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NHP

December 18, 1987

Mr. Andrew Creece
Division of SHS
World Health Organization
1211 Geneva 27
SWITZERLAND

RECEIVED IN REGISTRY
WHO-GENEVA
23. DEC. 1987
TO BE RETURNED TO: REG

Dear Andrew:

Enclosed is my report of my recent mission to Pakistan 17-27 November, 1987.

It consists of the following:

1. My report of the mission.
2. A copy of a recent letter of mine to Dr. Khan.
3. A copy of the brief written report prepared in Islamabad and discussed with Dr. Khan.
4. An assessment of local research talent.
5. A list of all persons visited (referred to as references in my report).
6. A copy of Dr. Khan's ideas on health insurance.

I believe I will be in Geneva from 4-15 January 1988 doing some work for Michel Jancloes and Dr. Khana. I hope we can have some time to discuss this material and some ideas I have about how to proceed in anticipation of your visit to Islamabad in March 1988.

Cordially,

Ralph

Ralph Andreano
Professor of Economics

Enclosures

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A

Report on Mission to Pakistan 17-27, November 1987
Professor Ralph Andreano

Overview

I was more than well received by the DG, Dr. Khan. Dr. Nabhil, the WR, was out of the country during my stay through I did meet him briefly in Dr. Khan's office. I was provided with a car, driver, and guide (Dr. Lahdi, a Medical Officer at the Federal Government Hospital) and other resources as requested. Dr. Khan was generous with his time and he made several appointments himself for me to see people. All in all, it was treated as a high level mission by GOP and Dr. Khan and I have nothing but praise for all the officials officials, especially Dr. Khan, for the time and energy they put into my mission.

The GOP has nearly finished its draft of the 7th five year plan (1989) and it includes language on instituting a program of Health Insurance throughout the country. The language is a bit vague, but it seems they are contemplating some type of catastrophic (or major medical) insurance and perhaps an extension of the Social Security Funds (now 3 in all, for industrial workers only, and run by the Provincial governments). The situation, I think, is very fluid and nothing definite is yet in place or even contemplated. A carry over from the 6th Plan, namely to use the private sector, will also likely be used in the insurance initiative. Most advise the GOP seems to be getting is from USAID and the World Bank has also financed (partially with AID) a large household survey (referred to in my report as the Paul Grosse survey). There is ample scope for WHO to be a key player here because I believe Dr. Khan wants a less controversial source for his technical guidance. Dr. Kahn, however, seems committed to a large scale expansion of Social Insurance but his ideas are still malleable and he is receptive to new ideas. I found him extraordinarily bright and articulate and I like him enormously. He has been designated by GOP

as the key player in any insurance program though most of the ideas for health insurance have been hatched in the Ministry of Planning (Reference 26).

I never had any discussions with the DG regarding recurrent cost issues and he wanted only to talk about health insurance. As you can see from my brief report to him written while still in Islamabad, I proposed some experiments using only GOP employees. I believe he is committed to doing whatever they do in insurance first with GOP employees. He was non-committed regarding some experiments. I do think, however, he bought my ideas about being conservative and about slowing the process down until we could be sure we had an adequate data base from which policy could be assessed.

Finally, I have extensive notes from all the interviews and I am using only a distilled version of these notes in this report. Two points standout from these interviews: (1) there is general dissatisfaction by consumers about the quality and availability of the so called "free" public services, (2) the private medical sector is huge and growing larger. Another generalization from the interviews is that GOP is really undecided about what to do regarding the health sector; in particular they do not see how to blend the public and private sectors and how (or if) health insurance can be the financing vehicle to do this. The political problems here are great and, I think, recognized by the DG; I don't know about the rest of the GOP (thought not on my list of reported contacts, I did visit briefly with the Parliamentary Secretary for Health, whose name I have neglected to write down, but she was extremely articulate and sensitive to the political issues inherent in any new financing option for health).

