relevance of each of these aspects in determining the urgency of a particular health service (as assessed by the relevant stakeholders), inclusion criteria need to be formulated.

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[13] Frölich and colleagues (2016) make a point in highlighting that - based on their insight - critical inpatient services are missing from the package, e.g. treatment of sexually transmitted diseases, particularly HIV/AIDS and all diseases caused by and/or related to HIV, injuries resulting from war, riots and terrorism, as well as mental disease. They also point out the need to pay attention to the rise of non-communicable diseases (NCDs), deeming the inclusion of preventive services necessary. Yet, Frölich et al.'s suggestions are also not based on rigorous inclusion criteria.

The challenge remains as to how the "good" afforded with available funds can be maximised. A systematic approach to priority setting needs to be adopted. Cost-effectiveness analysis (CEA) is a tool that is applied in different countries in decision-making around benefit package design. CEA may be helpful but not sufficient when it comes to tying a package that combines a broad variety of health services or interventions. It will be important to understand the actual budget impact associated with a particular package. The interplay of services over time becomes important. Budget impact analysis (BIA) needs to be combined with the analysis of potential scenarios. One of the key challenges of benefit package design lies in the requirement to project the key variables into the future, as historical information may not be suitable to characterise the context to be addressed with the optimised package.

Examples of systematic approaches to priority setting are often taken from high-income countries, yet different middle-income countries are well on their way to provide leadership when it comes to investing in priority-setting institutions: Thailand's Health Intervention and Technology Assessment Program (HITAP) is a prime example.

In practice, the main barrier to the realisation of approaches towards the optimisation of benefit packages lies in the lacking availability of required data. Different types of data would be required in order to ensure appropriate evidence for benefit package design. While there is abundant information available internationally in the form of published evidence on interventions and health technology, a systematic approach towards producing local evidence will be required. This implies the need for significant initial investment in data and monitoring systems.

5.2 Towards a uniform package

In the context of health reform in Pakistan towards UHC, putting a focus on the harmonisation of benefit packages across different schemes as they emerge will be vital. The equity principles reflected in UHC imply that health services should be made available to people based on need - and should therefore not differ according to membership in a particular scheme. No matter under what "label" envisaged contributory schemes such as a government employees' scheme will be implemented in KP, they should feature the same basic benefit package as the non-contributory schemes.

Apart from the equity objective, a uniform package is a prerequisite for the design of a transparent approach to risk equalisation.[14] The health reform process should ensure that funds would be pooled across revenue sources (i.e. contributory and

[14] Different countries (Argentina, Colombia, Mexico, and Thailand) have encountered difficult trade-offs between equity and financial sustainability as a result of divergent benefit packages between their respective social health insurance schemes on the one hand and the non-contributory (autonomous) programmes on the other (Cotlear et al., 2015).

non-contributory schemes) in order to reduce fragmentation and enhance the redistributive capacity of the system. Rigorous planning in line with set principles will enable pre-empting of fault lines.

5.3 Institutional requirements

Operating, monitoring and updating the benefit package require a solid governance framework. KP stakeholders have expressed the desire to institutionalise the upkeep of the benefit package. An "office", an "institute" or a "working unit" should be responsible for ensuring that the uniform benefit package is compiled and updated based on state-of-the-art decision-making according to principles to be laid out in the respective legislation.

The terms will have to be decided under which such a unit would operate, to what degree decisions would be taken by the unit, or simply recommendations made to another responsible body within future structures. It will be worthwhile for policy-makers in KP to study relevant set-ups in other countries. For example, it would be advisable to consider the role of HITAP in Thailand and to study the ideas for the National Health Insurance (NHI) Benefits Advisory Committee envisaged in South Africa. Obviously, there are also elements of respective structures with relevance for policy-making in Pakistan to be found in high-income countries, regarding, for example, the United Kingdom's National Institute for Health and Care Excellence (NICE) or the interaction between the Institute for Quality and Efficiency in Healthcare (IQWiG) and the Joint Federal Committee (G-BA) in Germany.

The design and implementation of structures to support a fair, progressive realisation of a uniform benefit package require synchronisation with the development of other parts of the system. Decisions that have already been made, e.g. on the set-up and legal form of the Health Care Commission (HCC), will also impact on the future format and position of the institution responsible for benefit package design. The way in which good governance will be realised in the future Pakistani health system also determine communication and participation in decision-making around the benefit package. In terms of modes of operation, for example, the role of civil society must be addressed from the outset: How are civil society standpoints taken into account, how will civil society be involved in benefit package design (e.g. in the form of citizen forums)?

