The problem with BISP health insurance

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This comment is a review of the health sector policy announced in the budget speech as part of which a new health insurance scheme will be launched for the poor under the rubric of the federal government's safety net program.

There are two elements in this policy intent. One relates to protecting the poor and the other centres on the means of enabling that. The standalone rationale for both of them is strong.

In principle, the decision by the government to financially risk-protect the poor against the vicissitudes of health is an admirable step since health problems constitute the most common economic shocks faced by poor households, as evidenced by the Planning Commission data. On the other hand, health insurance is a proven means of achieving financial risk protection. However, it must not be perceived that health insurance is the only way of protecting the poor against the risk of healthcare shocks in Pakistan's context given that there are other simpler ways of enabling that.

Before I dilate how that can be the case, some conceptual clarifications about the state's role in health financing are offered. The state is meant to ensure that health is financed through public means; either through 'revenues' or by 'pooling' financial resources. There are two ways of ensuring the latter: one is through insurance and the other is by creating pools of funds, through which cash transfers are made to fund waivers in hospitals for the poor. The idea central to public means of financing is fundamental to protecting people against having to pay out-of-pocket to access healthcare. Some

developed countries, which provide universal health financing coverage predominantly, use revenues to finance healthcare, as in the United Kingdom whereas another group of countries, of which Germany is the prototype, use insurance as a means of pooling.

Pakistan's health system is modelled on the UK's National Health Service. The Bhore Commission Report (1946), which served as the basis of institutional planning immediately after Pakistan's inception and the Beveridge Report, the blue print for the UK's National Health Service, had common authors and emerged around the same time. Pakistan's public health system, therefore, has a strong post-colonial imprint with a 'national health services' model operating, albeit with several gaps. Revenues finance the public system, which comprises over 15,000 health service facilities. Of course there are many pitfalls, lapses and gaps within this arrangement. Absent and 'ghost' health workers, closed basic health units, overcrowded hospitals, poor quality and performance are well-described manifestations of Pakistan's graft-ridden state health system, where inefficiencies are pervasive. This notwithstanding, its original character which embodied universal coverage principles must be brought to bear if any improvements are to be envisaged through reform measures.

Within this context, it must be appreciated that in this health systems model there is a multi-layered system of social protection already operational. Notional costs are levied at primary healthcare facilities for consultations. In hospitals, some costs at notional but most user's charges are subsidised. There is a mechanism to waive user's charges for the poor and a system functioning to label 'the poor' so. Essentially a local government certified Zakat certificate entitles the needy to free services that involve a user charge in public hospitals up to a limit of approximately 20,000. Over and above this, high-cost diagnostic and invasive procedures not

funded through Zakat are meant to be financed through Bait-ul-Mal.

These instruments do have their share of problems. Narrow coverage, poor targeting, lack of predictability about the size of the envelope, opportunities for patronage and abuse, lack of transparency in the use of resources, and corruption scams are some of these. However, with the right 'targeting tools' interfaced with the National Database Registration Authority and appropriate tracking technologies, some of these systemic fault-lines can be cemented. There are hospitals where these instruments are making a positive impact despite existing weaknesses and there is every reason to believe that their effectiveness can be enhanced with remedial measures.

Within this context, if the government's intent evident in the budget speech is to enhance financial risk protection for poor families, then the most plausible thing to do would be to ensure preferential access of the Benazir Income Support Programme (BISP) target families to exemptions/waivers in the existing social protection programmes. Various identification tools can be used for such families, which can allow them a special status in existing arrangements. The additional cost incurred in treating these patients through Zakat and Bait-ul-Mal can then be off-set by funds, which the government envisages allocating for health under the BISP and which currently, are earmarked for insurance.

If appropriately implemented this strategy will help achieve the objective of "improving access of target families of BISP to health care services" with far greater rigour, and efficiency compared to the health insurance route currently being explored.

In the proposed model, there would be no need to get into complex institutional reorganisation from the governance standpoint, which is needed to support the shift in health financing implicit in the new model being envisaged. The risk

of alienating the departments of health would be minimised since strengthening the existing arrangements would also be in their interest. The potential of garnering their support as a result thereof would be high. Thorny considerations of commercial viability vis-à-vis returns on public investments would also become irrelevant.

Most importantly, the proposed model would not restrict ‘covered’ healthcare costs to Rs25,000, which is what the insurance ceiling will allow for a family per annum. Instead, it will allow financial risk protection against catastrophic health expenditures, which involve much higher healthcare costs. In fact, this in essence, should be the objective of any health-related social protection programme. Furthermore, the strategy could have a positive knock-on systems-wide effect given that this would also be an opportunity to address some of the systemic avenues for exploitation, which exist within current channels.

The argument in favour of health insurance for this population in terms of its potential to draw on the private sector to deliver state-financed services is also somewhat out of line. On that score, population-based data from Pakistan Social and Living Standard Measurement Survey is telling in relation to the predominant role of public hospitals for the category of services being considered. This further substantiates the need to strengthen social protection financing.

Here it is acknowledged that levering the outreach of the private sector for delivering essential services is a critically needed reform measure. But there are significant legislative and institutional implications, for which the ground is not prepared yet. It is also acknowledged that health insurance, per se, is an important health financing strategy with its own applications even in Pakistan’s health system, where revenue is the main public means of financing health and that there are ways in which the base of social, private and community health insurance and Takaful can be

broadened.

In sum, the standalone rationale and merit of the reform measures is not being questioned. It is a question of achieving clarity in the policy objective and structuring the most appropriate means of achieving that. If the priority is to financially risk-protect the poor for health and to do it in the most cost effective and straightforward manner, then the government must rethink its current technical approach. The discouraging response of insurance companies to the expression of interest for the programme, admitted by the BISP managers, is also evidence of the need to do so.

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