

ORIGINAL ARTICLE

POLITICAL ARCHITECTURE AND LEGAL FRAMEWORK RELATED TO SOCIAL HEALTH PROTECTION SCHEMES IN PAKISTAN: QUALITATIVE INQUIRY OF POLICY MAKERS' VIEWPOINT

Sheraz Ahmad Khan, Ayaz Ayub*, Kashif Ahmad Khan**, Raheel Shahab Khan**,

Jawad Ahmad Shahzad**, Ayisha Jamil***

Public Health Association, Khyber Pakhtunkhwa & FATA, *Institute of Public Health and Social Sciences, Khyber Medical University, Peshawar, **Pak Cancer Support Group, ***Peshawar Medical College, Peshawar-Pakistan

Background: Pakistan is a federal state with three tiers of government. Following contentious general elections in 2013, ever first democratic transition took place in Pakistan. Subsequently, two social health protection schemes were launched. Current paper's objective is to understand the political context in which these schemes were launched and to explore the constitutional position of access to healthcare in Pakistan. This paper also explores the legal protection/ sustainability with regards to these schemes. **Methods:** We used qualitative research techniques with interpretivist paradigm and case-study approach. In-depth interviews were conducted, followed by content analysis. Triangulation and data saturation were observed to guide our sample size. Officials involved with these schemes at policy and implementation level were interviewed. Ethical approval was taken from ethics board of Khyber Medical University. Based on purposive sampling, in-depth interviews were conducted and thematic analysis was performed. **Results:** We identified two themes in response to question-1 of our interview, asking about the cause of action behind starting these schemes and their legal protection. These themes were: (i) [initiation of] Social Health Protection as democratization of healthcare, and (ii) [initiation of] Social health protection in legal void. Implicitly, these schemes are a product of grass root political activism and health found berth in election manifestos recently. Also, we deduce that health is not a constitutional right in Pakistan. These schemes lack constitutional guarantee and ensued in absence of overarching legal framework. **Conclusion:** These social health protection schemes are high on political agenda but lack constitutional and legal protection.

Keywords: Universal Health Coverage (UHC); Sustainable Development Goals (SDGs); Healthcare financing; Health insurance; Social health protection; Sehat Sahulat; Prime Minister National health program

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INTRODUCTION

Pakistan is a federal state with three tiers of government as envisaged in its 1973 constitution. Major shift in the constitution occurred in 2010 via 18th amendment which brought significant devolution of powers. Among 17 devolved ministries, health was one. Hence, the legislative and executive authority for healthcare delivery devolved to provinces.¹

Thereafter, health for first time vividly appeared in election manifestos. Two social health protection schemes were launched by incumbent government(s). Central government launched Prime Minister National Health (insurance) Program (PMNHP) and Khyber Pakhtunkhwa (KP) province launched its Social health protection initiative named "Sehat Sahulat Program (SSP)". Together, these schemes aspired to cover around

49 million people living under national poverty line, for all inpatient secondary healthcare services along with coverage for some tertiary and priority health conditions. These schemes are the biggest social health protection schemes in Pakistan's history with combined financial cost to public exchequer of Rs.14.98 billion or USD 143.2 million (SSP costing Rs.6.8 billion or USD 65.0 million and PMNHP costing Rs.8.18 billion or US\$ 78.2 million). Amidst the size and shape of these schemes, they have the potential to help achieving universal health coverage (UHC) and contribute towards health-related targets under Goal#3 of Sustainable Development Goals (SDGs).^{2,3}

Unfortunately, many such popular schemes have been rolled-back in past. Inter alia, the rolled-back schemes included Tawana Pakistan

Project, Women's Health Project, Family Health Project, People's Primary Health Care Initiative and the National Action Plan for Prevention & Control of Non-Communicable Diseases in Pakistan.⁴ Also, moving towards UHC in several countries needed various reforms, including constitutional reforms to recognize health as a basic right, modifying delivery system(s), mobilizing resources and above all political concurrence.^{5,6} Current paper is to understand the political context in which these schemes were launched and to explore the constitutional position and statutory backing of these schemes in order to have an idea of their legal protection/sustainability.

