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Sustainability of Social Health Insurance

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Sustainability of Social Health Insurance

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ACRONYMS

Benazir Income Support Program	BISP
Catastrophic Health Expenditure	CHE
District Health Office	DHO
District Medical Officer	DMO
Executive Committee of National Economic Council	ECNEC
Equalization Reserve Fund	ERF
Federally Administered Tribal Areas	FATA
Gilgit Baltistan	GB
Gesellschaft für International Zusammenarbeit	GIZ
Gross Domestic Product	GDP
Health Insurance	HI
Islamabad Capital Territory	ICT
Inpatient Department	IPD
International Labor Organization	ILO
Khyber Pakhtunkhaw	KPK
Ministry of National Health Sciences Regulation & Coordination	MNHSR&C
National Database and Registration Authority	NADRA
National Health Account	NHA
Non-Government Organization	NGO
Out of Pocket expenditure	OOPS
Out Patient Department	OPD
Prime Minister National Health Program	PMNHP
Proxy Means Testing score	PMT
Social Health Insurance	SHI
Social Health Protection	SHP
State Life Insurance Company	SLIC

Universal Health Coverage	UHC
Willingness to Accept	WTA
Willingness to Pay	WTP
Willingness to Purchase	WTP
World Health Organization	WHO

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ABSTRACT

"A sustainable health and care system is achieved by delivering high quality care and improved public health without exhausting natural resources or causing severe ecological damage." (WHO, 2003).

To maintain and enhance the human welfare health financing is the major supporting factor through a strongest of the health system. Without the necessary funds, no work force can be employed, medicines manufactured, procured, and no preventive and curative measures could be taken place, it requires to understand that financing is more than generation of funds. In order to achieve the UHC targets, health financing plays the fundamental role. A well designed health financing initiatives and its efficient implementation are effective ways and means to realize the goals of equality and justice in terms of financial contribution. The health risks are pooled, shared and resources are acquired according to the ability to pay in a well-established health financing system.

There are different forms of alternative financing, Social Health Insurance (SHI) is the one implemented in our country as Prime Minister National Health Program (renamed as Sehat Sahulat Program) that is a cashless scheme for the poor who are living below the poverty line. It is evident that SHI is the milestone towards the achievement of the UHC targets. The existing program can be made sustainable by including population above PMT 32.5 on contributory basis through payment of the premium so that benefits of resource pooling can be extended and equally distributed to the vulnerable groups of the population.

Key words: Social Health Insurance, Social Health Protection, Universal Health Coverage, Out of Pocket payments

1. INTRODUCTION

1.1 Introduction

Health financing is concerned with gathering, adding, allocating and mobilizing of money to cover the health needs of the people, individually and collectively in the health system. Health financing is a basic and important function of Health System, which contributes to achieve the overall goals of health sector. Hence financing is much more than simply generation of funds (WHO, 2003).

Furthermore, a considerably large share of household finances is absorbed by chronic illnesses leading to catastrophic health expenditures that affect other essential expenditures. Similarly according to NHA 2013-14, 32 % is the public expenditures on health spending out of which 23% was funded by federal government whereas 59% is funded by provincial government. The local bodies or district government funds are 13%. 63% are of civil setup on one hand and on the other 37% is disbursed via a military set up out of federal government spending. It is also considered that 90% OoPs expenditure of households and 67% of the health expenditures are in the private sector.

Pakistan has many problems in health sector including health financing, stewardship, workforce, service delivery system and data information system. Because of rising cost and access to better quality of life, healthcare in Pakistan has become a luxury. The one who is affluent and rich will get all perks of life because consumer has to pay directly from his pocket for healthcare services *(Farina, 2008).*

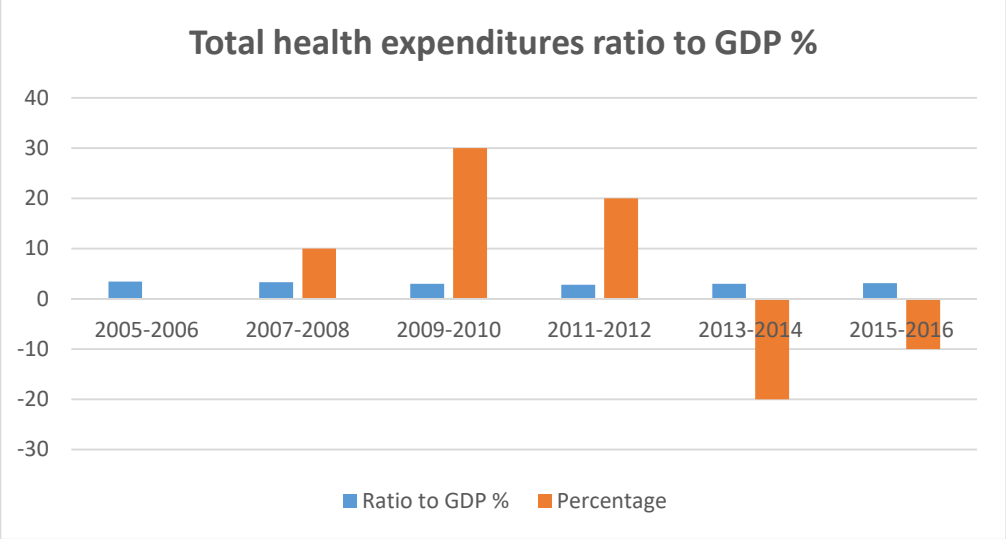
According to NHA report 2015-16, it has been observed that the annual per capita expenditure on health was Rs. 4688, while it was Rs. 4067 in 2013-14. Total health expenditures ratio to GDP is 3.1% while ratio to total private expenditures on health over total final consumption is 2.5% *(NHA, 2015-16).*

