Joint Progress Review
of Social Health Protection Initiative in Khyber Pakhtunkhwa

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Joint Progress Review of Social Health Protection Initiative in Khyber Pakhtunkhwa

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List of acronyms

BISP	Benazir Income Support Programme
BMZ	Federal Ministry of Economic Cooperation and Development (*Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung*)
DoH	Department of Health
GIZ	*Deutsche Gesellschaft für Internationale Zusammenarbeit*
GoKP	Government of Khyber Pakhtunkhwa
HCC	Healthcare Commission
HMU	Health management unit
HSRU	Health Sector Reform Unit
ICD	International Classification of Diseases
IPC	Inpatient care
IT	Information technology
KfW	KfW Development Bank (*KfW Entwicklungsbank*)
KP	Khyber Pakhtunkhwa
MIS	Management information system
NADRA	National Database & Registration Authority
NGO	Non-government organisation
NSER	National Socio-Economic Registry
OPC	Out-patient care
OPM	Oxford Policy Management
PKR	Pakistani Rupee
PBP	Performance based payment
PMNHP	Prime Minister National Health Program
PMT	Proxy means test
PMU	Project Management Unit
PR	Public relations
SECP	Security and Exchange Commission of Pakistan
SHP	Social health protection
SHPI	Social Health Protection Initiative
SLIC	State Life Insurance Corporation

ToR	Terms of reference
UHC	Universal health coverage
WHO	World Health Organization

Foreword

Post 18th amendment, the health care system in Pakistan has undergone major structural changes. There has been a considerable power shift to the provinces, particularly at the policy level, making individual health financing strategies a provincial subject. In this regard, Government of Khyber Pakhtunkhwa (GoKP) has taken a leading role by introducing a Social Health Protection Initiative (SHPI) scheme known as the "Sehat Sahulat Programme". The overall goal of this programme is to improve the health status of the targeted population through increasing access to quality health services and to reduce poverty through reduction of out-of-pocket payments for health expenditures.

The GoKP was not only willing to spend its resources to roll out the SHPI programme but has also expressed interest in its expansion in recent times. Not only has there been a considerable increase in population coverage since the launch of the programme, but there has also been expansion in terms of targeted districts. During this endeavor, the government has emphasised the importance of collaborative and integrated efforts by all the stakeholders. Considering social health protection as a new concept in Pakistan, it is further stressed that Health Department of GoKP should address programme design processes and related arising issues on a regular basis.

In this regard, the *"Joint Progress Review of the Social Health Protection Initiative in Khyber Pakhtunkhwa"* is a very good example that Health Department has just conducted. We acknowledge the efforts of GIZ Pakistan who commissioned an International Consultant of AOK International Consulting, specialising in health financing and health systems management, to support this task. Recommendations coming from the review would benefit the programme team for the successive phases of the scheme.

SHAHRAM KHAN TARAKI
Senior Minster Health
Government of Khyber Pakhtunkhwa

Preface

Social health protection is an important tool that helps in making health care accessible to everyone and aids in reducing poverty and inequality. A key objective lying behind the SHP concept is to achieve universal coverage leading to effective access to essential health care for all in need. Effective access to health benefits is only possible when certain conditions are met. For instance, it requires a right-based approach, affordability of necessary health care, availability of necessary health services which are of adequate quality and last but not least financial protection.

Based upon these core values, 'Sehat Sahulat Programme' of the Government of Khyber Pakhtunkhwa (GoKP) was launched in four districts of KP under phase I. Initially, 21% of the poorest households were given coverage and 30% was excepted to purchase it, thus covering 51% of the population. However, soon after its implementation, noticeable improvement in the health status of people was observed, which has encouraged the government to expand the programme to 69% of the population of the province. Given health as a priority, GoKP is further planning to start similar nature of schemes especially for the handicapped, government employees, artists, and judiciary of the province.

As a regulator of the scheme, GoKP has the perspective that expansion is worthwhile provided that there is proper monitoring, evaluation and feedback. The current *"Joint Progress Review of Social Health Protection Initiative in Khyber Pakhtunkhwa"* exhibits the government's strong commitment and its devotion to the cause. The review takes all the stakeholders of the scheme on board including purchasers, providers and regulators and programme beneficiaries to analyse the initial project design, related key processes like enrolment, empanelment, claims processing, provider payment and resource generation. The idea of involving all actors has come from the fact that an integration approach is best to make such schemes successful.

Lastly, I convey my gratitude to GIZ Pakistan and AOK International Consulting for their support and to all those who provided their thoughtful inputs to this review, which will hopefully lead to the betterment of the programme.

MUHAMMAD ABID MAJEED
Secretary to Government of Khyber Pakhtunkhwa
Health Department

1. Preamble

1.1 Background

With support of the German government through KfW Development Bank (KfW) (Support to Social Health Protection, BMZ no. 2009 66 168), Pakistan started to introduce its Social Health Protection Initiative (SHPI) in selected districts of the province Khyber Pakhtunkhwa (KP) and in Gilgit-Baltistan; of which the latter is not included in this review. The benefits of the programme's insurance scheme include maternity care, non-maternity hospitalisation, and post-hospitalisation assistance. In principle, one insurance policy covers a household of up to seven members but allows for extending coverage to additional members for additional costs.

Based on the Benazir Income Support Programme (BISP) launched by the Pakistani government in 2008, which provides targeted social assistance to the poor including 1,000 PKR cash transfers to vulnerable families, the Sehat Sahulat Programme was launched in early 2016 to protect these groups from high out-of-pocket expenditures, further impoverishment and indebtedness due to healthcare expenditures (Najab & Khan 2015: 3). A particular design feature of the SHPI programme is the full subsidisation of contributions for the poorest population quintile in the target areas. Beneficiary households are identified through data from the Benazir Income Support Programme (BISP) - a government agency providing various social-protection and mostly cash-transfer programmes.

Entitlement to BISP benefits is defined according to National Socio-Economic Registry (NSER) data. Based on a targeting survey realised by a proxy means test, the NSER assigns poverty (or PMT) scores to households. The poorest 21% of the SHP target population in KP have a PMT score below 16.17, which has been specified as cut-off score for fully subsidised enrolment into the SHPI scheme. The German Government provides Rs. 1233.256 million out of Rs. 1399.156 million financial support for Phase I of the programme in KP through KfW and technical assistance through GIZ in order to subsidise the implementation and initial activities of the SHP programme. These include preparatory studies and assessments, capacity building of stakeholders, sensitisation and information campaigns, and particularly the payment of contributions on behalf of the target group.

The programme aims to cover inpatient service costs in selected public and private hospitals by fully subsidising insurance coverage for the poorest population share in four out of 26 districts. In Phase I, the yearly contribution was fixed at PKR 1,700 per household of up to seven members, and the benefit package covered secondary-care inpatient costs up to PKR 25,000 per beneficiaries and year.

The Sehat Sahulat Programme comprised two stages, starting with the selection of appropriate insurance companies, which had to have sufficient experience in health insurance, organisational capability, quality of human resources and an adequate approach to the Programme. The second stage was content-related and aimed at preparing the elaboration of implementation proposals under the guidance of the Health-Sector Reform Unit (HSRU). Basic design features comprised the following areas:

i) selection of the target group: beneficiaries of the Benazir Income Support Programme (BISP)
ii) definition of the insurance unit: households comprising one household head, one spouse, up to four children + one elderly dependent person, e. g. parent of the family head
iii) services covered: inpatient care plus outpatient maternity care up to a ceiling of 25,000 PKR per beneficiary and year.[1]

For generating the needed resources, the programme set the yearly contribution per household at 1,661 PKR to be paid by the provincial government on behalf of the beneficiaries. Provider payment occurred cashless according to a detailed fee schedule that was in principle the same for public and private providers. The underlying PC-1 for programme Phase I defines the following objectives and indicators:

General Objective	To improve access to health services by the poorest population groups in the programme region through a reduction of financial barriers and the strengthening of the quality of health service provision. At the end of the project the health status of the population in the intervention districts will have improved and its poverty levels decreased.
Outcome Indicators	1) 21% of the poorest households in the intervention districts enjoy social health insurance coverage. 2) At least a further 30% of the non-poor district population purchases health insurance products, so that total coverage would exceed 51% of the population. 3) Out-of-pocket expenditure by insured households for inpatient care reduced by at least 51%.

GoKP 2013: 2

As implementing partner, the programme selected the consulting firm Oxford Policy Management (OPM), which can look back on longstanding experience in Pakistan. The above-mentioned objectives, outputs and indicators are reflected in the following programme indicators which had to be achieved with OPM support:

[1] These descriptions apply to Phase I of the programme rolled out between end of 2015 and December 31, 2016. Meanwhile, in Phase II, which started in January 2017, the scheme broadened coverage to another 1,800,000 households up to a PMT score of 24.51, thus covering an additional 30% of the population; at the same time, it extended the benefit package significantly by increasing the ceiling for secondary care, including tertiary as well as other benefits (N. N. 2017). In Phase II, the SHPI scheme covers the following:

- Secondary care: PKR 30,000 per member
- Tertiary care: PKR 300,000 per household
- Wage replacement: PKR 250/admission (3 days, 1 day elimination period)
- Funeral costs: PKR 10,000 per death during admission
- Transportation: PKR 2,000 referral to tertiary hospital

Programme indicator 1	100% of eligible poor households covered by subsidised health insurance' It is expected that all eligible households are covered by the programme.
Programme indicator 2	Over 50% of district population purchasing health insurance in order to control adverse selection, and keep utilisation rates in acceptable ranges, i. e. between 3 and 4 % for secondary level hospital care, implementing partners must cover at least 50% of the district population.
Programme indicator 3	Insured population utilisation rate of covered hospital care 3-4 %
Programme indicator 4	Out-of-pocket expenditure by insured households for inpatient care reduced by at least 50%

Naylor et al. 2011: 13f

The programme log frame defines a total of seven outputs to be achieved during the implementation, which implies a series of general changes regarding stakeholder capacity and the incorporation of certain procedures in day-to-day activities. Outputs 2 and 7 refer directly to capacity building objectives, outputs 4 and 6 consider the implementation of standards for improving quality of care, output 5 reflects the intention to realise demand-side financing for the public sector, and output 3 reflects the logic of improving management and quality of care through marketable products.

Output 1	Output 2	Output 3	Output 4	Output 5	Output 6	Output 7
Implementing partners are selected, Project memorandum between Government of Pakistan and KfW is signed, MOU with Provincial Governments are signed	Imlementing partner's capacity is strengthened in selected areas.	Implementing partners offer insurance products on a continuous basis to the district population and exempt the poorest 21% of households from paying premiums.	A hospital accreditation policy is enforced in hospital providers contracted by insurance implementing partners.	Public hospital providers use fee income obtained from insurance implementing partners to improve quality of care standards	Selected public and private hospitals apply uniform treatment protocols for a set of common conditions requiring hospitalisation.	The Provincial government in KP and GB built up significant experience in the stewardship of private health insurance providers.

1.2 Rationale behind the review

Recently, the Government of Khyber Pakhtunkhwa (GoKP) has taken the decision to further expand its social health protection programme to 69% of the population and to all districts of KP. Before starting this further roll-out of the SHPI scheme, the GoKP required a review of the progress made so far against the declared objectives and design of Phase I according to PC-1 (GoKP 2013). The provincial Department of Finance has asked the project to come up with a midline review of the process and intends to transfer the lessons learned from the review into the new expansion phase and furthermore to justify its costs. In this regard, the Department

of Health, Khyber Pakhtunkhwa requested the GIZ project "Support to Social Protection – Social Health Protection (SP-SHP)" to assist the SHPI team to design and facilitate a review of the progress made during the implementation of the project, and develop recommendations for continuation and upscaling of the initiative together with all stakeholders involved, including the implementers KfW and OPM.

Since the SHPI programme had been in operation for almost two years, the joint review takes into account the progress made against the initial project design and particularly against insurance specific key operational tasks such as enrolment and beneficiary management, resource generation, healthcare provision, claims processing, provider payment, and regulation. Detection and analysis of relevant topics were based on individual interviews, intensive desktop study on data provided by the project and its partners and other sources available. The findings were validated jointly with key stakeholders such as the health insurance provider (SLIC), health care providers (selected empanelled hospitals) and regulatory bodies; they also incorporated selected beneficiary perspectives.

Key objectives of a joint review were:

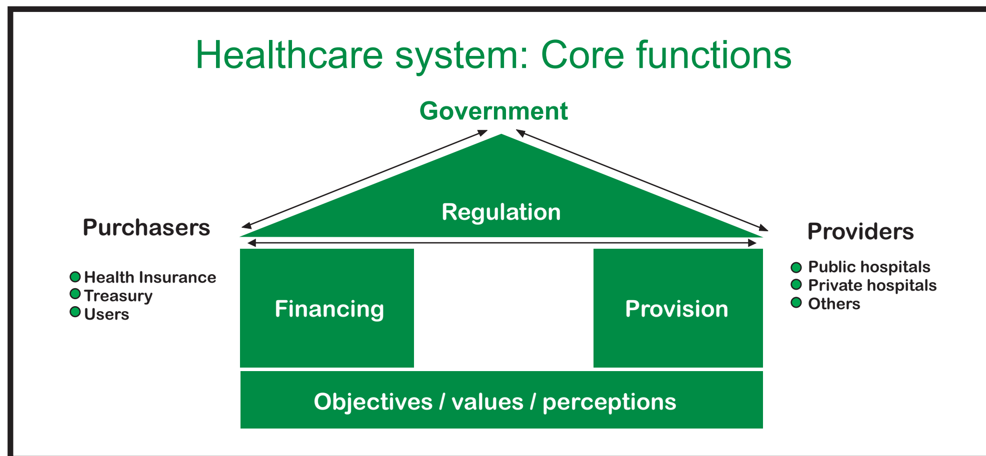
1. Assess the progress of the initiative in light of the key outputs as mentioned in the PC-1 of Phase I (ADP No. 192, Code No. 110614 Year 2013-2014);
2. Benchmark key processes against documentation and data made available by SHPI, SLIC and other stakeholders (OPM, KfW);
3. Identify key learnings and gaps from the implementation experience and formulate recommendations towards improving process relevant to ensure the intended outcome for the beneficiaries;
4. Present recommendations for rational expansion of the initiative.

1.3 Approach of the review

This progress review is not a third-party evaluation of the programme but a joint effort for assessing the current state of affairs in view of forthcoming perspectives and needs. Hence, the focus did not primarily lie on the objectives, indicators and outputs of the implementation project as such but on relevant performance areas of health insurance. Based on the theoretical framework of healthcare systems and their core functions as designed by the World Health Organization (WHO), the review will focus on priority areas of operation of health insurance schemes.

This approach derives from the understanding that health systems can ultimately be reduced to three basic functions, with key stakeholders responsible for each of them. Beyond health service provision, which is the most visible and familiar component of the health care system, health financing and regulation of the health-care sector are essential and indispensable functions of health systems and have to be equally taken into consideration. Hereby, healthcare provision refers to the way inputs such as money, personnel, equipment and drugs are combined to allow the delivery of health interventions or actions. Health financing comprises the mobilisation of funds, the allocation of available resources to regions, population groups, disease pattern and health services, and the remuneration of healthcare providers.

Finally, health care regulation refers to interventions mainly initiated by public authorities to balance unequal power of stakeholders and to correct market failures in order to safeguard access for all and ensure compliance of all actors in the health sector. In accordance with the above-mentioned key functions of healthcare systems, stakeholders in the sector can be assigned to three stakeholder groups: purchasers, providers and regulators.



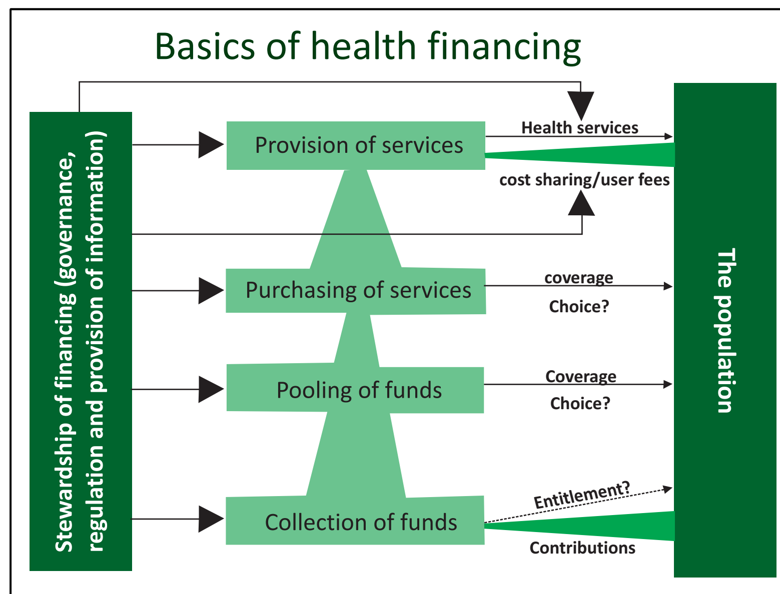
Own presentation

Health financing is obviously a key task of health insurance being responsible for raising funds for health, reducing financial barriers to access through prepayment and subsequent pooling of funds in preference to direct out-of-pocket payments, and allocating or using funds in a way that promotes efficiency and equity (WHO 2017). Contribution-based health systems[2] delegate resource generation, pooling of funds and provider payment to third parties, which are responsible for ensuring access to needed care for their beneficiaries and for managing the respective fund flows. Provision (or delivery) of health services refers to the way inputs such as money, staff, equipment and drugs are combined to allow the delivery of a series of health-related interventions. Last but not least, for a healthcare system to become functional, an overarching regulatory framework is required for establishing rules of the game and a common institutional framework.