MATERIAL AND METHODS

We used qualitative research techniques with interpretivist paradigm and case-study approach. Scientific and ethical approvals were taken from concerned boards of Khyber Medical University. We conducted in-depth critical case interviews to ascertain our study objectives. Non-probability purposive sampling techniques were used to interview six key informants including (i) Secretary to Government (Department of Health, Khyber Pakhtunkhwa), (ii) Project Director (Social Health Protection Initiative, Khyber Pakhtunkhwa), (iii) Director Technical (Prime Minister Health Insurance Program), (iv) Regional Chief (SLIC Insurance Corporation-Islamabad, working as Coordinator for PM Health Program), (v) Lead Insurance Consultant for Green Star Pakistan (community perspective), (vi) Lead Advisor (to Government of Pakistan) on Social Health Protection (Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)). Interviews were conducted in office settings.

After informed written consent, interviews were conducted, audio recorded and transcribed in verbatim. Thematic analysis was done. Initially, open coding was done. Codes carrying similar meaning were grouped together to form categories. Open codes and categories were read and re-read in order to understand the evolving meaning. Interviews were read in conjunction with project documents, constitution of Pakistan and other statutes in force. It led to formation of patterns in data and emergence of themes. Major themes were broken into subthemes. Data from interviews was augmented with field notes. Through reading records and considering interview responses, both policy and action plan(s) were interpreted with regards political backdraft and legal framework related to these projects.

Triangulation was ensured with methods and respondents' diversity. In method triangulation, we collected data in multiple formats and contexts. Respondents' triangulation was done by conducting at least two critical case interviews directly related to each project and additional two interviews with key person versed with both projects. Investigator's triangulation was ensured by taking an observer to each interview and taking of field notes by both interviewer and observer. Data was saturated after conducting six interviews and completing the archival research.

We had 10 questions in our interview and had 13 major themes at the end of our analysis. This paper reflects on findings for our question that asked about the cause of action behind these schemes and the level of legal protection they have. Findings for this research question are discussed in the form of two major themes in results section below.

RESULTS

We inquired about the basic ideology behind these social health protection (insurance) scheme(s). We inquired to know whether these schemes stemmed from party manifestos, development partners' persuasion or emerged subsequent to legislative assembly ruling(s). First theme that emerged in response to this question was, "[initiation of these] social health protection as democratization of healthcare". This theme had two related sub-themes including (i) politics and people [leading to initiation of these schemes], and (ii) improving access [in order to ensure access to healthcare and engage people in democratic process]. This theme implies that these schemes emerged as part of political process which entails rendering health services both as a challenge and opportunity. This theme was further corroborated by documentary analysis which confirmed that health insurance was part of election manifesto for both political parties in government now.

However, the high political support and prioritization of healthcare also led to political diversion whereby two provinces, i.e., Khyber Pakhtunkhwa (ruled by PTI) and Sindh (ruled by PPP) opted out from Prime Minister's National health program, as it would give political leverage to the central government (PMLN) at cost incurred to provinces. Moreover, these schemes are covered as an arrangement by the executive branch and lack sustainability as political uncertainty and roll-back of predecessor's initiatives are common in Pakistan. The stated objectives for these schemes are to enhance access, prevent catastrophic health expenditure and protect people from poverty via

government subsidy. The latent objective is to establish voluntary private individual health insurance as a social dividend of these schemes. With reference to preceding paragraphs, one official related to federal scheme said that:

“Giving health facilities to the public are responsibility of the state as per constitution of Pakistan. We know that healthcare in Pakistan has become very expensive and people are very poor, that is why the government has decided to give this social health protection to the people of Pakistan”. Interviewee-2

Another respondent however said that:

“Government needs projects that are well received and regarded in Public and make a stout political slogan ... the prospects of success in this Social Health Protection scheme were better”. Interviewee-1

One respondent while speaking on the objective of the scheme said that:

“Now that [affordability] has always been a barrier to access for our people who are too poor to afford the travel and medication expenditures. Therefore, the Government felt that there has to be some way of making healthcare accessible and affordable for the poor population”. Interviewee-1

Upon the highest level of government involvement, one respondent (Interviewee-3) said: “The idea came from the honourable Prime Minister himself who wants health services to the poor people to be ensured” while about the level of commitment towards the SSP, a respondent said that “it is being approved by the government and the Chief Minister”. Another respondent (Interviewee-2) associated with SSP said that: “The cost of this project is in billions. Now, this is the peak of commitment on part of this government to allocate billions of rupees to this project when the province is already having so many problems to deal with”.

