

(MACRO-FISCAL HEALTH FINANCING OF PAKISTAN)



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ABSTRACT

The purpose of this abstract is to provide an overview of the macro fiscal health factors in Pakistan. The study aims to identify and analyze the factors that contribute to the fiscal health of the country, including government revenue, expenditures, debt, and economic growth. Using a combination of primary and secondary sources, the research examines the current state of the macro fiscal health in Pakistan and analyzes the impact of past and present policies. The findings suggest that the fiscal health of Pakistan is heavily dependent on factors such as government expenditure, tax revenue collection, and external debt levels. It is evident that Pakistan's high debt to GDP ratio poses a significant threat to the country's macro fiscal health. The study also highlights the need for developing a strong and stable macroeconomic framework that promotes financial stability and long-term growth. This abstract is intended to provide a brief overview of the macro fiscal health factors in Pakistan. The research aims to provide policymakers and stakeholders with a better understanding of the current state of Pakistan's fiscal health and identify areas for improvement. Suggestions for future research include analyzing the impact of new policies and reforms on Pakistan's macro fiscal health.

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CHAPTER 1

INTRODUCTION

Healthcare financing is a major issue for the Pakistani economy. Pakistan's over 220 million people provide a significant problem when it comes to providing them with affordable, high-quality medical care. The health of populations and the quality of care received by individuals both benefit from a secure macro-financial framework.

OVERVIEW OF PAKISTAN'S HEALTHCARE SYSTEM

Since both public and private enterprises operate inside Pakistan, the government plays an essential role in both the delivery and regulation of the medical care market. It is nevertheless difficult for many individuals, particularly those living in rural areas, to get the medical care they need due to a dearth of appropriate facilities. The rising prevalence of both communicable and non-communicable diseases places a heavy burden on the country's healthcare infrastructure.

Policymaking in Pakistan's healthcare system is under the purview of the Ministry of National Health Services, Regulations, and Coordination. The basic, intermediate, and tertiary levels of the system all have significant gaps in availability and quality. Secondary and tertiary care are provided by public and private hospitals, respectively; primary care is provided through a network of Basic Health Units (BHUs) and Rural Health Centers (RHCs).

Pakistan's healthcare system faces significant challenges due to a shortage of qualified medical experts, obsolete facilities, and enough financing. Up view of these issues, it is clear that improved macro fiscal health financing is required to fill up the gaps and guarantee continued healthcare provision.

UNDERSTANDING OF MACRO-FISCAL HEALTH FINANCING

The phrase "macro fiscal health financing" refers to the method through which a nation's overall tax system is utilized to pay for medical treatment. This concept encompasses not just profitability but also the management of resources and the regulation of expenditures. It is

necessary to have a dependable macro fiscal health finance system in place in order to meet the demands of a population in terms of medical treatment.

In Pakistan, financing for medical treatment comes from a variety of sources, including the government and the private sector. The national budget receives funding from a variety of sources, including taxation, user fees, and social health insurance benefits. The majority of the funds that come from foreign sources come from individual contributors and philanthropic organizations located in other countries.

Establishing integrity and transparency in financial choices pertaining to healthcare may be facilitated by the use of effective budgeting, spending tracking, and auditing systems. These strategies improve the efficiency of healthcare by boosting production while simultaneously cutting waste and maximizing the use of available resources.

CURRENT STATUS OF MACRO-FISCAL HEALTH FINANCING OF PAKISTAN

There are a number of problems with Pakistan's existing method of funding healthcare on a macroeconomic scale. Because healthcare expenditure represents such a small portion of the overall GDP, many clinics and hospitals do not have the resources they need. Pakistan's healthcare expenditure in 2020-2020 was barely 0.4% of the country's GDP, despite the World Health Organization's recommendation that this number should be at least 6%.

Inadequate funding for the nation's healthcare system leads in poorly maintained buildings, a shortage of essential supplies, and inadequate staffing levels in hospitals. This illness creates substantial barriers that must be overcome in order to provide adequate medical treatment in underserved and impoverished regions.

Because medical treatment in Pakistan is so outrageously expensive, many people are required to spend a significant portion of their money on it. People who are already having trouble making ends meet may be dissuaded from seeking medical care if they are expected to make significant out-of-pocket payments for treatment.

SIGNIFICANCE OF THE STUDY

The current study has significance in a different context. First, the study highlights the current and past data of Pakistan, and at the same time, compares the data with past figures to see the current position of health sector of Pakistan. This helps researchers to identify the most important role of macro fiscal factors on the effect to Pakistan economy, Growth and Health

Financing sector. And secondly, this study help researchers to find out cross sectional interception of health financing with macro fiscal factors and how it can be improvised with revenue and tax collection.

LEARNING OBJECTIVE

The learning objective from studying the macro fiscal health factors of Pakistan can vary depending on the specific area of interest and the level of analysis. However, some general learning objectives could include:

1. **Understanding fiscal policy:** By examining the macro fiscal health factors of Pakistan, you can gain insights into the country's fiscal policy framework, including the government's revenue and expenditure patterns, budgetary decisions, and the impact of fiscal measures on the overall economy.
2. **Assessing fiscal sustainability:** Analyzing macro fiscal health factors allows you to evaluate the sustainability of Pakistan's fiscal position over the long term. This involves examining factors such as the government's debt levels, deficit financing strategies, and the ability to generate sufficient revenue to cover expenses.
3. **Identifying fiscal challenges and risks:** Through studying the macro fiscal health factors, you can identify the key challenges and risks that Pakistan faces in maintaining a stable fiscal position. This may include issues such as a high fiscal deficit, increasing public debt, inefficient tax collection, or structural weaknesses in public expenditure.
4. **Evaluating economic stability and growth prospects:** The fiscal health of a country is closely linked to its overall economic stability and growth prospects. By understanding the macro fiscal factors in Pakistan, you can assess how fiscal policies impact economic performance, including factors like inflation, unemployment, and investment levels.
5. **Comparing with international standards and best practices:** Studying Pakistan's macro fiscal health factors provides an opportunity to compare the country's fiscal policies and performance with international standards and best practices. This comparative analysis can help identify areas for improvement and potential policy recommendations.

6. Policy formulation and decision-making: A thorough understanding of macro fiscal health factors equips policymakers and decision-makers with the knowledge and insights needed to formulate effective fiscal policies. By examining past trends and current challenges, policymakers can make informed decisions to address fiscal imbalances and promote sustainable economic development.

Overall, studying the macro fiscal health factors of Pakistan provides a comprehensive understanding of the country's fiscal position, its impact on the economy, and the challenges and opportunities associated with fiscal management.

RESEARCH OBJECTIVE

- To study and analyze the macro fiscal factors which effects Pakistan's health sector directly and in-directly.
- To indicate the major changes in health financing of Pakistan.
- To find the impact of macro fiscal factors on health financing.
- To analyze the growth and un-employment effect on the economy of Pakistan.
- To study the drawbacks in health sector and analyze Pakistan's current fiscal position.
- To study the tax sector if Pakistan and its effect on health financing.

CHAPTER 2

Problem Definition and Requirement Analysis

Problem Statement

Pakistan's path to macro fiscal health financing is impeded by a number of factors. The provision of universal healthcare is hampered by factors such as inadequate revenue bases, tax evasion, and a reliance on personal spending. Because of the informal sector's high level of service but low tax contribution, public health funding is often inadequate.

Without universal health care, families must shoulder a heavy financial burden. When there aren't enough risk-sharing systems in place, individuals and families are less equipped to cope with substantial healthcare bills. In the absence of a universal healthcare system, taxpayers would be expected to shoulder a greater share of the cost.

Due to limited funds and conflicting priorities, healthcare financing is routinely delayed. Due to budget constraints and competing priorities like infrastructure development, education, and the military, it is challenging to prioritize healthcare and provide the resources to serve the needs of the people.

Research Gap

There is a lot of evidence to suggest that Pakistan's macro economy is thriving, but there is not nearly as much information on the factors that contribute to the economy's long-term viability. The impact that macroeconomic policies have on Pakistan's fiscal health as well as the efficiency of fiscal measures in terms of revenue collection, expenditure management, and the sustainability of debt are mostly untapped areas of research. In addition to this, it is essential to investigate the impact that regional geopolitical factors and international trade have had on the soundness of Pakistan's national economy. In research on Pakistan's macro fiscal health, focus has been given to external issues that endanger fiscal stability less often than other causes. Little research has been done on the effects that Pakistan's budgeting practices would have on the economy of the nation over the long run. In recent years, the government of Pakistan has prioritized activities aimed at maintaining economic stability above those aimed

at furthering larger-scale development objectives. Research has to be carried out to determine the extent to which governmental spending influences economic expansion and the size of the national debt over time. The next thing that has to be done is research on how changes in fiscal policy affect the percentage of the population that lives in poverty and the distribution of the national income. Pakistan has made a lot of progress toward more equitable development and the decrease of poverty, but there are still a lot of barriers to overcome. Because of this, it is very necessary to investigate the impact that Pakistan's diverse approaches to budgeting have had on the country's economy and the degree of poverty there. As a final point, there is a severe deficiency in research on Pakistan's macro fiscal health, which necessitates in-depth studies of the internal and external factors influencing fiscal sustainability, the link between fiscal sustainability and long-term growth, and the impact of fiscal policies on income distribution and the reduction of poverty. In conclusion, there is a serious deficiency in research on Pakistan's macro fiscal health.

