International Labour Organization

Social Protection in Action: Building social protection floors for all

Country Brief: Pakistan

© ILO

December 2021

Extending Social Health Protection in Pakistan: Accelerating progress towards Universal Health Coverage

1. Introduction

Pakistan has a public health care system which, in principle, can be accessed by all citizens. However, Pakistan lags behind other countries in the region in terms of health indicators. For example, the probability of dying from cardiovascular disease, cancer, diabetes or chronic respiratory disease between the age of 30 and 70 (SDG 3.4.1) was 29.41 per cent in 2019, which is higher than the corresponding figures for India (21.9 per cent) and Bangladesh (18.9 per cent) (WHO n.d. a). Furthermore, Pakistan's 2019 average of 13 International Health Regulations core capacity scores was 51.04, whereas neighbouring countries, India and Bangladesh, scored 95.28 and 77.75 respectively (WHO n.d. a). These results demonstrate that Pakistan still needs to improve its health outcomes through concerted efforts towards enhancing social health protection for its population.

Currently, there are few prepayment mechanisms in Pakistan (Malik 2015), and low government spending has made it challenging to ensure that public health services provide the required medicines and laboratory equipment for effective health care delivery at affordable rates. As such, most health services in Pakistan are provided by the private sector (Rabbani and Abbasi 2017). However, government employee schemes run by federal and provincial governments are in place, which are currently the largest social health insurance schemes for those in formal employment. Furthermore, there is currently political will and momentum to improve social health protection, particularly for the poor and those in the informal economy. Notably, the Sehat Sahulat programme was implemented in 2016 to improve access among the poor to quality and affordable medical services, with an ambitious goal to cover a third of Pakistan's current population in the coming years, and gradual efforts towards universal coverage.

2. Context

Pakistan's health sector has been evolving since the country's independence from the British Government in 1947 (Meghani, Sehar, and Punjani 2014). The Federal Ministry of Health (MOH) was the main steward and regulator of the

public health sector until it was dissolved in 2011 through the 18th Constitutional Amendment. Simultaneously, all responsibilities for the health sector, including planning and fund allocation, were devolved to provincial health departments (Global Health Workforce Alliance 2021). This made Pakistan the only country in the world at that time without a central structure, such as a ministry or department for health (Nishtar et al. 2013). However, the Ministry of National Regulations and Services was established in April 2012, which later became the Ministry of National Health Services, Regulations and Coordination, as its scope of work was expanded.

As a result of three democratic transitions from 2008 to 2018, health sector reforms are high on the political agenda. Accordingly, several political parties promised "health care for all" in their election manifestos in 2018 (Khalid et al. 2020). The National Health Vision 2016–2025 envisions a health system that provides universal access to quality essential health services without financial burden, with a focus on vulnerable groups (WHO 2018). Ministries and provincial departments of health are committed to increasing public health spending and improving the efficiency of health systems in their geographical domains with a goal to achieve universal health coverage (UHC).

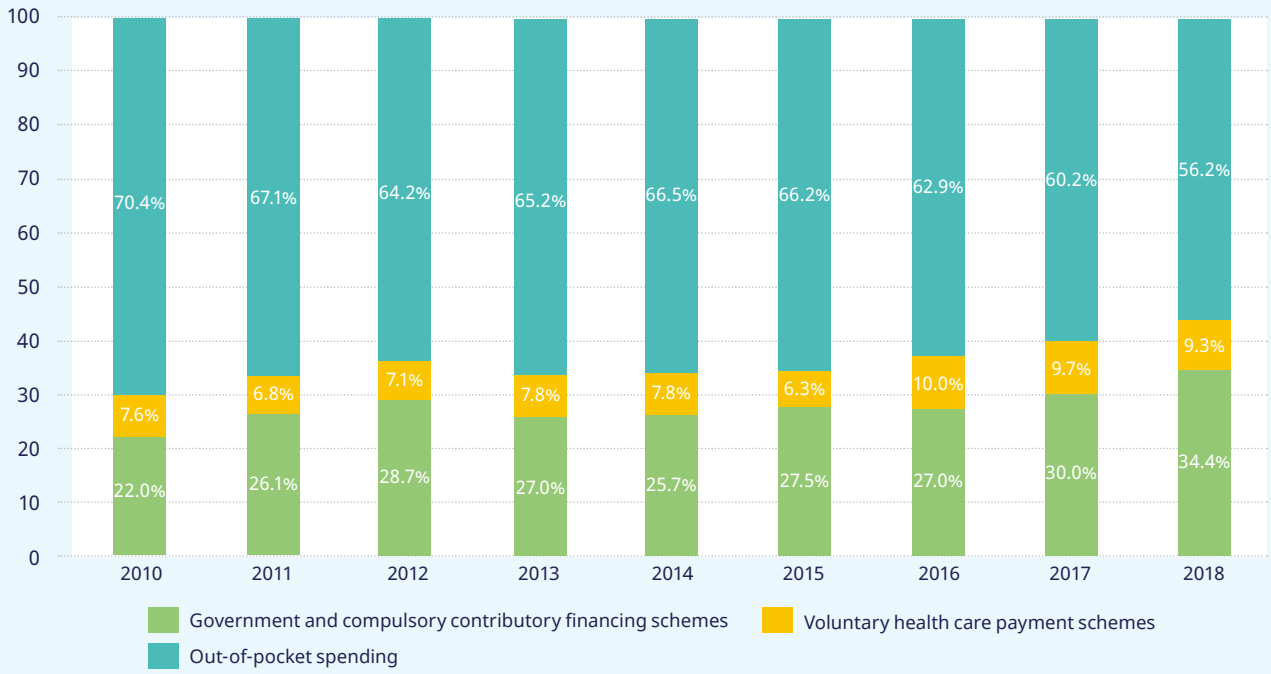
An especially noteworthy development has been the establishment of the Prime Minister's National Health Programme, later renamed the Sehat Sahulat programme, which was launched in 2016, constituting Pakistan's first large-scale social health protection scheme (besides than the specific programmes run for government and military employees). Predominantly targeting the poor, the aim is to improve access among vulnerable groups to quality and affordable medical services – including some services offered by private facilities – with the ambitious goal of covering 11 million families in 3–5 years. In addition to this scheme, due to the decentralization of the health system, several provincial social health protection schemes exist. These include the Punjab Employees Social Security Institution (PESSI) in the province of Punjab and the Khyber Pakhtunkhwa Employees Social Security Institution (KP ESSI) in the province of Khyber Pakhtunkhwa.