A lot of money is being made by MD's in private practice (though I did visit a few in the deepest poverty areas of Rawalpindi who could not be making very much) so there is some likelihood the private doctors will resist any new

insurance (financing) options if they perceive it will lower their income. I don't really think Dr. Khan appreciates this and his views of the private sector, I think, are a bit naive: not all the private doc's behaved as he did when he was in private practice. I am attaching to this report Dr. Khan's brief memo outlining his ideas on health insurance.

World Bank Study (Paul Grosse)

An extensive data set now exists that will be extremely useful for any GOP initiatives in Health Insurance. This study includes the following major data sources; a 10,000 household, Household survey on health care, financing, etc.; a large interview survey with private physicians, private hospitals, private employers, and autonomous agencies; extensive analysis of the drug sector. I am not going to recount all the preliminary findings from the Grosse study but it is an extremely rich data source and will be invaluable to the GOP (Dr. Khan, by the way, did not know about the study but I secured a copy of it for him from USAID). Several things do stand out from the study, however:

1. Private sector payments are twice the size of government expenditures.
2. People prefer private practice (by about 2-1) even if they have to pay.
3. Private physicians favor some scheme of health insurance but fear it will damage their FFS business.
4. The Social Security schemes are not popular with physicians because they lose some control; the ESSI schemes operate somewhat like preferred provider schemes in the U.S.
5. Drug costs (and abuse) are outlandish.
6. There is some support for community financing schemes through the Zakat (family welfare funds).
7. The supply of physicians is very large but widely maldistributed.
8. The private sector doc's and hospitals seldom buy any capital equipment.

9. Private hospitals for the most part do make money and their influence is growing especially in Karachi and Lahore.

10. People are not willing to pay user charges at Government facilities because of long waiting times and poor quality of services; but people are willing to pay for services they perceive to be "good".

Recommendations

I believe WHO should make a real effort to be of help to GOP on health insurance. I think we should offer someone to Dr. Khan for a month or so to get some of the basic data together. I also believe some high level WHO advisors should be dispatched to Islamabad (I think Dr. Khan wants this) periodically to help workout a coherent policy for GOP on health insurance. The process issues, for political reasons, are almost as important as the technical issues of design and implementation. I don't think GOP realizes how big the problem is and the kind of political opposition that could be mustered against any scheme if not promoted in the right way and with the proper incentives for all the key players.

Assessment of Local Research/Policy Analysis Resources - Islamabad

The local talent available to do economic analysis, policy related research is limited. Economists at the two local universities are few and not so much interested in micro issues as they are in growth, development and macro issues. (Reference 7) Still there is a lot of local talent available, especially recently retired high officials of government, capable of doing good research. There is a Health Economics Research Center (Reference 3) that has done some contract research and at least one of the researchers there (Reference 4) seemed well qualified. (I read 2 of his papers and had extensive personal discussions with him). The Director of NIPS (Reference 18) also seemed a live wire and very much capable of directing research and policy analysis. The physical facility is also good and he seems to have a cadre of recently retired government economists that he uses from time to time. The Institute for Development economics is a moribund place even though they have several Ph.D.'s from good universities. They have no interest in health though of course if research money were available I'm sure some talent there would be forthcoming. This is one place we should explore further.

One of the most articulate and sharpest persons I met was the Chief Executive for the Regional Development Finance authority. (Reference 19) He also had extensive smarts regarding the ins and outs of health insurance. He indicated that there were "young" economists in Islamabad who could do research but they are scattered throughout government but not in the Universities. But he said he would need time to develop the contacts. This, too, is an area worth pursuing.

Also impressive was the Chairman of Gallup Pakistan (Reference 8) who has a Ph.D. from MIT in Political Science. Most of his work is private sector polling and market research but he seemed also to think that local economics research talent could be developed. He impressed me and I think he is someone who could be used to develop some local talent.