REQUIREMENT ANALYSIS

The long-term prosperity of every nation depends on its capacity to keep its economy stable. A country's economic growth is directly tied to its level of fiscal security. This includes the government's ability to manage the country's finances, such as its revenue, spending, and debt levels. The policies of the government, the rate of economic expansion, the volume of international trade, and the size of the country's external debt are all factors that might compromise the country's macro fiscal health. Government efforts to improve Pakistan's macro fiscal health have been hampered by the country's sluggish economic development, high levels of public debt, and inadequate tax collection. Ineffective leadership and management are to blame for Pakistan's bloated budget. The fiscal imbalance that has developed as a result of the country's economic policies is unsustainable due to the high amount of foreign debt and poor tax collection. Pakistan's economic growth depends on the country's government continuing to exercise budgetary restraint. Pakistan's tax system is complicated and outdated, hence it brings in very little revenue for the government. Since tax collection is very low compared to GDP, the Pakistani government has trouble paying its financial obligations. Pakistan's yearly budget is affected by the country's tax system and the spending patterns of its citizens. The military, subsidies, and debt servicing absorb a significant portion of Pakistan's GDP. As a result, the possibility that long-term economic development will be aided

by public goods like healthcare, education, and infrastructure has lessened. Pakistan's macroeconomic position is worsened by the country's high amount of foreign debt. Pakistan's debt to GDP ratio has risen over the danger zone due to rapid rises in both domestic and foreign debt. The large level of foreign debt in Pakistan makes it difficult for the government to finance domestic economic initiatives, making the nation very sensitive to environmental changes. The macro fiscal health of Pakistan is affected by the country's tax policy, spending habits, and foreign debt. Pakistan requires a macroeconomic framework that prioritizes fiscal discipline, tax collection, and investment in public goods if it is to get its budget back on track.

There may be much that Pakistan may learn from the world's foremost authorities on macro fiscal health financing. Innovative finance arrangements and prioritizing health sector investment have allowed countries like Thailand, Malaysia, and Rwanda to successfully adopt universal health care systems. Health results, access to healthcare, and economic security have all improved in these nations.

For example, the Thai government pools its resources so that all people may get medical treatment if they need it. Contributions to a national health insurance scheme are now mandatory in Malaysia for both employees and their companies. To ensure its citizens have access to low-cost, high-quality medical treatment, the government of Rwanda instituted a community-based health insurance system.

It is crucial to create a method for spreading the expense of healthcare to ensure that individuals of varied financial capabilities have access to proper medical treatment. They provide essential guidance for the development of long-term macro-financial health funding policies and efforts in Pakistan.

The concept of caring for the ill is broad, including both the treatment of an individual and the care of a whole community. Most middle- and low-income nations struggle to provide their people with a full complement of health care services because of a lack of resources. Additional barriers exist for the poor to get medical attention due to social and economic factors such as gender, education, women's status, nutrition, and cleanliness. To address these issues, we need a healthcare system that does more than just cover the costs of medical care; ideally, it would also work to improve people's health in a variety of ways. Patient responsibility for healthcare budgeting is essential to an effective healthcare system, as stated by the World Health Organization in 2000. Slow progress has been made achieving the health-related Millennium Development Goals while the wealth-poor coverage gap has widened. Timely and appropriate medical treatment should be available to all people without regard to their ability to pay. The

World Health Organization (WHO) encourages all member states to create healthcare finance strategies tailored to their unique situations and long-term budgets for health system administration. (World health Organization 2000).

HEALTH FINANCING MECHANISM

Increased reliance on private health spending is expected to exacerbate current difficulties with healthcare access and affordability in the absence of a regulatory enforcement mechanism. There are more than a billion people in Africa and South Asia, and over 10% of them live in absolute poverty, meaning they make do on less than \$2 a day. Public health financing methods are inefficient and discriminatory, so those in the lowest income quintile already pay a disproportionate share of the nation's health care expenditures. The World Health Organization reported in 2005 that only around 5-10% of the population in low and moderate income nations had access to social security. Health finance systems that narrow coverage gaps to ensure universal access to health care must be prioritized since most low-income countries are not on track to meet MDG targets.

Based on measures of development such as the Human Development Index (HDI) and economic output, Pakistan ranks 125 out of 169 nations in 2010. Legislators have failed to create adequate health finance mechanisms despite a growing population and changing epidemiological patterns (i.e., varying sickness patterns) over the past decade, leaving many without access to even the most fundamental forms of medical care. The government of Pakistan allocates between 5.1% and 11.6% of GDP to health development, despite recommendations from the World Health Organization (Ahmed and Shaikh 2008; Nishtar 2006) that at least 5% of GDP be spent on health. Health care costs in OECD nations averaged 8.1% of GDP in 2011, according to OECD statistics. Social security and universal health care remain problematic areas for Pakistan, notwithstanding recent increases in health expenditure. Despite the fact that the most recent rises ignore inflation, population growth, and the burden of illness, this remains the case. This suggests that rather than increasing everyone's access to high-quality medical care, the bulk of the funds are utilized to pay staff and cover other administrative expenses. Nishtar (2010) claims that the health care system in Pakistan has several problems, including low quality, incompetence, and access. The failure of the government to provide adequate health care has led to these issues. There has to be a failsafe method of sending money between the planning stage and the actual implementation.

REVENUE COLLECTION

Money might come from a variety of places, including government grants, employee and community donations, private insurance, and consumer spending. Government expenditures and voluntary donations from the public make up the bulk of the funding for healthcare in Pakistan. The government of Pakistan is responsible for funding public health programs via general taxation and other sources (including bilateral and multilateral donors) in line with annual development goals (Ghaffar et al., 2000). A centralized finance ministry is responsible for collecting most taxes and distributing them both horizontally across states and vertically between the federal government and the several states. Thankfully, the government of Pakistan pays for more than 80% of all public sector spending. Health care costs \$6.40 per person, with the government covering around \$5.90 and development partners covering the remaining \$1.30. Dependence is not a big worry due to the fact that official development aid (ODA) has changed substantially over the past several years in response to changing global and local political objectives. People with low incomes often have to pay out of pocket for medical care, regardless of whether they visit a public or private clinic. Nationally, tertiary hospital funding has risen to become one of the largest non-developmental receivers of province budgets (Mohammad et al., 2007).

According to the Asian Development Bank (2005), just 5% of Pakistanis have health insurance. Private health insurance and the Islamic government's treasury, Bait-ul-Maal, are two alternative options for covering medical costs, although they only apply to a tiny fraction of the population. Islamic law mandates the payment of zakat, or 2.5% of any wealth over a set level that stays undistributed for a whole year, as another kind of luxury tax.

RESOURCE ALLOCATION

More people fall into poverty when private (out-of-pocket) health care costs rise to as much as 80% (World Health Organization, 2011). Local statistics shown in Figure 2 suggest this price might be as high as 73%. These ever-increasing costs are a significant reason why the healthcare access gap between the lowest and highest income quintiles has grown over the last several years. Low-income families already have a tough time of it because of the high cost of medical care. It is vital to have a safety net in place to protect individuals from the financially debilitating impacts of disease (Belay et al., 2010).

To allocate is to decide how something should be divided up among competing people, groups, or areas. (World Health Organization, 1996) One of the six pillars of health care systems is equitable funding. In the public sector, allocation formulas are vital because they ensure that underserved communities, individuals, and initiatives get enough funding. Health care services at the federal and provincial levels must be adequately funded to cover rising costs. Health care that is both egalitarian and accessible is impeded by an inefficient allocation of resources between developmental and non-developmental year plans. Historically, funding for development programs has lagged behind spending on health care for non-developmental goals. According to the Government of Pakistan (2005), salaries and other fixed expenses consume almost 80% of provincial health budgets. The government's expansion of developmental health projects in the provinces without accounting for population growth has resulted in insufficient coverage and low quality of public health services, particularly in rural regions. There are currently no available financial mechanisms that can either lower individual payments or increase tax pooling. There is still room for collaboration on novel approaches to funding medical care.

EXPENDITURE

Healthcare at the federal, provincial, and municipal levels in Pakistan is supported by tax revenue. Examining the many ways in which governments provide for medical care is both interesting and important. The federal government helps the provinces financially via tax transfers, subsidies, direct payments, and loans. The National Finance Commission (NFC) of Canada provides advice on a wide range of fiscal matters, including taxation and fee collection, borrowing capacity, and intergovernmental transfer payments (Ahmed et al., 2007). The provincial taxable pool includes both federally taxable assignments and provincially taxable income and transfers in kind. Budget items including pensions, subsidies, debt payments, and priority programs are subtracted from the total discretionary budget to arrive at the net divisible pool. The provincial government of Sindh kept 45% of the distributable fund for itself in 2004 and distributed the remaining 55%. Since its inception in 1947, the National Finance Committee's (NFC) method of allocating funds to provinces has been purely population-based. On 2010, the NFC instituted a redistribution mechanism that factored on demographics, economic development, provincial revenue, and inverted population density. As can be seen in Figure 3 from the Government of Pakistan (2010), the effort resulted in more fair allocations that better addressed the requirements of people in each area.

Pakistan's healthcare system has been affected by recent political reforms such as the 18th constitutional amendment and the local government Ordinance. This later modification provides provincial social service and health care organizations more independence in financial and administrative concerns. Devolving greater authority to the provinces might allow for more adaptability in health care spending plans. By allocating a bigger proportion of GDP to health expenditure, like OECD nations, Cuba has sustained political changes and improved mother and child health statistics (Pan American Health Organization, 2011). As a result of the announcement of a seventh NFC award in 2011, funding for health and social activities around the country was enhanced. Given the opportunity's potential health benefits, provincial health system financing should be increased and sustained. The new system should make it possible for everyone to have access to and make full use of health services. (Nishtar 2011).

BUDGETING

Primary health care institutions, which serve 80% of the population, have historically been underfunded by the Pakistani government in favor of more expensive specialist treatment (Nishtar, 2010). Health care pooling and purchasing are now the responsibility of individual provinces rather than the federal government (World Bank, 1998). Now more than ever, every country must pay its fair share of the cost of universal health care. It is possible that provincial accountability mechanisms might be enhanced to make healthcare spending more transparent and efficient. The provinces could also have trouble keeping tabs on federal payments since they lack the necessary resources. Decentralizing healthcare relies on local health systems being prepared for the transition (Spedo et al., 2009). While the provinces wait for the finalization of the transfer of money, they may take use of the federation's technical help to learn the skills and gain the experience necessary to manage and maintain their own resources. Healthcare systems in the poor countries require additional funding to be able to provide equitable health financing options. The World Health Organization estimates that low-income nations would need to spend at least \$35 per capita in order to fulfill the MDGs via universal coverage by 2015. Financial incentives granted by the most recent NFC award have been recognized as valuable by provinces in their new positions as guardians of the health and social sectors. The central government and the provinces no longer seem to be at odds over money and reserves according to the 18th amendment. To better assist those on lower incomes, we propose the following adjustments to provincial financing schemes.

