Policy Options for Financing Health Services in Pakistan

VOLUME IV
DEVELOPMENT OF PRIVATE HEALTH INSURANCE BASED ON MANAGED-CARE PRINCIPLES

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POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN

A Compendium

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Volume I **Summary Report**
by Marty Makinen

Volume II **Hospital Quality Assurance Through Standards and Accreditation**
by Greg Becker

Volume III **Hospital Autonomy**
by Stan Hildebrand and William Newbrander

Volume IV **Development of Private Health Insurance Based on Managed-Care Principles**
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Zohair Ashir studied the use of Muslim religious funds for financing health services for the indigent (Volumes 1, 3, and 5).

ABSTRACT

This report focuses on the potential for developing in Pakistan private health insurance programs based on managed-care principles. Fostering such programs would benefit the Government of Pakistan because encouraging private coverage of health care costs would reduce the burden that the government currently bears in financing health services. At the same time, promoting the development of a private-sector insurance industry with the managed-care approach would contain the costs of health services while improving the quality of care provided. This study surveys employees in Karachi and Islamabad to ascertain the market potential for private insurance programs and makes recommendations about developing these markets. It also presents the basic elements of a model managed-care health insurance program for Pakistan.

VOLUME IV - DEVELOPMENT OF PRIVATE HEALTH INSURANCE BASED ON MANAGED-CARE PRINCIPLES

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ACRONYMS, ABBREVIATIONS, AND GLOSSARY

AID	U.S. Agency for International Development (Washington, D.C.)
AKHS	Aga Khan Health Services
AKU	Aga Khan University
AKUH	Aga Khan University Hospital
AKUHS	Aga Khan University Health Services
Amir	Head of a Muslim State
ARI	Acute Respiratory Infection
Bait-ul-Mal	Welfare funds established by the Amir
BHUs	Basic Health Units
CCU	Cardiac Care Unit
CDA	Capital Development Authority
CDD	Controlling Diarrheal Diseases
CHW	Community Health Worker
CRHP	Cost Recovery for Health Project, Cairo, Egypt
chowkidar	Watchman
CV	Curriculum Vitae
CZA	Central Zakat Administration
CZC	Central Zakat Council
DHO	District Health Officer
DOH	Department of Health (provincial level)
EPI	Expanded Program of Immunization
ESSI	Employee Social Security Insurance
Fatamid Foundation	Blood Donor Agency
FGSH	Federal Government Services Hospital
FJMC	Fatimah Jinnah Medical Center
FMOH	Federal Ministry of Health of Pakistan
FP	Family planning
GDP	Gross Domestic Product
GMO	General Medical Officer
GNP	Gross National Product
GOP	Government of Pakistan
GP	General Practitioner
Hakims	Traditional health practitioners
HCFA	Health Care Financing Administration, U.S. Government
HFS	Health Financing and Sustainability Project
HMO	Health Maintenance Organization
HPAC	Healthcare Provider Accreditation Council
HPN	Office of Health Population and Nutrition
HT	Health Technician
ICT	Islamabad Capital Territory
ICU	Intensive Care Unit
IPA	Independent Practice Association
ISL	Islamabad
JCAHO	Joint Commission for the Accreditation of Health Care Organization
JPMC	Jinnah Postgraduate Medical Center
Katchi Abadis	Squatter Settlements
KEMC	King Edward Medical Center
KHI	Karachi