One respondent was not contented with current state of affairs and sounded his displeasure with separation of SSP and PMNHP. He said:

“What I personally believe is that there shouldn't be any politicking in two things, the one is education and the second is health...there shouldn't be any separate pool at provincial and federal level. It is understood that bigger the pool, lower the premium and better is the coverage”. Interviewee-2

Another respondent shared an interesting reason behind these schemes that:

“The basic ideology is to inculcate the idea of voluntary individual health insurance in general public. Now that through a social health protection scheme we are offering the poorest with health coverage via an insurance card, those who can afford the premium would say that we need it too”. Interviewee-5

If political reasons were not behind the segmentation of these schemes at federal and provincial level, resources could have been saved. One of our interviewees said:

“In my opinion, there shouldn't be any provincial or federal segmented schemes but one bigger National insurance scheme with a bigger pool where all the provinces should contribute with additional top up from the federal government, then on that bigger pool better prices and services could be negotiated”. Interviewee-6

All these quotes established one pattern i.e. people centred approach towards making healthcare more accessible and that health as a subject is moving-up along the priority list for political discourse. Second theme was that, “[these] Social health protection schemes [emerged] in a legal void”. This theme is broken into two subthemes, i.e., (i) varied legal interpretation [of constitution], and (ii) dubious [legal] sustainability plans. Both provincial and federal policy makers quoted article-38 of 1973 constitution as a guarantee to social health protection [but in fact, article-38 doesn't guaranty anything]. Whether or not health for all is a constitutional guarantee was not clear among our respondents. Moreover, there is no overarching legal framework to cover these social health protection scheme hence their sustainability in legal context is doubtful.

One of our respondents said: “Giving health facilities to the public is responsibility of the state as per constitution of Pakistan.” Interviewee-4. Another respondent said that: “Article-38 of the constitution ensures social health protection as a right”. Interviewee-3 However, after detailed documentary analysis, we concluded that neither social health protection nor access to healthcare is constitutionally guaranteed. Hence, article-38 (*which falls under principles of policy and not under basic rights*) has been wrongly construed in policy documents of these schemes.

Most of our respondents were nihilistic about the significance of legal protection for the schemes. One of our respondents said that:

“Coming to the legal framework part, you only need to promulgate a law when an existing law or rules impede your way to carry out certain activities. For the time being, there is no federal or provincial law that forbids this social health protection initiative to continue. Whenever we realize any impediments, we will formulate a legal framework”. Interviewee-2

To reflect further on current plea of policy makers, we reproduce a quote from another respondent who said:

“It is an executive order that 50% of the population comprising of the poor has to be covered...so, there is no legislation going on in this respect”. Interviewee-1

Now that health is not constitutionally guaranteed and an overarching legal framework for health insurance and social protection is lacking in Pakistan, launching and sustaining such massive schemes may falter under their own weight. Same concerns are reverberated in one respondent's quote, who said:

“Yes, legal protection is needed for whatever has already started to avoid discontinuation in case an incumbent government puts health at lesser priority. Interviewee-6

Some of our respondents do realize the significance of proper legislation for sustaining and expanding these initiatives as shown by the following quote:

“We will need a legal framework in long run...once we move on to essential contribution by the remaining population; we will have to necessitate it by law. Interviewee-2

However, another respondent at policy level spoke in pure contrast to the one above. He said:

“The basic aim is to establish health insurance as a “normal” and not as a “protection” concept. Even towards that end, our approach will be voluntary and not through an imposing law. Interviewee-1

DISCUSSION

Pakistan Tehrek-i-Insaf (PTI) under its manifesto vowed to declare human capital development as a