Table 1: Total Health Expenditures Ratio to GDP %

Year	Ratio to GDP %	Percentage
2005-2006	3.4	
2007-2008	3.3	10
2009-2010	3.0	30
2011-2012	2.8	20
2013-2014	3.0	-20
2015-2016	3.1	-10

Source NHA (2015-16)

Figure 1: Total health Expenditure Ratio to GDP%



In reaching health care services cost and poverty are the major hurdles. Healthcare cost paid out of pocket put a huge burden on the household expenses and resources especially on poor and deprived group of society. Almost two third (64.4%) of total health expenditures are funded through private sector according to latest available statistics, that is 89% is out of pocket health expenditures *(NHA, 2015-16).* It has been observed that 35% of total expenditures on health meet by government while 63.4% is the private expenditure out of which 91% is out of pocket health expenditures of households. 1.7% of total health expenditures are contributed by donors and development partners.

Funds utilization in the form of health expenditures is still low. This will increase gradually keeping in view the present trend 0.5 to 0.8 percent of a GDP over the last decade. These percentages are less than the bench mark set by WHO that is of at least 6% of the GDP is required to provide the basic necessary as well as lifesaving services.

In Pakistan Social Health Insurance (SHI) is inclined towards social welfare as it is funded by government, and implemented through the "Prime Minister National Health Program" (renamed as Sehat Sahulat Program) approved by Executive Committee of National Economic Council (ECNEC) at a cost of Rs. 9102.489 million providing insurance coverage to maximum 1.081 million beneficiaries in 2015-16, and it was revised to Rs. 8,179.092 to cover 1.019 million beneficiaries in 2017-18 which is in entirety of 3.056 million beneficiaries in phase I. In phase II of the program, the total number of beneficiaries was 61.500 million at a cost of Rs. 33971.320 million.

In reducing the high cost and prices of health care on the poor or general public health, insurance plays a significant role. Unpredictable health expenditures are converted to predictable health expenditures is due to health insurance. Generally it is accepted that insurance against the large and volatile health expenses is the important part of Social Health Protection (SHP) [Asgary, *et al* (2004)].

Contribution in the Insurance Premium

The health program which is being implemented with the financial contribution of both federal and provincial governments. Priority care premium is contributed by federal government while secondary care premium is contributed by provincial government. This mechanism was built in the program to share the responsibility between both federal and provincial governments in implementation of the program and assuring quality services to their poor beneficiaries.

Social Health Insurance (SHI) initiative is in preliminary phase in Pakistan. It is being implemented in 02 provinces while in other provinces there is no implementation at all. SHI as part of SHP is the solution to many problems regarding health inequities through access to health care and achieving the UHC targets.

The development partners and World Bank have helped provincial government of Punjab and GIZ (German government) Khyber Pakhtunkhaw (KP) to start SHI. The premium of Excess of Loss and Over Excess of Loss Coverage of Punjab, Sindh, KP and Baluchistan is shared between

Federal and Provinces on 50:50 percentages while all provinces pay their secondary care premium and premium for priority care treatment by the provinces is beared by the federal government. Complete HI premiums for the poor living in ICT, AJK, GB and FATA are covered with the support by federal government.

The treatment cost of the patient have revised in the phase II of the program. The secondary care premium has been raised to PKR. 60,000 per family per year while PKR. 300,000 is the premium for priority care treatment raised from PKR. 250,000. Another catastrophic priority care disease "Neuro Surgical Cases has been added in the program. Thus the program is now focusing on 08 priority care treatment instead of 07, and through the linkages with the PM's Fatal Disease Program, the beneficiaries of PMNHP (renamed as Sehat Sahulat Program) can access transplantation services (kidney & liver) from the empaneled hospitals. The transportation cost provided to non-local beneficiaries was PKR. 350 per discharge which is raised to 1000 per discharge. This facility is also provided to local women who have discharged after receiving maternity services.

The major objectives of the study are to:

i. Review the current health financing system including National Health Insurance Program, and its role in healthcare provision of the poor.

ii. Assess the feasibility of the Health Insurance (HI) in the country.

iii. Analyze the SHI as alternative to health financing tool and its sustainability in future.

