Healthcare Financing in Pakistan

1.0 INTRODUCTION

Healthcare financing is a complex issue that developing countries are faced with. Market failure often compels states to step in to regulate and provide health services and goods to the population. However, scarce resources, double burden of diseases, population growth, unregulated private sector, budget constraints coupled with displaced priorities, inefficient use of available health budget, weak tax base and administration, ignorance about alternative mechanisms are a few significant factors making financing of health care even more complex. These factors may well characterize health systems of many developing countries. Moreover, their relative importance in case of Pakistan's health system is well recognized.

Healthcare financing is the most vital part of policy planning and implementation. However, this aspect has not been explored meticulously; and indicates a need to explore all its aspects in an analytical manner. There remains a lot to do in this regard. This paper is a preliminary attempt towards efforts to address this gap.

1.1 DEFINITION

The term healthcare financing refers to the ways in which money is raised to fund health activities as well as how it is used (that is, the allocation of funds) *(CMH, WG 3, 2002)*. The definition signifies two important points i.e. ways or methods to finance and the utilization of that financing. Therefore, preliminary steps to assess any healthcare financing arrangements must look into methods as well as utilization of such financing.

1.2 DIFFERENT WAYS TO FINANCE HEALTH CARE

In theory, there are five methods of financing healthcare in a country. These include general and earmarked taxes; social insurance; private insurance; community financing; and out-of-pocket payments. In Pakistan, mainly two methods of financing healthcare are being used. These are general tax revenue and out-of-pocket payments. Social insurance and private insurance have a minor share in financing healthcare.

TheNetwork
for Consumer Protection

40-A, Ramzan Plaza,
G-9 Markaz, Islamabad
Pakistan, P.O.Box 2563
Tel: +92-51-2261085
Fax: +92-51-2262495
e-mail: main@thenetwork.org.pk
website: www.thenetwork.org.pk

ISBN 969-8807-22-5

1.3 MECHANISMS IN PAKISTAN

1.3.1 HOW HEALTH IS BEING FINANCED - AN OVERVIEW OF THE LAST DECADE

"Private insurance has a negligible role while Community Financing per se is yet not on the agenda."

Pakistan is facing lot of challenges as far as its healthcare financing is concerned. In broader terms, the country's overall social sector financing needs to be scaled up further to make it responsive to the real needs. Two major sources of the financing i.e. public and private sector are working in vertical directions with no linkages in the areas of financing and service delivery. According to estimates public sector provides 23 percent of the total health expenditures while rest (77) comes from out-of-pocket expenditures in the private sector *(CMH, WG 3, 2002)*. Only one million of the population is covered through social insurance provided by Employees Social Security organization *(Medium Term Development Framework, 2005)*, while another 0.93 million people have heath cover through PIA, Pakistan Railways, WAPDA, PTCL and Fauji Foundation. Armed forces institutions also provide medical cover to their employees *(Inventory of Health and Population Investment in Pakistan, 2005)*. Besides, public sector organizations, civil society is also contributing towards health of the population through its limited resources. Organizations like Edhi Foundation, Aga Khan Foundation, social marketing initiatives and others are providing healthcare to people in different parts of the country. According to estimates Aga Khan Foundation, Save the Children (US) and Saving Newborn Lives Initiative are running projects worth US$304.19 million. Al Shifa Trust spent Rs. 1615 million during 1986-2004 *(ibid)*. Private insurance has a negligible role while Community Financing per se is yet not on the agenda. The scenario that emerges from the above discussion makes it clear that the current rate of health financing is insufficient for the existing needs of the population. Therefore, it is worth considering how a gigantic health sector infrastructure

Table 1: Health and Nutrition Expenditure (Rs. in Million)

Fiscal Year	Development Expenditure	Current Expenditure	Total Expenditure*	As % of GDP
1995-96	5,741	10,614	16,355	0.8
1996-97	6,485	11,857	18,342	0.8
1997-98	6,077	13,587	19,664	0.7
1998-99	5,492	15,316	20,808	0.7
1999-00	5,887	16,190	22,077	0.7
2000-01	5,944	18,337	24,281	0.7
2001-02	6,688	18,717	25,405	0.7
2002-03	6,609	22,205	28,814	0.6
2003-04	8,500	24,305	32,805	0.6
2004-05	11,000	27,000	38,000	0.6

Source: Economic Survey 2004-05. current prices*

of 916 hospitals, 552 Rural Health Centers (RHCs), 5,301 Basic Health Units (BHUs) and 4,582 dispensaries *(Economic Survey 2004-05)* is being financed through general tax revenue. It seems that due to displaced priorities, public sector funding for health could not reach one percent of the GDP over the next few fiscal years. According to estimates health expenditures over the last fiscal year were 0.6 percent of the GDP *(ibid)* which is quite low as compared to the figures of first seven years of the previous decade. Table 1 provides information regarding health expenditure from 1995 to 2005.

However, according to the recent Economic Survey health expenditure has been rising at 14 percent per anum on the average over the last three years. Despite the fact that the overall percentage of GDP is lower now than when compared to the years ranging from 1995-96 to 2001-02.

"Due to displaced priorities, public sector funding for health could not reach one percent of the GDP over the next few fiscal years."

Table 2: Health Expenditure in Pakistan in comparison to some regional countries 2002 (Average exchange rate US$)

Country	THE % of GDP	GHE % of THE	Per Capita THE in US $	Per Capita GHE in US $
Pakistan	3.2	23	18	4
India	6.1	21.3	30	6
Iran	6	47.8	104	50
Sri Lanka	3.7	48.7	32	16
BD	3.1	25.2	11	3
Nepal	5.2	27.2	12	3

Source: World Health Organization. World Health Report 2005

A regional cross-country comparison shows that Pakistan has to go a long way in scaling up health expenditures. This is obvious from table 2, which illustrates that Pakistan's total health expenditure on health is 3.2 percent of the GDP; this is 6.1, 6.0 and 3.7 in case of India, Iran and Sri Lanka, respectively. While the per capita health expenditure in Pakistan is US$ 18 out of which, public sector provides only US$4; the rest comes from private sources i.e. out-of-pocket payments. In case of India, Iran, Sri Lanka these figures are US$30 and 6; US$104 and 50; US$32 and 16, respectively. Another point of concern is of inconsistency in data. The government health expenditures as percentage of total health expenditure and per capita government health expenditure as reported by WHO (2005) are 34.9 percent of GDP and US$5 respectively, while public health expenditure as percentage of GDP has been mentioned 1.1 percent by the World Bank. This is inconsistent with the information provided in Economic Survey 2004-05. The data from the last ten years reveals that public sector health expenditure has yet to reach at least 1 percent of the GDP. The low level of the health expenditure in Pakistan can be described simply to be less than the actual needs; the level of funding is not comparable with other countries in the region; and that it's below internationally recommended standards i.e. WHO's recommendations.

