HF-BTA 06
PN-ABU-578
94133

Report on Health Insurance in Pakistan: Observations and Situation Analysis

Ralph Andreano, Ph.D
Thomas Helminiak, Ph.D
University of Wisconsin-Madison, USA

This report represents a distillation of the work of three separate missions to Pakistan (Andreano, November 17-27, 1987; Helminiak, March 7-April 9, 1988; and Andreano April 4-9, 1988).

TABLE OF CONTENTS

Government

People

Economic Background

The Health Sector

- Health Inputs
- Health Expenditures
- Sector Development Objectives

Recurrent Costs Issues

- Problem Status
- Options

Present Status of Health Insurance

Rationale for Health Insurance

References

- Attachment I Observations on Health Insurance-Field Report
- Attachment II Codification of MAR
- Attachment III Suggested Steps and Timetable for Health Insurance Recommended to GOP

Pakistan came into existence on 14 August, 1947 with the partition of British India into the sovereign states of Pakistan and India. In 1971, East Pakistan, now known as Bangladesh, seceded. [1,2]

The government of Pakistan functions as a parliamentary democracy in a federal framework. The constitution provides for a president (who serves as chief of state), a prime minister (who forms the government), the National Assembly (directly elected) and the Senate (indirectly elected by the provincial assemblies, tribal councils and the Islamabad federal capital district).

Administratively, the country is divided into four provinces (Punjab, Sind, Baluchistan and North West Frontier), the Federally Administered Tribal Areas (FATA), Northern Areas and the Islamabad federal capital district. The four provinces are each headed by a governor (nominated by the federal government) plus a provincial parliament and are further divided into twenty divisions. These, along with the other major administrative units, are, in turn, divided into 89 districts and nearly 4,000 Union Councils (each representing a group of villages). [3,4]

People

With declining mortality and increasing fertility rates, the population accelerated after 1951 and is now (1988) about 105 million (making Pakistan the ninth most populous country in the world).[1] The present growth rate is estimated at 2.8 percent. [6] The estimated population density for the country is 130/sq km. Assuming the same distribution as existed for the 1981 census, the population would be divided among the major administrative areas as follows: Punjab Province -- 56.1% (287.0/sq km); Sind Province -- 22.6%

---

[1] Extrapolated from [5].

(168.2/sq km); Baluchistan Province -- 5.1% (15.6/sq km); North West Frontier Province -- 13.3% (99.7/sq km); FATA -- 2.6% (99.7/sq km); Islamabad -- 0.4% (375.6/sq km).[2] [The figure for Islamabad certainly under-represents its current size.] About 28 percent of the population is urban and 72 percent rural. [3]

The Government has estimated the current literacy rate at 30 percent. Until recently, most sources have given the estimated life expectancy at birth for Pakistan as between 50-52 years; however, the Government currently, in the draft, Seventh Five Year Plan (1988-93), [8, p.1] indicates life expectancy as 61 years -- a dramatic improvement, if correct. Similarly (from the same source), infant mortality is estimated at 80/1000 (compared to 119/1000 about five years earlier). [8, Table IV]

About 53 percent of the labor force is estimated to be engaged in agriculture, generally employing traditional cultivation procedures. The overall population employment rate (1987) is about 29 percent, comprising 49.4 percent for males and 7.1 percent for females. [9, p.4] Table 1 gives additional labor force detail.

---

[2]Adapted from [3].

Table 1: Pakistan Labor Force and Employment, 1 January 1987
(Population and employment numbers in millions)

Group	Pop.	Labor Force	%	Employed	Labor Force Participation Rate (%)	Population Employment Rate (%)
Total	100.70	30.4	100.0	29.2	96.1	29.0
Male	52.87*	27.24	89.6	26.1	95.8	49.4
Female	47.83*	3.46	11.1	3.4	98.1	7.1
Urban	28.5*	7.50	24.7	7.1	94.2	24.9
Rural	72.2*	22.93	75.3	22.2	96.7	30.7

* Based on 1981 population census ratios.

Source [9]: Government of Pakistan, Monthly Economic Statistics, September - October 1987, Government of Pakistan, Finance Division, Economic Adviser's Wing, Islamabad, p. 4. (Population employment rate figures in the table here were calculated from other table statistics given by this source.)

Economic Background

There was significant disruption to the Pakistan economy with the secession of Bangladesh in 1971; however, the economy has been growing strongly since 1977. During 1980-86 real GDP grew at an average of 6.7 percent. (Real GNP grew at a 6.5 percent rate.) [3] During the same period, real GDP per capita grew at an average of 3.5 percent.[3] Economic growth may have slowed slightly since 1986. According to one estimate, growth for 1986-87 was 5.6 percent; and for 1987-88 growth may further slow to 5.2 percent. [11] For 1985-86, per capita GDP (at the exchange rate for that period of Rps 16.83 to the dollar) was equivalent to $324.

Increasingly, since 1982-83, current expenditures have exceeded government revenues causing deficit financing to be a major feature of the Pakistan

[3]Since its fixed link to the U.S. dollar was terminated in 1982, the rupee has been depreciating significantly against the dollar -- at a rate exceeding the internal inflation rate. [10] Thus, during 1980-86, per capita GDP in current rupees converted to dollars only rose at an average 2.0 percent.

~~During the decade ending~~ 1986-87, the combined current expenditures of the federal and provincial governments have increased by more than five times, reaching 24.2 percent of GNP in 1986-87. The government, in its published "Highlights of the Draft Seventh Five Year Plan (1988-93)," recently frankly acknowledged that: "Currently we are financing not only our entire development budgetary outlay by borrowing but are borrowing also large amounts to meet our current expenditure. Debt servicing is rising rapidly which is further increasing revenue deficit leading to yet more borrowing to cover it." [7]

As of May 1988, Pakistan's foreign debt was estimated to be about $12 billion, or more than 34 percent of GNP. [12] After defense, interest payments account for the largest portion of current expenditure. (More than half of the current expenditure budget is devoted to defense and outstanding debt.) With continuing large budget deficits (in 1984-85 the deficit was equivalent to 8 percent of GNP), the debt servicing burden is mounting rapidly. Relative to exports of goods and services, debt servicing accounted for 28 percent of receipts in 1984-85; though debt servicing decreased to 27 per cent of these receipts in 1985-86, it nevertheless increased 10 percent in absolute terms. [13] In 1986-87, debt service payments increased by 32 percent over 1985-86; according to the 1987-88 budget there will be a 24 percent over 1986-87; and projected figures for 1988-89 indicate a further 28 percent increase over 1987-88. [14] Debt servicing was projected at 19.4 percent of the total federal budget for 1986-87 and at 21.7 percent of the total budget for 1987-88. Similarly, debt servicing was projected at 29 percent of all current expenditure in the 1986-87 federal budget and at nearly 33 percent of all current expenditure in the 1987-88 budget. [15,16]

In early May 1988, a parliamentary committee, set up by the Prime Minister to review expenditure projections of the Seventh Five Year Plan, was reported to be seriously concerned about the extent to which rising non-development

expenditures were crowding out development expenditures. Consequently (appearing to disregard the fact that increased development expenditure determines a need for increased current expenditures), the parliamentary committee proposed a complete freeze on current expenditures during the first two years of the Seventh Plan. [17]

On 28 May 1988, the Minister for Planning and Commerce, acknowledging that Pakistan has been living on borrowed time, having postponed key decisions in the past, described three necessary decisions: 1) reducing the enormous budgetary deficit by cutting nondevelopment expenditure and raising more resources; 2) decreasing dependence on external borrowing; and 3) improving the country's balance of payments.[4] [18]

The tax system in Pakistan is characterized as regressive and inelastic. [19] Government revenue is mainly derived from indirect taxes (mostly customs and excise duties), accounting for over 82 percent of revenue.[5] Stevens has noted that the federal government accounts for more than 90 percent of tax collections, with provincial governments collecting only 6.5 percent (1981 data) of total consolidated federal and provincial revenue. There seems to be little fiscal capacity below the provincial level. [20]

Accompanying its severe budgetary deficit, Pakistan is experiencing chronic balance-of-payments problems. The gap between foreign exchange receipts and payments is large and widening. For the five year period from 1983-84 to 1987-88, export receipts are estimated at $15.732 billion; and

[4]On the following day, 29 May 1988, President Zia ul-Haq removed Prime Minister Junejo from office and dissolved the National Assembly and the Federal Cabinet.

[5]The Seventh Plan comments: "There is a widespread reluctance to pay more taxes, partly due to a perception of colossal waste in public spending, and partly due to a perceived inequity in the burden of taxation, made worse by rampant corruption of tax administrative machinery." [7, p.4]

imports are estimated at $30.188 billion -- leaving a trade deficit of $14.5 billion. Meanwhile, both worker home remittances and external aid -- the major gap-filling sources -- have been diminishing. [21] Until 1982 the Pakistan rupee was linked to the dollar, at a rate of 9.90 rupees to the dollar. Since then, the rupee has depreciated considerably, standing at 18.00 rupees to the dollar in mid-1988.

