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REPORT ON THE WORKSHOP ON

POLICY OPTIONS FOR FINANCING HEALTH SERVICES in PAKISTAN

MARRIOTT HOTEL
ISLAMABAD
21st NOVEMBER 1992

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REPORT ON THE WORKSHOP ON POLICY OPTIONS FOR FINANCING HEALTH SERVICES

1.0 Address by Federal Director General-Health

The workshop began with an address by Federal Director General-Health Dr. Syed Mohsin Ali. The following is a summary of his address.

At the workshop held last February on health financing policy options, a consensus was reached that the problems of Pakistan's health system were well-known and well-documented:

- Poor health status indicators
- Few resources devoted to health
- Inefficient and ineffective use of resources
- Quality of services uneven
- Government allocations favor hospitals and personnel
- Government doctors devote minimum time to public service

The Federal Ministry of Health (FMOH) used the commentary from the workshop's participants to formulate a vision and a set of principles to guide work on health financing policy reform. The vision sees more resources devoted to health overall--from both the public and private sectors. It sees the resources coming from government being used to ensure that the poorest have basic health services available. The vision also includes making better use of the available resources. This vision translates to asking the portion of the population that has resources to contribute financially toward health services. It also means that the organization of health services must provide incentives for proper use of resources. Finally, it means targeting government's contribution to those in greatest need.

These are the guidelines for new approaches in the priorities areas for action: hospital management, quality assurance, private insurance, and delivery of services to rural populations. Pakistan is not alone in embarking on these kinds of reforms. Many other developing and developed countries are pursuing similar tracks.

The studies launched following the February workshop with assistance from USAID's Health Financing and Sustainability Project (HFS) are now well underway. The workshop discussion will cover the preliminary findings and recommendations of the HFS studies.

The Federal Ministry decided to concentrate the activities of the studies in Islamabad Capital Territory, with two exceptions: development of private managed-care insurance in both Islamabad and Karachi and development of quality assurance for hospitals nationally. Having worked out any bugs and having learned from experience in Islamabad, the testing stage will be followed with implementation by the provinces. The FMOH will help the provinces with implementation.

A great deal of progress has been made in all four components of the activity. A national workshop has been held on hospital quality assurance and recommendations are in the hands of the Federal D.G. for implementation. The market for private health insurance in Karachi and Islamabad has been assessed and a model managed-care product has been developed. Models for private contracting for the provision of rural health services in Islamabad Capital Territory are being put together. Options for a new management model for truly autonomous government hospitals are now available. Additional steps in all of the areas are underway or planned.

The FMOH is committed to implementing the findings of the studies. The problems are real and cannot be solved by making adjustments to business as usual.

The procedure followed may appear to be long, but the scope of the problems means that complex reforms must be made. Such reforms must be designed, tested, and refined before implementation. All of this takes time.

USAID has been supplying support for the studies and will continue to provide support to February 1993. The FMOH is grateful for that support. We will have to seek assistance from another donor to follow on from USAID. Last week the FMOH held a meeting with other donors at which several expressed interest in helping in this regard. However, the FMOH is committed to the reforms whether or not external help is received.

The work of the HFS team would not have been possible without the cooperation of many of the participants. We thank the more than one hundred people who have met with and otherwise cooperated with the HFS team for their important contributions.

The workshop is expected to lead to: a building consensus, continued cooperation with the studies, and you beginning to think about the testing and implementation stages of the reforms. The study team will benefit from your commentary.

2.0 Address by USAID Representative

On behalf of the USAID Mission in Pakistan, Dr Lois Bradshaw, O/HPN welcomed all the participants to the Workshop and expressed USAID's keen interest in assisting developing countries worldwide to reform their health care delivery systems to meet the challenges of the future. She reiterated Mission's support for not only this project but others as well in the health sector of Pakistan.

She stated the progress made so far by the Health Financing & Sustainability study in each of the four major components will enable the Federal Ministry of Health to continue with its ambitious plans to reform the health sector in Pakistan. The USAID was pleased to note the close cooperation and technical assistance provided by the health experts across the country, and encouraged by the willingness of the participants representing both the public and private sector to reach a consensus in developing long term goals for Pakistan.