This paper is based on a documents review with the objective of assessing healthcare financing in Pakistan. A framework developed by the Working Group 3 of the WHO's Commission on Macroeconomics and Health has been applied to the situation in Pakistan. Subsequently, financing options have been suggested based on that framework. In the end, recommendations have been made for consideration of policy makers in the public sector.

2.0 HEALTHCARE FINANCING: VARIOUS METHODS

As described previously there are five main healthcare financing methods. These include general and earmarked taxes; social insurance; private insurance; community financing and; out-of-pocket payments. A brief general description of each method has been provided in box 1. These have been discussed afterwards in the financing context of Pakistan.

BOX 1: VARIOUS METHODS OF HEALTHCARE FINANCING

The international experience shows that public expenditures (general tax revenue) on health are a potentially important source of financing of healthcare for the larger sections of society. Taxation is the main source of funding of certain types of healthcare. The main job of *taxation* is to raise revenue in a secure and reliable fashion. There are various sources of taxation. Main sources are *import duties*; excise tax; general sales tax; corporate income tax; personal income tax; social security; earmarked tax; user fees. A brief description of these taxes is given below:

The Import duties are a tariff rate in order to tax final goods, intermediate goods, inputs and raw materials. *Excise duties* are levied on alcohol, tobacco, petroleum products, vehicles and spare parts. A huge amount of revenue can be generated through this kind of taxation at a low administrative cost. Poor or low-income countries generate less than 2% of GDP against excise tax. However, studies suggest that this tax has potential to raise funds for health, especially when links are made between excisable products and poor health (smoking, drinking, and driving). The *general sales tax* has great potential to generate revenue, though equity concerns mar such enthusiasm. This concern needs to be addressed. Another source of revenue is *corporate income tax*. Although it is often difficult to legislate, it is a politically non-controversial type of taxation. *Personal income tax* has two characteristics: a source of sure taxation and potentially it can be progressive in nature. However, despite both its positive characteristics in many countries it has failed to become a potential source of revenue generation. Widespread under-reporting, poor tax administration and corruption often result into payment of this tax mainly by well-documented sectors (civil service and large corporations).

The *social security tax* is often viewed as part of income tax and is levied principally on employees in the formal sector. Originally these were insurance payments and are perceived in a way as earmarked tax as benefits can be drawn in the form of health services, pension etc. *User fees* although introduced in many countries have been found to be regressive and restrict the access to health by the poor, vulnerable, women and marginalized sections of society. In case of earmarked taxes, it may be said that when governments want to cut back on public expenditures, *earmarking* is one way to protect the health spending.

Apart from taxation, few other ways of financing have a significant role to play. *Social insurance* has three characteristics that distinguish it from other methods. First, it is compulsory, second, not every citizen is covered; third, benefits and premium in this scheme are set through laws established through legislation. This financing mechanism is very effective in the formal sector. *Private insurance* on the contrary is a voluntary

scheme. Private insurance does not consider risk or ability to pay which means preference is given to those who have no imminent risk and simultaneously are able to pay. The affluent class mostly prefers to be insured through this mechanism.

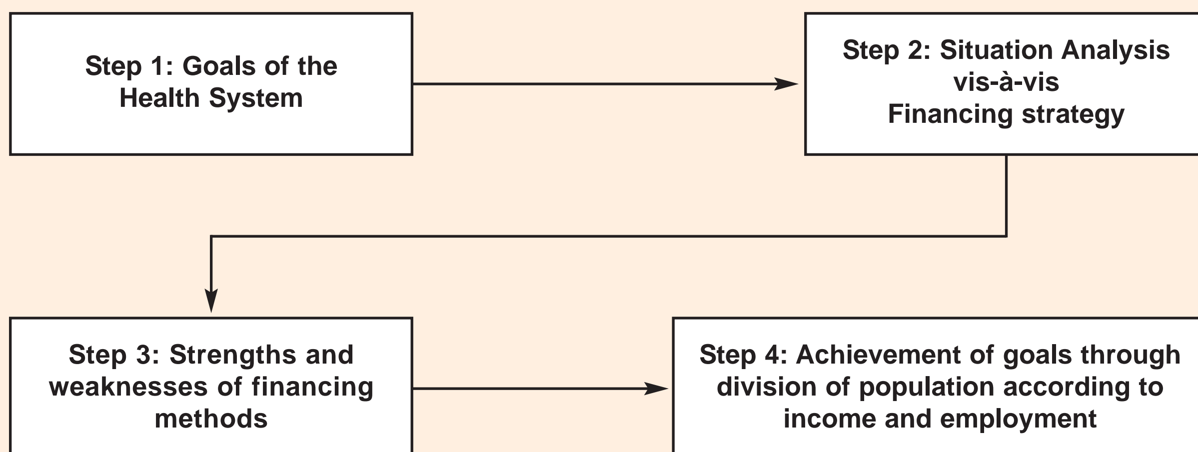
Out-of-pocket payments are one of the important financing mechanisms in developing countries. Through this mechanism, the patient pays to the provider for the goods and services he or she receives. The *community financing* mechanism is a useful method to re-direct out-of-pocket payment. Community financing involves tapping into the social cohesion and spirit of mutual assistance that can exist in a small community. These social forces would make it possible to organize prepayment schemes to fund and spend money locally, at the village and township level. Then the local community fund can organize primary care and perhaps fund a proportion of secondary services. In effect, the result is a community-based, mini health maintenance organization, with salaried practitioners, organized referral arrangements, and organized purchases of drugs and supplies. Secondary care is contracted with district hospitals.

Source: Mobilizing Domestic Resources for Health, 2002

3.0 CMH WORKING GROUP FRAMEWORK ON HEALTHCARE FINANCING

The concerns regarding universal access to health care and equity point to the importance of a financing strategy with a view to address such concerns. There has been a flurry of research at the international level regarding rational financing strategies. One of the significant developments in this regard is a framework developed by a *Working Group of the Commission on Macroeconomics and Health on Mobilizing Domestic Resources for Health (2002)*. This framework provides strategic options to finance healthcare aiming for different population groups. The framework involves four steps (Figure 1). The first step is to set goals for the health system. Second step, calls for situation analysis and capacity to raise financing to cater to the needs identified in situation analysis. Third,