3. Design of the social health protection system

- Financing

In 2018, per capita spending on health in Pakistan was US$42.87, which was equal to 3.20 per cent of GDP, while out-of-pocket (OOP) spending accounted for 56.24 per cent current health expenditure (CHE), government schemes and compulsory contributory health care financing schemes accounted for 34.42 per cent, and voluntary health care payment schemes accounted for 9.34 per cent (see figure 1).

▶ Figure 1. Current health expenditure by source of financing



Source: Adapted from WHO Global Heath Expenditure Database.

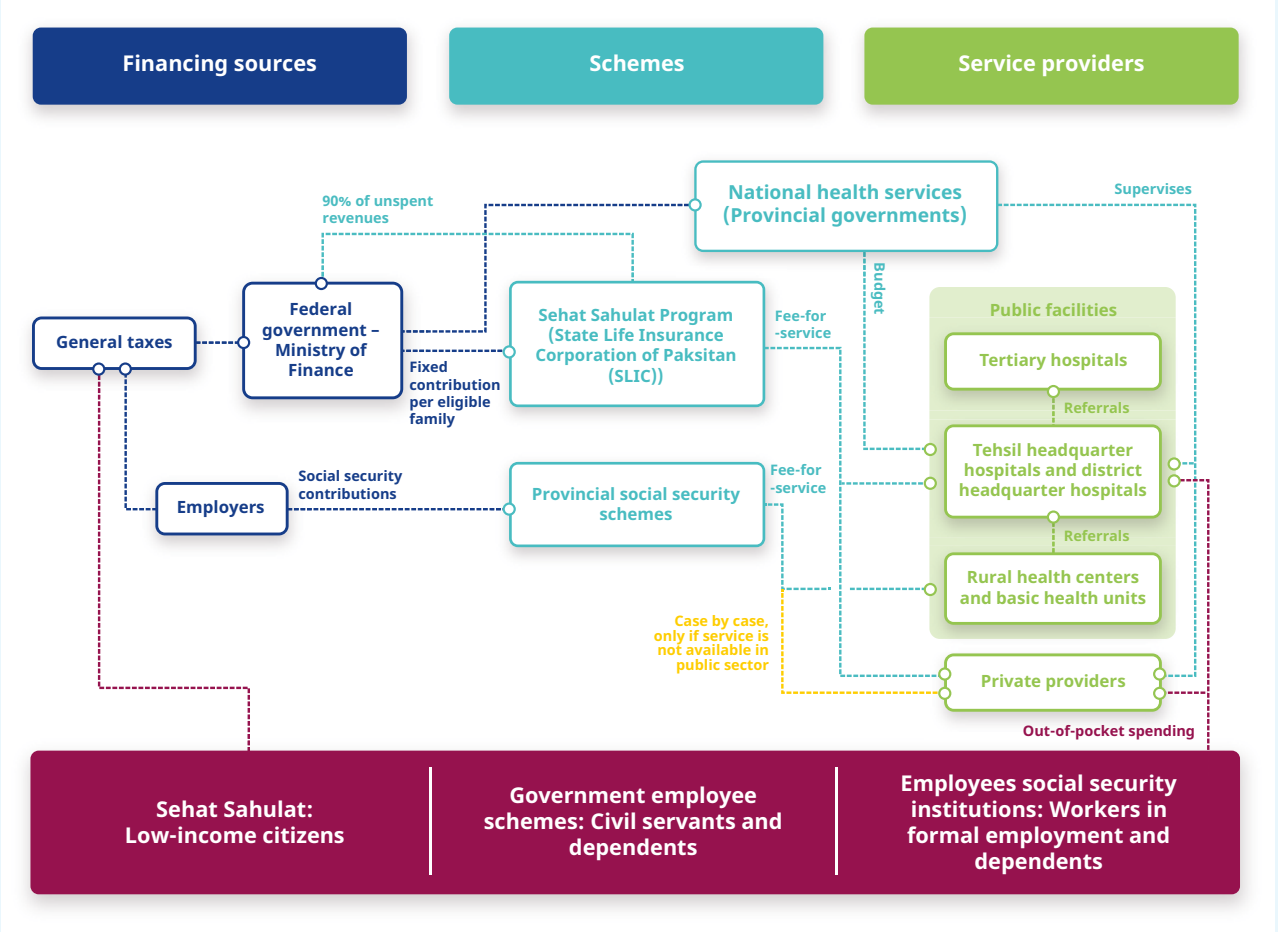
Services provided by the private sector are mainly financed through OOP spending by households, while most public services are financed and delivered through vertical programmes and by provincial authorities. National programmes for family planning and primary health care are funded by the provincial government, while public hospitals receive funding from both the federal and provincial governments (Malik 2015). The Federal Government provides constitutionally mandated transfers to provincial governments for the public health system, primarily sourced from federal taxes. These funds are then shared between provincial health departments, which oversee district headquarters hospitals and district governments, the latter of which are responsible for district-level public health facilities (Asian Development Bank 2019).