2. LITERATURE REVIEW

2.1 Social Health Insurance

SHI is the mechanism of risk pooling and gathering contributions from the organizations, households and from government in the form of revenues from the income tax. It all depends on the level of income more the income, more ability to pay and more willingness to pay [Carrin (2002)].

he Social Health Insurance (SHI) in developed countries reduces the catastrophic expenditures and out of pocket expenditures by spending more on healthcare facilities through general tax revenue, payroll taxes or sometimes both, while in developing countries consumer spend more than double on out of pocket expenditure hence Social Health Insurance program is complex financing technique because it depends on the implementation and design of the program which need to modify constantly, adjust cost, demand and behavior of the people (Maria, 2009).

Kashif in 2016 has studied the willingness of the people of Shiekhupura District, Pakistan for the health insurance by using contingent valuation method of the study. And concluded that insurance schemes are beneficial for the poor and they are willing to pay for such schemes.

2.2 Sustainable Healthcare System

The health care services are considered sustainable when it works under the organizational system with the ability to mobilize and distribute the resources for activities that can fulfil individual and public health needs (*Olsen,* 1998). The status of country in terms of healthcare determines its wellbeing and life quality of its people (*Andaleeb Siddiqui* and *Khandakar,* 2007).

Phillipine, Germany, Thailand and Costa Rica are the few successful examples who have achieved UHC through successful SHI system.

2.3 Rationale of the Study

Health care is a high resource commodity in entire consumption. It requires significant budgetary outlays and involves financial cost. Pakistan is not in a position to bear all the expenses from their own resources. Through the current SHI initiative, the government wants to reach poorest of the poor with a comprehensive package of quality health care. Health care insurance as a financial arrangement needs to be sustained through focus on the policy making and its

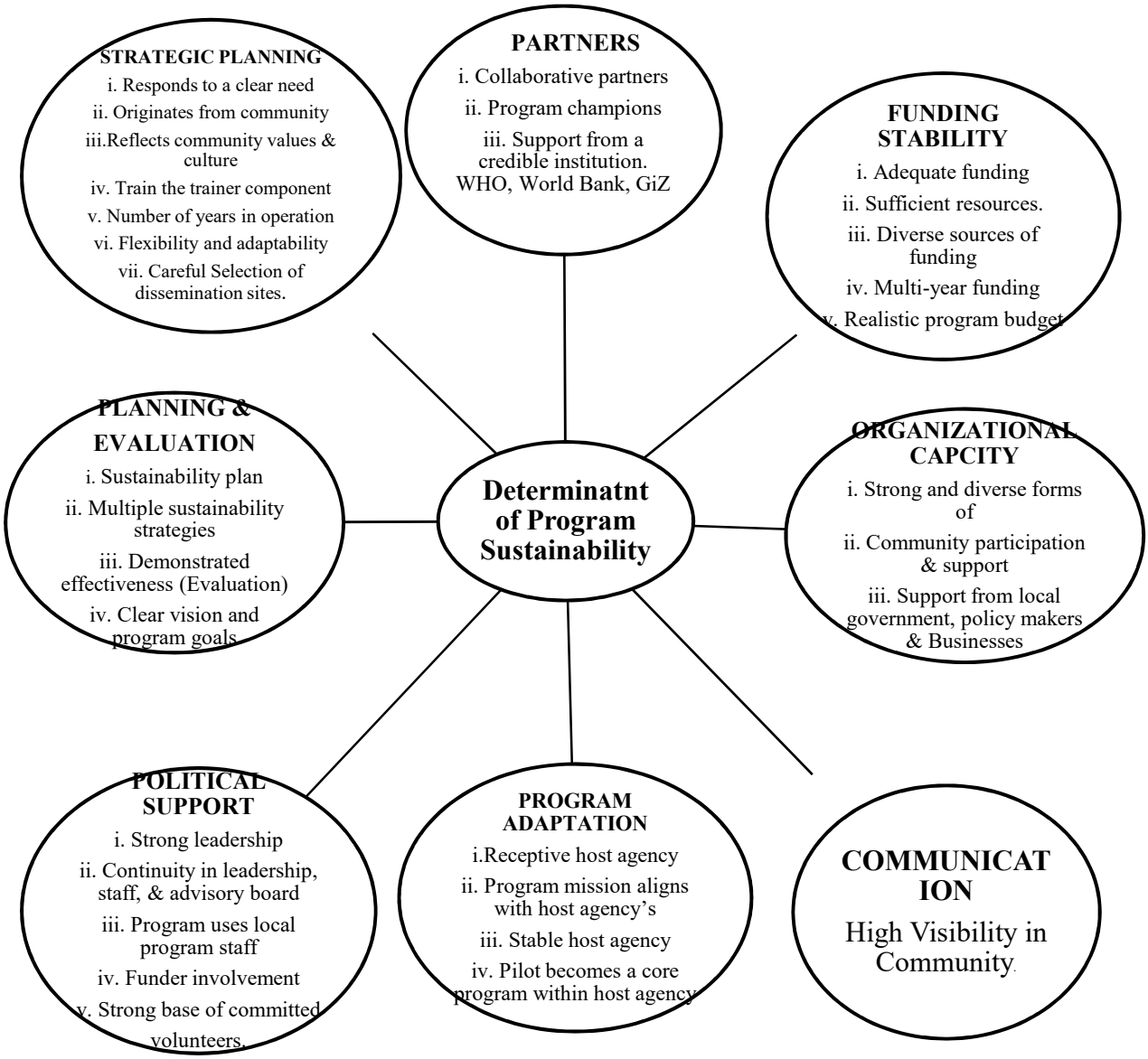
implementation. This research is aimed to explore avenues for sustaining the present Health Care Insurance and its extension to middle income tiers of the society.

