Social protection strategies and health financing to safeguard Reproductive Health for the poor: making a case for Pakistan

Position Paper Series No 1

Health Services Academy

Social protection strategies and health financing to safeguard Reproductive Health for the poor: making a case for Pakistan.

Babar Tasneem Shaikh

Arslan Mazhar

Shahzad Ali Khan

Assad Hafeez

Health Services Academy, Islamabad

1st February 2012

Background

Annually, 150 million people face economic disaster due to direct consequences of paying for healthcare services. Amongst them, around 100 million individuals are pushed into poverty every year because they have to bear most of the expense out of pocket while seeking health care[1]. Only one out of five individuals has any sort of social security mechanism, whereas 1.3 billion of the globe population are absolutely unable to seek health care services. Due to such financial limitations and issues of accessibility, about 500, 000 women die due to pregnancy and childbirth related complications and millions of children perish due to preventable causes each year[2]. The health system of the country must be financed adequately so that people can access and be covered for promotive, preventive, curative and rehabilitative services. Regarding coverage of health services, there is marked variation where high income countries are 20 times more likely to have skilled birth attendants as compared to the low income countries[3]. This dilemma predominately prevails in the resource constrained settings and Pakistan is one example where health financing options and social security mechanisms for the households are either non-existent or very limited.

With a maternal mortality ratio of 278/100,000 live births, contraceptive prevalence rate of 29.6% and only 39% deliveries attended by the skilled birth attendants, Pakistan ranks 65th in Gender Inequality Index with an overall Human Development Index ranking of 125th over the last 3 years[4]. Pakistan also has low reproductive health status indicators in comparison with other countries of the region. Around 25,000 women die each year due to pregnancy-related complications. With an infant mortality rate of 78 per 1000 live births, at least 300,000 infants (including 160,000 neonates) die annually in their first year of life. Contraceptive prevalence (CPR) is stagnating in the last decade at 29.6%, after sharp increase in the earlier decade from 11 to 28 percent. About 37 percent of married women do not want to have more births after three children, yet do not protect themselves against unwanted pregnancies. This results in approximately, 890,000 induced abortions annually in Pakistan[5].

Around 0.6% of GDP and least developmental expenditures on health have been incurred over the last two decades in Pakistan. Most of the proportion in the allocation has gone to recurring costs mainly of

hospitals, serving hardly 15% of the urban population. Out of total health expenditures in Pakistan, government spends only US$4 out of US$17 per head per year, and US$13 is out of pocket private expenditure[6]. Direct taxation and out of pocket payments are the predominant modes of healthcare financing in the county. Other modes of financing in the country are private insurance, Employees Social Security Institution (ESSI) social protection funds such as *Zakat*[*] and *Bait ul Maal*[†], which cover small segments of the population[6,7]. Various options and innovate mode of financing for healthcare have not been earmarked due to mere spending on PHC services which is decisive for attaining the universal coverage for the vulnerable population. OECD countries are an example in case where direct payments have been replaced by various forms of prepayment such as social, community based and commercial private insurance[8]. At this point in time, when health sector in Pakistan is facing reforms, streamlining of the alternative financial arrangements to lessen financial hardship faced by the poor in the restrained resource settings is critical.

Noteworthy, the expenditure in MNCH programmes were on the higher side during fiscal year 2007-2008[7] in relation to other service delivery programmes. However, indicators specific to Goal 4 and 5 of the MDGs seem to be slowly progressing in past few years despite presence of MCH specific service delivery structures strengthened with Skilled Birth Attendants (SBAs) and community health workers, and three tiered health care system with basic and comprehensive Emergency Obstetric Care (EMOC) services. Only 39% of the population prefer deliveries by SBAs leaving a huge gap of unskilled care during the obstetric and postnatal phase of mothers[9]. MMR is quiet high in rural Pakistan[10], where maternal and obstetrics complications prevail due to insufficient number of SBAs, lack of competency and affordability issues while seeking care in basic and comprehensive EMOC facilities[11]. A reduction in the maternal mortality ratio (MMR) can only be envisaged if major focus on universal coverage of vulnerable population, such as women of reproductive age, is developed with the identification of diverse healthcare financing options, particularly in the rural parts of Pakistan.