The Sehat Sahulat programme is financed by the government, which pays a fixed contribution per eligible family to the State Life Insurance Corporation of Pakistan (SLIC) (Sehat Sahulat Programme 2021b). 90 per cent of any unspent revenues is refunded to the government at the end of the three-year contract period with SLIC (Sehat Sahulat Programme 2021b). While the government initially aimed to introduce scheme contributions as eligibility expands, recent expansions in the Northwest Khyber Pakhtunkhwa region and Federal territories have been facilitated on a non-contributory basis; whether contributions will be introduced in the future as planned, remains uncertain (GIZ 2021; Thiede 2017; Sehat Sahulat Programme 2021b). Claims costs per family in 2017 amounted to PKR1,005 (US$6.20) (Sehat Sahulat Programme 2021b).

The PESSI scheme is funded through employer contributions equal to 6 per cent of covered workers' wages, which is paid directly to the administrative body (PESSI 2018b), and the KP ESSI scheme is funded through employer contributions equal to 7 per cent of the covered workers' wages (Sajid 2016).

Figure 2 provides a visual overview of the national-level social health protection system in Pakistan.

▶ **Figure 2. Overview of main financial flows of the social health protection system in Pakistan**



Source: Authors.

- Governance

The Sehat Sahulat Programme was launched in 2016 following approval by the Executive Committee of the National Economic Council (ECNEC) (Ehsan Qazi 2019). The Programme is administered by the State Life Insurance Corporation (SLIC) (Sehat Sahulat Programme 2021b). The SLIC is responsible for enrolment of beneficiaries, contracting of providers, data management, and monitoring and evaluation (Thiede 2017). A third-party administrator (TPA) is appointed through an open tender process. Competing insurance companies submit information on their technical capabilities, as well as financial bids based on their estimates of the costs of future claims and administration (Sehat Sahulat Programme 2021b). Two separate schemes exist under the umbrella of the Sehat Sahulat Programme, with one scheme funded at the Federal level for beneficiaries in the Federal regions and Punjab province, and another scheme run in Khyber Pakhtunkhwa, funded by the provincial government. The two schemes operate in a similar fashion, with some differences in the benefit packages offered.

PESSI and KP ESSI were both established through the Provincial Employees Social Security Ordinance of 1965, and the latter was based on a recommendation from the ILO (KP ESSI 2021a). The PESSI scheme operates as an autonomous body

administered by the Labour and Human Resource Department of the Government of Punjab province (PESSI 2018b). KP ESSI is governed by a state body headed by the Khyber Pakhtunkhwa's Provincial Minister for Labour, and is reportedly self-sustaining without financial assistance from the Provincial or Federal Government (KP ESSI 2021a).

- Legal coverage and eligibility

The Sehat Sahulat programme predominantly targets the poor. When it was first launched, Sehat Sahulat covered people earning less than US$2.00 per day living in the provinces of Punjab and Khyber Pakhtunkhwa, as well as those living in Federal regions, namely Islamabad Capital Territory, Azad Kashmir and Gilgit-Baltistan regions. Over the years, the geographical scope of coverage has been gradually expanded. Dr. Faisal Sultan, the Special Assistant to Pakistani Minister of Health, claimed in October 2021 that the scheme has now been extended to the entire country (BR Web Desk 2021). Coverage is family-based, comprising husbands, wives and any unmarried children. In addition, persons with disabilities who are formally registered with the National Database and Registration Authority who hold a computerized national identity card are covered in these regions. Transgender persons are covered country-wide, but must comply with the same registration and identification criteria as persons with disabilities (Sehat Sahulat Programme 2021b).