With regard to the priority objectives of the review and in order to assess key insurance processes such as enrolment, health financing and health-service provision as laid down in the ToR, this appraisal applies the analytical concept described above. Data collection, information gathering and the workshop held during the mission of this consultancy in Pakistan were clustered around the following six areas, which are crucial for operating health-insurance: (1) Beneficiaries, (2) resource generation, (3) health-service provision, (4) claims processing, (5) provider payment and (6) health-sector regulation. The review relies on information gathered from representatives of the three stakeholder groups as well as from selected beneficiaries. This approach generates comprehensive overview and insight, delivers

[2] This term refers to those health systems where resource generation is mainly based on contributions to be paid as a precondition for being entitled to take out health services; this term is more generic because it included social health insurance, private health insurance, government-borne health insurance, company-based insurance, micro-insurance as well as health savings accounts.

appraisals from different angles and, hence, provides a triangulation of findings. At the same time, the one-by-one assessment of the above-mentioned key functions of healthcare systems facilitates the critical appraisal of the Sehat Sahulat Programme and allows to draw systemic conclusions, which tend to get lost when focusing on particular problems and specific day to day issues.



Source: Kutzin 2008:10

2. Findings regarding health-insurance performance

2.1 Beneficiaries and enrolment[3]

Available contracts, manuals and rules for enrolment

The roll-out of Phase I of the Social Health Protection Initiative (SHPI) in Khyber Pakhtunkhwa (KP) started with an awareness and initial enrolment campaign run by non-government organisations (NGO's) hired for this particular purpose. On the one hand, the campaign comprised information spread by mass media, and on the other hand, events at local level during which insurance cards were handed over to the beneficiaries. State Life Insurance Corporation (SLIC) drafted the necessary contracts for outsourcing this task to NGO's following general requirements. The contracts defined the duties and responsibilities of the two parties, including the operative requirements of the successful bidder. However, no further guidelines or operation manual were applicable and available. As the contract determined the timely and financial framework but not the objectives to be achieved, NGO activities ended before all eligible beneficiaries had been enrolled.

Table 1: Organisation development funds used for procurements in 2016

Item	Allocated Amount	Amount Consumed	Balance Remaining
Community Mobilisation / Awareness			
Community Mobilisation	15,000	0	15,000
Awareness & Brand Presence	3,200	0	3,200
Marketing Contractor	4,800	0	4,800
SLIC-managed Awareness Campaigns			
Health Seminars	1,600	0	1,600
Radio	12,000	12,000	0
Television Commercials	10,000	10,000	0

Source: SLIC 2017: 28;
Source does not provide currency!

After round 1 of the enrolment campaign, it became clear that a relevant share of the target group had not yet been reached. Thus, SLIC engaged another NGO for a second round of the enrolment process. However, the effect of round 2 remained limited except for Malakand where the number of households enrolled increased by more than 23%, while it grew just by 10% in Mardan and did not have any measurable effect in the two other districts as shown in table 2 below.

[3] Corresponds basically to Programme Objective 1

Achievement of enrolment targets

The enrolment process turned out to be more challenging and time consuming than expected. Identifying eligible households from the data base provided by Benazir Income Support Programme (BISP) was cumbersome due to outdated data sets, which had to be revised and cleared up, and to BISP data transfer into the SLIC system. Despite these challenges, a high share of eligible households and individuals did register into the Sehat Sahulat Programme during Phase I as shown in the following table:

Table 2: Enrolment data per district

Name of District	Total Population	Population exempt	Households exempt
Chitral	403,691	84,775	10,731
Malakand	619,108	130,013	15,952
Mardan	1,935,249	406,402	48,381
Kohat	762,411	160,106	21,348
Total target population	**3,720,459**	**781,296**	**96,412**

PC-1: p. 17

According to these figures and estimation that the total population in KP was 21,137,659 when the programme started, the programme targeted initially 17.6% of the total population in the province, and the population share to be covered free of charge under Phase I was 3.7% of the KP population.[4] After the initial awareness and enrolment campaigns, SLIC has stepwise taken over the task to register and enrol beneficiaries in the SHPI scheme making use of its country- and province-wide network of offices and agents; however the marketing strategies hitherto applied to selling life insurance required and still requires adaptation to be suitable for selling health insurance products.

Table 3: Health-insurance cards distributed in 2016

District	Target	Round 1	Round 1+2	Net effect round 2	% Enrolled
Mardan	49,000	40,955	45,168	4,213	92.18%
Malakand	18,000	13,197	16,289	3,092	90.49%
Kohat`	22,000	15,706	15,706	0	71.39%
Chitral	11,000	7,896	7,896	0	71.78%
Total	**100,000**	**77.754**	**85,059**	**7.305**	**85.05%**
				Average	*81,46%*
				Stand.dev.	***11,42%***

Sources: SLIC 2016: 4, SLIC 2017: 10;
Shaded part of the table: calculations of the author

[4] This figure shows the dimension of the expansion from the first stage up today.

Overall enrolment in Phase I included 85,059 households or 85% of the target group that comprised altogether 680,472 individual beneficiaries (Source: SLIC). It is interesting to observe the large variation in coverage rates between the four pilot districts: Percentages of coverage rates differ for about 20 points showing that the enrolment campaign was significantly more effective in Mardan and Malakand than in Kohat and Chitral. In its 2016 progress report, SLIC explained the relatively low enrolment rate in Kohat with the need to trace many internally displaced persons; in Chitral, lack of infrastructure aggravated by severe weather conditions made enrolment cumbersome (SLIC 2016: 12). The 2017 report states that 15% of the target population could not be located because "it is nearly impossible to enrol 100% of a specified target from an old data set. This target population tends to be more transient, with no real trail for tracking them down". In fact, a high level of informality, the lack of a proper resident's registration system and population mobility make it very ambitious to aim at enrolling 100%. Beyond infrastructure and accessibility issues, these inter-district differences require careful analysis in order to elaborate purposeful strategies for the further rollout of the programme.

With regard to the objective to cover "at least a further 30% of the non-poor district population which purchases health insurance products, so that the total coverage would exceed 51% of the population", the programme still has to produce notable outputs. Voluntary health-insurance products developed by SLIC in Phase I did not achieve market maturity. This was not so much attributable to the development of the design and its approval within SLIC itself, but mainly to legal formalities and binding requirements for getting formal approval and licensing of the Security and Exchange Commission of Pakistan (SECP).[5]

Enrolment process

During the initial enrolment phase, both SLIC and the NGO's contracted for conducting an awareness campaign and the handover of insurance cards adhered to the procedures and processes designed for enrolling the target group into the scheme. The enrolment essentially proceeded according to the rules of the game, except for the initial stage when local politicians intended to take over card distribution events and to personally and politically benefit from the enrolment process.[6] Attempts to usurp the implementation of health-insurance cover were observed in several occasions but have thereafter gone down significantly; however, worries persist that further expansions of the scheme might expose card distribution activities to the risk of political usurpation.[7]

[5] The SECP licensed the voluntary health insurance product to be marketed by SLIC only in September 2017 and, thus, in Phase II. Since the voluntary health-insurance product will be available only from Phase III onwards, this review does not provide details beyond the fact that it was not provided during Phase I (and II).

[6] Information gathered from key informants and corroborated during the workshop.

[7] Appraisal expressed by key informants during the workshop.

Effectiveness of the awareness campaign

As mentioned above, the insurance company outsourced communication to NGOs as third parties that were responsible for public-relations (PR) campaigns in the media and the distribution of insurance cards. In absence of a defined communication strategy and work plan, awareness creation, sensitisation and expected enrolment of (potential) beneficiaries in the scheme were essentially provided as isolated and time-limited activities and not seen as ongoing and permanent tasks. This approach did not only underestimate the needs for successfully addressing a population with a very low or even absent level of knowledge that requires much more sensitisation. People first have to understand the concept of health insurance, which hitherto had hardly been known in Pakistan. Moreover, creating awareness and enrolling beneficiaries into social health protection is not a one- or two-time effort but a continuous and essential task of insurance providers and requires adequate resource allocation within the scheme.

In the initial phase of the programme, SLIC did not fully take over responsibility for the enrolment process; the purchaser, in fact, financed the enrolment activities but sourced out the responsibility for carrying out the PR-campaign and thus gave away essential tasks at the expense of losing control over the results. The effectiveness of the card-distribution process was successful as far as the handout of insurance cards was concerned (as shown in Table 3) but the level of awareness provided by the NGOs was limited: According to SLIC's assessment, beneficiaries could understand and remember a few characteristics of health insurance but were unable to remind more detailed technical aspects (SLIC 2016: 12).

Data management in beneficiary enrolment

SLIC has successfully designed and implemented a beneficiary registration and management system for enrolling beneficiaries and updating membership data. Based on data provided by BISP, which had been updated and completed afterwards, SLIC has set up a comprehensive and detailed beneficiary data base, which is also available online for all stakeholders on the Sehat Sahulat Programme Website. The online data retrieval is slow but provides a number of important data focussing particularly on the following topics:

- Beneficiaries enrolled
- Beneficiary data used for member count → contribution collection
- Health Expenditure for services → provider payment (cf. 2.5).

It remains, however, unclear who the keeper of the beneficiary and other data is. Only SLIC experts in information technology (IT) have currently full direct access to the database and can extract information, whereas the management and technical staff within SLIC as well as in the government depend on IT people to extract the data needed for monitoring enrolment, utilisation, expenditures and other relevant issues. Moreover, the MIS system is not yet prepared for automatic processing required for smoothly managing health-insurance schemes, e. g. provision of aggregated data sets and control operations such as the detection of unusual utilisation patterns according to district or provider. In this regard, the MIS is not yet fully

functional and needs further inputs for effectively supporting monitoring and decision-making.

Another crucial issue is confidentiality of the data compiled in the system. Following a demand from the GoPK, SLIC made the database accessible without password protection or any other restriction. Providing open access to confidential data such as people's health status and services taken out is a major problem and needs to be resolved as soon as possible. Although transparency is highly desirable for such an innovative and important strategic project, it however has to be carefully weighed against the personal right to privacy. Making all individual information accessible for everybody reflects a wrong understanding of transparency. The general public should have access to accumulated and elaborated data showing the performance of the SHPI scheme but not to any individual and personal information.

a) First instalment of 10% cost of annual premium for the total beneficiary population of the covered area shall be paid to the State Life, within one month of the signing of agreement, upon mobilisation of services and receipt of detailed Inception Report and respective invoice.

b) Second instalment of 85% in the first year and 80% in the subsequent years of the cost of premium shall be paid to State Life within 30 days of receipt of necessary documents related to enrolment/registration of beneficiaries, in the format to be developed by State Life with covering detailed interim report and Invoice, verified by the Consultant.

c) Third instalment of 5% in the first year and 10% in subsequent years of cost of premium shall be retained and paid by the government to the State Life within 30 days of the receipt of the detailed Interim Report and Invoice (with necessary verifiable documents) after verification of additional enrolment of 2.5% for the first year, 4.5% for second year, 6% for third year, 7% for fourth year and 8% for fifth year of the general population of the district. No payment shall be retained after enrolment of 28% population of the district.

GoKP 2015:10

2.2 Resource generation

Raising sufficient funds for providing needed health services to beneficiaries is one of the core functions of health insurance. Resource generation for the SHPI scheme is established via fund transfers from the Treasury of the province of KP. The terms and conditions of the contribution payment of the government to the insurance provider are clearly regulated in the corresponding PC-1 as shown above

Hence, contribution payment on behalf of the beneficiaries depends basically on the number of enrolled households. Furthermore, the transfer of funds is bound to a proof of enrolment in the first two years and additionally to achieving the enrolment of a certain population share.

Table 4: Transfers from GoKP to SLIC

Year	Contributions		
	Billed	Received	Outstanding
2016	136,908,395	130,874,425	6,033,970
2017	106,722,677	0	106,722,677
Total	**243,631,072**	**130,874,425**	**112,756,647**

Source: SLIC

According to available information, the GoKP has disbursed the due funds timely and according to the agreed arrangements. Data provided by SLIC show some funds, which have not yet been disbursed declared as "outstanding" (see Table 4); however, from the point of view of GoKP, which is responsible for contribution payment on behalf of the poor covered by the SHPI scheme, these funds have not been transferred, because the requirements defined by the PC-1 are not yet met by the insurance company.

In addition to the general regulation, PC-1 (p. 11) also specified the amount for initial planning and set-up tasks:

Annual Operating and Maintenance Cost after Completion of the Project	Being a social protection scheme, the annual operating and maintenance cost amounting to **PKR. 185.054 million** would be required in the form of Annual Premium for the poorest 21% population of the programme districts.

Appropriateness of contributions

Various stakeholders expressed to be confident that the contributions defined by the SHPI programme are sufficient and suitable for covering healthcare costs incurred by the insured beneficiaries. The generally positive assessment of the amount of revenues regarding coverage of expenditures for the defined benefit package is corroborated by the fact that SLIC has not yet demanded for a revision of the calculation of transfers they receive on behalf of their enrolees. Total expenditure until October 2017 amounted to PKR 121,668,620, with a surplus of PKR 9,205,805 on SLIC's account.[8]

Resource generation for the SHPI scheme relies on a capitation system based on the number of (heads of) households and occurs in the form of bulk transfer from Treasury to SLIC. Hereby, the level and availability of funds depend ultimately on the government that decides on contributions and modes of payment. Thus, availability of funds for the SHPI scheme relies much more on political than technical, economic or actuarial criteria. Stakeholders appraise the fiscal revenues in KP to be currently sufficient for subsidising health insurance for the poor and even for larger population shares. However, a rigorous assessment of the fiscal revenues of the province is required to confirm this assessment.

[8] Information provided by SLIC for this review.

It is worth mentioning that the delay in the implementation of and marketing for an additional insurance product for covering at least 30% of the population on a voluntary basis has so far not met the initial expectation of cross-subsidising the health insurance financing for the poor. This attempt has to be verified once the product is implemented and has achieved a critical number of enrolees. The voluntary product will provide different packages for different contributions, meaning that enrolees can buy broader insurance coverage or services at better facilities if they are willing to pay higher prices, which follows the principle of equivalence. This implies that cross-subsidisation will only occur within one contribution (or risk) cluster, in which beneficiaries who pay higher contributions will make a claim on costlier services and thus "eat up" their own contributions. Redistribution other than from the healthy to the ill are not likely to happen in such a design. The desired cross-subsidisation of the pro-poor SHPI scheme is thus still to be verified. For achieving measurable cross-subsidisation between different socio-economic groups, the principle of solidarity has to come into play: People contribute according to ability to pay, and get health services according to need.[9]

Overall, the sustainability of the SHPI scheme managed with the current contribution level has to be questioned and will depend on a series of factors and important decisions to be made in future, such as the expansion of population coverage, benefit package covered, the available resources, policy preferences, etc. The fact that SLIC has achieved a surplus of slightly above 9 million PKR should not be a reason for rash optimism. It has to be pointed out that the utilisation rate under the scheme has been very low. Compared to the average rate in Pakistan and particularly in KP, the initial utilisation rate of 2.26% is significantly below the utilisation level of inpatient and maternity services exhibited in the last National Health Accounts for Pakistan:

Table 5: Type of healthcare accessed 2013-2014 by province in %

Province	Inpatient	Delivery	Outpatient	Self-medication	Total
Pakistan	**8.45**	**4.97**	**75.37**	**11.21**	**100**
Punjab	10.84	5.84	79.19	4.12	100
Sindh	4.42	3.75	73.98	17.85	100
KP	11.29	4.49	66.10	18.12	100
Baluchistan	5.38	8.50	79.41	6.70	100

Source: Pakistan Bureau of Statistics 2016: 45

2.3 Healthcare provision / service delivery

Benefit package

The benefit package was designed, defined and explicitly established in a list attached to all relevant programme contracts. In Phase I, the SHPI scheme covered secondary inpatient care

[9] In a tax-borne social protection scheme, cross-subsidisation from better-off to poorer population groups depends on the progressivity of the tax system.

up to a value of PKR 25,000 per beneficiary and year. This medical-services package covered most relevant health needs of the target population except for some tertiary-care services such as cardiologic interventions, haemodialysis and cancer. The respective treatments are complex, expensive and can easily exceed the individual PKR-30,000 coverage and empty the balance on the beneficiary's card.[10] In Phase II, inclusion of tertiary-care services has contributed to overcoming these constraints and effectively broadened health care coverage. Neither the brief assessment among key actors in the implementation process of SHPI in KP nor the spot check among a small beneficiary group provided evidence of relevant coverage lacks detected so far.

Provider contracting

One of the biggest challenges was empanelling public hospitals while extending the service delivery. The empanelment process exposed public hospital providers to a series of changes for which they were neither willing nor ready. It took a long time and assistance from PMU & OPM to convince them to start providing Sehat Sahulat beneficiaries with health services. The idea of "competing" with private hospitals for patients in order to generate revenue was not compatible with the mind set and the operational conditions in public healthcare facilities.

Convincing public hospitals to join the programme network turned out to be a difficult task. Hospitals were unfamiliar with purchaser-provider contracts, output-based financing and case-based payment, and it was not easy to convince them to adopt to the new way of charging for services. Some hospitals were reluctant to join the scheme because of religious reasons regarding insurance. Others were resistant to join fearing they would be susceptible to tax authorities. Most feared not being paid on time, or at all. The problems have been addressed, and since claims payment has improved, the trust of providers in the programme increased. The word of timely and trouble-free payment has spread and the hospitals that were initially reluctant now join the programme (SLIC 2016: 12).

A number of contracts exist between the different stakeholders involved in the SHPI scheme, which determine the overall framework of the programme and regulate contractual tasks and duties of payers and providers. Beyond the Memorandum of Understanding between the Government of Pakistan and KfW ("Phase-I-Agreement") and the agreements between the GoKP and SLIC ("Phase-II-Agreement", Chapter 4.9), provider registration at the Healthcare Commission is a mandatory requirement for empanelment under the SHPI scheme. Provider contracting is one of the tasks delegated to SLIC as purchaser of health services. For this purpose, the insurance provider has elaborated different types of standard contracts, one for public and one for private hospitals; besides that, SLIC has made special agreements with selected

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[10] Normal deliveries with a mean cost of PKR 9,500, and low-complexity surgeries such as tonsillectomy or appendectomy that cost on average PKR 14,200 and 13,500, respectively, usually do not create major financial hardship for patients. The SHPI scheme did not protect users of complex treatments from impoverishment, On the other hand, cardiologic interventions such as angioplasties with one drug eluted stent amount to PKR 216.720,00, and with 2 stents even to PKR 288.072,86 and thus widely exceed the Phase I package.

secondary- and tertiary-care providers that were in the condition to make use of their monopoly position either regarding geographic accessibility or provision of special services, or both.