However, she regretted the inability of the USAID Mission in Pakistan to continue its participation in the HFS project beyond February 1993 due to circumstances beyond their control. Dr Bradshaw acknowledged the support shown by the Federal Minister of Health and the Secretary for this project. She said the USAID was especially appreciative of the effort made by the Director-General, Health, Dr Syed Mohsin Ali in pursuing with the study and providing assistance to the HFS team of consultants in completing their work.

3.0 Overview

The Federal Ministry of Health (FMOH) has begun to take steps to reform the organization and financing of Pakistan's health system. To do so, the FMOH has been assisted by USAID's Health Financing and Sustainability (HFS) Project. The FMOH and HFS sponsored a workshop on the progress made on the reforms on 21st November 1992. The purpose of the workshop was to provide collaborating organizations and individuals from the public and private sectors from all of the provinces with an update on the status of activities begun in January 1992.

The reform initiative being made is based on the FMOH's vision for the financing of health services. The vision was arrived at from an identification of the problems plaguing the health system. The vision was then used to derive a set of principles to guide the design of the package of components making up the reform initiative. The initiative is composed of an integrated set of actions that are mutually reinforcing. In addition, the initiative contributes to the achievement of several of the social action programme's (SAP) objectives and other national programs.

The vision of the FMOH is based on the consensus statement of the problems facing the Pakistan health system arrived at as a result of the deliberations of the first HFS workshop in February 1992. The consensus on the problems may be summarized as follows:

- Pakistan's indicators of health status are poor for its level of per capita income and rate of economic growth
- Relatively few resources are devoted to health
- More could be achieved if the available resources were used efficiently and effectively
- The quality of services provided in both the public and private sectors is uneven
- Allocations of government resources favor hospitals and personnel, to the detriment of drugs and supplies, and primary care
- Government doctors devote a minimum of their time to their public-sector duties and as much as possible to their private practices

The FMOH vision for health financing can be summarized as follows:

- Target the use of scarce government resources available for health to serve the poorest in the population
- Improve the effectiveness of health services and the efficiency of their delivery
- Increase the share of national output devoted to health from both the public and private sectors
- Increase private-sector involvement in the health sector

From the vision a set of principles was derived to use in formulating the initiatives to respond to the problems. The principles are:

- To require those who are able to pay to make financial contributions toward the costs of their health care
- To put into place methods of financing and organization which contain incentives for efficiency and quality
- To target allocations government allocations toward the poor in both urban and rural areas

Using the principles and the commentary of the February 1992 workshop, the FMOH instructed the HFS consultants to begin work on four initiatives:

- Development of a quality assurance mechanism for both public and private hospitals
- Autonomy for government hospitals
- Development of the private insurance market in Karachi and Islamabad
- Development of alternative models for the organization and financing rural health services

The FMOH decided to have HFS develop these components of the initiative for initial testing in Islamabad Capital Territory (ICT). The combination of hospital autonomy, insurance development, and new rural organization and financing is to be linked together through referrals and other arrangements in what is termed the "Islamabad Model". In addition, HFS has been asked to help stimulate the development of the private insurance market in Karachi along the lines of the managed-care approach. The initiative is to be pursued in phases, beginning with designs of the components, followed by their testing (primarily in Islamabad), then by full-scale implementation at the provincial level.

HFS is approaching its work in a collaborative fashion. HFS has assembled a team of external and national technical experts (see Appendix A for a list of the technical experts) who have devoted more than 80 person weeks of effort to the initiative this year. The effort on the initiative includes countless hours devoted to it by the Federal Minister, Secretary, Director General, and Deputy Director General. Anne Aarnes, Lois Bradshaw, and Dr. Arjumand Faisel of USAID and the USAID Child Survival Project also have contributed many hours and resources. The HFS experts are combining their technical knowledge and experience from other countries with consultations with Pakistani practitioners in formulating recommendations on the designs of the various components of the initiative. They have conducted consultations with at least 105 individuals, including 40 in the public sector, 35 in the private sector, and 30 from international agencies.

