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Designing the first ever health insurance for the poor in Pakistan - A pilot project

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Abstract

Several developing countries lack a medical insurance system with universal coverage, so access to medical services is not easy, principally for people living in poverty.

One of the biggest issues for designing healthcare systems in developing countries is how to include those not formally employed. Therefore, it is important to implement targeted interventions so that the most in need are not left out. The World Health Report 2000 distinguishes four functions for the health system to fulfill: (i) the provision of health services; (ii) the creation of the necessary investment and training resources for health; (iii) health financing; and (iv) government stewardship.

The need for Health insurance in the developing world is again relevant because there is no compulsory health insurance in Pakistan. This special communication is a discussion of how we in Pakistan have proposed a design for the first ever indigenous health insurance system for the poor. What various other developing countries have done and the policies adopted to provide health coverage to their people have also been reviewed

Keywords: Medical insurance system, Healthcare systems, World Health Report, Pakistan.

Introduction

Several developing countries lack a medical insurance system with universal coverage, so access to medical services is not easy, principally for people living in poverty.[1]

Poor people are less likely to seek care than high income people.[2] One of the biggest issues for designing healthcare systems in developing countries is how to include those not formally employed.[3]

Background:

Medical health insurance in Japan was started in early 1900.[4] In Cuba, to create a Community Health Programme, several steps were taken keeping in mind the indigenous population. Doctors worked with other healthcare providers in conjunction with community neighbourhoods.[5-7]

A WHO review done in 1998, studied 82 non-profit health insurance schemes for people in the informal sector: The Study showed that very few of these schemes covered large populations or a great percentage of eligible population.[8,9] In Vietnam, a separate scheme was operated for very poor people under which 100% of the premium was paid from the provincial government budget directly into the health fund. In Korea, the poor were instead theoretically integrated into the system through subsidized premiums. In Philippines, house holds requiring subsidies were identified by local governments. These countries have responded to the issue of how to provide coverage for the poor by creating a special low income card or scheme for the poor rather than integrating them into the main health insurance system.[9,10] In Rwanda, a project was launched, establishing 54 CHIs in three districts in July 1999. In two Community Health insurance (CHI) schemes in Ghana and Mali, 53% and 25% of the target population of 25 000 and 200 000, respectively, was covered. And in Senegal, one CHI reached a coverage rate of 26% after 3 years of operation whereas another achieved an enrolment rate of 82%. One study on the Bwamanda Hospital Insurance Scheme in the D.R. Congo shows that in 1986 when the scheme was established, 32 600 people or 28% of the district population joined within 4 weeks. Over the years, membership climbed to 66% in 1993 and seems to have stabilized at 61% in 1997. Another study on the Lalitpur Scheme in Nepal shows that population coverage in the target areas rose from 19-20% in 1983 to 27-48% in 1995.[11,12]

Understanding Pakistan:[13]

Pakistan's population was more than 170 M .In 2008 with an annual growth rate of almost 2.4%. Literacy rate was about 54% according to government estimates and the inflation rate was more than 25% in 2009: the cost of living is becoming out of control for majority of the people. Monthly minimum wage was Rs. 6,000 (US $ 73) per month.

Identifying the Cost drivers globally in the developing world, in Health insurance Technology/ Specialization, Prescription Drugs, Medical Inflation, Moral Hazard/Adverse Selection, Usage Increase, New treatments and Unnecessary treatments. Hence, we can anticipate these challenges for Pakistan.

For the road to future we would need to create our own models where we focus on rural / micro insurance, Dialogue between Providers, Insurers, Increase in numbers & premiums and as well as Working with Government .[14]

Pilot Project - Pakistan:

Introduction:

The Benazir Income Support Programme (BISP) had been started by the Government of Pakistan with the preliminary provision of Rs.34 billion (US $ 425 million approximately) for the year 2008-09. Imperative to note is the fact that this was the third largest allocation in the entire budget. This amount is 0.3% of the GDP for the year 2008-09.[14]

Beneficiary Eligibility Criteria:[14]

According to the programmes the following types of families are eligible for enrolment in the BISP:

In Possession of National Identity Card by the female beneficiary ; Monthly familial income less than Pak rupees 6000/. And subject to the above two conditions , widowed / divorced women ,with any physically disabled family member, with any mentally challenged family member and with any family member suffering from a chronic disease.