Unfortunately, the attempts to receive the various contracts or contract forms used by SLIC did not succeed and only one contract with public providers was available for the review. The document called “Agreement with Hospital” defines basically the following:

- General and IT infrastructure
- Medical equipment
- Technical requirements defined
- Establishment and role of SLIC medical officer
- Principle and mode of provider payment
- Right to routine inspections and audit without further specification
- Prerequisites of admission, esp. pre-authorisation of admission by SLIC staff.

For provider contracting, there is one manual available setting the rules for hospital contracting (“Hospital empanelment criteria”). Provider duties are established regarding willingness to provide health services to the target group and fulfilment of the due requirements; further explanations in the contract are limited to rather general and thus vague arrangements regarding fees, claims processing and reimbursement. Operational procedures are lacking specification, an operational manual for contracting providers is lacking, information provided to hospitals is not standardised, apparently insufficient, and not given on a regular and adequately budgeted bases. Moreover, SLIC-provider contracts do neither include mandatory transfer of relevant routine data on a continuous basis nor the respective procedures, guidelines and manuals.

Table 6

District	**N°**
Mardan	9
Malakand	7
Kohat	4
Chitral	6
Total	**26**

Source: SLIC

Until date, SLIC has empanelled a total number of 26 hospitals in the four project districts (see table 6). Even more meaningful than the bare number of contractual partners is the fact that SLIC has meanwhile also actively taken the decision to cancel the empanelment of hospitals, when they did not comply with the rules or exhibited undesired behaviour. One case was the empanelment cancellation of the private Salma Shad Hospital in Kohat – although this provider was not yet deleted from the SHPI database when this review was done. The fact that SLIC takes action when providers infringe the contracts furnishes proof of the fact that the insurance company is willing, prepared and ready to monitor provider activity and behaviour and to assume its steering role in the SHPI scheme.

Access to health services

Contracts and agreements determine access to inpatient care (IPC) and selected other services free of charge at the point of service for beneficiaries, including financial coverage of pre-hospitalisation outpatient and emergency services whenever they induce a hospital admis-

sion. SLIC has successfully deputed medical officers as "gatekeepers" in all empanelled hospitals, who are physically present during daytime working hours. Gatekeepers have become a functional part of the insurance's risk-management policy by controlling access to care on a one-to-one case basis. SLIC-appointed medical officers are also entitled to continuously supervise health care provided to beneficiaries in order to detect over- or under-treatment but cannot intervene in treatment issues and thus not determine the type of care provided to SHPI beneficiaries. Beneficiaries can take out SHPI services provided that the following three prerequisites are satisfied:

- Use of empanelled hospital providers
- Positive balance on insurance card
- Pre-authorisation by facility-based SLIC medical officers (= "gatekeepers")

Although the rules and procedures of admission are set by SLIC in the hospital contracts, practical issues arise in the day-to-day managing of inpatient services:

1. SLIC medical officers are only present during day time; in case of hospital admissions of emergency cases outside working hours, later authorisation by SLIC staff is required within the next 24 hours. If an admission is not authorised by facility-based medical officers, providers bear the financial risk of non-reimbursement and have to make sure to get paid by the patient (SLIC 2017b: Agreement with hospitals 3.6).
2. Repeatedly, providers have charged SHPI beneficiaries for consultations, emergency treatments and laboratory or other diagnostic tests provided before admission. Together with the consultation fees, which range from PKR 20 in secondary public hospitals to up to PKR 5,000-6,000 in tertiary hospitals, pre-admission costs can amount to relevant expenditures and is supposed to be part of the covered benefit package whenever beneficiaries are thereafter admitted. Particularly in the beginning, confusion existed but partly still exists among both providers and SHPI beneficiaries.
3. Although geographic and infrastructure conditions vary between and within the four pilot districts, and despite the above-mentioned confusion in some cases, SHPI beneficiaries perceive access to services provided in empanelled hospitals as good. Guidance within health facilities, however, is often insufficient due to a lack of information and trained personal. Consideration of private and cultural aspects and overall guidance within health facilities offer room for improvement.

Altogether, service delivery has effectively started and beneficiaries have taken out a considerable number of health services provided under the SHPI scheme. The total number of medical benefits taken out by beneficiaries in 2016 amounted to more than 7,000. The following table provides an overview of the district-wise distribution of services and the share of the various benefits covered during the first year of operation of the SHPI scheme:

Table 7: Services delivered under the SHPI scheme in 2016

District	Male			Female				Both
	Surgical	Non-Surgical	*Total*	Surgical	Obstetric	Non-Surgical	*Total*	**Grand Total**
Mardan	613	580	*1,193*	844	174	1,185	*2,203*	**3,396**
Malakand	341	83	*424*	504	134	195	*833*	**1,257**
Kohat	92	712	*804*	124	49	1,400	*1,573*	**2,377**
Chitral	2	17	*19*	4	3	34	*41*	**60**
Total	**1,048**	**1,392**	**2,440**	**1,476**	**360**	**2,814**	**4,650**	**7,090**

Source: SLIC 2016: 7

According to this data, there is a large variation between the four pilot districts with regards to the share of SHPI-services utilisation since almost half of all services were taken out in Mardan, one third in Kohat, less than one fifth in Malakand, and less than one per cent in Chitral. Taking into account the population size and the number of beneficiaries per district, these findings show large variations in hospitalisation rates between the four districts as shown in the following table 8. It is particularly worth mentioning that the utilisation rate in Mardan is 100 times higher than in Chitral.

Table 8: District-wise utilisation of SHPI services

District	Share of SHPI services	No. of services	No. of households	No. of beneficiaries	Utilisation rate
Mardan	47,9%	**3,396**	45,168	84,775	4.01%
Kohat	17,73%	**2,377**	15,706	406,402	0.58%
Malakand	33,56%	**1,257**	16,289	130,013	0.97%
Chitral	0,85%	**60**	7,896	160,106	0.04%
				Average	*1.40%*
				Standard deviation	*1.54%*

Source: SLIC 2016: 7

Furthermore, data also show a surprising variety with regard to the type of services provided between districts. For male beneficiaries, Mardan exhibits an almost equal distribution of surgical and non-surgical services, Malakand an over fourfold predominance of surgical compared to non-surgical services, whereas Kohat and Chitral delivered approximately eight times more non-surgical than surgical treatments. For women, the relation between surgical and non-surgical services is very similar in Malakand, Kohat and Chitral, and also in Mardan, if gynaeco-obstetric are added to surgical services.[11]

[11] It is worth mentioning, utilisation data for female SHPI beneficiaries are inconsistent as the total number does

It has to be stressed that these figures correspond to the above-mentioned low utilisation rate of slightly over 2%. Due to the short duration of Phase I, it is practically impossible to make any useful assessment of utilisation trends under the SHPI scheme. With this in mind, a comparison of the services taken out by beneficiaries during the first semester of 2016 and 2017 might be meaningful. The following table exhibits the respective data for 2016 and 2017, disaggregated for male and female beneficiaries and according to type of service:

Table 9: Benefits taken out under the SHPI scheme according to type of service and district

Jan 1, 2016 – June 30, 2016

District	Male			Female				Both
	Surgical	Non-Surgical	Total	Surgical	Obs/ Gyn	Non-Surgical	Total	Grand Total
Mardan*	331	299	630	349	91	679	1120	1750
Mala-kand**	235	49	285	348	109	126	584	868
Kohat**	45	85	130	57	33	227	318	448
Chitral***	0	5	5	0	2	17	19	24
Total	**612**	**438**	**1050**	**755**	**235**	**1050**	**2040**	**3090**

* 1st Feb 2016 – 31st Dec., 2016

** 16th Feb 2016 - 31st Dec., 2016

*** 17th Mar 2016 - 31st Dec., 2016

Jan 1, 2017 – June 30, 2017

District	Male			Female				Both
	Surgical	Non-Surgical	Total	Surgical	Obs/ Gyn	Non-Surgical	Total	Grand Total
Mardan	284	44	328	262	130	134	526	854
Mala-kand	248	58	306	287	63	100	450	756
Kohat	116	649	765	218	29	1,325	1,572	2,337
Chitral	6	12	18	2	6	21	29	47
Total	**654**	**763**	**1,417**	**769**	**228**	**1,580**	**2,577**	**3,994**

Source: SLIC 2017a: 16

not correspond to the sum of the separated data (addition of data on surgical, obstetric and non-surgical services provided in the four districts accounts for a total number of 3,264, whereas the table depicts 4,650 services).

Table 10: Variation of service utilisation

Change 2016-17	Male			Female				Both
	Surgical	Non-Surgical	Total	Surgical	Obs/Gyn	Non-Surgical	Total	Grand total
Absolute	42	325	367	14	-7	530	537	904
Relative	6,86%	**74,20%**	34,95%	1,85%	**-2,98%**	**50,48%**	26,32%	29,26%

Own calculations of the consultant

Different from the appraisal expressed in the programme progress report 2017 (SLIC 2017), these data show an increase of the total service utilisation by almost 30% and not 60%, if the shorter period of operation in 2016 is taken into consideration (services started only between February 1st and March 17th of 2017). While the overall increase is not really surprising, since beneficiaries become more aware of the benefits of insurance coverage, the pronounced variations between different types of services require further analysis: Non-surgical services experienced a sharp increase for both men and women, while surgical treatments exhibited only a small increase and gynaeco-obstetrical services even declined.[12]

SLIC has successfully set up a database for registering health-service utilisation and fund flows for provider payment. The SHPI database managed by SLIC provides ample and supposedly near-to-complete information of quantity and location of service provision as well as on the corresponding expenditure incurred by the insurance company. Hence, comprehensive data on health-service delivery is available and provides the purchaser with necessary information for controlling the use of health services and relevant expenditure patterns. The database is operational and allows for monitoring the use of services, capturing information about diagnoses, disease patterns and type of inpatient services taken out, and overseeing healthcare provision under the scheme as a whole and for each single provider. The following table provides an example of data extracted from the SHPI MIS showing services, which are frequently taken out. The light-grey part shows original data as provided by SLIC, the right column the average costs per case calculated for this review.

[12] Average change rate: 27,62%, standard deviation 26,14%

Table 11: Selected SHPI services according to number, overall and average expenditure

Procedure	Cases	Cost	Average cost
Non-surgical	4.435	7.160.100	1.614,45
Appendectomy	763	10.245.000	13.427,26
Tonsillectomy – Bilateral	769	10.885.750	14.155,72
Haemorrhoidectomy	211	3.045.760	14.434,88
Caesarean Delivery	128	2.529.000	19.757,81
Hysterectomy – Abdominal	182	3.754.000	20.626,37
Cataract With intra-ocular lens	104	2.369.000	22.778,85
Estimation	37	3.526.138	95.301,03
Angioplasty 1 stent (Drug Eluted)	15	3.250.800	216.720,00
Angioplasty 2 stents (Drug Eluted)	14	4.033.020	288.072,86
CABG	9	2.693.880	299.320,00
Total	**6.667,00**	**53.492.448**	***Average: 91.473,57***
		Standard deviation: 117.691,58	

Source: SLIC; shaded part of the table: calculations of the author

Despite the considerable amount of data available for the SHPI scheme, information collected and processed by SLIC for managing the SHPI scheme in KP do not yet provide the full range of functions for automatic monitoring and supervision of a large health-insurance scheme. This is partly attributable to the fact that SLIC has not provided standardised guidelines and operational manuals for data entry by providers, and a uniform digital data entry format is yet not available in all empanelled hospitals. As a result, data collection happens mostly in an unsystematic, often spontaneous manner rather based on the attitude of individual health facilities than on structured instructions. This makes even the data, which are collected and entered into the database difficult to "digest" for the MIS.

As a consequence of the lack of uniform coding, data entered by providers exhibit a series of inconsistencies and incoherencies, which derive from unstructured entry of diagnoses and unclear or missing classification of diseases. As shown in the following tables of the most frequent diseases, some obvious overlap of disease categories hamper data analysis and make clear-cut classifications very difficult. The following table serves as an example for detectable weaknesses of data collection. The data below highlighted in light grey were initially provided according to the number of cases; for the purpose of this review, it appeared relevant to calculate the average case costs per procedure (or diagnosis) (right column) and to order the list according to this indicator:

Table 12: Most frequent diseases

Procedure	Cases	Cost	Average cost
Plasmodium Falciparum Malaria	1.062	1.665.100	1.567,89
Non-Surgical	4.435	7.160.100	1.614,45
Typhoid And paratyphoid Fevers	599	1.077.200	1.798,33
Drainage of large abscess	147	1.022.600	6.956,46
Normal delivery	138	1.312.400	9.510,14
Appendectomy	763	10.245.000	13.427,26
Tonsillectomy – bilateral	769	10.885.750	14.155,72
Haemorrhoidectomy	211	3.045.760	14.434,88
Cataract unilateral	107	1.551.000	14.495,33
Caesarean section	128	2.529.000	19.757,81
Cholecystostomy	106	2.129.000	20.084,91
Hysterectomy - abdominal	182	3.754.000	20.626,37
Total	**8.647**	**46.376.910**	**Average: 11.535,80**
			Standard deviation: 7.189,74

At first, the procedures listed in table 12 show a mix of treatments (most cases) and diagnoses (malaria, typhoid and paratyphoid fever). Moreover, it is easily detectable that the classification of all procedures, which do not require surgery, under the extremely broad term "non-surgical" does not provide useful information about the disease patterns and needed treatments. Hence, this category does not provide insight in medical-care needs and make it very difficult to assess and monitor the respective expenditures without further data being available. In particular, the very high number of Malaria tropica raises questions, since the share of Plasmodium-falciparum infections is much smaller than Plasmodium vivax, and Malaria on the whole is a rare health problem in KP. Moreover, it is not clear why some diagnoses such as malaria and typhoid fever (marked in red), which require medical but not surgical treatment, are listed separately from the category "non-surgical".

Secondly, other findings like the relatively high numbers of tonsillectomies and, to a lower extent, haemorrhoidectomies and cholecystotomies raise questions, since the indication for throat particularly in children surgery has significantly dropped worldwide, and the second surgery occupies a surprisingly high position compared to other operations covered by the scheme and might not in all cases justify IPC; last but not least the category "Cholecystostomy" would require a closer look at procedures and indications.

Altogether, disease-related data collection under the SHPI scheme in KP still offers much room for improvement. Available information about diagnosis and medical needs lacks a useful structure and a minimum of standardisation for being useful and for monitoring health-service

delivery and related indicators. Although the database includes an option to enter diagnosis according to the International Classification of Disease (ICD),[13] SLIC has not yet made concrete steps to require and enforce a more uniform and reliable data entry. Provider contracts do not define the tasks of healthcare providers in this regard, which would be required for ensuring the collection of solid and useful data on service provision under the scheme.

With more standardised and, at the same time, more differentiated data available, the usability and value of the information collected such as the number of services, claims and expenditures would gain much more relevance. For example, the added value of knowing the average length to be 1.5 days remains widely unclear as long as it includes very different types of hospital care, such as day, secondary and tertiary care, which obviously implies very different complexity and hence duration of treatments; without more specific data on precise diagnoses and medical procedures, the added value of such data remains insignificant.

SLIC data exhibit a relevant number of “referred cases” and provided an Excel data sheet on the number, costs and locations of these cases. According to these data, the total number of “referred cases” accounts up to date to 343 cases treated in five tertiary-care hospitals, without information of the time frame. The basic understanding of “referred case” would be that of “referral” meaning that these are the patients referred from secondary-care providers for more complex treatments. However, consultations with stakeholders revealed that the category “referred cases” actually record the patients who directly access tertiary care without first consulting secondary providers. This explains the large variation of average costs per referral-case and particularly the unexpectedly low average costs for some referred cases treated in tertiary-care hospitals, which provide usually much more costly health services. Anyhow, this finding should be an occasion for further investigations in order to find out the reasons.

Data on actual referrals (or re-referrals) were not available for this review. In theory, SLIC medical officers at facility level (“gatekeepers”) at secondary level authorise referral from secondary to tertiary hospitals, and their colleagues in tertiary hospitals on their part authorise the admission. Obviously, the rules for referrals and re-referrals are not very clear and have not been adequately communicated; clear-cut guidelines and operational manuals are still to be developed managing referral and re-referral procedures. This would be, at the same time, an indispensable precondition for making the Management Information System (MIS) suitable for continuous and timely data analysis and standardised monitoring of referrals and re-referrals within the SHPI scheme.

Quality of health services

Healthcare services are often lacking satisfactory quality levels, and improving quality in the healthcare sector is a challenge in Pakistan and in KP. With this in mind, improving quality of care has been priority of the SHPI programme from the very beginning. One core design feature of the scheme is output-based financing since providers get paid according to services

[13] As a side product of the parallel implementation of the Prime Minister National Health Programme.

delivered. Additional revenue generated by treating beneficiaries of the insurance scheme shall provide hospitals with resources to improve quality.

Quality assessments can focus on the three categories “structure,” “process” and “outcomes”. Structure refers to the context in which health care is delivered, including hospital buildings, staff, financing, and equipment; process denotes the transactions between patients and providers throughout the delivery of healthcare, and outcomes describe the effects of healthcare on the health of patients and, in the long run, populations (Donabedian 1988). With regards to these categories, the SHPI scheme has achieved different levels of involvement in quality issues.

The programme directly targets *structural quality* by stipulating a number of preconditions for hospitals to be eligible for being contracted by the scheme. As mentioned in 2.1, hospitals have to fulfil some minimal infrastructure conditions for being empanelled and entitled to be reimbursed for services delivered to SHPI beneficiaries. The criteria defined by SLIC for contracting providers is defined in contracts and guidelines for empanelment

With regard to *process quality*, however, the SHPI scheme and SLIC have not yet developed and incorporated strategies for improving quality of care provided to beneficiaries. Treatment standards and medical protocols have been implemented by the KP health authorities in some places, but the insurance company is not yet involved in setting up guidelines and manuals for ensuring that health services occur according to standard guidelines and protocols, which are also perceived too ambitious for the KP context. The due measures are not yet adequately reflected in contracts, guidelines and manuals. SLIC neither enforces improvement of healthcare delivery through their contracts with healthcare providers nor has implemented incentives for improving quality of care.

