



Health Financing Progress Matrix assessment Pakistan 2023

Summary of findings and recommendations



World Health
Organization

Health Financing Progress Matrix assessment **Pakistan 2023**

Summary of findings and recommendations



**World Health
Organization**

Health Financing Progress Matrix assessment, Pakistan 2023 summary of findings and recommendations

ISBN 978-92-4-008493-3 (electronic version)

ISBN 978-92-4-008494-0 (print version)

© World Health Organization 2023

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization (<http://www.wipo.int/amc/en/mediation/rules/>).

Suggested citation. Health financing progress matrix assessment: Pakistan 2023 summary of findings and recommendations. Geneva: World Health Organization; 2023. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

Sales, rights and licensing. To purchase WHO publications, see <https://www.who.int/publications/book-orders>. To submit requests for commercial use and queries on rights and licensing, see <https://www.who.int/copyright>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

Design and layout by Phoenix Design Aid, Denmark

Contents

| | |
|---|------|
| Acknowledgements..... | v |
| About the Health Financing Progress Matrix..... | vi |
| About this report..... | viii |
| Abbreviations | ix |
| Methodology and Timeline..... | x |
| Executive summary of priority areas | xii |
| | |
| UHC Performance in Pakistan | 1 |
| Summary of key findings by assessment area | 4 |
| Detailed findings and recommendations by desirable attributes of health financing | 6 |
| | |
| Stage 1 assessment..... | 11 |
| Stage 1. Health coverage schemes and programmes in Pakistan | 12 |
| Health expenditure by Stage 1 coverage schemes..... | 14 |
| | |
| Stage 2 assessment..... | 15 |
| Summary of ratings by assessment area..... | 16 |
| Performance rating by question..... | 17 |
| Performance rating by UHC goals..... | 18 |
| Performance rating by intermediate objective | 19 |
| | |
| Resources..... | 20 |
| | |
| Annexes..... | 22 |
| Annex 1: Selected contextual indicators..... | 23 |
| Annex 2: Desirable attributes of health financing..... | 27 |
| Annex 3: HFPM assessment questions..... | 29 |
| Annex 4: Questions mapped to objectives and goals..... | 31 |

Figures

| | |
|---|----|
| Fig. 1. Four phases of HFPM implementation..... | vi |
| Fig. 2. Service coverage index trend in Pakistan 2000-2021 | 1 |
| Fig. 3. Antenatal care and DPT3 coverage by income in quintile in 2017 | 2 |
| Fig. 4. Trend in catastrophic health spending in Pakistan 2001-2018..... | 3 |
| Fig. 5. Impoverishing out-of-pocket health spending in Pakistan 2001-2018 | 3 |
| Fig. 6. Expenditure flows by scheme (Sankey diagram)..... | 14 |
| Fig. 7. Average rating by assessment area (spider diagram)..... | 16 |
| Fig. 8. Average rating by goals and objectives (spider diagram)..... | 16 |
| Fig. 9. Assessment rating by individual question | 17 |
| Fig. 10. Assessment rating by intermediate objective and final coverage goals | 18 |
| Fig. A1.1. Health expenditure indicators for Pakistan..... | 23 |
| Fig. A1.2. Revenue sources for health in Pakistan | 24 |
| Fig. A1.3. Revenue sources disaggregated 2020..... | 24 |
| Fig. A1.4. Cigarette affordability in Pakistan..... | 25 |
| Fig. A1.5. Excise tax share in Pakistan (cigarettes)..... | 25 |
| Fig. A1.6. Total tax share in Pakistan (cigarettes)..... | 26 |

Acknowledgements

The World Health Organization (WHO) and the Ministry of National Health Services, Regulation and Coordination (MoNHSRC), Pakistan, would like to thank all those who contributed to the completion of this assessment. WHO is especially thankful to the MoNHSRC for agreeing to commission this study and for their support in reviewing and giving feedback, in particular Dr Sabeen Afzal, Deputy Director, Ministry of National Health Services Regulations and Coordination, Islamabad for her valuable comments and support.

Thanks are extended to Dr Awad Mataria, Regional Adviser Health Economics and Financing, WHO Regional Office for the Eastern Mediterranean, Egypt, Cairo, and Dr Palitha Mahipala, WHO Country office in Pakistan, Islamabad, for supporting the assessment. In addition, thanks are extended to Dr Assad Hafeez, Ex-Director General at Ministry of National Health Services, Regulation, and Coordination and Dr Raza Zaidi at the Health Planning, System Strengthening and Information Analysis Unit (HPSIU), and to Sonia Riaz from the Sehat Sahulat Programme for reviewing the assessment and providing useful feedback. Special gratitude is also due to Breshna Orya, Global Fund for HIV TB and Malaria, and to Jahanzaib Sohail, World Bank Country office in Pakistan for reviewing this report and providing valuable comments.

The assessment was initially commissioned from and conducted by the Department of Community Health Sciences, Aga Khan University, Karachi, Pakistan with Wajeeha Raza as the Principal Investigator under the guidance of Dr Sameen Siddiqi.

This summary report was initially drafted by Justine Hsu (Department of Health Financing and Economics, WHO headquarters) and Matthew Jowett (Department of Health Financing and Economics, WHO headquarters), with support from Faraz Khalid (WHO Regional Office for Eastern Mediterranean, Cairo, Egypt) and additional contributions from Dr Ali Shirazi, Dr Syed Baqer Jafri, and Dr Muhammad Naveed Asghar from the WHO Country office in Pakistan, Islamabad. As noted earlier, Dr Sabeen Afzal provided valuable comments as did Dr Mohsin Raza Khan, National Consultant for Health Financing, seconded to MoNHSRC as part of technical support provided by WHO.

Further input was provided by Susan Sparkes, Gabriela Flores, Callum Brindley, Julien Dupuy and Helene Barroy (Department of Health Financing and Economics, WHO headquarters). Special thanks to Juan Solano (Department of Health Financing and Economics, WHO headquarters) who compiled and analysed data from official sources to generate all charts and diagrams used in the report.

This work was prepared in the context of the Country Cooperation Strategy between the Ministry National Health Services, Regulation and Coordination the WHO Country Office in Pakistan, and was made possible thanks to the funding from WHO's core funders, with additional support from the UK Government and the Universal Health Coverage Partnership funded by the European Union.

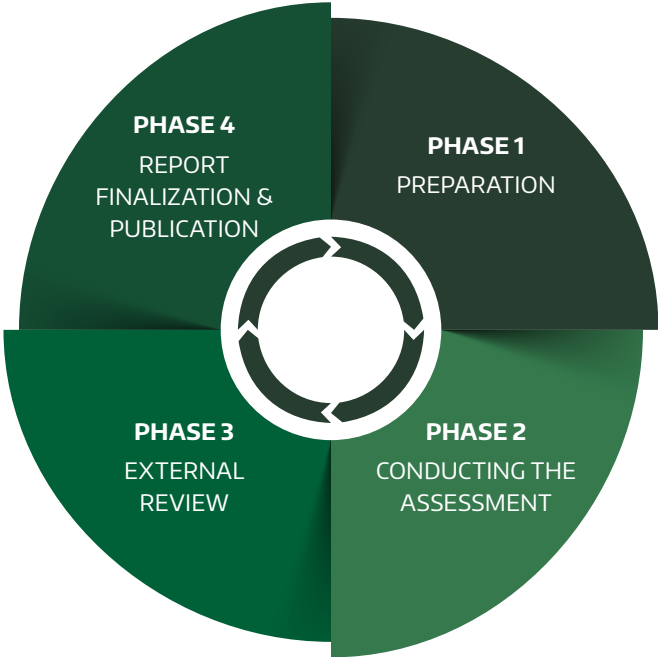
About the Health Financing Progress Matrix

The Health Financing Progress Matrix (HFPM) is WHO’s standardized qualitative assessment of a country’s health financing system. The assessment builds on an extensive body of conceptual and empirical work and summarizes “what matters in health financing for Universal Health Coverage (UHC)” into nineteen desirable attributes, which form the basis of the assessment.

By identifying areas of strength and weakness in the current health financing system, priority policy directions are indicated in the recommendations. HFPM assessments support the monitoring of country progress in the development and implementation of health financing policies, complementing quantitative indicators on service coverage and financial protection.

HFPM assessments are implemented in four phases as outlined in Fig. 1 and, given that the assessment requires no primary research, can be implemented within a relatively short time period. In addition to providing information to feed into development and review of health financing strategies, the monitoring of policy development and implementation progress over time, HFPM assessments also support technical alignment across stakeholders, both domestic and international.

Fig. 1: Four phases of HFPM implementation



Phase 2 of the HFPM consists of two stages of analysis:

- Stage 1: a mapping of the health financing landscape consisting of a description of the key health coverage schemes in a country. For each, the key design elements are mapped, such as the basis for entitlement, benefits, and provider payment mechanisms, providing an initial picture of the extent of fragmentation in the health system.
- Stage 2: a detailed assessment based on thirty-three questions of health financing policy. Each question builds on one or more desirable attributes of health financing and is linked to relevant intermediate objectives and the final goals of UHC.

Further details about the HFPM are available online:

<https://www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/health-financing-progress-matrix>

About this report

This Health Financing Progress Matrix high-level summary report provides a concise summary of the key strengths and weaknesses in Pakistan's health financing system, together with priorities areas of health financing which need to be addressed to drive progress towards UHC; findings are presented in several different summary tables, including both the seven assessment areas, and the nineteen desirable attributes of health financing systems. By focusing both on the current situation, as well as priority directions for reforms, this report also informs an agenda of analytical work and related technical support. The latest information on Pakistan's performance in terms of universal health coverage (UHC) and key health expenditure indicators.

This report represents the fourth and final phase in the HFPM implementation process in Pakistan (see Fig. 1 earlier) and is based on the detailed responses for each question conducted in Phase 2, which involves completion of HFPM Stages 1 and 2, and which were subject to external review (Phase 3). Detailed responses to individual questions are available on the WHO HFPM database of country assessments or upon request.

Abbreviations

| | |
|---------|---|
| DHS2 | Demographic Health Survey |
| DTP3 | Diphtheria, Tetanus Toxoid and Pertussis Vaccine |
| EPI | Essential Programme on Immunization |
| EPHS | Essential Package of Health Services |
| GDP | Gross Domestic Product |
| GGHE.PC | general government health expenditure per capita |
| GGHE-D | domestic general government health expenditure |
| HFPM | Health Financing Progress Matrix |
| MoNHSRC | Ministry of National Health Services, Regulation and Coordination |
| OOPs | out-of-pocket payments |
| PFM | public financial management |
| PHC | primary health care |
| SCI | Service Coverage Index |
| SDGs | Sustainable Development Goals |
| UHC | universal health coverage |
| USD | United States Dollar |
| VAT | Value Added Tax |
| WHO | World Health Organization |

Methodology and Timeline

With a population of over 220 million, three out of the four main provinces in Pakistan are currently investing in the development and expansion of a social health protection programme, with the fourth province focused on building public-private partnerships to progress towards UHC. The conversation around health financing and improving financial protection was a dominant feature of the discourse surrounding the 2018 elections, since when the new federal and provincial governments have shown a strong interest in adopting health financing reforms.

In late 2018, the new federal government in Pakistan and WHO discussed the need to assess ongoing health financing reforms in the country. Following the discussions, the Ministry of National Health Services, Regulation and Coordination (MoNHSRC) invited WHO to assess the current health financing system in Pakistan. In response, the WHO mission, comprising of a team of health financing specialists from WHO headquarters in Geneva, the WHO regional office in Cairo, and an international consultant, visited Pakistan in January 2019. The overarching objective of the mission was to conduct a health financing diagnostic review and to support federal and provincial governments in improving planning for public sector financing.

With the support of the WHO Pakistan country office and provincial departments of health, the mission met relevant stakeholders in three provinces, reviewed the direction of health financing reforms and mapped out the existing financial protection/social health protection arrangements in the country. One of the immediate action points agreed with the Director General Health at MoNHSRC in the mission debriefing session was to conduct an in-depth assessment of the different functions of health financing policy using WHO's health financing matrices.

WHO commissioned the systematic completion of the Health Financing Progress Matrix to the Aga Khan University (AKU) Karachi, a leading academic institute in Pakistan with a strong team of health economists and health systems experts. The first step was for WHO and AKU to collate existing evidence on health financing in the country. The evidence included peer reviewed literature, government reports, reviews conducted by donors, and development partner reports. Further, WHO and AKU reached out to provincial health departments, Deutsche Gesellschaft für Internationale Zusammenarbeit, and the Asian Development Bank, to gather additional resources related to health financing in Pakistan; this repository was continuously expanded during the analysis.

WHO headquarters, WHO Regional Office for the Eastern Mediterranean and AKU worked very closely as a team and used a step ladder approach to fill out and score each of the assessment questions. The primary source of information was the repository of available literature but where no relevant literature was available key informants were contacted. For instance, there was insufficient information on questions related to capacity of the health and finance departments to understand and apply public financial management rules, and so the team at AKU consulted with a senior official at finance department involved in the budget formulation process, as well as the director of a tertiary care hospital who provided important insights on the mechanisms used to purchase services. Question rating was conducted by senior experts at AKU and WHO headquarters, independently of each other; there was consistency in scores for 85% of questions, with a health financing expert at WHO Regional Office for the Eastern Mediterranean proposing final scores for the remaining 15% of questions, which were agreed following internal discussions.

In 2022 the findings were reorganized according to the revised HFPM version 2.0 structure; during 2022 and into 2023 the assessment was further updated to reflect more recent policy developments. This summary report was drafted by WHO Regional Office for the Eastern Mediterranean and WHO headquarters and reviewed by the MoNHSRC and the WHO Country office in Pakistan, Islamabad, as well as by the Global Fund and World Bank, both partners in the Sustainable Financing for Health Accelerator of the Global Action Plan for Health Lives and Well-being.

The Principal Investigator was an external contributor hired through a WHO procurement contract; declaration of conflict of interest was managed in the processes related to this contract.