The HI system is being followed in many developed and developing countries with encouraging results. Pakistan may replicate a tailored and customized version of the Health Care Insurance. It analyses the available resources for Social Health Insurance (SHI) through self-payments as a mean of sustainability after completion of the PMNHP (renamed as Sehat Sahulat Program) which is subsidized by the government through tax generated resources.

3. Theoretical Framework

The current Health Insurance program (renamed as Sehat Sahulat Program) is based on the concept of Micro Insurance. It is the way of providing protection to the low-income people or economically deprived group of the society. For those who are earning less than US$ 2 or less (those who are lying below the poverty line) in accordance with the risk involved against some regular premium payments. Poor does not have access to sufficient health risk protection, therefore they have greater probability to fall in poverty trap and face catastrophic episodes. The conceptual framework used in this study shows that the health services are sustainable provided they are working under an organized system, have long term ability to mobilize and allocate sufficient resources result in the healthcare activities, and meet the needs of the people's health.

Figure 2: Conceptual Framework to check the Sustainability of Social Health Insurance Program in Pakistan



4. DATA AND METHODOLOGY

This research study is based on the framework of PMNHP's (renamed as Sehat Sahulat Program) mid line survey report and used here as secondary data source.

4.1 Quantitative Component

For this, a household survey was administered on the families enrolled in PMNHP (renamed as Sehat Sahulat Program). Two categories of households were surveyed as given below:

i. Enrolled in Program + Hospitalized (used the card services).

ii. Enrolled in Program, but not used card services.

4.2 Qualitative Component

It was meant to explore the experiences of a range of stakeholders with the implementation process of PMNHP (renamed as Sehat Sahulat Program) and to provide a contextual comprehension of the trends and findings of the quantitative component. Informed consent was obtained and objectives of the study were explained before each interview.

4.3 Sampling Framework and Technique

List of both categories of households for all the districts was available with the PMNHP office in Islamabad and was acquired to make a sampling framework. The population to be surveyed was expected to be homogenous as all were below poverty households. Sampling unit was the household enrolled in the program.

4.4 Survey Tool

The questionnaire developed for the baseline survey was used with small changes and guidance was drawn from Pakistan's Household Integrated Economic Survey (HIES) questionnaire for the sections on household's personal information, housing conditions, expenditures on food & other non-durable products, and assets. Pakistan's National Health Accounts' Out of Pocket expenditure questionnaire was consulted for sections on health financing. Questionnaires used by World Bank Pakistan Office and University of Manheim in their studies

on health insurance in the country were accessed for questions related to healthcare utilization patterns, coping strategies, and reasons for neglecting healthcare.

Some additional questions related to the beneficiaries' experience of enrolment, healthcare utilization, and complaints redressed were added in the questionnaire.

4.5 Research Design

Focus of the research was to capture experiences of the beneficiaries and the stakeholders involved in implementation of the program and a cross sectional research design was adopted and a mixed methods approach, encompassing quantitative and qualitative techniques was undertaken.

4.6 Data Collection

A letter was issued by the Department of Health Economics, Pakistan Institute of Development Economics (PIDE), Islamabad to administration of all the selected hospitals and related implementation partners (hospitals, NGOs, SLIC, and NADRA) about the objectives and timing of the data collection activities.

4.7 Ethical Considerations

Informed consent was obtained from each respondent. The respondent's name or any other characteristic, which could help identify the person, was not recorded. Privacy was provided to the participants during the interview. Confidentiality of the information provided during data collection process was ensured to the respondents.

4.8 Limitations of the Study

Following limitations were observed during the study:

i. Sustainability is a long run process that cannot be fully measured in 3 years but on the basis of annual evaluation strategic planning can be done to make the program sustainable in the long run.

ii. The results of the current study are not comparable with that of the WHO survey because of the difference on the basis of questionnaire and on the basis of sample size.

iii. Instead of field survey telephonic interviews have been done because of less access to the field (other cities) cost and time constraints to get a clear and exact picture while the survey done by WHO, they, have the trained staff for this purpose.

iv. Hospitalization from the demand side (patient perspective) has been considered but the supply side (hospital perspective) is not taken into consideration.

