Ehsaas Catastrophic Health Expenditure policy

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Context

WHO defines Catastrophic Health Expenditure (CHE) as out-of-pocket (OOP) spending for healthcare that exceeds 40% of household income net of subsistence needs. Estimates suggests that 1–2% of the world population suffers from financial catastrophes due to OOP medical costs each year.

CHE is an equally significant challenge in Pakistan. There are financial gaps in the current healthcare system leading to 56% of healthcare expenses being out-of-pocket in Pakistan (compared to 44% for low-income countries and 41% for heavily indebted poor countries[1]). It is estimated that ~1% of the population in Pakistan is pushed below the poverty line each year due to out-of-pocket health care expenditure[2].

To address this challenge, the government introduced the Sehat Sahulat program (SSP) to improve financial access to good quality medical services through a health insurance scheme. The program provides coverage to ~7.7 Mn[3] families across ~1500 treatment packages (covering secondary care and priority treatment) at ~450 medical facilities across the country. SSP plans to expand its current selected beneficiary coverage to universal health coverage across Punjab, ICT and GB in the coming months based on the Prime Minister's directive.[4] In addition to this, KP scaled up the program across its province as Sehat Sahulat program plus, to provide universal health coverage to all KP residents (~6.5 million families). *(Details in Exhibit 1)*

Exhibit 1: Overview of public insurance programs

	Sehat Sahulat	KP Sehat Plus
Geographical coverage	▪ Punjab, AJK, ICT, GB, ex-FATA and Tharparkar	▪ All individuals with KP as permanent address on CNIC
Income groups	▪ Households with PMT score below 32.5 (monthly income ~ <Rs. 20k) ▪ Universal coverage in AJK, ex-FATA and Tharparkar	▪ Universal (no income cut-off)
Coverage amount	▪ Capped at Rs. 360k per family/year (additional Rs.360k on need-basis)	▪ Capped at Rs. 1 million per family/year (additional funds for extremely poor on need-basis)
Hospitals	▪ 450+ public, private and military hospitals (with ~150 empaneled in KP) ▪ Hospitals assessed and selected by insurance partner (State Life Insurance Company) ▪ Patients enrolled in either program can avail treatment at any empaneled hospital	

[1] 2018, World Health Organization Global Health Expenditure database

[2] 0.87% of of population pushed below $1.9 (2011 PPP) in 2015 (1.3% in 2013). WHO and World Bank Data

[3] www.pmhealthprogram.gov.pk. however, this includes ~1.2 Mn families from KP that were covered prior to Universal health coverage.

[4] Prime Minister of Pakistan has announced this publicly and provided direction to the program to scale up.

Need for an additional health financing system

While the Sehat Sahulat program has been able to provide significant cover to the population, there are certain limitations inherent to the adoption of insurance in Mixed Health Systems[5] that need to be addressed. These include the following:

1) **Limitation of health insurance to address catastrophic health expenditure in all cases**– currently, families can avail health services of PKR 360,000 – 1,000,000 per year. While this level of coverage is sufficient to protect beneficiaries against most health expenses, it does not provide a safety net for households with catastrophic health expenses beyond this range (e.g., cancer treatment, transplants, cardiac surgeries, etc.), leaving many households at the risk of facing financial distress.

2) **Limited public sector hospital coverage** – majority of public sector hospitals in Pakistan have not been covered under the existing programs so far, due to hospital onboarding challenges. This has led to many patients in public sector hospitals being exposed to significant out of pocket expenditure in the public healthcare system.

3) **Undocumented sector** –a large number of individuals remain undocumented, and whilst they may be the most vulnerable, the government is unable to pay premiums on their behalf.

4) **Geographic** – in addition, Sehat Sahulat is currently not operational in many geographic areas.

5) **Out-patient services** – Sehat Sahulat does not cover outpatient services

While the government aims to expand Sehat Sahulat program to all provinces in a similar manner to KP, only the first gap of lack of universal coverage will be resolved. The gaps around annual limits, and lack of public sector hospital coverage will remain and need to be addressed.

A fund-based solution can complement the existing insurance-based Sehat Sahulat program to provide Universal Health Coverage in such contexts. A fund-based system refers to a strategic purchasing system that buys/purchases services from hospitals based on a set of eligibility criteria and rules (This does not refer to the fund-based system that makes payments to hospitals based on DRGs.[6])

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[5] Nishtar S. Mixed Health Systems Syndrome. Bull World Health Organ 2010;88:74-75. doi: 10.2471/BLT.09.067868 http://www.who.int/bulletin/volumes/88/1/09-067868/en/

[6] Patient classification system that standardizes prospective payments to hospitals and encourages cost containment initiatives

A Mixed Health System[7]—of which Pakistan is an example—is one in which both public and private health service delivery co-exists but where out of pocket payments are a major means of health financing. In such settings, typically there are hybrid health financing arrangements, i.e., revenue funded basic services, along with full coverage for a select group of people with entitlements; possibly insurance for some of those in the formally employed sector and social health insurance for the entitled based on a set of criteria but with ceilings; notwithstanding, out of pocket payments predominate as a means of health financing.

Global precedents for catastrophic fund in parallel to universal health insurance

Mexico

In 2004, the government of Mexico introduced a social health protection system called the Seguro Popular (People's health Insurance) guaranteeing access to health. Additionally, the government also launched a fund, the Catastrophic Health Expenditure Fund (CHEF), to protect people registered with Seguro Popular against catastrophic health expenditure.