List of Persons Contacted - Islamabad - Rawalpindi
November 17-27, 1987

1. Professor Dr. A. J. Khan, Director General, Health.

2. Dr. Safder-ur-Rehman, Deputy Director General, Health.

3. Dr. M. Mohsin Mubarak, Research Director, Health Services Research Centre, (HSRC).

4. Mr. Aqueol, M.A. (Econ), Researcher at HSRC.

5. Mr. H. U. Beg, Formerly, Secretary of Finance. *

6. Dr. Muhammad Afzal Ezaz, President, Pakistan Medical Association, Punjab.

7. Mr. Sarfraz Khan Qureshi, Joint Director, Pakistan Institute of Development Economics, Quaid-i-Azam University (PIDS).

8. Dr. Ijaz Gilani, Chairman, Gallup Pakistan.

9. Dr. Javed Irshad, Dental Surgeon, Rawalpindi.

10. Dr. Irshad Muhammad, Dental Surgeon, Rawalpindi.

11. Dr. Munawwar Hussain, Ex. Director, Medical Services and Management Consultants, Karachi.

12. Dr. David Dunlop, USAID (Visiting Consultant).

13. Mr. Raymond Martin, Chief, Office of Health, USAID.

14. Mr. Jacques Tawil, Area Manager, SOGREAH, Consulting Engineers (France).

15. Dr. Ali Masood Akram, Ex. Director, Pakistan Institute of Medical Sciences (PIMS).

16. Dr. A. Majid Rajput, Deputy Director, (PIMS).

17. Dr. A Hafeez Akhtar, Chief, Department of Medicine Islamabad Hospital Complex.

18. Dr. M. S. Jillani, Chief Executive, National Institute of Population Studies (NIPS).

19. Mr. Muzaffar Mahmood Qurashi, Chief Executive, Regional Development Finance Corporation.

20. Dr. Zafar Lodhi, Medical Officer, Federal Government Health Services (Dr. Lodhi acted as my guide, interpreter, translator, etc.).

21. Dr. Nadeen-ur-Rehman, Medical Officer Detoxification Center, PMA House, Rawalpindi.

22. Mr. Saeed Rashed, Statistian, Private Consultant (has a PC).

23. Dr. Inamil Haq, Drug Controller, Ministry of Health.

24. Dr. Mazhar Hussein, Private Physician with clinic in Rawalpindi.

25. Dr. Inam and Dr. Hafiz Akhter, Twin Cities Medical Center, Rawalpindi.

26. Dr. Siraj-ul-Haq Mahmud, Director of Planning GOP. *

27. The WHO Country Representative was out of the country during my visit but I met him briefly on the day of my arrival in Dr. Khan's office.

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MADISON 53706

DEPARTMENT OF ECONOMICS
Social Science Building
1180 Observatory Drive

December 9, 1987

COPY

Dr. A.J. Khan
Director-General of Health
Ministry of Health, Government of Pakistan
Islamabad
Pakistan

Dear Dr. Khan:

I want to thank you most profoundly for all the courtesies you extended to me during my recent visit to your lovely country. I very much enjoyed our discussions and I hope to have the pleaure again of serving you, your government, and the people of Pakistan. I believe, as I told you, that initiation of health insurance principles in Pakistan is very feasible. Much will depend on how large a factor you want insurance coverage to become integrated into the financial structure of health services in the country. Also, how much of a role you want the private sector to play will also be an important issue. As we discussed there are a number of possible models to pursue in Pakistan including the one you seem to like a lot namely of using some of the social insurance funds as a starting point to introduce insurance principles. In my brief written report to you and in our personal conversations I stressed that it is best to proceed conservatively and cautiously so that we can have success with any program first on a modest scale before extending activities nationwide. I do think, as I believe we discussed, that several approaches should be pursued and not just one approach. I had suggested to you some modest experiments with government employees and even if these were done there is an enormous amount of planning and research that would have to be completed if these programs were to be given the best chance to succeed. I think it would be very good if you could visit some other countries where similar experiences with extending health insurance could be instructive for Pakistan. In particular we discussed South Korea, Thailand and Malaysia. If you wanted to see some of the less desirable aspects of social insurance funds at work nearly any South American country would do. Perhaps Mexico would be a fair place to see.