Executive summary of priority areas

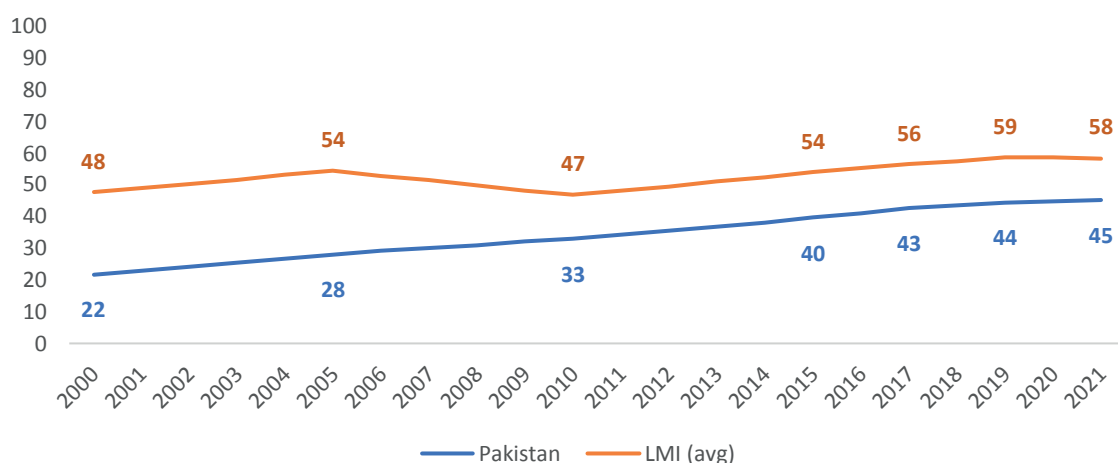
The WHO Health Financing Progress Matrix (HFPM) assessment was conducted in Pakistan to assess the current health financing system up until December 2022, with a view to identifying priority areas needing policy shifts to help accelerate progress towards UHC. This Executive Summary is supplemented by more detailed recommendations for all health financing functions in subsequent sections.

- Given concerns of sustainable financing with low capacity for mobilizing revenues and low prioritization for the health sector, and to address important gaps in matching revenues to scaling-up the provision of an essential package of health services, there is a critical need to:
 - Continue development of an overall health financing framework, along with province-level health financing strategies, within which there is a focus on developing a holistic domestic resource mobilization agenda for health. This could include consideration of diversifying revenue sources, reviewing the current design of federal excise taxes on tobacco, and examining greater revenue raising opportunities at provincial level.
 - Analyse and summarize historical data to benchmark Pakistan’s health spending alongside other countries at similar levels of development would form a solid basis for a more informed dialogue on domestic resources for health with counterparts in the Department of Finance.
 - Adopt key recommendations from recent evaluations of the underlying public financial management (PFM) such as building capacity of the MoNHSRC and provincial authorities to engage in budget dialogue and negotiations, reviewing budget structures (currently classified by inputs to better reflect health priorities), and increasing budget execution rates by addressing bottlenecks and streamlining spending modalities (also beneficial for emergency situations).
- Progress towards UHC in Pakistan could be accelerated through greater coordination in the scale-up, nationally, of the Sehat Sahulat Programme:
 - a priority should be to ensure a common national set of benefits entitlements is established and implemented across the different health coverage schemes (see Stage 1 assessment); this is envisaged through alignment with the UHC Benefit Package’s Essential Package of Health (EPHS) and using the EPHS as a shared set of core services across provincial-level adaptations, which strategically would be a very positive development.
 - Aligning and streamlining beneficiary and service utilization information systems across the different schemes is also of high priority.
 - Outline various pooling options for the Sehat Sahulat Programme where each possible mechanism is assessed for the ability to redistribute risks, feasibility based on the political economy context across provinces, and overall sustainability from a coverage and financing perspective.

UHC Performance in Pakistan

Sustainable Development Goal (SDG) indicator 3.8.1 relates to the coverage of essential health services. It is a service coverage index (SCI) with a score between 0 and 100 defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, and services for noncommunicable diseases, as well as indicators of service capacity and access. In Pakistan, the SCI almost doubled between 2000, from a score of 22, and 2021 with a score of 45, but remains significantly lower than the average score of 58 amongst lower middle-income countries according to latest available data in 2021.

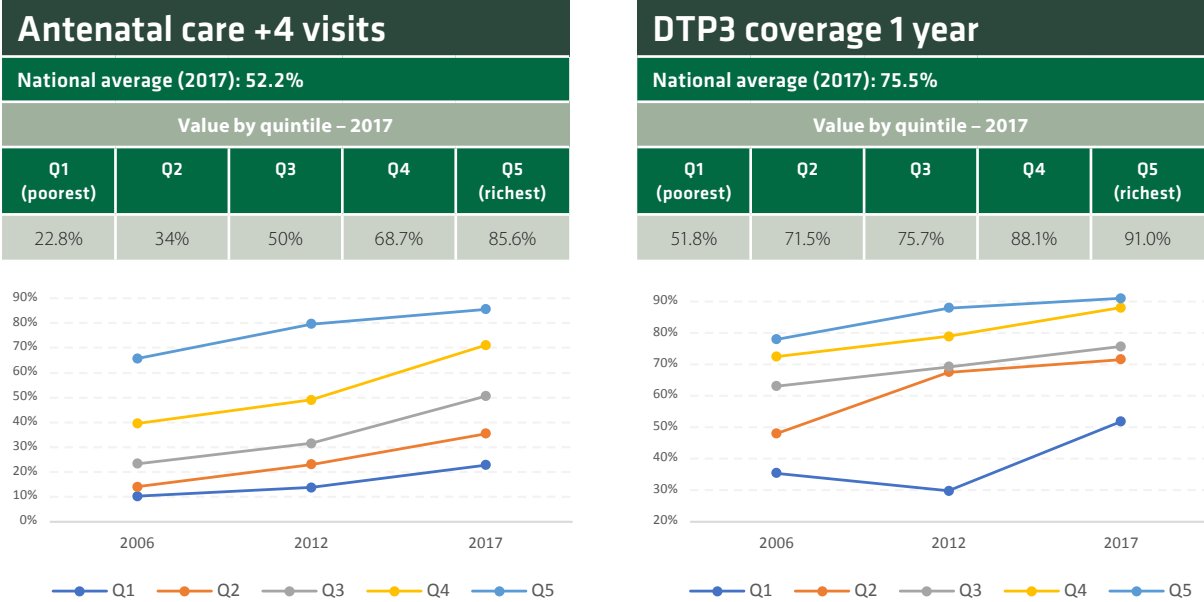
Fig. 2: Service coverage index trend in Pakistan 2000-2021



Source: Global Health Observatory 2023 (<https://www.who.int/data/gho/data/themes/topics/service-coverage>, accessed 1 August 2023)

Disaggregated information on service coverage is available for certain components of the index, as shown in Fig. 3, allowing a clearer picture of how access varies across income groups. While inequalities across income groups decreased slightly between 2006 and 2017, moreso for DTP3 coverage, they remain highly significant, in particular for antenatal care.

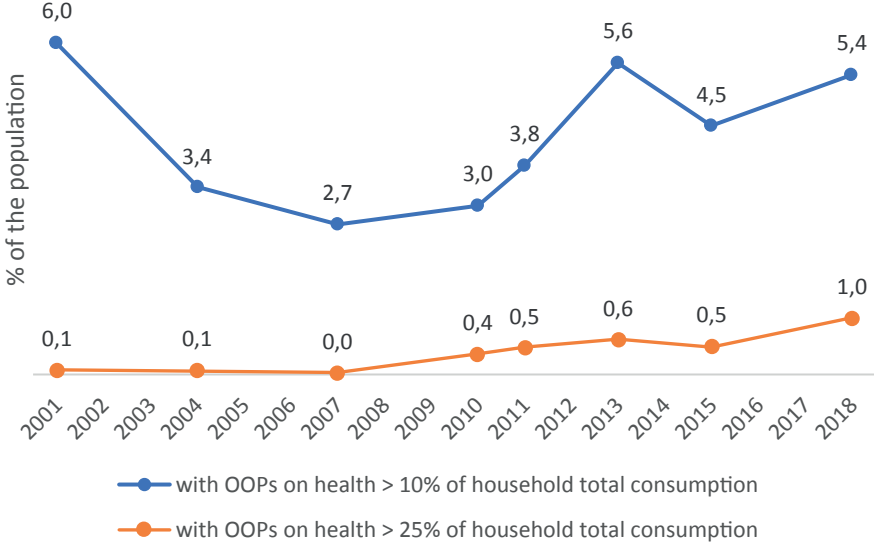
Fig. 3. Antenatal care and DPT3 coverage by income in quintile in 2017



Sources : Antenatal care +4 visits – <https://apps.who.int/gho/data/view.main.94030>, accessed 1 August 2023; DTP3 coverage 1 year – <https://apps.who.int/gho/data/view.main.94200>, accessed 1 August 2023

SDG indicator 3.8.2 relates to financial protection, measured in terms of the level of catastrophic health spending, and defined as the “proportion of the population with large household expenditure on health as a share of total household expenditure or income”. Two thresholds are used, the first based on spending greater than 10% of the household budget, with the second based on spending being greater than 25% of the household budget. In Pakistan the latest estimate based on the 10% threshold, which is for 2018, continues the trend of a steady increase since 2007. At the 25% threshold incidence rates have remained relatively stable, with a slight uptick in 2018.

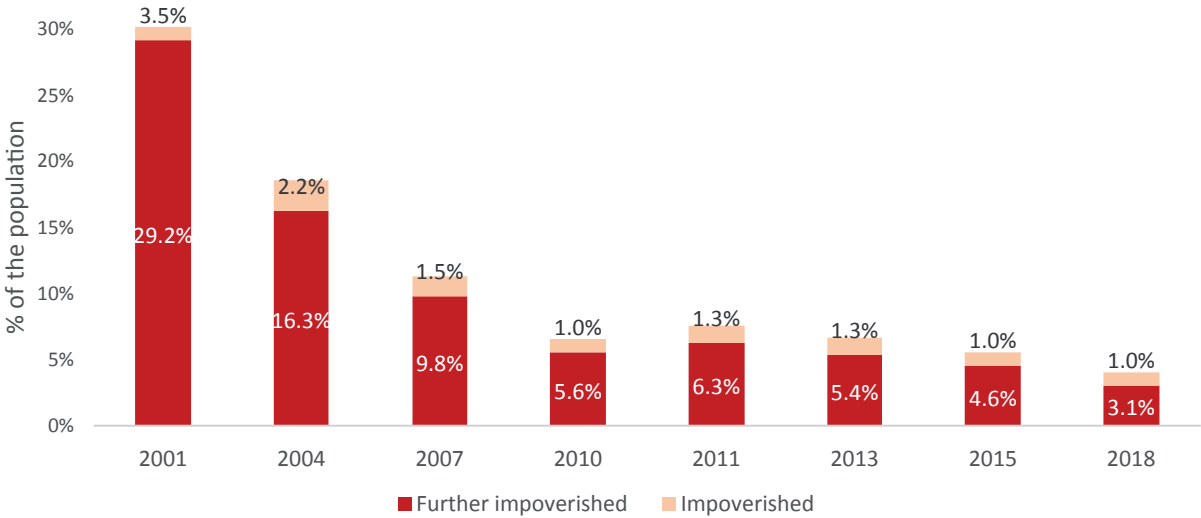
Fig. 4. Trend in catastrophic health spending in Pakistan 2001-2018



Source: <https://www.who.int/data/gho/data/themes/topics/financial-protection>, [accessed 10 April 2023]

Though not an official SDG indicator, an additional metric of financial protection looks at health spending which leads to impoverishment. Indicators are defined as the proportion of the population pushed into, or further into, poverty as a result of out-of-pocket health spending. The poverty line used is 1.90 \$PPP¹ per person per day and where even the most basic standard of living is not guaranteed. In Pakistan, the level of impoverishment due to out-of-pocket health spending is very low and has reduced over the years as depicted in Fig. 5.

Fig. 5. Impoverishing out-of-pocket health spending in Pakistan 2001-2018



Source: <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4892>, accessed 1 August 2023

¹ Purchasing Power Parity

Summary of key findings by assessment area

| Summary of findings and recommendations | | |
|---|---|------------------------|
| Assessment area | Summary findings | Status |
| Policy process & governance | Pakistan's MoNHSRC has developed a National Health Vision (2016-2025) document and published a more detailed health financing status report in December 2022. Following devolution in 2011, provinces have developed provincial health sector strategies. Roundtable dialogue would continue to foster greater alignment in planning, budgeting, and policy actions across all levels of the government given previously noted issues in coordination. Financial and non-financial accountability, particularly the latter, is hampered by large vertical health programmes with a multitude of parallel information and monitoring systems lacking interoperability. Efforts have been made to create governance structures to enable greater coherence across the vertical programs and the system (e.g. through provincial MoH restructuring), and while positive this has largely not changed parallel programmatic financial flows. | Progressing ● ● ● ● |
| Revenue raising | Budget allocations to health in Pakistan have been historically low, representing less than 5% of government spending and 1% of GDP in 2020. This underlines the importance of developing a domestic resource mobilization agenda for health, which considers the diversification of revenue sources, for example through the development of health taxes; tobacco prices in Pakistan are some of the lowest in the world. Greater capacity to gather accurate cost data, analyse utilization patterns, and identify matching revenue sources, would result in more realistic forecasts and minimize fluctuations in medium-term development and performance-based budgeting frameworks. | Progressing ● ● ● ● |
| Pooling revenues | In Pakistan, the government is implementing approaches to incrementally enhance risk sharing, for example through plans to expand population coverage in some provinces through the Sehat Sahulat Programme (formerly known as the Prime Minister National Health insurance programme), amongst population groups with greater capacity-to-pay. This would enhance risk pooling although the financial sustainability of coverage expansion remains in question, particularly given that these funds remain in the annual development budget and therefore are not regularized into the recurrent budget. Policy should lead to greater risk-sharing between the healthy and the sick, and between higher and lower income households, to improve efficiency, equity in access to health services, and improved financial protection. | Progressing ● ● ● ● |
| Purchasing health services | In Pakistan resources in the health sector are allocated predominantly via input-based line-item budgets. This highlights weaknesses in underlying systems to monitor population health needs and provider performance, which are critical to inform purchasing decisions, ensure that flows are allocated in line with health needs, reach vulnerable populations, and incentivize the efficient provision of quality care. Pakistan has positive experiences from the implementation of global budgets and case-based payments and incorporating design features from contracting models e.g. competitive selection, target-setting, as well as reviewing price schedules to mitigate distortions across services in both public and private sectors. Many provinces e.g. Baluchistan, Sindh, Punjab contract private sector firms and providers for the provision of PHC-oriented services. The use of pooled resources to purchase a coherent and core set of Essential Package of Health Services is being implemented in a phased approach, starting with Islamabad and only for a subset of primary health care interventions. | Progressing ● ● ● ● |
| Benefits & entitlements | In 2020 Pakistan developed an Essential Package of Health Services (EPHS), including province-specific packages, with implementation starting with a subset of interventions and with phased roll-out across provinces. Implementation needs to be accompanied by sufficient levels of financing, and relevant supply-side improvements and reforms, to ensure its realization, especially as subnational fiscal space analysis indicated important gaps in matching revenues to the provision of the EPHS, even with a subset of interventions. In terms of alignment with service delivery, this is being determined through a baseline survey mapping facility readiness in selected districts. The EPHS aims to address inequalities in access to health care. However, OOP payments remain high, and drivers of OOP spending are likely from outpatient settings, though other social protection programmes are piloting coverage of outpatient services. | Progressing ● ● ● ● |