Figure 1: Framework on Healthcare Financing in terms of Equity and Healthcare



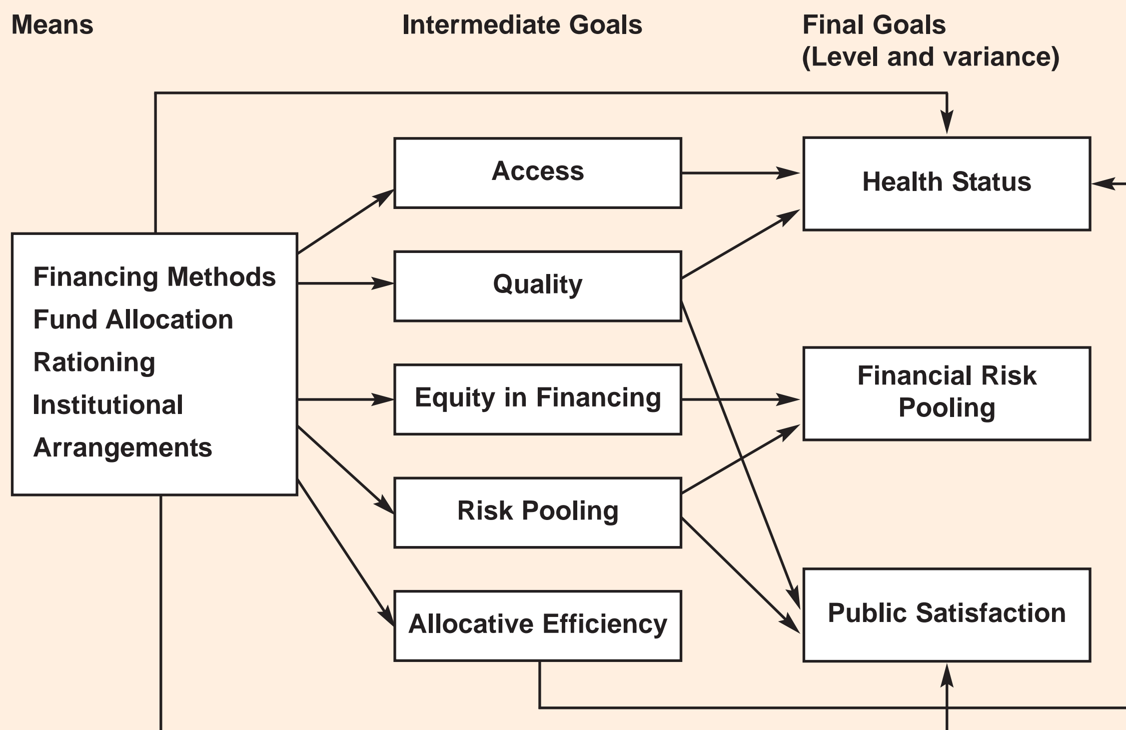
Developed from: Framework of Working Group 3 of the Commission on Macroeconomics and Health, 2002. Report of the group: 'Mobilization of Domestic Resources for Health'.

“Framework suggests breakdown of population into income and employment groups in order to set alternate financing mechanisms.”

relative strengths and weaknesses of various financing methods would be considered to know the potential of such methods before their application. Finally, alternative combinations of financing mechanisms should be assessed to achieve health goals. At this step, framework suggests breakdown of population into income and employment groups in order to set alternate financing mechanisms.

A preliminary examination of the framework shows that it starts with identifying goals of a health system and in the fourth step, shows direct relationship between financing and the achievement of the set goals. This signifies the correlation between healthcare financing and the goals attributed to a health system. This correlation is more evident in figure 2 below:

Figure 2: Relationship between Financing Instruments and Goals



Source: Mobilizing Domestic Resources. WHO WG 3 on CMH 2002.

The figure illustrates broader goals of a given health system and suggests how intermediate goals which are the product of a well defined financing mechanism influence final goals. Therefore, setting up of goals also depends upon capacity of a country to spend on health. Here strong linkage between financing mechanisms and finals goals is obvious.

3.1 APPLICATION OF THE FRAMEWORK ON HEALTHCARE FINANCING IN PAKISTAN

An attempt has been made in this paper to apply the Framework on Healthcare Financing to Pakistan's healthcare with a view to assess whether its priorities are well set out. For this purpose, National Health Policy 2001 has been examined. The health policy documents are the major guiding documents that set the stage for five-year plans and annual plans in Pakistan, as a set policy process describes *(Lashari 2004)*. Besides, some other documents describing allocations for health and overall financing strategy have also been included in the analysis that include Medium Term Development Framework 2005-10, Poverty Reduction Strategy Paper of Pakistan, Economic Survey of Pakistan and Annual Budget 2005-06.

STEP 1: GOALS OF THE HEALTH SYSTEM

As described in figure 2 any health system should have a set of final goals to be achieved in a certain period. These goals are health status, financial risk pooling and public satisfaction *(CMH, WG 3, 2002)*. In this context if we examine the policy of 2001 it seems that the policy does not specify word 'goals', however, it talks about 'vision' and 'objectives'. As policy is meant for the next 10 years - four years have already passed - we can look into the mix of its vision and objectives for the purpose of this analysis. Some of the important points provided in the vision and objectives are given in Matrix 1 along with goals specified in MTDF 2005-10.

Matrix 1: Goals of a health system and Health Policy, 01 and MTDF 2005-06

Goals of a Health System	Health Policy 2001	MTDF 2005-10
Health Status	- Protecting people from hazardous diseases; promoting public health; upgrading curative care facilities; enhancing equity, efficiency and effectiveness. - Reducing widespread prevalence of communicable diseases. - Promoting greater gender equity. - Bridging basic nutrition gaps in the target population. - Creating pubic health mass awareness.	To provide quality care to reduce infant, child and maternal mortality as well as to improve nutritional status of children less than five years.
Financial Risk Pooling	No mention in the vision / objectives	Federal Social Security System; provincial and district social security for employees and; Health insurance under BDN
Public Satisfaction	- Addressing inadequacies in primary and secondary health services. - Removing managerial and professional deficiencies in district health system. - Correcting urban bias in the health sector. - Introducing required regulation in private sector. - Effecting improvements in the drug sector.	

Source: National Health Policy 2001, Federal Ministry of Health; Medium Term Development Framework 2005-10, Planning Commission of Pakistan.

Matrix 1 provides the information that the focus of the policy is on improving health status and quality of services while relying on traditional financing mechanisms i.e. budgetary allocations and donor support. In this regard many vertical programs are underway which include FP and PHC; EPI; roll back malaria; TB program; nutrition program; HIV/AIDS program; mental health and; health awareness program.

The MTDF discusses healthcare financing and talks of a scheme for federal government employees and limited social insurance under WHO's Basic Development Needs (BDN) program. However, the commitment regarding financial risk pooling is not reflected so strongly - as committed in the goals/objectives - from financial outlay 2005-10 in which only 1.1% of the total health allocation of Rs. 85 billion has been earmarked for health insurance during the five years period in discussion.

"Globally, almost identical estimates have been recommended for developing countries to incorporate into their financing strategies."

STEP 2: SITUATION ANALYSIS AND INCORPORATING IT INTO FINANCIAL STRATEGY

Regarding step 2 of the framework, this section will deal with three questions. First, while doing a situation analysis of the financing strategy, it will be clarified whether Health Policy 2001, MTDF 2005-06, PRSP and Annual budget have conducted any analysis in this regard. Secondly, what is the financial strategy in the area of healthcare? third, does that strategy meet the requirements of needs on the ground? Therefore, the discussion in this section will be concluded by identifying gaps between needs and the expenditure.