LDC	Lower Division Clerk
LHV	Lady Health Visitor
Liaquat	Hospital (Karachi)
LZC	Local Zakat Council
Mali	Gardener
MCB	Muslim Commercial Bank
MCH	Maternal and Child Health
M.O.	Medical Officer
Mohalla	Neighborhood
MSH	Management Sciences for Health
Mustaheqeen	Needy People
Naib/Qasid	Orderly/Housekeeper
NGOs	Non-Governmental Organizations
NICVD	National Institute of Cardiovascular Diseases
NJI	New Jubilee Insurance Company
NWFP	North West Frontier Province
ORT	Oral Rehydration Therapy
p.a.	per annum
PAHO	Pan American Health Organization
PCP	Primary Care Physician
parchi fee	Registration or door fee when using a health facility
PCSP	Pakistan Child Survival Project
PGMI	Post Graduate Medical Institute, Lahore
PHC	Primary Health Care
PIA	Pakistan International Airways
PIMS	Pakistan Institute of Medical Sciences
PMDC	Pakistan Medical and Dental Council
PMRC	Pakistan Medical Research Council
PPGP	Pre-Paid Group Practice
PPO	Preferred Provider Organization
PZC	Provincial Zakat Council
RHC	Rural Health Center
Riba	Interest (or usury)
Rs.	Pakistani Rupees (approximately Rs. 25 = U.S. $ 1.00 in 1992)
SAP	Social Action Program
SES	Socio-economic status
SESSI	Sindh Province ESSI
Shariah	Islamic Laws
TA	Technical Assistance
TBA	Traditional Birth Attendant
Tehsil	Zone Within a District
Tehsil Hospitals	Hospitals Within a Zone
UI	The Urban Institute
USAID	U.S. Agency for International Development (Mission)
Ushr	Islamic levy on agricultural production given to the poor
VHW	Village Health Worker
Waqf	Property endowment to a religious or charitable purpose
WHO	World Health Organization
Zakat	An obligatory Islamic religious donation for the indigent

AN OVERVIEW OF THE STUDY
"POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN"

INTRODUCTION

This is one volume in a set of five reporting on work performed between 1991 and 1993 by the Federal Ministry of Health (FMOH) of Pakistan with the assistance of USAID's Health Financing and Sustainability Project (HFS). The purpose of this study was to design four financial and organizational reform initiatives to improve the delivery of health services in Pakistan.

Volume I of this series summarizes the overall study and presents the recommendations made in each program area. Volumes II through V are technical reports that address the following issues:

- Assuring quality health services by establishing national standards for accrediting hospitals
- Granting autonomy to government hospitals
- Developing private health insurance based on managed care principles
- Providing new models for delivering health services in rural areas

OBJECTIVES OF THE REFORM

The FMOH's new approaches to financing and organizing health services are intended to:

- Make more resources available to the health sector by increasing the share of the gross domestic product allocated to health.
- Increase efficiency in the use of resources by improving the cost-effectiveness of health spending.
- Ensure physical and financial access to basic health services for lower socio-economic status groups, both rural and urban.

GUIDING PRINCIPLES

The FMOH set out the following principles to guide the design of the four initiatives:

1. Those who have the resources must contribute to the cost of the health services they use, principally through paying user fees, often facilitated through insurance mechanisms.

2. New methods must be developed to organize the way in which services are delivered, including offering incentives to service providers for efficiency, cost effectiveness, and quality.

3. Government allocations must target lower socio-economic status groups.

CHOOSING THE APPROACHES

In 1990, a broad-scope study of Pakistan's health care system was conducted by the FMOH with assistance from the U.S. Department of Health and Human Services' Health Care Financing Administration (HCFA). This study identified a list of areas in which organizational and financial reforms might be made.

In order to narrow down these areas and to design specific initiatives within them, USAID made available to the Government of Pakistan the technical services of its Health Financing and Sustainability (HFS) project. From 1991 to 1993, staff and consultants from the HFS project gathered up-to-date information, consulting with government and private health service providers, provincial and federal health officials, employers in both the private and public sectors, insurers, and donor agencies such as the World Bank and UNICEF that are interested in health.

This information was synthesized and presented at a workshop organized by the FMOH in February 1992. Also presented were approaches to financing and organizational reform that had been identified in the 1990 HCFA study. After listening to commentary from workshop participants, the FMOH selected for further study the four areas identified at the start of this section. Partly, these were selected because it was felt that changes in one area would support changes in another. For example, granting autonomy to government hospitals (Volume III of this study) would free these institutions to work towards meeting nationally established standards of quality (the initiative described in Volume II). Hospitals would also benefit from the development of private, managed-care insurance plans (Volume IV). Such insurance plans would, in turn, use the information gained by independent assessments of hospital quality to choose facilities with which to associate. Furthermore, strengthened rural services (Volume V) would reduce the burden on government hospitals, and, as government hospitals improve, they would better serve as referral sites for rural services.