[*] Zakat is the Islamic concept of luxury tax, which comprises an amount of 2.5% of the dormant wealth (over a certain amount unused for a year) collected and used in only specified categories.

[†] A treasury of an Islamic government used to provide income for the needy, including the poor, elderly, orphans, widows, and the disabled.

Rationale and methodology

This position paper is an attempt to provide deep insight into the opportunities for financing for Reproductive Health in Pakistan through exploring options and initiatives initiated by the government, non-government organizations (NGOs) and the donor sector. All forms of pro-poor mechanisms such as micro-health insurance, community based insurance, vouchers, conditional cash transfers, income support programs, rural support programs etc, have been discussed followed by key recommendations to instigate most applicable social protection strategies for the women of reproductive age while incurring healthcare cost. This review was strengthened by reports and official documents of the government, NGOs and the development partners to quote the figures and data as well as to support the case. Peer reviewed articles on the subject and the context were also consulted *en route* through Medline and Google Scholar.

Existing state of affairs

Beside direct taxation and out of pocket payments, other modes of heath financing are Employer's contribution (5.07%), donors (1.64%) and philanthropy (0.92%). Though various forms of social protection mechanisms are there on ground to cater the health needs of the impoverished population, however there is no explicit programme or intervention to finance reproductive health services and to provide a safety net in this regard. The main impediments in this scenario are quite obvious: low spending, dependency on existing modes of financing with fewer alternative options, issues with fund mobilization and utilization are some of them to mention[12]. Recent reforms in Pakistan allow provinces to govern health related subjects as laid down in the devolution framework. Setting priorities and identifying health financing options for the poor are now primary responsibilities of the provinces. Unfortunately, the provinces have a history of investing more in the secondary and tertiary care facilities as compared to primary health care which is supposed to serve by and large the poor masses in this country.

Various forms of health financing mechanisms to safe guard poor have been introduced by the government, private sector and donor organizations in Pakistan. These initiatives though operational in

the country for quite some time now, but they cover only small proportion of the population and limited services coverage.

a. Government Initiatives

Existing government owned social protection and safety net arrangements are *Zakat* and *Bait-ul-Mal* which primarily exempt fee for poor who are seeking care in the public hospitals. Federally administered *Bait-ul-Mal* significantly contributes toward the poverty alleviation through providing window opportunity for poorest of the poor to seek high cost diagnostic and invasive procedures not covered under *Zakat*, for instance. Micro-financing options such as Individual Financial Assistance for destitute, child support program and disability care are core functions of *Bait-ul-Mal*[13]. Similarly, *Zakat* certificate authorized by the local government entitles poor to seek free healthcare in the government health care facilities. *Zakat* fund also facilitates micro financing for the poor through grants and stipends. However, these safety net arrangements add up only 0.45% to the total health expenditure regardless of having structured institutional arrangements[7]. Another initiative is the National Rural Support Programme (NRSP) which is currently operational in 54 out of 138 districts of Pakistan, is working for rural development and poverty reduction through offering micro health insurance schemes. NRSP microfinance poverty program has enabled the rural men and women with knowledge and skills to seek timely and appropriate healthcare[14]. Similarly, Benazir Income Support Program (BISP) is another safety net arrangement by the federal government which uses targeting process to identify poor for offering microcredit options, exclusively for the rural women in Pakistan[15]. At the provincial level, the Punjab Health Sector Reform Programme (PHSRP) aims to improve quality and coverage of reproductive health services at PHC facilities with introduction of the health cards in three districts of Pakistan[16]. PHSRP provides other micro financing options too, in addition to medication and hospitalization for the poor.

b. NGO sector initiatives:

Social protection is considered as a collective social responsibility in any nation that should encompass multiple sectors with a mix of public and privately governed programs, specific to the vulnerable population of any country. NGOs have significantly contributed in the social sector especially of rural