It was reported in the Pakistan press, on 24 April 1988, that the World Bank was withholding a $200 million agricultural sector loan to Pakistan due to 'longstanding concern over the country's macro-economic performance and the government's overall budgetary position.' The Bank was reported as considering the fiscal deficit to have grown too large to be manageable without adversely affecting the stability of the economy. Effective measures, by Pakistan, to improve its fiscal and balance-of-payments position have been urged by the Bank. [22]

Among the measures proposed by the draft Seventh Five Year Plan (1988-93) to improve the fiscal problem are: reduction in income tax exemptions and improvement in tax collection and administration; broadening the sales tax; reduction of subsidies; establishment of user charges in education and health; promotion of the private sector, through deregulation, in order to transfer much of the government's budgetary burden to the private sector. [7, p.4]

The Health Sector

Overview: Until recently the health sector in Pakistan has received relatively low investment priority. During the Sixth Five Year Plan (1983-1988) and continuing with the Seventh Five Year Plan (1988-93), the Government is providing large real increases in funding, though as a proportion of GNP, the allocation remains modest. In terms of achieved investment under the Sixth Plan, the health sector -- with an investment of Rs 12 billion (1987-88

prices), or 4 percent of the total -- ranked seventh in sectoral priority (behind energy, transport and communications, water, physical planning and housing (which includes allocations for water supply and sewerage), education, and industry and mineral. [7, p.4] In the Seventh Plan allocation, the health sector remains at 4 percent of the total, while receiving an allocation of Rps 14 billion (1987-88 prices).

Total government (federal and provincial) expenditure on health, since 1972-73, is shown, relative to GNP, in Table 2. The expenditure data for 1972-88 are at current factor cost. However, the expenditure data for 1988-93 are planned allocations under the Seventh Five Year Plan (1988-93) and are presumed to be at constant (1987-88) cost. Though total expenditure is observed to still represent a low percentage of GNP, at just 1.10 percent in 1987-88 the share for health has been rising over the past five years. Table 2 also indicates the dramatic increase in recurrent expenditure which has occurred recently (though only shown in current costs) and which is scheduled to continue during 1988-93 (shown in constant costs).

Private payments for health services dominate funding of the health sector in Pakistan; however, until the Sixth Five Year Plan, the role of the private sector was not taken into account. Up to now, though, the capital expenditure contribution of private providers in health has been minor. For 1981-82, the World Bank estimated total public and private expenditure at 3.2 percent of GNP, or $13.30 per capita at the existing rate of exchange. [23, p.21] Estimates for 1986-87, by a private consulting group (engaged by the World Bank)[6], place total public and private health expenditure at 3.5

---

[6]The version of this report (also referred to as the Gross report), which was reviewed in Pakistan, had not yet been accepted by the Government of Pakistan at the time of the review. Consequently, information based on references to this report should be considered cautiously.

percent of GNP, or about $11.60 per capita at the exchange rate for this period.[7] [24]

In terms of public expenditure on health, the federal government, as noted earlier, is the major mobilizer of funding. However, with substantial transfers from the federal government -- added to more modest provincial revenues, the provincial governments have major responsibility for health services in Pakistan.

[7]Depreciation of the rupee, relative to the dollar, was in excess of internal price inflation for Pakistan in this period. In real terms (1981-82 prices), per capita health expenditure increased from $13.30 in 1981-82 to about $14.50 in 1986-87.

Table 2: Total Government (Federal and Provincial) Expenditure on Health (Million Rupees)

Year	Development Expenditure	Non-Development Expenditure	Total Expenditure	G.N.P.	Total Expenditure % GNP
1972-73	95.55	171.90	267.45	61877	0.43
1973-74	175.67	210.10	385.77	82307	0.47
1974-75	363.00	278.00	641.00	104704	0.61
1975-76	629.10	360.64	989.74	122728	0.81
1976-77	540.00	439.20	979.20	141462	0.69
1977-78	512.00	558.60	1070.60	172064	0.62
1978-79	569.00	641.60	1210.60	192571	0.63
1979-80	717.00	661.89	1378.89	228886	0.60
1980-81	942.00	749.82	1730.82	270288	0.64
1981-82	1037.00	993.10	2030.10	315183	0.64
1982-83	1183.00	1207.00	2390.00	365585	0.65
1983-84	1526.00	1564.90	3090.90	412343	0.75
1984-85	1587.45	1785.12	3372.57	469200	0.72
1985-86	1881.51	2393.81	4275.32	526569	0.81
1986-87	2615.00	3270.00	5885.00	573146	1.03
1987-88	3114.41	3600.00	6714.14	610400	1.10
1988-89	2907.7	4720.0	7627.7		
1989-90	2998.5	5584.0	8582.5		
1990-91	2959.6	6720.0	9679.6		
1991-92	3041.6	8465.0	11506.6		
1992-93	3092.7	10642.0	13734.7		

* Expenditure data for 1972-88 are at current factor cost. (It is not clear which are actuals and which are budgeted amounts.) Data for 1988-93 are planned allocations under the Seventh Five Year Plan (1988-93) and are presumed to be at constant (1987-88) cost.

Source: [8] All data are from the Draft Seventh Five Year Plan (1988-93), Ch. 16, Health and Nutrition. Data for 1972-88 are from Table III and data for 1988-93 are from Table XVI of the Draft Plan.

The objective of developing a nationwide integrated health care system, determined during the Sixth Five Year Plan, is to be pursued in the Seventh Plan. It is expected that the target of providing a Basic health Unit or a Rural Health Center in each union council will be reached by 1990.

Health Inputs: Under the Sixth Five Year Plan (1983-88) it was decided to post physicians in each rural Basic Health Unit. Meanwhile, the production of physicians has been greatly emphasized in Pakistan -- to the extent that a physician "glut" has been referred to. On the one hand, it has been suggested that it was necessary to create a physician surplus to overcome the traditional reluctance of physicians to accept posts in rural areas. On the other had, it has also been suggested that the decision to staff the Basic Health Units with physicians was an attempt to deal with the problem of unemployed physicians. As of 1982-83, there were an estimated 20,000 physicians in Pakistan (2.2/10,000), with a distribution of 18,800 in urban areas and 1,200 in rural areas. In 1987-88, there were an estimated 36,000 physicians (3.4/10,000), with about 28,000 in urban areas and 8,000 in rural areas. [8, Table IV] The Government lists, among the successes of Sixth Five Year Plan, its measures to deal with the unemployment of doctors. Of the approximately 18,000 physicians produced during the Plan period, 13,000 were employed by the public sector; and doctors seeking to establish private clinics were assisted by government loans. [8, p.2]

There are also a considerable number of traditional practitioners (more than 37,000 registered) plus nearly 16,000 homeopaths, mostly working in the private sector, who are an acknowledged component of health policy under the Seventh Five Year Plan.

As of mid-1988, there are an estimated 63,600 hospital beds in Pakistan (0.6/1,000). [8, Table VI] However, as Stevens has cautioned, many of these

beds may be in facilities too small to offer the diagnostic and support services usually associated with facilities that are thought of as hospitals.

Pakistan has a great shortage of nurses. At mid-1988, there are only about 10,000 nurses (0.1/1,000) in the country. [8, Table VI]

According to Government data, access to clean water improved from 38 percent of the total population (22 percent of the rural population and 77 percent of the urban population) in 1982-83 to 53 percent of the total population (45 percent of the rural population and 80 percent of the urban population) in 1987-88. [7, p.4]

Regarding access to sewerage facilities, the Government estimates an improvement from 16 percent of the total population (4 percent rural population and 48 percent urban access) in 1982-83 to 23 percent of the total population (10 percent for the rural and 52 percent for the urban population) in 1987-88. [7, p.4]

Appreciable inefficiency is believed to exist in the utilization of medical service resources in Pakistan. The sector study by Gross, estimates that the workload of medical practitioners, in both office and hospital practice, could be increased by 50 to 60 percent. The same study also refers to low occupancy rates in the government hospitals. [24] Further, there is a common perception among observers that there is excessive prescription of drugs in both the public and private sectors.

Health Expenditures: According to the Gross study, funding sources, for the Rps 20.433 million expenditure on health for 1986-87, had the following distribution: Government (all levels), 34.5%; Semi-government organizations, 5.4%; Private employers, 1.0%; Foreign aid, 4.4%; Private households, 53.1%; Voluntary agencies/missions, 0.9%; Other 0.8%. [24]

In terms of status of service provider, the Gross study found that private sector providers accounted for 57.1 percent of total health expenditure and 69.5 percent of all recurrent health expenditure. The private sector accounted for only 6.0 percent of capital expenditure, however. While government services accounted for 32.8 percent of total health expenditure, the government share of recurrent expenditure was 24.5 percent and its share of capital expenditure was a dominant 88.7 percent. [24] (These estimates do not include defense expenditures on health.)