Health care delivery systems include the allocation of funds, the provision of health services, the cultivation of health-related human resources, and the maintenance of a sufficient supply of drugs and medical equipment. According to the World Health Organization (2011), provinces need to increase health sector funding by a factor of four in order to meet MDG targets. For a change to be evidence-based, a swift and transparent procedure is required. Our limited resources need to be used more wisely, and we can no longer afford to ignore the most pressing problems. Health financing decisions need a number of processes, including scenario and vision analysis, resource and constraint assessment, solution development and implementation, and ongoing monitoring and evaluation (World Health Organization, 2005). Provinces in Pakistan need to adopt these actions to modernize health financing systems in light of the present epidemiological and political realities in the country. The bulk of health expenditure is allocated to non-developmental accounts, which has received little attention (Ahmed and Shaikh, 2008; World Health Organization, 2011). The provinces may now reallocate funds from the developing to the non-developing sector, where they can be used more effectively in the health and social sectors. To keep up with our rapid growth and implement our numerous horizontal projects across all three levels of healthcare provision, we will require a sizable budget. According to the World Bank (1993), public and preventive health care should get the bulk of healthcare financing, with private and public insurance picking up the slack. Since they impact the most defenseless members of society, maternal and child health care should be a top priority right now. (Mazhar and Shaikh 2012).

TAX SYSTEM

In contrast to the formal economies, which have a well-structured tax system and registered tax payers, the informal sector in Pakistan accounts for the vast majority of economic activity and pays less than 20% of GDP to general taxes (Nishtar, 2010). Both the federal government and individual states need to seek direct taxes on businesses and people with vigor. The same holds true for the implementation of any changes to the legislation that are essential for the collection of taxes in line with their text. A transparent accountability system is essential for enticing the underreported informal sector and other revenue-generating sectors, such as agriculture, to contribute to the tax base and increasing overall revenues. The trust of the people in government programs will increase as a result of this. The new health-related tax incentives under Indonesia's revised general taxation system helped achieve these objectives (World

Health Organization, 2005). The MDGs will not be met by 2015 unless the provinces reallocate some of their tax funds to public health initiatives.

Over sixty nations already have a universal health care system (SHI; World Bank, 2006). To improve access to healthcare for all Thai citizens, the 30-Baht plan was implemented. Patients' out-of-pocket expenses, which are more common in the private health sector, were lowered by this innovative funding technique (Sreshthaputra and Indaratna, 2001). With Pakistan's present trend toward decentralization, an effective assessment of SHI on a smaller scale is now possible (Abrejo and Shaikh, 2008). Alternatives to traditional health insurance, such as prepaid vouchers and conditional cash transfers, have been proposed to increase access to health care for low-income persons and encourage more responsible service use (Bellows et al., 2011; Doetinchem et al., 2008). In addition to other stewardship obligations, provincial governments are responsible with executing a national health agenda and equitably distributing resources across the health care system (Saltman & Ferroussier-Davis, 2000). Pakistan has a "double burden of disease," with about equal numbers of individuals suffering from communicable and non-communicable disorders. Hospitalization and other treatments for chronic diseases may cost a lot of money, and the government should help pay some of those costs. Now that provinces have their own budgets thanks to reforms in 2011, it is the perfect moment to provide districts more say over regional issues. At the district level, poverty indicators may be more readily managed, and population estimates can be more precise (Mazhar and Shaikh, 2012). If the federal government isn't involved, state and municipal governments may concentrate on identifying and enacting solutions. As part of its policy framework, the government has suggested a social security system that is organized by district (Planning Commission, 2005). The time has come to look at alternative healthcare finance models and for the government to increase healthcare sector investments. There are substantial domestic finance alternatives available via direct and indirect taxes, and they should be investigated promptly. Higher taxes on excesses like air travel, foreign currency transactions, and other luxuries are one possible route for indirect taxation (World Health Organization, 2005). The health care system would profit from the increased tax revenue and the healthier population that would result from increasing the price of cigarettes and other harmful items. However, the federal government and the several provinces must agree to implement any novel health finance schemes. Since provinces now have a bigger financial interest in the healthcare system, they should explore innovative approaches to healthcare funding. The federation plays an essential role in bolstering the provinces' technical and administrative skills, which in turn helps to progress distinctive health financing systems and foster inter-provincial peace. More effort is required

to scale up these novel ways to financing, despite the fact that cost-sharing and co-funding pilot projects have been developed in a number of areas around the nation. Low-income people may benefit greatly from community finance's ability to pool funds for medical treatment (Ekman, 2004). Since many of them do not have health insurance, this is extremely crucial. Provincial governments must now devise plans to provide sufficient funding in order to expand residents' access to healthcare, notably maternal and child healthcare services (Mazhar and Shaikh, 2012).

ECONOMIC GROWTH

There is a lot of poverty in Pakistan because of the unpredictable macroeconomic indicators and the unequal economic development. Pakistan has not been able to reach MDG objectives due to a lack of resources despite the government's best efforts to reduce poverty via job creation, assistance for the poor, and better social indices (Government of Pakistan, 2007). Foreign assistance is crucial for developing nations as it helps to supplement native fundraising efforts and close the funding gap. Ejaz, et al. (2011) suggest enhancing the health care budget by working with reputable international NGOs and development partners. Helping low-income nations alleviate poverty and boost investment in health sector development plans requires widespread international cooperation. Financial capacity building in low- and middle-income countries is a top priority for high-income nations as part of their Official Development Assistance obligations (World Health Organization, 2005). According to the World Health Organization (2001), if every nation invested \$35 USD per person on health, it would allow the government to prioritize health-related development programs above those that do not contribute to the MDGs. Weaning ourselves off that percentage of money should be the ultimate aim, even if Pakistan's health sector has never been totally reliant on donor support for health except for a few vertical projects.

Pakistan took the initiative to address the country's health care requirements by creating the first national health plan in the world in 1960. To better serve the public interest, public-private partnerships (PPPs) are one kind of health sector reform. PPPs aim to formalize and sustain task-oriented relationships between the public and private sectors. In most cases, this calls for both parties to participate in the decision-making process and use their imaginations. Both access and demand for primary care services are expected to increase as a result of public-private partnerships (PPPs). Medical care is one of the "basic necessities" that the government must provide for its population, as stated in Article 38(d) of Pakistan's 1973 Constitution.

National security tends to take priority above human development, preventing the government from fulfilling its constitutional commitment to strengthen Pakistan's healthcare system. One of the biggest obstacles to progress in Pakistan is the dismal state of the country's healthcare system. Two separate epidemics have hit Pakistan. While infectious illnesses like polio have been eliminated in many nations, noncommunicable diseases like obesity and diabetes continue to plague the United States. Pakistan has comparatively good health indices, including low infant mortality (approximately 100 per 1000 live births) and high maternal mortality (340 per 100 000 live births), in comparison to other developing nations.

Accessible, inexpensive, and effectively administered primary care is often overlooked in Pakistan's privatization efforts. One possible explanation is that the public and private Sectors in Pakistan are too unequally positioned politically and socially to work together on health care policy and its implementation. Since 1947, when the Indian subcontinent was partitioned, Pakistan has been deeply divided among bureaucrats, technocrats, and the military. This results in a high disease burden, a scarcity of medical personnel, high absenteeism rates, and insufficient patient access to healthcare services[1], as well as a lack of a consistent type of interaction between the public and private sectors in the country's health care system. "Contracting out" of health services is turning over to the private sector government-run health facilities including basic health units, rural health clinics, and hospitals that are either underutilized or unnecessary, as stated in Pakistan's National Health Policy from 2001. The goal is to improve community coordination of clinical and nonclinical service delivery [2]. A rural assistance program was used to put this into action.

GOVERNMENT EXPENDITURE

The influence of public expenditure has been the focus of study conducted by a number of academic institutions. The great majority of these studies have made use of a technique called benefit incidence analysis, which involves interviewing individuals in their own homes. An indication of whether or not public spending is progressive or regressive may be found in how benefits are distributed across factors such as location, caste, religion, gender, etc. [see example], and whether or not the proportion of different income groups varies appropriately. Other authors that have made significant contributions to the discussion of this problem include Gupta et al. (1998, 2002), Christian (2002), Rasmus et al. (2001), Younger (1999), Demery and Verghis (1994), Jorge (2001), Roberts (2003), Hyun (2006), David and Stephen (2000), and Gupta et al. On this topic, some of the studies that may be looked at include those by Flug

et al. (1998, 2005), Lamiraud et al. (2005), SPDC (2004), ESCAP (2003), Norman (1985), Castro et al. (2000), Hamid et al. (2003), Sakellariou and Harry (2004), Shahin (1999), and others. 14% of total education investment goes to the lowest quintile of income groups, 36% goes to the poorest half of income groups, and 33% goes to the richest quintile, according to Rasmus et al. (2001) and other progressive research that investigate the distribution of public spending. Other studies that look at the distribution of public expenditure have arrived to similar conclusions. According to Hyun (2006), the fact that those living in poverty in Thailand benefited from government subsidies (in-kind transfer income) led him to the conclusion that such transfers lowered poverty levels. Younger (1999), with the use of a dataset from Ecuador, demonstrated that public investment improves health and education indicators in low-income countries using a combination of benefit and behavioral strategies. Using 56 different data sets, Gupta et al. (2002) and other researchers from across the globe came to the conclusion that rising public expenditure on health and education was associated with higher rates of school attendance as well as lower rates of newborn and child death. According to Norman (1985) and other studies evaluating the regressiveness of the incidence of public expenditure, a significant portion of governmental spending, such as that on education and health, for example, benefits higher income groups more than it benefits lower income groups. According to studies carried out by Castro-Leal et al. and carried out in numerous African countries, public investment in curative care benefitted the wealthy more than it helped the poor. In addition, Hamid and colleagues (2003) demonstrated that there is a significant amount of difference across countries. Subsidies for lower levels of education are typically more regressive than subsidies for higher levels of education. On the other hand, subsidies for higher levels of education tend to be more progressive than subsidies for lower levels of education. Demery and Verghis (1994) demonstrated that whereas expenditure on elementary and secondary education was positively and negatively biased toward progress, respectively, spending on higher education was shown to be regressive in absolute terms and only moderately inclined toward development. Presents in the form of services or goods, as opposed to monetary ones, almost always end up being more beneficial to the person who receives them. Advocates for more financing for public schools often use the social rate of return as evidence to support their positions. According to research conducted by Pascharropolous (1994) and the World Bank (1995), the basic education of a kid offers the highest rate of return on investment. The education system from kindergarten through high school often receives less funding from governments than does higher education. Lanjouw and Martin (1999), using data from rural India, demonstrate that even modest changes to the scope of a program may have significant