Pakistan by investing in health, education, women development, community mobilization and micro-credit schemes. Some of these NGOs' initiatives are worth mentioning because they offer social protection mechanisms and community based insurance for women of reproductive age keeping in view of high fertility rate and low antenatal coverage. Marie Stopes Society (MSS), Health and Nutrition Development Society (HANDS) and Greenstar Social Marketing have adopted client centered approach by using the private provider model to provide affordable and quality reproductive health family planning services in Pakistan[17,18,19]. Community based insurance, micro finance programs and pre-payment mechanisms such as voucher schemes brought in by the private non-profit sector have resulted in considerable uptake of institutional deliveries as well as promotion of birth spacing. These social franchise networks use social marketing strategy to create demand for RH and FP services among the couples looking for quality services at their doorsteps[20]. However, these franchised networks have been limited to the urban centers or at the most peri-urban segments of population largely. Other notable example of health care financing is by the facilitation of community based saving groups supported by Aga Khan their Rural Support Programme in northern areas of the country, thus empowering the women for dealing with financial constraints in accessing quality pre and post natal, delivery at the facility and care of neonates[21]. Last but not the least, Heartfile's Health Financing provide a health equity fund to safeguard the poor from medical impoverishments[22]. Health equity fund facilitates cash transfers to protect the poor against catastrophic spending on health through using appropriate validation mechanisms with integration of National Database Registration Authority and transparent priority criteria for identifying poorest of poor.

c. Donor Initiatives

Fundamental challenge for the development partners is to help the developing countries in establishing social safety nets, principally in the informal sector. With regards to social protection strategies, German Technical Cooperation (GIZ), World Health Organization (WHO) and International Labor Organization (ILO) have recently established a consortium in Pakistan for ascertaining social protection mechanisms in the economically deprived communities[2]. GIZ has contributed actively in interprovincial coordination and facilitation between the different federal and provincial institutions, already working on social protection for the poor in Pakistan[23]. Development partners have tried to prioritize equity and financing issues of MNCH,

as investment case in the developing countries of Asian region[24]. UNICEF and World Bank developed a costing tool called Marginal Budgeting for Bottlenecks (MBB), aimed at estimating marginal resources required for overcoming MNCH related health system constraints. MBB helps in planning and estimating cost and impact of investments in order to scale up coverage and quality of MNCH related interventions[25]. This tool is being used to strategize the action plans for the health sector of Pakistan.

What are the options for scaling up social protection strategies?

While seeking RH care in Pakistan, poor quintiles have always confronted the threat of catastrophic out of pocket expenditure. Meagre budget, imbalance in allocations, mismanagement of finances, and poor governance has resulted in dismal state of health indicators in Pakistan[26]. Visible and concrete pro-poor health strategies for the poor have been tested; nevertheless, limited attempt has been made to scale up such strategies, particularly for saving lives lost because of preventable reproductive health problems e.g. deaths due to pregnancy related causes, unsafe abortions, reproductive tract infections, fistula etc. These issues are confronted by the poor on daily basis in this country and while coping with these challenges, out of pocket payments exacerbate inequity and poverty. Presently, social security schemes available for the formal sector are not practicable means of financing for the informal sector which comprises large proportion of population working on daily wages and contractual employments. Inability to shell out payroll taxes from the informal sector and incapability of the government to make contributions for this enormous segment of the poor rural population need to be thought out[27]. However, it can be suggested that if there is an integrated approach, not only among these private enterprises but also with the government, social health insurance can be scaled up for ensuring a universal coverage for providing RH services to the poor[28].

Enrolling and collecting contributions from the informal sector which comprises mostly the poor non-working people and the daily wagers is quite impractical and therefore it is one of the major limitation for the initiation of SHI in the country. Social protection arrangements, voucher schemes with pre-payment mechanisms, cash transfers and micro financing strategies have been commonly used to improve RH services utilization and for addressing the equity issues in the informal sector. To deal with equity, various

mechanisms have been tested for identifying, enrolling and validating poverty status for those receiving assistance in informal sector. Financial risk protection for the RH care of informal sector must be kept as a priority by the provinces, after the recent health sector reforms. Small scale investments by the government and private sector on social protection for healthcare need to be solidified for scaling up of the RH services utilization by the poorest quintiles and for ensuring the attainment of universal coverage.