The figures quoted from different sources show that Pakistan needs to work out how to maintain minimum standards of financing healthcare. Globally, almost identical estimates have been recommended for developing countries to incorporate into their financing strategies. In this regard, CMH (WHO), some independent researchers and IMF have come up with such estimates. As per *CMH (2001)* recommendation it has been worked out that for a set of interventions that include TB, malaria, HIV, Immunization, IMCI, maternal health etc., a low income country (including Pakistan) needs an additional amount of US$14 per person per year. With the current financing of US$23 per person in low-income countries, expenditure by 2007 needed would be around $34 per person per year in such countries. Moreover, as shown in table 2, Pakistan spends US$18 per person per year as total health expenditure, while, contribution of public sector in this regard is only US$4. On the contrary, CMH suggests a major contribution from public sector outlay in this regard. There are two particular reasons to suggest this. First, to cover public goods (such as infectious diseases control); where individuals lack the incentive on their own to take the necessary protective actions. Second, to ensure access for the poor, who lack adequate household funding *(ibid)*. The recommended expenditure by CMH are comparable with other studies done by David Evans, Chris Murray et al and a study done by IMF *(ibid)*. Furthermore,

the commission has clarified that expenditure recommended does not ensure comprehensive care, rather a minimal level of interventions that would address major communicable diseases and maternal and prenatal conditions that account for a significant proportion of the avoidable deaths in low-income countries.

Pakistan is lagging behind in terms of expenditure on health from public outlay incurred by low-income countries. As shown in table 3 low-income countries spend US$23 on average per person per year in current dollars while Pakistan spends US$18 out of which public outlay is US$4 in contrast with US$13 by other low-income countries. Therefore, incurring US$34 on health by the year 2007 as per WHO recommendation would need drastic measures in the health system of Pakistan. This would ensure a comparable health status and would enable the health sector to scale up efforts to achieve the Millennium Development Goals. Therefore, an analysis of current expenditures and needs should be the first step. Such an analysis would identify the gaps in the system.

"Pakistan is lagging behind in terms of expenditure on health from public outlay incurred by low-income countries."

Table 3: Domestic Spending and Donor Assistance 1997-99 and current level in Pakistan

Region / Country	Public expenditure on health (US$ per person)	Total expenditure on health (US$ per person)	Donor Assistance for health (per person)	Donor Assistance, annual average
Low income countries	13 (1997)	23 (1997)	0.94 (1997-99)	US$ 1,666 Million (1997-99)
Pakistan	4 (2004-05)	16 (2004-05)	–	Rs. 1 billion (2005-06)

Sources: Pakistan Development Forum, 2004; Annual Budget 2005-06; CMH Report 2001

Lower per capita health expenditure as compared to other regional countries mentioned in the literature; low budgetary spending pointed out by PRSP (PRSP , 2003); and low level of expenditure in terms of GDP as suggested by Economic Survey 2004-05 are complemented with some other issues. Delays in disbursements, low utilization and rent seeking behavior further complicate the situation. Official reports suggest that utilization of allocated funds is not up to expectations. Dr Akram Shaikh, Deputy Chairman Planning Commission as quoted by daily *Dawn (May 30, 2005)* said that during first seven months of the fiscal year 2004-05 about 49 percent of the PSDP was utilized while he assumed that by the end of the fiscal year utilization will reach 97 percent. As against such assumption, figures of fiscal year 2003-4 suggest that only 60 percent of the funds were utilized during ten months of that year according to pre budget press briefings last year.

A recent study conducted by Technical Assistance Management Agency (TAMA) on Fund Flow and Expenditure Tracking of the programs of the National Health and Population Welfare Facility (NHF) during fiscal year 2003-04 and 2004-05 have found many flaws in the flow of funds. National Health Facility is a DFID funded project.

According to the study, release mechanisms vary for different NHF programs. In this regard, funds for five health programs remain at the federal level and no transfers are made down to the provinces or district levels. Programs in this category include Malaria Control, EPI, AIDS Control, TB Control and Nutrition. For the two programs i.e. population welfare and Primary Health Care and Family Planning Program, the funds are transferred to provinces and districts.

It takes 7 to 8 weeks to issue a sanction in the Ministry of Health for Family Planning & Primary Health Care program (FP & PHC). In case of Ministry of Population Welfare, it takes 3 to 4 weeks to issue a sanction. Therefore, a major delay occurs at federal level. The overall tracking of funds flow shows that for Population Welfare Programs, the transfer of funds to a district level took 70 and 73 days during the FYs 2003-04 and 2004-05, respectively. Transfers for contingent expenditure at the districts for FP & PHC program reached end points in 88 and 59 days respectively. Salaries and stipends for the same program were disbursed after 76 and 67 days, respectively.

"The capacity to prepare a Cash Plan is non-existent at the district levels."

The study reveals that most of the time is being consumed at federal level mainly because it involves many offices and various documentations. A comparison of sanctions during various quarters show that the Ministry of Health (MoH) have been processing sanctions in certain quarters even within two weeks of beginning of a quarter and Ministry of Population Welfare (MoPW) has done so in a week's time. Therefore, it is evident that sometimes the system works efficiently. The study suggests that the delays regarding sanctions lie with the initiation process and deficiencies in documentation. Due to the deficiencies in documents, these are sent back for necessary corrections subsequently taking more time. In addition to the normal sanction process, a new system of Cash Plan (CP) has been introduced from this year. All program managers have to prepare detailed CPs, which would be used as a basis for release of PSDP funds. However, the capacity to prepare a Cash Plan is non-existent at the district levels.

After consumption of much time at federal level, another major delay takes place at Sub-Office of AGPR (Accountant General of Pakistan Revenue) which takes 2-3 weeks to issue seal authority for transfer of funds. With under-staffing and old style of working, AGPR has become inefficient in timely transfers. Transfer of these salaries into commercial banks and delays in getting salaries takes almost 1-3 weeks. The only effective channel in the

series is the State Bank of Pakistan, which takes one day to clear the sanction request. The study provides insight into delays in utilization of funds and subsequent lapse of funds at the end of the fiscal year.

This situation analysis needs to be compared with the existing financing strategy. Healthcare in Pakistan is being funded mainly through two channels i.e. budgetary allocations and out-of-pocket payments. The social insurance through social security scheme in the formal sector has about 1 million members *(MTDF 2005-10).* The financing of healthcare through these channels has been discussed to some extent in the MTDF. Although, it cannot claim to be a comprehensive financing strategy, does in a limited fashion talk of multiple effects of financing mechanisms like the amount of money to be raised; equitable financing and; efficiency of resulting goods and services. It discusses the direct targeting of the poor through *Zakat* funds i.e. helping poor in hospitals through such funds. It also suggests that cost of care may be waived-off for those people who cannot afford to pay. Furthermore, MTDF has suggested a health insurance plan for federal government employees as mentioned elsewhere in this paper.

"The PRSP counts the challenges of financing within the health sector as internal challenges that preclude an improved health status of the population."