Also as I noted in our discussions there are those very important pieces of work that should be undertaken as soon as possible. This work is necessary whatever you decide you want to do in the way of health insurance in the country:

(1) The medical Attendance Rules for GOP employees must be filled in by codifying existing practices in GOP hospitals and clinics. What I mean is that we must write out in detail the actual benefits and services that employees now get from the hospitals and clinics. This is essential if we are to price the insurance on the basis of benefits received.

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(2) We must calculate actual, total expenditures by government (including drugs) and out of pocket costs by employees on all services whether covered or not by Medical Attendance Rules.

(3) We must extract from the World Bank financed Household survey (the study I showed you and we discussed) a separate computer run for all government employees.

As I mentioned to you I am quite prepared to come again, perhaps in late February or mid-March, to supervise the doing of this basic research. I want to stress that these things need to be done no matter what model(s) you decide to pursue so long as we are focusing on government employees as the basis of any program. I am going to be in Geneva from 4-15/16 January of next year and will have further discussions with Andrew Creece at that time. If you are in Geneva I do hope we can visit. In the meantime, I wish you the best success in your important responsibilities and trust the new year will be a good one for you and the people of Pakistan.

Respectfully,

Ralph Andreano
Professor of Economics

RA/sod

cc: Andrew Creece, WHO Geneva

OBSERVATIONS ON HEALTH INSURANCE IN PAKISTAN

PROF. RALPH ANDREANO 11/24/87

Overview/Observations

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 indentifiable, actuarily 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 (in public services) quality of care 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.

2. Government resources for health services are not likely to increase by very much if at all 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 ~~gt~~ be 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) ~~a provisionally operated~~ Three social security schemes for industrial workers with contributions wholly paid by employers (currently total contribution is 7% of 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 alongwith all other citizens not elsewhere covered, are entitled to use government and provincial hospital services as well. Most private sector ~~promote~~ FIRMS except small (<10 employees) non-industrial FIRMS offer some limited but unspecified benefits to employees.

4. The Government of Pakistan objectives in pursuing this ~~approved~~ Approach must be clearly kept in view at all times.

- To increase ~~, by shifting,~~ 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 ~~complete~~ 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 ~~above~~ 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 pri~~ritize~~VATISE 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 ~~used~~ 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 employees, employee, and by ~~general~~ GENERAL government taxation (to cover those people unemployed or in very small employment units such as agriculture) This would produce a system with 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 ~~clinic~~ 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 ~~increasing~~ exercising their choice they will influence the behaviour 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 <u>new</u> 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 procedure institutions must comply with - i.e., case review, fees review, infection control, etc.).

<u>How can we start?</u>

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 ~~more~~ 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 ~~compated~~ compared to previous system and utilization levels.

  (b) Quality and consumer satisfaction.

  (c) What factors ~~must~~ 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.

What do we need to do to start?

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 ~~Grant~~ GOJ. 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. Assembly 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.

15

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 Groups 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 ~~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 ~~may~~ MANY HMO's we want to have formed.

3. Setting of incentives needed to attract physicians.

4. Actuarily 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 stimulating and ~~leaing~~ formation of clinic group practices in private sector.

Postcript

A more complete and fuller version of this report will be completed when I return home and will be sent to D.G. I must also prepare a report of my mission for WHO which, in due time, will also be forwarded to GOP.