The future roadmap for healthcare financing of poor women of reproductive age could be based on integration between the government health services at the basic and secondary healthcare facilities in close liaison with the private sector. The former being strong by virtue of its vast infrastructure and human resource, whereas the latter might contribute in terms of investment, thus promoting public private partnership. Such an agreement of cooperation between public and the private sector on objectives, methods and implementation of low cost mechanisms can improve accessibility, equity and quality of RH care among deprived population[29]. Recent reforms have also enabled provinces to govern and delegate health related subjects even to sub-district level administrative bodies, thus providing platform for active participation of the marginalized communities and involvement of for-profit and non-profit private sector. This sort of mixed health system arrangement can virtually tackle the RH issues, particularly in seeking antenatal, obstetrics and postnatal care. Lastly, the donor contributions through the performance based funding mechanisms can further strengthen this public private partnership for scaling up a community based insurance and the social security arrangements in low income groups.

The other practicable option for the provincial government is to adopt some of the best practices from the private sector. Pakistan *Bait-ul-Mal* is already involved in the economic rehabilitation and healthcare provision for the poor in Pakistan in about 192 hospitals around the country[27], which is fairly low to provide social safety nets for a much larger disadvantaged group. There are certain limitations in *Bait-ul-Mal* such as validation of the poverty status, costs incurred, time spent while looking out for healthcare, and informal payments borne by the users' side. These limitations can be addressed through the adoption of tools and strategies tested by the private sector working on various schemes of social protection and community based insurance.

Private sector and some of the NGOs' initiatives suggest solutions for addressing the limitations of the larger health systems. Some of the successfully implemented initiatives are pre-paid voucher schemes, community based insurance and micro finance programs. Health equity fund is also an efficient strategy for risk pooling in the informal sector[27]. This fund is able to address catastrophic out-of-pocket payments through providing exemption systems in health facilities and direct cash transfers. Such funding mechanism can be adopted within the scope of *Bait-ul-Mal's* work to transfer cash to the poor. It has been demonstrated that the electronic database of NADRA can be used for validation of economic status of the poor and needy population. Further advancement in the electronic database to continuously update the status of low socio-economic groups shall promote fairness and equity in funds distribution. Technology setup and a health equity fund have potential for scaling up social protection arrangements, with a specific focus to safeguard the vulnerable women for providing them with essential reproductive health services in the government facilities. Similarly, vouchers schemes have shown to overcome the financial impediments faced while seeking antenatal, postnatal and institutional care, hence preventing a catastrophic spending on health[9,30,31]. Combined with the social marketing strategies, vouchers have proven to be an effective instrument in uptake of reproductive health services in resource constraint settings[32]. These recent developments in healthcare financing can be considered for scaling up in the public domain. Community based insurance and micro financing programmes are scalable through the development of community based saving groups organized locally. Social mobilization on RH issues and sensitization on the micro financing options are quite practical solutions with the help of the community based health workers in the two national programmes. Around 110,000 LHWs and 15,000 community based midwives are committed to the mandate of decreasing the maternal and under five mortality rate[33,34]. These two cadres can actually ensure community involvement in the identification, prioritization and management of resources made available through community based micro financing programmes. In Pakistan, private franchised service providers have been able to improve the access and quality of RH care through performance based financing[35]. Moreover, identification and prioritization of demand side issues resolve impediments in seeking antenatal, institutional deliveries and postnatal care. To attain these objectives, scaling up franchising of RH services is quite an optimistic modality for making the

health system of Pakistan more responsive[36]. Franchised private service providers have very aptly used a client centered approached such as demand-side financing mechanism to promote the RH services utilization by the poor women of reproductive age.

Conclusion

A system based on pre-payment and financial risk pooling that ensures equitable access to needed quality health services at affordable prices in which contributions to the system are based on ability to pay and benefits are based on need[37]. This paper has made an attempt to provide an insight into the latest developments and potentials with regard to the social protection and health financing to safeguard RH for the poor in Pakistan. The analysis explored various forms of social protection arrangements and initiatives being implemented by the government, private and the developmental sector. A range of processes and mechanisms to safeguard poor are presented for the researchers, NGOs, development partners and most importantly the policy makers to deliberate and ponder upon. All social protection strategies i.e., community based insurance, vouchers, conditional cash transfers, income support programs, rural support programs etc, have been appraised followed by few scalable options and modalities to mitigate out of pocket expenditures by the poor which impede a timely and appropriate health care seeking. Public sector financing has to be increased by at least 50% of the current allocation in order to cover the lag in achieving MDGs[3839]. Within the ambit of the government health facilities and institutionalization of public social security arrangements, social safety nets must be introduced in collaboration with the private sector. It is further suggested to merge various government funds from *Zakat, Bait-ul-Mal* and other pools into one to create a reasonable fund for social protection at the national level. With limited fiscal space, narrow tax base and allocation of resources skewed towards other sectors, adoption of risk pooling mechanisms and provision of accessible and quality health services seems feasible through a meaningful public private partnership in the times to come.