Summary of findings and recommendations

| Assessment area | Summary findings | Status |
|---|---|------------------------|
| Public financial management | There is limited flexibility of health spending in Pakistan given that most of the health budget goes towards salaries and other fixed costs, leaving little scope for adjustments to better meet priorities. The health budget is constructed through a mix of input-based line items and programmatic envelopes such as for vertical health programmes for malaria, and immunization, as well as for primary health care. Within these programmatic envelopes, however, funds are still allocated according to input-based line-items, constraining the ability to make marginal shifts in the use of activity funds. While the overall process for developing budgets involves some consultation between the Finance Department for the recurrent budget and the Planning and Development Budget Department for the development budget, and each department, it has been noted that there is limited dialogue with the health department. In Pakistan’s context of devolution, it is critical that, in tandem with additional responsibilities given to provinces, their capacity to plan, budget, procure and report on spending also be strengthened to ensure strong administrative and financial management. | Progressing ● ● ● ● |
| Public health functions and programmes | Various evaluation reports of International Health Regulations (IHR) capacities in Pakistan e.g. the 2016 Joint External Evaluation of IHR Core Capacities, and the 2021 IHR State Party Self-Assessment Annual Report, indicate that Pakistan is hindered by coordination problems during implementation due to devolved governance, gaps in support for legal frameworks, and the lack of a costed roadmap. Recently, the MoNHSRC (with the support of the World Bank) updated a costed Action Plan for Health Security and completed a Health Security Financing Assessment. In general, Pakistan places quite low in these reports in terms of average scores for financing and governance related actions. Rigidities in PFM systems do not currently support a timely response to public health emergencies such as during the recent COVID-19 pandemic. Although there are existing emergency provisions for federal and local governments to fast-track spending for urgently needed medical supplies, there are no accompanying guidelines which set the criteria for this. | Progressing ● ● ● ● |

Detailed findings and recommendations by desirable attributes of health financing

| Policy process and governance | |
|---|---|
| Desirable attribute GV1 | Health financing policies are guided by UHC goals, take a system-wide perspective and prioritize and sequence strategies for both individual- and population-based services |
| Key areas of strength and weakness in Pakistan | The MoNHSRC developed a National Health Vision which provides an overall strategy for the health sector, including for health financing. In addition, following devolution in 2011, provinces have developed provincial health sector strategies, although it is unclear how interconnected health planning and policy-making is across provinces and in coordination with the national level. It has been noted that a comprehensive assessment of the whole health system is lacking, although a health financing status report is currently being prepared by the MoNHSRC and plans are underway to establish a new national health financing framework. This is complemented by targeted analysis, including in relation to cross-programmatic efficiency analysis to address fragmentation between health programmes and the overall system. Existing health financing analyses, for example of revenue raising, pooling, contracting in/out, expenditure tracking, and public financial management, etc., typically focus on an individual province or programmes, e.g. evaluations of the 'Sehat Sahulat' social protection programme. |
| Recommended priority actions | Take a system-wide approach as the basis for a strategy focused on UHC to help ensure synergy and complementarity of provincial strategies and the National Health Vision. Clearly specify the roles of different stakeholders in implementation plans to increase the effectiveness of policy interventions and build greater alignment in planning and budgeting across government levels and programmes. Replicate the HFPM assessment across all provinces, given diversity across contexts and for more tailored findings. Provincial findings could then be discussed to share lessons learnt from challenges faced and good practices/approaches in addressing these. |
| Desirable attribute GV2 | There is transparent, financial and non-financial accountability in relation to public spending on health |
| Key areas of strength and weakness in Pakistan | Since 2005, Pakistan's Bureau of Statistics regularly conducts and publishes comprehensive analyses of national health accounts; these reports cover expenditures for all major categories and increase the transparency of how public revenues are used in the health sector. However, such data are not systematically used to inform health financing policies. Financial accountability is the remit of the Controller General of Accounts and the Auditor General of Pakistan at the federal level, and the Auditor General provincial offices at provincial level, with provincial government budgets released on a quarterly basis. In terms of non-financial accountability, performance monitoring and reporting systems are in place, but exist in parallel e.g. for specific disease programmes, and lack interoperability. District health information systems, along with a multitude of programmatic information systems, are extensive but not coordinated to enable a system-wide perspective of the health system or utilization e.g. in Punjab there are 100+ information/data systems/forms that do not speak to each other. |
| Recommended priority actions | Continue the mapping of all existing reporting systems in the health system, including those related to vertical disease programmes (which was started through the cross-programmatic efficiency analysis) with need for more detailed mapping, to inform ways to increase interoperability i.e. the progressive harmonization of information through the adoption of common definitions to render heterogenous data more comparable. Another priority is to link facility data to budget and expenditure data, to build a clearer picture to inform a range of policies, e.g. resource allocation and purchasing decisions, building on strong existing financial management systems in Pakistan. Connect district health information systems covering primary and secondary facilities with those covering tertiary facilities and establish rules for information standardization and sharing, as this would also contribute the development of policies supporting integration of care across levels of the system. |
| Desirable attribute GV3 | International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments |
| Key areas of strength and weakness in Pakistan | Evaluations are currently carried out for individual provinces and typically focus on a specific health financing topic. In other words, they are not necessarily adopting a system-wide perspective nor explicitly concerned with identifying interactions, unintended effects, or responses from other parts of the health (financing) system. In addition, some health financing functions have been relatively less covered in sector strategies (notably those on purchasing and benefits) while others (e.g. revenue raising and expenditure tracking) are institutionalized and regularly carried out. Even for those well-studied aspects, linking evidence generated from such analyses to policy is noted to be lacking. System-wide data and evaluations are hampered by the multitude of parallel information systems and limited capacity to incorporate evidence into health policy, although this capacity varies across provinces. A technical working group has been recently established in 2021 and should be leveraged for developing robust policies in a coordinated manner. |
| Recommended priority actions | Strengthen capacity for conducting health policy applied analysis and or health systems research in the MoNHSRC and in provincial departments of health by ensuring fulfilment of the Terms of Reference of the health financing technical working group (i.e. diagnose performance, identify reforms areas, etc.). Build evidence-to-policy platforms through actions such as more regular and more structured dialogue between policy-makers and stakeholders, formal cooperation between researchers and policy-makers, and/or establishing a working group comprised of representatives from the bureau of statistics, ministry of planning and development, and ministry of finance to regularly engage in a policy dialogue on health financing. |

Revenue raising

| | |
|---|--|
| Desirable attribute RR1 | Health expenditure is based predominantly on public/compulsory funding sources |
| Key areas of strength and weakness in Pakistan | Allocations to the health sector in Pakistan have historically been low, representing less than 5% of overall government spending in 2019 and remaining at around or less than 1% of GDP. However, Pakistan's national vision document does recognize the importance of public spending for health and has set a target to increase this from 0.6% to 3% of GDP by 2025. Unfortunately, the recent COVID-19 pandemic will have a negative impact on the broader economy. In addition, the spending target was not accompanied by any specific plans for how the government would gradually increase domestic resources for health, although the federal government of Pakistan has recently developed important strategies to increase taxation given it has a low tax-to-GDP ratio of 12.6% in 2018, for which the IMF estimates that it could be nearly doubled to 22.3%; thus there is potential for increasing funding for health in Pakistan. At the provincial level, Baluchistan KPK and Punjab (Sind health strategy has expired) have developed provincial strategies to raise revenues for health, but, based on 2016 estimates, no province has reached the 3% goal and there is also huge variation across provinces, ranging from 0.9% to 2.4% of GDP, with no province reaching the target. |
| Recommended priority actions | Continue development of a national health financing framework, along with province-level health financing strategies, within which is a focus on a holistic domestic resource mobilization agenda, including consideration to diversify revenue sources (see RR4). Develop the capacity of health policy-makers to address the insufficient level of revenues directed to health and to engage strongly in negotiations (e.g. capacity to analyse and summarize historical data and benchmark results alongside other countries at similar levels of development for a more informed dialogue on domestic resources for health with counterparts in the Department of Finance). Leverage participation of civil society to advocate for more resources directed to health. |
| Desirable attribute RR2 | The level of public (and external) funding is predictable over a period of years |
| Key areas of strength and weakness in Pakistan | To foster predictability over a period of years, Pakistan engages in a medium-term budget planning process. Five-year plans are developed at the national level by the Planning Commission of Pakistan and budget strategy papers developed by the Ministry of Finance. Based on the five-year plans, provincial planning and development departments then allocate the budget across its development portfolios, including health, with projections for the next three years. Despite such forecasts, there has been a high degree of fluctuation over the past 15 years, although in a positive manner as the health budget allocation as a percentage of provincial GDP has almost doubled since 2010 across all four main provinces. For the non-development budget, the finance department of each province also forecasts revenues and expenditures for the upcoming three years, though this is done for the overall budget and the paper does not include budgets by departments. |
| Recommended priority actions | Strengthen the health sector's input into the formulation of medium-term development frameworks by increasing their capacity to make more realistic forecasts (e.g. through historical or actual data, analysis of utilization patterns) and thus reduce fluctuations. (Apply a multiyear lens to both the development and non-development parts of the health budget in order to develop a more comprehensive health-specific medium-term plans. |
| Desirable attribute RR3 | The flow of public (and external) funds is stable and budget execution is high |
| Key areas of strength and weakness in Pakistan | The degree to which there is stability in the flow of public (and external) funds depends on its purpose and the mechanism through which it flows through the system. Line-item budgets related to salary payments are typically released on time and stable; in comparison, funds for contracted employees, especially front-line workers, can often experience delays and are relatively less stable. There is also anecdotal evidence of delays in budget release for projects and vertical programmes. Regarding budget execution in Pakistan, rates have improved over the years with a rise from approximately 57% to 80-90% in 2016-17 across provinces. This improvement was observed in tandem with devolution as individual provinces gained greater authority in procurement processes which facilitated utilization of the budget; however more efforts are needed to move away from the large number of line-items that constrain flexibility in the distribution of resources. Despite this improvement, there are still means to further improve underlying spending modalities. According to a World Bank assessment of PFM, obstacles hindering a more efficient use of budgets include poor cash management, delayed release of funds, cumbersome payment processes, and poor federal-provincial coordination. |
| Recommended priority actions | Maintain the positive trend of increasing budget execution rates by both continuing to build provincial capacity for credible budgeting and by further streamlining spending modalities and consolidating line-items, addressing PFM bottlenecks to spending (e.g. reducing steps in payment processes, identifying underlying causes for delayed release of funds/instability, etc.). Doing so would also improve the government's capacity to respond flexibly and in a timely manner to national health emergencies. |
| Desirable attribute RR4 | Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms |
| Key areas of strength and weakness in Pakistan | Pakistan has considered putting in place various fiscal measures to incentivize healthier behaviours. These include proposals for an earmarked public health tax and a 'sin tax' on tobacco products – however, proposals are still in the formulation rather than implementation stage. Despite an initial proposal made in December 2018 for an earmarked public health tax, it was not included in a subsequent budget announcement in January 2019 nor reflected in the budget. The design of proposed policies would also benefit from review; for example, while Pakistan has a two-tiered tax on tobacco products, prices on such products in Pakistan are some of the lowest in the world, weakening the intended effect of such taxes. |
| Recommended priority actions | Start discussions for developing implementation plans in order to move from current government discussions regarding the introduction of fiscal measures to actual implementation (where any earmarking of new revenues from such taxes should follow global good practice and be additional, rather than offset by budget allocations). Engage with interest groups with advocacy material that highlights the double benefits of first improvements in health outcomes, and second a source of supplementary public revenues. |