DESIGNING THE INITIATIVES

Following the 1992 workshop, the Federal Ministry of Health, through the technical services of the HFS Project, pursued studies in each of the four selected areas. The study team was composed of seven national and nine external experts. Ultimately, three more workshops were held at which proposals in these areas were presented and feedback was obtained. The goal of this consultative

approach was to gain the benefit of the wisdom and experience of all the important actors involved in Pakistan's health sector. This approach was also intended to build consensus concerning how to best address and implement reforms.

What follows is the technical report and the recommendations in the field of health insurance.

VOLUME IV

DEVELOPMENT OF PRIVATE HEALTH INSURANCE BASED ON MANAGED-CARE PRINCIPLES

EXECUTIVE SUMMARY

PRIVATE HEALTH INSURANCE

PURPOSE

The Federal Ministry of Health would like more Pakistanis to be covered by health insurance paid for by beneficiary and employer contributions. A private insurance system would include mechanisms that limit increases in health care and administrative costs. The current growth in the government's responsibility for financing health services would be reduced by any growth in private health insurance coverage.

PROBLEM

The Government of Pakistan is pursuing approaches in the reform of its hospitals and its rural health services which will result in consumers being asked to pay for the services they use. User payments, particularly for hospitalization, would be greatly facilitated if insurance mechanisms existed that shared the financial risks. Presently, the few private health insurance programs in Pakistan are plagued by escalating costs, fraud, and abuse. Thus, insurance companies are reluctant to offer health coverage, and employers worry about how to provide health benefits to their employees. New approaches to health insurance are needed to allay fears so that expansion of coverage may be attained to complement the changes being planned at government hospitals and, to a limited extent, in rural health facilities.

DESCRIPTION OF THE INITIATIVE

This initiative is designed to stimulate the development of private-sector insurance mechanisms based on managed-care principles. The focus is on designing ways to guide and support the development of insurance programs in two urban markets, Karachi and Islamabad. Managed-care principles are espoused to address the problems of cost escalation, fraud, and abuse prevalent in current indemnity-style insurance arrangements. Managed-care principles can be used in many designs. Whichever form is used, managed-care principles include having competitive prospective payment mechanisms to help contain costs. Under prospective payment, providers are given a fixed sum to have a set of services made available to a given group of people. This leaves providers with no financial motive to over-treat patients or to add ineffective, costly technologies. Further, providers are motivated to control unnecessary utilization rather than being tempted to join with the insured to defraud the insurer or the employer. Lastly, payments are made from the insurance organization directly to providers, bypassing the insured and closing off an opportunity for fraud.

METHODS

A multidimensional approach was taken to identify the problems inhibiting the development of health insurance in Pakistan and to recommend possible solutions. This approach included having technical visits made by external consultants associated with managed-care programs in the United States. Along with a Pakistani consultant, they conducted interviews and meetings in 1992 with representatives of the health sector and with members of the health insurance industry to assess the feasibility of using managed-care principles in the design of health insurance plans. An assessment of the health practices currently being used in Karachi and Islamabad also was done in order to understand how the health care delivery systems operate. To determine their interest in participating in a managed-care plan and to gather baseline data about them, employers of mid-size companies in Karachi and Islamabad were surveyed. In addition, an analysis was done of the Employee Social Security Insurance systems in each of the provinces.

These analyses found that, unless changes are made in the overall approach to health insurance, the share of the population covered by insurance is unlikely to grow and the performance of existing providers is likely to remain unsatisfactory. Under current circumstances, the general business environment is not conducive to encouraging good health insurance practices; both financial incentives and legislative measures are lacking. The result is that providers are wary of health insurance. A promising way out of this situation is to find methods of stimulating the development of private health insurance in the country.

RECOMMENDATIONS

To facilitate the development of health insurance using managed-care principles in Pakistan, the following recommendations are offered:

Near-Term Government Actions:

Conduct insurance workshops in Karachi and Islamabad for potential insurers, employers, and providers to present this study's findings. The Health Financing and Sustainability (HFS) report on insurance development should be made available to workshop participants since it offers planning and technical information about the current market for a managed-care product. The report's implementation plan could serve as the strategic plan for potential insurers to conduct feasibility analyses.

Help potential insurers acquire technical training in designing and operating managed-care plans. Request donor organizations to provide such training to insurers, employees, and providers as a part of technical assistance programs.