HFS began its work in January 1992, when a team of consultants visited Peshawar, Lahore, Karachi, and Islamabad, and consulted with officials from Balochistan to establish the most critical problems facing the Pakistani health system in terms of financing and organization. Following the gathering of this information from sources in both the public and private sectors, an initial workshop was conducted in early February. The workshop gathered the people interviewed to try to reach agreement about the most critical problems and to comment on a menu of possible approaches to them. As mentioned above, consensus was reached on the critical problems. The participants made many comments on the menu of possible approaches. With the participants's comments in mind, following the workshop, the FMOH chose to assign to HFS the four components of the initiative listed above.

The workshop that is the subject of this report is an interim briefing of the participants in the first workshop and others who have become involved in the reform process since. The briefing was intended to inform participants about the components chosen for the initiative, what progress has been made on them, and where the initiative will go in the future. In addition, participant commentary on the progress to date was solicited.

Another workshop is planned for February at Bhurban. This workshop will mark the end of the HFS assistance to the FMOH. USAID is winding down its assistance to Pakistan, so other donor support for the reform initiative may be needed. The World Bank, UNICEF, and other donors have expressed interest in following on USAID, through the framework of assistance to the Social Action Programme. By February, HFS will have completed the designs for tests of the hospital autonomy and rural models components and will have assisted with the formation of a quality assurance body and the stimulation of the private market for managed-care insurance.

In the following sections each of the four components of the initiative is briefly summarized, as it was during the workshop. The component presentations were made by the following individuals:

- Quality Assurance - Dr. S. Mohsin Ali, Federal Director General-Health

- Alternative Rural Models - Mr. Marty Makinen, HFS Team Leader

- Private Insurance Development - Mr. Zohair Ashir, HFS Deputy Team Leader and Mr. Raja Habib, HFS Insurance Specialist

- Hospital Autonomy - Mr. Marty Makinen, HFS Team Leader

The presentations followed a common format: statement of the objectives of the component; progress made by HFS to date, including preliminary findings and recommendations; remaining steps to be taken by HFS; statement of where the component is expected to stand when HFS wraps up its work at the end of February 1993; and what steps will be needed beyond February 1993 to see the initiative implemented. The presentations took about 15 minutes each and were followed by 45 minutes of questions and discussion by the workshop participants.

4.0 Presentation on Quality Assurance for Hospitals

Dr Syed Mohsin Ali presented the findings of the Quality Assurance (QA) for Hospitals component of the study. He stated the central objective of introducing QA standards in Pakistan was to improve the overall quality of patient care in the country. The purpose of the component is to identify a process by which standards can be introduced, recommend a system for monitoring these standards and ensure that the standards and accreditation process are developed and implemented with the participation from both the public and private sector.

He reviewed the progress made which included the assessment of existing standards in the private and public sector, examination of various alternatives for development of hospital standards and the review of hospital standards models developed in other countries. There was a consensus amongst the health professionals in this country for the need to develop hospitals standards now. Dr Ali said he was especially encouraged by the progress made during the workshop arranged with HFS assistance in June 1992. The aims of the workshop were fully achieved through a consensus based recommendations which were submitted to him by the participants of that workshop.

He reviewed the final recommendations which included the agreement that standards are required nationally and the creation of an autonomous national body with provincial chapters which should define how the process of standards could be developed. This national body should be legally empowered to carry out its mission. The recommendation also supported that accreditation at this time should be voluntary but some consideration should be given to making registration of hospitals compulsory.

Dr Ali told the participants the work on the QA for Hospitals part of the HFS study is complete and is now awaiting implementation through his office. He explained that the FMOH is working with the provinces to elicit their reaction to these recommendations and would soon embark on its implementation. He expressed his satisfaction with the negotiations taken place

so far with some of the donors who are interested in assisting the FMOH in the implementation of these recommendations.

Commentary on Quality Assurance for Hospitals

The participants were generally supportive of the recommendations described by Dr Ali. However they expressed their concern if the degree of "autonomy" envisaged for the national body would be sufficient to meet its objectives. In addition they again debated if the accreditation process should be made voluntary or compulsory. There was strong support that the hospital standards and quality mechanism should be applied not only to hospitals but to all other health providers as well.

5.0 Presentation on Alternative Rural Models

The objective of the alternative rural models component of the initiative is to improve service delivery to rural populations. This is to be accomplished by providing incentives for effective and quality service provision. This may be attained through such means as contracting with private-sector groups, introducing some user charges to have beneficiaries begin to share the cost of their care, retaining revenues earned from user payments at the facility for quality improvements and staff motivation, continuing government subsidies to help ensure financial access for all, always keeping in mind protection of the access of the poorest, and involving the community in oversight of the services.