Pooling revenues

| Desirable attribute PR1 | Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds |
|---|---|
| Key areas of strength and weakness in Pakistan | <p>In Pakistan, pooling is highly fragmented with distinct pools for specific subpopulation groups which limits the ability to redistribute funds and hence also limits health system performance. The largest pools (see Stage 1) are the various health budgets which funds direct provision. Smaller pools exist for the military, autonomous organizations, employees' social security institutions, mandatory employer-based health insurance in the private sector, and voluntary health insurance schemes. Funds for vertical programmes (HIV, TB, malaria, EPI) are also not pooled at any level of the system, which limits opportunities for efficiency improvements. The multiplicity of pools has led to concern that funds are not used optimally to address inequities and inefficiencies. In response, there is a commitment to enhance redistribution with the National Health Vision stating that the government will establish pro-poor social protection initiatives. This has subsequently been reflected in legal documents and through a recent pooling mechanism established for the three social protection programmes using tax revenues to cover the poorest populations currently providing coverage to 45 million families.</p> |
| Recommended priority actions | <p>Outline various pooling options for the Sehat Sahulat Programme where each possible mechanism is assessed for its effect on the redistribution of health risks, its feasibility based on the political economy context across provinces, and its overall sustainability from a coverage and financing perspective. Ensure that evidence generated from baseline and medium-term implementation evaluations of the Sehat Sahulat Programme are fed into the design of future policies as the programme extends beyond initial implementation in Punjab province and extends into the remaining provinces.</p> |
| Desirable attribute PR2 | Health system and financing functions are integrated or coordinated across schemes and programmes |
| Key areas of strength and weakness in Pakistan | <p>Integration and coordination of health financing functions across schemes is hampered by the historical multiplicity of pools with each scheme and health programme having its own set of benefits and using different payment methods to pay providers. This has embedded both inequities and inefficiencies into the health system, for example through the overlaps in benefits with members of the military funds who are also entitled to access services in public hospitals. Currently, the systems to share and consolidate performance information across schemes funds are limited, which impedes the development of system-wide strategies to accelerate progress to UHC. Nevertheless, there are some good displays of coherence in the design of benefit packages, and in the purchasing of health services, across the major social protection programmes which increasingly provide a coherent set of benefits and where both contract-out to the same insurance company.</p> |
| Recommended priority actions | <p>should be closely monitor implementation of the universal Essential Package of Health Services through an M&E framework in order to ensure alignment across health financing and service delivery. Leverage the positive experiences in building coherence across two of the three social protection schemes by further harmonizing benefits and purchasing arrangements with the remaining third social protection programme. In addition, incremental steps to enhance the interoperability of information systems across the different pools would support coherent system-wide strategies.</p> |

Purchasing health services

| Desirable attribute PS1 | Resource allocation to providers reflects population health needs, provider performance or a combination |
|---|---|
| Key areas of strength and weakness in Pakistan | <p>In Pakistan, resources to health are allocated predominantly via input-based line-item budgets, the majority of which is for salaries, with little scope to adequately consider other factors such as population health needs or provider performance. There is thus currently little assessment of population health needs, not least given the underlying capacity for public health surveillance has been noted to be limited. As described in the governance domain, there is limited discussion on how to improve purchasing in Pakistan, and this aspect remains understudied.</p> |
| Recommended priority actions | <p>Strengthen underlying health information systems to monitor population burden of disease is a critical source of evidence that can be used to better inform purchasing approaches. Review provider payment methods and contracting models to incorporate consideration of provider performance, equity targets, measures reflecting quality of care, etc.), considering also particular vertical programmes with distinct revenue streams.</p> |
| Desirable attribute PS2 | Purchasing arrangements are tailored in support of service delivery objectives |
| Key areas of strength and weakness in Pakistan | <p>Current purchasing arrangements in the public sector do not have explicit incentives in support of service delivery objectives such as improving quality of care or strengthening the coordination of care. It is also unclear if contracting models include consideration of such criteria, and the impact of global budgets vis-à-vis these aspects has not been widely studied. However, each province in Pakistan (except Baluchistan) does have a health care commission with a clear mandate to monitor quality of care. Responsibilities of these commissions include provider accreditation (for 3 out of 4 provincial commissions) and the development of service delivery standards (for 2 out of 4 provincial commissions). Pakistan also has a large private sector: although many focus on higher cost, more expensive services to the population, some operate under more affordable public-private partnerships with design features including competitive selection, target-setting, and profit-sharing mechanisms to improve quality of care.</p> |
| Recommended priority actions | <p>Review design features of public-private partnership models for more explicit incentives to improve quality of care and/or integration in the delivery of care. Strengthen the capacity of the remaining provincial health commissions to monitor quality of care such that all four commissions carry out accreditation of providers and develop minimum service delivery standards. This could be supported by a cross-provincial learning exchange to also ensure coherence and foster equity.</p> |

Purchasing health services

| | |
|---|---|
| Desirable attribute PS3 | Purchasing arrangements incorporate mechanisms to ensure budgetary control |
| Key areas of strength and weakness in Pakistan | In Pakistan, current purchasing arrangements in the public sector do not adequately ensure budgetary control given they are predominantly input-based at primary, secondary and tertiary levels. There are, however, notable exceptions to this such as purchasing arrangements in select specialized tertiary-level hospitals which employ global budgets, and social protection schemes which employ case-based payments. In the private sector, which is a major part of the provider landscape, reliance is on fee-for-service, which can contribute to escalating system-level costs through supplier-induced demand, especially as new technologies become more widespread for example for diagnostics. |
| Recommended priority actions | Identify lessons learned from the experience with the implementation of global budgets and case-based payments. Review price schedules against global good practice, ensuring congruence with the cost of producing such services and mitigating distortions across services and public/private sectors. |

Benefits and entitlements

| | |
|---|--|
| Desirable attribute BR1 | Entitlements and obligations are clearly understood by the population |
| Key areas of strength and weakness in Pakistan | In 2020, Pakistan developed a national Essential Package of Health Services (EPHS) based on evidence from the Disease Control Priorities 3 project, identifying 107 interventions. Its provincial localization has also been completed and province specific packages developed and approved in 2021/early 2022. Prior to this, entitlements in the public sector were explicitly defined in only two out of four provinces through minimum service delivery standards, and the degree to which these were clearly understood by the population was unknown. For those services provided under social protection programmes, although entitlements have been explicitly defined, a survey showed that beneficiary awareness about services available to them was only approximately 46%. Regarding benefits provided by other schemes, the degree to which these are understood by their beneficiaries is unclear. |
| Recommended priority actions | Undertake specific communication efforts and related supply-side adjustments alongside the phased implementation of the national EPHS across all provinces to ensure the population understands their entitlements and obligations. |
| Desirable attribute BR2 | A set of priority health service benefits within a unified framework is implemented for the entire population |
| Key areas of strength and weakness in Pakistan | Pakistan recently completed an extensive process to identify a set of priority health service benefits for its entire population which is to be applied in a phased and tailored manner across all provinces. Prior to this, only two of four provinces had defined a set of health benefits in their minimum service delivery standards. Benefits currently provided by other programmes are limited, e.g. those provided by social protection programmes were previously limited to inpatient services (i.e. these did not cover outpatient care until a recent pilot of the inclusion of outpatient care in Islamabad and in one district of the Khyber Pakhtunkhwa province) and are available only to those under the minimum wage. |
| Recommended priority actions | Linking the EPHS with the expansion of the Sehat Sahulat Programme would promote further alignment in the health system. Provide technical support to provincial departments of health to support the adaptation of plans for roll-out; hold workshops across provinces to review their experiences and share lessons learned; develop an M&E framework; review available data on fiscal space and health financing to ensure sustained health financing. |
| Desirable attribute BR3 | Prior to adoption, service benefit changes are subject to cost-effectiveness and budgetary impact assessments |
| Key areas of strength and weakness in Pakistan | Pakistan recently relied on evidence from the Disease Control Priorities third edition to develop its UHC priority benefits package. Subnational fiscal space analysis was also carried out through technical assistance provided by the World Bank in support of ESPH roll-out, though significant gaps in financing were identified. Previously, the design of publicly provided benefits did not follow a systematic process and criteria varied across provinces. For specific benefits related to social protection programmes, these were developed by a steering committee, though the process and criteria have not been made available and it is unclear how much they were informed by evidence (e.g. coverage omitted outpatient services despite these representing 80% of out-of-pocket payments). |
| Recommended priority actions | Strengthen country capacity to conduct cost-effectiveness analysis and budget impact assessments such that these are regularly conducted and institutionalized to inform decision-making regarding future revisions to benefit package design, entitlements and or patient obligations. This could be fostered by establishing health economic units or technical working groups within provincial/federal departments of health and through technical assistance focused on building local technical skills. |

Benefits and entitlements

| | |
|---|---|
| Desirable attribute BR4 | Defined benefits are aligned with available revenues, health services, and mechanisms to allocate funds to providers |
| Key areas of strength and weakness in Pakistan | Subnational fiscal space analysis indicates important gaps in matching revenues to the provision of defined benefits of the EPSH, even with initial implementation of the subset of 88 (out of 107) health interventions. Under the revenue raising domain (see RR1), it is noted that Pakistan has a very low tax-to-GDP ratio, underlining the critical need to develop an agenda for mobilizing domestic resources and diversify sources of funds. In terms of alignment with health services, this is being determined through a baseline survey mapping facility readiness using the Service Availability and Readiness Assessment (SARA) approach in selected districts. SARA survey results of 12 UHC priority districts were disseminated in March 2022. |
| Recommended priority actions | Develop a domestic resource mobilization agenda (see RR1) to ensure alignment with the benefits package and revenues. Additional resources could be gained through further reprioritization of health, pro-health taxes (see RR4), and/or identifying and addressing sources of inefficiencies. Consider a more gradual implementation of the EPSH, based on fiscal realities to better match costs with revenues sources. |
| Desirable attribute BR5 | Benefit design includes explicit limits on user charges and protects access for vulnerable groups |
| Key areas of strength and weakness in Pakistan | The EPSH aims to redress inequalities in access to health care and represents an important commitment to progressing towards UHC. Currently, public facilities charge a user-fee for diagnostic tests and certain services, though these are heavily subsidized. Vulnerable population groups can also benefit from other social safety nets such as zakat or baitulmaal, which also provide some means for financial protection through cash transfers or income support. Other vulnerable groups, i.e. those who are under the minimum wage, are protected under social protection programmes wherein there is no co-payment needed to access services. Nevertheless, OOP payments are prevalent in Pakistan (see RR1). Many people access services in the private sector, paying OOP where fee-for-service is the predominant method of payment. |
| Recommended priority actions | Review conditions of access to the package as well as the sufficiency of public funds (see BR4). Conduct an analysis to identify the drivers behind OOP spending. |

Public financial management

| | |
|---|--|
| Desirable attribute PF1 | Health budget formulation and structure support flexible spending and are aligned with sector priorities |
| Key areas of strength and weakness in Pakistan | In Pakistan, the health budget is divided into two main categories: (i) the development budget, which is received from the Planning and Development Department and (ii) the non-development (i.e. recurrent) budget, which is allocated by the Finance Department. The development budget has a higher degree of flexibility given that provincial health departments can submit proposals for specific health programme envelopes annually along with budgetary requests to the Planning and Development Department. Nevertheless, this part of the budget only represents approximately 20% of the total, and thus the scope for flexible spending is limited and is not necessarily sustainable. For the non-development budget, flexibility for spending is constrained as a large majority of the budget is dedicated to salaries and other fixed costs. Furthermore, as responsibility for the budget rests primarily with the Finance Department, the Health Department has limited scope to influence allocation decisions. In addition, this part of the budget is substantial, representing 80% of the total. While the overall process for developing budgets involves some consultation between the Finance Department and each department, it has been noted that there is limited dialogue with the health department whose influence is not strong. |
| Recommended priority actions | Strengthen the health sectors' engagement in budget dialogue processes with the Department of Finance by building capacity at both federal and provincial levels specifically in formulating more robust initial budgets and analytics to forecast over multiple year both the development and non-development parts of the health budget. Introduce incremental adjustments to the Chart of Accounts (together with complementary accountability mechanisms) to allow for greater flexibility in the management and use of budgets, particularly at district and facility levels. Review rules and modalities for spending (see RR3) to streamline the approval process and increase flexibility in budget overall, especially during a national health emergency. |
| Desirable attribute PF2 | Providers can directly receive revenues, flexibly manage them, and report on spending and outputs |
| Key areas of strength and weakness in Pakistan | Despite extensive devolution in Pakistan, the autonomy of public providers to manage funds is currently constrained due to the predominant reliance on line-item budgets, and the fact that allocations are typically based on historical requirements. However, some tertiary-level facilities receive global budgets, which allows greater scope in management of finances and operations whilst helping to manage cost escalation. Experience with contracting also suggests that such providers may have greater management over revenue streams, although given that studies show mixed results further understanding of enabling factors are required. |
| Recommended priority actions | Review experiences from global budgeting in tertiary care facilities, as well as more flexible approaches to budgeting at the primary care level used in other countries, to identify lessons that could potentially be applied to other providers in Pakistan. Incorporate clear performance indicators in contracting arrangements to further ensure the efficient use of resources and accountability. Review the functionality of financial management systems and build capacity, including at provincial level, for reporting and analysis. |

Stage 1 assessment

The health coverage schemes included in the Stage 1 assessment were selected according to the criteria outlined in the HFPM Country Assessment Guide. The aim is not to conduct an inventory, but rather to describe the main health schemes and programmes which make up the health system, and around which health financing and other policies are made, and through which money flows to health facilities.