Government funding and expenditure for health care occurs at three levels: federal, provincial and local. In terms of contributed revenue (1986-87) the federal government accounted for about 49.5 percent of the total, the provinces for about 45 percent and local government for less than 6 percent. On the other hand, federal ministries expended just 26.5 percent of the government total, while the provinces were responsible for almost 66 percent. [24]

Employer funding of health services occurs through the health share of employer contributions to the Employee Social Security Institutions, through employer payment for private sector services provided to employees and through employer operation of health services for their employees.

Of private household expenditure on health, the Gross study found purchases of drugs to account for 63.2 percent of the total. Private medical consultations were 21.4 percent and private hospitals accounted for 3.5 percent. User fees for government services were just 4 percent of the total. [24]

The growth in pharmaceutical expenditures has been great in recent years. In 1985, the per capita consumption of drugs was estimated to be Rs 47.00 ($2.78). [24] In April, 1988, it was reported that, following an expression of concern by the Federal Minister of Commerce over the rising trend of

pharmaceutical imports, the Health Division and the Registration Board had decided to restrict the registration of imported drugs and medicines. [25]

Sector Development Objectives: Under the Seventh Five Year Plan (1988-93), it is proposed to increase the number of physicians by more than 15,000 (an increase of 42 percent), to obtain a ratio of about 4.4 doctors per 10,000 population. More than 20,000 hospital beds are to be added (an increase of nearly one-third), to achieve a ratio of 0.7 beds per 1,000. The Plan proposes an additional 144 rural health centers (an increase of 29 percent) and 1,948 primary health care facilities/Basic Health Units (an increase of nearly 56 percent).[3] [8, Table VI]

Under the Seventh Plan, it is expected that primary health care will be made available in all union councils of Pakistan (compared to 85 percent coverage in 1988). The target rate for infant mortality in 1993 is 60/1000 (compared to 80/1000 in 1988); and target life expectancy in 1993 is 63 years (compared to 61 years in 1988). [8, Table IV]

The Recurrent Costs Issue in the Pakistan Health Sector

Problem Status: The Government acknowledged the significance of the recurrent costs issue in health in the document for the Sixth Development Plan (1983-88), stating: "The most important difficulty facing the public sector health services is insufficient funds to meet the recurring expenditure. In many

[3]Despite declared development emphasis on primary health care, a recent article in the Pakistan press gave a cynical appraisal, observing, in part: "Although Pakistan in fact has a high national doctor - patient ratio for a developing country, both the government and the private sectors give little practical attention to basic health care. Moreover, many are becoming prone to the 'seminar syndrome' with jargon filled conferences on health management systems sponsored by international aid agencies, but little credible work in the field." [26]

cases the infrastructure is available but cannot be utilized in full because of the shortage of funds for personnel, medicines and maintenance." [27, pp. 412-13]

A World Bank health sector review, conducted in 1983, noted that in the 1981-82 health budget, capital expenditures exceeded two-thirds of the operation and maintenance expenditure (compared to a normal one-third relationship for developing countries). The review speculated that this circumstance might be reflective of constrained operating and maintenance budgets, especially in the case of the provincial governments. The Bank review also observed that during the fiscal year periods, 1971-75 and 1976-82, the real value of government operating and maintenance expenditure actually declined. [23, pp. 24-25]

Stevens, in his analysis of health sector financing under the Sixth Plan, expressed strong skepticism regarding the ability of the public sector to meet the recurrent expenditure requirements of the Plan.[9] [8, pp. 10-17]

The Sixth Five Year Plan proposed to introduce user charges for government health services, as a way to meet a substantial portion of the recurrent cost demands under the Plan. In fact, as the draft Seventh Five Year Plan (1988-93) admits, the user fee proposal did not succeed.

The published "Highlights of the Draft Seventh Five Year Plan (1988-93)" cautions: "The limited feasible growth in current expenditure on the social sectors will have to be kept in view while formulating the investment programme for these sectors. Otherwise, physical assets in the social sectors will be

---

[9]Another World Bank report, reviewing the proposed Sixth Five Year Plan, voiced similar skepticism on the ability to meet the health sector's recurrent costs. Noting that health operating and maintenance expenditures were projected at 4 percent of total federal and provincial recurrent expenditure, compared to 2 percent in 1982-83, the report stated, "it is clear that the expansion of health sector operating and maintenance requirements is very ambitious and is likely to run into financial constraints." [6, pp. 117-18]

created whose utilization will not be insured due to inability to bear their operational costs." [7, p.4] However, it is questionable whether the fiscal projections for the Seventh Plan adequately reflect this caveat.

Looking at the recurrent cost burden of the rural health network of rural health centers and Basic Health Units, under the Seventh Plan, the Gross report is dubious about the ability of the provinces to allocate sufficient revenue. Given the generally predominant share of their likely health budgets that is expected to be demanded by the rural facility network, the provinces would face considerable pressure to either severely cut hospital expenditures or to find additional revenue sources. [24]

Pharmaceuticals are a major (and likely inappropriately large) component of recurrent costs. The Gross study found that the cost of medicines represented 40 to 50 percent of many hospital budgets. [24] At present the government health services supply, without charge, those drugs that are stocked by the facility. For inpatients, as well as some groups of outpatients, necessary drugs that must be obtained outside the government facility are also purchased by the government. (The availability and range of stocked drugs seems to vary between different facilities at different levels of government. The federal hospitals seem to have a greater range of available drugs than do the provincial hospitals.)

When the recurrent budget for the fiscal year begins to grow tight, however, some limitations will appear on the supply of free drugs. In March 1988 (four months before the end of the fiscal year) this limitation seemed moderate at Federal Government Services Hospital in Islamabad. Then, the Superintendent in Charge of Stores was simply modestly reducing (for outpatients) the quantities for prescriptions needing to be filled by outside purchase, in some instances, or asking some higher grade federal government employees (entitled to government purchase of all necessary drugs) to purchase

the drugs themselves and obtain reimbursement from the budget of their government department. However, during the following month the budgetary limitation on drugs became extreme at Federal Government Services Hospital. The newspaper, The Muslim, reported on 25 April, 1988:

> The Federal Government Services Hospital, popularly known as "Polyclinic" has run out of its stock of medicines for the fiscal year 1987-88 causing great hardship to indoor as well as outdoor patients.
>
> The hospital sources said that even the supply of medicines and life-saving drugs for the wards have been stopped. The patients of all categories have to rush to the market all the way to procure medicines.
>
> The acute shortage has occurred, the sources said, due to utilization of the entire budget allocation for the current year for medicines falling in the vicinity of around Rs 20 million....
>
> There is a critical and panic like situation prevailing in the hospital as low salaried patients are put to great predicament due to non-availability of even common drugs.... [28]

On 4. June, 1988 (after the announcement by the government, in early May, that it would attempt to freeze non-development expenditure for two years and also after the dismissal of the Junejo government on 28 May by the President), another article in The Muslim commented:

> It is said that the Junejo government seriously thought of putting a cap on non-development expenditures. But scope among them was found to be rather restricted.... It made more sense not to build new hospitals or health units then to build them and not appoint any staff, and not provide any medicines or other aids, although some of these expenditures are now being paid out of development budget. But on the whole the maintenance of existing social community only economic services are part of non-development expenditures. Cutting this is foolish if not suicidal. The old parliament and government were rather hazy about actual priorities....

Options: The proposals offered, in and out of government, for dealing with the recurrent costs problem in health, include increased application of user charges for government health services, privatization of some health services presently operated by the government, introduction of some form of health

insurance and improved efficiency in the production and utilization of government health services.

As noted earlier, user charges for government services were proposed under the Sixth Five Year Plan (1983-88), as a way of meeting a significant portion of recurrent costs during the period.[10] However, the extension of user charges under the Sixth Plan reportedly met with great resistance by the public and, consequently, were mostly withdrawn.[11]

Currently (1988), at Federal Government Services Hospital in Islamabad (one of two federal MOH hospitals)[12] very modest user fees are applied only to those who are admitted to the semi-private 'Officers' Wards' (also know as 'paying wards'), plus (in principle) to those (not employed by the federal government) receiving certain diagnostic tests and who -- in the opinion of the physician -- 'can afford it.' (It is our impression that the application of these diagnostic test fees are fairly casual and that serious collection attempts are not made.) The semi-private room charge, including three meals and "tea," is only Rps 22($1.25) per day, for those who are not federal [illegible]nt employees. Federal government employees (of officer grade 16+) may use the semi-private rooms for a fee (said to apply to the meals there) of only Rps 5($0.28) per day. Non-federal government employees using the semi-private rooms are also (again, in principle) assessed fees for surgical procedures.