5. RESULTS AND DATA ANALYSIS

5.1 Results

Table 2: Willing to Pay

WTP	Reduction in HE through Card					Total
	.00	25%	50%	75%	No Reduction in HE	
No	3	2	2	5	23	**35**
Yes	0	3	0	4	8	**15**
Total	**3**	**5**	**2**	**9**	**31**	**50**

Total of 35 patients out of 50 were not willing to pay for the health insurance and 15 patients were willing to pay for it. 9 respondents out of total of 50 said that their health expenditures were reduced to 75% amongst which 5 respondents were not willing to pay.

It was noticed that patient are not willing to pay for the health insurance. When the patients were asked; were they willing to pay premium on the condition that if government will provide them health insurance and the consumer have to pay the premium.

More expenditure are incurred by the patients who have multiple diseases while on the other side cardiovascular and cancer patients have high treatment cost thus less reduction in healthcare expenditures. The amount in card is not sufficient to treat the diseases that is cancer and cardiovascular diseases and the patients are not willing to pay for the insurance.

The above analysis concludes that the lack of education, stable income source and less WTP for the health insurance provided by the government become the hurdles for the government in providing such cover in its own resources.

On the other hand if government is providing such cover and make it compulsory for the beneficiaries to pay for it then they must have to allocate more money.

Table 3: Mode of Payment Health Bills * Reduction in HE

Mode of Payment Health Bills	Reduction in HE Through Card					Total
	.00	25%	50%	75%	Health expenditure remained unchanged	
OOPs	2	3	1	1	9	**16**
Borrowed	0	0	1	0	5	**6**
Charity Organization	0	1	0	0	0	**1**
Multiple Response	1	1	0	8	16	**26**
Health Allowance	0	0	0	0	1	**1**
Total	**3**	**5**	**2**	**9**	**31**	**50**

It can be seen in the above table 3, that 31 respondents said that expenditures remain the same when it was asked about the reduction in health expenditures by using health card. There is no reduction in health expenditures patients are paying directly from the pocket or borrow from someone at the time of service need. While using the health card patients are paying from their pockets and the reimbursement process is too slow.

Regarding awareness about insurance 25 respondents said yes and other 25 respondents' responds as no. Whereas 22 respondents said yes for the awareness about health insurance while the other 28 respondents said no.

Only 15 respondents were willing to pay the premium for health insurance if provided by the government among which 03 were unaware of the HI and 12 were familiar with the HI, while 35 says no to this question as the basic reason was the health expenditure remains the same and the card is only covering is hospitalization for certain number of diseases. Out of these 35 respondents 22 were not familiar with the HI and 13 were of the HI.

All the services were available at the time of service need on the utilization of health card. 30 respondents were those who have used the health card and they avail the facility as required. 14 respondents were those who did not use the card but the services they required are available to them.

Determinants of Funding Stability

The present insurance program is funded by GoP without any foreign aid and grants. It is PSDP funded for 3 years and after the completion of PC-I it will become the part of the recurrent budget. And as the program will become the part of the regular budget the fruitfulness of it will then be possible. On the other hand the program is made sustainable if Equalization Reserve Fund (ERF) ratio that is 95/5 % is distributed in such a way that the 95% of the government share is allocated for the general public for health insurance on the contributory basis.

Cost Dimensions of Health Insurance

Cost implications of health decisions and understanding of cost manners are critical at all levels of health care from the individual doctor-patient meet to managerial macro level decisions. Availability and scarcity of resources that invariably characterizes the financial status and crisis which affects overall health sectors, allocation and availability of resources to the HI through strengthening of the supply side.

Equalization Reserve Fund

To protect the financial interest of all stake holders, Equalization Reserve Fund (ERF) is planned which will ensure recovery of unutilized premium during a contractual period, by the government. As per this ERF, any unspent amount along with profit earned by the insurance company at the end of each year shall be distributed between the insurance company and the government, as per a mutually agreed formula.

Unit Cost

The use of regular unit cost enables analysts to use the same sources for different economic evaluations, limiting one potential source of variability: if different costs are calculated for different interventions, this will be a result of differences in resources used rather than different valuations of each type of resource. Care should be taken when comparing unit costs across countries as the definitions of resource items may vary.

Financial Unit Cost Analysis

PMNHP(renamed as Sehat Sahulat Program)

(PHASE-l)

Beneficiaries

Table 4: Unit Cost of Potential Families (Phase I)

Province/ region	Original PC-1	1st Revised PC-1	2nd Revised PC-1	Net decrease in number of potential families (million)
Punjab	1.288	1.946	1.611	0.335
Sindh	0.978	1.478	0.514	0.964
Khyber Pakhtunkhwa	0.817	0.151	0.053	0.098
Balochistan	0.245	0.370	0.260	0.11
AJK	0.161	0.244	0.235	0.009
Gilgit Baltistan	0.027	0.082	0.081	0.001
FATA	0.185	0.280	0.241	0.039
Islamabad	0.100	0.100	0.061	0.039
Total	3.801	4.651	3.056	1.595

From the above table 7 coverage of SHI of potential families has been reduced in Sindh province from 1.478 million to 0.514 million and in KP from 0.151 million to 0.053 million although 100% financial support was from federal government for both the provinces. Similarly, the overall SHP initiative coverage throughout Pakistan has also been reduced to 1.595 million families or by 34.3%. This is either because of reduction in the poverty and beneficiaries are now above the poverty line or low coverage.