This health insurance model (HELP) is designed such that it could simultaneously be undertaken as a subsidy partner scheme running parallel to the main programme.

To protect the poor, it is proposed that a health insurance scheme (HELP) should be offered to the recipients of BISP. The protection would be extended for in-patient treatment of designated medical and surgical conditions but with limited liability while excluding out-patient visits and tests. Out-patient diagnostic tests would however be covered if they lead directly to the admission of the patient.

It is proposed that eligible family units be enrolled to the Health Expenditure and Livelihood Protection for the poor (HELP) Scheme with the entitlement of a family being up to Rs.25,000/year. An additional benefit suggested is that for each admission, the family be allowed the minimum official wage of one week (Rs.1500) as compensation for lost earnings. The premium for each family is anticipated at Rs.500 per annum but this would be determined by a risk-carrier selected by BISP.

The HELP scheme would be operated through insurance companies selected by competitive bidding of premium for provision of service in a block of Districts designated by BISP at the start up but eventually in each Administrative Division of the country. The envisaged insurance scheme for the poor would require involvement of the BISP, the participating insurance companies, and the Federal and Provincial Health authorities, the health care providers and the beneficiaries linked by an information technology backbone with a chip-enabled card as its central features.

The major insurance companies of the country would be invited to offer competitive bids for services in the block of designated Districts at the commencement but once the national poverty scoring is complete, each individual Administrative Division. Lists of BISP - eligible families identified by Poverty Scoring and registered by NADRA, would be provided to the selected firms, which in turn would be expected to enroll the eligible families in their Districts/Division(s). Each enrolled family would be issued a chip-enabled card which would have personal details of the family members and biometric details of the head of the family to whom it would be issued. An annual fee of Rs.30/- is proposed for registration and renewal but this would be waived in the first year of the Scheme. The success of the scheme would be contingent on having a robust Information Technology platform with chip-enabled cards to minimize fraud. The insurance companies, with the selected smart card vendors, would issue cards to the beneficiaries and card readers to the health facilities. The data would be up-loaded simultaneously to servers of the insurance companies and the Central Monitoring Cells at both Federal and Provincial levels. The successful insurance companies would enter into service agreements with public and private healthcare establishments in their defined Districts/Division(s). These facilities would have to satisfy the minimum service facility criteria determined by the Federal Health Ministry. In the case of public hospitals, arrangements would be made for the facility to retain the earnings from the scheme for staff reward and service upgrades.

The Federal health ministry would assume stewardship role in delineating the spectrum and standards of healthcare to be offered to the beneficiaries and in monitoring the quality of the services. The provincial health departments would work in tandem with the Federal Health Ministry and the provincial BISP units to ensure success of the HELP scheme.

After starting a pilot project and evaluating its results, we need to observe its success and sustainability further. So that we can mandate compulsory participation and create a truly universal system. Beginning with small-

scale local insurance plans and gradually broadening the reach of the system — has particular relevance for developing countries today.[5]

Once BISP's HELP project has run for one year , we will be able to study enrolment and factors influencing people's decisions to join in. The World Health Report 2000 outlined three health financing sub functions in: revenue collection, pooling of resources and the purchasing of services.[8] Hence, when evaluating the results of this pilot project in Pakistan , we would observe the factors influencing the performance of this model of insurance on the health financing sub functions: (a) Revenue Collection enrolment, (b) Pooling of resources and (c) services.

However for successful implementation, the suggestions for the team running a HELP project on ground effectively should be able to:

Create awareness and meet the demand for health care and financing, create ways for aligning the services of all concerned, concentrating on enhancing affordability and decreasing costs and swift coverage and health benefit to all.

The three main prerequisites for the introduction of universal healthcare according to our observation can therefore be summarized as: strong political will, proper administrative capacity, and an incremental approach. Naturally, the incremental approach to broadening the system will be governed by financial considerations: in other words, whether the overall rate of economic growth and development is sufficient to generate the taxes and premiums needed to continue extending the reach of the system.[5,15-17]

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