---

[10]The specific financing logistics are not clear. We're uncertain whether an arrangement for retention of the charges within the health sector was determined, or whether the charges were to be forwarded to the Finance Ministry -- with recurrent expenditure funding fully drawn from federal or provincial finance ministries.

[11]Some user charges (very modest) were, in principle, applied by the provinces prior to the Sixth Plan. But, as Stevens describes, the collection of the fees (which were income dependent) was not very successful. [20, p.19]

[12]There are also three federal autonomous hospitals.

For one example given, the total fee (including anesthesia, consultant physician and surgery) was Rps 150($8.47). (We were told that this fee schedule was established in 1932.) Again, there is no serious attempt to collect these fees. There are no fees (even in principle) for the general wards.

Although the published "Highlights of the Draft Seventh Five Year Plan (1988-93)" lists, among its proposals for reducing the current account deficit, the imposition of "outdoor and indoor patient fees,"[13] [7, p.4] the health chapter in the draft Seventh Plan, itself, only makes incidental reference to possible user fee extension under the Seventh Plan. (The chapter does as noted earlier, refer to the non-success of the proposal for user fees under the Sixth Plan. Most likely, a significant application of government health service user fees, in the immediate future, is regarded to have poor political feasibility.)[14]

Privatization of health services was also proposed as a major component of the Sixth Plan, which stated: "The Sixth Plan framework is based on a new compact between public and private sector.... There will be significant load-shedding of government's financial burdens so as to mobilize private financing and to enable to the government to concentrate on those functions which it alone can perform." [27, p.14] It was especially hoped that the expansion of

---

[13]Pakistan terminology for outpatient and inpatient is "outdoor" and "indoor".

[14]The Gross study argues that its finding of substantial out-of-pocket payments for health services in Pakistan shows user charges to already be a reality and accepted by consumers. On the other hand, the Gross study also found a preference by consumers for care delivered by private doctors, as opposed to government doctors. [21] Acceptance by consumers of government service user fees will likely be dependent on a perception of improved quality in the government health services.

private hospital capacity would allow the government to reduce its large budget burden in this area.

The draft Seventh Plan, however, acknowledges the substantial failure of the proposed private sector expansion, relative to the established targets: With the addition of 6,000 private sector hospital beds, only 25 percent of the target was reached; and only half of the proposed 10,000 additional private sector doctors was realized. The failure to reach the established goals was attributed to "lack of proper incentives." [8, p.2]

Nevertheless, the draft Seventh Plan lists encouragement of the establishment of private clinics and hospitals among its major policy directions. It seems unlikely, though, that privatization -- at the present level -- will provide much relief to government recurrent costs in the near future.

Improved efficiency in the production and utilization of health services might offer substantial recurrent cost savings. The principle approach of the Seventh Plan towards increased efficiency in the health sector appears to be through efforts to decentralize the health bureaucracy. While these efforts may ultimately be helpful to the recurrent cost situation, the extent and timing of that help are difficult to determine.

It seems that, in large part, health insurance has assumed, in the Seventh Plan, the hopeful role given to user fees in the Sixth Plan for alleviating the recurrent cost gap. Health insurance is prominently referred to, both in the published "Highlights" and in the draft Seventh Plan, itself, though the specific form that will be pursued -- let alone implementation logistics -- are evidently nebulous, at best.

The Seventh Plan "Highlights" notes: "Health insurance will be started, particularly in the urban areas. The burden of health insurance will be on the

employers and for certain critical illnesses, the Government will be responsible up to 80 percent of the cost of the care." [7, p.5]

The draft Seventh Plan, itself, states, among its "major policy directions": "Health insurance, at least, for critical illness will be introduced while Employees Social Security will be extended." [8, p.4]

Later in the draft Seventh Plan: "Health Insurance provides bright prospects of sharing cost of the health care. To begin with all citizens will be offered limited health insurance for critical illness. Health Maintenance Organizations based on the entrepreneurship of health professionals will be encouraged. Employees Social Security will be extended to units employing as low as two persons while this will be extended to non-industrial labour as well." [8, p.24]

And, finally, in the draft Seventh Plan: "Health Insurance will be introduced to reduce the burden on the public purse while social security will be extended to non-industrial sector and user's charges introduced in secondary and tertiary care facilities." [8, p.25]

The health insurance option is further discussed in the following sections.

Present Status of Health Insurance in Pakistan: There is, at present, essentially no private health insurance market in Pakistan. (Reportedly, one insurance company has been offering health insurance to its own executives. There may, also, be a few restricted policies -- mostly accident-related -- in force through other companies.) Federal government employees, as well as employees of the autonomous government agencies, receive certain health benefits. Probably the most prominent health insurance scheme in Pakistan today is that operated by the Employee Social Security Institutions in three of the four provinces. Also, many employers, exempted from participation in the

Social Security health scheme, offer their own health benefit program (usually as a condition of their exemption) to their employees.

The Employee Social Security Institutions (ESSIs) operate in Punjab, Sind and North West Frontier provinces (in which more than 90 percent of Pakistan's population is resident). The Social Security scheme was introduced by the government in 1967 to provide benefits to industrial workers and their dependents. The benefits include certain cash payments, mostly related to inability to work; however, most of the revenue of the semi-autonomous ESSIs supports the health insurance component of the program. The ESSIs cover all workers in establishments with ten or more employees, although there is an opting out arrangement. (If employee representation advises the ESSI that they do not wish their employer to be required to join, the employer will usually be exempted from ESSI membership. This presumably occurs where employers offer health benefits superior to those available through the ESSI.) Membership is also limited to employees earning less than Rps 1,500 per month. Since the elimination of the employee contribution in 1972, the program has been financed by the employer contribution, which is established at 7.0 percent of employee earnings. Government employees, including the autonomous agencies, are excluded from membership.

The ESSIs operate their own hospitals and dispensaries; and they hire physicians on either full or part-time contracts. Health care benefits include inpatient and outpatient care (including specialist care), maternity care, medicines, diagnostic tests, rehabilitation services and some artificial limbs and prostheses. Dental care is also covered. Apparently, the health care

benefits for dependents are somewhat more limited than those granted employees, however.[15]

Stevens, looking at ESSI enrollment statistics for Punjab Province (year to which the statistics applied not clear -- possibly 1981), found 244,000 primary beneficiaries, which, including dependents suggested a total of about 1.5 million beneficiaries. This was estimated to amount to about 70 percent of the eligible ESSI enrollment for Punjab Province at that time. [20, p.42]. However, enrollment in the Punjab ESSI did not increase during the three years subsequent to 1981 (actually declining slightly), standing at 237,303 in 1984. The Sind Province ESSI enrollment also declined slightly during this period, from 167,864 in 1981 to 142,286 in 1984. The North West Frontier Province ESSI, at an estimated 25,000 in 1984, was somewhat above its 1981 enrollment of 21,178 -- though not much changed from its year earlier enrollment of 24,653 in 1980. [24] (We have not seen ESSI enrollment data beyond 1984.)[16]

Contributing factors in the stagnant enrollment levels might include the opting-out arrangement and the earnings limit. It is also possible that employers are managing to evade ESSI enrollment through various measures. The Gross study reports little community or union pressure against employer attempts to evade ESSI enrollment. This lack of pressure against evasion was attributed to the high unemployment in Pakistan and to a second-class stigma of ESSI institutions -- suggested to be due to the exemption of government employees from ESSI enrollment. [24]

---

[15] It has been suggested that many may be unaware of their eligibility for the various cash benefits of the program -- including sickness, injury and maternity leave, death grant and disability and survivors pensions.

[16] Be reminded of various eligibility exclusions, involving government employees, establishments with fewer than ten employees and those whose earnings are above the limit -- Rps 1,000 until 1986 and Rps 1,500 subsequently.

For 1983-84, total income of the ESSIs was Rs 183.7 million (derived from Rs 163.8 million in member contributions -- Rps 404($31.00) per worker plus Rps 19.9 million from other income.) Expenditures totaled Rps 148.0 million and included Rps 102.7 million for medical care, Rps 16.6 million for cash benefits, Rps 23.9 million for administration and Rps 4.9 million for other expenditures. [24]

Efforts to extend ESSI enrollment might include removing the government employee exemption, lowering (from the current ten employees minimum) the size of establishments required to join, raising the salary limit for eligible employees and attempting to reduce enrollment evasion.

As Stevens points out, the ESSI program may be considered responsible for more insurance coverage than is reflected in its enrollment figures. It is possible that for some of the establishments that opt out of ESSI, the independent provision of health care benefits to their employees was encouraged by the alternative ESSI requirement. (Statistics on the non-ESSI provision of health care benefits by employers have not been obtained.)