Operational Cost

Operating costs are expenses associated with the maintenance and administration of a business on a day-to-day basis. It also considers marginal costs, being defined as the additional costs of the production of an additional service unit, are used.

Total operational cost for 3 years for Federal PMUs

Capital Cost of Health Insurance

Health Insurance Program PMNHP (renamed as Sehat Sahulat Program) a total amount of Rs. 3037.377 million has been incurred in 1 year (2014) which was significantly higher than the following year's i.e Rs. 2651.817 and 2489.899 million respectively.

The table 31 (in appendix) shows the secondary premium cost and priority care premium cost for 03 years as constant cost and this trend shows that it will remain the same for next 2 years in total 5 years.

Secondary care treatment cost 50,000 while priority care treatment cost 250,000. The unit cost per patient varies patient to patient and treatment. In phase II, the treatment cost has been revised; the secondary care premium has raised to PKR. 60,000 per family per year while PKR. 300,000 is the premium for priority care treatment raised from PKR. 250,000. Another catastrophic priority care disease "Neuro Surgical Cases is added in the program. Thus the program is now focusing on 08 priority care treatment instead of 07.

Excess of Loss Coverage

During the course of an admission for treatment, if a beneficiary has exceeded their coverage limit, all treatments that specific admission, including complications and or additional treatments will be covered. In the event of a life threatening case where the coverage limit will be exhausted by the admission (or has already been exhausted) the beneficiary will be eligible for life saving / stabilizing treatment, upon which they will be transferred to a government facility (Bait ul Mal, Zakat). The treatment and the transportation charges excess of the program coverage limit will be covered.

Over Excess of Loss Coverage

The "Excess of Loss Coverage" includes provision of PKR 60,000 per family per year on top of Excess of Loss Coverage for secondary care coverage and provision of PKR 300,000 per family per year on top of Excess of Loss Coverage for priority care coverage.

The "Over Excess of Loss Coverage" includes provision of PKR per family per year on top of Excess of Loss Coverage for secondary care coverage and provision of PKR 300,000 per family per year on top of Excess of Loss Coverage for priority care coverage. The contingency funds are

maintained by the program to meet the catastrophic health expenditure of the beneficiaries beyond "Over Excess of Loss Coverage" and unforeseen expenditure if any.

5.2 Data Analysis

Following are the three fundamental factors lead closer towards universal health coverage;

i. increase of funds for health.

ii. reducing the financial barriers to reach through prepayments and subsequent pooling of funds in preference to direct out of pocket payments

iii. allocating or using funds in a way that promotes efficiency and equity.

Health risks pose the greatest threats to the poor families, including their lives and livelihood. Be remaining at the risk health expenditures become a burden for the poor when there comes any health shocks and they are in the situation to least afford it. These shocks entail big cost on poor and non-poor among the surveyed households that results in deepening of the poverty for the households.

The health profile of Pakistan is characterized by high population growth rate, high infant and child mortality rate, high maternal mortality ratio, and a dual burden of communicable and non-communicable diseases. As a lower-middle income country in South Asia, Pakistan has a population of over 207 million. General government expenditures, households' out of pocket expenditures, and development partners/donors' contributions make 33%, 60%, and 0.8% of the total health expenditures.

Annual per capita health expenditure is US$. 39.5 Public sector health expenditures are 9.3% of total government expenditures and ratio of total health expenditures over GDP is 3%. Public health spending in the country is the lowest in South Asia. Health financing indicators are poor than the averages of lower middle-income countries.

Cumulative health expenditures of federal and the provinces are estimated at Rs 384.57 billion for fiscal year 2017-18 which is 31.75 percent higher than the actual expenditures of Rs 291.90 billion realized during fiscal year 2016-17.

Table 5: Health and Nutrition Expenditures

Fiscal Year	Public Sector Expenditure (Federal & Provincial)			Percentage Change	Health Expenditures as % of GDP
	Total Health Expenditures	Development Expenditures	Current Expenditures		
2012-13	125.96	33.47	92.49	128.51	0.56
2013-14	173.42	58.74	114.68	37.68	0.69
2014-15	199.32	69.13	130.19	14.94	0.73
2015-16	225.87	78.50	147.37	13.32	0.77
2016-17	291.90	101.73	190.17	29.54	0.91
2017-18	384.57	130.19	254.38	31.75	1.12

***Expenditure figure for the respective years are for the period (July- Feb)**

Source: Economic Survey 2017-18 (Finance Division)

The OoP health expenditures for 2011-12, 2013-14 & 2015-16 including reimbursement figures, estimated at national level by OoP survey are Rs.315 billion, Rs.470 billion & Rs.542 billion respectively. The table below gives the breakup of the gross OoP by region/province.