Stage 1. Health coverage schemes and programmes in Pakistan

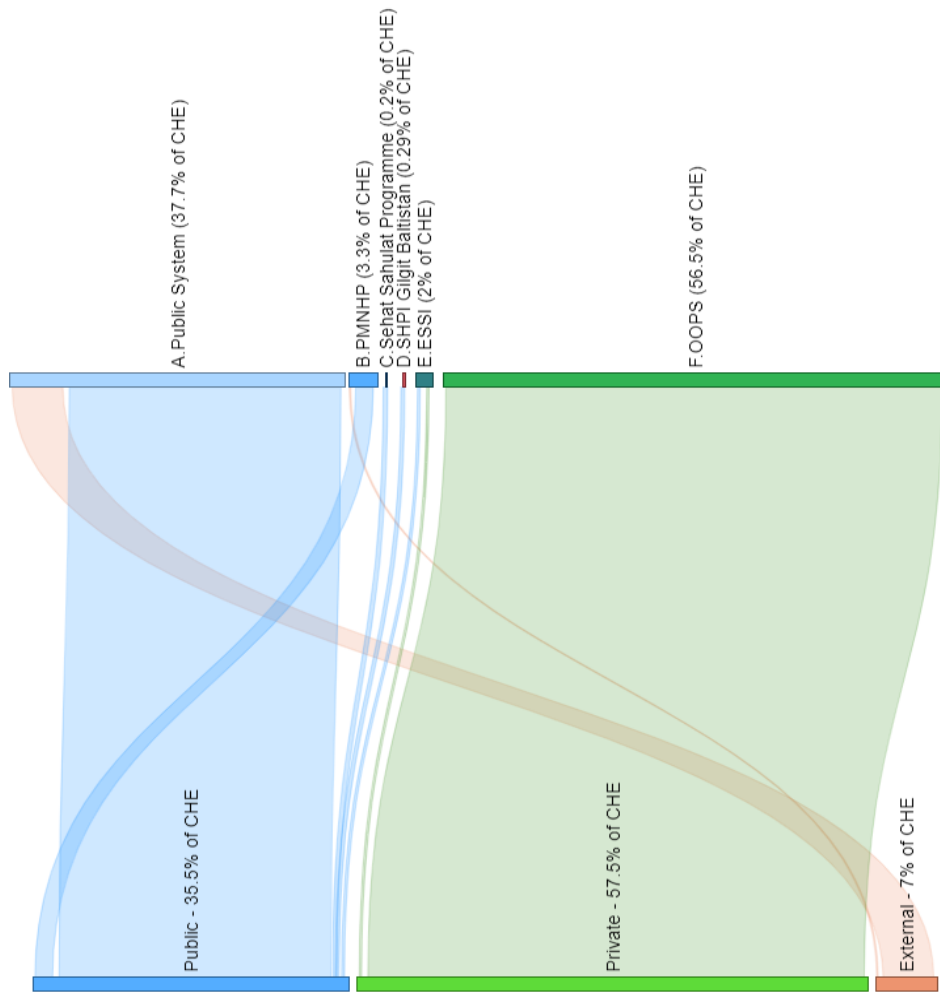
| Key design feature | Public system (federal and state budgets) | Sehat Sahulat Programme (previously known as the Prime Minister national health programme) | Sehat Sahulat Programme (Khyber Pakhtunkhwa province social health protection initiative) | Social health protection initiative (Gilgit Baltistan province) (Ended in 2021) | Employees Social Security Institution |
|---|--|--|---|---|---|
| A) Focus of the scheme | This includes those parts of the health system funded directly through government health budgets (both federal and state), and hence is nationwide in nature. Parastatals, such as railways and armed forces also fall under the public system. | Enrollment Unit: Family Beneficiary selection criteria: Families earning less than \$2 per day Members covered: All family members as per National Database Registration Authority database (husband, wife, and unmarried children) | Enrollment Unit: Household Beneficiary selection criteria: Households earning less than \$2 per day in Khyber Pakhtunkhwa | Enrollment Unit: Household Beneficiary selection criteria: Households earning less than \$1 per day in Gilgit Baltistan | Under the ordinance, compulsory for all establishments (private industries and commercial establishments) that employ 10+ persons |
| B) Target population | All citizens are served through health budgets. Specific schemes e.g. railways target their respective employees. | All permanent residents Islamabad, Punjab, Gilgit Baltistan, Azad Jammu and Kashmir, Federally Administered Tribal Area, District Tharparkar in Sindh (initially targeting the poor) | All permanent residents of Khyber Pakhtunkhwa (initially targeting the poor) | All permanent residents of Gilgit Baltistan (initially targeting the poor) | Formal sector workers and their dependents |
| C) Population covered | Universal | 36 million families (August 2022) | 9.4 million families (August 2022) | 363,725 families | 6.89 million individuals (2013 estimate) |
| D) Basis for entitlement/ coverage | Automatic, based on citizenship | Automatic | Automatic | Automatic | Mandatory |
| E) Benefit entitlements | Public health programmes, vaccinations, subsidized for primary, secondary, and tertiary, depending on the level of facility (basic health unit, rural health centre, district headquarter hospital, and tertiary care hospital) | First-level and tertiary-level health care services included in the EPHS and hospitalization services (required inpatient and day care) in the form of a 'High-cost priority care treatment package' and 'Low-cost secondary care treatment package' | Basic: emergency treatment (requiring admission), maternity services, fractures and injuries, general surgery, and general medicine; Advanced: cardiovascular, diabetes, kidney diseases, breast cancer and neurological diseases | Indoor (i.e. requiring the patient to be admitted) health care: Cashless Secondary care: PKR 25,000/person/ household/ year and 175,000/household/ year 2 Tertiary care not provided and no priority diseases Additional benefits: Ambulance/ transportation: PKR 1000, Medication: Five days medicine at time of discharge, Day surgeries are covered Limit beyond coverage: Nil | Both outpatient and inpatient services, with a financial cap on the latter |

| Key design feature | Public system (federal and state budgets) | Sehat Sahulat Programme (previously known as the Prime Minister national health programme) | Sehat Sahulat Programme (Khyber Pakhtunkhwa province social health protection initiative) | Social health protection initiative (Gilgit Baltistan province) (Ended in 2021) | Employees Social Security Institution |
|--------------------------------------|--|--|--|---|--|
| F) Co-payments (user fees) | Public facilities (mainly hospitals) often charge a subsidized user fee for some laboratory tests, medicines, and procedures where the fee is a predetermined fixed amount | No official co-payment | No official co-payment | No official co-payment | No official co-payment |
| G) Other conditions of access | <p>95% from public revenues collected at federal level from direct and indirect taxes</p> <p>General budget allocations to provincial governments (NFC Award)</p> <p>Users make co-payments (registration fee, payments for diagnostics, out of stock medicines and supplies) at public facilities</p> | <p>Full premium payment made by Public Exchequer (federal and provincial governments)</p> <p>Phase 1: PKR 8.1 billion for 3.2 million families for 3 years</p> <p>Phase 2: PKR 33 billion of Federal Share for 5 years</p> <p>Secondary & priority health care premium is paid by Provincial -Government of Punjab through Punjab Health Initiative Management Company; however, earlier Priority health</p> | <p>KFW funding in 4 pilot districts, KP provincial government funding for rest of 22 districts</p> <p>Phase 1: PKR 3.8 billion per year for about 2.5 million households</p> <p>Current phase: PKR 100 billion</p> | <p>KFW and provincial government contributions make 75% and 25% of funding respectively</p> <p>Phase 1: PKR 193.833 million for 5340 households in 1 district</p> <p>Phase 2: PKR 393.104 million for 21000 households in 5 districts</p> | Employers' contribution (7% of employees' salary) |
| H) Revenue sources | National pool of public revenues allocated through NFC Award to Provinces representing the bulk of public expenditure Provincial governments decide on allocations to health with limited (but growing) revenue raising capacity | Some national pooling through federal contributions; otherwise through provincial pools (based in turn on national pooling through NFC Award) | Provincial tax-based pool (federal transfers make approximately 60%) | Donor funding pooled with provincial tax-based pool | National |
| I) Pooling | <p>Extensive supply-side funding, i.e. salaries and other inputs</p> <p>Approximately 90% total public spending on health</p> | <p>Payment against agreed treatment packages.</p> <p>Reimbursement cheques issued by insurance company to service providers as per already agreed package rates</p> | <p>Payment against agreed treatment packages</p> <p>Reimbursement cheques issued by insurance company to service providers as per already agreed package rates</p> | <p>Payment against agreed treatment packages</p> <p>Reimbursement cheques issued by insurance company to service providers as per already agreed package rates.</p> | [ESSI owns and runs its network of dispensaries, hospitals, and treatment centres] |

Note: Other entities that provide coverage in Pakistan relate the armed forces under the Ministry of Defence and which receives federal transfers like any other government entity and allocates a portion of their budget to health initiatives. In addition, there are various autonomous parastatal bodies (e.g. the Pakistan Atomic Energy Commission, Pakistan Railways, etc.) which provide coverage for their employees and gather funds from various sources, primarily relying on direct and indirect taxation as well as federal transfers to pool funds but also sometime receive government grants, fees, investments, and endowment funds.

Health expenditure by Stage 1 coverage schemes

Fig. 6. Expenditure flows by scheme (Sankey diagram)



WHERE DO SCHEMES/PROGRAMMES REVENUES COME FROM?

| STAGE 1 SCHEMES | PUBLIC | PRIVATE | EXTERNAL | TOTAL |
|---|--------|---------|----------|-------|
| A.Public System (federal and state budgets) | 83% | - | 17% | 100% |
| B.Prime Minister National Health Programme (PMNHP) | 83% | - | 17% | 100% |
| C.Sehat Sahulat Programme | 100% | - | - | 100% |
| D.Social Health Protection Initiative Gilgit Baltistan (SHPI) | 100% | - | - | 100% |
| E.ESSI | 51% | 49% | - | 100% |
| F.FOOPS | - | 100% | - | 100% |

HOW ARE REVENUE SOURCES DISTRIBUTED ACROSS SCHEMES/PROGRAMMES?

| STAGE 1 SCHEMES | PUBLIC | PRIVATE | EXTERNAL |
|---|--------|---------|----------|
| A.Public System (federal and state budgets) | 86.1% | - | 92.0% |
| B.Prime Minister National Health Programme (PMNHP) | 7.6% | - | 8.0% |
| C.Sehat Sahulat Programme | 0.6% | - | - |
| D.Social Health Protection Initiative Gilgit Baltistan (SHPI) | 0.8% | - | - |
| E.ESSI | 2.9% | 1.7% | - |
| F.FOOPS | - | 98.3% | - |
| TOTAL | 100% | 100% | 100% |

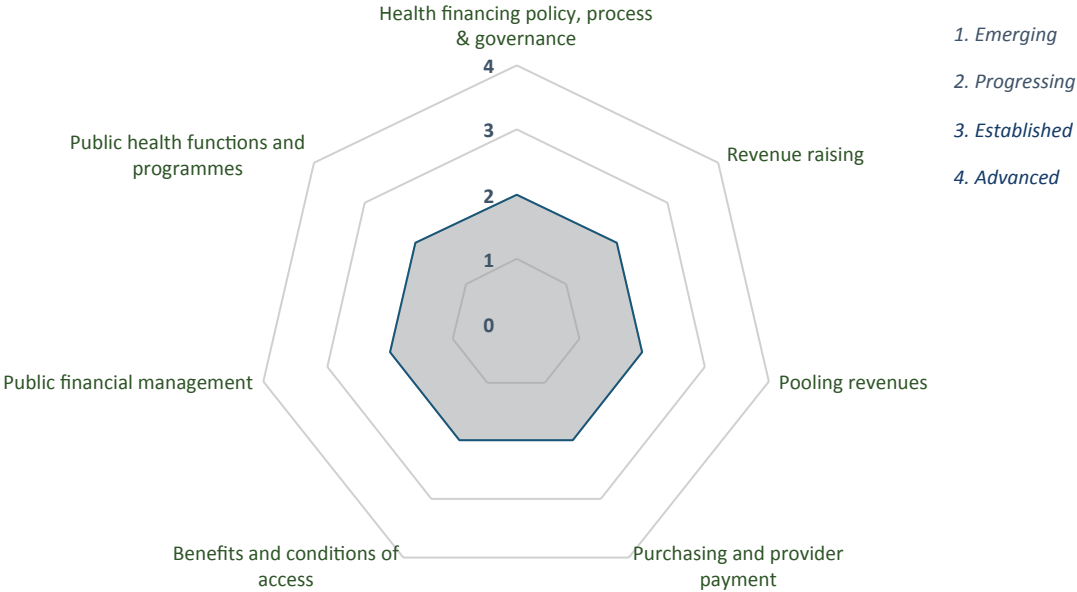
Source: Author estimates based on the HF x FS breakdown available using Health Accounts 2018 (PBS - Pakistan Bureau of Statistics), supplemented by the most recent expenditure estimates for the schemes/programmes identified in Stage 1. (See reference 28).

Note: CHE: current health expenditure.

Stage 2 assessment

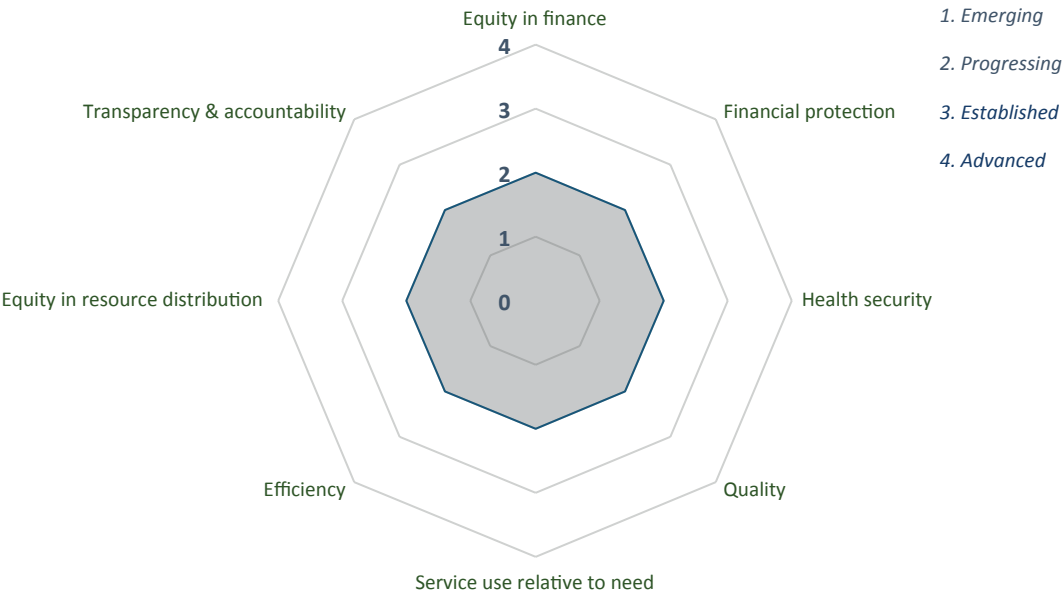
Summary of ratings by assessment area

Fig. 7. Average rating by assessment area (spider diagram)



Source: Based on HFPM data collection template v2.0, Pakistan 2022

Fig. 8. Average rating by goals and objectives (spider diagram)