Encourage selected health care providers in Karachi and Islamabad to launch their own managed-care plan. The FMOH should consider trying to persuade selected providers in Karachi (such as the Aga Khan University Hospital) and in Islamabad (such as the Pakistan Institute of Medical Sciences) to start their own managed-care plans. To induce them into taking the initiative, the FMOH could purchase health services from them for a selected group of federal employees, providing them a ready client base until the plan becomes financially self-sustainable.

Give potential insurers financial incentives for inventing a managed-care health insurance plan. Private sector employers could be stimulated to purchase insurance by extending to them a temporary tax break when making their first purchase of a managed-care product. Once in the health care plan, benefits would be expected to keep them there without their tax incentive. State-owned organizations also could be induced to purchase managed-care insurance using funds currently spent on providing medical services.

Arrange for a government-backed demonstration of a managed-care plan. The GOP or Provincial Governments should consider showing off the attractive feature of managed care by contracting with private health insurers that use managed-care principles to provide services for a selected group of government employees.

Near-Term Insurer Actions:

Revise the HFS model of managed-care benefits based on employer survey feedback. It is recommended that potential insurers price the basic package described in this survey, then price asked-for "add ons." These include dental care, health coverage for members' parents, and the possibility of arranging for treatment abroad in special cases.

Conduct a feasibility study for introducing a managed-care product.
The employer survey conducted during the HFS study on insurance indicated a strong interest in learning more about a managed-care plan. Seventy-four percent of those surveyed asked for follow-up information. This suggests that it would be in the interest of potential insurers (insurance companies or providers) to take the next steps in defining and pricing a package of services to test the market.

Market managed-care plans to multinational and state-owned organizations. Multinational and state-owned organizations provide more liberal and generous health benefits than other employers in Pakistan These organizations are open to accepting concepts like managed care. In the employer survey, they indicated a desire to improve health coverage for all employees. Employees at management levels are better educated and more conscious of the importance of providing high quality care and of controlling escalating medical costs, the primary benefits of a managed- care product. Therefore, insurers may wish initially to target this category of employer.

Long-Term Government Actions:

Enact national legislation to provide the framework for managed-care insurance programs. Such legislation could allow for the revision of Employment Social Security Insurance, and to establish a national body to oversee insurance issues in Pakistan.

Revise the policy on Employee Social Security Insurance (ESSI). There are a number of areas that government can intervene in the ESSI program to improve its effectiveness. These include:

- Raising the income ceiling of ESSI-eligible employees and indexing it to inflation (i.e., have it increase annually by the rate of inflation). Also, employees who pierce this ceiling should be allowed to stay in the program, if they so desire.
- Making all non-supervisory employees eligible for enrollment in the ESSI program.
- Encouraging employee contributions on a monthly basis to further improve ESSI-provided services.
- Contracting with private providers on a capitation basis.
- Permitting employers to opt out of ESSI by selecting alternative insurance programs.

Conduct a study to assess the advantages and disadvantages of compulsory health insurance of employees by employers. Study the impact of such a policy on employment and competitiveness.

The HFS study concludes that employers in Pakistan are interested in exploring further the potential benefits of private health insurance and that, if the above recommendations are pursued, insurers could be attracted to offer private health care insurance plans based on managed-care principles.

1.0. INTRODUCTION

The development of private insurance based on managed-care principles in Pakistan is seen by the Federal Ministry of Health (FMOH) as an important way to address several of the major problems currently faced in the health sector. Expansion of private health insurance would help mobilize more resources for health, it would contribute to greater efficiency and would improve the quality of services offered. It would result in private payment for costly services such as hospitalizations. Using managed-care principles would put incentives in place for containment of costs and for increased health prevention efforts. Competing insurers would require participating providers to reach and maintain standards of quality. Furthermore, as private health insurance develops, the government would be able to reduce its subsidies to those able to pay, concentrating the freed-up resources on assisting those who are poorer.

The development of private health insurance also would complement and be complemented by the initiatives on hospital autonomy and quality assurance proposed in the overall Health Financing and Sustainability (HFS) study. Autonomous hospitals would be able to increase their revenues by competing for contracts with insurance organizations. Furthermore, the hospital standards and accreditation system that is expected to be developed through the quality initiative would provide insurers with information about which hospitals offer the best value for money.