Outcome quality is certainly the most challenging category that requires more sophisticated measures for assessing success. Although the PC-1 explicitly states, “to improve the health status of the population in the province by ensuring access to a high quality health care” (GoKP 2013: 1), SLIC and the SHPI scheme do not clearly define or establish outcome measures in contracts or other written documents. Outcome quality can be assessed during hospitalisation or in case of re-hospitalisation in the same facility, but the scheme cannot systematically register post-hospitalisation events. Moreover, it does not establish benchmarks for detecting and analysing performance.

In view of the expansion of the programme it should not go unmentioned that - different from Phase I – the SHPI scheme has meanwhile included burial subsidies in case of death during inpatient care covered by the scheme. At the moment of the review, the total number of cash subsidies paid out for funeral costs amounted to 16 (= 0.12%) equivalent to an expenditure of PKR 160,000. This is worth mentioning because it proves SLIC’s capacity to include other than IPC services into the benefit package.

Complaint mechanism

The need to provide beneficiaries with the possibility to claim for their rights and report inadequate treatments, the scheme has implemented formal grievance mechanisms, which are included in contracts and agreements (e. g. Agreement GoKP-SLIC: 4.15 (GoKP 2016: 9). Beneficiaries may call or visit the local beneficiary centre in Peshawar during normal working hours for resolving "local" issues. The centre is open. The most common complaint of beneficiaries is not receiving a health card, or losing a health card. Moreover, a hospital contact centre has been established for providing assistance to health facilitation staff. The helpline is staffed with a trained advisor well versed in the health management information system to help field staff troubleshoot software related issues (SLIC 2017: 7).

However, it remains unclear how the scheme deals with complaints and whether and to which extent beneficiaries are making use of their right to complain. The grievance mechanism is not linked to the MIS and complaint management occurs on a one-to-one basis where SLIC staff deals with all cases individually. Other stakeholders perceive a lack of clarity hampering the effectiveness of the complaint mechanism in place.

Table 13: List of common reasons for calls

Nature of Calls	N°
Addition of Hospitals	20
Card Information	1309
Duplicate card request	12
info about cities	181
Info about covered districts of KPK SSP	244
Info about enrolment	547
Info about KPK SSP	698
info about members covered	557
info about program and hospital	1245
info about state life	15
info about treatment	1147
New Baby Enrolment in card	1
Panel Hospital Information	2487
Suggestion that SSP KPK program should be for people who are not included in BISP survey.	70
Test call	12

Source: SLIC 2017: 26; period not specified

2.4 Claims processing

The health-insurance provider responsible for managing the SHPI scheme has successfully implemented claims-processing procedures as precondition for provider payment for services provided to SHPI beneficiaries in the four districts, where the programme started, and meanwhile also in all other KP districts. Hospitals can submit their invoices to SLIC in order to get paid for all services included in the benefit package provided that the individual health-insurance card has a positive balance. Both purchaser and providers consider the claims processing

transparent and fair. Particularly in the initial phase, SLIC needed quite long to process claims and reimburse providers, but meanwhile invoices are paid in about 30 days. Delays occur but are not any more a major problem of the SHPI scheme.

Rules of claims processing

The contracts between GoKP and KfW, GoKP and SLIC and between SLIC and providers establish general rules for claims processing, including the formal documentation required by the insurance company for accepting and processing provider invoices.[14] The above-presented arrangements contain personal information of the beneficiary, cash-receipt acknowledgement and several documents related to the reason of IPC and the services taken out. Obviously, the level of information available for claims processing is directly linked to data quality, accuracy and reliability. Hence it is inevitable that the limitations of data entered into the MIS are also reflected in claims processing.

5. PROCESSING OF CLAIMS

5.1 The claim is initiated from the State Life MIS system. A claim report for all beneficiaries, who have been discharged since the last claim submission, will be generated by the system. This claim report along with the required documentation will be submitted to the State Life.

5.2 Required documentation for each patient:

- Readable copy of beneficiary (or head of household) CNIC Card and SLPC
- State Life system documents:
  - o Initial outpatient referral form
  - o Admission form
  - o Discharge feedback form signed by the attending physician and beneficiary
- Patient treatment chart
- Copy of patient discharge slip
- Cash receipt acknowledgement from the beneficiary for any cash disbursements made on the program's behalf

The said documents should be under the covering letter of the Hospital.

5.3 Only claims included in the State Life'sMIS system may be submitted for approval 5.4 The Hospital shall make available to State Life such information /additional information and assistance as may be required by State Life with regard to settlement

of the claim.

Source: Agreement with Hospital, 5.2 (SLIC 2017b)

[14] Particularly Agreement with Hospital, 5.2 (SLIC 2017b)

The revision of health care delivered and billed is exposed to the fact that diagnoses and procedures are not submitted in a standardised format that is easy to process but in a more or less unsystematic manner and with free-text diagnoses. More detailed and practice-oriented instructions such as written operational manuals for making claims processing more and more an automatic task are not yet available. Until now, claims processing occurs largely undocumented, and providers perceive a lack of transparency. The SLIC Agreement with Hospitals defines explicitly, which documents and data hospitals have to submit for initiating claims processing (see previous page).

Moreover, SLIC has not yet defined contractual requirements for hospitals to provide routine data beyond the above-mentioned documents needed for claims processing. No formalised, detailed and structured guideline has been developed so far for incentivising or enforcing improved quality of care as precondition for (full) reimbursement of providers.

Empanelled healthcare providers miss adequate documentation of all processes and steps to be taken for claims processing. Obviously, most information and communication occurred verbally between SLIC and providers, but adequate documents such as meaningful written guidelines and useful operational manuals are still to be provided. Moreover, claims-processing capacities still offer room for improvement on both sides; while SLIC has certainly made much progress in administering health-insurance tasks, provider preparedness for claiming and invoicing still offers some challenges.

Table 13: Number of claims

Total number of claims received:	≈ 13,000
Total number of claims processed:	≈ 9,000

Source: SLIC

Even though SLIC applies a rather inefficient and time-consuming strategy for claims processing applying individual case-per-case revision, SLIC has proven capable to absorb and process a relevant number of claims arriving from the empanelled providers, as shown in table 13. The following table exhibits the detailed number of claims received and processed since the scheme started to operate until the end of October 2017 as well as the respective invoice amounts and fund flows according to provider type:

Table 14: Claims ratios

Hospital type	Cases	Claims incurred	Claims received for processing	Claims paid	Outstanding	Share of Claims paid
Private	12,156	110,984,364	91,452,165	75,614,521	15,837,644	68.13
Public	701	10,684,256	8,545,213	7,584,215	960,998	70.98
Total	**12,857**	**121,668,620**	**99,997,378**	**83,198,736**	**16,798,642**	**68.38**

Source: SLIC

Moreover, SLIC provided the following performance data, which show a significant imbalance between the number of incoming claims and of reimbursements paid out.

Capacity is certainly more developed in (some) tertiary-care hospitals and exhibits some variations among the various providers empanelled by the SHPI scheme. The number of unsettled and unpaid claims might be an indicator for a certain level of uncertainty and remaining lack of understanding on provider side. When the scheme started, SLIC provided initial information and training for claims processing to selected staff of empanelled hospitals. Moreover, SLIC medical officers at facility level are expected to support hospital personnel in preparing the claims. After the start-up phase, SLIC has not planned and budgeted any further provider training.

Table 15

Claims received per day	19
Average cost per claim	9,464
Number of claims paid per day	200
Average time of claim payment	30 days

Source: SLIC

Particular challenges exist in the public sector where the short-term staff turn-over prevents the needed level of continuity of the management. This widespread personnel policy in public hospitals contributes to a low level of awareness, ownership and particular understanding of the SHPI scheme and its implications for hospital providers. Training and information provided by SLIC to public-hospital managers is not sustainable because the staff is frequently transferred and newly incoming staff is not adequately prepared for managing the scheme. SLIC does not feel capable for repeating capacity building for all new staff whenever changes happen.

Understanding and enforcement of rules

In a nutshell, the strategy of the insurance company to spread information, guidelines and training and to familiarise empanelled providers with claims processing faces some essential challenges and offers room for improving effectiveness and sustainability. Refusals of claims, which happen from time to time, create repeatedly confusion and quarrels between SLIC and providers. This situation underpins the need for clearer and more explicit written documentation on the respective procedures as well the laws and duties of all stakeholders involved.

Both providers and beneficiaries confirm cases of non-adherence to the rules and regulations established by the SHPI scheme. One critical issue is coverage of pre-admission outpatient or emergency services, which are to be covered whenever hospitalisation follows outpatient clinical assessment. This creates confusion among beneficiaries and undermines their trust in health insurance.

SLIC has the right to enforce rules by establishing criteria to be fulfilled and ultimately denying payment for claims which do not follow the guideline requirements. However, unless providers fall behind the minimum requirements for empanelment, the insurance company cannot force providers to meet treatment protocols, medical guidelines or certain standards of care.

As mentioned above, revision of provider claims and invoices occur on a case-by-case basis through checks of each single incoming claim. Albeit time consuming and a bit laborious, this procedure has proven to be effective for detecting wrong claims and attempts of fraud. To a large extent, monitoring and controlling rely on individual initiatives of SLIC staff who dedicate

themselves to assess and analyse healthcare provision and resource utilisation under the SHPI scheme.

2.5 Provider payment

SLIC has successfully implemented regulations and rules for provider payment on behalf of the SHPI scheme. All relevant contracts define timeliness of provider payment, and contract annexes provide detailed information about fees per case. During programme Phase I, SLIC paid uniform reimbursement fees for secondary and tertiary care cases, respectively. The SHPI scheme has established case-based provider payment, hence providers are reimbursed per admission and diagnosis and not per service item. While fee for service incentivises providers to increase their clinical activity and as a result the volume billed to the insurance, case payment focuses on technical efficiency to make better use of available resources and reduce average length of stay; at the same time, they also encourage hospitals to increase the number of patients. Hence, according to economic theory, the payment method applied by the SHPI scheme tends to both stimulate hospital admissions and discourage overuse during hospitalisation. Hence, provider payment per case induces an intrinsic incentive for increasing efficiency - but at the expense of comprehensiveness and quality of care. For this reason, it is so important to monitor and assure quality of care under all payment methods, which move financial responsibility from purchaser to providers.[15]

There have been complaints from providers about delayed reimbursement of claims. With an average 30-days period of provider payment time, however, SLIC generally tends to achieve the timeliness objectives of claims processing. Reimbursement rates were uniform in the beginning and in principle they still are; however, some providers have meanwhile made use of their monopoly position and imposed higher package prices or additional fee-for-service payment (e. g. Aga Khan Hospital in the district of Chitral). This is not yet seen as a major challenge but underscores again the need for more explicit written guidelines and manuals, and for more intensive capacity building in order to make all stakeholders involved more familiar with the arrangements, rules and schedules of the SHPI scheme.

Stakeholders tend to be satisfied with the level of reimbursement fees paid by the SHPI scheme; except for some rates appraised by tertiary care providers as too low for covering their costs, providers perceive them generally as adequate. This assessment, however, has to be seen in the light of partly inconsistent or limited understanding of the basic principles of case payment. Moreover, it was not clear to which extent providers perceive the revenue from the scheme as positive, negative or no incentive. Rules of reimbursement seem to be clear in the private but not in the public sector. Likewise, providers' capability to absorb revenue from the SHPI scheme varies between hospitals: Private providers can easily deal with the additional income whereas the use of additional funds creates significant challenges for public providers and needs further clarification in the programme design. Currently, distribution of

[15] Besides for case payment, this applies also to capitation and budget financing.

reimbursement and allocation of revenue present a problem in the public sector; this is mainly due to three following reasons:

- Funds distribution formula have been elaborated but not yet implemented;
- Until recently, no criteria were available of how to use the revenue for improving quality;
- General allocation mechanisms for the public-sector have been developed but not yet implemented.

In principle, hospital providers shall use additional revenue from the SHPI scheme for immediate improvement and scaling up of facilities. A notification published by the Department of Health in KP as early as in 2016 provides empanelled hospitals with instructions of how to distribute the revenue received from the SHPI scheme:

i. The insurance fund reimbursed to the public sector hospitals empanelled for the project, shall be apportioned into retained amount and deposited amount at a ratio of 75:25.

ii. The 75% of the insurance funds retained by the empaneled hospitals shall be expended as per the following breakup:

Share	Detail
60%	On measures to ensure improved quality standards in the respective Health Institutions. The amount so retained will be reflected in the budgets of the respective Health Institutions and will be specified for particular quality standards.
25%	On Doctors providing services to the insured patients.
10%	On Nursing staff / Paramedics providing services to insured patients.
02%	On Administrative/management staff of the concerned hospitals
03%	On Repair expenses

iii. The remaining 25% of the income be deposited in a separate Health insurance fund account to be maintained at provincial level for future extension of the scheme to other districts

Notification No. PO-IV/H/6-7/SHPI/2016 (GoKP 2016)

On the one hand, this notification establishes that one in every four PKR reimbursed to a public hospital has to be returned to Treasury on a special account for further expansion of the scheme. On the other hand, six out of every ten PKR paid to a hospital has to be spent for improving infrastructure and equipment; 25% should be used for topping salaries of medical and another 10% for topping the wages of nursing staff. This clear notification, however, has not been used in all public facilities for several reasons, either because the management simply ignored it or it turned out to apply this rule due to diverging interests, imbalanced

power relations or envies among different personnel groups. The above-mentioned fast turn-over of personnel in public health facilities has certainly not been supportive for implementing the rules according to the notification.

The SHPI scheme does not apply explicit cost containment methods beyond the essential risk-management features included in the design, which target either at containing expenditure or utilisation

Cost-containment strategies applied by the Sehat Sahulat Programme:	
Price containment	Case payment (not fee for service!)
	Limitation of reimbursement fees (Agreement II: 3.7)
	Implementation of a coverage ceiling
Utilisation containment	Pre-selection by medical SLIC staff
	Some exclusions defined (but rather vaguely)

2.6 Regulation

Steering, guidance and clear-cut rules of the game are crucial for health-insurance performance. Good governance in health financing, a prerequisite for universal health coverage (UHC), requires both fair regulation and purposeful stewardship. Having the office, duties, and obligations of a steward in mind, stewardship refers to the conducting, supervising, or managing of something; especially the careful and responsible management of something entrusted to one's care.[16] Stewardship "involves three key aspects: setting, implementing and monitoring the rules for the health system; assuring a level playing field for all actors in the system (particularly purchasers, providers and patients); and defining strategic directions for the health system as a whole" (Murray & Frenk 2000: 726).

The GoKP has furnished convincing proof of political will to invest in SHP; however, political will is a necessary but certainly insufficient precondition for successfully implementing social-policy strategies. Stewardship, which refers to the wide range of steering, managing and controlling functions carried out by governments as they seek to achieve national health policy objectives, is of utmost importance. Public policy is ultimately responsible for defining the roles and responsibilities of the various stakeholders in place, particularly public, private and voluntary providers (as well as civil society), in the financing and provision of health care. The PC-1 on the SHPI for KP sets the goal "The Provincial government in KP [and GB] built up significant experience in the stewardship of private health insurance providers" (Output 7, GoKP 2013: 19).

[16] Definition according to Merriam Webster: https://www.merriam-webster.com/dictionary/stewardship.

Stewardship of the private sector is certainly important but definitely insufficient for managing a broadly public and tax-based health-insurance scheme. However, it has to be stressed that effective stewardship in the SHPI scheme in KP is hampered by the weakness of the bodies overlooking the scheme and unclear interaction of the various actors involved in regulation. Various government levels are involved in the implementation of the scheme, but decision-making does not seem to be fully coordinated and aligned and does not reflect what is happening on the ground. High-level policy decisions stipulate the general framework and overall goals of SHP. These decisions are mainly driven by political priorities and strategies and do not adequately take into account technical, feasibility and sustainability aspects; this reflects ultimately the need of relevant bodies to adopted their stewardship roles. To a relevant extent, this is attributable to the fact that subordinated political institutions have not yet set up the necessary capacity or interference in the implementation process.

As a matter of fact, the role of the Steering Committee composed by political and technical authorities of KP and external implementers the steering committee in its current composition does not have the mandate and setting to effectively overlook the health-insurance scheme and decide upon the further strategy of the SHPI programme. The roles of authorities and public bodies in steering and decision-making processes is still to be defined. The Healthcare Commission as technical body sticks mainly to its task of provider regulation but has not yet played a proper role in rolling out the scheme; this is mainly due to lack of funds, expertise and human resources. The Department of Health (DoH), in turn, does not yet use its opportunities to better prepare public-sector providers for taking over their role and duties in the SHPI scheme. And, last but not least, the Health Sector Reform Unit (HSRU) still offers room for consolidating its coordinating role and particularly to better harmonise and align political and technical priorities for SHP. It has to be stressed that stewardship also means taking political decision together with technical staff, e. g. expansion of the scheme was decided without taking into consideration technical aspects.

Weak regulation also applies to quality of health care provided under the Sehat Sahulat Programme. The various agreements mention or refer to practically all quality issues, but the transfer from paper into practice is yet to be operationalised. In fact, private providers claim already for guidelines and manuals on quality issues.

2.7 Cross-cutting issues

Capacity building

During the set-up phase, the KfW-SLIC programme had allocated funds for capacity building at various levels of the healthcare and health-financing system. About 60% of these funds have been spent, the rest is not yet fully allocated because of the delay in starting the additional voluntary insurance product. SLIC has stepwise expanded its health-insurance personnel in KP to currently approximately 250 staff. Another step for improving performance was decentralising claims processing. Initially all claims were sent to and processed at SLIC headquarters in Karachi; this caused significant delays in provider payment. Meanwhile, SLIC has set up a claims-processing unit in KP for processing incoming claims. With regard to the MIS,

SLIC will have to further strengthen the capacity to operate as a health insurer; this means that the MIS has to provide all means for the up-to-date management of beneficiary enrolment, fund flows including contributions and expenditures, provider contracting and service provision in order to be prepared for short-term adjustments as well as middle- and long-term strategic planning.