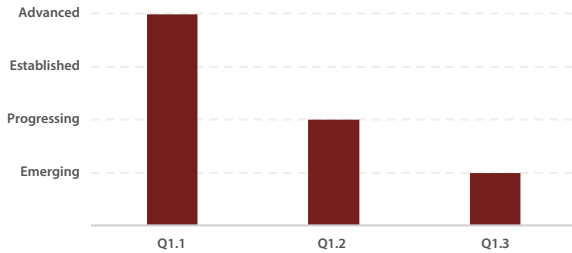


Source: Based on HFPM data collection template v2.0, Pakistan 2022

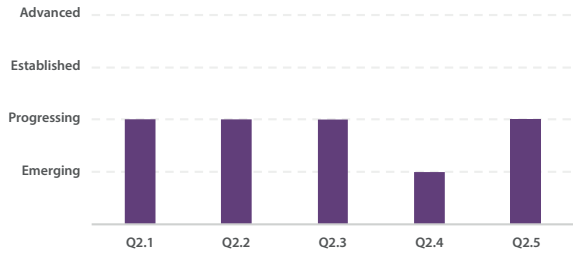
Performance rating by question

Fig. 9. Assessment rating by individual question

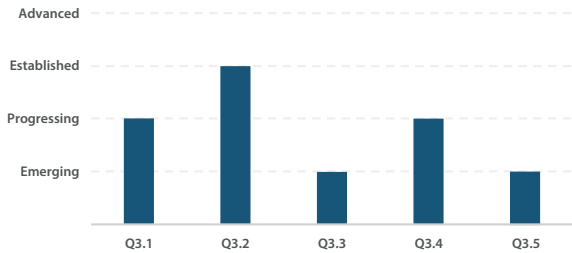
1. Health financing policy, process & governance



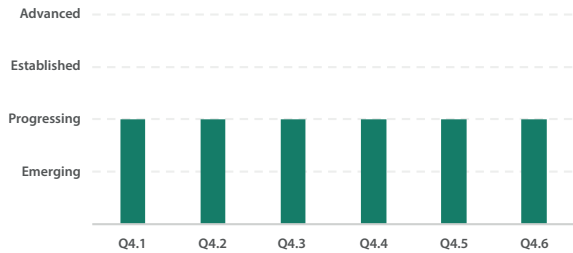
2. Revenue raising



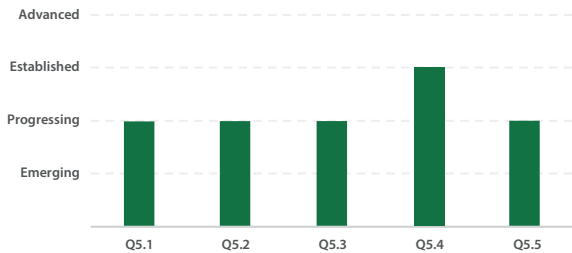
3. Pooling revenues



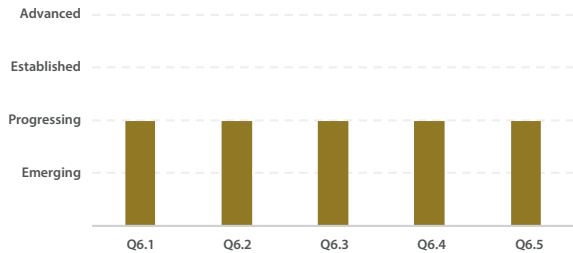
4. Purchasing and provider payment



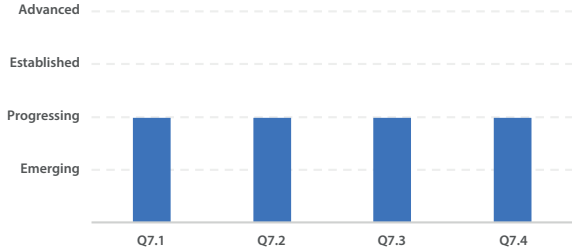
5. Benefit and conditions of access



6. Public financial management



7. Public health functions and programmes

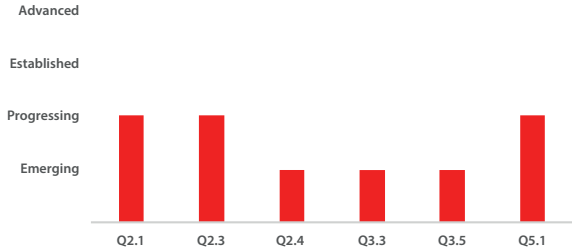


See Annex 3 for question details

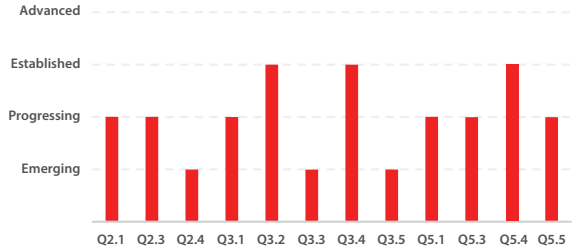
Performance rating by UHC goals

Fig. 10. Assessment rating by intermediate objective and final coverage goals

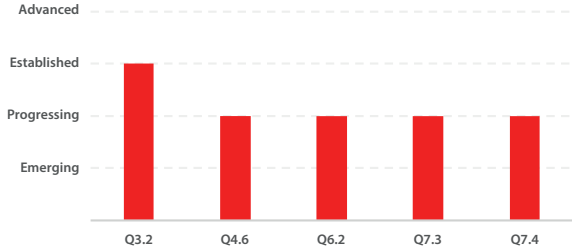
Equity in finance



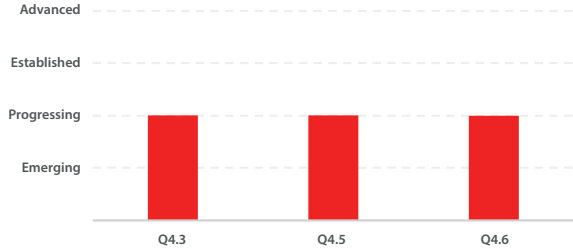
Financial protection



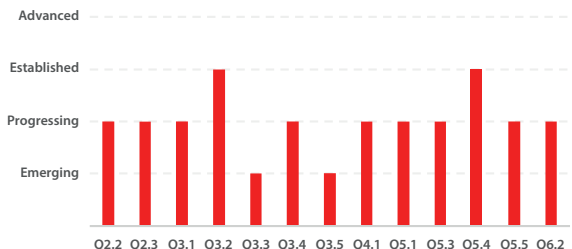
Health security



Quality



Service use relative to need

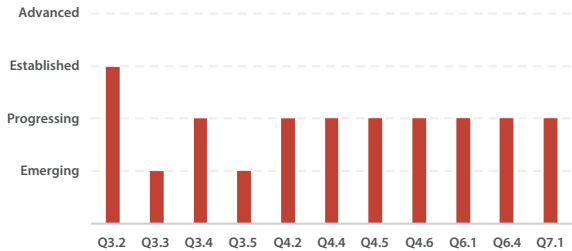


See Annex 3 for question details

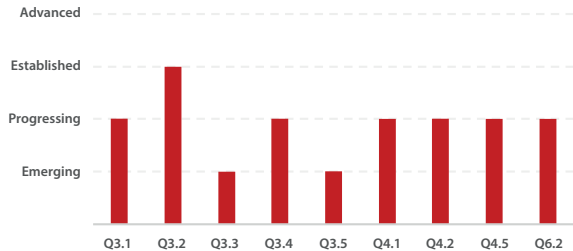
Performance rating by intermediate objective

Fig. 10. (continued). Assessment rating by intermediate objective and final coverage goals

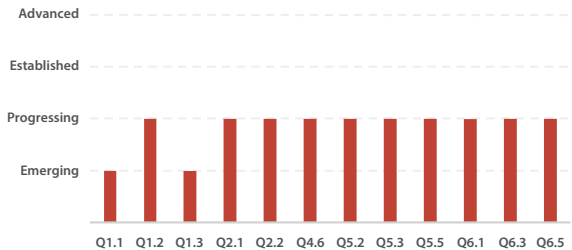
Efficiency



Equity in resource distribution



Transparency & accountability



Resources

1. Jowett M, Kutzin J, Kwon S, Hsu J, Sallaku J, Solano JG. Assessing country health financing systems: the Health Financing Progress Matrix. Geneva: World Health Organization; 2020 (Health financing guidance, no. 8). Licence: CC BY-NC-SA 3.0 IGO. <https://apps.who.int/iris/handle/10665/337938>
2. The Health Financing Progress Matrix: country assessment guide. Geneva: World Health Organization; 2020 (Health financing guidance, no. 9). Licence: CC BY-NC-SA 3.0 IGO. <https://apps.who.int/iris/handle/10665/337969>
3. Department of Health, Balochistan. 2013. Balochistan health sector strategy 2013-2018. Available at: <https://phkh.nhsr.cpk/sites/default/files/2019-06/Balochistan%20Health%20Sector%20strategy%202013-18.pdf>
4. Department of Health, Khyber Pakhtunkhwa. 2010. Khyber Pakhtunkhwa health sector strategy 2010-2017. Available at: <http://healthkp.gov.pk/public/uploads/downloads-42.pdf>
5. Department of Health Government of Khyber Pakhtunkhwa. Sehat Sahulat Programme. Available at: <https://sehatsahulat.com.pk/>
6. Finance Department, Government of Khyber Pakhtunkhwa. 2017. Khyber Pakhtunkhwa public financial management reform strategy 2017-2020. Available at: <https://www.finance.gkp.pk/article/khyber-pakhtunkhwa-public-financial-management-reform-strategy-2017-20>
7. Health Department, Government of Punjab. 2012. Draft Strategy Health Sector of Punjab, 2012–2020. Available at: https://pspu.punjab.gov.pk/policy_plans
8. Khalid F. 2018. Implementation process evaluation Prime Ministers National Health Programme.
9. Malik MA, Van de Poel E, Van Doorslaer E. 2017. Did contracting effect the use of primary health care units in Pakistan. *Health Policy and Planning*, 32(7):1032-1041.
10. Ministry of National Health Services Regulation and Coordination. 2016. National Health Vision Pakistan 2016-2025. Available at: <https://phkh.nhsr.cpk/sites/default/files/2020-12/National%20Health%20Vision%20Pakistan%202016-2025.pdf>
11. Ministry of National Health Services Regulation and Coordination. Sehat Sahulat. Available at: <http://www.pmhealthprogram.gov.pk>
12. Nishtar S, Boerma T, Amjad S, et al. 2013. Pakistan's health system: performance and prospects after the 18th Constitutional Amendment. *The Lancet*, 381(9884):2193-2206.
13. Pakistan Bureau of Statistics. 2009. National Health Accounts 2005-2006. Available at: <https://www.pbs.gov.pk/national-accounts>
14. Pakistan Bureau of Statistics. 2012. National Health Accounts 2007-2008. Available at: <https://www.pbs.gov.pk/national-accounts>
15. Pakistan Bureau of Statistics. 2013. National Health Accounts 2009-2010. Available at: <https://www.pbs.gov.pk/national-accounts>
16. Pakistan Bureau of Statistics. 2014. National Health Accounts 2011-2012.. Available at: <https://www.pbs.gov.pk/national-accounts>
17. Pakistan Bureau of Statistics. 2016. National Health Accounts 2013-2014.. Available at: <https://www.pbs.gov.pk/national-accounts>
18. Pakistan Bureau of Statistics. 2018. National Health Accounts 2015-2016. Available at: <https://www.pbs.gov.pk/national-accounts>
19. Pakistan Bureau of Statistics. 2021. National Health Accounts 2017-2018. Available at: <https://www.pbs.gov.pk/national-accounts>
20. Punjab Health care Commission. 2013. Minimum Service Delivery Standards for Primary and Secondary Health Care in Punjab. Available at: <https://dhqbhakkar.punjab.gov.pk/msds>.
21. Sindh Health Care Commission. 2018. Sindh Service Delivery Standards for Clinics and Primary Health Care Facilities. Available at: <https://shcc.org.pk/page.aspx/clinical-governance/service-delivery-standards>
22. Technical Resource Facility. 2019. Strengthening public financial management system of Punjab Health Department.

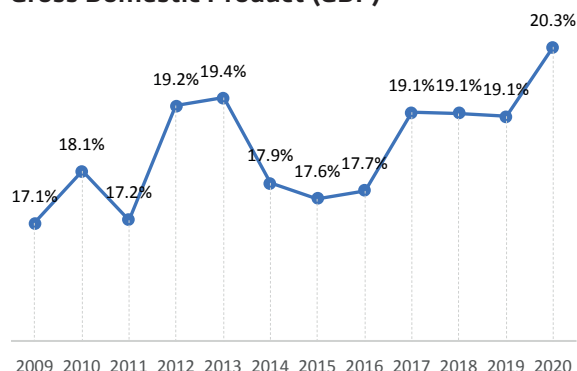
23. World Bank. 2017. Public financial management and accountability to support service delivery. Washington DC: World Bank.
24. World Health Organization Regional Office for the Eastern Mediterranean. 2018. Strengthening health financing systems in the Eastern Mediterranean Region towards universal health coverage. Cairo: World Health Organization Regional Office for the Eastern Mediterranean.
25. Zaidi S, Riaz A, Rabbani F, et al. 2015. Can contracted out health facilities improve access, equity, and quality of maternal and newborn health services? Evidence from Pakistan. *Health Research Policy and Systems*, 13: S54.
26. Zaidi S. 2012. Sindh Health Sector Strategy 2012-2020. Government of Sindh, 1-124. Available: https://ecommons.aku.edu/cgi/viewcontent.cgi?article=1215&context=pakistan_fhs_mc_chs_chs
27. Pakistan Bureau of Statistics (2021). National Health Accounts Pakistan 2019-20. Available: <https://www.pbs.gov.pk/publication/national-health-accounts-pakistan-2019-20>
28. Global health expenditure database [online database]. Geneva: World Health Organization; (<https://apps.who.int/nha/database>, accessed 1 August 2023).