National emergency. Health sector emergency under this broad heading was meant to increase expenditure on healthcare six folds in absolute terms and to enhance health expenditure from 0.86% of the GDP to 2.6% in five years and to increase the public-sector coverage by 100%.⁷ Pakistan Muslim League Nawaz (PMLN) manifesto 2013 under chapter on “framework for social change” vowed to increase spending on health by at least three times and to reach up to 2% of GDP by 2018. Their manifesto included launching a National Health Insurance Initiative for the whole country, whereby the vulnerable poor segments shall be covered first on government paid premium while better off people would have the option to get enrolled under the scheme on paying Rs.300/- per year per family. It stipulated for sponsorship and execution of the initiative by respective provincial government(s).⁸ These promises and subsequent initiatives are in contrast to the former democratic cycle in Pakistan starting in 1988 and ending in 1999. That wave of democracy didn't see any significant investment in social sector like health and education.⁹ In this current wave of democratization starting from 2003, access to free primary education and access to information got established as constitutional rights.¹⁰ With reference to general elections in 2013, health got place at main stage politics, both antecedent and following the elections. These schemes hence reflect democratization of healthcare.^{11,7,8,2,3,}

Literally, democratization means “the introduction of democratic principles” and in practical terms it entails “the action of making something accessible to everyone”.¹² Democratization of healthcare means enabling people to have an active role in deciding about their health and healthcare. Implicitly, democratizing healthcare is to engage people and promote social equity in healthcare services.¹³ The first pre-requisite of engagement is through giving people voice and role in making decisions regarding systems that affect their health. Hence, by including healthcare provision in election manifestos and giving people the choice to vote for a proposed manifesto or otherwise is synonymous to active public engagement. Second prerequisite for democratization is the promotion of social equity by health professionals and institutions, thus shifting from patient-centred to person-centred healthcare provision. On litmus of definition and prerequisites quoted above, schemes under discussion hold merit to be labelled as democratization of healthcare.

Hence, SSP and PMNHP schemes emerged as part of political process, as health insurance and enhancing coverage was part of election manifesto for PMLN and PTI. After 2013 general election, PMLN-led government in centre started Prime Minister National health program (PMNHP) and PTI-led government in KP started its social health protection (SHPI) in the name of Sehat Sahulat Program (SSP) as pledged beforehand. It is heartening to see that political leaderships at highest level supported these initiatives. One respondent affiliated with the federal scheme said, "The idea came from the honourable Prime Minister himself who wants the health services to the poor people to be ensured". Another respondent affiliated with the provincial scheme said, "While we were inaugurating four districts' scheme, the Chief Minister was very pleased and pledged that very soon we'll extend this scheme to the entire province [26 districts]."

This political ownership brought enthusiasm to both schemes but also proved as a divisive point that fragmented the National level scheme. PMLN-led government in centre and two major provinces proposed Prime Minister's National health program (PMNHP). It was proposed that all provinces shall pool-in resources with the central government to co-sponsor the PMNHP. Amidst partisan-divide, Sindh and KP opted out of PMNHP. KP started its own Social Health Protection scheme while Sindh took a different path. The prima facie motive for opting out were the divergent political gains and perceived political encashment which the central Government (formed by the Pakistan Muslim League- Nawaz) would have at cost to provinces.^{14,15} Government of Punjab (PML-N), Baluchistan (PML-N in coalition), Gilgit Baltistan (PML-N) and Azad Kashmir (PML-N) became part of the Prime Minister health program as political gains were convergent.^{16,17}

Such democratization strives across the globe have brought considerable healthcare reforms and have put those countries on road towards Universal health coverage. Seguro Popular, a popular social health protection initiative in Mexico has enrolled 55.6 million people, including 72.3% of those poor people who had no access to contributory insurance schemes.¹⁸ Seguro popular is a typical example of healthcare democratization.¹⁹ Rashtriya Swasthya Bima Yojna (RSBY) of India which covered 300 million Indians by 2010 is another example. It accounts for a quarter of India's population and covers around 180 million people living under the national poverty line, hence promoting social equity.²⁰

Though, ascendance of healthcare in political debate is a positive beginning, partisan-divides can be detrimental to national level reforms. Constitutional provision(s) and central statutory frameworks can remedy such politically divisive circumstances, circumventing differences in best public interest. Constitutional status of healthcare in Pakistan and the legal fabric of Pakistan with regards to healthcare are reflected upon in following paragraphs.