In Phase I, there was an intensive orientation towards providers, but thereafter activities were mostly focused on SLIC. Enhanced capacity building, however, is not only desirable for SLIC, but also for other stakeholders involved in the Sehat Sahulat Programme. Before the programme started, health insurance was widely unknown by citizens and even healthcare providers. The latter, for instance, will have to further develop their capacity particularly in contract management and claims processing, but also in how to deal with output-based payment systems, quality management and increasing demand for services. The capacity of the Project Management Unit (PMU) to manage and supervise the scheme has slightly improved, and monitoring and evaluation has also benefitted from institutional improvements. Nonetheless, there is still a need to build up capacity in the field of regulation, steering and stewardship; the Sehat Sahulat Programme emerged within a very short period and mainly as a *ad-hoc* social-policy measure for improving SHP in KP. Several counterparts are involved in the setup of the scheme, but roles and responsibilities are not clearly assigned and the capacities for steering and supervising the scheme still have to be built.

Design features

Health-financing reforms aiming at improving service delivery through market mechanisms such as output-based provider payment are *per se* more suitable for private than for public providers. Hitherto experience gathered since the implementation of the SHPI scheme in KP reconfirms this general assessment: It turns out to be much more challenging to make the intended incentives work in public facilities. Inclusion of the private sector was much easier compared to public-sector health facilities. In view of the complexity of the above-mentioned reasons it would be too simple to blame public hospitals or their management. But obviously the programme started underestimating the challenges that would arise for the public sector to join and make benefit of the SHPI scheme. As a focus was put on supporting the set-up of purchaser-provider arrangements, overall management issues and in particular resource management, it is not surprising that the underlying concept turned out to be intrinsically more suitable to private-sector stakeholders than for the public sector. While private providers have proven to be well prepared and capable to deal with the options provided by setting up the SHPI scheme, public providers will still need more support from both SLIC and health authorities in order to be able to cater with the opportunities provided by the SHPI scheme.

Objectives and incentives of the SHPI programme in KP are obviously not fully aligned with general regulations and conditions in the public sector. Strategies for controlling or preventing misuse and fraud include often strict rules and instructions, which make it challenging or even cumbersome to deal with innovations. Public hospitals' problems to absorb and manage add-

upon revenue beyond the traditional yearly budget financing did not only derive from ignorance and instability of staff but also to a large extent from the tight regulations in place.

On the other hand, providing health services to Sehat Sahulat beneficiaries in public facilities challenges the common practice of health professionals to reduce their activities in the public sector as far as possible for their own benefit in private practice. It can be observed that pubic secondary facilities tend to push away patients, including SHPI beneficiaries, either towards tertiary care or private providers. The common concurrent practice mainly of physicians who work both in the public and private sector creates a conflict of interests and the demand of health professionals for additional or compensatory payment.

SHPI programme in Pakistan's endeavour to achieve UHC

The KfW-supported SHPI in KP pursues a double-tracked approach combining publicly financed SHP for the poor and a marketable health-insurance product for wealthier population groups in KP. Implementation and marketing of such an additional voluntary insurance product for covering at least 30% of the population on a voluntary basis has not yet started. The programme implementers still adhere to this concept, and an adequate insurance product was recently accepted by the competent supervising body. However, the initial target to reach 30% of the population has become questionable since the GoKP has decided to expand the SHPI scheme to up to 69% considered as needy. Taking into account those who are covered by other schemes, the remaining target group has meanwhile become smaller than 30% of the population.

Moreover, the assumption of the voluntary product to cross-subsidise health insurance for the poor is yet to be verified once the product is implemented and has achieved a critical number of voluntary enrolees. As described above, for achieving measurable cross-subsidisation between different socio-economic groups and ultimately universal health coverage (UHC), the principle of solidarity has to come into play: People contribute according to ability to pay, and get health services according to need.[17] International experience shows that the coexistence of solidarity- and equivalence-based SHP schemes has undesired effects on performance and fairness. This is evident in different countries such as Germany and Chile, which have achieved UHC but face severe efficiency and equity gaps. Combining two different and even contradictory principles of revenue generation for healthcare is not the best way for achieving UHC and requires strong stewardship as well as a series of effective steering mechanisms.

[17] In a tax-borne social protection scheme, cross-subsidisation from better-off to poorer population groups depends on the progressivity of the tax system.

3. Lessons learned

3.1 Beneficiaries and enrolment

Enrolling beneficiaries in health insurance cannot be a one- or two-time activity but has to be a continuous and day-to-day action that is embedded in the strategic planning and budgeting policies of the company or scheme. Outsourcing of the targeting and enrolment process can make sense during the set-up period when large numbers of beneficiaries have to be registered within a short time and the scheme is still busy with all others implementation tasks. After the initial phase, however, enrolment should become and stay a core task of the insurance scheme itself. Therefore, the scheme has to set up sufficient offices, staff and other infrastructure for satisfying the demand and preventing queuing and long waiting times.

The empanelment of hospitals turned out to be a rather tedious and difficult process, although important differences existed between public and private providers. The purchaser had to negotiate with each single provider individually, since the providers were not formally organised in a representative and participatory institution that would have allowed collective negotiations on behalf of all hospitals or at least on behalf of groups of hospitals. This created problems not only for the initial empanelment but thereafter also for healthcare provision because each provider is a separate entity and has to be supervised as such for quality of service delivery. Contractual relations between purchaser and providers would be easier if there were hospital associations and other provider organisations in place in KP and Pakistan. Unfortunately, due to the infantile insurance market and the poorly organised medical sector, such provider organisations do not exist and force the purchaser of services to enter into negotiations with individual providers.

3.2 Resource generation

Stakeholders appraise the flat-rate contribution of initially PKR 1,700 and thereafter PKR 1,549 per household as adequate and sufficient for covering the benefit package for all beneficiaries. Likewise, fiscal revenue is basically regarded as high enough. With regards to financial sustainability, however, it is indispensable for further assessing the fiscal space available for subsidising health insurance for the population in KP. This is particularly relevant for two reasons:

1. Utilisation of the SHPI scheme has so far been significantly below the level to be expected in the medium or long run according to recent national and provincial data as well as international experience. An actuarial reassessment of the contributions (and also reimbursement fees, see 3.5) is necessary in view of the most-recent available data on utilisation of inpatient and maternity services in KP.
2. SLIC is still contractually committed to enrol uncovered population on a voluntary basis: Recently finalising the basic additional product with a similar benefit package to be provided with different riders for offering various coverage ceilings. However, the original expectation to cross-subsidise the sponsored scheme for the poor with higher contributions of voluntary enrolees of the planned additional insurance product did not yet come true.

Moreover, the assumed potential to cross-subsidise the publicly financed scheme has to be critically reassessed.

3.3 Healthcare provision / service delivery

Since the empanelment process was concluded, the SHPI provider network has been generally functional and accessible. Despite the health-facility assessments performed in 2010 and 2011 for KP, some hospitals seem to lack – at least temporarily - sufficient staff and technical equipment or supplies such as radiography or special laboratory tests.[18] This is mainly due to the fact that public providers are essentially remunerated according to budget financing – receiving a certain amount of money every year, which is supposed to cover all expenditures for personnel, equipment and running costs – and are used to the hitherto only way to formally demand additional money from the DoH. On the other hand, public hospitals are not yet fully enabled to use the revenue generated through service delivery to beneficiaries of the Sehat Sahulat Programme for investing in quality improvements.

The empanelment process is essentially clear but needs more support and institutionalisation by written documents, operational manuals, monitoring instruments and strategic planning. Empanelment and particularly monitoring of empanelment are continuous tasks that require allocating adequate staff and budget for the process as such and for the due capacity building.

In a more strategic perspective, SLIC – in close co-operation with the Healthcare Commission (HCC) - should further develop the empanelment procedures applied during the implementation phase stepwise into a more purposeful accreditation policy, starting with voluntary accreditation. This could create competition and pressure on other providers to achieve accreditation. SLIC should support providers to set up their own hospital plans and put more emphasis in exploiting its purchaser tasks and contributing to further develop the provider network from registration with the HCC and empanelment by the insurance company into a full-scale accreditation process. Supporting or enforcing the setup of clinical expert advisory groups can be a first step for elaborating and implementing treatment protocols.

With regard to the benefit package, the most critical challenge derives from the exclusion of outpatient care (OPC). Including OPC in the benefit package has the potential to enforce a more rational use of resources because many health problems can be solved at primary level and without the need of hospitalisation. On the other hand, managing OPC requires a series of regulatory arrangements and efficient control for preventing misuse and fraud. In a setting with unsatisfactory levels of governance, where adequate and qualified provider associations are not in place and thus not available as counterparts, inclusion of OPC will require both careful actuarial assessments and effective cost control.

OPM expects additional OPC cover of the Sehat Sahulat Programme to increase the contribution from approximately PKR 1.500 to up to 7,000 or PKR 10,000 per household and year, including expectable oversupply and misuse. This might be the funds that will be needed for

[18] Information gathered from stakeholders during the workshop.

paying fee for service (because payment per-case is much more difficult in OPC). However, other options for provider remuneration exist, and e. g. capitation is promising to allow much lower contributions. At the same time, paying OPC providers with a flat rate per head or household would restrict overuse and oversupply, but require strict quality control for preventing undersupply.

Although clear-cut rules for cost coverage, which are indispensable for providing reliable financial protection, exist, their dissemination and understanding still offers room for improvement. The main responsibility in daily practice lies with providers who need to be adequately prepared by the insurance scheme. Beneficiaries cannot be expected to understand the arrangements when they are looking for medical care. On the other hand, it has to be stressed that insurees are usually very sensitive towards non-fulfilment of expectations; even minimal out-of-pocket payments in an allegedly cost-free social protection scheme can severely undermine confidence and trust.

3.4 Claims processing

Capacity building on both sides – providers and insurance – is a key condition for good performance of claims processing and hospital remuneration; therefore, more sensitisation and training will be required. Claims processing is particularly challenging in public facilities. Until now, preparing the needed documents and papers is the task and responsibility of medical staff and particularly of the medical management. This is understandable since the process depends until now on physicians and nurses for specifying diagnoses and treatments. Moreover, the high frequency of staff turnover is a problem for the SHPI scheme to operate because it hampers the establishment of claims processing and billing as routine procedures in public hospitals, and thereby challenges the effectiveness and sustainability of the SHPI scheme as a whole.

SLIC has not yet implemented automatised procedures and routines for detecting all relevant provider strategies to "optimise" claims or exploit the scheme because the MIS system does not include automatic claims-processing features and benchmarks for continuously monitoring service provision and claiming. This prevents the insurance company to improve its ability to detect misuse and fraud, which occurs in all healthcare and health-financing systems and tends to increase when providers and/or beneficiaries start to get used to claims processing and payment modes.

3.5 Provider payment

The SHPI scheme reimburses providers according to cases or diagnoses, thus transferring financial responsibilities to the provider side instead of bearing the whole risk alone. Policy makers and SLIC management have meanwhile developed a basic understanding of case-based provider payment but the awareness of strengths, weaknesses, the potential and implications of different payment methods is not yet fully explored. There is no perfect system, all types of provider payment have their own advantages and risks. Case payment as applied by the SHPI, for instance, creates incentives for hospitals to work efficiently provided that they

are aware of costs of services; at the same time, case payment might go beyond rationalising procedures and induce rationing and undersupply. Quality assurance and improvement are hence crucial for output-based provider payment.

As purchaser of services for a large number of beneficiaries, SLIC has a very strong market position in the health sector, because insurers channel a huge demand for health benefits. Compared to individual patients, health insurance has much more power for pressing healthcare providers to implement quality management and control. However, the insurance company managing the SHPI scheme is not yet using its market power to impose treatment protocols, negotiate bulk discounts or enforce quality standards. It should be stressed that treatment protocols and standardised procedures can effectively contribute to improving quality in the healthcare sector.

3.6 Regulation

Regulation plays a major role in the health sector and particularly for health insurance coverage. Health regulations and standards are necessary to ensure compliance and to provide safe care to users of the healthcare system. Healthcare regulation includes monitoring practitioners and facilities, provide information about entitlements, duties and changes, promote safety and ensure legal compliance and quality of health services. WHO states "the art of regulating well … is to develop regulatory strategies and frameworks that pursue a middle path, by allowing the carefully controlled introduction of innovative approaches without surrendering major responsibility for achieving good overall outcomes for patients. It is in this balance, in understanding regulation as a means rather than an end that the way forward must lie" (Saltman et al. 2002: xiii). Obviously, the art of regulation of the Sehat Sahulat Programme still offers room for improvement. This applies to both, the design and enforcement of the regulatory framework of the insurance programme. For making regulation work for the health-insurance programme to become successful and sustainable, stewardship is a key prerequisite.

Of course, policy decisions are ultimately taken by the Government, which is responsible for public policies and policy making; however, politicians should be motivated and convinced to check their decisions as far as possible against facts and empirical data. For enforcing evidence-based policy making, government decisions should be backed by sound technical facts and assessments. Stakeholders involved in the implementation of SHPI in KP are required to prepare themselves for providing politicians with adequate and suitable technical advice.

As a matter of fact, the political decision to rapidly expand the SHPI scheme to an ever-growing population share creates incalculable risks with regard to performance, financial viability and sustainability. Firstly, rapid expansion makes it impossible to carefully analyse strengths and weaknesses of the approach and steps chosen so far and to learn important lessons before broadening the scope and coverage of the scheme. Likewise, an accelerated extension puts in danger the representable achievements up to now. If the IPC rate keeps the growth rhythm shown between 2016 and 2017 and comes closer to the level in KP estimated by the authors

of the most recent National Health Accounts, revenue based on a lowered per-household contribution might not suffice to cover all services beneficiaries are entitled to. Without taking these framework conditions adequately into account, expanding the health-insurance scheme is associated with the risk of failure and political discontent.

3.7 Cross-cutting issues

Many management arrangements and procedures of the SHPI scheme are still organised in project mode and in a kind of handcrafted manner. This is normal and unavoidable during the implementation phase but requires transition into more developed and specified procedures over time and according to the growing number of beneficiaries, providers and/or services covered. A large bulk of tasks and duties in health insurance are routine process and thus require repetitive or even automatised management. This causes the need for SLIC to move away from day-to-day management towards longer term and strategic planning and administration.

Setting up health insurance in a country without considerable experience is challenging. Even stakeholders involved are not familiar with concepts and strategies in health financing and with the terminology used in the context of social health protection. This was evident in the broad diversity of answers and appraisals in the questionnaire-based individual assessment of the scheme performed during the review workshop. For achieving the needed level of technicality and a common understanding of terms and concepts, earmarked capacity building for the various actors in the health sector will be of utmost importance. The better stakeholders understand health insurance, the better they are prepared for negotiating and deciding upon crucial issues of the Sehat Sahulat fund and the clearer and easier to access will the scheme be for users. A common understanding of feasible approaches and key challenges of including OPC in the benefit package will be a prerequisite for finding the way to share financial responsibility between purchaser and providers in a way that is mutually acceptable.

Pakistan is currently striving for implementing social health protection to the people and making important steps on its path towards UHC. As social policy is a highly political task and as such closely linked to party interests and strategies, a situation of politically motivated competition might occur. Decision makers have to be aware that in sensitive areas such as social protection, there is a narrow line between political tactics and disappointing the public. On the other hand, running various similar programmes with overlapping target groups is not only confusing for people but inefficient. Hence, the SHPI scheme in KP is strongly advised to search for the largest possible alignment with (all) other social (health) protection schemes such the Prime Minister National Health Program (PMNHP) and others that might show up, independent from political rivalries that might exist. In KP, both SHP programmes have empanelled partly the same hospitals, (e. g. Al Khidmat Hospital, Zia Medical Complex and Pakistan Institute of Medical Sciences (PIMS) (secondary care) as well as Rehman Medical Institute (RMI) (tertiary care) in Peshawar), and SLIC is managing the purchaser role for both schemes. The existing linkages should be used and further extended as far as possible in order to explore and elaborate synergies for improving social protection of the people.

The SHPI programme was set up from the scratch, and processes and procedures developed one by one and often as provisional or temporary arrangements. As the health-insurance scheme matures and shifts from project to political-programme mode, there will be an increasing need for moving away from day-to-day and rather hand-made procedures into longer term planning and management. The programme design was developed under the objective to strengthen output-based health financing in the target provinces or districts.

With regard to the overarching approach of the SHPI programme in KP developed and piloted with support from German Development Cooperation through KfW financial assistance, a concluding observation is permitted. The law of supply and demand that underlies output-based payment in healthcare is but one way to steer healthcare service delivery. It can work, but expecting economic incentives created to become driving forces of changing public-sector attitudes will remain wishful thinking unless additional efforts are made for setting up a framework that is equally conducive for all types of healthcare providers to deal with.

4. Recommendations

The recommendations presented in the final chapter of this joint-review report are the result of the analysis of documents and data, of interviews and questionnaires, and mainly of the discussions and inputs during the workshop with relevant stakeholders held on October 30 until November 1, 2017, in Islamabad. The external expert added some additional recommendations derived from his assessment of the programme (highlighted in grey). In line with the structure of the approach applied in the review and in this report, the recommendations are grouped according to main insurance tasks and performance areas.

4.1 Beneficiaries / Enrolment

Awareness and communication is a joint responsibility of the Government and SLIC, without a clear allocation of responsibilities. The unclear duality of tasks and roles tends to limit both enrolment and utilisation. The contract between the GoKP and SLIC also reduces the role of the health-insurance company to enrolment communication only. However, roll-out, registration and enrolment of beneficiaries were largely effective and successful but not complete. As the SHPI matures, the enrolment strategy should be strengthened:

- Intensify cooperation with NADRA for identifying, targeting and approaching those citizens who are eligible for the Sehat Sahulat Programme.
- Convert enrolment from a time-limited, specific action into a regular activity of the insurance provider. The respective communication strategy needs to be prepared beyond the ongoing marketing campaign to effectively create awareness of access and usage of the health insurance programme among intended recipients and partners to the scheme.
- Since enrolment is on regular basis, wherein those left-out visit the SLIC zonal office at Peshawar and get enrolled. SLIC however, shall authorise all its District Monitoring Officers to enroll the households that are left during the community registration activities, at the District level. People may not travel to Peshawar, keeping the logistics and financial barriers in view.
- Establish more enrolment facilities independent from healthcare providers all over the province for making inscription easier, join the single-windows approach. Enrollment is already independent of healthcare providers. However, a one window operation would be ideal and the matter should be taken up with the One Widow Operation project, under discussion at the Planning & Development Department.
- As purchaser of health services, SLIC should focus more intensively on developing and putting into praxis a more detailed and useful programme documentation in written format in order to make routine procedures more reliable.
- In addition, SLIC has to invest heavily in capacity building within the own corporation and in training of all stakeholders involved in the scheme and particularly in the registration of beneficiaries.
- Since Govt is the Regulator, thus, all complaints pertaining to the scheme may be addressed to PMU-SHPI, the PMU will examine the it and may relegate it to SLIC. The SLIC

shall act thereupon, keeping both regulator/PMU and the complainant informed of its final outcome. This entire process needs to be linked and MIS supported so as to institutionalise and systematise the system.