Federal government employees receive an entitlement to health care services, by virtue of their federal servant status. There is no premium payment, either by the employees or on their behalf by an employer department. The entitlement to health care services is given by the Central Services (Medical Attendance) Rules, 1958, commonly known as just the Medical Attendance Rules (MAR), plus subsequent amendments. Employees of the autonomous government agencies and the military are not covered by the MAR and have their own, separate health care arrangements. Eligibility under the MAR includes current and retired federal government employees, their spouses, dependent children and parents of the employee, if residing with and dependent on the employee. Those eligible to receive health care benefits according to status

as a federal government employee or qualified dependent are known as "entitled" patients.

Entitled patients may seek care directly, without special authorization, from any federal medical facility. The federal government operates two hospitals (Federal Government Services Hospital in Islamabad and Jinnah Postgraduate Medical Centre in Karachi), six medical centers, forty-four dispensaries and nine MCH centers. Federal government employees enjoy no special status, relative to the public at large, at the three grant-in-aid, autonomous hospitals (Pakistan Institute of Medical Sciences in Islamabad, Shaikh Zayed Hospital in Lahore and National Institute of Cardiovascular Disease in Karachi). Entitled persons located in areas where a federal government hospital is not accessible, may utilize a provincial government hospital, after first obtaining authorization from the federally-appointed Authorized Medical Attendant (AMA) for the area. In some cases, where the AMA finds it necessary, authorization might be given to attend a private hospital. In cases of emergency, AMA authorization may be provided retroactively. To the extent that any charges are levied for authorized care from a non-federal facility (including the autonomous hospitals), reimbursement may be obtained by completing certain forms.

There is a modest differentiation of health care benefits for entitled persons, depending on their federal employment grade. Those of grades 16 and above (also known as "Class I Officers"), are eligible for some benefits not available to those in lower grades. The additional benefits available to those of grade 16 and above essentially consist of eligibility to occupy the semi-private "Officers' Wards" (which are air-conditioned and receive superior service), for the trivial charge of Rps 5 per day, and eligibility to obtain necessary pharmaceuticals, not stocked by the hospital, without charge as an

outpatient. (There is no charge for necessary drugs for inpatients, regardless of grade or whether or not the patient is entitled.)

Those in grades 1-15 receive a "Medical Allowance" of Rps 50 per month, which is intended to be used for such uncovered costs as outpatient use of pharmaceuticals which are not stocked by the hospital (but which would be obtained by the hospital, without charge, for those of grade 16 and above). Since the Medical Allowance is modest and might easily be used up, in the case of significant illness experience by a family, a patient of grade 1-15 might also make an appeal to the Medical Superintendent in Charge of Stores at the hospital for purchase of a non-stocked pharmaceutical by the hospital, without charge. Additionally, patients may file specified forms for reimbursement, from their individual government department, for such out-of-pocket expenses as drugs which had to be purchased outside the hospital at personal expense. For amounts up to Rps 1,000, the individual government department may authorize the reimbursement. Higher amounts need to be referred to the MOH for authorization, except in the case of "continued and chronic disease," in which case the individual department may authorize up to Rps 10,000.

While specific health care benefits and limitations are supposedly defined by the MAR and occasional amendments, its seems that very few federal physicians have ever seen -- or even heard of -- the MAR. Most simply say that 'everybody knows what benefits entitled persons can receive.' However, some physicians seem confused -- at least on some points. Since the MAR was prepared thirty years ago, it is somewhat out of date; and there does not seem to be a complete set of subsequent amendments kept anywhere.

Many of those interviewed (at Federal Government Services Hospital and in the MOH) suggested that some priority might be accorded to entitled federal employees at the greatly overcrowded federal hospital. While there was some ambiguity regarding the nature of such priority, as practiced, it was often

said that an entitled patient was less likely to be refused admission in an non-emergency situation. (There was poor agreement regarding the value of entitled status with regard to the lengthy queues in the outpatient departments.

Except for the special benefits for those of grade 16 plus, the health care benefits of entitled persons are mostly the same as those which are supposedly available to the general public. One difference is that where, in principle, non-entitled persons who could afford to pay, would be asked to pay for some diagnostic procedures and tests and for surgery performed (if admitted to a semi-private ward), entitled persons -- regardless of ability to pay, would not be asked to pay. Also, where referral to, or emergency use of a non-federal facility results in any levied fees, only the entitled federal employee could claim reimbursement.

The health care benefit, at authorized facilities, includes treatment without any charge for any inpatient (general ward) and outpatient care, lab tests, X-rays, necessary drugs (as detailed above), vision care, dental care, hearing care, blood and blood transfusions, maternity care, physical therapy, radiation therapy, kidney transplants and ambulance service (if provided by one of the few federal hospital ambulances in the territory served by them).

No prostheses, artificial limbs or durable medical equipment are supplied. In the case of vision care, eyeglasses and contact lenses are not provided. In the case of dental care, fillings are only done with cement; and crowns, bridges and dentures are not provided. Orthodontic services are not covered. Hearing aids are not provided.

An apparently valuable benefit enjoyed by entitled federal employees, is that of referral for treatment abroad, at government expense for medical conditions that cannot be adequately treated in Pakistan. However, though most seem to consider this a guaranteed benefit, it is currently extended as a

special gesture of the President and is not a contractual benefit in the sense of the other benefits. Patients have been referred abroad on the recommendation of one of three Medical Boards (located in Lahore, Islamabad and Karachi) and the subsequent approval of the Prime Minister. The number of patients referred abroad seems to be fairly modest. (The referrals abroad, though available to all grades, appear to strongly favor -- by a ratio of eight to one for a recent period -- those of grade 16 and above.)

Zakat and Ushr are two locally administered funds, operating in the context of Islamic precept, to reduce social disparities. Zakat is funded by a 2.5 percent annual levy on various financial assets. Ushr is collected from every landowner, lessee and grantee at the rate of 5 percent of the produce share (less an irrigation allowance). [1. p.281] While these funds presumably finance some health care needs of poor persons, little detail on this has been obtained.

Rationale for extension of health insurance in Pakistan: Government expressions of intent, in connection with the Seventh Five Year Plan, to extend health insurance in Pakistan suggest a vaguely articulated interest that may, at this point, be open to various approaches -- including public, quasi-public and private orientations. While the MOH has initially, with W.H.O. consultant assistance, been considering a possible health insurance program for federal government employees, commitment to this approach seems uncertain. It seems clear that the government, having experienced great resistance to its user charge effort, is now interested in any form of insurance that can -- with less controversy -- alleviate the recurrent cost burden in the government health sector. Such alleviation might occur either through a public insurance plan that offered cost recovery for public services, or through a private (or

quasi-public) plan that served to reduce the demand (and necessary funding) for public services.

Generally, health insurance offers the potential for improved equity, relative to equivalent cost-recovery user charges, insofar as the funding is spread between both the ill and those fortunate enough to remain healthy. For this reason, there may be fewer complaints (improved political feasibility) in insurance as opposed to user fee funding. By the same measure, the spreading of insurance collections over a broad insured population allows the potential for greater cost recovery than would usually be feasible from user charges alone. It is reported that health insurance arrangements are often popular in developing countries, where populations appreciate (value) the protection against the financial risk of illness.

Health insurance, besides its values in accommodating private risk aversion and improving social equity, can be employed as a tool to raise production and allocative efficiency in the health services sector. This depends on the development of health insurance structures that encourage competition between suppliers of care and that offer internal incentives for production and allocative efficiency. An advantage of Pakistan, relative to the potential for supply-side efficiency through competition, is its relatively large and growing supply of physicians.

It is clear that the potential exists for some experiments in health insurance in Pakistan. (Especially see Attachment I) However, the amount of basic research that needs to be done is enormous if one is to make wise and politically valid policy choices. There is some doubt about the GOP's willingness to support this hard research and/or experimentation. A possible way to proceed was outlined to the GOP (see Attachment I) and some important work has been done in codifying the MAR, a necessary step for any actuarial

study that might be needed for any possible insurance scheme (see Attachment II). A way to proceed was outlined to the GOP during April 4-9, 1988 (see Attachment III). The possibilities are good for insurance schemes, especially those with both public and private components, to be developed in Pakistan but the GOP must be willing to make the commitment to participate in, if not do, all the necessary hard work. So far this had not happened.

Attachment I.

OBSERVATIONS ON HEALTH INSURANCE IN PAKISTAN - FIELD REPORT

Overview/Observations

1. Various concepts and principles of health insurance can be applied to Pakistan. Some brief observations why this is so:

   A. People/consumers presently are accustomed to paying for services in the private sector.

   B. There is an ample supply of well-trained physicians.

   C. There are identifiable, actuarially homogeneous groups (i.e. government employees, employees of autonomous firms, etc.)