The FMOH is eager to explore the prospects of developing Pakistan's private health insurance market. The approach chosen would include programs along the lines of managed-care efforts which have proven successful in the United States. The initial target groups would be large employers in urban centers. It is expected that after gaining experience and confidence during this period, insurers would expand coverage and market size to include larger portions of the population.

To help the FMOH address issues related to fostering the growth of private health insurance in Pakistan, a team of local and U.S.-based consultants was formed in February 1992. The FMOH requested that the work on the insurance initiative focus on two cities, Islamabad and Karachi.

1.1. Background of Health Insurance in Pakistan

Only a limited amount of health insurance now exists in Pakistan. The government is interested in the potential of the insurance market in the country. The seventh national five-year plan declares this interest.

Provincial Employee Social Security Insurance (ESSI) programs mandated (but not run) by the government provide insurance to industrial workers. Employers of these workers are required to pay into a fund 7 percent of the wages of workers earning up to Rs. 1,500 per month. As the Rs. 1,500 limit has not been raised since 1986 (although it is currently being revised upward to Rs. 3,000), there has been a reduction in the number of workers eligible for insurance since their pay level, raised by inflation and other factors, exceeds the current Rs. 1,500 ceiling.

The ESSI program provides medical services to non-government workers and their dependents through its own dispensaries and hospitals, and by paying for some inpatient services. The program does not enjoy good support from employers who frequently fund it for less than their full complement of employees, or fail to fund it at all.

The private health insurance market in Pakistan is just beginning to develop. It appears to be centered in Karachi and is largely limited to corporate executives and non-residents, particularly employees of multinational organizations and foreign governments. Insurers seem to be reluctant to enter this market for fear of losing money due to irregularities in the system, false claims by providers and chemists, expectations of full recovery of the medical allowance by beneficiaries, and fear of outright fraud or abuse. Only the New Jubilee Insurance (NJI) Company of Karachi has entered this market with enthusiasm. It now has over 25,000 people covered (Berman, 1992). Life insurance was denationalized in the last few years, and private insurance companies appear to use health insurance primarily to complement the commercial, life, and fire insurance portfolios of their preferred customers.

While government health services are "free," a number of factors suggest that a potential market for private health insurance exists in Pakistan:

- There is widespread dissatisfaction with existing government health services.
- Consumers are accustomed to paying for medical services in the private sector which accounts for the majority of the health expenditures in Pakistan (Berman, 1992).

1.2. Objectives of the Study

The specific objectives of the HFS study on private health insurance were developed after the February 1992 workshop, and were refined through subsequent consultation with FMOH officials. The objectives for this study were:

1. To review the existing health insurance market and the products currently available and to assess the potential for a managed-care service in the Karachi and Islamabad areas.

2. To define the incentives needed to encourage the establishment of a private sector health insurance market.

3. To conduct a survey of employers to help potential insurers ascertain the market for a managed-care product in Karachi and Islamabad. Also, to determine the level of interest among medium-to-large employers for a private managed-care health insurance product.

2.0. METHODS

This study on the development of private health insurance in Pakistan involved a broad array of policymakers and health professionals. The study relied heavily on an interactive process of data collection. Components of the study methodology were:

- **Development of the Terms of Reference**

  The terms of reference for this study of insurance were developed over a period of time beginning with the 1990 Phase I study, moving to the January 1992 research and the February 1992 framework workshops, and continuing during Marty Makinen's visit to Pakistan in July 1992 and a special team planning meeting held in September of that year. During this time, many discussions were held with USAID/Islamabad and with the FMOH to refine the scope of work of this project.

- **Visits to Pakistan by External Consultants**

  The visits of Harris Berman and Jon Kingsdale, executives of the Tufts Associated Health Plans of Boston, in February and April 1992, respectively, assessed the potential for the development of a private health insurance market, particularly for managed care, in this country. These visits culminated in a report that outlined what a managed-care health insurance plan for Pakistan might look like. This report was used to present information on managed care to Pakistani officials and to health care and insurance industry personnel. It was also given to those who were asked to fill out the insurance market survey developed for this study as a way of helping them understand and respond to survey questions.

- **Interviews with Health Sector Representatives**

  Over the course of the insurance study, interviews and meetings were held with health care providers, insurance companies, employers, and officials of the FMOH. These interviews are an important part of the findings presented later in this volume.