Eligibility for the scheme is linked to the Benazir Income Support Programme (BISP) —the government's flagship social protection scheme— with the BISP census providing the basis for many of the government's means-tested programmes, including the Sehat Sahulat scheme (Sehat Sahulat Programme 2021b). BISP data are used for the registration of families for issuance of "Sehat Insaf" cards (The Nation 2019). The National Socio-Economic Registry (NSER) of the BISP is used to identify and enroll eligible citizens, each of whom are given a unique identifier number. A Nationwide Poverty Scorecard Survey enables BISP to identify eligible households through proxy means testing, which determines the welfare status of affiliated households on a scale from 0 to 100. Families with a PMT of 35 are eligible for the programme (Sehat Sahulat Programme 2021b). Eligibility for the programme can be checked by sending an SMS with the person's National Identity Card Number to a number provided by Sehat Sahulat (Sehat Sahulat Programme 2021b).

Within the province of Punjab, PESSI covers employees working in industries or commercial establishments who receive monthly wages of no more than 22,000 Pakistani rupee (PKR), equivalent to US$145 per month (Zafar et al. 2008). Within the province of Khyber Pakhtunkhwa, KP ESSI covers employees of registered companies. Male employees aged 21 and above are eligible, as well as female employees who are unmarried. For both schemes, dependents of eligible employees are covered.

- Benefits

Benefits of the Sehat Sahulat programme are provided through two packages: the priority care package and the secondary care package. There are no exclusions and all pre-existing conditions are covered (Sehat Sahulat Programme 2021a). Each package has an "initial coverage" amount, which is available to all beneficiaries, and an "additional coverage" amount, which can be allocated to families in "life threatening situations and in case of maternity" (Sehat Sahulat Programme 2021a). The following services are included in the priority care package: inpatient services (all medical and surgical procedures); heart diseases (angioplasty/bypass); diabetes mellitus completion; burns; limb saving treatment, implants and prosthesis; end stage kidney diseases/dialysis; chronic infections (hepatitis/HIV/rheumatology); organ failure (liver, kidney, heart and lungs); cancer treatment (chemotherapy, radiotherapy and surgery); and neurosurgical procedures (Sehat Sahulat Programme n.d.). Outpatient care is only covered for a single post-discharge follow-up visit, and beneficiaries are provided with a voucher upon discharge (Asian Development Bank 2019).

Through its secondary care package, the Sehat Sahulat programme provides the following services: inpatient services; emergency treatment requiring admission; maternity services (normal delivery and C-section); maternity consultation for family planning, immunization and nutrition; 4 antenatal check-ups and 1 postnatal check-up; fractures and injuries; post-hospitalization; local transportation costs of PKR1,000 (US$6.20) up to three times per year; and provision of transport to tertiary care hospitals (Sehat Sahulat Programme 2021b).

Both the PESSI and KP ESSI schemes provide unique benefits packages defined through a positive list. Medical benefits offered through the PESSI scheme include treatment of heart

disease with bypass surgery; CT scans; treatment of breast cancer; dialysis; diagnosis and treatment of gastroenteritis; treatment of hepatitis; prosthetics; diagnosis and treatment of dengue fever; 24-hour ambulance services; and transportation of human remains (PESSI 2018b). Medical benefits offered through the KP ESSI include hospitalization; free medicines if prescribed by associated doctors; dental care related to employment related injuries; angiography, angioplasty and heart surgery; and ambulance services. In addition to medical care, both PESSI and KP ESSI beneficiaries are eligible to receive cash benefits in case of sickness, injury, maternity, disability, survivorship, funeral, and "iddat" (the period of waiting that a woman must observe after the death of her husband or divorce) (PESSI 2018a); (KP ESSI 2021b). For beneficiaries of the PESSI scheme, cash benefits also include free education for insured workers' children, and undefined financial assistance (PESSI 2018a).

- Provision of benefits and services

Public health facilities account for 30 per cent of total health expenditure, with the remaining 70 per cent accounted for by private providers (Hassan et al. 2017). For the national public health services, there is no formal or explicit method for allocating budgets to public health facilities, and resource allocation is predominantly based on historical spending and political and other influences, with some informal assessment of performance and patient load.

Enrolment of eligible beneficiaries for the Sehat Sahulat programme is conducted by beneficiary enrolment centres available in all districts, with electronic registration possible for those who live far from an enrolment centre. Eligible persons receive a Sehat Sahulat Insaf card from the card distribution centre in his or her district which the member has to use to access treatment at health facilities (Sehat Sahulat Programme 2021a).

Services under the Sehat Sahulat scheme are provided through empaneled hospitals, including both public and private hospitals that have successfully satisfied the Hospital Empanelment Criteria; this includes criteria on health facility equipment, management, health staff, clinical practice, laboratory services, pharmacy and client rights (GIZ 2019). Benefits are portable between districts and provinces. Hospitals empaneled in Sehat Sahulat include 300 public and private hospitals in 84 districts (Sehat Sahulat Programme 2021a). There were 1,279 public hospitals, 5,527 Basic Health Units (BHUs), 686 Rural Health Centres (RHCs), and 5,671 dispensaries in 2018. In terms of personnel, there were 220,829 registered doctors, 22,595 registered dentists, and 108,474 registered nurses in 2018 (Pakistan Ministry of Finance, 2018). Under the scheme, hospitals are reimbursed after patient claims have been submitted (Sehat Sahulat Programme 2021a). Reimbursement is based on fixed rates agreed between hospitals and insurance companies, with the exception of cancer treatment, which may use a fee-for-service payment model.