   D. There is widespread dissatisfaction with existing public services.

      - Government services are supposedly "free" but long travel and waiting times are involved.
      - Consumer satisfaction with quality of care (in public service) is low.
      - There are great inequities in benefits received from the services by different occupational and/or income groups in Pakistan.

   E. Government of Pakistan resources for health are very inequitably distributed, i.e. people who can afford to pay for publicly provided services do not do so (urban middle class workers) and people who cannot pay for services (i.e. rural people) do not receive adequate free services.

* Mission Report by Professor Ralph Andreano 11/24/87.

2. Government resources for health services are not likely to increase sufficiently in the years ahead.

   - Recurrent costs are high and will get higher and there is insufficient provision to use cost recovery methods (i.e. user charges) to mitigate this problem.
   - Private sector expenditures, now already 70% of the total, will continue to grow.
   - Present inequities in access to services will get more so unless the system of financing of health services is changed.

3. Government of Pakistan is committed to changing the financing system for health care in the 7th Plan and to do so by introducing various insurance schemes.

   - The existing types of health insurances schemes are: (1) a very limited indemnity type scheme for executives administered by State Life Insurance Co., and (2) three social security schemes for industrial workers with contributions wholly paid by employers (currently total contribution is 7% with about 5% earmarked for health services). (ESSI)
   - Federal government employees have their own scheme of care delivered through Federal Government Health Services Hospitals and Polyclinics and governed by the Medical Attendance Rules (1958).
   - Almost all of the autonomous institutions offer health benefits to employees within the premises or on a referral basis to a physician and/or dentist approved panel: such people along with all other citizens not elsewhere covered, are entitled to use government and

provincial hospital services as well. Most private sector firms except small (< 10 employees) non-industrial firms offer some limited but unspecified benefits to employees.

4. The Government of Pakistan's objectives in pursuing this approach must be clearly kept in view at all times.

- To increase resources available to those who cannot pay anything for services and especially to rural areas.
- To mobilize and make efficient, with high public acceptance, the government provincial health services and delivery system.
- To enhance equity in access and distribution of services.
- To enhance the private sector capabilities in extending the health system.
- To keep containment of costs and expenditures of the total health care system (public and private) within the economic capacity of the country.

5. Government of Pakistan has three basic choices:

- It can leave the existing system alone and do nothing. The most likely outcome of this strategy is some of the same of what has been happening in recent years: more and more expenditure will take place in the private sector: present inequities will be further exacerbated; government could continue to privatize hospitals also to facilitate this trend of shifts to private sector, fee for service financing: a likely outcome of this policy would be that some years hence the proportion of GDP being spent on health care would rise significantly and medical care costs and prices would also rise with

the appropriate public outcry about the "high cost of medicine," and what is government going to do about it.

- A second choice is to move the entire population of Pakistan into Social Security-like schemes producing, therefore, a national health insurance system financed by employers, employees, and by general government taxation (to cover those people unemployed or in very small employment units such as agriculture). This would produce a system will all health care facilities and employees under control of one or more of these schemes (there could be <u>one</u> national scheme or what seems more likely for Pakistan, several schemes throughout the nation). There are decided costs and benefits to this strategy; it has the appearance of equity but it does not guarantee this, nor does it guarantee that the health institutions and personnel in the schemes will have the incentives to offer high quality care at the least cost possible. Also, it is not at all clear that this would diminish the support of private sector, fee for service, medicine in Pakistan.

- The third choice is a mixed one; utilizing different kinds of health insurance schemes, extending social security in some possible directions, and permitting some private sector growth under controlled conditions of price and quality. From my observations of the structure of the Pakistan economy and society, it is a mixed system of financing, insurance, public and private that is anticipated by government of Pakistan as it has articulated its ideas in the 7th Plan for health insurance coverage extension.

A Mixed Financing System

1. A variety of approaches seems possible following some general principles; for example:

   - Consumers must be satisfied with the quality of services even if they do not pay much for them; otherwise they will opt out of any insurance plan to seek care in the fee service system. Consumers must have more than one choice of service provider if by exercising their choice they will influence the behavior of providers (i.e. hospitals/doctors, etc.).
   - Providers must have an incentive to offer high quality care going beyond the prescription pad. Provider incentives could be money (i.e. put doctors at financial risk) prestige, equipment, etc.
   - Government must be an active monitor of cost, utilization levels and quality whether or not care is received in the private or public sector.

2. Several types of insurance could be offered so as to segment population groups according to their preferences and their ability and willingness to pay for services.

   - We could offer (publicly or through private sector) catastrophic or major/medical type insurance employment-based and by diagnosis or catagorical levels.
   - We could moderately expand existing social security schemes or initiate some new ones for very well defined groups, e.g. GOP employees.

We could initiate some HMO and PPO arrangements in urban areas among certain select and actuarily homogenous groups.

3. There are some basic things GOP must do to provide the infrastructure for any kind of change in the health sector financing system. For example,

- It must codify minimum benefits in specific detail, it must do so for present benefits received by various groups, and it must specify benefits for any new insurance covered groups.
- It must set standards (even if these are internal standards) on methods of payments to providers when the private sector uses public institutions.
- It must legislate some GOP authority for monitoring costs and expenditures of the system and a quality assurance system. (The quality assurance system should be hospital based but government could outline the process and procedures institutions must comply with - i.e., case review, fees review, infection control, etc.)

How can we start?

1. Conservatively. Perhaps, with a group for which GOP has some direct ability to influence, i.e. its own employees.

- I think we should partition GOP employees into two groups: (1) Grade 1-15, (2) Grades 16-22.
- For Group I we could fashion a social security type model; for Group II we could try an HMO or PPO type scheme.

- We could do both groups on an experimental basis first before extending to the whole of the employees. These experiments could be anywhere but there are certain things we would want to learn from such experiments: such as:

  (a) Costs of care compared to previous system and utilization levels.

  (b) Quality and consumer satisfaction.

  (c) What factors motivate providers? consumers? etc. etc. etc.

  From these experiments we would hope to learn how and at what expected cost we could extend the approaches on a national scale.

<u>What do we need to do to start?</u>

1. Existing benefits for Group I and II must be explicitly codified and criteria set for who is eligible to participate.
2. We must calculate actual expenditures of both groups by government and by themselves and obtain demographic data on employees and dependents.
3. Begin the lengthy process of designing and costing these experiments as well as what we want the experiments to help us with and how to evaluate them.
4. Secure financing of the design of the experiments from USAID, ADB, etc. once we have made a budget based on (3).
5. Assemble a local team in and out of the Ministry to assist with design, monitoring, analysis, and evaluation of the experiments.

Recommendations for D.G. Decisions

1. Begin internal GOP discussion on the need and expectations for the experiments and obtain GOP approval.
2. Begin discussions with key elected officials in Parliament.
3. When approval is granted, appoint a team.
4. Make a preliminary estimate of the cost of designing the experiments and a budget.
5. Secure funding for designing the experiments, if needed.

SOME THOUGHTS ON THE EXPERIMENTS

General

1. We must draw up the exact specification of existing benefits.
2. We must identify the total eligible persons for Group I and II (i.e. do we include retired people, all family, all extended family, etc.).

Group I Experiment

1. Sample size needed.
2. Procedures for assignment of eligibles into experimental and control groups.
3. Design of the benefit package; inclusion of some benefits not now included (i.e. dental, home care, drugs, "Greenchannel," etc.; co-pay variations.
4. Negotiate with hospitals over rates of payment to be charged to the SS funds.
5. Design of the evaluation instrument.
6. Location of sites; assigned beds or dedicated facility?

7. Briefing of medical personnel.

8. Base-line health status, utilization, expenditure levels of experimental and control groups.

Group II Experiment

1. (1-5 plus 7 above)

2. Discussion with private physicians; decision on how many HMO's we want to have formed.

3. Setting of incentives needed to attract physicians.

4. Actuarially pricing the capitation fee.

5. Fixing the enrollment period and educational and marketing steps needed.

6. Preparing RFP for physician groups to bid on.

7. Bidder conference - Telling bidders what the capitation fee covers, what their risk is, etc.

8. Negotiating instruments for HMO's to use with hospitals and other provider (a variation; we could select the hospitals and negotiate for the HMO's but the capitation fee must include hospitalization and drugs).

9. Profiles of practice patterns of MD's and assurance that there is an appropriate blend of general medicine and specialists in HMO's.

Miscellaneous thoughts about the experiments.

1. Both experiments should last long enough to get statistically valid data to make inferences on a national extension.

2. We might decide in advance for either the Group I or II experiments if we want to add (invite?) participation in the experiment from appropriate autonomous institution groups (i.e. general employees might be in Group I executives, middle and upper management in Group II).