To date HFS has assessed clinical quality in rural areas of Islamabad Capital Territory, and has begun: estimating costs of providing services at Basic Health Units (BHUs) and Rural Health Centres (RHCs); assessing private groups's interest in participating in contract provision of services; studying referrals between rural areas and the hospitals Islamabad and Rawalpindi; defining the role of communities in oversight; and studying how religious funds, like Zakat and Bait-ul-mal, could be used to help ensure financial access for the poor.

HFS has found some reluctance among private groups to participate in these schemes, because of skepticism about government's follow through. Communities in ICT have little experience with involvement in such activities. There is a need for a strong referral link between the rural facilities and the urban hospitals. In addition, HFS has found that many people in rural ICT are already paying significant sums for health services in the private sector and for transport to town for care. Consumers have told HFS that they would expect the quality of services offered to improve if they are asked to begin to share in paying for them.

The following are the steps that remain to be taken by HFS. The studies of costs, referrals, private interest, religious funds, and community involvement will be completed. HFS will develop model tenders and contracts for private contractors. To allow the maximum to be learned from the first experiences with these methods of organization, HFS will design a monitoring and evaluation plan. The design of this component will benefit from study of the

experiences of Bolivia, Thailand, Korea, and Zaire, where similar approaches have been used successfully. HFS will produce a summary of its activities and recommendations regarding the rural component in the final report.

When HFS's work is finished in February 1993, a plan will be ready for testing of the rural models in ICT. The plan will include model tenders and contracts, estimates of costs and prices, advice about the role of the community, a recommended referral system, plans for involving religious funds in paying for the poor, and a monitoring and evaluation plan.

Following HFS's work several steps will need to be taken to implement the reforms. The tests will need to be conducted in ICT. Their results will need to be monitored and evaluated to draw lessons for adjustment. Then the model should be replicated at the provincial level.

Commentary on Alternative Rural Models

This component of the initiative attracted much commentary and lively debate among participants. First, Federal D.G. Dr. Mohsin Ali mentioned that the Federal Minister of Health has in mind a concept that the funds currently spent by government on district health services could be turned over to insurance companies to insure care for the population. The HFS team noted that the contracting for BHU and RHC services could be a first step toward testing this concept.

Several of the participants questioned whether Islamabad Capital Territory could be considered representative of the rural areas of the majority of the country. The suggestion was made that this would call into question the validity of the results of tests of the model conducted in ICT. The District Health Officer for ICT defended how representative ICT would be of rural areas generally.

The participants wanted to know whether preventive services would be included in the services provided to rural representatives under the proposed alternatives. They were reassured by the HFS consultants that preventive services would be included. Then questions were asked regarding the feasibility of preventive services being included in user payment systems.

A number of participant comments underlined the importance of community involvement in the potential for success of such an approach as the one proposed. Building the concept of community ownership of rural health services was suggested.

Support also was given by participants to decentralization of control of administration of health programs in rural areas as a complement to the proposed approach.

The role of medical officers is the final issue that provoked much discussion. Several participants noted the difficulty of attracting medical officers to rural service, even in these times of high unemployment among medical officers. Many proposals were advanced for attracting medical officers to rural service, including debate over whether they would be willing to work

for private contractors. Participants were divided over whether models of service delivery should be considered that did not include medical officers at BHUs and RHCs.

6.0 Presentation on Private Health Insurance

This presentation also began with the review of primary objectives of this element, which is to provide encouragement to the private sector insurance market and to develop viable options for insurance mechanism in Pakistan's health sector. The purpose is also to enable the beneficiaries to share the financial risks, which results from pooling of resources under an insurance health plan. The introduction of private health insurance along the Managed Care principles now widely practiced in other countries also complements both the autonomization process and user charges, which are an integral part of this study. The FMOH hopes the findings of this study would act as a stimulant for the private sector to take initiatives in helping reform the health system in Pakistan.