effects on the demographics of the population it serves. Shahin (1999) discovered that in Côte d'Ivoire, females disproportionately lag behind males in terms of enjoying the benefits of public expenditures in education. This was shown to be the case in the country. According to "The Impact of Public Expenditure on Health and Education in Guinea," page 29, the ratio of revenue as a percentage of total government expenditure to spending is inversely related to spending. Bjorn and Li (2004) arrived to the same result after collecting data from families in 18 different regions in China during the years 1988 and 1995. There are many problems that need for solutions to be found. It has been stated that increasing the amount that the government spends would have a mixed impact on people's skills. Whether or whether poverty can be properly managed is more dependent on the distribution of resources within health and education than it is on the amount of GDP that is dedicated to these areas. More students entered elementary school and continued their education through the fourth grade in countries where more money was dedicated to both elementary and secondary education. Primary (preventive) healthcare is often given a greater priority in nations that have better rates of baby and child survival. Second, those making the decisions need to take into consideration any and all prospective expenses. In order to formulate rational policies, it is essential to have a clear understanding of who will be accountable for the expenses and who will profit from the changes. There are a lot of questions that need to be addressed before policymakers can address them, such as how to reduce the amount of money wasted by the government and how to make it so that the poor have a lighter financial load. Where would be the limited resources of the government be allocated in order to have an impact on the battle against poverty? As a consequence of this, those responsible for formulating public policy may make use of the information obtained from incidence studies in order to design public assistance programs that are more just and efficient. There has been a significant amount of research carried out on the topic of the predominance of government expenditure in both developing countries and prosperous ones. On the other hand, the vast majority of the extant study literature is based on material that has since become stale and was obtained through household surveys. Second, since countries collect their data in a variety of unique methods, it is difficult to make valid comparisons between the results of other countries. Seldon and Wasylenko (1992) came to the conclusion that neither the effect on separate groups nor the influence of incidence when grouped by gender or place are taken into account. A paucity of written material exists on the issues that have an impact on the public expenditure in Pakistan, which is the fourth point. Two studies have been conducted in an effort to provide a solution to this issue; however, Sabir (2003) and Hussain et al. (2003) both exhibit methodological shortcomings. For instance, Sabir

(2003) has a three-step plan in place on 1. When compared to the funding allocated for other national objectives, Pakistan's health and education budgets are among the lowest in the world. The government spends 0.5% of GDP on healthcare, whereas it spends 2.1% of GDP on education (GOP, 2005-06). This is despite the significant disparities that exist throughout the country. In the years 2001 and 2002, Muhammed Akram and Ahmed Nawaz Hakro were responsible for the production of 30 HIES records. This study is fascinating because it analyzes the distribution of government financing for primary schools according to gender and location, demonstrating that these programs are beneficial to low-income individuals in all four jurisdictions. However, in order for females to be admitted to primary schools, they must first overcome a number of additional obstacles. The inhabitants with the lowest incomes get a smaller share of the government assistance available for higher education than those with the highest incomes. The study also makes use of urban/rural labels, although such classifications are incorrectly applied to the data. The study conducted by Hussain et al. (2003) performed an incidence analysis by averaging the expenditures utilizing secondary data. Both the Gini Index and the Representation Index were used in order to investigate the financial differences that exist across schools. They came to the conclusion that there were no discernible distinctions between the proposed budgets of the many different school districts. In contrast to other efforts made to quantify economic disparity, the primary emphasis of this investigation is on the amount of funding allocated to educational institutions. None of the aforementioned research provides a comprehensive examination of the subject in the Pakistani context because (1) they relied on obsolete data sets that were aggregated from secondary sources, (2) they focused solely on educational attainment in their analyses, and (3) they used different methods. In addition, Hussain et al. (2003) use the GINI and concentration factors in order to evaluate the progressiveness of expenditures. Thirdly, in their calculations, they have not included in the costs that are connected with receiving medical treatment.

CHAPTER 3

DESIGN AND IMPLEMENTATION

In this chapter, the design is to be described which is used in order to find out the impact of Macro-Fiscal factors affecting health financing. It contains the details regarding the data structure, data collection period and the methods employed for the purpose of data collection and analysis.

METHODOLOGICAL CHOICES

This study is quantitative, and a statistical method will be utilized to collect the data which will be primary.

DATA COLLECTION METHOD

This study includes data of Pakistan in comparison with its macro-fiscal indicators which indicate the growth in health sector. All of the indicators directly/indirectly effect Pakistan's economy and health sector. All the data is extracted from International Monetary Fund (IMF), World Bank and World Health Organization (WHO). The duration of data has been 12 years from 2011-2022.

RESEARCH DESIGN

The research strategy lays forth the big picture for the study. The study's objectives and methods are laid forth in the research methodology. The methodology of a research includes the processes of data gathering, measurement, and analysis. The problem is analyzed quantitatively here using secondary data (Time series).

TYPE OF INVESTIGATION

This research study attempted to investigate the major indicators effecting the health financing in Pakistan. This study is uni-directional that is, it shall attempt to find out the impact of indicators on Pakistan's Economy. The nature of the study shall be explanatory.

VARIABLES OF THE STUDY

The major variables in this study are Health and the indicators effecting health factors. Health Financing is dependent variable while on the other side Total Health Expenditure, Government Health Spending, Out of the pocket expenditure, Growth, Un-Employment, Inflation, Gross Debt, Expenses, Revenue, Non-Tax Revenue and Other Taxes are all independent variables which directly or indirectly effects the health sector of Pakistan.

ANALYSIS MODEL

This study aims to investigate the impact of independent variables in health sector.

DATA ANALYSIS

Data analysis has been performed using excel. The following procedure has been performed to test the above mentioned model using the information gathered in this study.

REPORTING OF TESTS RESULTS

After checking the data collected for the returns of the stock market by using several tests. The results of these test are then interpreted and concluded.

CHAPTER 4

TESTING AND DEPLOYMENT

Overview of Research Methodology

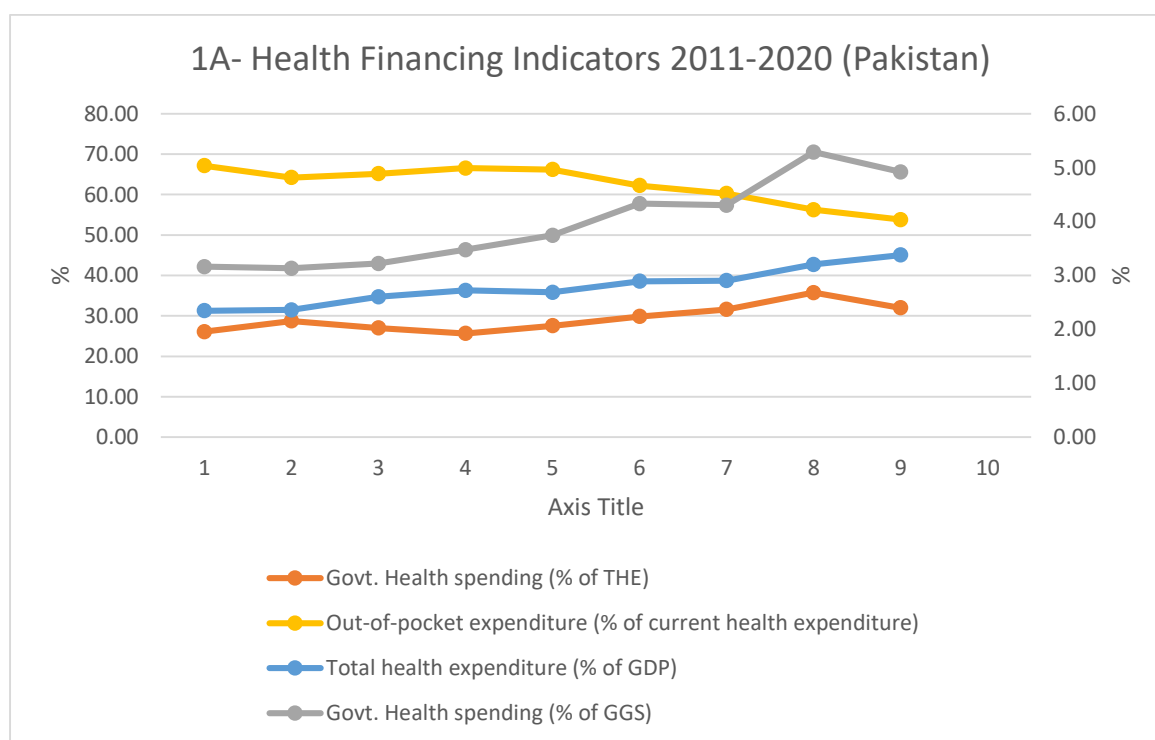
This chapter presents the data collected from the listed firms of the world, World Bank, World Health Organization (WHO) and International Monetary Fund (IMF), and processed through EViews to answer the research questions. The Results and findings of the indicators i.e, Dependent and Independent variables. In this part, the researcher discussed the examination of variables using descriptive statistics, correlation, and regression among the variables. Also, the research discoursed, the results and their interpretation of whether the independent and dependent variables are related. Moreover, do the independent variables influence the dependent variables or not? This chapter examines the relationships between the variables.

Descriptive Statistics

The average value of the variables is represented through mean and dispersion from the mean value is called or represented by standard deviation. In table 1, Mean and SD values represent the averages and variance exclusively between the dependent variable, independent and control variable for the impact of earning management with the assistance of Control variables.