To contextually explain our study's second theme, i.e., "[these] Social health protection schemes [emerged] in a legal void", we present the following argument based on our documentary analysis.

Status of "Health as a Right" in Constitution(s) of Pakistan: Both SSP and PMNHP derive their inference of social health protection (SHP) from article-38 of constitution. These schemes are based on assumption that SHP is guaranteed under article-38, however, in our considered view, this inference is unsubstantiated and article-38 of the constitution is wrongly construed. 1973 constitution established fundamental rights from article 09 – article 28 while it embodies the "principles of policy" in article 29 – article 40. The former articles are guaranteed while the later are constitutionally subjected to availability of resources with the state organ or authority to whom such principle(s) relate. Also, no action was to lie against such state organ or authority for promulgating a law or ensuing an action on grounds that it didn't fulfil one or more principles enlisted in "Principles of Policy". Hence, we deduce that neither "Right to health" nor "social health protection" is constitutionally guaranteed in Pakistan.

In connection to above, it is imperative to see the constitutional status of healthcare services' provision. Therefore, we studied in detail the 1973 constitution both before and after the landmark 18th constitutional amendment with the following narrative summary.

Legislative and Executive Mandate Regarding Provision of Health Services after 18th constitutional amendment: Through amendment(s) pertaining to subject-matter "Federal and Provincial Laws," changes incorporated in Article-42 abolished the long concurrent legislative list. After abolition of then concurrent list, provision of health services became a provincial subject along with 16 other subjects.¹ Hence, the federal health ministry ceased to function, making Pakistan a federal state without a federal health ministry.²¹ However, like other 16 devolved ministries, some functions of health ministry like regulation and

coordination were designated to various federal divisions, which later-on led to reconstitution of National Health (regulation and coordination) Ministry with regulatory and coordination role. Now that schemes under review are bold steps towards achieving UHC, and provided that they lack constitutional embodiment and legal framework, it is now expedient to see the provincial and federal governments' statutory and executive authority viz-a-viz taxation and pooling resource as the concept of pre-pooling is central to the concept of UHC.

Legislative & Executive Mandate Regarding Taxation to Pool Resources for Health Services: Part-I of Federal legislative list under Item(s) # 43–54 enumerates various heads for raising revenue. These heads inter alia include custom duties, excise duties, income tax (excluding agricultural income), corporate taxes, sales tax, capital value(s) tax, tax on natural resources, terminal taxes on passengers and goods carried by sea, rail and air and taxes on production capacities of machineries and plants. This list virtually includes all rich avenues under which governments raise revenues, with potentials to form a pool and shift towards UHC. As federal government has exclusive right to legislate on these item heads (which confer executive authority over the same), it gives massive leverage to federal government to raise revenues.

Now, federal government can't provide health services, while provinces can't impose taxes on these enumerated items to raise revenue and establish a stable health fund. Here comes the bottleneck. An ambitious overture either by federal or provincial government(s) can be unconstitutional and irredeemable. In this situation, provincial government(s) may not be able to impose a broad-based tax like GST on goods to raise a health fund, nor can federation impose a tax meant for one or two provinces. Raising revenue where everybody contributes will be challenging for provincial governments. Based on these facts, we opine that the disintegrated healthcare system and disproportionate taxation mandate between the centre and provinces after 18th constitutional amendment will have negative consequences for achieving UHC.

Achieving UHC is a comprehensive reforms package. Countries marching towards UHC have enshrined health as a constitutional right, brought structural reforms and resorted to some form of statutory, social or political concurrency. The same stands essential for Pakistan. In Chile, right to health protection was established by article 19 of the constitution which

defined state's responsibility to ensure free and equal access to healthcare in conformation with the law.^{5,6} In Pakistan, both the PMNHP and SSP are executive arrangements with no constitutional or legal guarantees. Inconsistencies in these schemes are not subject to judicial redress for ensuring access. Chile in 2005 introduced the "Health Guarantees Law 19.966" to reduce the inequities and under the said law, the right to health services for 40 diseases was ensured. This list was up-scaled to 80 diseases in 2013. This law tied these diseases with judicial and administrative mechanisms to ensure provisions of the required services.²² Similarly, Cuba has guaranteed health as a constitutional right since 1959 revolution and the Cuban national health service is rendering guaranteed universal health coverage free of cost since 1970s.^{23,24} Venezuela in 1999 under article(s)-83, 84 of its constitution established health as a fundamental human right, to be guaranteed by state.²⁵ Mexican constitution under article-4 confers upon its citizens the right to health. This right to health was truly realized in 2003 when the Mexican Congress revised Mexico's general health law and established the Mexican social protection system in health. This system, named "Seguro Popular", extended the health protection cover to around 52 million people till 2012.^{19,6,5} Both PMNHP and SSP (combined) aspired to cover an impressive sum of 49.1 million people making 25.1% of the Pakistan's population.²⁶