INTRODUCTION OF HEALTH INSURANCE SCHEME

A PROPOSAL TO START THE HEALTH COVER THROUGH INSURANCE IN PAKISTAN

C O N T E N T S

		Pages
1.	Introduction	1 - 2
2.	Present Hospital System	2 - 3
3.	Health Insurance Scheme for Insurance Executives	3 - 4
4.	Social Security Scheme for Industrial Workers	4 - 5
5.	The Present Proposal	5 - 6
6.	OUtline of the Health Insurance Proposals for Salaried persons earning over Rs.2000/- per month/ The premium and benefits.	6 - 7

INTRODUCTION OF
HEALTH INSURANCE SCHEME

A PROPOSAL TO START THE HEALTH COVER
THROUGH INSURANCE IN PAKISTAN

by Dr A K Ko

1. INTRODUCTION:

Insurance has become a part of modern living - life insurance, general insurance, fire, accident and may other kinds of insurance. Health Insurance is an important part of it in all developed countries and many developing countries.

In Pakistan not much has been done in regard to health insurance. New Zealand Insurance Company has been covering a limited number of company executives for the last 20 years or so. A few other insurance companies have also been providing a very limited cover to only a few people and that too only for accidents or restricted hospitalization on reimbursement basis. The employees Social Security Scheme was introduced about 25 years ago by the Government for the Industrial workers, it seems to be providing good service to the low paid employees.

In the developed inustrial countries, health insurance has played a major role in the development of medical services and medical facilities for the people. In many countries, most of the hospitals belong to the insurance companies, and in many other countries health insurance schemes are run by the Government. Some of these schemes are limited only to a few benefits and in case of others more comprehensive health cover is provided. In countries where health insurance schemes are run by private insurance companies,

Contd.....P/2.

these schemes have always been very profitable both to the patients and to the companies, so much so that the Governments have to make certain rules and regulations to control the excessive profit making by these private commercial insurance companies.

In Pakistan insurance companies were prosperous; but due to lack of training and knowledge of health insurance and the risks involved, no company seriously entered in this field. If they would have taken interest, then by this time many hospitals owned by the insurance companies would have been built and the pressure over the facilities provided by the Government would have been considerably lessened.

As a matter of fact, health insurance is needed more in a country like Pakistan than anywhere else. We inherited an old-fashioned hospital system from the British, which was completely abandoned in their own country in favour of a health insurance scheme called National Health Service, in 1948, but we are still continuining with it.

2. PRESENT HOSPITAL SYSTEM:

This system, the reminiscent of the British colonial days, is based on the fact that the Government is responsible to provide free medical care to its servants and to the ~~servants~~ ' servants. As far as rest of the public is concerned, either they should not fall ill or if they do they should arrange to pay themselves or receive a second-rate treatment, i.e. hours of standing in the queue and receive some plain coloured water or buy their own medicines. Many people who have understood the uselessness of this coloured water and importance of their time wasted in waiting, run to the

Contd ...

21

private doctors and hospitals. At these private hospitals standard of service is better, but thdse are expensive and run mostly on commercial basis, so the poor suffers have to pay a lot for the service they receive. It is for these people that a Health Insurance Scheme is very much needed n and is essential.

Insurance companies covering the health scheme will provide their own hospitals and in this way they very poor hospital bed ratio of Pakistan i.e. 6 beds for 10,000 population (as against 80 in the USA and 25 in Turkey) will become a lot better.

Now that most of the insurance business is State controlled, there are tremendous opportunities for the State Life Insurance Corporation or a new Insurance Company to provide health cover to the public through a well planned health insurance scheme.

3. HEALTH INSURANCE SCHEME FOR INSURANCE EXECUTIVES:

State Life has already taken a step in this direction by introducing a health insurance scheme for its own executives on a limited scale. On paper the scheme appears good, but in practice there are many short comings in the scheme therefore, this scheme did not become popular with most of the persons it covers, because of the following reasons:

(i) The cover does not provide the service, but only the reimbursement. It means that the patient must spend the money first, get the receipts and then claim, and receive the reimbursement. All persons may not have ready money available with

Contd.....P/4 22

them to spend first resulting in hardships to the sufferers.

(ii) The procedure of reimbursement is cumbersome even for the isured executives.

(iii) The system can exact cheating, as it may not be difficult to get bogus receipts from chemists or even doctors - as is often complained in case of Government's reimbursement Scheme to the Government servants.