- Currently, enrolment is exclusive responsibility of SLIC. Other options such as the PMU or DoH, potentially using community health workers or branchless banking agents, can be helpful for enrolling difficult-to-reach citizens into the scheme. This will require investments by the government to develop these capacities, but allow the insurance company to focus on its role as a purchaser of services.

4.2 Resource generation/Financing

The SHPI scheme is basically financed by the GoKP by block transfers to SLIC according to a lump sum per enrolled household. Hence, financial viability and sustainability rely exclusively on the Treasury of KP. During Phase I, resource transfers covered the due costs but the 30% rise of services documented between the first semester of 2016 and 2017, implies growing expenditures. Thus, the following recommendations are of utmost importance:

- The cost of a tax-borne health-insurance scheme needs to be considered in the medium- and long-term and requires adequate budgeting. As the overall government health expenditure has been low compared to regional and peer countries, particularly those with healthcare insurance programmes, the fiscal impact of the Sehat Sahulat Programme has to be observed.
- Safeguarding financial sustainability is key for health insurance. Before expanding the SHP programme, a sound assessment of the fiscal space is indispensable for preventing major problems or even failure of the scheme.
- The 30% rise of services delivered between the first semester of 2016 and 2017, the increase of the hospitalisation rate, general indicators for KP and international experiences make additional funding for the Sehat Sahulat Programme very likely to be necessary in the near future. The government of KP is thus strongly advised to revise the level of flat-rate contributions per household in order to prevent SLIC from needing to access the reserve funds or even to make losses.
- Expanding public health insurance to non-poor population groups opens the opportunity to implement differentiated contribution subsidies. While the poorest groups should still get their contributions fully paid, subsidies should be stepwise reduced as people's ability to pay increases according to the PMT scale. At a later stage, income-related contributions can be implemented.
- The Sehat Sahulat Programme is recommended to not implement user fees or other forms of co-payment; out-of-pocket payment for health care have a series of undesired effects, which are inconsistent with the objectives of SHP and ultimately contradictory with UHC.

4.3 Healthcare provision

SHPI beneficiaries have started to take out health services covered by the scheme since early 2016, after SLIC had selected and empanelled a series of hospital providers according to some

structural prerequisites for delivering IPC. Except for some cases when SLIC suspected or detected irregular attitudes, empanelment is basically applied as one-time action without a long-term perspective for monitoring and supervising hospitals. Moreover, SLIC has not yet developed a proper strategy to set up a provider-accreditation policy including the implementation of treatment protocols for SHPI-covered services in KP. These finding lead to the following recommendations:

- Optimise the utilisation of private as well as public sector healthcare providers.
- Provider empanelment still offers much room for developing into an effective means of quality assurance and improvement by strengthening the contractual mechanisms for enforcing and controlling quality of healthcare services under the prerequisite of cost-effective pricing. The respective process may become more purposeful and effective if empanelment is done between the insurance company and associations of healthcare providers, rather than negotiations with individual providers.
- The minimum standards of service have to be ensured through a more effective registration and licensing regime of the KP HCC. The fact that registration and provisional licensing by the HCC is a pre-requisite for hospitals to be empaneled does not yet always guarantee a desirable level of quality.
- The programme is an opportunity for the government to bring private providers into the regulatory framework and also create institutions or organisations in the private sector to ensure adherence to the required level of quality in service delivery.
- SLIC needs to establish mechanisms for continuously monitoring providers and revising empanelment. Accepting hospitals as providers of SHPI benefits should not be a one-time task but a continuous process that is included in SLIC's management plan, human-resources policy and budget allocation. Contractual liability should be a part of the performance evaluation of the insurance company.
- As strong purchaser in the health sector, SLIC has the potential to promote provider accreditation: Starting from provider registration by the HCC, and based on the empanelment requirements for the SHPI scheme, the insurance company could support the competent authorities to initiate voluntary accreditation as first step to a proper accreditation policy.
- In view of the challenges for several providers to fulfil the standards, which are already in place, it seems recommendable to start implementing not more than 20 high-priority protocols for treatment, which have been costed and are ready to be applied in hospital procedures. In order to create incentives for hospitals to introduce these protocols, they could be linked with provider payment: Once they can furnish proof of successful implementation of treatment protocols, hospitals get their reimbursements topped up with some additional revenue.
- Being important for controlling hospital admissions and procedures, the scheme has not yet made full use of the potential of the "gatekeepers" installed in empanelled hospitals. Beyond their role of access control, "gatekeepers" should get a more pro-active role in the system as "pilots" or guides helping beneficiaries/patients find their best way through the healthcare system. They can support beneficiaries to make best use of their insurance

cover by indicating them the most suitable providers to use for certain treatments in view of the current balance on the cards.

- For overcoming the temporary or even long-term lack of equipment and/or staff, public hospitals might be authorised to enter into sub-contract with private institutes, which provide the needed facilities. Such an arrangement can contribute to overcome the geographic unavailability of certain services in some districts in KP.
- In a more general approach, SLIC as purchaser of a significant amount of health services should support providers to become more familiar with the case-based payment system, the use of additional revenue and ultimately to set up their own hospital plans. All in all, SLIC needs a clearer company vision and mission of health insurance and to set up a specialised department or branch to effectively manage the Sehat Sahulat Programme and potentially other health-insurance funds.
- For making information about diagnosis and medical needs more rational and useful for monitoring and assessing health-service provision, the scheme should require providers to enter information on diagnosis, reasons for hospitalisation and other relevant disease pattern of SHPI beneficiaries in a standardised, reliable and easy-to-process format. The due tasks have to be included in the contracts between SLIC and hospital providers.
- Communication about the Sehat Sahulat Programme should not be the exclusive task of the insurance company; the Government as initiator of the programme and particularly healthcare providers should contribute to promote the scheme and create awareness among the target groups.

4.4 Claims processing

SLIC has successfully implemented and also rationalised claims processing for SHPI beneficiaries treated in empanelled hospitals. Despite some isolated discussions and queries between the insurer and individual hospitals, the needed procedures are established and functional. However, claims processing is mainly done manually and on a one-to-one case basis. The imminent shift from project to political-programme mode will require more standardised and automatised management information system (MIS) based on useful routine health-insurance data.

- Entering the right information and data is key for achieving an MIS that is suitable for continuously monitoring health-service production and fund flows and to detect all types of “runaways” beyond established benchmarks.
- The MIS system should automatically catch coded diagnoses per case, mean length of stay for all cases, average costs incurred per case, assignment of diagnoses to provider level, and facility prevalence of procedures to be continuously measured and monitored in a way that the system raises alarm whenever the data exceed certain benchmarks.
- SLIC’s claims processing should automatically provide empanelled hospitals with up-to-date access to the current state of their claims and invoices in order to improve transparency and accountability.
- Hospitals should explore the possibilities to shift a part of the bureaucratic workload to

other than medical or nurse staff in order to make claims-processing more efficient.

- The DoH has to carefully revise its staff policy in public providers and ensure that hospital managers, who have been trained by SLIC, remain in their positions or, if this is impossible, that newcomers receive needed training on claims processing and billing as soon as possible.

4.5 Provider payment

In the healthcare sector, payment methods offer a series of steering mechanisms for both purchasers and health authorities to influence health-service delivery and provider attitudes. The SHPI programme applies a relatively simple form to apply PBP remunerating providers according to the number of services and a predefined fee schedule. Quality criteria do not yet play a role in the scheme, and SLIC has not prepared a strategy to use PBP for quality improvement. This leads to the following recommendations:

- Establishing treatment protocols and other standard procedures for improving quality of health care. Compared to individual patients, health insurance has much stronger market power for pressing healthcare providers to implement quality management and control.
- As a matter of fact, SLIC could start linking treatment protocols, once they are applied in hospital procedures, with reimbursement. Using its contractual power, SLIC should explore the opportunity to establish the application of treatment protocols and other standards as a precondition for provider payment and bind (full) reimbursement to the extent in which providers meet the agreed commitments.
- Policy makers and SLIC management shall further develop their understanding and awareness regarding case-based provider payment in order to fully comprehend the strengths and weaknesses of this and other payment methods.
- SLIC should use its market position as purchaser of health services for a huge number of beneficiaries to enforce quality by binding reimbursement to certain standards to be implemented by empanelled hospitals, applying simple forms of performance-based provider payment. In addition, the achievement of quality standards, particularly with regards of processes and outputs, should be reflected regarding additional incentives such as top-up payments to providers or staff.

4.6 Regulation

Clear leader- and stewardship are key conditions for the Sehat Sahulat Programme to achieve its objectives and successfully implement SHP to KP citizens. Stewardship is not only required for steering the private sector, as stated in PC-1, but also for all stakeholders involved, let it be the public purchaser or public and private secondary- and tertiary-care providers.

- Political decisions based on sound analyses are a key prerequisite for SHP systems to operate effectively, efficiently and for the good of the people. All further political steps for setting the course have to be based on evidence and rational planning.
- Health authorities have to create the conditions required for setting up an SHP scheme;

therefore, all stakeholders and particularly for all providers to be equally prepared for treating health-insurance beneficiaries and dealing with the corresponding tasks and procedures.

Moreover, government authorities responsible for the healthcare sector are required to set the institutions right and to provide public and private stakeholders with necessary support. They have to further develop their commitment to manage and steer the SHPI scheme. The preparedness of relevant actors, such as PMU which is currently under resourced and lacks autonomy needs to be looked into from perspective of the regulatory and stewardship role. Moreover, for sustainability a legal framework or SHPI law with clear objectives and nomenclature may be developed.

- Health-sector authorities have to set favourable framework conditions for all stakeholders to achieve social-protection objectives without major hindrance. Therefore, they have to implement and enforce adequate and effective legal and regulatory conditions.
- For the Healthcare Commission to become capable to play a proper and more decisive role in the roll out of the SHPI scheme, more financial resources, technical expertise and trained human resources are required.
- The DoH, on its part, will have to put more emphasis on preparing public hospitals to cooperate with the SHPI scheme. As superior authority, the DoH should support public providers in their contractual relation with the Sehat Sahulat Programme, help them make best use of the additional revenue from the scheme, and ensure stability of human resources by harmonising the turnover of management staff with the training and capacity needs required for dealing with the insurance company.
- Last but not least, the Health Sector Reform Unit (HSRU) should have a stronger stake in better coordinating the various actors involved and harmonising political and technical priorities for SHP and ultimately UHC.

4.7 Cross-cutting issues

After the rather smooth start of the SHPI scheme, political decision-makers went for an accelerated double amplification within less than one year when they decided to expand both the group of eligible citizens and the benefit package at the same time. Rapid expansion in a premature state is as ambitious as risky. Albeit the changes implemented since early 2016 did not yet create major challenges to the programme, further expanding the eligible target group without carefully assessing and balancing available revenue and needed resources can endanger the SHPI scheme.

- Instead of covering the whole province within very short time, it would have been recommendable to stepwise expand to one or two more districts at the time. This would allow to carefully assess the results and to try out different strategies or “experiences” without changing the whole scheme. Moreover, a more cautious expansion strategy would permit decision-makers to find solutions for detected problems at the local or district level, to develop hereby useful lessons learned and to apply them thereafter at larger scale.
- It is highly recommendable for politicians and decision-makers to abstain from rapid

changes of the scheme. Further adjustments should be strictly bound to previous analyses and sound assessments.

- Before any coverage expansion, the GoKP has to analyse the fiscal space in order to adapt all further steps to the resources available.
- The purchaser, i.e. SLIC is required to improve its capacity especially in areas such as technical knowledge about health insurance and understaffing. More number of staff both at the district and provincial level is required to deal with the gate keeping effectively. Besides, in order to curtail the delay being occurred in reimbursement of claims to the hospitals, the existing financial powers of the provincial team of SLIC, needs to be enhanced by delegating autonomy.

Further expansion or essential change of the Sehat Sahulat Programme will have to capitalise the synergies between the various stakeholder in the healthcare sector, namely the DoH, PMU, insurance companies and healthcare providers. Based on the conditions achieved during the preceding programme implementation, a series of in-depth analyses will be required in order to ensure sustainability and prevent major shortcomings:

- Careful assessments of demographic and epidemiologic conditions of the target population, sound actuarial calculations and the rigorous appraisal of the fiscal space should be an indispensable requirement for further planning of SHP in KP.
- Pending reforms and changes of core insurance issues such as eligibility of beneficiaries, contributions and benefit package should rely on
    - Mapping of health facilities to get a complete picture of public and private providers, their capacities and future investment needs;
    - the burden of disease in KP in order to detect the priority health needs;
    - public-expenditure review for determining the fiscal space;
    - costing studies in order to consolidate the price structure in public and private hospitals and adjust the fee schedule;
    - analysis of options for provider-payment, including the assessment of requirement, feasibility and impact.

In the end, the two inconsistent concepts as well as the twofold approach of the SHPI programme in KP tend to challenge the overall objective to achieve universal health coverage (UHC) in KP: On the one hand, tax-borne flat-rate contributions as applied in the SHPI scheme for soon almost two thirds of the population undermine the opportunities to implement income-related contributions and thus cross-subsidisation according to the principle of solidarity, a key condition for expanding coverage to the whole population. On the other hand, setting up a voluntary health-insurance product designed according to the principle of equivalence will ultimately withdraw contributors from the public scheme and reduce the potential to achieve cross-subsidisation from better off to poorer population groups. The hitherto applied strategy will have to undergo some adjustments in order to contribute to the overarching objective of universal health coverage. The expansion of population coverage achieved

until now. For covering the whole population, the programme should further strive for mandatory enrolment of all citizens taking the following strategies into account (cf. Thiede 2017: 21f):

- Complete tax-borne subsidisation of insurance contributions should apply to the neediest population groups only;
- The level of subsidisation should stepwise decrease according to beneficiaries' ability to pay;
- Better-off citizens will have to enrol in the public system paying the contribution on their own; in addition, they might have the option to buy additional insurance for topping up coverage of the SHPI scheme, e. g. for IPC in private hospitals or wards.

Since the population has already been informed about the expansion of health-insurance coverage free of charge to almost two in every three people in KP, the option to implement differentiated contributions according to purchasing power will come with the next major change of the benefit package such as coverage of OPC.

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6 Annexure

6.1 Focus Group Discussion Questions for SHPI beneficiaries who are registered and utilised service

1. Beneficiaries' knowledge about the SHPI programme

- How did you come to know about this programme?
- On a scale from 1 (I do not agree at all) to 10 (I absolutely agree), how would you rate the SHPI programme in general?
    - 1: I don't agree at all – 2 – 3- 4- 5: I somewhat disagree – 6: I somewhat agree – 7 - 8 – 9 – 10: I absolutely agree
- Are you aware which benefits are for people holding the card? Could you please recall them?
- How many people around you do know this programme?
- What information about the programme would you like to get?
- What is your perception: Do you believe that the program is really targeting and capturing the neediest (or poorest) people?
    - Please tell us: Did someone try to influence you for availing or not availing the insurance card?

2. Beneficiaries' understanding and experience of the enrolment process

How did you get information about the registration process? Was the communication easy to understand or did you perceive it rather as confusing?

Did someone ask for any compensation or any other reward from you for the registration or during the enrolment process?

- Was the card collection centre easily identifiable and accessible?
- How well did you understand the registration and enrolment process of the programme?
- Did you face any difficulty fulfilling registration process requirements?

3. Beneficiaries' attitude towards card utilisation

- How easy/ difficult was the card receiving process after registration?
- What information have you received from the office while receiving card?
- How good did you understand card utilisation and benefit package details?
- What kind of utilisation issues have you experienced so far?
- What other benefit package in your opinion should be offered not covered in card?
- Do you believe this card will improve your health status?
- Do you believe this card will help you to save money?

4. Beneficiaries' experience regarding hospital services

- Please tell us where did you use the card and for which disease? Who was treated and your relation to him/her?
- Please tell us during treatment did you pay or ask any amount to the hospital?
- Please tell us how much are you satisfied from the treatment and hospital's services?
- How much time (days) it took since first visit to the hospital till discharge?
- Please tell us were you given post treatment/discharge medicines?
- Please tell us were you given wage loss amount and how much?
- Please tell us were you given maternity transportation charges (In case of maternity cases)
- How did you find behavior of the hospital/ hospital staff?
- In your opinion how hospitals can improve their services? Or what are the necessary services must be available in the hospitals?
- How many times were you referred to other hospitals and why?

5. Beneficiaries' perspective regarding complaint redressal mechanisms

- What kind of complaint redressal mechanisms exist for your queries in this programme?
- What type of complaints have you lodged so far?
- How was the response from the complaint office to resolve your issues/ queries? And in how much time your complaint was resolved
- Why do you think such kind of service/ office is necessary?
- In your opinion what are best way to lodge complaints?

6. General perception

- What would you expect from a health insurance scheme?
- How reliable / trustful is the insurance scheme?
  - Do you plan to renew your membership after this year? Yes ☐ No ☐
  - Which health services are most important for you?
  - Are you content with the benefit package covered by the scheme?
  - How could the SHP programme be improved?

Wrap up question:

Please feel free to ask/ inform anything that you wanted to say but was not asked.

6.2 Focus Group Discussion Questions for SHPI beneficiaries who are registered and *not* utilised service

1. Beneficiaries' knowledge about the SHPI programme

- How did you come to know about this programme?
- On a scale from 1 (I do not agree at all) to 10 (I absolutely agree), how would you rate the SHPI programme in general?