Some more discourse on the issue of financing would be found in the *Poverty Reduction Strategy Paper (PRSP) (2003).* The PRSP counts the challenges of financing within the health sector as internal challenges that preclude an improved health status of the population. These internal challenges include low government expenditures on health services - a major share of which has been focused on tertiary health care; weak policy formulation and poor management with overstaffing and inadequate expenditures on key inputs such as essential drugs, equipments, and operational supervision activities. Based on the issues faced by the health sector, tentative financing needs have been identified for a medium term. According to tentative calculations of PRSP the adequate financing of priority programs such as LHW, MCH, HIV/AIDS, malaria, TB, health education, reproductive services, human resource development, capacity building, enhancing the non-salary budget for existing facilities and improved allocation for population program will need an additional Rs. 10-12 billion per anum. This will necessitate increase in sectoral financing from 0.5 to 0.8 percent of GDP over the medium term and then moving to 1 percent of GDP in the long term.

Apart from MTDF and PRSP's financing strategy for health, we refer to WHO's *CMH Report (2001)* that informs; on average developing countries do spend US$23 per person annually. The author estimates that, Pakistan needs to raise upto US$7 per capita besides current level to be comparable with that figure as a whole and would need more than double the amount that is being spent by the public sector (US$4) in this regard. Beside that by the fiscal year 2006-07 Pakistan would need to raise an additional US$18 per person from its existing expenditure per person for a minimum package of health interventions. An explanation of current budgetary arrangements is in order.

"It is also important to note that the health sector has to pay the cost of utilities like electricity and gas on commercial rates, which creates many financial constraints on the health sector."

An analysis of budgetary expenditures on health reveals quite a few deficiencies in health care financing. The country's annual budget remains based on current prices, which includes inflation. In addition, raise in salaries also is accounted in budget documents. Due to this factor, the annual budget is being enhanced by 3.5 percent. By looking at inflationary trends during the last decade, it is evident that the later period of 1990s i.e. 1998-2000 has shown a marked decrease in inflation that decreased to 5.7 percent as compared to average of the decade, which was 9.7 percent (Economic Survey 2004-05). However, it has again started rising and this year reached to double-digit level. Thus, any increase in health expenditure may be explained in terms of these two factors as well i.e. rise in salaries and inflation. Another important factor needs to be considered. That is the development expenditure. This expenditure is investment expenditure that includes building, equipments, repairs, and maintenance; thus, this is not a direct expenditure towards improvement in services or health status, which brings impact over the period. By now development expenditure in health is 40.74 percent of actual while current expenditure is about 60 percent. Out of current expenditure, about 70 percent is spent on salaries. It is also important to note that the health sector has to pay the cost of utilities like electricity and gas on commercial rates, which creates many financial constraints on the health sector. This pressure enhances further due to rise in the cost of these utilities. Such costs bring additional negative impact on health expenditure. This overall picture exerts more pressure on health expenditure; leaving little space for flexibility in the existing budget. In addition, the current budget has taken a significant shift from the traditional health expenditure pattern by taking out building of human resource infrastructure from the sector and transferring it to Higher Education Commission (HEC). As per the budget of 2005-06, schemes worth Rs. 350.764 million have been allocated to HEC *(PSDP 2005-06)*. According to a heath-financing expert, this shift will erode about 20 percent of the health budget thus, resulting into decrease of health expenditure up to the level of less than 5 percent of GDP. Such allocation would also create managerial issues of dual financing and control.

3.2 DEVOLUTION

In addition, some more discussion is in order in respect of the newly placed institutional arrangement that is the recent process of devolution. Devolution is commonly known as third tier of governance. Though local governments remain in focus since independence however, traditionally this tier has been made functional time and again as per the objective situation, the point remains that it brings with it some positive changes. Pakistan has been experiencing a major decentralization reform in its history. A commitment to this end had been made in the Constitution of 1973. Article 37 (i) of the Constitution notes that: "The state shall decentralize government administration so as to facilitate expeditious disposal of its business to meet the convenience and requirements of the public." *(Devolution in Pakistan Annex 1, 2004)*

According to devolved arrangements, all health facilities in a district except

tertiary/teaching hospitals have been placed under the control of Executive District Officer (Health) - EDO (Health). Training and staff development institutions that were earlier under the divisional headquarters are now largely under the EDO-H. *(Devolution in Pakistan: An Assessment and Recommendations for Action, July 2004)* Devolution has made prominent the vulnerability of some of the financial and service delivery arrangements in the wake of un-satisfactory preparations for such a change. For example, a major intervention in the health sector towards health of the population is its vertical programs. However, these have posed serious problems at the local government level 'because they limit local government's autonomy in preparing the budget'. This has been revealed in a joint report of ADB, DFID and the World Bank released in July 2004. Furthermore, the lack of local ownership is most marked in relation to the Lady Health Workers, but similar problems of delays in the release of funds from the province and weak supervision and monitoring by the districts beset the EPI, MCP, and TB DOTS programs (*ibid*). Importantly, districts do not allocate funds or other resources for monitoring and supervision of a vertical program, and without this involvement, program targets are unlikely to be met (*ibid*).

It is evident that due to centralized functioning, district health authorities have little space to make financial plans according to their needs. The problem lies at two levels i.e. federal to district and provincial to district level. As far as the provinces are concerned delays in disbursement of funds, political interference especially in case of opposition district *nazims* and some decisions related to vertical programs being taken at provincial level are some of the important impediments. While, in case of federal government, vertical programs provide hardly any space to districts regarding ownership or making any financial arrangements. The control in relation to program and finances points towards another important area that is the relationship between federal and provincial governments. The National Finance Commission Award (NFC) is the main area of consideration in this regard (Box 2).

"It is evident that due to centralized functioning, district health authorities have little space to make financial plans according to their needs."

The situation analysis of financing of healthcare in Pakistan provides a few conclusions: Lower level allocations from tax revenue for the health sector as per regional comparison; disproportionate amount being spent on tertiary care with an urban bias; gross inequity, inefficiency prevailing in distribution of funds and low utilization which excludes poor and low income people from the health system. The documents reviewed for the purpose do not set a coherent financing strategy to address such complex challenges. An increase in financing would be only one part of the strategy; second and most important is equitable distribution and efficient utilization of such funds. Therefore, the situation on the ground needs a well-informed financing strategy which should aim to finance the health sector in a way that would improve health status through access, equitable distribution, risk-pooling which would result in allocative efficiency and quality of care. In this context, identifying gaps between needs and expenditures would help in shaping a feasible financing strategy.