An "**office**", an "**institute**" or a "**working unit**" should be responsible for ensuring that the **uniform benefit package** is **compiled** and updated.

6 Governance framework for the process

6.1 Principles of process governance

Good health system governance is a prerequisite for equity, efficiency and sustainability in the financing and provision of healthcare services, but establishing governance principles for the reform process itself is just as important. Any change process that impacts on different stakeholder groups within society requires participation, transparency and accountability.

Participation is often not taken seriously enough in reform processes. Here it refers both to the contribution of voluntary labour as well as active participation in political processes. Participation is particularly important to address one of the main conflicts that health reform must resolve: Efficiency and budget control versus equity and improved livelihoods.

Transparency should begin at the community level with the public being made aware of health reform issues. Regular and comprehensive stakeholder communication is critical for policy success. This implies that stakeholder consultations ought to be institutionalised – also in the reform process as such.

Responsiveness of a health reform process to the expectations of the system's clients should result automatically if the process respects the principles of participation, transparency and accountability, i.e. good governance. Legitimacy ought to be established in two directions, upward and downward (Thiede, 2016). An example of the upward characteristic of legitimacy is the realisation of the right to participate (and to vote). The downward perspective describes the accountability of stakeholders at the policy level towards their constituency.

Determining a governance framework for the reform process will have to be one of the first steps ahead. The governance framework will have to specify modes of inter-provincial coordination for this policy area that build on existing mechanisms.

6.2 Managing the complex network of stakeholders

There is often little understanding among policy-makers regarding the requirements and needs of other stakeholders in health reform, such as the needs of hospital managers in remote districts or patients with chronic diseases. Key stakeholders in KP's process of health reform towards the UHC goal have been identified by means of stakeholder dialogue and an associative exercise at a meeting with policy-makers (see section 2.1.4).

Managing the network of stakeholders and assigning roles and responsibilities adequately in a way that is both socially responsible and oriented towards effectiveness is as critical for the successful reform process as it is difficult to accomplish. The process needs to be shaped without creating premature structures that may pre-empt inefficiencies.

The initial steps of managing the multi-stakeholder network will require setting up formal agreements, project structures and task teams. It will be the leading stakeholder's (i.e. the Health Department's) responsibility to create a common understanding of the collaborative approach. The leading stakeholder will also be responsible for integrating capacity building and for establishing feedback mechanisms.

6.3 The relationship of the UHC process and the Health Sector Strategy

The Health Sector Strategy 2010-17, collaboratively developed between the KP Department of Health and the Technical Resource Facility (TRF; now: TRF+), a technical support initiative funded by DFID with a main focus on reproductive, maternal, newborn and child health (RMNCH) as well as nutrition, has been extended into 2018. A new health sector strategy for KP is being planned for launch in 2018.

The UHC strategy and the health sector strategy, which aims at "[improving] the health status of the population in the province through ensuring access to a high quality, responsive healthcare delivery system which provides acceptable and affordable services in an equitable manner" (HLSP, 2010, p. 2), resemble two sides of the same coin. It will be important to ensure that the UHC goal and the associated reform process will be adequately reflected in and coordinated with the health sector strategy. The health sector strategy should provide the comprehensive overview of outcomes and indicators and form the basis of an all-inclusive monitoring system.

6.4 Monitoring

A strong system for monitoring and evaluation (M&E) is essential for effectively pursuing UHC (WHO, 2014). Fair progressive realisation of UHC must involve M&E of resources, coverage and health outcomes. In the context of process governance, the process of policy formulation itself ought to be monitored and evaluated.

Fair progressive realisation of **UHC** must involve **monitoring and evaluation** of **resources**, **service coverage** and **health outcomes**, and of the **policy process.**

M&E of resources requires tracking specific categories of expenditure by financing source. The respective information is best gathered by institutionalising the System of Health Accounts (SHA)(OECD/Eurostat/WHO, 2011). Monitoring on the basis of SHA would ensure, inter alia, that the patterns of out-of-pocket expenditure would be tracked – currently a major obstacle towards equity. SHA would contribute to achieving transparency (see section 6.1) and ensure that civil society can follow, criticise and challenge the process.