(iv) For those deserving, the cover is limited.

(v) Even with the advice of All friends and relatives, it is not easy for the insured to get to the right doctor or right facility at the right time. This guidance is not available.

There are other draw-backs as well, however, this was at least a beginning and efforts can allways be made to improve the system.

4. SOCIAL SECURITY SCHEME FOR INDUSTRIAL WORKERS:

Regarding the Social Security Scheme, this is a compulsory scheme for the industrial workers. This is a very useful health insurance scheme. Most of the insured are very happy and satisfied with it. Others specially at smaller places are not that satisfied because the scheme does not have its own health facilities.

As the scheme is for the low paid industrial workers, these secured workers do not receive a sympathetic approach by the management of the scheme. The management makes the workers feel as if they are distributing alms to the poor and not as if they have paid for it and they deserve the attention and respect. The hospital card is also poor

Contd.....P/5.

because of the want of their own hospitals inspite of huge funds collected (now they have started building their own hospitals). However, this scheme has to be streamlined.

5. THE PRESENT PROPOSALS:

The present proposal for health insurance can be divided into 3 phases:

(i) An insurance cover is provided to the government employees earning Rs.2000 and above (i.e. Basic Pay Scale 17 and above) or those private individuals who want to participate in this scheme.

(ii) Improvement of the Social Security Scheme of Industrial Workers and including in it all industrial and commercial personnel earning upto Rs.2000 per month.

(iii) Provision of a simple health cover scheme for the farmers and the rural workers.

The first priority is given to those earning over Rs.2000 per month. These are the middle-class people, the backbone of the country's economy. These are educated people and they will understand the importance of insurance and their cooperation and understanding will spread the idea of health insurance to others who cannot or do not understand it. In view of their education, it will be easier to manage the scheme successfully with them. Once it is successfull, the State Life Insurance Corporation can approach the Government for the control of the Social Security Scheme, organisation

Contd.....P/6

for improvement and its enhancement to include all persons earning upto Rs.2000 per month in it.

Later a wide-spread scheme for the rural workers and farmers can be developed and by that time the whole health insurance system should be so well knit that every single person all over the country receives a reasonable medical cover.

6. OUTLINE OF THE HEALTH INSURANCE PROPOSAL FOR THE GOVERNMENT EMPLOYEES EARNING OVER RS.2000 PER MONTH.

(i) Initially it should be a voluntary scheme and not compulsory. The premium may be calculated on number of persons insured in one town, city or area.

(ii) The Vovernment should pay Rs.100/- per month and the insured Rs.50/- per month as premium.

(iii) This will cover the person insured, his wife, children and parents.

(iv) They will be provided free outpatient treatment, free investigations, free hospitalization and free surgical operations. Free consultations and free emergency cover.

(v) The premium for private persons should be on individual basis, but group should be given concession. as all types of persons will included.

(vi) Regarding private companies it should be entirely up to the companies (employers) participating in it to decide the share of contribution between them and their employees.

(vii) Whatever share the employee will pay, it should be income tax free.

(viii) Any person not salaried who wishes to join, should also be taken in the scheme with a little increased premium.

Contd.....P/7.

25

(ix) The premium can be paid monthly, quarterly or yearly.

(x) Complete cover should be provided to the insured.

(xi) The insurance company should have its own hospitals, outpatients, medical and para-medical staff. Until such period that they builds their own hospitals and other facilities they can have contracts with present private hospitals or Government hospitals.

Certain exclusions will have to be made, where facilities by the Government or through the Workmen Compensation Act (life vaccination and immunization or industrial injury etc.) are available.

Full details of this scheme and its working can easily be eleaborated. For this a meeting of the expert in Insurance the Health, the Finance, the Establishment, Social Welfare and Planning Ministry may be called to discuss the detail. First the scheme should be introduced with the Federal Government employees in cities, later the scheme can be extended to the Provincial Government employees and the employees of the Autonomous bodies.

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