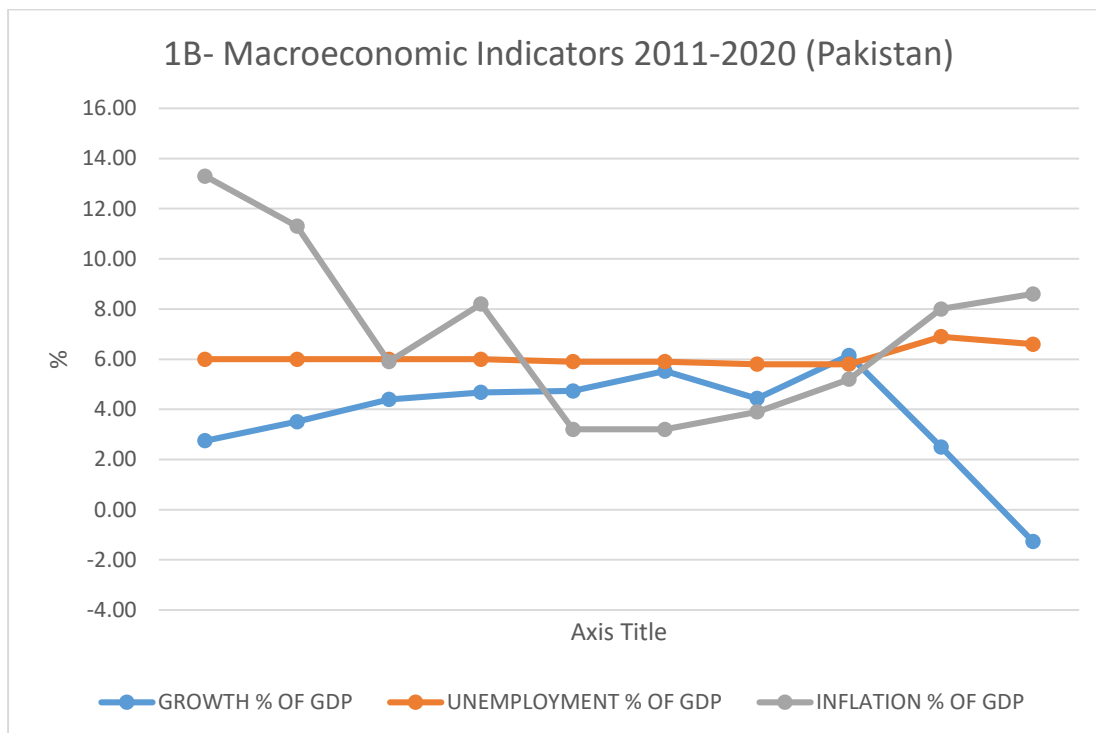
DESCRIPTIVE STATISTICS OF VARIABLES

Pakistan	Total health expenditure (% of GDP)	Govt. Health spending (% of THE)	Govt. Health spending (% of GGS)	Out-of-pocket expenditure (% of current health expenditure)	GROWTH % OF GDP	UNEMPLOYMENT % OF GDP	INFLATION % OF GDP	Gross Debt-to-GDP	Deficit (% of GDP)	Spending % of GDP	Revenue % of GDP	Taxes on income, profits, and capital gains (% GDP)	other taxes (%GDP)	non tax revenue (% of GDP)
Mean	2.85	29.80	4.05	61.88	3.74	6.09	7.08	69.21	6.82	18.65	12.69	3.54	5.54	3.20
Median	2.81	29.29	4.02	63.21	4.41	6.00	6.95	65.45	6.50	19.08	13.08	3.59	5.57	3.16
Maximum	3.41	35.73	5.29	67.14	6.15	6.90	13.30	87.60	8.90	20.30	13.96	3.92	5.88	4.30
Minimum	2.34	25.66	3.13	53.81	-1.27	5.80	3.20	58.90	4.60	17.19	11.21	3.20	5.20	2.60
Std. Dev	0.36	3.23	0.77	4.54	1.99	0.34	3.26	9.13	1.48	0.95	1.02	0.25	0.23	0.45
Skewness	0.24	0.47	0.26	-0.56	-1.61	1.73	0.56	1.27	0.13	-0.07	-0.36	-0.04	-0.18	1.30
Kurtosis	-1.11	-0.93	-1.62	-1.23	3.38	2.10	-0.58	0.47	-1.63	-1.09	-1.81	-1.81	-1.45	2.88



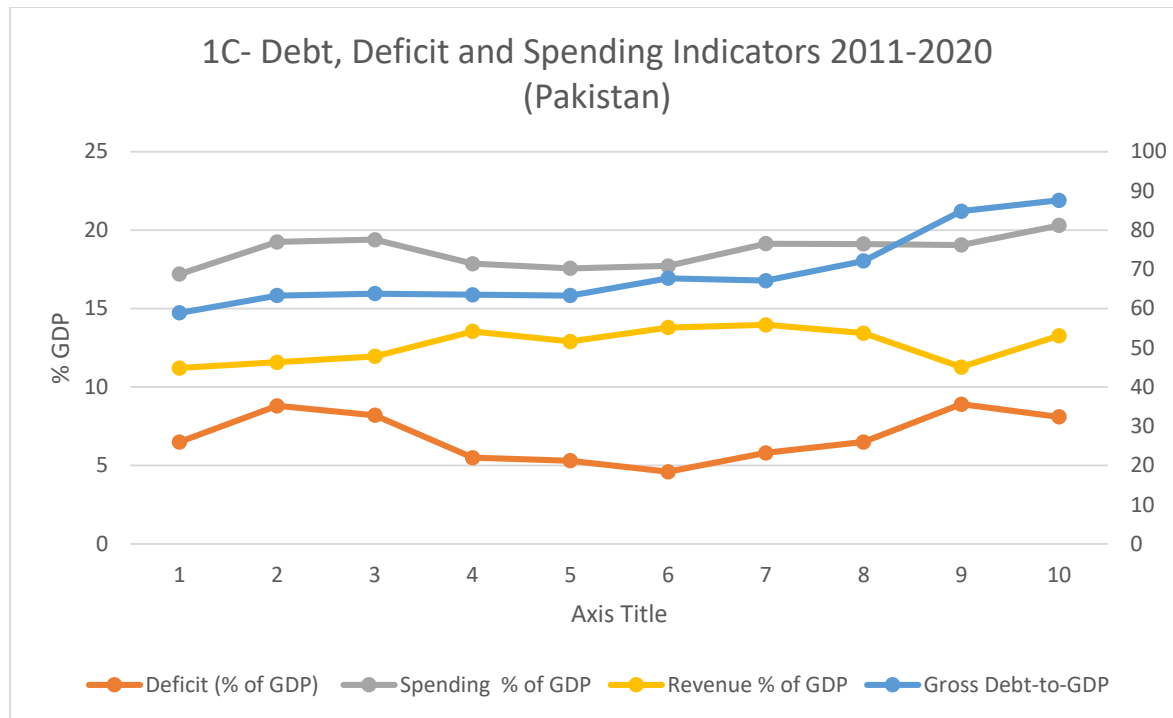
Total health expenditure in % of GDP: In 2011 the total health expenditure towards the health sector of Pakistan was 2.34. It means that if the total GDP size of Pakistan's economy is 348 billion us Dollar, only 2.34 percent of the total GDP of Pakistan was spent on health sector in

Pakistan. Similarly the trans continued in 2012 where a slightly 0.2% was seen in the increase health care expenditure by the Government of Pakistan resulting in 2.36% of the total GDP of Pakistan. Similarly a major surge in the health expenditure was witnesses during the election periods when in 2013, the health expenditure by the government of Pakistan increased by 0.24% leading to 2.60%. And a similar surge was seen during 2018 elections where the total health expenditure rose to 3.20% in the budget of 2018-2019. However the Government of Pakistan also increased the total health expenditure during COVID period resulting to 3.38 and 3.41 % of the GDP in order to tackle COVID -19. As majority of the health expenditure incurred on purchasing vaccines, developing isolation center and buying doctors related protective kit for fighting covid-19. However, the average amount of money spent on the healthcare center remained around 2.85% of the GDP.



Government expenditure of the total health expenditure: The Government of Pakistan has continuously allocated a minimal portion of its total development budget on health sector. In 2011 the government only incurred 26.09% of the expenditure on health sector which means

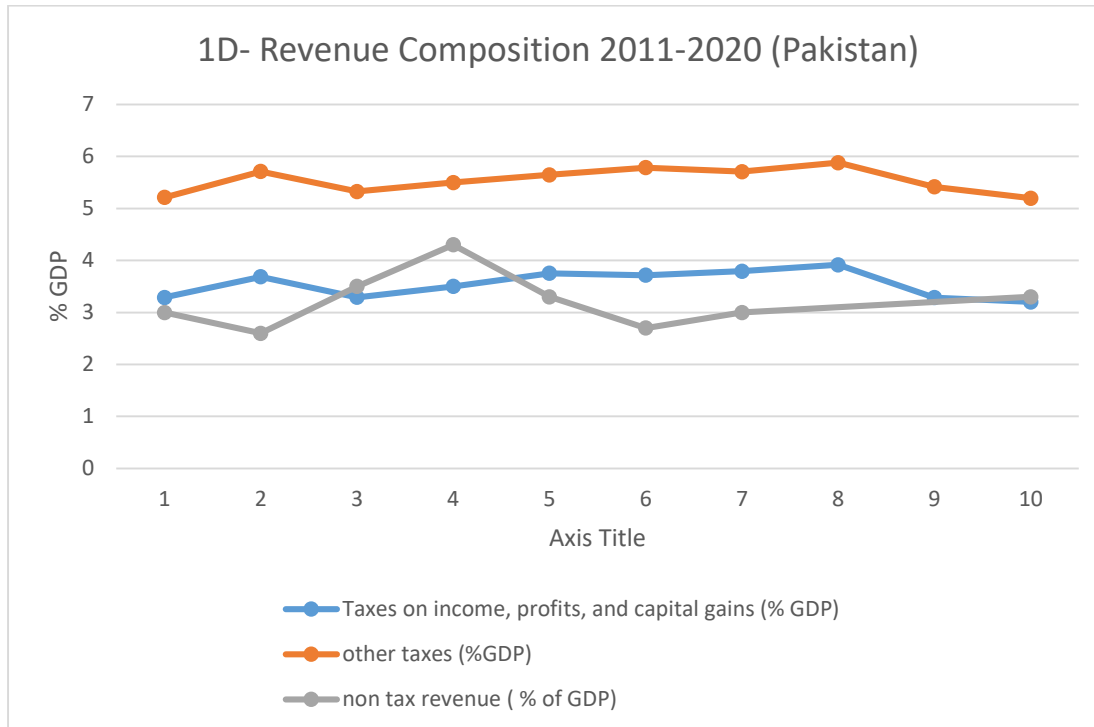
that rest of the expenses on health care was made by the people of Pakistan from their out of pocket expenditure. Similarly, from 2012-2015 the total government spending revolved around 27 -28% of the total health spending, while rest of the 72-73% were paid by the people of Pakistan. However, during COVID period in 2020 the Government increased its health spending to around 33% to tackle the COVID related challenges.