Also, pursuant to such constitutional and legislative reforms, Atun *et al.* quoted good examples in favour models that distributed financial liability for healthcare at various tiers of government. Brazil did this under its unified health system wherein various tiers of government transfer resources for healthcare. The health fund gets 20.5% share of the federal revenue, minimum 15% share of the municipalities' revenue and at least 12% share in the states' revenue go to the health fund. Peru and Uruguay present similar evidence to guide policy and establish a more sustainable pool. Peru sponsors its health system via private OOP contribution around 35%, employers' contribution to the social security of 31% and through government budgetary allocations making another 31%.^{27,5} It is interesting to note Peru's systematic approach towards establishing UHC. Peru has ensued its march towards UHC since 1990s, decentralizing her health system and enhancing social participation.²⁸ In 2009, Peru promulgated the "Framework Law on universal health insurance". This law by statute made necessary that all citizens be provided

comprehensive health insurance with a gradual expansion. Also, it is mandated that the government shall subsidize the insurance so that basic services are gradually increased and match the social security package.²⁹

Though there is a deficit of constitutional protection, absence of overarching legal framework and paucity of any court decree to establish the right to health in Pakistan, we hope that the essence of constitutional protection and need for an appropriate legal framework will be realized soon.

CONCLUSION

In Pakistan, two concurrent social health protection schemes are rolled-out, one each by federal government and provincial government of Khyber Pakhtunkhwa. These schemes are a product of democratization of healthcare and are ensued in a legal vacuum. Constitution of Pakistan doesn't envisage the "right to health" and there is no overarching health insurance law in Pakistan. Also, after the 18th constitutional amendment, though provinces have the constitutional responsibility of healthcare provision; they don't have the constitutional right to pool resources via rich vestas. Federal government though has constitutional leverage to pool resources, doesn't have the authority to provide healthcare in provinces. So, responsibility to provide health services vests in provincial whereas means for raising revenues vests with the federal government. This responsibility-and-resource mismatch, added with lack of constitutional guarantee(s) and absence of overarching health insurance law will make path towards UHC bumpy. We conclude that the disintegrated healthcare system and disproportionate taxation mandate between the centre and provinces after 18th constitutional amendment will have negative consequences for achieving UHC. In such fragmented and untested constitutional division(s) and amidst partisan divide (*whereby ruling parties in centre and provinces have competing priorities*) further segmentation and resource wastage will occur on operational grounds.

Recommendations: We recommend that a National political consensus shall be formed with regards to UHC. Through such a larger consensus, constitutional reforms conformal with needs of UHC should be brought. We recommend that a comprehensive law for health insurance shall be promulgated for establishing a National health insurance structure with cohesive integration of all provinces alike. Till constitutional and statutory reforms are made, we recommend that political

deadlocks should be avoided in order to overcome fiscal loss and make transition towards UHC smoother.

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AUTHORS' CONTRIBUTION

SAK conceived the research idea, prepared interview guide, conducted interviews and wrote the manuscript draft, AA helped in research designing and conducting interviews, KA guided during interviews and helped in constitutional/legal interpretation, RSK helped in data analysis and served as interviews' observer, JAS helped in data analysis and writing discussion, AJ contributed towards data analysis and various drafts of our manuscript. All authors read and approved the final manuscript.

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Address for Correspondence:

Dr. Sheraz Ahmad Khan, Deputy Director (M&E), Social Health Protection Initiative, Health Department, Peshawar, Khyber Pakhtunkhwa -Pakistan

Cell: +92 333 923 3757

Email: drsheraz.ak@gmail.com