PESSI beneficiaries can access medical treatment at official Social Security Hospitals free of charge. E-cards are used to access benefits (PESSI 2021b). Health services or facilities that are not available at Social Security Hospitals may be arranged through other hospitals at no additional cost to patients, even if care is only available abroad (PESSI 2018a). KP ESSI beneficiaries can access medical treatment at the scheme's medical units and government hospitals, free of charge. KP ESSI has established 35 medical units in Khyber Pakhtunkhwa province: 1 hospital, 1 poly clinic, 12 medicare centres, 12 dispensaries, 1 dental unit and 8 medical posts (KP ESSI 2021c). PESSI and KP ESSI beneficiaries are issued with a social security card which allows them to avail of medical services from Social Security Hospitals (KP ESSI 2021d; Zafar et al. 2008).

4. Results

- Coverage

The number of beneficiaries of the Sehat Sahulat programme increased from 2.4 million families in early 2018 to 3.2 million families across 38 districts in October 2018, as reported by the National Database and Registration Authority (Yusufzai 2018). [1] It is the largest of the publicly governed health care schemes, and includes

[1] Assuming that families enrolled in the scheme comprise of an average of 6.27 members—a figure used in the study by (GIZ 2019)—the 3.2 million families covered in October 2018 constitute about 20 million individuals, which amounts to slightly less than 10 per cent of Pakistan's total population in 2018. The goal of 11 million families would translate to 68.97 million individuals, slightly less than a third of Pakistan's population in 2019.

coverage of care at private facilities. As previously noted, the programme aims to expand coverage to around 11 million families within 3–5 years by increasing the income threshold and extending the programme to all employees of government institutions, including employees of universities and medical institutes (Sehat Sahulat Programme 2021a).

A study conducted in 2019 on the health sector in the Khyber Pakhtunkhwa province found that, of the estimated population of 30.5 million, the estimated number of beneficiaries of the Sehat Sahulat Programme is 19.2 million, accounting for over 60 per cent of the population of the province (Asian Development Bank 2019). In early 2021, the government expressed ambitions to expand the scheme's original target coverage, and offer universal coverage through the scheme nationwide; to this end, coverage in the Federal regions is gradually being expanded (Dawn.com 2020; White-Kaba 2020). Besides Khyber Pakhtunkhwa province, the Sehat Sahulat Programme has been operational in Punjab, Azad Kashmir and one district of Sindh province, namely Tharparkar (BR Web Desk 2021). In addition, there are an estimated 7.84 million beneficiaries covered through schemes for formal workers, though the vast majority of those covered (7.16 million) are employed in the public sector, within the government or the military. Overall, these figures imply that 27.16 million persons in Khyber Pakhtunkhwa province are covered by a health protection scheme, accounting for nearly 90 per cent of its population.

However, there are reports that only a fraction of those officially covered have been able to benefit from the programme. For example, a news article stated that although by September 2020, 5 million families were issued Sehat Insaf cards and thus formally a part of the Sehat Sahulat Programme, in practice only 93,000 were found to have utilized benefits from the programme (Qayyum 2020).

As for the employee schemes, the overall number of secured workers under PESSI is 918,343 while the number of dependents is 5,508,708. [2] KP ESSI coverage gaps remain high, with an official report published by KP ESSI in 2014 noting that out of the province's 7.3 million total workforce, only 60,000 workers are affiliated with KP ESSI, with an additional 340,000 dependents (KP ESSI 2014).

- Adequacy of benefits/financial protection

A cycle of ill health and poverty in Pakistan is exacerbated by inadequate financing of the health sector (Arshad et al. 2016). There are limited prepayment mechanisms in place and low government spending has led to high levels of OOP spending by households, which, as noted above, comprised 56.24 per cent current health expenditure in 2018. This places a significant financial burden on poor households. However, the Government has made commitments to expanding financial protection, particularly for health.

- Responsiveness to population needs
    - o Availability and accessibility

There are large disparities between the rich and the poor in terms of access to health services (Kurji et al. 2016). One study undertaken in Baluchistan province found an unusually high level of inequity in the utilization of almost all public health services. In particular, the utilization of services such as post-natal consultation, institutional delivery and tetanus toxoid injections for pregnant women were found to higher among wealthier segments of the population (Malik and Ashraf 2016).

There are also considerable variations in the resources allocated to urban and rural public health facilities due to fragmented sources of funding. In some localities, most of which are urban areas, the public health system provides a wide range of services, including heart and cancer treatments as well as treatments for other critical illnesses. However, in rural areas, the availability of public care services is lower.

[2] The official PESSI website reports the number of secured workers and their dependents under the programme for each directorate (PESSI 2020).