Exhibit 2: Features of the health program

	Seguro Popular	**CHEF**
Administered by	State government	Federal government
Target population	State	Beneficiaries of Seguro popular + population without any social security
Payment to service provider	Capitation basis[8]	Per case basis
Interventions covered	284	59

While Seguro Popular covered common and low-cost illnesses, CHEF targeted more selected interventions where absence of coverage would endanger the financial health of the beneficiaries significantly. CHEF initially covered 4 interventions and was scaled to 59 by 2013 to include specialized health conditions like cancer, kidney transplants, hepatitis C, tumor etc.

With over 10 million patients served in its first 10 years, WHO appreciated the impact of CHEF as "…not … an end in itself, but rather a complementary component of the health

[7] Nishtar S. Mixed Health Systems Syndrome. Bull World Health Organ 2010;88:74-75. doi: 10.2471/BLT.09.067868 http://www.who.int/bulletin/volumes/88/1/09-067868/en/
[8] Insurance model i.e. fixed payment to health care service providers for each enrolled person assigned to them per period of time, irrespective if the person seeks care or not

system". It also identified CHEF as having positive impact on service providers through access to increased financial resources that enabled improved health outcomes.[9]

China

As part of its broader health reforms, China has made significant efforts to provide universal health care to its population. A prominent element of this effort has been the Catastrophic Medical Insurance (CMI) scheme, focused on protecting catastrophic health expenditures associated with critical illnesses.

By 2011, China was near its goals of universal coverage through its 3 insurance schemes cumulatively covering more than ~90% of its population[10.] These 3 schemes included UEBMI, URBMI and NRCMS, (with the latter two merged in to one scheme, Basic Medical Insurance). However, the effectiveness of these programs was inconsistent across the country due to the varying ability of regional governments to fund comprehensive benefits package (annual caps varied from RMB 35,000-100,000).

In 2012, China launched CMI - designed to reimburse patients whose out of pocket medical expenses exceeded coverage provided by BMI. CMI is also based on WHO's definition of catastrophic expense (cost to be higher than 40% of net income) based on which patients get reimbursed for out-of-pocket expenses incurred over a certain amount. The program has been applauded for reducing CHE incidence from 4.8% to 0.1% for covered medical expenses.

A safety net for catastrophic health expenditures to complement Sehat Sahulat

Given the current landscape and the importance of protecting the vulnerable, there was a need for a program, designed to act as a complementary initiative to the current programs, which addresses the gaps to ensure no one falls into poverty due to healthcare expenses.

To address this need, Ehsaas Tahafuz was designed as Pakistan's first ever shock-oriented safety net program to provide coverage specifically against catastrophic health expenditures to vulnerable communities. The program works in partnership with service providers (hospitals) that identify patients requiring financial support. Patients identified are then assessed by Tahafuz against an eligibility criterion. For eligible patients, hospitals are directly reimbursed for pre-defined treatment costs.

Tahafuz has defined its coverage principles to complement already existing Sehat Sahulat program and plug in any gaps. The program was built keeping in mind 5 key principles:

1) **Provides universal access** – Offers coverage to every citizen of Pakistan regardless of race, gender, socio-economic class, provincial residence etc. Due to financial constraints, currently Tahafuz is supporting beneficiaries with PMT (Proxy Means Test)

[9] Mexico -Catastrophic Health Expenditure Fund, WHO, 2015
[10] China's health care reforms, Health International, Volume number 10, 2010

score of 44 and below. However, there is an opportunity to turn the program into a fully universal program as long as the health expense incurred is catastrophic in nature.

2) **Cater to only catastrophic expenditure**– Provides coverage for health expenses that are catastrophic in nature and not covered in the existing SSP system

3) **Complements existing insurance programs** – Prevents duplication of efforts and costs with the existing programs by serving patients as detailed in Exhibit 2.

4) **Coverage for all essential treatments** – Ensures all required health treatments, services and products are available to eligible beneficiaries

5) **Promotes accountability and improvement** – Uses digital mechanisms to monitor and evaluate beneficiary experience and service provider performance. This allows tapping donors and private philanthropists more meaningfully.

Exhibit 3: Current 3-check eligibility criteria

Check 1	**Alternative insurance check** Patient qualifies for step 2 if: ▪ Patient is **not enrolled** in Sehat Sahulat, OR ▪ Patient is **enrolled** in Sehat Sahulat but: - **Hospital is not empaneled** by SSP/KP Sehat Plus, OR - Patient has **exceeded coverage** provided by SSP/KP Sehat Plus, OR - **Condition is not covered** under Sehat Sahulat
Check 2	**Poverty threshold check** – Patient qualifies for step 3 if **PMT score is below 44** (avg. household income ~PKR 26,000)
Check 3	**Catastrophic expenditure check** – Patient is eligible for Tahafuz if cost of treatment required is >40% of patient's estimated income less food costs (WHO definition)

The eligibility criteria ensures that the funds are only used to address needs of deserving patients who would otherwise remain neglected and unserved.

The Tahafuz system is paperless, mobile-phone centered and technology-based. It is currently operational in one city and is being scaled up. Its automated workflows, supply-chain management, tracking and time-shaping, and pre-configured rules for eligibility ascertainment, help overcome abuse and mistargeting of social protection funds. These features have made the system responsive and accountable. The system turns around patient requests for assistance in less than 24 hours. In addition, micro-transaction alerts and personalized login credentials for web viewing enable transparency and accountability. Ehsaas Tahafuz will run as per the parameters outlined in this Policy to complement Sehat Sahulat to ensure efficient use of public resources and to build synergies between complementary programs.