The total out of pocket expenditure by the citizens of Pakistan remained around 64.17% in 2011. It means the maximum portion of the total health related expenditure were incurred by the citizens on their health issues. This trend continues furthermore as the out of pocket expenditure of the citizens remained settled at 65-67% over the years from 2012-2018. However, a substantial cut was seen in the year of 2019 and 2020. In both years the out of pocket expenditure by the citizens reduced to 53% and 57% respectively. This sudden decrease was the result of the increase Government expenditure on healthcare of citizens in order to fight covid-19.

The growth of overall productivity in the economy which respect to production and consumption of goods and services in Pakistan has remained within 5% from 2011-2020. In

the 2011 it was seen that growth of GDP remained at 2.75% whereas in 2012 it grew to 3%. The major change occurred during election year when the GDP reached 6%. However, the overall average growth remained at 3.74%.



Unemployment as % of GDP: The unemployment as a percentage during most of the time from 2011-2020 remained at 6%. The major reason of this consistency is due to low literacy rate in Pakistan coupled with lack of government spending on the employment generation activities. It must be seen that during COVID-19 the unemployment ratio increased in 2020 to 6.9%, highlighting that most of the workers were laid off due to industrial lockdown. As a result unemployment ratio increased with the shrink of GDP to -1.27% in terms of growth. Showing that decrease in productivity in economy was accompanied by unemployment crisis.

The overall Inflation in Pakistan stood below 9% from the year 2011-2020. This was the reason of increased government subsidies provided to industrial sector in the form of low price electricity and taxes which decrease the cost of production from manufacturing goods. As a result inflation during the timeframe of 2011-2020 kept in control.

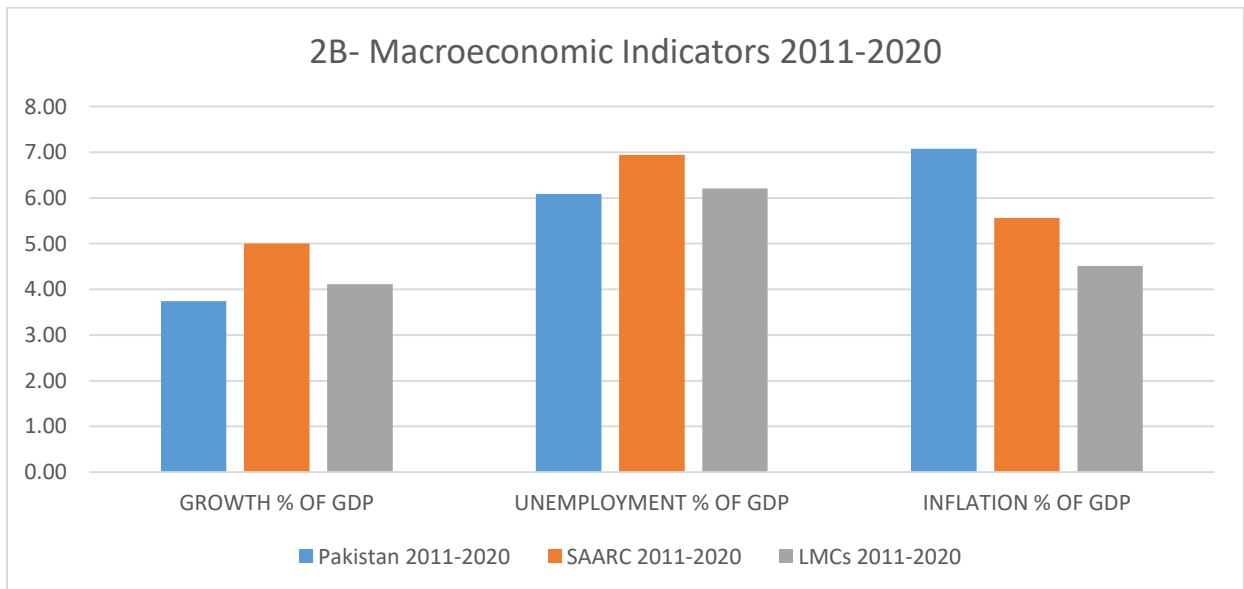
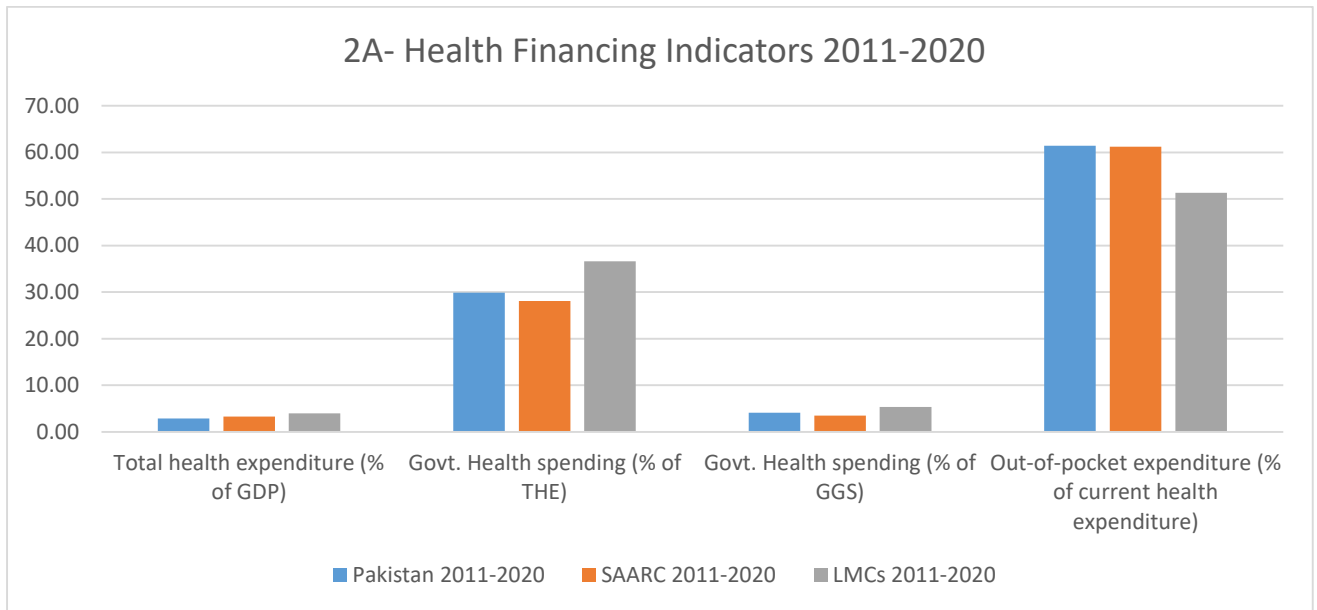
Average summary

		1	2	3	4	5	6	7	8	9	10	11	12	13	14
		Health Financing Indicators				Macroeconomic Indicators			Debt, Deficit and Spending Indicators				Revenue Composition		
Countries	Years	Total health expenditure (% of GDP)	Govt. Health spending (% of THE)	Govt. Health spending (% of GGS)	Out-of-pocket expenditure (% of current health expenditure)	GROWTH % OF GDP	UNEMPLOYMENT % OF GDP	INFLATION % OF GDP	Gross Debt-to-GDP	deficit (% of GDP)	Spending % of GDP	Revenue % of GDP	Taxes on income, profits, and capital gains (% GDP)	other taxes (%GDP)	non tax revenue (% of GDP)
Pakistan	2011-2020	2.85	29.89	4.14	61.41	3.74	6.09	7.08	69.21	6.82	18.65	12.69	3.54	5.54	3.17
SAARC	2011-2020	3.28	28.09	3.48	61.22	5.00	6.95	5.57			15.10	12.37			
LMCs	2011-2020	4.01	36.59	5.37	51.34	4.11	6.21	4.51			16.52	14.77			

		Health Financing Indicators			
Countries	Years	Total health expenditure (% of GDP)	Govt. Health spending (% of THE)	Govt. Health spending (% of GGS)	Out-of-pocket expenditure (% of current health expenditure)
Pakistan	2011-2020	2.85	29.89	4.14	61.41
SAARC	2011-2020	3.28	28.09	3.48	61.22
LMCs	2011-2020	4.01	36.59	5.37	51.34

		Macroeconomic Indicators		
Countries	Years	GROWTH % OF GDP	UNEMPLOYMENT % OF GDP	INFLATION % OF GDP
Pakistan	2011-2020	3.74	6.09	7.08
SAARC	2011-2020	5.00	6.95	5.57
LMCs	2011-2020	4.11	6.21	4.51

Debt, Deficit and Spending Indicators					
Countries	Years	Gross Debt-to-GDP	deficit (% of GDP)	Spending % of GDP	Revenue % of GDP
Pakistan	2011-2020			18.65	12.69
SAARC	2011-2020			15.10	12.37
LMCs	2011-2020			16.52	14.77



