

# Romancing health insurance

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With all the four provincial budgets for 2008/09 tabled, the annual provincial development programmes for the next year have been unveiled. The provincial development budgets range from 22.12 to 41.13 percent of the total outlays, with Punjab spending the highest and Balochistan the lowest. 1.84-12.15 percent of the total provincial development budgets have been allocated for health, with Sindh allocating the highest in relative terms. On the whole, provincial health allocations suffer from limitations that are somewhat similar to those described for the federal health budget in the writer's article in The NEWS on June 20. However, a consistent reference to health insurance as a potential means of financing health in budget speeches has prompted this opinion in an attempt to bring clarity to the potential therein.

First of all, it is important to recognize that there are broadly two means of financing health – public and private. Public sources, which include tax and pooling (social health insurance and exemptions are the two ways of pooling) are more equitable in protection against health expenditure than private sources, inclusive of private insurance and out-of-pocket payments. Public sources must therefore

be prioritised. However, as opposed to this, private out-of-pocket payments account for 70 percent of the means of health financing in Pakistan, as is the case in many other developing countries. Revenue allocations for health currently stand at Rs270 per capita. In view of the need for investments of the order of Rs2,700 per capita per year and limitations to correspondingly enhance revenues, other options for financing healthcare clearly need to be explored.

The potential within social health insurance (SHI) as a mean of financing health has been explored time and again in Pakistan. Official development agencies and experts have advocated the need for its mainstreaming into planning, but governments have been unable to institutionalise arrangements.

In the early 1990s, World Bank and Japanese bilateral assistance supported a health insurance pilot in NWFP, which was later discontinued. More recently, when the Asian Development Bank provided technical assistance to the Government of Pakistan for social protection in 2005, it envisaged five areas, of which social health insurance was one. Its development study (ADB TA 4155-PAK) had a component on health insurance,

which recommended the introduction of a social health insurance scheme on a 'start small and grow' basis. However, the final Social Protection Strategy 2007, did not appropriately include health in its core instruments. In the NWFP, German bilateral agencies have focused on introducing SHI with support from the religious community capitalising on its non-profit solidarity characteristics. The federal government has also looked into the possibility many times and the Government of Punjab has constituted task forces to explore options. Each evaluation reiterated the need to build this as an option for financing healthcare in Pakistan.

The priority now is to develop a concerted vision for a way forward. While it is important to draw lessons from other countries where public sources of financing ensure universal coverage, a way forward must be locally suited. In this context it would be important to note what the current sources of public financing are, and the potential within them to be scaled up. As a first step, there is the need to earmark a higher percentage of revenues to finance the delivery of a package of essential services. In terms of the alternative public

sources, opportunities in Pakistan can be categorised, based upon whether they apply to the formally or the non-formally employed sector.

First, Social Security which is one of the five charges imposed by labour legislation on private employers in Pakistan, supports an insurance scheme under which private employees in a certain category receive healthcare through the health infrastructure of the Employees Social Security Institutes in three provinces. There are an estimated 5.65 million employees and their dependants covered under this. The government should use this as a platform for increasing social health insurance coverage for those in the formally employed sector.

Secondly, there are an estimated 800,000 individuals and their dependants covered under private health insurance in the corporate/private sector. As such, there is limited role of private health insurance in Pakistan as the primary source of coverage because of issues of affordability, and only countries in the world where private health insurance is mandatory and therefore a major mode of financing healthcare are Switzerland and Uruguay. Growth of private health insurance is correlated with economic

growth in general and growth of the formally employed sector in particular. It is only when employers subscribe to global employment practices and factor in health benefits for a large number of employees that health insurance companies with investment capacities and appropriate domain experience have an incentive to operate in developing countries; by underwriting a large number of people in a pool they can also create an opportunity health providers would wish to avail and may compete for, hence bringing down costs. The government should therefore analyse the current policy environment for private insurance companies balancing financial incentives with appropriate safeguards and explore incentives for employers so as to encourage them to subscribe. However, in doing so, they should ensure that these measures help to decrease inequities.