  1: I don't agree at all – 2 – 3- 4- 5: I somewhat disagree – 6: I somewhat agree – 7 - 8 – 9 – 10: I absolutely agree
- Are you aware which benefits are for people holding the card? Could you please recall them?
- How many people around you do know this programme?
- What information about the programme would you like to get?
- What is your perception: Do you believe that the program is really targeting and capturing the neediest (or poorest) people?
- Please tell us: Did someone try to influence you for availing or not availing the insurance card?

2. Beneficiaries' understanding and experience of the enrolment process

- How did you get information about the registration process? Was the communication easy to understand or did you perceive it rather as confusing?
- Did someone ask for any compensation or any other reward from you for the registration or during the enrolment process?
- Was the card collection centre easily identifiable and accessible?
- How well did you understand the registration and enrolment process of the programme?
- Did you face any difficulty fulfilling registration process requirements?

3. Beneficiaries' attitude towards card utilisation

- Have you ever utilised the insurance card? If not: What are the reasons of not utilising the card?
- Please tell us: Do you know how many people of your family can use this card?
- Are you aware if the insurance card covers all needed care or if it defines limits of the package?
- Which information did you get from the office when you received the card; did they explain you how to use it?
- Do you believe this card will help keep you healthy?
- Do you believe this card will help you to save money?

4. *Beneficiaries' viewpoint regarding hospital services*

- In your best knowledge: Please tell us where and what for you can use this card?
- Have you or your family ever taken out health services using the card?

  Yes☐ No ☐

  - If yes: What have been your or your family's experiences with healthcare services you have received with the insurance card?
  - If not: Did someone, who went through treatment under this card, tell you anything about hospital's services?
- According to you are empanelled hospitals the best in your locality?
- On a scale from 1 (I do not agree at all) to 10 (I absolutely agree), how do you think about the following statement: The health-insurance scheme makes a government hospital affordable for us.

  1: I don't agree at all – 2 – 3- 4- 5: I somewhat disagree – 6: I somewhat agree – 7 - 8 – 9 – 10: I absolutely agree
- On a scale from 1 (I do not agree at all) to 10 (I absolutely agree), how do you think about the following statement: The health-insurance scheme makes a private hospital affordable for us.

  1: I don't agree at all – 2 – 3- 4- 5: I somewhat disagree – 6: I somewhat agree – 7 - 8 – 9 – 10: I absolutely agree

5. *Beneficiaries' perspective regarding complaint redressal mechanisms*

- What kind of complaint redressal mechanisms exist for your queries in this programme?
- What type of complaints have you lodged so far?
- How was the response from the complaint office to resolve your issues/ queries?
- Why do you think such kind of service/ office is necessary?
- In your opinion what are best way to lodge complaints?

6. *General perception*

- What would you expect from a health insurance scheme?
- How reliable / trustful is the insurance scheme?
- Do you plan to renew your membership after this year? Yes ☐ No ☐
- Which health services are most important for you?
- Are you content with the benefit package covered by the scheme?
- How could the SHP programme be improved?

Wrap up question:

- Please feel free to ask/ inform anything that you wanted to say but was not asked.

6.3 Agenda for workshop on “Progress of the Social Health Protection Initiative (SHPI) in Khyber Pakhtunkhwa”

Day	Time	Agenda item
Monday 30 Oct	12:00 – 12.30	Opening followed by Introduction of participants
	12:45 – 14:00	Lunch & prayer break
	14:15 – 15:30	Jens Holst: Presentation of preliminary results and recom-mendations, discussion
	15:30 – 16:00	Question & Answers
	16:00 – 16:30	Coffee break & prayer break
	16:30 – 17:00	Comments by selected participants and ensuing plenary discussion
		Dinner
Tuesday 31 Oct	09:00 – 09:30	Brief introduction of the work in groups, presentation of the topics
	09:30 – 12:30	Workgroups sessions (flexible coffee break)
	12:30 – 14:00	Lunch break
	14:00 – 15:30	Presentation of the workgroup discussions, findings, ob-servations and recommendations
	15:30 – 16:00	Coffee break
	16:00 – 18:00	Continuing workgroup presentations; plenary discussion on results
Wednesday 1 Nov	09:00 – 10:30	Conducted discussion on conclusions and recommenda-tions
	10:30 – 11:00	Coffee break
	11:00 – 12:30	Wrap up

6.4 Workshop presentation of preliminary findings

Progress review of Social Health Protection Initiative (SHPI) in Khyber Pakhtunkhwa

Preliminary findings

Open questions

Inputs for discussion

Dr. med. Dr. PH Jens Holst
Consultant for AOK International Services
on behalf of giz Pakistan

Outline of the review report

- Objective: Present the results of the joint progress review of Social Health Protection Initiative (SHPI) in Khyber Pakhtunkhwa
- Content: Assessment of the SHPI scheme from different angles:
  - Against key health-insurance features
  - Against the logical framework of the GoKP-KfW programme
- Structure of the report:
  1. Assessment of achievements
  2. Assessment of strengths and weaknesses
  3. Analysis of future challenges
  4. Recommendations

Procedure

- Presentation of the background of the review and the hitherto findings in this workshop
- Joint elaboration on key features of health insurance and the objectives of the SHPI programme
- Compilation of workshop results to be fed in the report
- Writing the 1st draft of the report (until Nov. 15th, 2017)
- Sharing the draft among all stakeholders involved
- Finalising a consensual and shared draft report

Expectations from the workshop

- Critical assessment and verification of preliminary findings gathered from
  - intensive desktop studies of relevant documents and data of the SHPI programme
  - through seven skype interviews + one telephone interview
- Sensitisation regarding relevant topics of health-financing
- Better and in-depth understanding of critical features of the health-insurance scheme
- Triangulation of information from different stakeholders
- Condensed and consensual findings and results

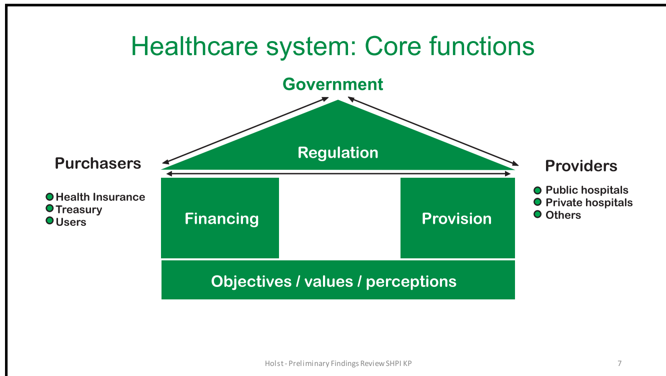
Programme objectives

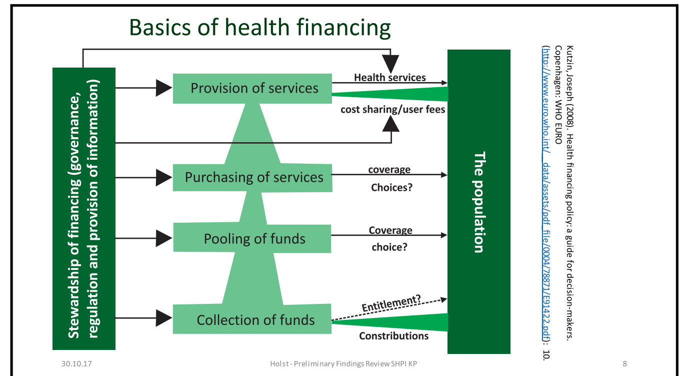
- **21 % of the poorest households in the intervention districts enjoy social health insurance coverage**
  - Programme indicator 1 for implementing agency:
    "**100% of eligible poor households covered by subsidised health insurance**". It is expected that all eligible households are covered by the programme."
- **At least a further 30 % of the non-poor district population purchases health insurance products, so that total coverage would exceed 51 % of the population."**
  - Programme indicator 2 for implementing agency:
    "> 50 % of district population purchasing health insurance" in order to control adverse selection, and keep utilisation rates in acceptable ranges, i. e. between 3 and 4 % for secondary level hospital care, implementing partners must cover at least 50 % of the district population

ProgrammeObjectives/ Outcomes

- **Out-of-pocket expenditure by insured households for inpatient care reduced by at least 51 %.**
  - Programme indicators 3 and 4 for implementing agency:
    Insured population utilisation rate of covered hospital care 3-4% and
    Out-of-pocket expenditure by insured households for inpatient care reduced by ≥ 50 %

Outputs	
1. Relevant MoU's signed	**4. Hospital accreditation policy enforced**
2. Partner's capacity strengthened in selected areas	5. Public hospital providers use SHPI revenue for improving quality
3. Implementing partner offers insurance product on a continuous basis	6. Government of KP has acquired significant experience in the stewardship of private health providers





Key areas of health-insurance performance

- Percentage of population covered: Coverage of the target group
- Percentage of households with catastrophic spending
- Number / distribution of empanelled providers
- Benefit package based on explicit efficiency and equity criteria?
- Utilisation of health services
- Claims ratio
- Percentage of expenditure on administrative costs
- Ratio of prepaid contributions to total costs: Premium – (Reimbursement + admin. costs)
- Main cost drivers (epidemiologic-financial analysis)

Key areas of health-insurance performance

- Efficiency incentives for insurer
- Efficiency incentives for providers for encouraging the appropriate level of care?
- Monitoring mechanisms in place: Rules and plans for audits, claims review, peer-review committee, patient complaints mechanism, full information on claimant rights, …
- Definition and documentation of key health-insurance procedures
- Readiness of insurer to manage the scheme:
  - Availability of written guidelines and manuals
  - Effectiveness of assigning patients to providers
  - Average time of claims processing
- Readiness of regulatory bodies: Effectiveness of supervision

Preliminary findings: Health-insurance performance

Key features of health financing and health insurance:

1. Beneficiaries / enrolment
2. Resource generation (contributions, “premiums”)
3. Healthcare provision
4. Claims processing
5. Provider payment

Healthcare system: Core functions

Basics of health financing

Legend for following slides:

Green: Achieved

Yellow: To be clarified

Red: Not yet implemented

Beneficiaries / Enrolment (≙ programme indicator 1)

Available contracts, manuals and rules:

- Two awareness and initial enrolment campaigns run by NGO’s hired for this particular purpose. While the respective contracts made the rules where more or less clear, no applicable manual was available.

Achievement of enrolment objectives:

- Identification of eligible target population via BISP data base facing problems due to outdated data sets, need to revise and purify data and to transfer BISP data into the SLIC system

Beneficiaries / Enrolment (≙ programme indicator 1)

Name of District	Total Population	Population exempt	Households exempt
Chitral	403,691	84,775	10,731
Malakand	619,108	130,013	15,952
Mardan	1,935,249	406,402	48,381
Kohat	762,411	160,106	21,348
Total target population	**3,720,459**	**781,296**	**96,412**
Total population in KP	*21,137,659*		
Target population shares	*17,6 %*	*3,70%*	

Beneficiaries / Enrolment (≙ programme indicator 1)

- Enrolment versus total target group: **85,059 households (= 680,472 beneficiaries)** out of 100,000 (?) eligible households → 85.06 %
- Surprisingly large variation in coverage rates (20 percent points) between districts → Analysis of the reasons + elaboration of purposeful strategies required
  - Reason given by SLIC Report 2017: 15 % of the target population could not be located because "it is near impossible to enrol 100% a specified target from an old data set. This target population tends to be more transient, with no real trail for tracking them down"
- In fact, a high level of informality, the lack of a proper resident's registration system and population mobility make it too ambitious to aim at enrolling 100 %.

Beneficiaries / Enrolment (≙ programme indicator 1)

- Target group beyond BISP beneficiaries ("other 30% of the district population" – PC-1) was not approached; SLIC developed an ins-urance product but official registration delayed implementation

Adherence to regulation:

- Enrolment occurred widely according to the rules of the game

Effectiveness of the awareness campaign:

- First PR-campaign during roll out not sufficiently effective so that another round was needed
- Information for (potential) beneficiaries was essentially provided as one-(or two-)time activity and not designed as ongoing and permanent task → low level of knowledge among target group(s)

Beneficiaries / Enrolment (≙ programme indicator 1)

Responsibility for the enrolment process:

- The purchaser financed and sourced out the responsibility for caring out the PR-campaign → Pushing away essential purchaser tasks and loss of control the over results

Data management in beneficiary enrolment:

Detailed beneficiary data available at the

- Successful design and implementation
- Generally good functionality (but sometimes a bit slow)
- Collection of a large number of important data on
  - Beneficiaries enrolled
  - Beneficiary data used for member count → contribution collection
  - Expenditure for health services (see Topic 5)

Beneficiaries / Enrolment (≙ programme indicator 1)

But: Data do not provide the desirable added value

- Beneficiary data used for member count → transfer of contributions on behalf of target group
- Unclear use and usability of data collected beyond this (and the other tasks referred to below)
- Who is the custodian of the beneficiary (and other) data → Confidentiality is a major concern!

Beneficiaries / Enrolment (≙ programme indicator 1)

Reliability or fairness of enrolment process

- Registration and hand-over of insurance cards was performed by third party in two consecutive campaigns; particularly in the beginning there were repeated intents to use the enrolment process for political purposes, this was overcome

→ Further information required from the workshop

Strengths and weaknesses of the enrolment process?

→ Further information required from the workshop

Resourcegeneration

Clear-cut regulation in place

according to "Agreement for "Micro health insurance scheme" under German Financial Cooperation and Islamic Republic of Pakistan"

a) First instalment of 10% cost of annual premium for the total beneficiary population of the covered area shall be paid to the State Life, within one month of the signing of agreement, upon mobilisation of services and receipt of detailed Inception Report and respective invoice.

b) Second instalment of 85% in the first year and 80% in the subsequent years of the cost of premium shall be paid to State Life within 30 days of receipt of necessary documents related to enrolment/registration of beneficiaries, in the format to be developed by State Life with covering detailed interim report and Invoice, verified by the Consultant.

c) Third instalment of 5% in the first year and 10% in subsequent years of cost of premium shall be retained and paid by the government to the State Life within 30 days of the receipt of the detailed Interim Report and Invoice (with necessary verifiable documents) after verification of additional enrolment of 2.5% for the first year, 4.5% for second year, 6% for third year, 7% for fourth year and 8% for fifth year of the general population of the district. No payment shall be retained after enrolment of 28% population of the district.

Resource generation

Initial planning (PC-1: p. 11)

Annual Operating and Maintenance Cost after Completion of the Project	Being a social protection scheme, the annual operating and maintenance cost amounting to Rs. 185.054 million would be required in the form of Annual Premium for the poorest 21 % population of the programme districts.

Year	Contribution transferred		
	Billed	Received	Outstanding
2016	136,908,395	130,874,425	6,033,970
2017	106,722,677	0	106,722,677
Total	243,631,072	130,874,425	112,756,647

Data provided by SLIC

Resourcegeneration

Flat-rate contribution: ≈ 1,500 Rp. / household

Adequacy of contributions:

- Overall positive rating of level of contributions as defined by the programme

Total expenditure until today	121,668,620
"Balance contribution – reimbursement ("balance fund/premium available")	9,205,805

Sustainability of contributions (= premium):

Very low utilisation rate until today: 2.26 % compared to the general situation in KP:

Resourcegeneration

Table 23: Type of health care accessed 2013-14 by province in %

Province	Inpatient	Delivery	Outpatient	Self-Medication	Total
Pakistan	8.45	4.97	75.37	11.21	100
Punjab	10.84	5.84	79.19	4.12	100
Sindh	4.42	3.75	73.98	17.85	100
KP	11.29	4.49	66.10	18.12	100
Baluchistan	5.38	8.50	79.41	6.70	100

Source: Pakistan National Health Accounts 2013-14

Healthcare provision / service delivery

Benefits package Phase 1:

- Benefits package designed, defined and explicitly presented in a list attached to all relevant programme contracts: medical + non-medical benefits:
  In-kind benefits: Secondary care up to a value of 25,000 Rp/year
- Benefits package for medical care supposed to cover all relevant health needs of the target population; inclusion of tertiary-care services has overcome some constraints

Healthcare provision / service delivery

Provider contracts and contracting (= empanelment):

- MoU between Gov. of Pakistan and KfW ("Phase-I-Agreement")
- Agreements between Gov. of KP and SLIC ("Phase-II-Agreement")
- Registration at Healthcare Commission required
- Agreement(s) between SLIC and hospital providers ("Agreement with Hospital") defining
  - General infrastructure
  - Medical equipment
  - Technical requirements defined
  - Individual case-wise supervision by SLIC
  - Right to routine inspections and audit without further specification
  - Prerequisites of admission: Pre-authorisation by SLIC staff

Healthcare provision / service delivery

Available manuals:

- Rules for hospital contracting ("Hospital empanelment criteria")

Successful empanelment of 26 hospitals in the project districts:

Mardan	9
Makaland	7
Kohat	4
Chitral	6
Total	26

One case of empanelment cancellation → effective follow-up of fulfilment of prerequisites (?) [Salma Shad Hospital, Kohat (private)] → not yet updated on website or re-empanelled ?

30.10.17 Holst - Preliminary Findings Review SHPI KP 25

Healthcare provision / service delivery

Available manuals:

- Provider duties defined regarding willingness to provide health care to beneficiaries and fulfilment of the due requirements; further explanations in the contract limited to general + vague arrangements regarding fees, claims processing and reimbursement.
- Operational procedures are lacking specification, no operational manual for contracting providers, information provided to hospitals not standardised, apparently insufficient, and not given on a regular and adequately budgeted bases.
- Moreover, the SLIC-provider contracts neither include mandatory transfer of relevant routine data on a continuous basis nor the respective procedures, guidelines and manuals.