- **Team Planning Meeting**

  A special planning meeting of the HFS team of technical experts for the insurance component was held in Boston, Massachusetts in September 1992. During this planning session, work plans and details relating to the employer survey were developed.

- ▲ Survey of Employers in Karachi and Islamabad

  To assess the interest of employers in a managed-care health insurance plan, a survey was conducted in November and December 1992 of 52 selected businesses based in Karachi and Islamabad. This survey is the basis of the findings and analysis described in this report. The employers in medium- to large-size firms were drawn from a "reasoned sample" of companies in the two cities.

- ▲ Health Financing and Sustainability Workshops

  During the course of the HFS study, three workshops were held in Pakistan to give Pakistani health policy planners and administrators a chance to express their views about insurance and the health sector and to learn more about the work being performed under this study. In the February and November 1992 workshops, issues relating to the development of private health insurance along managed care lines were discussed. This enabled the technical experts to build a work plan that included the opinions and views of workshop participants.

- ▲ Final Report on the Development of Private Health Insurance Based on Managed-Care Principles

  This report is the final step in carrying out the methodology of the insurance study. A draft copy was submitted for comment to the FMOH and to USAID/Pakistan. A summary was presented to the participants in the February 1993 workshop, and their feedback has been incorporated. This report also was commented on by external reviewers.

2.1. Issues that Need to be Addressed in Order to Develop Private Health Insurance

Questions addressed in this private health insurance study are:

1. What can be done to improve the efficiency and quality of care provided in the provincial Employee Social Security Insurance (ESSI) systems?

2. Are the current health care systems in Karachi and Islamabad open to the development of private and managed-care health insurance?

3. What is the nature of the private health insurance market in Islamabad and Karachi and what products could be planned that would be attractive to this market?

4. Looking beyond Karachi and Islamabad, what is the potential for managed-care health insurance in Pakistan?

5. What would a benefits package and a managed-care health insurance program for Pakistan look like?

6. What do major employers in the country think about the prospects for private managed-care health insurance in Pakistan?

7. What are the legal issues related to managed-care health insurance in Pakistan?

8. What has to be done to encourage the development of a private insurance market?

3.0. FINDINGS

The findings of this study are presented in reference to the questions listed in Section 2.0. As mentioned earlier, the FMOH requested that the investigative efforts related to insurance be focused on the cities of Karachi and Islamabad since these cities seem to have the most immediate potential users of managed-care insurance programs.

3.1. The Employee Social Security Insurance Systems

Pakistan's provincial ESSI program was among the long list of items that HFS proposed to the FMOH for study. HFS gathered information about the ESSI in preparation for the February 1993 workshop at which the long list also was discussed. Following the workshop, the FMOH decided that, although the ESSIs should not be a major focus of this study, it wanted the study team to make a summary assessment of the program.

Employee Social Security Insurance is a non-governmental, self-financing insurance scheme which has been operating in most of the provinces since 1967. Mandated by the participating provincial governments, this program provides direct outpatient and pharmacy services to its members and reimburses them for inpatient services. It was initiated to extend health coverage to private-sector, non-supervisory employees and their dependents. Employers are required to pay 7 percent of an eligible employee's salary to ESSI. For many years, only employees earning less than Rs. 1,500 per month were eligible. Recently, the government has decided to raise this ceiling to Rs. 3000 per month, and should implement this decision soon. Currently, the program is under-subscribed, under-funded, and has trouble meeting its objectives.

In some cases, however, such as in the province of Sindh, the program enjoys considerable support from both employers and employees. In Karachi, the Sindh Employee Social Security Insurance (SESSI) program owns and operates some outpatient and hospital facilities. These facilities suffer from shortage of funds and capital availability, but the services they provide are extensively used by the eligible population. Strengthening such facilities by improving the infrastructure and by providing additional capital would enable SESSI to offer quality medical care at a reasonable price.

The ESSI concept has two major flaws. First, it operates as a bureaucratic organization. Since funding is assured regardless of performance, efficiency is poor and quality of care is low. Second, the maximum wage allowable for inclusion in ESSI is adjusted only rarely; as a result, many who need it are excluded from using the program. Also, given inflation, ESSI revenue

declines in purchasing power every year. For example, at a rate of inflation of 5 percent, the purchasing power of ESSI funds over a ten-year period would fall by about 40 percent. With these two fundamental flaws, it is little wonder that ESSIs have poor reputations. They often have declining resources to work with in an institutional set-up where there is no incentive for responsiveness to consumers.