Thirdly, there are examples of community health insurance within the country; this involves not-for-profit pre payment plans with voluntary membership. In general, the cost implications of administering policies in far flung rural areas when transferred to the insured generally make the premium unaffordable and stan-

dalone. However, microfinance institutes (MFIs) in Pakistan are attempting to address this issue by offsetting administrative costs in pilot projects; these involve one time purchase of policies, which MFIs sell to their clients; some initial encouraging results have been demonstrated. In this case the government should attempt to offset the risk associated with their size and vulnerability by providing subsidies and underwriting costs.

The fourth option for pooling is through cash transfers. Theoretically, a local-government-certified Zakat form entitles the needy to free services that involve a user charge in public hospitals; high cost diagnostic and invasive procedures not funded through Zakat are meant to be financed through the Bait-ul-Mal. However, there are many weaknesses in this system; in addition, the funding pool has a narrow base; only 11 percent of Zakat funds and 8 percent of Bait-ul-Mal funds were allocated for health in 2007-08. Here the priority for the government is to broaden their base for health, but even more importantly to introduce transparency promoting measures in governance that can eliminate the wide scope for patronage and abuse and discretionary use of power

and exploitability of procedures in targeting social protection funds.

The issue of health insurance therefore has to be seen in the broader context of the need to expand public financing in order to provide universal coverage for healthcare. Expanding the base of social health insurance for those in the formally employed sector and community insurance in cases where it is sustainable, the use of private insurance for equitable outcomes and broadening of the base of exemption systems will help to enhance public sources of health financing and will contribute to social health protection; these measures need to be prioritised in the short to medium term. As a long-term goal universal social health insurance and restructuring of social welfare and social security systems should be pursued. These necessitate complex organisational changes such as separating provider and purchaser functions, enacting appropriate legislation and building further on the system of individual registrations through the National Database Registration Authority. It must be recognised, however, that these changes can only be brought about by institutions that project long-term and have the ability to cascade complex changes into concrete action.

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looked into the possibility many times and Government of Punjab has constituted task forces to explore options. Each evaluation reiterated the need to build this as an option for financing healthcare in Pakistan.

The priority now is to develop a concerted vision for a way forward. Whilst it is important to draw lessons from other countries where public sources of financing ensure universal coverage, a way forward must be locally suited. In this context it would be important to note what the current sources of public financing are, and the potential within them to be scaled up. As a first step, there is the need to earmark a higher percentage of revenues to finance the delivery of a package of essential services. In terms of the alternative public sources, opportunities in Pakistan can be categorized based upon whether they apply to the formally or the non-formally employed sector.

First, Social Security, which is one of the five charges imposed by labor legislation on private employers in Pakistan, supports an insurance scheme under which private employees in a certain category receive healthcare through the health infrastructure of the Employees Social Security Institutes in three provinces. There are an estimated 5.65 million employees and their dependants covered under this. *The government should use this as a platform for increasing social health insurance coverage for those in the formally employed sector.*

Secondly, there are an estimated 0.8 million individuals and their dependants covered under private health insurance in the corporate/private sector. As such there is limited role of private health insurance in Pakistan as the primary source of coverage because of issues of affordability; the only countries in the world where private health insurance is mandatory and therefore a major mode of financing healthcare are Switzerland and Uruguay. Growth of private health insurance is correlated with economic growth in general and growth of the formally employed sector in particular. It is only when employers subscribe to global employment practices and factor in health benefits for a large number of employees that health insurance companies with investment capacities and appropriate domain experience have an incentive to operate in developing countries; by underwriting a large number of people in a pool they can also create an opportunity health providers would wish to avail and may compete for, hence bringing down costs. *The government should therefore analyze the current policy environment for private insurance companies balancing financial incentives with appropriate safeguards and explore incentives for employers so as to encourage them to subscribe. However, in doing so, they should ensure that these measures help to decrease inequities.*

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