Differences between Pakistan, SAARC & LMICs

		A				B			C				D		
		1	2	3	4	5	6	7	8	9	10	11	12	13	14
		Health Financing Indicators				Macroeconomic Indicators			Debt, Deficit and Spending Indicators				Revenue Composition		
Countries	Years	Total health expenditure (% of GDP)	Govt. Health spending (% of THE)	Govt. Health spending (% of GGS)	Out-of-pocket expenditure (% of current health expenditure)	GROWTH % OF GDP	UNEMPLOYMENT % OF GDP	INFLATION % OF GDP	Gross Debt-to-GDP	Deficit (% of GDP)	Spending % of GDP	Revenue % of GDP	Taxes on income, profits, and capital gains (% GDP)	other taxes (%GDP)	non tax revenue (% of GDP)
Pakistan	2011	2.34	26.09	3.16	67.14	2.75	6.00	13.30	58.9	6.5	17.19	11.21	3.287	5.213	3.00
	2012	2.36	28.75	3.13	64.19	3.51	6.00	11.30	63.3	8.8	19.24	11.57	3.687	5.713	2.60
	2013	2.60	27.00	3.22	65.17	4.40	6.00	5.90	63.8	8.2	19.39	11.95	3.292	5.328	3.50
	2014	2.72	25.66	3.48	66.52	4.67	6.00	8.20	63.5	5.5	17.85	13.54	3.502	5.498	4.30
	2015	2.69	27.54	3.74	66.18	4.73	5.90	3.20	63.3	5.3	17.57	12.90	3.752	5.648	3.30
	2016	2.89	29.84	4.33	62.22	5.53	5.90	3.20	67.7	4.6	17.71	13.79	3.715	5.785	2.70
	2017	2.90	31.59	4.30	60.24	4.43	5.80	3.90	67.1	5.8	19.13	13.96	3.792	5.708	3.00
	2018	3.20	35.73	5.29	56.24	6.15	5.80	5.20	72.1	6.5	19.11	13.44	3.918	5.882	#N/A
	2019	3.38	31.98	4.92	53.81	2.50	6.90	8.00	84.8	8.9	19.05	11.27	3.285	5.415	#N/A
2020	#N/A	#N/A	#N/A	#N/A	-1.27	6.60	8.60	87.6	8.1	20.30	13.27	3.201	5.199	3.30	
Average Pakistan	2011-2020	#N/A	#N/A	#N/A	#N/A	3.74	6.09	7.08	69.21	6.82	18.65	12.69	3.54	5.54	#N/A
SAARC	2011	3.21	28.24	3.55	62.51	5.11	6.98	10.68	52.6	4.7	14.54	11.47	4.9	8	0.9
	2012	3.26	27.60	3.57	62.97	5.47	7.05	7.84	53.9	4.8	15.82	12.45	4.9	7.9	1
	2013	3.63	23.58	3.45	67.99	6.03	7.14	6.34	56.2	4.7	16.17	12.46	4.7	8	0.9
	2014	3.54	23.91	3.45	66.44	6.94	6.97	5.15	56.4	4.6	14.61	11.50	4.6	8	1.1
	2015	3.52	25.61	3.57	64.66	7.34	7.10	3.83	57.5	4.8	14.88	12.25	4.6	8.2	1.2
	2016	3.44	26.70	3.55	63.19	7.68	7.06	4.91	58.3	4.9	14.93	12.58	4.5	8.2	1.2
	2017	2.99	31.49	3.51	56.85	6.53	7.00	4.54	60.1	5	15.19	12.44	4.4	8.4	1.2
	2018	3.04	29.71	3.33	56.69	6.33	7.00	3.86	60.4	5	15.05	12.90	4.5	8.3	1.3
	2019	3.10	31.78	#N/A	56.04	3.84	6.95	3.76	61.1	5.2	#N/A	#N/A	5.3	8	1.2
2020	#N/A	#N/A	#N/A	#N/A	-5.23	6.20	4.72	62.20%	8.10%	#N/A	#N/A	5.30%	7.90%	1.20%	
Average SAARC	2011-2020	#N/A	#N/A	#N/A	#N/A	5.00	6.95	5.57	51.71	4.38	#N/A	#N/A	4.25	7.31	1.00
LMICs	2011	4.04	33.37	5.16	54.98	4.78	6.22	8.51	35.7	5	16.96	15.82	6.3	8.5	1.7
	2012	4.12	34.18	5.03	53.90	4.47	6.18	7.12	34.8	4.6	17.73	16.17	6.1	8.4	1.7
	2013	4.17	33.23	4.79	55.03	4.99	6.15	4.31	35.3	4.6	17.94	15.83	5.8	8.5	1.7
	2014	4.12	34.96	5.05	52.78	5.82	6.08	3.98	36.2	4.5	17.41	15.06	5.8	8.5	1.7
	2015	4.18	35.92	5.48	52.79	5.00	6.25	3.35	37.3	4.8	16.83	14.78	5.7	8.6	1.7
	2016	4.21	37.05	5.74	51.90	5.69	6.19	3.01	38.5	4.9	15.81	14.12	5.6	8.6	1.7
	2017	3.93	39.43	5.53	48.94	5.10	6.08	4.21	39.6	5.1	15.93	14.11	5.4	8.7	1.7
	2018	3.83	38.16	5.53	48.00	4.82	6.02	3.78	41	5.2	15.97	14.69	5.5	8.6	1.7
	2019	3.76	39.13	#N/A	48.17	3.68	5.50	3.66	42.1	5.4	#N/A	#N/A	5.5	8.5	1.7
2020	#N/A	#N/A	#N/A	#N/A	-3.22	7.40	3.18	45.3	9.5	#N/A	#N/A	5.3	8.6	1.6	
Average LMICs	2011-2020	#N/A	#N/A	#N/A	#N/A	4.11	6.21	4.51	38.58	5.36	#N/A	#N/A	5.70	8.55	1.69

Pakistan

Total health expenditure (% of GDP): The values range from 2.34% to 3.42%. This indicates the percentage of Pakistan's GDP that was spent on healthcare over the years 2011 to 2020. The average value for this indicator over the entire period is 2.85%.

Govt. Health spending (% of THE): The values range from 26.09% to 35.73%. This represents the percentage of the total health expenditure that was funded by the Pakistani government. The average value for this indicator over the entire period is 29.89%.

Govt. Health spending (% of GGS): The values range from 3.13% to 5.83%. This indicates the percentage of the general government spending (excluding health) that was allocated to

healthcare. The average value for this indicator over the entire period is 4.14%.

Out-of-pocket expenditure (% of current health expenditure): The values range from 52.40% to 67.14%. This represents the percentage of healthcare expenses paid directly by individuals without any financial support from insurance or the government.

GROWTH % OF GDP: The values range from -1.27% to 6.15%. This indicates the annual growth rate of Pakistan's GDP during the years 2011 to 2020. A negative value indicates an economic contraction.

UNEMPLOYMENT % OF GDP: The values range from 5.80% to 6.90%. This represents the unemployment rate as a percentage of Pakistan's GDP, showing the proportion of the labor force that was unemployed compared to the overall economic output.

INFLATION % OF GDP: The values range from 3.20% to 13.30%. This indicates the inflation rate as a percentage of Pakistan's GDP, showing the rate at which prices of goods and services were increasing or decreasing in the economy.

Gross Debt-to-GDP: The values range from 58.9% to 87.6%. This shows the ratio of Pakistan's gross debt (total debt) to its GDP, reflecting the country's debt burden in relation to its economic output.

Deficit (% of GDP): The values range from 4.6% to 9.5%. This represents the government budget deficit as a percentage of Pakistan's GDP, indicating how much more the government was spending than it was earning during each year.

Spending % of GDP: The values range from 14.71% to 20.30%. This indicates the government's total spending as a percentage of Pakistan's GDP, reflecting the overall level of government expenditure.

Revenue % of GDP: The values range from 11.21% to 13.96%. This represents the government's total revenue as a percentage of Pakistan's GDP, showing how much money the government collected from various sources during each year.

Taxes on income, profits, and capital gains (% GDP): The values range from 3.201% to 5.713%. This indicates the percentage of GDP collected through income taxes, corporate taxes, and taxes on capital gains.

Other taxes (% GDP): The values range from 5.199% to 5.882%. This represents the percentage of GDP collected from other forms of taxes, such as sales taxes, excise duties, etc.

Non-tax revenue (% of GDP): The values range from 2.60% to 4.30%. This indicates the share of non-tax revenue (e.g., dividends, fees, fines) in Pakistan's overall GDP.

SAARC Countries

Total health expenditure (% of GDP): The values range from 3.04% to 3.63%. This indicates the percentage of the respective country's GDP that was spent on healthcare over the years 2011 to 2020.

Govt. Health spending (% of THE): The values range from 23.58% to 32.31%. This represents the percentage of the total health expenditure (THE) that was funded by the government of each SAARC country.

Govt. Health spending (% of GGS): The values range from 3.33% to 5.83%. This indicates the percentage of the general government spending (excluding health) that was allocated to healthcare for each country.

Out-of-pocket expenditure (% of current health expenditure): The values range from 54.81% to 67.99%. This represents the percentage of healthcare expenses paid directly by individuals out of their own pockets without any financial support from insurance or the government.

GROWTH % OF GDP: The values range from -5.23% to 7.68%. This indicates the annual growth rate of each country's GDP during the years 2011 to 2020. A negative value indicates an economic contraction, and a positive value indicates economic growth.

UNEMPLOYMENT % OF GDP: The values range from 6.20% to 7.14%. This represents the unemployment rate as a percentage of each country's GDP, showing the proportion of the labor force that was unemployed compared to the overall economic output.

INFLATION % OF GDP: The values range from 3.76% to 10.68%. This indicates the inflation rate as a percentage of each country's GDP, showing the rate at which prices of goods and services were increasing or decreasing in their economies.

Gross Debt-to-GDP: The values are represented in percentage form, ranging from 52.6% to 62.20%. This shows the ratio of each country's gross debt (total debt) to its GDP, reflecting the country's debt burden in relation to its economic output.

Deficit (% of GDP): The values are represented in percentage form, ranging from 4.7% to 8.10%. This represents the government budget deficit as a percentage of each country's GDP, indicating how much more the government was spending than it was earning during each year.

Spending % of GDP: The values range from 14.54% to 16.96%. This indicates the government's

total spending as a percentage of each country's GDP, reflecting the overall level of government expenditure.