References

1. GTZ-ILO-WHO. Consortium on Social Health Protection in Developing Countries. Eschborn: 2007. http://www.socialhealthprotection.org/social_protection_health.php [accessed on 18th December 2011].
2. Wieczorek-Zeul H. Social health insurance in development cooperation. Extending social protection in health; developing countries experiences, lessons learnt and recommendations. GTZ-ILO-WHO, Berlin: 2005.
3. World Health Organization. World Health Report 2010. Health Systems Financing: The path to universal coverage. Geneva: 2010.
4. United Nations Development Programme. Human Development Report 2010. The real wealth of the nations: Pathways to human development. New York: 2010.
5. Rasheeda G, Shah ZH, Fikree F. Unwanted Pregnancy and Post Abortion Complications: Report from Health Care Professionals and Health Facilities. Population Council, Islamabad: 2004.
6. Shaikh BT. Health care system in Pakistan In: Health care systems: A global survey. Rout HS (Eds.): New Delhi, India: New Century Publications; 2011.
7. Nishtar S. Choked pipes. Reforming Pakistan's mixed health system. Oxford University Press, Karachi: 2010.
8. Doetinchem O, Schramm B, Schmidt JO. The benefits and challenges of social health insurance for developing and transitional Countries. In: Laaser U, Radermacher R (Eds.): Financing health care - A dialogue between South Eastern Europe and Germany, Lage. Series International Public Health; Vol 18: 2006
9. Agha S. Impact of a maternal health voucher scheme on institutional delivery among low income women in Pakistan. Reproductive Health 2011; 8:10.
10. Midhet F, Becker S. Impact of community-based interventions on maternal and neonatal health indicators: Results from a community randomized trial in rural Balochistan, Pakistan. Reproductive Health 2010; 7:30.
11. Jan R, Mohammed YJ, McIntyre H. Implementing midwifery led care in Pakistan. Pract Midwife 2011; 14(6):32-4.

12. Nishtar S. The Gateway Paper. Financing health in Pakistan and its linkage with health reforms. J Pak Med Assoc. 2006; 56 (4):25-42.
13. Government of Pakistan. Pakistan Bait-ul-Mal. Prime Minister Secretariat, Islamabad. http://www.pbm.gov.pk/new/MDs_Message.html [accessed on 12th December 2011]
14. National Rural Support Programme. Islamabad. http://nrsp.org.pk [accessed on 12th December 2011]
15. Benazir Income Support Programme, Government of Pakistan. Islamabad. http://www.bisp.gov.pk [accessed on 12th December 2011]
16. Punjab Health Sector Reform Programme. Health department, Government of Punjab, Pakistan. http://www.phsrp.punjab.gov.pk/index.html [accessed on 12th December 2011]
17. Marie Stopes Society. Safe Motherhood. http://mariestopespk.org/projects/safe-motherhood [accessed on 12th December 2011]
18. Greenstar Social Marketing. Family Planning and Reproductive Health. http://www.greenstar.org.pk/FPRH.htm [accessed on 12th December 2011]
19. Health and Nutrition Development Society. Marginalized Areas RH & FP Viable Initiatives (MARVI). Mid-term Review Report; 2009. http://www.hands.org.pk/beta1/images/stories/pdf/ResearchReports/MidTermReview/MARVI.pdf [accessed on 12th December 2011]
20. Agha S. Changes in the proportion of facility-based deliveries and related maternal health services among the poor in rural Jhang, Pakistan: results from a demand-side financing intervention. Int J Equity Health 2011, 10:57.
21. Aga Khan Development Network. Microfinance for Women in Northern Pakistan. AKDN Publications; 2007. http://www.akdn.org/publications/case_study_akam_women_pakistan.pdf [accessed on 12th December 2011]
22. Heartfile. Health Financing. Islamabad: 2009. http://www.heartfilefinancing.org [accessed on 12th December 2011]
23. Government of Pakistan. Health: New Growth Framework. Planning Commission Newsletter. Planning and Development Division, Islamabad 2011;12 (12).