Notably, in the province of Khyber Pahktunkhwa, 1.45 doctors are available per 1,000 people in urban areas, while in rural areas the corresponding figure is only 0.36 (Asian Development Bank 2019). Moreover, there is evidence of gender inequalities in accessing health care, with Pakistan's 2019 CPIA gender equality rating lower than 85 per cent of other countries analyzed, including India, Nepal and Bangladesh. [3] Women therefore seek care less frequently than men, which has a negative impact on women's health status and general wellbeing (Arshad et al. 2016).

Despite these disparities, an analysis of health statistics by wealth quintiles, represented in table 1 below, suggests that for the listed health indicators, the poorest quintile (Q1) saw greater improvements from 2013 to 2018 than the wealthiest quintile (Q5), lending some support to the equalizing effect of Pakistan's social health protection system. In particular, substantial progress has been made when it comes to maternal and child health, and this progress was more significant for the poorest quintile.

▶ Table 1. Comparison of evolution of national health indicators by wealth quintile

	Q1			Q5			DID*
Indicator	2013	2018	Change	2013	2018	Change	ΔQ1- ΔQ5
Under-5 mortality rate (per 1,000 live births)	119	100	-19	48	56	8	-27
Infant mortality rate (per 1,000 live births)	90	76	-14	44	53	9	-23
Antenatal care (any skilled personnel) (% of women with a birth)	53.6	67.7	14.1	96.9	98	1.1	13
Assistance during delivery (any skilled personnel) (% of births)	34	49.8	15.8	85.8	93.9	8.1	7.7
Problems in accessing health care (getting money for treatment) (% of women)	54.3	45.7	-8.6	9.2	11.1	1.9	-10.5

Note: The first quintile (Q1) comprises the 20 per cent of the population with the least wealth, and the last quintile (Q5) comprises the 20 per cent of the population with the most wealth.

Source: Adapted from World Bank Data.

As exemplified by the evolution of national health indicators noted above, despite facing challenges, Pakistan has a history of strong programmatic interventions that have successfully improved social health protection for its citizens, For example, the Lady Health Worker Programme (LHWP) has been operated throughout the country since 1994, which equips female health workers with the skills to provide essential primary health services in rural and urban slum communities (WHO 2008). Evaluations of the LHWP have shown that populations served by the programme have significantly better health outcomes than the general population—a strong result considering its focus on rural and marginalized populations (Women Deliver 2016). In addition, several Health Equity Monitor indicators, including neonatal, infant and under-five mortality rates, as well

[3] CPIA gender equality ratings are assessed on a scale from 1 to 6, with higher scores indicating higher gender equality (World Bank n.d. a).

as immunization coverage for diseases such as measles and polio, have improved for the poorest wealth quintile in the past decade (WHO n.d. a).

- Quality and acceptability

Despite these efforts, in line with resource distribution disparities, there are noteworthy differences in the quality of care offered in urban and rural areas. This, combined with perceptions of private services as superior quality, has caused a large proportion of the population to pay out-of-pocket for care in private facilities, even if such services are available in public facilities. Some studies find that patients have expressed dissatisfaction with services provided by their doctors, including unavailability of specialist doctors, seeing different doctors during each visit, absence of a physical examination, and fear of asking questions (Jalil et al. 2017). However, there are some individual reports of high levels of patient satisfaction with the Sehat Sahulat programme (Hussain 2019; The Nation 2020), although it must be noted that patient satisfaction is not systematically measured and monitored at national level as it is in many countries.

▶ 5. Way forward

Despite some signs of progress, OOP spending in Pakistan remains high and the social health protection system is fragmented. The multi-sectoral and multi-stakeholder Ehsaas Strategy was launched in 2019 to address fragmentation and enable better coordination between the institutions involved in administering national poverty alleviation and social protection programmes which target the mustahiq (deserving) population. This includes not only health schemes such as the Sehat Sahulat Programme, but broader financial assistance programmes such as Bait-ul-Mal [4] and Zakat. [5] Ehsaas is intended to bring such schemes and other components of social protection under one division to better serve the community (Government of Pakistan 2019a; ILO 2019). Ehsaas currently encompasses 115 policy actions under four pillars: (i) making the government system work to create equality; (ii) safety nets for the disadvantaged; (iii) jobs and livelihoods; and iv) human capital development (Government of Pakistan 2019b).

Furthermore, the establishment of a new Ministry of Social Protection/Poverty Alleviation to address fragmentation of social protection mechanisms has been announced. The BISP, Bait-ul-Mal, and Zakat, among others, are to be coordinated by the new ministry (Pakistan Ministry of Finance 2019). Under the overarching Ehsaas framework mentioned above, two of the executing agencies of Poverty Alleviation and Social Safety Division (PASSD), namely Bait-ul-Mal and the Pakistan Poverty Alleviation Fund, signed an MoU to collaborate on strengthening women's economic empowerment and elevating women's roles in society (Benazir Income Support Programme 2019). As noted elsewhere, there is also coordination between SHP schemes and BISP on targeting of beneficiaries.

▶ 6. Main lessons learned

- Due to under-investment and resulting gaps in affordable access to health care, payments for health care services are primarily comprised of OOP spending, with many health care services provided by private facilities. This has led to significant disparities in access to health care between the rich and the poor.
- Fragmentation of schemes and limited population coverage have reduced the collective impact of social health protection schemes in Pakistan. The Government is addressing fragmentation through improved coordination structures and the launch of a new, large-scale health protection scheme, largely driven by a strong political will to improve access to health care for the poor population.