3. For all experiments expected benefits and costs should be listed in advance even if all cannot be quantified.

Other Experiments/Programmes (Longer-term)

1. Begin/invite private insurance companies to design and price a major medical/catastrophic insurance policy under government specification. Test market in private sector.

2. The Zakat (family welfare funds) for possible community based/financed insurance scheme in rural areas.

3. Try HMO's, PPO's in some other groups by GOP stimulation and formation of clinic group practices in private sector.

Attachment II.

HEALTH CARE BENEFIT ENTITLEMENTS OF FEDERAL GOVERNMENTS SERVANTS (DRAFT): CODIFICATION OF MEDICAL ATTENDANCE RULES (MAR)

This interpretation of the health care benefits, to which Federal Government Employees (FGEs) are entitled due to their employment status, is based on an understanding of the Central Services (Medical Attendance) Rules, 1958 (hereafter referred to as the MAR), supplemented by the advice of Ministry of Health officials consulted and by advice from interviews with staff members operating the various clinics and other units at Federal Government Services Hospital (FGSH), in Islamabad. Some additional information was obtained by limited visits to Federal Government (FG) dispensaries and one Provincial Government (PG) hospital, Rawalpindi General Hospital, as well as the federal autonomous hospital in Islamabad, Pakistan Institute of Medical Sciences (PIMS). An improved interpretation of the actual FGE health care benefit might have been obtained from visits to other FG hospitals, in Karachi and Lahore. While such visits were recommended by the MOH, circumstances have not allowed the visits to be made thus far.

Eligibility

According to the MAR, the health benefits apply to "all Government servants, other than (i) those in railway service; and (ii) those in inferior service whose conditions of service are prescribed by rules made or deemed to be made by the Central Government, when they are on duty or on leave or under suspension in Pakistan or on foreign service in Pakistan." The various federal

* Part of Mission Report, Dr. Thomas Helminiak, 7 March - 9 April, 1988.

Locations where health benefits may be obtained

Entitled persons may seek care directly, without special authorization, from any federal medical facility. (The FG operates two hospitals, FGSH, in Islamabad, and Jinnah Postgraduate Medical Center (JPMC) in Karachi. The FG also operates six medical centers, forty-four dispensaries and nine MCH centers. There also are three grant-in-aid, autonomous hospitals, PIMS, in Islamabad, Shaikh Zayed Hospital, in Lahore, and National Institute of Cardiovascular Disease (NICVD), in Karachi. At PIMS, Islamabad (a tertiary care facility, but presently operating without any referral requirements), all services are now provided without any charge to all patients, whether FGE/entitled or general public.)

FG servants located in areas where a FG hospital is not accessible, may utilize a PG hospital after first obtaining authorization to do so from the official in the area who is designated by the FG as the Authorized Medical Attendant (AMA). In some cases, where the AMA finds it necessary, authorization might be given to attend a private hospital. In cases of emergency patients can seek care from FG or other facilities, if necessary without the prior authorization of the AMA. In these cases, subsequent authorization of the AMA would need to be obtained for the emergency treatment from the non-federal facility. To the extent that charges are levied for any services obtained from a non-FG facility (including the grant-in-aid hospitals, if they levy charges), reimbursement may be obtained by the FG servant, assuming AMA authorization has been obtained, after filling in the appropriate forms.

[MAR sections 2.(f)(i) and 2.(f)(ii), which differentiate between certain benefits available to Class I FGEs and those not in Class I (that is, Grades 1-15) seem to suggest that Class I FGEs might more readily obtain care at their residence though even here authorization by the AMA appears necessary.

autonomous bodies and the military are not covered by the MAR benefit. (These have their own, separate health care benefit arrangements.)

Both current and retired FG servants, plus specified members of their families are entitled to the MAR health care benefit. Specified family members who are also entitled include the wife, or husband, of an FGE. Additionally, legitimate children and step-children "residing with and wholly dependent" on the FG servant are entitled. (Sons and step-sons are considered wholly dependent until they complete the age of 18 years, after which they will only be considered dependent if certified by the FG servant. Daughters and step-daughters are considered wholly dependent until they are married, after which they will only be considered dependent if certified by the FG servant. An FGE wife or husband is entitled as long as not "judicially separated.") MAR amendments have extended the entitlement of family members to also include the parents of the male or female FG servant who are residing with and dependent on the FG servant. (An MAR explanation notes that the "expression 'residing with' shall not be so construed as to exclude any member of the family of a Government servant wholly dependent upon such servant but not actually resident with him, as for example, the son or daughter of a Government servant studying at a place other than his headquarters, or the wife of a Government servant temporarily away from such headquarters.")

There is some differentiation of the entitled health care benefit between both (1) currently employed FG servants and retired servants; and (2) Class I (that is, those of Grade 16 and above) and those not in Class I (that is, those of Grades 1 to 15). This differentiation is described in the outline of individual service benefits, below.

Subparagraph (ii), dealing with non-Class I FGEs, uses the language, "illness which compels the patient to be confined to his residence," whereas subparagraph (i), dealing with Class I FGEs, excludes this restricting phrase. Nevertheless, it is not known that Class I FGEs do more readily obtain AMA authorization for residence care than non-Class I FGEs.]

Members of Parliament and FG servants in grades 21 and 22 are allowed to utilize military hospitals on referral. (This is by special authorization from the Prime Minister.)

Specific health care benefits and limitations

Outdoor treatment: FG servants may report directly, without referral requirements, to any FG facility (dispensary, medical center, or hospital) they choose and obtain a medical consultation without any charge. There is no limitation on the number of times any person can obtain a medical consultation. De facto limits may operate in terms of staff limitations, relative to demand for consultations, resulting in waits of perhaps an hour or more at FGSH, for example. Similarly, these staff limitations, cause consultations to be brief, perhaps less than a minute. Some believe that the FG servant may, sometimes, be given some priority -- resulting in a shorter wait for a consultation. Similarly, it is suggested that the FG servant will be given somewhat better attention in the brief consultation than the general public. Neither of these points, however, is given in the MAR. The actual application of priority treatment for FG servants is at FGSH was not verified.

Indoor treatment: Patients can obtain indoor treatment from any FG hospital, without charge. There is no limitation on the number of days of indoor treatment that may be obtained without charge. All indoor hospital services, including surgery, are also without charge to all entitled patients. All

medicines considered necessary for treatment of the indoor patient are supplied without charge. (All indoor hospital services, including medicines, are also provided to non-entitled patients, without charge.) As noted previously, where either a FG hospital is not accessible, or there is a referral to a non-FG hospital, any charges levied may be reimbursed, given that there was prior authorization by the AMA to use the non-FG hospital (unless it was an emergency).

While the crowding (with apparent 100 percent occupancy at FGSH), may result in some patients being unable to obtain indoor treatment (in non-emergency situations), it is said that FG servants are given priority when they require indoor treatment. (One doctor remarked that they are obligated to admit a FG servant, even if it means putting 2-3 patients in a bed.)

For indoor treatment, admission to "Officers' Wards" (also known as "paying wards"), which at FGSH are two-bed rooms) is allowed to Class I Officers, of Grade 16 and above. Here there is only a nominal meal charge, amounting to (at FGSH) just Rps 5 per day, covering all meals and tea. (In hospital general wards, there is no meal charge.) (In Rawalpindi Government Hospital (a FG hospital), the meal charge in the Officers Wards is Rps 10 per day.)[Regarding indoor treatment, the MAR specifies treatment including "such accommodation as is ordinarily provided in the hospital and is suited to his status" (section.(1)(iv).]

Lab tests and X-rays: All necessary laboratory tests and X-ray procedures are available to FG servants without cost, assuming they are ordered by a doctor at a FG facility, or by an AMA for performance at a non-FG facility. If the diagnostic procedure is done at an FG facility, there will be no charge to the

patient. If done at some other facility where there is a charge to the patient, the patient may seek reimbursement through the reimbursement forms process. There are no limitations regarding the number or the expense of the necessary tests that may be obtained by the FG servant. If the tests are not available at a FG facility, referral will be made to whatever facility can provide the tests and reimbursement for any charges may be obtained.

Drugs: [According to the MAR, section 2.(i)(ii) and 2.(i)(iii), entitlement includes: "the supply of such medicines, vaccines, sera or other therapeutic substances as are ordinarily available in the hospital; [and] the supply of such medicines, vaccines, sera or other therapeutic substances not ordinarily so available as the authorized medical attendant may certify in writing to be essential for the recovery or for the prevention of serious deterioration in the condition, of the Government servant". While no amendment of the MAR, relating to the supply of drugs to entitled patients, has been obtained, the application of the rule regarding drugs not ordinarily available in the hospital is somewhat different.]

Entitled indoor patients, regardless of grade, are supplied with whatever drugs are considered necessary by the doctor, whether or not available in the hospital, without charge to the patient. [This is the case for the non-entitled, as well.]