24. Asian Development Bank. Impact of Maternal and Child Health Private Expenditure on Poverty and Inequity those constraints. Technical Assistance Report, Research and Development Technical Assistance; 2008. Project Number: 41252. http://www.adb.org/Documents/TARs/REG/41252-REG-TAR.pdf [accessed on 25th December 2011]
25. World Health Organization. Marginal Budgeting for Bottlenecks: Costing tool. The Partnership for Maternal, Newborn and Child Health. Research and Development Technical Assistance; 2011. http://www.who.int/pmnch/topics/economics/costing_tools/en/index12.html [accessed on 25th December 2011]
26. Shaikh BT, Hatcher J. Health seeking behavior and health services utilization in Pakistan: challenging the policy makers. J Public Health (Oxford). 2005; 27(1):49-54.
27. Nishtar S, Khalid F, Ikram A, Kazi A, Abbas Y, Mirza YA, et al. Protecting the poor against health impoverishment in Pakistan: proof of concept of the potential within innovative web and mobile phone technologies. World Health Report 2010;55
28. Abrejo FG, Shaikh BT. Social Health Insurance: can we ever make a case for Pakistan? J Pak Med Assoc 2008; 58(5): 267-270.
29. Asian Development Bank. Specific Pro-Poor Activities in PPPs, Public Private Partnership Hand Book, Philippines; 2008:81-84. [cited December 26 2011] [Available from URL: http://www.adb.org/Documents/Handbooks/Public-Private-Partnership/Public-Private-Partnership.pdf
30. Ir P, Horemans D, Souk N, Van Damme W. Using targeted vouchers and health equity funds to improve access to skilled birth attendants for poor women: a case study in three rural health districts in Cambodia. BMC Preg Childbirth 2010;10:1
31. Rob U, Rahman M, Bellows B. Using vouchers to increase access to maternal healthcare in Bangladesh. Int Q Community Health Educ. 2009-2010; 30(4):293-309.
32. Van Rossem R, Meekers D. The reach and impact of social marketing and reproductive health communication campaigns in Zambia. BMC Public Health. 2007;7: 352.

33. Ministry of Health. National Programme for Family Planning and Primary Health Care. Government of Pakistan, Islamabad: 2009. http://www.phc.gov.pk [accessed on 2nd January 2012]
34. Government of Pakistan. National Maternal Newborn & Child health Programme. Program Overview. http://www.mnch.gov.pk/overview.php [accessed on 2nd January 2012]
35. Shah NM, Wang W, Bishai DM. Comparing private sector family planning services to government and NGO services in Ethiopia and Pakistan: how do social franchises compare across quality, equity and cost? Health Policy Plan 2011; 26 Suppl 1:i63-71.
36. Ejaz I, Shaikh BT, Rizvi N. NGOs and government partnership for health systems strengthening: a qualitative study presenting viewpoints of government, NGOs and donors in Pakistan. BMC Health Serv Res. 2011; 11: 122.
37. Ministry of Health & Population and GIZ: Assessment of the Government health financing system in Nepal: Suggestions for reform. Kathmandu: 2011.
38. Mohammad KB, Hafeez A, Nishtar S. Public sector health financing in Pakistan: A retrospective study. J Pak Med Assoc. 2007; 57(6):311-6.

Corresponding Author:

Dr Babar Tasneem Shaikh, MBBS, MBA, MPH, PhD, FRCP Edin

Department of Health Systems & Policy,

Health Services Academy,

Chak Shahzad, Park Road, Islamabad, Pakistan.

t: +92-51-9255590-94, Ext. 102

f: +92-51-9255591

m: +92-333-2303403

e: shaikh.babar@gmail.com