Revenue % of GDP: The values range from 11.47% to 15.82%. This represents the government's total revenue as a percentage of each country's GDP, showing how much money the government collected from various sources during each year.

Taxes on income, profits, and capital gains (% GDP): The values range from 4.4% to 5.3%. This indicates the percentage of GDP collected through income taxes, corporate taxes, and taxes on capital gains.

Other taxes (% GDP): The values range from 7.9% to 8.4%. This represents the percentage of GDP collected from other forms of taxes, such as sales taxes, excise duties, etc.

Non-tax revenue (% of GDP): The values range from 0.9% to 1.3%. This indicates the share of non-tax revenue (e.g., dividends, fees, fines) in each country's overall GDP.

LMICs countries

Total health expenditure (% of GDP): The values range from 3.73% to 4.21%. This indicates the percentage of the respective country's GDP that was spent on healthcare over the years 2011 to 2020.

Govt. Health spending (% of THE): The values range from 33.23% to 40.43%. This represents the percentage of the total health expenditure (THE) that was funded by the government of each LMIC.

Govt. Health spending (% of GGS): The values range from 4.79% to 5.74%. This indicates the percentage of the general government spending (excluding health) that was allocated to healthcare for each country.

Out-of-pocket expenditure (% of current health expenditure): The values range from 46.89% to 55.03%. This represents the percentage of healthcare expenses paid directly by individuals out of their own pockets without any financial support from insurance or the government.

GROWTH % OF GDP: The values range from -3.22% to 7.40%. This indicates the annual growth rate of each country's GDP during the years 2011 to 2020. A negative value indicates an economic contraction, and a positive value indicates economic growth.

UNEMPLOYMENT % OF GDP: The values range from 5.50% to 7.40%. This represents the unemployment rate as a percentage of each country's GDP, showing the proportion of the labor force that was unemployed compared to the overall economic output.

INFLATION % OF GDP: The values range from 3.01% to 8.51%. This indicates the inflation rate as a percentage of each country's GDP, showing the rate at which prices of goods and services were increasing or decreasing in their economies.

Gross Debt-to-GDP: The values are represented in percentage form, ranging from 35.7% to 45.3%. This shows the ratio of each country's gross debt (total debt) to its GDP, reflecting the country's debt burden in relation to its economic output.

Deficit (% of GDP): The values are represented in percentage form, ranging from 4.5% to 9.5%. This represents the government budget deficit as a percentage of each country's GDP, indicating how much more the government was spending than it was earning during each year.

Spending % of GDP: The values range from 15.39% to 16.96%. This indicates the government's total spending as a percentage of each country's GDP, reflecting the overall level of government expenditure.

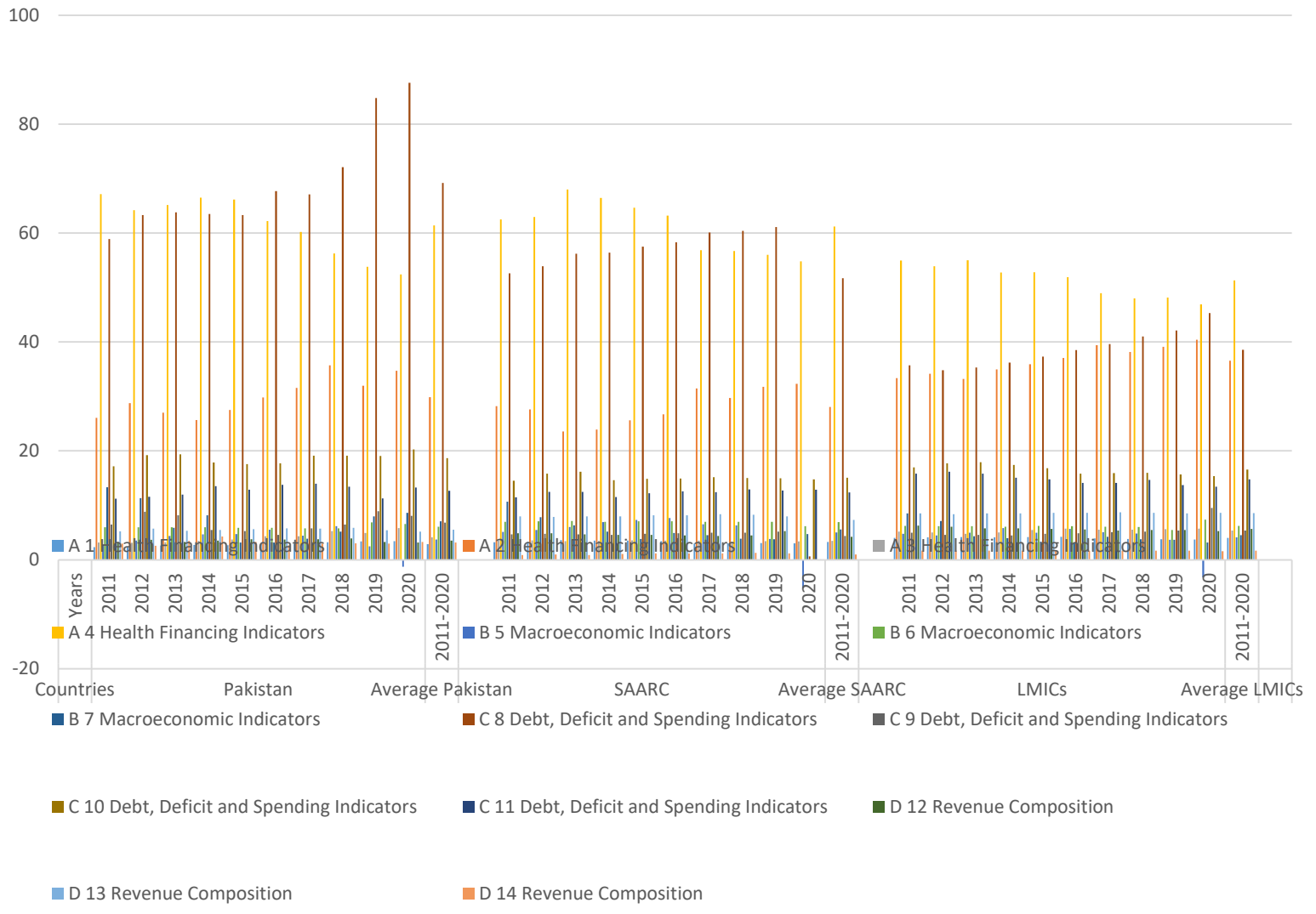
Revenue % of GDP: The values range from 13.44% to 16.83%. This represents the government's total revenue as a percentage of each country's GDP, showing how much Money the government collected from various sources during each year.

Taxes on income, profits, and capital gains (% GDP): The values range from 5.3% to 6.3%. This indicates the percentage of GDP collected through income taxes, corporate taxes, and taxes on capital gains.

Other taxes (% GDP): The values range from 8.4% to 8.7%. This represents the percentage of GDP collected from other forms of taxes, such as sales taxes, excise duties, etc.

Non-tax revenue (% of GDP): The values range from 1.6% to 1.7%. This indicates the share of non-tax revenue (e.g., dividends, fees, fines) in each country's overall GDP.

Chart Title



Chapter 5

CONCLUSION

LIMITATIONS

Data Limitations: The project's findings are limited by the availability, quality, and reliability of the data used. Data gaps, missing information. Additionally, the project might have relied on secondary data that was collected for other purposes, potentially leading to limitations in addressing specific research questions or variables of interest.

Data Access Limitations: we face problem of access to data because of restrictions by regulatory authorities.

RECOMMENDATIONS AND CONCLUSION

Recommendations:

Increment Government Spending on Medical care: The public authority ought to focus on medical care as a vital area for venture and dispense a higher extent of its spending plan to wellbeing funding. This will assist with guaranteeing the accessibility of sufficient assets for medical care administrations, framework advancement, and human asset limit building.

Reinforce Medical coverage Projects: Extending and fortifying health care coverage projects can assist with decreasing dependence on personal installments and give monetary security to people. The public authority ought to zero in on growing the inclusion of existing projects, like the Sehat Sahulat Program, and investigate choices for presenting compulsory health care coverage plans.

Upgrade Productivity in Wellbeing Spending: Working on the effectiveness of wellbeing spending is fundamental to boost the effect of accessible assets. This can be accomplished through measures like better monetary administration, diminishing inefficient use, and executing practical medical services intercessions.

Focus on Wellbeing Framework Advancement: Expanding interest in wellbeing foundation, including the development and upkeep of medical care offices, is vital. This will assist with further developing availability to quality medical services administrations, especially in underserved regions, and diminish the weight on tertiary consideration offices.

Advance Fair Asset Designation: Endeavors ought to be made to guarantee evenhanded dispersion of wellbeing funding assets across various areas and populace gatherings. Designated intercessions ought to be carried out to address the medical services needs of rustic regions and minimized networks, zeroing in on further developing admittance to essential medical care and preventive administrations.

Encourage Public-Private Organizations: Drawing in the confidential area through very much controlled public-private associations can assist with extending medical care administration arrangement and influence extra assets. Cautious checking and guideline are important to guarantee moderateness, quality, and openness of administrations given by the confidential area.

Conclusion:

Macroeconomic variables, including monetary limitations, have restricted the public authority's capacity to allot adequate assets to wellbeing supporting in Pakistan. Notwithstanding the significance of medical services, the public authority has confronted difficulties in expanding its consumption on the area due to contending requests and restricted financial space. Lacking government spending on medical services has prompted a weighty dependence on personal installments by people in Pakistan. This present circumstance puts a huge monetary weight on families, especially the defenseless and low-pay populaces, who might battle to bear the cost of fundamental medical care administrations.

Lacking Wellbeing Foundation: Restricted public interest in medical care framework has brought about deficient offices and administrations, further worsening the difficulties looked by the wellbeing area. Deficient financing has frustrated the turn of events and upkeep of medical services offices, prompting holes in availability and nature of care. Macroeconomic elements have added to an inconsistent circulation of wellbeing supporting assets across various areas of Pakistan. Provincial regions and underestimated networks frequently face more noteworthy provokes in getting to quality medical services because of restricted assets allotted to their areas.

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