[4] Through Individual Financial Assistance (IFA) and various support programmes, Bait-ul-Mal supports the poor, widows, destitute women, orphans and disabled persons, providing general assistance, education, medical treatment and rehabilitation, and child support (Bait-ul-Mal 2019).

[5] Zakat is currently running a range of programmes for the poor which include Guzara Allowance for the chronic poor, marriage grants for poor single women, free treatment for poor patients, and educational stipends for the students of Deeni Madaris and government Institutes (Zakat n.d.).

References

Arshad, Shumaila, Hira Waris, Maria Ismail, and Ayesha Naseer. 2016. "Health Care System in Pakistan: A Review." *Research in Pharmacy and Health Sciences* 2 (3): 211–16.

Asian Development Bank. 2019. *Khyber Pakhtunkhwa Health Sector Review: Hospital Care*.

Bait-ul-Mal. 2019. "Individual Financial Assistance", available at: http://www.pbm.gov.pk/ifa1.html.

Benazir Income Support Program. 2019. "Ehsaas Press Releases – Benazir Income Support Programme", available at: https://www.bisp.gov.pk/Detail/YzBmMmY1N2ItNTE5OS00YzlhLWIwNGUtZDc2NWI2MTFlMjE3.

BR Web Desk. 2021. "Sehat Sahulat Programme Extended to Entire Country: Dr Sultan." *Business Recorder*, 4 October 2021.

Dawn.com. 2020. "KP Govt Launches Sehat Sahulat Programme for All Residents of Province." *Dawn*, 20 August 2020.

Ehsan Qazi, A. 2019. *Sustainability of Social Health Insurance*. Pakistan Institute of Development Economics (PIDE).

GIZ (the Deutsche Gesellschaft für Internationale Zusammenarbeit). 2019. *Data Analysis of the Central Management Information System of the Federal Sehat Sahulat Program*.

——. 2021. *Working in Partnership for Social Health Protection in Pakistan*.

Global Health Workforce Alliance. 2021. "Pakistan", available at: https://www.who.int/workforcealliance/countries/pak/en/.

Government of Pakistan. 2019a. *Prime Minister's Policy Statement - Ehsaas*.

——. 2019b. *The Multi-Sectoral and Multi-Stakeholder Ehsaas Strategy*.

Hassan, A., K. Mahmood, and Hudebia Allah Bukhsh. 2017. "Healthcare System of Pakistan." *International Journal of Advanced Research and Publications* 1 (4).

Hussain, Hannan. 2019. "Understanding Pakistan's Efforts to Align Quality Healthcare with Sustainable Development Goals". South Asia@LSE blog. Available at: https://blogs.lse.ac.uk/southasia/2019/10/28/understanding-pakistans-efforts-to-align-quality-healthcare-with-sustainable-development-goals/.

ILO (International Labour Organization). 2019. *Mapping Social Protection Systems in Pakistan: The Status of Current Systems in Line with the UN Social Protection Floor Concept*.

Jalil, Aisha, Rubeena Zakar, Muhammad Zakria Zakar, and Florian Fischer. 2017. "Patient Satisfaction with Doctor-Patient Interactions: A Mixed Methods Study among Diabetes Mellitus Patients in Pakistan." *BMC Health Services Research* 17 (1): 155.

Khalid, Faraz, Maria Petro Brunal, Abdul Sattar, Samia Laokri, Matthew Jowett, Wajeeha Raza, and David R. Hotchkiss. 2020. "Assessing the Efficiency of Sub-National Units in Making Progress Towards Universal Health Coverage: Evidence from Pakistan." *Health Systems & Reform* 6 (1): e1617026.

KP ESSI (Khyber Pakhtunkhwa Employees Social Security Institution). 2014. *Social Protection Strategy for Workers*.

——. 2021a. "Employee Social Security Institution", available at: http://essi.kp.gov.pk/page/employee_social_security_institution/page_type/message.

——. 2021b. "Functions", available at: http://essi.kp.gov.pk/page/functions.

——. 2021c. "Objectives", available at: https://essi.kp.gov.pk/index.php?/page/objectives.

——. 2021d. "Requirements for Social Security Card (R-5)", available at: http://essi.kp.gov.pk/page/requirements_for_social_security_card_r_5.

Kurji, Z., Z.S. Premani, and Y. Mithani. 2016. "Analysis of the Health Care System of Pakistan: Lessons Learnt and Way Forward." J Ayub Med Coll Abbottabad, 28 (3): 601—604.

Malik, Muhammad Ashar. 2015. *Universal Health Coverage Assessment Pakistan*. The Aga Khan University.

Malik, Sadia Mariam, and Nabila Ashraf. 2016. "Equity in the Use of Public Services for Mother and Newborn Child Health Care in Pakistan: A Utilization Incidence Analysis." *International Journal for Equity in Health* 15 (120).