Punjab has the highest share (54%) of the total OoP health spending, followed by Sindh (24%). KP (including FATA) has 16% share while Baluchistan has just 5% share of the total OoP health spending.

It is also indicates that delivery cases occurred by 4.97%. Further analysis of data on the type of health care accessed by provinces reflects that the share of self-medication is highest in KP (18.12%) followed by Sindh (17.85%) and the lowest share is of Punjab (4.12%). The percentage share of outpatient is highest in Baluchistan (79.41%) then of Punjab (79.19%), Sindh (73.98%) and the lowest share are of KP (66.10%). For the Inpatient services, the highest share is of KP (11.29%) and the lowest share is of Sindh (4.42%) [(NHA, 2016-17)].

Table 6: Out of Pocket Health Expenditure by Type of Health Care 2015-16 in %

Province	Inpatient	Outpatient	Medical, Products, equipment's & appliances	Total
Pakistan	**24.10**	**28.58**	**47.32**	**100**
Punjab	22.86	30.67	46.47	100
Sindh	30.58	24.30	45.12	100
KP	14.02	36.21	49.77	100
Baluchistan	14.42	29.74	55.84	100

Source: NHA Report 2013-14

Analysis of the OoP health expenditure 2015-16 data reveals that in Pakistan, around 24% of the total OoP expenditure are incurred on in-patient services while OoP spending as outpatient care for their illness is 29%. About 47% are spent on Medical Products, equipment & appliances. Some indicators or questions pertaining to the category "Medical Products, equipment & appliances" indicates that this category also covering the expenditure mostly incurred on self-medication. Self-medication means those who are taking medicines from pharmacies without consultation/prescription, or all those people who are taking medicines for long lasting diseases like diabetes and high blood pressure that was al-ready prescribed by doctors.

Further analysis of data on the type of health care accessed by provinces reflects that share of Medical Products, equipment & appliances is highest in Baluchistan (55.84%) followed by KP (49.77%), Punjab (30.67%) and Sindh (29.74%). The percentage share of outpatient is highest in KP (36.21%) followed by Punjab (30.67%), Baluchistan (29.74%) and the lowest share is of Sindh (24.30%). For the Inpatient services, the highest share is of Sindh (30.58%) and the lowest share is of KP (14.02%) [(NHA, 2015-16)].

6. DISCUSSION AND CONCLUSION

6.1 Discussion

This paper describes the different components in the following order; (i) empanelment of hospitals, (ii) claims processing and reimbursement to hospitals, (iii) beneficiaries' knowledge about the program, (iv) enrollment and (v) utilization of health services. Across all these categories, there is significant inter-district variation that requires further investigation.

This is critical when analyzing the results of questions pertaining to enrolment and utilization of services, given the high probability that the head of the household was on the forefront on these matters.

It is also important to ensure a minimum standard for empanelled facilities as there is evidence that the supply of health services in certain areas is increasing due to the program. Additional facilities being developed should be built keeping the criteria in mind and should not operate on the ground set by the relaxed criteria.

The empanelment criteria are focused on infrastructure, equipment, and human resource availability. There are no mechanisms in place to measure quality of clinical and management processes and outcomes. The PMNHP's (renamed as Sehat Sahulat Program) Monitoring & Evaluation framework should be enhanced to measure these two aspects of quality.

The mechanism for complaint registration by the beneficiaries at the empaneled facilities presents a conflict of interest as both gatekeepers at the facility level i.e. KPO and DMO are employees of the SLIC. PMNHP (renamed as Sehat Sahulat Program) needs to place their representatives to avoid this mechanism, so that beneficiaries can get their complaints not only registered and but duly resolved as well. It was evident from the beneficiaries' survey that majority of the complaints went unresolved.

One of the key limitations in the interaction between insurance company and hospitals is lack of availability of treatment protocols that could set the parameters for various treatment modalities. As the program is set to expand across the country, it would perhaps be sensible for SLIC to set treatment protocols in collaboration with provincial health care commissions and share them with empaneled hospitals. For this, capacity of both SLIC and hospital needs to be built.

The community networks played the biggest role pointing at the need to emphasize a greater role for community leaders in the information dissemination process. This engagement is necessary at the conceptualization phase, so that information material is adequately adapted to the literacy level of the community. Community leaders should also be engaged at the dissemination phase, as in some cases, BISP lists have proven to be inadequate in terms of identifying the beneficiaries.

In terms of sources of information regarding eligibility, NADRA had a critical role but has not been imputed as an actor in the communication campaign. NGOs that were initially expected to play the largest role have made only modest contribution. Furthermore, the need for a formal systematic mechanism within NADRA for making the initial and follow up calls has been highlighted, so that the adequacy of the message being communicated and scale of outreach can be assessed.

Monitoring of communication activities cannot be done without a rigorously laid out plan with specific tasks and roles assigned to relevant stakeholders. In order to accomplish this in a strategic manner, the campaign should be revised by first developing a Theory of Change (ToC) so that the end goal and the steps leading towards that goal are clearly outlined.