The principles of Managed Care were briefly reviewed. It is a form of prepaid medical care service managed by an insurance company or any other party which contracts with the providers to extend health care services to its members (group of employers and employees). In this regard substantial progress was reported by the HFS team. This included the assessment of potential for Managed Care in Karachi and Islamabad, scrutiny of existing insurance products available in the market and a review of planned products under development in the insurance sector of Pakistan. In addition the HFS team met with selected providers in both the cities to assess their interest and role in developing a Managed Care product.

It was reported that a model of proposed benefits package has been produced by the HFS Consultants encompassing availability of preventive, outpatient, inpatient and other services (durable equipment and ambulance). This summary of benefits is being currently tested by conducting a survey of 30 to 50 employers based in Karachi and Islamabad. The employers were selected through a reasoned survey and includes representation from the multinationals, public and the private sector companies. The HFS has already completed its work relating to making some recommendations for the Employee Social Security Insurance (ESSI).

The presentation then focussed on the remaining steps of this component between now and February 1993. It was stated the ongoing employer survey and its findings will be completed soon, as well as the modifications to the proposed summary of benefits package will be undertaken based on employers responses. The HFS will continue to work with FMOH to identify prospective donors who may wish to assist in the testing and implementation of the final recommendations. It was also envisaged a Monitoring and Evaluation Plan would be submitted to the FMOH to enable it to revise its policies vis a vis insurance practices proposed.

Therefore, the status at February 1993 when the project's USAID assistance is expected to end, the FMOH will have in its possession the recommendations for--- options for introducing private health insurance (Managed Care) in Pakistan, employers survey and its findings,

proposed Managed Care model of benefits package and a summary of legal opinions if any are required to implement the recommendations. Beyond February 1993 it is anticipated the following work will need to be undertaken. Implementation of HFS recommendations by FMOH, offer of HFS study findings by the Federal Ministry to prospective insurance companies and the execution of Monitoring and Evaluation plan for periodic revision of policies.

Commentary on Private Health Insurance

The majority of participants expressed satisfaction with the progress made so far in the development of Private Health Insurance along the lines of Managed Care principles. The participants urged the HFS consultant's team to explore further the possibility of including the poor population's access to benefit from private health insurance. In addition, some concerns were voiced over the ESSI segment, which the consultants agreed to investigate further before the end of this project.

7.0 Presentation on Hospital Autonomy

The following summarizes the presentation made on the hospital autonomy component of the initiative. After the summary of the presentation, the commentary of the workshop participants on this component is recapitulated.

The objective of the hospital autonomy component of the health financing reform initiative is to grant managerial and financial autonomy to government hospitals. This autonomy is to allow the hospitals to improve the quality of patient care, increase efficiency, and generate additional funds by charging fees for services.

HFS has researched the autonomy currently offered to some hospitals (e.g., NICVD and PIMS) and found it to be inadequate. HFS also studied the autonomy and functions of private trust hospitals and autonomous organizations in sectors other than health. This research has allowed HFS to develop a new autonomy concept and a model for management of an autonomous hospital.

The remaining steps for HFS to take in this component are to develop options for the financial relationship between the autonomous hospitals and the government and draft legislation to correspond to the new autonomy concept.

By the end of HFS's work plans will be ready for the implementation of autonomy for PIMS and FGSH. These plans will include a draft of the legislation needed to grant the institutions adequate autonomy to achieve the stated objective and a plan for making the management changes indicated by the management model developed.

Following the wrap up of HFS's work the legislation will need to be acted on to permit true autonomy. Also, the steps needed to implement the management model at PIMS and FGSH

will need to be followed. Once the hospitals are operating as truly autonomous entities, their performance needs to be monitored to generate data that may be evaluated to determine the successes and failures of the reform. This will allow corrections to be made and replication of the approach more broadly in government hospitals in the provinces.

Commentary on Hospital Autonomy

The commentary of the workshop participants on the hospital autonomy component focused on two related concerns: whether "true" autonomy can be achieved and what is required to achieve "true" autonomy. The first concern reflected the feeling among the participants that government will be reluctant to give up enough control over its hospitals to allow management to have the power and incentives to achieve the stated objective. The participants indicated that they think this step is essential to the proper functioning of the hospitals.

The second concern was a debate over how much autonomy is needed for the hospitals to function as desired. Some participants insisted that absolute autonomy was required, with no government role in oversight whatsoever. Others argued that a workable, limited role by government would be compatible with achieving the objectives.