The following suggestions are offered to address these flaws:

- Index to inflation the maximum wage for eligibility for ESSI. This would permit workers in the same wage group always to be covered. It also would protect the purchasing power of ESSI revenues.

- Allow all non-supervisory employees to enroll in ESSI.

- Permit employers to opt out of ESSI by making contracts with other providers for the same amount of money (7 percent of wages up to the maximum) in order to obtain the same basic package of health care benefits. This would force the ESSIs to compete on the basis of quality of service or to lose members and their contributions to non-ESSI providers.

- Permit and encourage ESSIs to contract with providers on a capitation (fixed annual payment per individual or family covered) basis. This would permit ESSIs to use competition among providers to control costs and improve quality.

3.2. The Condition of the Health Care Delivery System in Karachi and Islamabad

Islamabad is the capital of Pakistan. It is a new city; construction began in 1960. Its population is approximately 500,000. Although the center of government, it has limited commercial or industrial activities at this time. Karachi, on the other hand, has a population of over ten million and is the largest commercial and industrial city as well as the largest port in the country.

Based on interviews conducted with a variety of consultants, insurance company executives, and health care providers in Karachi and Islamabad, the following picture of the Karachi and Islamabad health care delivery systems emerged. The conditions and characteristics highlighted below are those related to the feasibility of private managed-care programs.

The major characteristics of these cities' health care delivery system are:

- Most medical care settings, both public and private, lack important, even rudimentary, technology. Few health care delivery institutions meet the minimal standards of service now available in moderately developed Asian countries.

- The quality of training and of care delivered is highly variable.

- Few physicians specifically trained in general practice are available. Most of the general practitioners begin practice right after finishing medical school and their residency program; few have post-graduate experience.

- Most general practitioners are expected by patients to prescribe in order to justify charging for a visit.

- Poly-pharmacy (prescribing an excessive number of medications) is rife and patients demand it (chemists are free to prescribe medicines without the approval of a physician).

- Most patients skip the general practitioner and go directly to specialists who enjoy higher prestige.

- The quality of care varies according to the patient's socioeconomic status.

- There is an abundance of hospital capacity in Karachi. (In 1989, 123 hospitals and approximately 12,000 beds of highly variable quality were listed as available — 1 bed for every 420 people). This compares with an estimated need of approximately 9,000 beds (Aga Kahn University Hospital Report, 1989).

- Many large employers provide medical care to their employees (and, in some cases, to their dependents) from a panel of selected providers (doctors, hospitals, and diagnostic facilities), some employ general practitioners who can refer patients to panel-approved hospitals and specialists.

- Employee health benefits, which are shallow, typically include a cash allowance, a capped allowance per hospitalization or per year, or some combination of the two. There is no tradition of co-payment as distinct from a ceiling on the monetary value of insurance.

- Employee health benefits often distinguish between inpatient and outpatient care. The more generous health benefit plans not only select providers, but set fees, manage referrals, and review utilization.

- Employers, providers, and insurers recognize the rising cost of medical benefits and admit the presence of abuse and corruption in the administration of these benefits.

- In general, employers support the need for raising the standards of medical care and are willing to consider health insurance products which can contain costs and provide better-quality health services.

3.3. The Current Private Health Insurance Market and its Planned Products

The private health insurance market is just starting to develop in Pakistan. Most private and state-owned insurance companies do not offer health care insurance products, instead concentrating on the commercial and life insurance business. The few that offer health insurance products, do so mainly to retain the commercial and life insurance portfolio of their preferred clients.

Still, two companies in the private sector have made health insurance available to their clients: the New Jubilee Insurance Company and the Adamjee Insurance Company, both based in Karachi.

3.3.1. New Jubilee Insurance Company

Of the two companies, New Jubilee Insurance (NJI) seemed most interested in promoting health insurance products. It also is the only private, large insurance company which has a separate division to handle the health insurance market. NJI sells health insurance products to interested companies which may or may not have commercial and other insurance business with NJI.