Meghani, S.T., S. Sehar, and N.S. Punjani. 2014. "Comparison and Analysis of Health Care Delivery System: Pakistan Versus China." *International Journal Of Endorsing Health Science Research* 2 (1): 46–50.

Nishtar, S., T. Boerma, S. Amjad, A.Y. Alam, F. Khalid, I-u. Haq, and Y.A. Mirza. 2013. "Pakistan's Health System: Performance and Prospects after the 18th Constitutional Amendment." *The Lancet* 381 (9884): 2193–2206.

Pakistan Ministry of Finance. 2018. *Pakistan Economic Survey 2017-18*.

——. 2019. *Economic Survey 2018-19*.

PESSI (Punjab Employees Social Security Institution). 2018a. "Healthcare Benefits", available at: https://www.pessi.gop.pk/hcb.php.

——. 2018b. "Overview", available at: https://www.pessi.gop.pk/overview.php.

——. 2020. "Directorates of Social Security", available at: https://www.pessi.gop.pk/dsslhrg.php.

Qayyum, Khalid. 2020. "Sehat Sahulat Programme Fails to Achieve Targets". *The Express Tribune*, 22 September 2020.

Rabbani, Fauziah, and Imran Naeem Abbasi. 2017. "Accreditation and Health Care Quality Assurance in Pakistan: A Desk Review." *Pakistan Journal of Public Health* 7 (3): 174–79.

Sajid, Imran Ahmad. 2016. *Lecture on Labour Welfare in Khyber Pakhtunkhwa, Pakistan.*

Sehat Sahulat Programme. 2021a. *Benefit Package (2019-2021).*

——. 2021b. "Sehat Sahulat Program", available at: https://www.pmhealthprogram.gov.pk/.

——. n.d. *Diseases Covered under the Program.*

The Nation. 2019. "PM Launches Sehat Insaf Cards Programme", The Nation, 5 February 2019.

——. 2020. "Sehat Sahulat Programme Running Successfully: SAPM Health". *The Nation*, 23 January 2020.

Thiede, Michael. 2017. *Guiding Document for the Development of a Roadmap towards Achieving Universal Health Coverage.* GIZ Pakistan.

White-Kaba, Mary. 2020. "On a Fast Track to Universal Health Coverage in Pakistan". Healthy DEvelopments Blog. Available at: https://health.bmz.de/stories/on-a-fast-track-to-universal-health-coverage-in-pakistan/.

WHO (World Health Organization). 2008. *Pakistan's Lady Health Worker Programme.*

——. 2018. *Pakistan Country Cooperation Strategy at a Glance.*

——. n.d. a. "Global Health Observatory Data". Available at: https://www.who.int/data/gho/data. Accessed 27 February 2020.

——. n.d. b. "Global Health Expenditure Database". Available at: https://apps.who.int/nha/database. Accessed 27 February 2020.

Women Deliver. 2016. "The Pakistani Lady Health Worker Program: Providing Care to Underserved Populations". Women Deliver Blog. Available at: https://womendeliver.org/2016/pakistani-lady-health-worker-program-providing-care-underserved-populations/.

World Bank. n.d. a. "World Development Indicators", Databank. Available at: https://databank.worldbank.org/source/world-development-indicators. Accessed 27 October 2021.

——. n.d. b. "Health Nutrition and Population Statistics by Wealth Quintile". Available at: https://datacatalog.worldbank.org/dataset/health-nutrition-and-population-statistics-wealth-quintile. Accessed 20 January 2021.

Yusufzai, Ashfaq. 2018. "Number of KP Health Initiative's Beneficiaries to Increase by 600,000". *Dawn*, 4 November 2018.

Zafar, M. I., S. R. S. Abbasi, Z. Batool, and I. Shahid. 2008. "A Study of Medical Facilities Provided by Punjab Employees Social Security Institutions to the Labourers in the Faisalabad City." *The Journal of Animal and Plant Sciences (Pakistan)* 18 (2–3): 94–98.

Zakat. n.d. "Overview: Zakat & Ushr Department", available at: https://zakat.punjab.gov.pk/overview.

Supported by LUXEMBOURG AID & DEVELOPMENT

This profile was prepared by Sven Engels (ILO) and Afzal Asad Sayeed (Collective for Social Science Research, Karachi, Pakistan) and benefited from the review, inputs and quality assurance of Imran Masood, Gul Rukh Mehboob and Muhammad Uzair Afzal (GIZ), as well as Lou Tessier, Henrik Axelson and Nga Leopold (ILO).

The Editor of the series is Valérie Schmitt, Deputy Director, Social Protection Department.

This country brief is extracted from and one of 21 country profiles published in the ILO's report: "Extending social health protection: Accelerating progress towards Universal Health Coverage in Asia and the Pacific".

Contact information

International Labour Organization
Social Protection Department
Route des Morillons 4
CH-1211 Geneva 22
Switzerland

ILO Regional Office for Asia and the Pacific
United Nations Building
Rajdamnern Nok Avenue
Bangkok 10200
Thailand

T: +41 22 799 7239
E: socpro@ilo.org
W: www.ilo.org/asia
www.social-protection.org

ISBN 9789220359280 (print)
ISBN 9789220359297 (PDF)