BOX 2: NATIONAL FINANCE COMMISSION (NFC) AWARD

National Finance Commission (NFC) Award is an arrangement through which the federal government transfers funds to provincial governments. This transfer has four components: federal divisible pool providing revenue sharing; straight transfers that include the royalties, charges and excises after deducting a federal collection fee to the province of origin; special lump sum transfers are provided to NWFP and Balochistan provinces for backwardness; and in 1999, a fourth component was effectively added to the Award, the " Octroi and Zila Replacement Grant" although in practice the transfers of the 2.5 percent GST began only from fiscal year 2002-03. The NFC Award has been remaining the cause of disagreement between provinces because of their respective shares. According to The News, June 2, 05The last award announced in 1996 went into effect in July 1997 for a time span of 5 years. However, it is still in force despite expiration of the specific period because of lack of consensus over a new Award. The provinces differ on the criteria set for the Award. Sindh has demanded the share based on revenue collection. Punjab stresses for a population basis while NWFP and Balochistan are insisting on area and backwardness to be made the basis for the Award. Under the fifth Award, Punjab got 57.88 percent; Sindh got 13.54 percent; Balochistan 3.5 percent while NWFP got 5.3 percent of the share from divisible pool. It is assumed that the new NFC Award would be based on a revised Divisible Pool allocation formula. The new formula might be extended beyond the criterion of population to include area or the Human Development Index (HDI). Although, the exact implications of a revised formula or increase in share on services in provincial and district governments may be speculated, there would however, be a significant change in the share of the provinces that would result into increased allocations for the districts. For instance, an assessment of six districts' allocations under current and new NFC i.e. at 37.5 percent and 50 percent shares respectively portrays that on average there would be 163 percent increase in allocations as compared to previous budget of six districts namely Killa Saifullah, Bannu, Faisalabad, Bahawalpur, Karachi and Khairpur studied by a joint study conducted by ADB, DFID and WB.

ADB, DFID and WB. Devolution in Pakistan: An Assessment & Recommendations for Action, July 2004; The News, June 2, 05

Matrix 2: Identifying Gaps between Expenditures and Needs

Financing Needs (micro to macro level)	Wither financing	Gaps between needs and financing
- Supply of essential drugs-Diagnostic facilities-Funds for health promotion and out reach activities - Salaries and vehicles (LHWs, SBA, paramedics and nurses) - Funds for referral system and HMIS-EmOC and IMCI facilities - Fully equipped operation theatres- Emergency and Trauma centers-Cost of care-Reallocation within the sector: urban to rural, curative to preventive, redirecting out-of-pocket payments-Equitable distribution	- Low financing (0.6% of GDP)-Low utilization - Delays in disbursement-Politically, socially and ethnically strong get more funds - Most of the expenditure through private sector (77% of THE) - Increasing cost-Meager amount on subsidies	- Expenditure do not compare with the needs (low expenditure) - Allocative inefficiency - Low utilization-Major part of utilized funds go to the payment of salaries - Inequitable distribution: poor and low income groups excluded - Expenditures on PHC and at grass-roots level not being monitored so no clue about outcomes and wastage - Lack of capacity to plan and implement financing strategy - Issues of technical, economic and allocative efficiency - Cost of care unbearable for poor and low income even difficult for well off, specially catastrophic cost

Source: National Health Policy 2001, Federal Ministry of Health; Medium Term Development Framework 2005-10, Planning Commission of Pakistan.

STEP 3: STRENGTHS AND WEAKNESSES OF FINANCING METHODS

The financing mechanisms in Pakistan - as discussed elsewhere in this paper - mainly include out-of-pocket payments and general tax revenue with a negligible role of social insurance. The effectiveness of these mechanisms would be clearer by looking into their relative strengths and weaknesses. Such analysis would also be useful regarding any future financing strategy. Besides, all financing mechanisms would also be reviewed in this section regarding the strengths and weaknesses with a view to their relative importance for financing in Pakistan. Matrix 3 contains strengths and weaknesses of various mechanisms.

Matrix 3: Strengths and Weaknesses of different financing methods

Financing Methods	Strengths	Weaknesses
General Tax Revenue	General Flexible and concern for equity *Import duties* work well as a substitute of weak tax administration and narrow tax payingExcise duties have advantage of raising huge amount of revenue at low admin. Cost. *Excise duties* earmarking possible if link is built between excise duties and health (smoking, drinking and driving) *GST:* great potential to generate substantial amount *Corporate Income Tax:* Convenient to collect and politically less controversial *Personal Income Tax:* potential as best tax to obtain more revenueCan be progressive when addressing equity issues. *Payroll tax - Social security tax:* Being an earmarked tax for future benefits is justifiable.Providing potential for earmarked taxes. *Earmarking:* tax on alcohol and tobacco would get popular support if clearly associated with financing healthcare.A way out to protect health budget when governments want to cut back public spending. *User Fees:* If poor exempted, this can be a source of additional income (conditional strength) Specific A main source of provision of public goods in health Primary healthcare provision Health promotional activities through LHWs, SBA and other outreach staff Spending on communicable diseases and vaccination Potential for social insurance	General Often regressive when equity concerns not addressed. *Import duties:* not an ideal method to generate revenue for health *GST:* equity concerns being indirect tax *Corporate Income Tax:* legislation not simple due to international accounting practices. Therefore, not a reliable source. *Personal Income Tax:* Widespread under-reportingPoor tax administration and corruption Mainly contributed by well-documented service sector. Unlikely to be a major way to raise extra resources *Payroll tax - Social Security:* If capped at certain income, becomes regressive In low-income countries same weaknesses as of income tax. *Earmarking:* If tied to a particular expenditure, less flexibility would be left to the government. *User Fees:* Extremely unequal distribution of income and wealth, this fee is regressive and restricts poor from access to health. Specific More funding for tertiary care with urban bias Little access to poor and low income Inefficient distribution and disbursement Can't fulfill minimum needs No consideration for risk pooling

Out-of-Pocket payments	A huge amount being spent on private services can be redirected towards risk pooling methods. In low-income countries 40-50% of the expenditure comes from OOP (Berman 989).	Cost of care borne through OOP pushing people into poverty No reliability of services Doctor's choice may overwhelm and result into more cost Issues of affordability, accessibility and equity
Community Financing	Potential of becoming a community based, mini health maintenance organization, with salaried practitioners, referral, purchase of drugs and supplies, secondary care contracted with district. Prepaid and compulsory CF ensures risk poolingCommunity accountability	Rural poor and low income household don't have limited capacity to pay
Social Insurance	Effective method to cover formal sector	No attraction for non-formal sector
Private Insurance	Financing may be raised from those who can pay.	Premium reflects byres risk rather than ability to pay Only higher income group can pay Insurance companies prefer only healthy persons leaving sick and elderly to be paid from tax revenue Problems of risk selection

Based on information from: MTBF 2005-10 draft; CMH, WG 3, 2002

STEP 4: ACHIEVING GOALS BY DISTRIBUTION OF POPULATION INTO INCOME AND EMPLOYMENT GROUPS

Pakistan is the seventh most populous country in the world with a population of 152.53 million (include latest figure from FBS site). Despite the estimates that the current population growth rate stands at 1.9 percent per anum, this is still high compared to developing countries where the rate is 1.7 percent *(Economic Survey 2004-05)*. The unchecked growth in population gives rise to many unprecedented problems of poverty, unemployment, kachi abadis, environmental degradation etc. Above all, it puts enormous pressure on existing health and educational facilities. In the context of health, it is evident from discussion in the paper that due to limited financing methods achievement of health goals seems to be a far cry especially when the country has to meet MDGs.