8.0 Summary

Once the HFS activities have been completed, additional steps will be needed to implement the reforms. In the near-term the following will need to be done:
test the alternative rural models in ICT; grant autonomy to PIMS and FGSH and assist them to convert to operating in the new status; assign the quality assurance function to a body and begin developing and applying standards; and further assist the development of private managed-care insurance in Islamabad and Karachi. In the medium-term the components of the initiative should be monitored and evaluated to learn lessons from their initial implementation. After having been revised, they should be implemented in the provinces, probably beginning with a single district in each. To complement the implementation, there should be a development of the monitoring, evaluation, and analysis capabilities of the Federal and Provincial Ministries of Health. In the long-term national implementation should be achieved.

The Federal Ministry of Health has embarked on a reform initiative with four components: development of a quality assurance mechanism for hospitals; autonomy for government hospitals; development of private insurance following a managed-care approach; and development of alternative models for the organization and financing of rural health services.

This initiative is expected to result in better health services for the poor, higher quality health services throughout the system, new mechanisms for financing health services, and incentives for greater private sector participation.

APPENDIX A
Health Financing and Sustainability (HFS) Team
for
POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN

Name	Role	Quality Assurance	Rural Models	Private Insurance	Hospital Autonomy
Marty Makinen	Team Leader	■	■	■	■
Zohair Ashir	Deputy Team Leader	■	■	■	■
Rick Yoder	Lead Consultant		■		
Stan Hildebrand	Lead Consultant				■
Greg Becker	Lead Consultant	■			
Charles Stover	Original Team Leader[1]	■	■	■	■
Raja Habib	Actuary			■	
Afzal Siddiqi	Legal Specialist	■	■	■	■
Dr. Bob LeBow	Physician		■		
Dr. Zafar Ahmed	Physician		■		
Sikander Lalani	Accountant		■		
Dr. Kamran Khawaja	Physician		■		
Dr. Harris Berman	Managed Care			■	
Jon Kingsdale	Managed Care			■	
Dr. Atif M. Mian	Physician		■		

N.B. Shaded area indicates component on which the team member has worked.

[1] Left HFS to take a resident advisor position in the Philippines.

بسم اللہ الرحمٰن الرحیم

file
Corr. P
HFS

Director General, Health
Additional Secretary to the
Government of Pakistan
Islamabad

No. 1-1/92-DGH/AS

December 23, 1992

Subject: **FOLLOW-UP ON POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN WORKSHOP HELD ON NOVEMBER 21, 1992.**

My dear Dr. Rushna Ravji,

1. Please refer to my letter dated November 9, 1992 regarding workshop on the *Policy Options for Financing Health Services in Pakistan* which was held on November 21, 1992.

2. I am happy to report that the workshop was a success. The Federal Ministry of Health was extremely satisfied with the attendance of the participants and their keen interest in contributing actively towards the workshop objectives. The primary objective was to provide the participants with a status report regarding the preliminary findings of the Health Financing & Sustainability (HFS) study.

3. I would take this opportunity to express my thanks and appreciation to all the participants and observers who made this workshop successful by their presence and active interest in the proceedings.

4. Enclosed with this letter is a report containing the workshop proceedings which will provide you with current status of this study since its inception in January of 1992. We have taken special note of the comments and views expressed by the participants and have included them as inputs to the remaining work plan of the Health Financing & Sustainability study.

5. I would like to reiterate and emphasize that the primary objective of the HFS study was the formulation of policy towards options for financing health services in Pakistan. The follow up process to this measure is the testing and implementation of the recommendations of the study. We hope either through the assistance provided by international donor agencies or the Federal Ministry of Health, this process would continue beyond February 1993.

6. I regret that many of you could not attend the workshop due to other prior commitments and hopefully the enclosed report would prove beneficial to you in this regard. However we are planning to conduct the final workshop in February 1993 during which the final report and its recommendations would be presented. We look forward to your participation in this very important endeavor towards reforming the health care delivery system in Pakistan.

With kind regards,

Yours sincerely,

(DR. S. MOHSIN ALI)

Dr. Rushna Ravji
Public Health Physician,
O/ HPN, USAID
Islamabad