Annexes

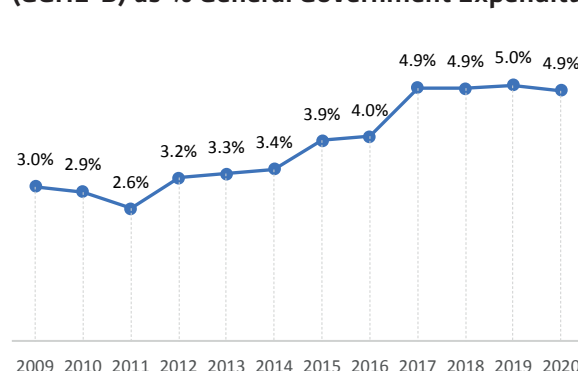
Annex 1: Selected contextual indicators

Fig. A1.1. Health expenditure indicators for Pakistan

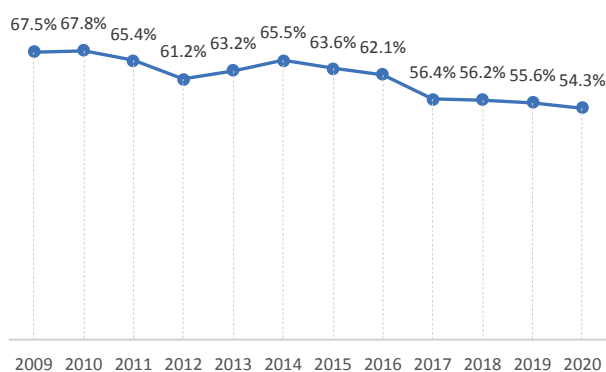
General government expenditure (GGE) as % Gross Domestic Product (GDP)



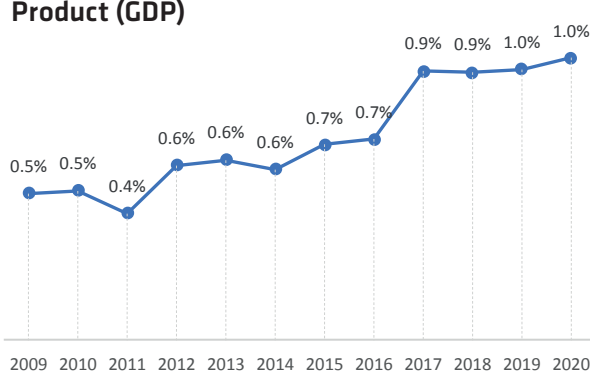
Domestic General government health expenditure (GGHE-D) as % General Government Expenditure (GGE)



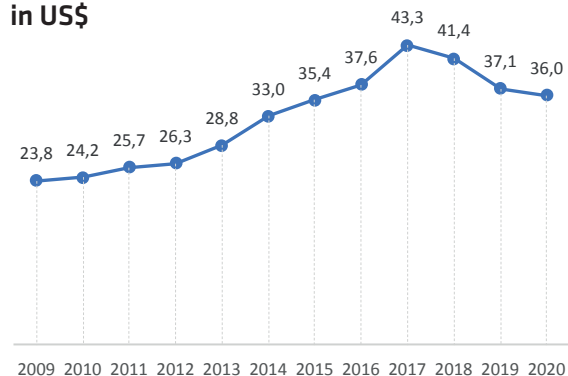
Out-of-pocket spending as % Current health expenditure (OOPS % CHE)



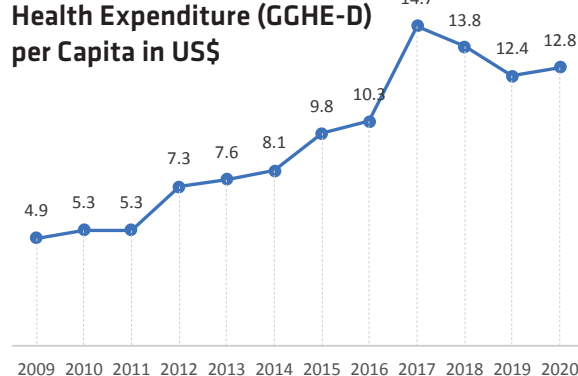
Domestic General government health expenditure (GGHE-D) as % Gross Domestic Product (GDP)



Current Health Expenditure (CHE) per Capita in US\$

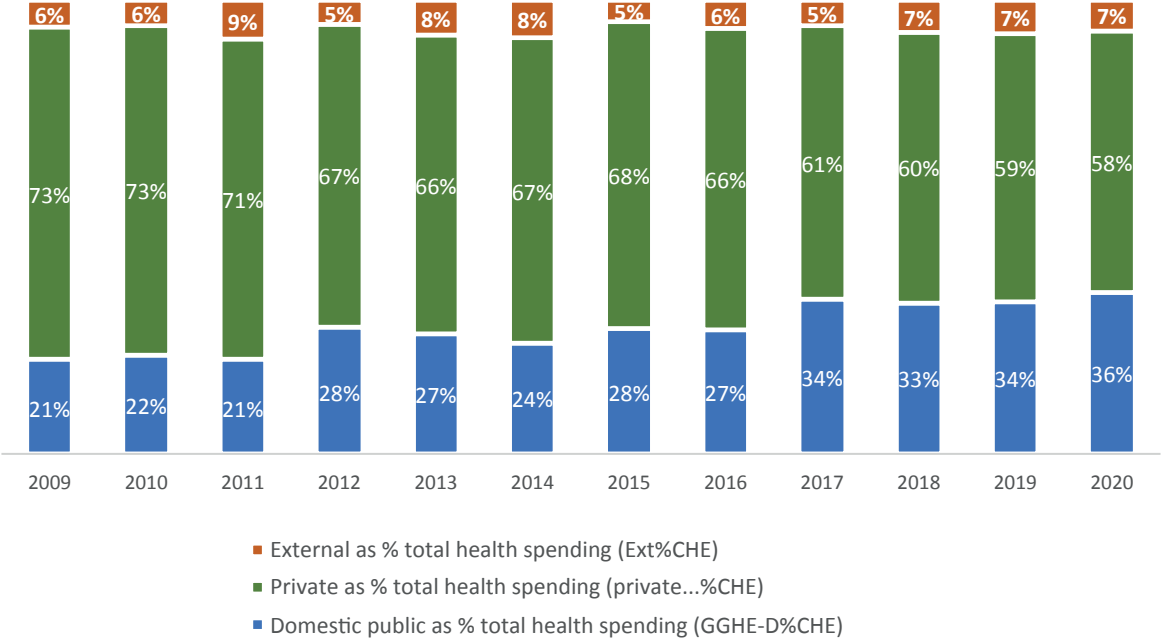


Domestic General Government Health Expenditure (GGHE-D) per Capita in US\$



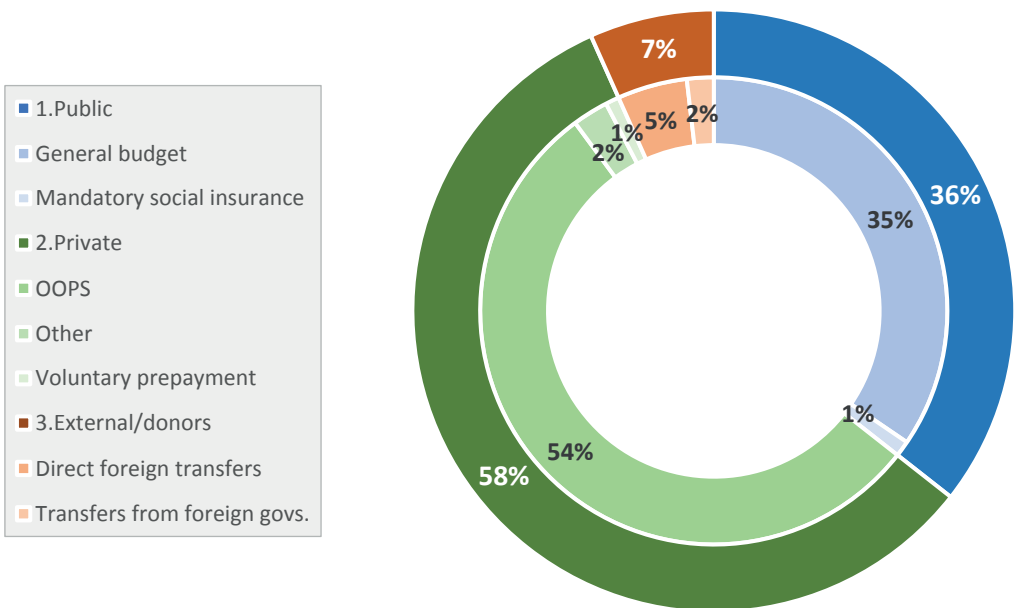
Source: WHO Global Health Observatory, 2023 (<https://apps.who.int/nha/database/Home/Index/en>, accessed 1 August 2023)

Fig. A1.2. Revenue sources for health in Pakistan



Source: WHO Global Health Observatory, 2023 (<https://apps.who.int/nha/database/Home/Index/en>, accessed 1 August 2023)

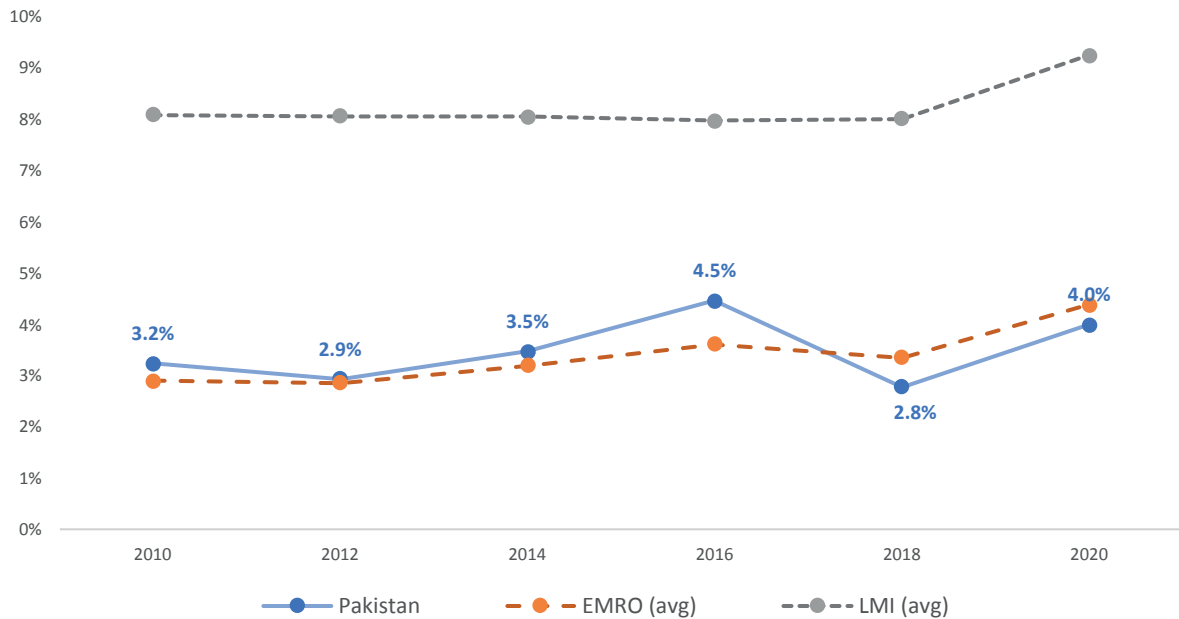
Fig. A1.3. Revenue sources disaggregated 2020



Source: WHO Global Health Observatory, 2023 (<https://apps.who.int/nha/database/Home/Index/en>, accessed 1 August 2023)

Fig. A1.4. Cigarette affordability in Pakistan

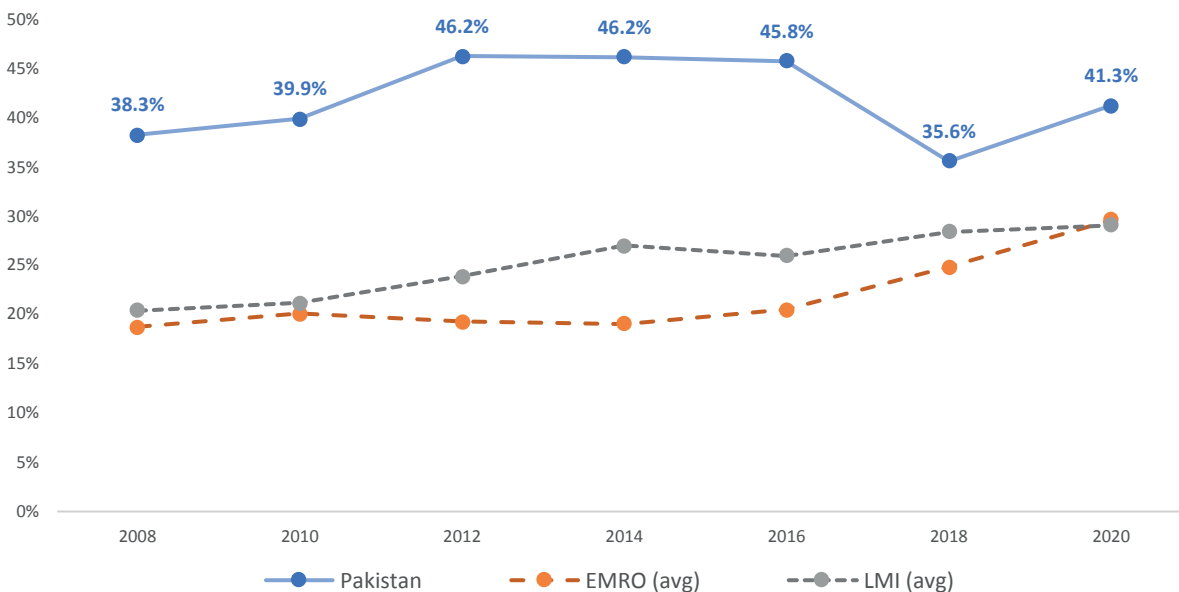
Reducing affordability is an important measure of the success of tobacco tax policy and is measured in terms of THE%GDP per capita required to purchase 2000 cigarettes (100 packs) of the most sold brand. Fig. 15 presents this data for Pakistan showing that cigarettes have become less affordable in recent years, although remain well below the average for lower middle-income countries.