"An analysis of the population should be conducted to find out how the population is divided into income and employment segments."

Step 4 of the framework is being applied to the population of Pakistan in this background. An analysis of the population should be conducted to find out how the population is divided into income and employment segments. After establishing these groupings, we shall apply different financing methods as appropriate for the group concerned in the context of strengths and weaknesses of the methods as discussed elsewhere in this paper. The framework proposed a division of population according to income and employment status. Therefore, the population is being divided along these two lines.

3.4 POPULATION SEGMENTS ACCORDING TO INCOME

First, the focus would be on population distribution based on income and its status according to geographic areas. For this purpose, data available from different documents including Economic Survey, Annual Report of SPDC 2004 and UNDP's National Human Development Report (NHDR) 2003 have been reviewed.

According to a NHDR/Pakistan Institute for Development Economics (PIDE) survey[1] , at present, 78% of sick persons go to the private sector for healthcare while 22% go to the public sector *(UNDP. National HDR. 2003).* The ratio of different economic groups regarding seeking care from private sector is 79.5 percent for extremely poor, 74.4 percent for poor and 82.2 percent for non poor. For this purpose three categories of providers have been included in private providers i.e. Private sector (allopathic); Homeopath, Hikmath and others and; compounder or chemist *(ibid).* According to the survey ratio of poor and richest in the areas of study was 83.7:16.1 from mean income point of view *(ibid).* The UNDP report has developed a Human Development Index (HDI) for the country according to which Punjab, Sindh, NWFP and Balochistan have a ranking of 1,2,3,4 respectively. The ranking of 1 to 4 was used in a way that 1 indicates more human development and 4 with less human development. While ranking according to rural and urban was: Sindh (urban), Punjab (urban), NWFP (urban), Balochistan (urban), Punjab (rural), NWFP (rural), Balochistan (rural), Sindh (rural). The analysis provides some insight regarding any future financing strategy with respect to prioritizing regions on geographic basis.

"The income distribution in Pakistan is skewed in favor of the rich. This has created a great divide between the rich and the poor."

The income distribution in Pakistan is skewed in favor of the rich. This has created a great divide between the rich and the poor. According to the SPDC Report (2004) income share of richest 20% quintile of the population in 2002 was 47.6 percent and that of lowest 20% quintile was 7.0 percent. In case of urban and rural, the ratio was 50.3:43.2 percent and 6.6:8.0 respectively.

3.5 POPULATION SEGMENTS ACCORDING TO EMPLOYMENT

According to Economic Survey 2004-05, Pakistan has a total labor force of 45.23 million. Out of this, 41.75 million are employed while 3.48 million is unemployed. Out of this labor force, 30 percent is working in the formal sector while 70 percent is in the informal sector. Further breakup reveals that in rural areas ratio of formal and informal sectors is 27.1:72.9 percent respectively, while in urban areas the ratio is 32.8:67.2 percent respectively. Regarding the unemployed out of labor force of 3.52 million, 2.09 million belong to rural areas while 1.43 million belong to urban areas of Pakistan. The sector wise break up provides information that out of the total labor force 17.97 million are employed in agriculture, 5.73 million in manufacturing and mining, 2.43 million in construction, 6.18 million in wholesale and retail

1. The National Human Development Report/PIDE Survey 2001 was conducted in eight rural and urban poor communities of the country. Sample of 2,240 households was taken from seven districts of all the provinces. The survey may not be a representative of whole country but provides a rich source of data. (Pakistan National Human Development Report 2003. UNDP)

trade, 2.40 million in transport, 0.44 million in financing and insurance and 6.27 million in community and social services. This data provides evidence that the informal sector is dominant over formal sector across the country as well as in urban and rural areas. While, a major portion of the labor force is employed in the agriculture sector. Besides, the greater number of unemployed people is located in rural areas as compared to urban areas.

"The informal sector is dominant over formal sector across the country as well as in urban and rural areas."

The review of population distribution according to income and employment suggests the following few concluding points:

- 77% to 78% of the total health expenditures are borne by the private sector through out-of-pocket payments while public sector share is 22.9 percent.
- In the seven poorest districts of Pakistan 83.7 percent, people are poor while the ratio of the rich is just 16.2%.
- According to HDI ranking urban areas of Pakistan are well off as compared to rural areas of Punjab, NWFP, Balochistan and Sindh. The names of the provinces (rural areas of these provinces) have been given according to their actual ranking order.
- Richest 20% quintile holds about 50 percent of the national wealth and poorest 20% quintile holds only 7 percent of total national wealth.
- Out of total employment, 30 percent is in formal sector while 70 percent is in the informal sector of the economy. A more detailed review shows that formal sector has lesser employment as compared to non-formal sector in case of rural as well as urban areas.
- The number of unemployed is more in rural areas as compared to urban areas.

In first three steps of the framework, a detailed review has been conducted. At step one; the goals of the health sector in the context of Pakistan have been identified by referring to National Health Policy 2001 and MTDF 2005-10. In step two, these goals were further explored in the context of situation analysis of financing and incorporating that into existing financing arrangements. At this stage, some important gaps were identified and discussed. These gaps are the result of a mismatch between needs and financing mechanisms. In the third step, strengths and weaknesses of the five financing methods were discussed; some specific points were discussed with reference to Pakistan's situation. In the final step, population was described through two different social grouping i.e. income and employment. This gave an insight into how population is distributed which calls for a well thought out financing strategy in Pakistan. Although it is a rough estimation of population distribution, it provides a clear view for different financing options. Based on this distribution, a broader outline of options has been worked out in Matrix 4.

It is evident from matrix 4 that keeping in view the population distribution based on income and employment, a combination of four financing methods is a better option instead of current two mechanisms of tax revenue and

Matrix 4: Healthcare Financing Options in Pakistan		
Population Distribution/Health Expenditure pattern etc.	**Financing Options**	**Remarks**
77% payments are out-of-pocket (OOP) and 23% by public sector. All groups extremely poor, poor and non poor go to private in majority	Increase tax revenue; channeling OOP through Community Financing, Social Insurance and Private Insurance	Beside increase in tax revenue its efficient use, timely disbursement and proper monitoring is important. Issues of equity may be addressed through tax revenue by subsidizing for poor and needy.
An analysis of poorest districts of Pakistan reveals that 83.7% are poor as compared to 16.1% are rich	More tax revenue in these areas to ensure equitable access to health; community financing to enable poor to get care; private insurance for affluent to lessen burden on tax revenue	The tax revenue has potential to be flexible and equitable. Specific targeting suggested
HDI Ranking: All rural areas are backward as compared to urban areas. Numbering sequence is rural areas of Punjab, NWFP, Balochistan and Sindh	More tax revenue targeted as per the sequence; community financing and social insurance	Tax revenue targeted at specific regions on equitable basis
50% of the total wealth is held by 20% riches quintile and 7% is held by 20% poorest quintile	Tax revenue targeted at poorest; greater scope for private insurance for 20% richest quintile	Poorest group identified in broader terms for targeting through tax revenue vis-à-vis potential group identified for private insurance.
30% of total employment in formal sector while 70% in informal sector	Social Insurance for formal sector and Community Financing for informal along with tax revenue targeting	Clear cases for social insurance and community financing
More unemployed in rural areas	Tax revenue targeting	Another potential segment for tax revenue

out-of-pocket payments. Both have capacity constraints in terms of accessibility, affordability and equitable distribution of health outcomes.