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Healthcare provision / service delivery

Access to services / health care:

- Available manuals
  - Information required whether standard contracts available and applied?
  - Does the insurance company enter into special agreements with (selected) providers?
  - To which extent do providers meet the commitments?
- Regulation on access
  - Contracts and agreements determine access to IPC free of charge for beneficiaries, including financial coverage of pre-hospitalisation outpatient/emergency services whenever admission occurs

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Healthcare provision / service delivery

Access to services / health care:

- Regulation on access

Prerequisites of access to inpatient care defined:

- Use of empanelled hospital providers
- Positive balance on insurance card
- Pre-authorisation by SLIC medical officers (= "gatekeepers") at facility level prior to admission

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Healthcare provision / service delivery

Access to services / health care:

- Practical issues affecting access to health care
  - Pre-authorisation for emergency cases when SLIC staff is absent, later authorisation by SLIC staff; in case of dispute financial risk covered 100 % by provider (Agreement II: 3.6)
  - Repeatedly, providers charge SHPI beneficiaries for consulta-tions, emergency treatments and lab or other tests taken out prior to admission; in tertiary hospitals, this can amount to 5,000-6,000 Rp. → Confusion among beneficiaries, undermining of the concept of financial protection

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Healthcare provision / service delivery

Access to services / health care:

- Practical issues affecting access to health care
- **"Gatekeepers"**
  - Successfully installed in all empanelled hospitals and are physically present during daytime.
  - Functional part of the insurance's risk-management policy by controlling access to care on a one-to-one case basis
  - Not allowed to intervene in treatment issues, but continuous supervision care → prevent over- or under-treatment
  - However: Potential not yet fully used → development from "gate-keepers" to "pilots" or guides through the healthcare system

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Healthcare provision / service delivery

Access to services / health care:

- Overall assessment:
  - **Service delivery has effectively started**
  - **Beneficiaries have taken out a considerable number of health services provided by the SHPI scheme**

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Healthcare provision

Claims delivered Jan 1, 2016 – June 30, 2016									
District	Male			Female					Both
	Surg-ical	Non-Surgical	Total	Surg-ical	Obs/Gyn	Non-Surgical	Total		Grand Total
Mardan*	331	299	630	349	91	679	1120		1750
Malakand**	235	49	285	348	109	126	584		868
Kohat**	45	85	130	57	33	227	318		448
Chitral***	0	5	5	0	2	17	19		24
Total	612	438	1050	755	235	1050	2040		3090

* 1st Feb 2016 – 31st Dec, 2016; ** 16th Feb 2016 - 31st Dec, 2016; *** 17th Mar 2016 - 31st Dec, 2016

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Healthcare provision

Claims delivered Jan 1, 2017 – June 30, 2017								
District	Male			Female				Both
	Surg-ical	Non-Surgical	Total	Surg-ical	Obs/Gyn	Non-Surgical	Total	Grand Total
Mardan	284	44	328	262	130	134	526	854
Malakand	248	58	306	287	63	100	450	756
Kohat	116	649	765	218	29	1,325	1,572	2,337
Chitral	6	12	18	2	6	21	29	47
Total	**654**	**763**	**1,417**	**769**	**228**	**1,580**	**2,577**	**3,994**

Source: SLIC 2017: 16

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Healthcare provision

Variation 1st semester 2016 to 1st semester 2017

District	Male			Female				Both
	Surg-ical	Non-Surgical	Total	Surg-ical	Obs/Gyn	Non-Surgical	Total	Grand Total
No.	42	325	367	14	-7	530	537	904
Share	6,86%	74,20%	34,95%	1,85%	-2,98%	50,48%	26,32%	29,26%

Average change rate: 27,62 %, Stand.dev. 26,14 %

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Healthcare provision: Service production

Surgical procedures	Cost	Cases	Average cost
Plasmodium Falciparum Malaria	1,665,100	1,062	1,567.89
Non Surgical	7,160,100	4,435	1,614.45
Typhoid And paratyphoid Fevers	1,077,200	599	1,798.33
Drainage of Large Abscess	1,022,600	147	6,956.46
Normal Delivery	1,312,400	138	9,510.14
Appendicectomy	10,245,000	763	13,427.26
Tonsillectomy – Bilateral	10,885,750	769	14,155.72
Haemorroidectomy	3,045,760	211	14,434.88
Cataract ? Unilateral	1,551,000	107	14,495.33
Casearean Delivery	2,529,000	128	19,757.81
Cholecystostomy	2,129,000	106	20,084.91
Hysterectomy - Abdominal	3,754,000	182	20,626.37
Total	46,376,910	8,647	Average: 11,535.80
			Stand.dev.: 7,189.74

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Healthcare provision: Service production

Procedure	Cost	Cases	Average cost
Non Surgical	7,160,100	4,435	1,614.45
Appendicectomy	10,245,000	763	13,42.26
Tonsillectomy – Bilateral	10,885,750	769	14,155.72
Haemorroidectomy	3,045,760	211	14,434.88
Casearean Delivery	2,529,000	128	19,757.81
Hysterectomy – Abdominal	3,754,000	182	20,626.37
Cataract With iol	2,369,000	104	22,778.85
Estimation	3,526,138	37	95,301.03
Angioplasty 1 stent (Drug Eluted	3,250,800	15	216,720.00
Angioplasty 2 stents (Drug Eluted)	4,033,020	14	288,072.86
CABG	2,693,880	9	299,320.00
Total	53,492,448	6,667.00	Average: 91,473.57
			Stand.dev.: 117.691.58

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Healthcare provision / service delivery

- Average length of stay of IPC: 1.5 days
- Total number of deaths during hospitalisation → burial subsidies paid out: 16 (= 0.12 %) → total burial subsidy: 160,000 Rp.

Referrals:

- "Gatekeepers" at secondary level authorise referral from secondary to tertiary hospital
- "Gatekeepers" at tertiary level authorise admission
- Information to be gathered from the workshop: Rules, guidelines and manuals developed and available for referrals and re-referrals?
- Does the MIS allow for standardised follow-ups of referrals and re-referrals?

Healthcare provision / service delivery

- Large variation in referral case costs

Hospital	Referred from	Cases	Cost	Av. Cost/referral
Khyber Teaching Hospital	Chitral	4	135.600	33.900,00
Khyber Teaching Hospital	Kohat	6	41.800	6.966,67
Khyber Teaching Hospital	Malakand	10	153.600	15.360,00
Khyber Teaching Hospital	Mardan	22	305.400	13.881,82
Lady Reading Hospital	Chitral	6	85.200	14.200,00
Lady Reading Hospital	Kohat	6	671.400	111.900,00
Lady Reading Hospital	Malakand	19	700.862	36.887,47
Lady Reading Hospital	Mardan	64	2.510.524	39.226,94
Mardan Medical Complex	Malakand	15	66.000	4.400,00
Northwest General Hospital	Chitral	2	306.989	153.494,50

Healthcare provision / service delivery

Hospital	Referred from	Cases	Cost	Av. Cost/referral
Northwest General Hospital	Kohat	8	2.164.067	270.508,38
Northwest General Hospital	Malakand	14	1.509.781	107.841,50
Northwest General Hospital	Mardan	57	3.223.190	56.547,19
Rehman Medical Institute	Chitral	6	707.500	117.916,67
Rehman Medical Institute	Kohat	29	2.968.307	102.355,41
Rehman Medical Institute	Malakand	32	2.868.379	89.636,84
Rehman Medical Institute	Mardan	43	5.799.252	134.866,33
Total	4 districts	343	24.217.851	Aver. 70.605,98
				St.dev. 70.047,19

- **Unexpectedly low average costs for some referred cases!**
- **Any investigation occurred for finding out the reasons?**

Healthcare provision / service delivery

Quality of health care:

Structural quality:

- Important criterion for provider contracting: Included in contracts and guidelines, required for empanelment

- Process quality:
  - Requirements: Quality assurance committee and selected quality measures in place (e. g. readmission)
  - Not yet adequately reflected in contracts, guidelines and manuals
  - The insurance company has not yet started to implement minimal treatment standards and medical protocols
  - No enforcement of quality improvement
  - No incentives for improving quality
- Outcome quality:
  - No outcome measures defined or established in contracts
  - Post-hospitalisation events not registered
  - No benchmarks established for detecting and analysing performance

Healthcare provision / service delivery

Database for utilisation of healthcare services established and functional for

- Monitoring the use of services
- Capturing information about diagnoses / disease patterns / type of IPC
- Overseeing healthcare production for each provider under the scheme

However: Data do not provide the desirable added value

- No standardised guidelines and operational manuals for data entry by providers available
- No standardised data entry format provided → data collected in a unsystematic, often arbitrary manner → "indigestible" information
- Many inconsistencies and deficiencies in the data provided by providers

Claims processing

Rules of claims processing:

- General rules established in the contracts between GoKP and KfW, GoKP and SLIC and between SLIC and providers, including the formal documentation required*
- No detailed written operational manual for claims processing available?
- No contractual requirement to provide routine data beyond the documents needed for claims processing
- No formalised, detailed and structured guideline available regarding quality of care, treatment protocols, and other standards
- Agreement II, 5.2

Claims processing

Clarity of regulation and understanding of rules:

- Further information required for assessing the strategy of the insurance company to spread information, guidelines and training and to familiarise empanelled providers with claims processing
- Refusal of claims
- Various sources – providers as well as beneficiaries - confirm non-adherence to the rules e. g. with regards to coverage of pre-admission outpatient or emergency care

Claims processing

Enforcement of rules

- SLIC has the right to enforce rules by establishing criteria to be fulfilled and ultimately denying payment for claims which do not follow the guideline requirements
- Unless providers fall behind the minimum requirements for empanelment, the insurance company cannot force providers to meet treatment protocols, medical guidelines or certain standards of care

Claims processing

Capability of the insurance company to process claims:

- SLIC has currently core team of 5 + ≈ 280 staff in the field
- SLIC proven capable to absorb and process a relevant number of claims arriving from the empanelled providers:
- Total number of claims received: ≈ 13,000
- Total number of claims processed: ≈ 9,000
- **Individual case-per-case revision of claims**

Claims received per day	19
Average cost per claim	9,464
Number of Claims payed per day	200
Average time of claim payment	30 days

Claims processing

Share of claims processed:

Hospital type	Cases	Claims incurred	Claims received for processing	Claims paid	Outstand-ing	Share of Claims paid
Private	12,156	110,984,364	91,452,165	75,614,521	15,837,644	68.13
Public	701	10,684,256	8,545,213	7,584,215	960,998	70.98
Total	12,857	121,668,620	99,997,378	83,198,736	16,798,642	68.38

Claims processing

Control of appropriateness of claims and fraud

- Revision of claims occurs on a case-by-case basis through checks of each single incoming claim
- SLIC has proven to be able to detect wrong claims and attempts of fraud
- It is an open question whether claims processing allows SLIC to detect all relevant strategies to “optimise” claims and exploit the scheme
- No automated claims processing procedures designed and implemented

Provider payment

Regulations /rules /schedules

- All contracts define timeliness of provider payment
- Contract annexes provide detailed information about fees per case
- Phase I: Unique level of payment for secondary / tertiary providers, respectively
- Provider payment determined as case payment (=payment per case, not per service)

Timeliness of payment

- Average time of claim payment: 30 Days

Provider payment

Adequacy of fees, incentives

- Informants tend to agree with the level of reimbursement fees under the SHPI scheme and perceive them generally as adequate but perceive some rates as too low for covering costs
- Tertiary care providers consider some fees too low for covering their costs → to which extent have providers understood and got used to the principle of case payment?
- Case payment induces an intrinsic incentive for increasing efficiency – at the expense of comprehensiveness and quality of care !
- The design of provider payment does not include incentives for providers to increase ensure and improve quality of care

30.10.17 Holst - Preliminary Findings Review SHPI KP 49

Provider payment

Provider capability to absorb reimbursement revenue

- Obviously not a problem for private providers
- But: Use of additional funds by public providers yet to be clarified!
  → Recent notification might solve the problem

Cost containment

- Price containment:
  - Case payment (not fee for service!)
  - Limitation of reimbursement fees (Agreement II: 3.7)
  - Implementation of a coverage ceiling

30.10.17 Holst - Preliminary Findings Review SHPI KP 50

Provider payment

Risk management → utilisation containment:

- Pre-selection by medical SLIC staff
- Some exclusions defined (but rather vaguely)
- No other strategies for cost containment such as:
  - Limitation of provider choice – probably not an issue in KP ?
  - Reduction of benefits
  - Reduction of financial coverage (copayments) } Contrary to UHC!

30.10.17 Holst - Preliminary Findings Review SHPI KP 51

Social Health Protection Initiative Database

- Successful design and implementation
- Generally good functionality (→ sometimes a bit slow)
- Collection of a large number of important data on
  - Beneficiaries
  - Use of services
  - Expenditure for health services
- **But: Data do not provide the desirable added value:**
  - Structure and usefulness of database
  - Quality and consistency of data
  - Consistency
  - **Confidentiality is a major concern!**

30.10.17 Holst - Preliminary Findings Review SHPI KP 52

Thank you very much for your attention!

آپ کی توجہ کا شکریہ

Vielen Dank für Ihre Aufmerksamkeit

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30.10.17 Holst - Preliminary Findings Review SHPI KP 53

6.5 Presentation of interim results

Preliminary conclusions drawn from the workshop

Jens Holst

General perception

- High motivation and commitment
- Outstanding working atmosphere
- Intensive content-related discussions
- Fruitful group work and interaction
- Good opportunity for exchange beyond daily needs
- High level of technicality
- Problem- and solution-oriented discussions
- Clarification of relevant topics

11.01.2018 Holst - Workshop SHPI - Additional findings 2

Some additional findings

Beneficiaries / Enrolment

- Enrolment process has turned out to be very cumbersome due to incomplete, outdated or even wrong data, limited resources allocated to enrol beneficiaries, lack of clear-cut enrolment criteria, difficulties to track the target population
- No formal programme documentation in written form → Increased capacity required for SLIC for training counterparts
- SLIC proposal for insurance unit: Families, not households

11.01.2018 Holst - Workshop SHPI - Additional findings 3

Some additional findings

Resource generation

- Fiscal space is there - but depends on government decisions – fiscal space has to be further assessed
- No proper revenue generation mechanism in place
- Initial expectative of cross-subsidisation through voluntary enrolees covered by additional insurance product did not come true
- Contribution assessed as adequate for covering the benefit package ← No demand from SLIC to revise externally determined premium

11.01.2018 Holst - Workshop SHPI - Additional findings 4

Some additional findings

Healthcare provision

- Benefit package: Basically covering health needs - but OPD is missing!
- Empanelment process essentially clear - but insufficiently supported: More documentation and monitoring required
- Contracts one-by-one on individual basis, providers feel not sufficiently trained for entering in contracting
- Private hospital satisfied with contracting; public providers feel that they have not fully been taken on board.
- Overall accreditation policy not yet developed; only step towards accreditation made so far: Registration with Healthcare Commission

11.01.2018 Holst - Workshop SHPI - Additional findings 5

Some additional findings

Healthcare provision

- Overall accreditation policy not yet developed; only step towards accreditation made so far: Registration with Healthcare Commission
- Standards for secondary and tertiary care available but not yet disseminated
- Accessibility to facility not a problem, but guidance within facilities due to the lack of information and trained personnel hamper utilisation
- Gatekeepers at hospital level: New areas of activities for HFO and more guidance

11.01.2018 Holst - Workshop SHPI - Additional findings 6

Some additional findings

Healthcare provision

- SLIC is still contractually committed to enrol uncovered population on a voluntary basis: Recently finalising the basic additional product with a similar benefit package to be provided with different riders for offering various coverage ceilings
- Treatment protocols included in documents but has to be expanded
- A clinical expert advisory groups can be a first step for setting up treatment protocols.
- Some work has been going on for looking into best practices
- Lack of clarity hampers the effectiveness of complaint mechanism!

11.01.2018 Holst - Workshop SHPI - Additional findings 7

Some additional findings

Regulation

- Important decisions taken without consulting relevant stakeholders and technical staff → Decisions of political government do not reflect what is happening on the ground
- Interaction of the various regulators not clear; no proper role of the Healthcare Commission in rolling out the scheme due to lack of funds, expertise and human resources
- Lack of regulation on quality, all quality issues mentioned in the agreements are yet on paper but not put into practice.
- Private sector providers claim for guidelines and manuals on quality

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Some additional findings

Claims processing

- Claims processing is transparent and fair
- Providers lack adequate documentation for claiming their services, most communication is verbal.
- Capacity building on both sides key condition for claims processing and reimbursement
- Particular challenge in the public sector: Lack of continuity → low awareness and ownership

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Some additional findings

Regulation

- Complaints from providers about delayed reimbursement
- Claims process undocumented; training and sensitisation required!!!
- Weak bodies overlooking the scheme: Steering committee, no subse-quent bodies for monitoring, rules might exist but are not available
- Bodies do not adopt stewardship roles – capacity on stewardship needs to be developed
- Stewardship also means taking decision together with technical people, e. g. expansion of the scheme was decided without taking into consideration technical aspects

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Some additional findings

Provider payment

- Rules of reimbursement clear in private but not in the public sector → need more information about
- Distribution of reimbursement and allocation of revenue is a problem in the public sector:
  - Funds distribution formula elaborated but not yet implemented
  - No criteria available of how to use the revenue for improving quality
  - General public-sector mechanism available but not yet implemented
- Initial revenue was supposed to be used for immediate improvement and scaling up → incentives have to be created immediately and not postponed

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Some additional findings

Cross-cutting issues

Capacity building:

- Funds for capacity building mainly disbursed (60 %), not yet fully allocated because the wider product has not yet started
  - SLIC Staff in KP: increased to 250
  - Claims processing decentralised
  - Capacity in HMU slightly improved
  - Capacity in M&E improved but not yet sufficient
  - Orientation to providers only in Phase 1
- Strong need for capacity building in contract management and claims processing

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Some additional findings

Cross-cutting issues

Design features

- Rapid expansion makes it impossible to look back and analyse strengths and weaknesses
- Design pushes rather towards private sector:
  - Easier inclusion of private sector
  - Secondary facilities tend to push away either towards tertiary care or private providers → Conflict of interest due to double engagement of physicians

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Some recommendations

- Monitoring of empanelment process has to be a continuous task
- Initiate accreditation policy with voluntary accreditation
- Start implementing 20 treatment protocols to be applied in hospital procedures and can be linked with payments.
- SLIC should support providers to set up their own hospital plans
- Enrolment should not start from hospitals → adverse selection
- Apply PC-1 with regards to stewardship
- Need for moving away from day-to-day management towards longer term and strategic planning

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