M&E of service coverage is of critical importance to accountability and participation. The selection of the right indicators is extremely difficult. Here, the M&E exercise will serve the continuous adaptation to challenges in service delivery and the fine-tuning of the reform process.

Monitoring health outcomes (based on ever-improving health information systems) will assist in achieving both wide-ranging health improvement and a fair distribution of health in society. Again, appropriate feedback should ensure that reform processes pick up on the data without delay to ensure that health services are responsive to health needs and socioeconomic differences in needs.

6.5 UHC Task Force

The idea of a UHC Task Force was developed at a Round Table with stakeholders that took place in Islamabad on 28 September 2017. The term “steering committee” that was also used may not be quite appropriate for the envisaged multi-stakeholder body, as the term is commonly linked to the context of a project, rather than the long-term processes towards UHC, which comprises numerous projects that require coordination and which is - so far - open-ended.

The purpose of the Task Force would be to design the strategy towards UHC, to set goals and outline a roadmap, to ensure that a transparent process is brought on track and appropriately monitored, and ultimately to advise the Minister of Health on the development of respective policy and legislation. The Task Force may also recommend the commissioning of research works as deemed appropriate.

The composition of the Task Force needs to reflect the **multitude of stakeholders**. While the largest possible representation should be ensured, the Task Force should be kept at manageable size. The Task Force ought to be a forum of experts from **all areas concerned**, supported with international expertise. Apart from generating relevant ideas and proposing the design of the health system, the duties of the Task Force would include regular information of the public as to be agreed with the Ministry of Health. A secretariat to be established at the Ministry of Health that will include the HSRU shall support the work of the Task Force and ensure continuity of the process.

The Task Force should comprise at least one official from the KP Health Department and representatives of other relevant government departments, including Finance and Planning & Development. Identified key stakeholders should be included, particularly representatives from the group of public and private healthcare providers, representatives from the insurance industry, from the healthcare products industry, from civil society, religious institutions, and academia. As the Task Force will have to be built on expertise, its composition needs to reflect proficiency in the medical field, in public health, in health economics, health financing, information systems and actuarial science. Long-term commitment is required in order to ensure continuity and steadiness of the process.

The Task Force should be obliged to invite submissions of interested parties on different aspects of health reform. It ought to be given the freedom to consult with any authority, entity or person necessary in order to achieve set goals.

The **purpose** of the **Task Force** would be to **design** the **strategy** towards UHC, to **set goals** and outline a **roadmap**, to ensure that a **transparent process** is brought on track and appropriately **monitored**, and ultimately to **advise** the **Minister of Health** on the development of respective policy and legislation.

7 Outlook

As Pakistan is gearing up for general elections in 2018, health will be high on the contesting parties' agendas. Given Pakistan's commitment to UHC, the timing may be right to initiate a concerted health reform effort towards UHC.

The KP Government has indicated the province's dedication to UHC and specified that social health protection coverage of the poor population across all districts represented a step in that direction. Planning has already extended to other population groups, yet a vision of the eventual design of the health system is outstanding.

This Guiding Document tries to lend shape to ideas communicated by different stakeholders and to link them to principles and experiences in order to distil action areas, guidance and priorities for the design of a roadmap and the organisation of the policy process under a UHC strategy. It is meant as an initial synopsis of some of the key topics along the path to UHC against the background of the current discussion in Pakistan.

Political consensus needs to be reached at the highest level before major health reform can be initiated. The preceding sections sketch the framework for cooperation once the decision has been made to move ahead. The processes will be complex and interlinked. Policy-making will require systemic and intersectoral thinking.

Budgets will certainly determine the feasible scope and duration of the reform project. This will be particularly true in the short to medium term, as the health financing strategy will be under development. The success of major policy projects depends on the key stakeholders' sustained engagement beyond the first wave of excitement and public attention. The success of health reform projects in particular depends to a large degree on the thoroughness of the financing approach. It will be important to develop a clear idea of the cornerstones of the health financing strategy that will reflect the design features with a view to the health financing functions - collection of funds, pooling, and purchasing/provider payment. Along the duration of the process, it will be important to budget appropriately for the reform process (development budget vs. current budget).

The policy process towards UHC ought to reflect the central functions an efficient health system fulfils towards the economy as a whole. A system that impacts positively on people's health and the quality of life of all Pakistanis and that significantly reduces the economic consequences of ill health could stand as a backbone for the country's economic and social development.

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