Furthermore, it would be appropriate to mention some limitations of applying this framework. Due to time limitation, non-availability of reliable data, and limited scope of the paper it was not possible to apply the framework more thoroughly. However, a broader outline for a financing strategy has been chalked out. This needs to be further explored in terms of geographic distribution and the size of different income and employment groups. Besides, more data would be needed to come to a clearer conclusion.

"The responsibility of state as provider of health may not be overlooked."

A point, which comes out strongly is the need for drastic reforms. More specifically tax revenue has to be increased because that ensures provision of public goods, access to care by all segments especially poor and marginalized. The need to increase tax revenue is much clear from matrix 4, which reveals that at all the six stages of financing options; tax revenue has been mentioned as a potential source. Therefore, the responsibility of state as provider of health may not be overlooked. This finding is identical to many studies that

emphasize the responsibility of state to provide healthcare to the population. This becomes further evident from analyzing Box below. WHO's Commission on Macroeconomics and Health has suggested fundamental healthcare financing reforms in low-income countries. The results of application of the framework in this paper and reforms suggested by CMH (Box 3) possess some identical points. Both emphasized on increasing tax revenue and channeling out-of-pocket payments into pre payments schemes.

BOX 3: HEALTHCARE FINANCING REFORMS IN LOW-INCOME COUNTRIES

The Commission on Macroeconomics and Health set up by the World Health Organization in January 2000 has suggested a six steps strategy for healthcare financing reforms in low-income countries' settings. These steps include:

- Increased mobilization of general tax revenues for health, on the order of 1 percent of GNP by 2007 and 2 percent of GNP by 2015
- Increased donor support to finance the provision of public goods and to ensure access for the poor to essential services
- Conversion of out-of-pocket expenditures into pre-payment schemes, including community financing programs supported by public funding, where feasible
- A deepening of the HIPC (Highly Indebted Poor Countries) initiative, in country coverage and in the extent of debt relief (with support from the bilateral donor community)
- Efforts to address existing inefficiencies in the way in which government resources are presently allocated and used in the health sector.
- Reallocating public outlays more generally from unproductive expenditures and subsidies to social sector programs focused on the poor.

Source: Macroeconomics and Health: Investing in Health for Economic Development. Report of the WHO's Commission on Macroeconomics and Health. December 20, 2001

4.0 RECOMMENDATIONS

- Based on discussion and application of WHO framework on healthcare financing in Pakistan, it is recommended that a new healthcare financing strategy should be finalized in line with broader health goals.
- A combination of financing methods may be adopted as a part of financing strategy including tax revenue; community financing; social insurance and private insurance. Specific utility of each method and its targeted users have been discussed. Tax revenue has a significant role to play. It will have to ensure equitable distribution of resources and provision of public goods.
- The bottlenecks in timely disbursement of funds should be addressed along with proper utilization and monitoring.
- The reallocation of tax revenue within health sector is an essential step to be taken to avoid skewed nature of financing towards urban and curative services, this leaves about 70 percent of the population living in rural areas in vulnerable situation without basic healthcare.

- The current health budget of 0.6 percent of GDP is very low. Steps should be taken to increase that up to 1% in medium term and 2% in the long term. In this regard earmarking, cut in non-productive expenditures, donor support, excise duties may be useful ways to think about.

5.0 BIBLIOGRAPHY

- ADB, DFID, WB. Devolution in Pakistan Annex 1 - Recent History, July 2004, ADB, DFID, World Bank. 2004.
- ADB, DFID, WB. Devolution in Pakistan: An Assessment and Recommendations for Action, July 2004, ADB, DFID, WB. 2004
- Ibid
- GoP. *Pakistan Economic Survey 2004-05*
- ibid
- GoP. *Annual Budget 2005-06*
- GoP. *Poverty Reduction Strategy Paper (PRSP)*. Ministry of Finance, Government of Pakistan. December, 2003.
- Government of Pakistan, Planning Commission, Draft Medium Term Development Framework (MTDF), 2005-10
- Government of Pakistan, Draft Medium Term Budgetary Framework (MTBF), 2005-10
- Lashari T, *Pakistan's National Health Policy: Quest For A Vision*. TheNetwork for Consumer Protection, 2004.
- Ministry of Health & Ministry of Planning and Development, GoP in collaboration with WHO. *Inventory of Health and Population Investment*. 2005. WHO.
- ibid
- Mangi NA, *Making PSDP more Effective*. Economic and Business Review, Daily Dawn. May 30-June 5, 2005
- PSDP 2005-06, Government of Pakistan, Planning Commission, Planning & Development Division, June 2005
- SPDC. *Social Development in Pakistan, Annual Review 2004*. SPDC. 2004
- The News, June 2, 2005 (http://www.jang.com.pk/thenews/jun2005-daily/02-06-0-2005/metro...) accessed on July 24, 2005.
- ibid
- UNDP. Hussain A, *Pakistan National Human Development Report*, 2003. UNDP
- Ibid
- ibid
- WHO. *Commission on Macroeconomics and Health*, WHO, 2001
- ibid
- ibid
- Wasay A, Baloch TH et al. *'Fund Flow and Expenditure Tracking Study'*, interim report. TAMA. January 2005
- WHO, CMH, Working Group 3. *Mobilization of Domestic Resources for Health*. 2002.
- Ibid
- World Bank. http://devdata.worldbank.org/hnpstats/HnpAtaGlance.asp?sCtry=PAK,Pakistan(Accessed on July 3, 2005).

ACKNOWLEDGEMENTS

The author is extremely grateful to Dr Fazle Hakim Khattak, Deputy Chief, Health, Planning Commission, Peter Cosgrove, Faculty, Department of Community Health Sciences, Aga Khan University, Dr S Akbar Zaidi, a renowned economist, Dr Faisal Bari, Executive Director, Mehboobul Haq Centre for Human Development, M Irfan, a renowned economist, Ali Qadir, Executive Coordinator, TheNetwork for Consumer Protection, and Dr Shafqat Shehzad, Research Fellow, Sustainable Development Policy Institute (SDPI) for their review and valuable inputs in this paper. An acknowledgement is also due to Kashif Jamal, Assistant Project Coordinator, Health Policy Unit for his extensive research support, especially in conducting literature search for the paper.

Author:
Dr. Talib Lashari, Programe Coordinator, Health Policy Unit of TheNetwork for Consumer Protection.