In the case of outdoor treatment, those in grades 1-15 and all retired FG servants are only entitled to obtain those drugs that are available in the hospital, without charge. Those in grades 1-15 receive a "Medical Allowance" of Rps 50 per month, which is intended to be used for such uncovered costs as drugs not available in the hospital. (Since the Medical Allowance does not

vary by size of family and since the Rps 50/month may quickly disappear for any significant drug requirement, patients of grades 1-15 may make a plea, to the Medical Superintendent in Charge of Stores (at FGSH) for an exception to the rule. Apparently, such exceptions are usually granted; the signature of the Medical Superintendent in Charge of Stores (on the medicine slip which prescribes the drug) allows the patient to obtain the drug from the "Local Purchase" section at the hospital.) Those in grades 1-15 may also purchase, out-of-pocket, a drug that is not available in the hospital and seek reimbursement, by completing a reimbursement form. For amounts up to Rps 1000, the individual department of the FG servant may authorize the reimbursement. Amounts in excess of Rps 1000 must be referred to MOH for authorization, except in the case of "continued and chronic disease," in which case the individual department of the FG servant may authorize up to Rps 10,000.

Retired FG servants are not entitled to obtain any prescribed drug (by an FG doctor), without charge, through the Local Purchase section of the hospital.

[In cases of budget stringency for the hospital (which tends to occur during the last few months of the budget year), the Medical Superintendent in Charge of Stores may begin to restrict local purchase authorization. Persons, including Class I officers, may be asked to purchase the drugs out-of-pocket and then seek reimbursement.]

Vision care: All vision care services and procedures are supplied without charge, except for procedures considered a luxury (such as intraocular lens transplants). For procedures that cannot be done at FGSH (such as detachment operations and laser treatment for bleeding coagulation) there is referral to

JPMC, without charge to the patient and with transport provided. Eyeglasses and contact lenses are not covered under the MAR benefit.

Dental care: Most dental services, including extractions, dental surgery and fillings are provided. Dental fillings are only done with cement; silver alloy is not provided. Crowns, bridges, dentures or any other prostheses are not provided. Orthodontic serves are not provided.

Hearing care: Hearing care services are provided; however, hearing aids are not provided.

Prostheses, artificial limbs, durable medical equipment: Not provided.

Blood and blood transfusions: These are provided without charge. (Blood donations from the relatives of patients are requested; however, if this is not possible, the blood transfusions are still provided without charge.)

Ambulance service: Ambulance service is provided if a FG ambulance is used. However, at FGSH, only three - four ambulances are effectively available for patients (not counting those reserved for Parliament, visiting dignitaries and breakdowns). Also, the FGSH ambulances do not go beyond the Islamabad District boundary.

Maternity care: Maternity services are provided without charge.

Physical therapy: Physical therapy services are provided without charge.

Immunizations: Immunizations are provided without charge.

Radiation therapy: Radiation therapy is provided without charge. (Not available at FGSH, but available through referral to JPMC, Karachi.)

Organ Transplants: Kidney transplants are provided without charge.

Referral abroad: Regarding medical conditions that cannot be adequately treated in Pakistan, referral for treatment abroad, at Government expense, may be granted. However, (contrary, apparently, to popular impression) referral abroad is not an entitlement under the MAR; rather such referral abroad is being granted as a gesture of the Prime Minister and the President. Thus, such referral abroad is not part of the law and could be withdrawn. Patients are sent abroad on the recommendation of a Medical Board (there are three -- located in Lahore, Islamabad and Karachi) and subsequent approval of the Prime Minister.

Attachment III

Suggested Steps and Timetable Recommended to GOP

on Health Insurance

8 April, 1988

April/May 1988:

1. Appoint Special Team (or Working Group) on Health Insurance.
2. Write terms of reference for the Team.
3. Convene first meeting of the Team.
4. Begin limited work on updated MAR and Expenditures.

Notes: (a) The team should be small and empowered to bring onto the staff for limited periods of time others to do special tasks as required by work plan. Two types of individuals on Team:

(1) prestigious individuals

(2) working staff, inside and outside of MOH

(b) Dr. Khan should be Chairperson of this Team and designate someone inside MOH to act on his behalf when he is not available.

May/June 1988:

1. Special Team prepares a work-plan and budget.
2. Ralph Andreano visits Pakistan to meet with Team and to elaborate work plan and budget.

June - December 1988:

All work is completed, policies available for adoption, a limited number of options ready for adoption in 1989.

REFERENCES

[1] Akhtar, R., Pakistan Yearbook 1985-86, East and West Publishing Company, Karachi-Lahore, 1985.

[2] Qureshi, M. L., Planning and Development in Pakistan, Review and Alternatives 1947-1987, Vanguard Books Ltd., Lahore, 1984.

[3] G.O.P., Pakistan Basic Facts, 1985-86, Government of Pakistan, Finance Division, Economic Adviser's Wing, Islamabad, 1986.

[4] Rashid, S. A., I. Kazmi, S. H. Rizvi and S. Haq, "Health Care Financing, Pakistan," Unpublished paper prepared for Asian Development Bank Conference on Health Care, Manila, 27 July - 3 August, 1987.

[5] G.O.P., Monthly Statical Bulletin, Vol 35, No. 4, April, 1987, Government of Pakistan, Statistics Division, Federal Bureau of Statistics.

[6] World Bank, Pakistan, Review of the Sixth Five Year Plan, The World Bank, Washington, DC, 1984.

[7] "Highlights of the Draft Seventh Five Year Plan (1988-93)," The Pakistan Times, Lahore, March 10, 1988, pp. 4-5.

[8] G.O.P., Draft Seventh Five Year Plan (1988-93), Chapter 16, Health and Nutrition.

[9] G.O.P., Monthly Economic Statistics, Sept. - Oct. 1987, Government of Pakistan, Finance Division, Economic Adviser's Wing, Islamabad.

[10] National Bank of Pakistan, Monthly Economic Letter, Vol. 15, No. 1, January, 1988, p. 11.

[11] "Living beyond our means," [Editorial] The Muslim, Islamabad, April 23, 1988, p. 4.

[12] Batt, B. I., "Drastic cut in expenditures to diffuse economic crisis," The Muslim, Islamabad, May 12, 1988, p. 6.

[13] Institute of Policy Studies, Pakistan State of the Economy, 1986-87, Report of a Working Group, March 1987, Institute of Policy Studies, Islamabad, 1987.

[14] Khan, A. M., "First year of 7th plan - financing problems," The Muslim, Islamabad, May 9, 1988, p. 7.

[15] G.O.P., Federal Budget in Brief, Financial Year 1986-87, Government of Pakistan, Finance Division, Islamabad, 1986.

[16] G.O.P., Federal Budget in Brief, Financial Year 1987-88, Government of Pakistan, Finance Division, Islamabad, 1987.

[17] Hashmi, A., "Two year freeze proposed on non-development spending," The Muslim, Islamabad, May 9, 1988, p. 1.

[18] Lodhi, M., "Pakistan running out of economic options: Dr. Haq," The Muslim, Islamabad, May 29, 1988, p. 7.

[19] Bukhari, J., "Tax system lacks elasticity," The Muslim, Islamabad, June 5, 1988, p. 9.

[20] Stevens, C. M., "Alternatives for Financing Health Services in Pakistan," December 1983, unpublished (U.S.A.I.D.).

[21] Khan, A. M., "Some thought for budget," The Muslim, Islamabad, May 7, 1988, p. 7.

[22] Lodhi, M., "World Bank withholds $200m sector loan to Pakistan," The Muslim, Islamabad, April 24, 1988, p. 1.

[23] World Bank, Pakistan Health Sector Report, World Bank Report No. 4739-PAK, Population, Health and Nutrition Department, September 30, 1983.

[24] G.O.P., "Health Sector in Pakistan, A Financing and Expenditure Study," Draft Final Report, Government of Pakistan, Ministry of Planning and Development, Planning and Development Division, Technical Assistance Project Cell, unpublished, (1987-1988) [Note: This report, at the time references were drawn from it, had not yet been accepted by the Government of Pakistan. Information based on references to this report should, therefore, be treated cautiously. Page numbers from the copy reviewed were not legible; consequently, it was not possible to cite specific pages.]

[25] Khan, A. H., "Rising imports of drugs and medicine," The Muslim, Islamabad, April 7, 1988, p. 7.

[26] "Priorities in health," [Editorial] The Muslim, Islamabad, April 22, 1988, p. 4.

[27] G.O.P., The Sixth Five Year Plan 1987-88, n.p., n.d.

[28] Qureshi, S., "Polyclinic without medicines 'but not for the privileged'," The Muslim, Islamabad, April 24, 1988, p. 8.

[29] Ahmed, N., "Budget Making Simplified," The Muslim, Islamabad, June 4, 1988, p. 7.