The payment mechanism for NGOs was reportedly linked to number of cards distributed and not explicitly linked to information dissemination. High rate of utilization, as has been suggested in the comparison between those who used the cards and those who didn't, was related to better knowledge. As an insurance company, SLIC may be averse to greater financial outlays which will be linked to greater utilization. Hence, there exists a conflict of interest in SLIC being responsible for hiring and monitoring of NGOs that are responsible for educating the beneficiaries and SLIC's incentive to minimize financial outlays.

Another possible solution could be a mobile enrolment center. As the scale of this program is unprecedented, piloting these ideas in some of the districts that the program will expand into will allow for better assessment of their viability.

Limited supply of health services has been cited as a major challenge, whereby in some districts commute to the relevant empanelled facility takes more than an hour to the beneficiaries. This was most notable in Skardu and Rahim Yar Khan. The immediacy of the need for inpatient

services and duration it takes to reach the facility poses a serious challenge to the program's ability to improve the health outcomes of the target population. Although a modest transportation allowance is part of the program, it is not nearly enough to address the needs of some of the remote areas where the program is being implemented and that do not have access to a viable transportation network.

Information on expenditure pertaining to the prescribed inpatient care and existing card balance is supposed to be shared with the beneficiary at the front desk of the empaneled health hospital.

Health utilization behavior is deeply linked with the individual's knowledge of their financial capacity to pay for services. Hence a stronger monitoring mechanism for performance of KPOs needs to be in place to ensure that this information is adequately and timely relayed to the beneficiaries.

Despite these lapses of information transmission, most beneficiaries reported that the balance on the card was enough to cover the services that they needed. This represented a visible success of the HI program initiated by the government.

The out of pocket payments on inpatient care for those who used the card were found to be less than those who did not. However, the sample size of each of the groups was not enough to declare the difference statistically significant. Further, familiarity with the health system and visitations to the health facility can lead to knowledge of further health related issues that are catered through only services provided by Out Patient Department (OPD).

Complaints and grievances redressal has emerged as a critical weak point across various stages of the program and has impacted multiple stakeholders. For service utilization, majority of the respondents who had grievances did not get their complaint registered, and only a fraction of those who made the complaints, found them resolved.

The managers and DMOs of few hospitals shared that beneficiaries who are injured in disputes cannot be treated under the HI program; this presents a problematic value judgment and goes against the fiduciary responsibility that hospitals and the program owe to the public. Assessing why such injuries occur and who is the victim and who is the aggressor is beyond the

scope of hospitals and the program. The principle of equity in health service delivery dictates that people are treated solely based on their medical conditions.

It has been noticed from primary data of the government HI program that many of the beneficiaries were not informed about the balance on their card upon admission. Similarly, many of the beneficiaries were not informed about the balance on their card when they were discharged from the hospital. Such a situation has adversely affected the satisfaction level of the patients.

Conclusion

SHI is a milestone toward social welfare development. In the form of SHI that ensures identified underprivileged population gets access to entitled healthcare in a dignified manner without any financial obligations.

In order to cover the whole population it can be on the basis of willingness to pay and willingness to accept of the people

HI program has the potential to cover the whole population provided program like BISP had a legislative cover to work well and the sustainability of the program is thus ensured in the long run. . To make the health budget a significant part of the GDP, it is better for the GoP to put this burden on HI. The heavy financial subsidy to implement HI creates a few questions; if this could be the actual risk pooling onboard, it means additional financial allocation for payment to the third party against the health services provision. There is no revenue generation from other sources than public sector to ensure continuity of such type of HI services [(HCF vs HI by Dr. F.H. Khattak, HSA, Nov, 2017)].

7. RECOMMENDATIONS

i. The impact of any adopted budget can be measured subject to its proper utilization, and resource allocation within the concerned department. Since it's a subsidized program the budget impact is necessary to keep looking at. The increase or decrease of a budget will directly affect the beneficiary prolong the project period enhance the project cost. This will also cause social repercussion which will adversely affect the sustainability aspect of the project.

ii. As Quetta has been quoted one of the locations where finding quality services have been a concern, it would be prudent to further explore this finding and find mechanism to incentivize such hospitals to join the program.

iii. Given the multiplicity of stakeholders involved, there should be clearly outlined complaints and grievance restore mechanisms for each stakeholder. Hospitals who want to lodge complaints with the program against payment delays should be offered a platform.

iv. The Services that are unduly diverted to other hospitals because of profit motivation need to be addressed. Such reports and repeat behavior should be flagged and adequate measures including penalties and credible threat of de-empanelment should be put in place.

v. There is the need for the government to improve the cost effectiveness of healthcare services provision as the cost recovery is extremely important. Otherwise it would be very difficult to address the key matters of reducing cost, allocative efficiency and societal equity.

vi. The public sector hospitals that fulfill the required criteria defined by the SLIC should take initiatives to get themselves on panel so that the standard of public hospitals is improved and the problem of commute to facility may resolve.

vii. There should be emphasis on educating the beneficiaries on different aspects of the program in the sequence of program activities through electronic and print media.

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