Source: WHO report on the global tobacco epidemic 2019 (<https://www.who.int/teams/health-promotion/tobacco-control/%20who-report-on-the-global-tobacco-epidemic-2019>, accessed 1 August 2023)

Fig. A1.5. Excise tax share in Pakistan (cigarettes)

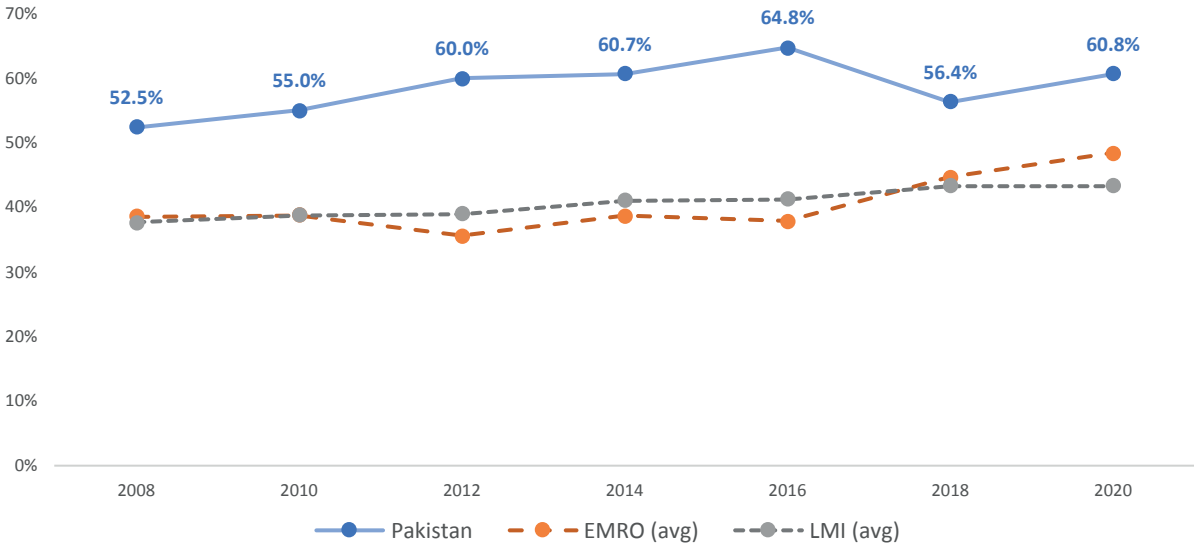
WHO recommends an excise tax share of 70%. Total tax share includes import duties and levies.



Source: WHO report on the global tobacco epidemic 2019 (<https://www.who.int/teams/health-promotion/tobacco-control/%20who-report-on-the-global-tobacco-epidemic-2019>, accessed 1 August 2023)

Fig. A1.6. Total tax share in Pakistan (cigarettes)

This indicator represents the best comparable measure of the magnitude of total tobacco taxes relative to the price of a pack of the most widely sold brand of cigarettes in the country. Total taxes include excise taxes, VAT/sales taxes and, where relevant, import duties and/or any other indirect tax applied in a country.



Source: WHO report on the global tobacco epidemic 2019 (<https://www.who.int/teams/health-promotion/tobacco-control/who-report-on-the-global-tobacco-epidemic-2019>, accessed 1 August 2023)

Annex 2: Desirable attribute of health financing

Policies which help to drive progress to UHC are summarized in terms of nineteen desirable attributes of health financing policy. For further information see: <https://www.who.int/publications/i/item/9789240017405>

| Table 1: Desirable attributes of health financing systems | | |
|---|-----|--|
| Health financing policy, process & governance | GV1 | Health financing policies are guided by UHC goals, take a system-wide perspective and prioritize and sequence strategies for both individual and population-based services |
| | GV2 | There is transparent, financial and non-financial accountability, in relation to public spending on health |
| | GV3 | International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments |
| Revenue raising | RR1 | Health expenditure is based predominantly on public/compulsory funding sources |
| | RR2 | The level of public (and external) funding is predictable over a period of years |
| | RR3 | The flow of public (and external) funds is stable and budget execution is high |
| | RR4 | Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms |
| Pooling revenues | PR1 | Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds |
| | PR2 | Health system and financing functions are integrated or coordinated across schemes and programmes |
| Purchasing & provider payment | PS1 | Resource allocation to providers reflects population health needs, provider performance or a combination |
| | PS2 | Purchasing arrangements are tailored in support of service delivery objectives |
| | PS3 | Purchasing arrangements incorporate mechanisms to ensure budgetary control |
| Benefits & conditions of access | BR1 | Entitlements and obligations are clearly understood by the population |
| | BR2 | A set of priority health service benefits within a unified framework is implemented for the entire population |
| | BR3 | Prior to adoption, service benefit changes are subject to cost-effectiveness and budgetary impact assessments |
| | BR4 | Defined benefits are aligned with available revenues, health services and mechanisms to allocate funds to providers |
| | BR5 | Benefit design includes explicit limits on user charges and protects access for vulnerable groups |
| Public financial management | PF1 | Health budget formulation and structure support flexible spending and are aligned with sector priorities |
| | PF2 | Providers can directly receive revenues, flexibly manage them and report on spending and output |

Table 1: Desirable attributes of health financing systems

| | | |
|---|-----|--|
| Public health functions & programmes³ | GV1 | Health financing policies are guided by UHC goals, take a system-wide perspective and prioritize and sequence strategies |
| | PR1 | Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds |
| | PR2 | Health system and financing functions are integrated or coordinated across schemes and programmes |
| | PS2 | Purchasing arrangements are tailored in support of service delivery objectives |
| | PF1 | Health budget formulation and structure supports flexible spending and is aligned with sector priorities |

Annex 3. HFPM assessment questions

| Assessment | Question number code | Question text |
|---|----------------------|---|
| 1) Health financing policy, process & governance | Q1.1 | Is there an up-to-date health financing policy statement guided by goals and based on evidence? |
| | Q1.2 | Are health financing agencies held accountable through appropriate governance arrangements and processes? |
| | Q1.3 | Is health financing information systemically used to monitor, evaluate and improve policy development and implementation? |
| 2) Revenue raising | Q2.1 | Does your country's strategy for domestic resource mobilization reflect international experience and evidence? |
| | Q2.2 | How predictable is public funding for health in your country over a number of years? |
| | Q2.3 | How stable is the flow of public funds to health providers? |
| | Q2.4 | To what extent are the different revenue sources raised in a progressive way? |
| | Q2.5 | To what extent does government use taxes and subsidies as instruments to affect health behaviours? |
| 3) Pooling revenues | Q3.1 | Does your country's strategy for pooling revenues reflect international experience and evidence? |
| | Q3.2 | To what extent is the capacity of the health system to re-distribute prepaid funds limited? |
| | Q3.3 | What measures are in place to address problems arising from multiple fragmented pools? |
| | Q3.4 | Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits? |
| | Q3.5 | What is the role and scale of voluntary health insurance in financing health care? |
| 4) Purchasing & provider payment | Q4.1 | To what extent is the payment of providers driven by information on the health needs of the population they serve? |
| | Q4.2 | Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers? |
| | Q4.3 | Do purchasing arrangements promote quality of care? |
| | Q4.4 | Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services? |
| | Q4.5 | Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions? |
| | Q4.6 | To what extent do providers have financial autonomy and are held accountable? |

| Assessment area | Question number code | Question text |
|--|----------------------|--|
| 5) Benefits & conditions of access | Q5.1 | Is there a set of explicitly defined benefits for the entire population? |
| | Q5.2 | Are decisions on those services to be publicly funded made transparently using explicit processes and criteria? |
| | Q5.3 | To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms? |
| | Q5.4 | Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients? |
| | Q5.5 | Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms? |
| 6) Public financial management | Q6.1 | Is there an up-to-date assessment of key public financial management bottlenecks in health? |
| | Q6.2 | Do health budget formulation and implementation support alignment with sector priorities and flexible resource use? |
| | Q6.3 | Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting? |
| | Q6.4 | Are there measures to address problems arising from both under- and over-budget spending in health? |
| | Q6.5 | Is health expenditure reporting comprehensive, timely, and publicly available? |
| 7) Public health functions & programmes | Q7.1 | Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies? |
| | Q7.2 | Do pooling arrangements promote coordination and integration across health programmes and with the broader health system? |
| | Q7.3 | Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness? |
| | Q7.4 | Are public financial management systems in place to enable a timely response to public health emergencies? |

Annex 4: Questions mapped to objectives and goals

Each question represents an area of health financing policy, selected given its influence on UHC intermediate objectives and goals, as explicitly defined below.

| Objective / goal | Question number code | Question text |
|--|----------------------|---|
| Equity in resource distribution | Q3.1 | Does your country's strategy for pooling revenues reflect international experience and evidence? |
| | Q3.2 | To what extent is the capacity of the health system to re-distribute prepaid funds limited? |
| | Q3.3 | What measures are in place to address problems arising from multiple fragmented pools? |
| | Q3.4 | Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits? |
| | Q3.5 | What is the role and scale of voluntary health insurance in financing health care? |
| | Q4.1 | To what extent is the payment of providers driven by information on the health needs of the population they serve? |
| | Q4.2 | Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers? |
| | Q4.5 | Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions? |
| | Q6.2 | Do health budget formulation and implementation support alignment with sector priorities and flexible resource use? |
| Efficiency | Q3.2 | To what extent is the capacity of the health system to re-distribute prepaid funds limited? |
| | Q3.3 | What measures are in place to address problems arising from multiple fragmented pools? |
| | Q3.4 | Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits? |
| | Q3.5 | What is the role and scale of voluntary health insurance in financing health care? |
| | Q4.2 | Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers? |
| | Q4.4 | Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services? |
| | Q4.5 | Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions? |
| | Q4.6 | To what extent do providers have financial autonomy and are held accountable? |
| | Q6.1 | Is there an up-to-date assessment of key public financial management bottlenecks in health? |
| | Q6.4 | Are there measures to address problems arising from both under- and over- budget spending in health? |
| | Q7.1 | Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies? |
| | Q7.2 | Do pooling arrangements promote coordination and integration across health programmes and with the broader health system? |

| Objective / goal | Question number code | Question text |
|--|----------------------|---|
| Transparency & accountability | Q1.1 | Is there an up-to-date health financing policy statement guided by goals and based on evidence? |
| | Q1.2 | Are health financing agencies held accountable through appropriate governance arrangements and processes? |
| | Q1.3 | Is health financing information systemically used to monitor, evaluate and improve policy development and implementation? |
| | Q2.1 | Does your country's strategy for domestic resource mobilization reflect international experience and evidence? |
| | Q2.2 | How predictable is public funding for health in your country over a number of years? |
| | Q4.6 | To what extent do providers have financial autonomy and are held accountable? |
| | Q5.2 | Are decisions on those services to be publicly funded made transparently using explicit processes and criteria? |
| | Q5.3 | To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms? |
| | Q5.5 | Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms? |
| | Q6.1 | Is there an up-to-date assessment of key public financial management bottlenecks in health? |
| | Q6.3 | Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting? |
| | Q6.5 | Is health expenditure reporting comprehensive, timely, and publicly available? |
| Service use relative to need | Q2.2 | How predictable is public funding for health in your country over a number of years? |
| | Q2.3 | How stable is the flow of public funds to health providers? |
| | Q3.1 | Does your country's strategy for pooling revenues reflect international experience and evidence? |
| | Q3.2 | To what extent is the capacity of the health system to re-distribute prepaid funds limited? |
| | Q3.3 | What measures are in place to address problems arising from multiple fragmented pools? |
| | Q3.4 | Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits? |
| | Q3.5 | What is the role and scale of voluntary health insurance in financing health care? |
| | Q4.1 | To what extent is the payment of providers driven by information on the health needs of the population they serve? |
| | Q5.1 | Is there a set of explicitly defined benefits for the entire population? |
| | Q5.3 | To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms? |
| | Q5.4 | Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients? |
| | Q5.5 | Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms? |
| | Q6.2 | Do health budget formulation and implementation support alignment with sector priorities and flexible resource use? |

| Objective / goal | Question number code | Question text |
|-----------------------------|----------------------|---|
| Financial protection | Q2.1 | Does your country's strategy for domestic resource mobilization reflect international experience and evidence? |
| | Q2.3 | How stable is the flow of public funds to health providers? |
| | Q2.4 | To what extent are the different revenue sources raised in a progressive way? |
| | Q3.1 | Does your country's strategy for pooling revenues reflect international experience and evidence? |
| | Q3.2 | To what extent is the capacity of the health system to re-distribute prepaid funds limited? |
| | Q3.3 | What measures are in place to address problems arising from multiple fragmented pools? |
| | Q3.4 | Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits? |
| | Q3.5 | What is the role and scale of voluntary health insurance in financing health care? |
| | Q5.1 | Is there a set of explicitly defined benefits for the entire population? |
| | Q5.3 | To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms? |
| | Q5.4 | Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients? |
| | Q5.5 | Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms? |
| Equity in finance | Q2.1 | Does your country's strategy for domestic resource mobilization reflect international experience and evidence? |
| | Q2.3 | How stable is the flow of public funds to health providers? |
| | Q2.4 | To what extent are the different revenue sources raised in a progressive way? |
| | Q3.3 | What measures are in place to address problems arising from multiple fragmented pools? |
| | Q3.5 | What is the role and scale of voluntary health insurance in financing health care? |
| | Q5.1 | Is there a set of explicitly defined benefits for the entire population? |
| | Q5.4 | Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients? |
| Quality | Q4.3 | Do purchasing arrangements promote quality of care? |
| | Q4.5 | Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions? |
| | Q4.6 | To what extent do providers have financial autonomy and are held accountable? |
| Health security | Q3.2 | To what extent is the capacity of the health system to re-distribute prepaid funds limited? |
| | Q4.6 | To what extent do providers have financial autonomy and are held accountable? |
| | Q6.2 | Do health budget formulation and implementation support alignment with sector priorities and flexible resource use? |
| | Q7.3 | Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness? |
| | Q7.4 | Are public financial management systems in place to enable a timely response to public health emergencies? |



For additional information, please contact:

Department of Health Financing and Economics
World Health Organization
20 avenue Appia
1211 Geneva 27
Switzerland

Email: healthfinancing@who.int
Website: http://www.who.int/health_financing

