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Sustainability of Social Health Insurance

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PIDE POLICY VIEW POINT

SUSTAINABILITY OF SOCIAL HEALTH INSURANCE

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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% only. 63% funds are of civil setup on one hand and on the other 37% of funds are 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.

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 of total private expenditures on health over total final consumption is 2.5% *(NHA, 2015-16).*

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). It is approved by Executive Committee of National

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Economic Council (ECNEC) at a cost of Rs. 9102.489 million. It provides 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)].

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 a 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. 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.

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.

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 aimed to analyze the

SHI as alternative to health financing tool and its sustainable option to serve the poor population through provision of subsidized health care in future.

Major Findings

- 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.
- 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 and 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' responded 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 are hospitalization for certain number of diseases. Out of these 35 respondents 22 were not familiar with the HI and 13 were aware 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 health card but the services they need are available to them.

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 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)].

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 health 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 State Life Insurance Company 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.

viii. The existing SHP in the form of PMNHP can be made sustainable by including population above PMT 32.5 on contributory basis that is they pay the premium so that benefits of resource pooling can be extended to the vulnerable groups.

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