A review of current health insurance services provided by NJI reveals a membership base of 15,000 to 18,000 people. At this time, NJI provides a limited range of services, basically extending indemnity-based health insurance coverage. However, NJI has made arrangements with most of the leading hospitals in the city for NJI-covered patients; in this way, it follows some managed-care principles.

In discussions with HFS, NJI offered some suggestions about ways to develop the private health insurance industry. They included:

1. Introduce legislation requiring employers to provide health insurance benefits for all employees (the current legislation only applies to employees in the Rs. 3000 per-month-or-less income bracket).

2. As part of the same legislation, allow employers to opt out of ESSI and buy health coverage from insurance companies on the open market.

3. Provide tax breaks that would encourage employees and employers to purchase health insurance. For example, allow employers and employees to write off their health insurance premiums against their tax burden.

Currently, NJI is concentrating on employers in the Karachi area and is selective about its clients. Only recently has NJI chosen to actively promote its health insurance product on a larger scale by, among other things, placing front-page advertisements in a leading newspaper.

In seeking to help develop the private health insurance industry, the FMOH may wish to keep in touch with NJI since it seems to be the most likely company to promote health insurance products in an aggressive manner. It may also have the greatest potential for providing private health insurance on a national scale.

3.3.2. Adamjee Insurance Company

Adamjee is the largest private insurance company in Pakistan. It offers a limited number of health insurance products to individuals and businesses. Its health insurance portfolio, however, only extends coverage to clients who depend on Adamjee for commercial and other general insurance. In its meetings with HFS, Adamjee Insurance expressed reluctance to expand beyond this client base.

3.3.3. Other Insurance Companies

Similar views were expressed by the State Life Insurance Company and by Alpha Insurance, other Karachi-based companies. A change in these companies' strategic position on health insurance is not expected any time soon.

It should be noted that these insurers' assessment of the viability of private health insurance products is a function of the current environment. If the government were to introduce legislation requiring employers to provide health insurance benefits to their employees, the private health insurance market would broaden and the interest of other insurance companies might increase dramatically.

4.0. THE POTENTIAL FOR MANAGED-CARE INSURANCE IN PAKISTAN

4.1. Assessing the Potential for Managed Care

In order to assess the potential for a managed-care health insurance program in Karachi and Islamabad, preliminary discussions and interviews were conducted by HFS insurance specialists with a cross section of employers, providers, and potential insurers in both the cities. These interviews were the base for exploring the feasibility of developing private health insurance in Pakistan and for testing some of the concepts which have made managed-care successful in other environments. Interviewees were asked a series of questions about the current health benefits provided by their employers and about their reactions to a model managed-care health insurance program. They were given the brief description shown in Exhibit 1 of a proposed managed-care product under consideration for Pakistan.

4.2 Description of Managed Care

EXHIBIT 1

A BRIEF DESCRIPTION OF MANAGED CARE FOR SURVEY PARTICIPANTS

Principles of Managed Care

1. Prepayment (premium) for a specified package of medical care services (benefits).
2. Delivery of services, primarily through a network of providers (hospitals, clinics, and physicians) selected by the health plan (health insurance company).
3. Provider and health plan share financial incentives for the plan's successful operation (risk sharing).
4. Systematic medical management by the health plan to assure delivery of high quality, cost-effective services to plan members.

EXHIBIT 1
A BRIEF DESCRIPTION OF MANAGED CARE
FOR SURVEY PARTICIPANTS (CONTINUED)

Organization

In practice, managed care in the United States takes several distinct organizational forms:

- Pre-Paid Group Practice (PPGP) under which a multispecialty group (or groups) agrees to deliver a package of services to members enrolled in the health plan. Typically, a separate organization is set up to market the plan, enroll members, price and collect premiums, and generally manage financing of the health care services. Members are entitled to obtain specified types of medical care (e.g., obstetrical care, pediatric, hospital, drugs) directly from the multispecialty group(s) at the direction of the physician group, or from other providers (hospital, chemist, specialist) with which the group normally works. Because a large share of the multispecialty physician group's income depends on attracting members and keeping total costs below total expenses, the group tries to tightly manage the cost and quality of services.

- Another form of managed care is an Independent Practice Association (IPA). It is somewhat more complex than the Pre-Paid Group Practice and requires sophisticated data gathering and measurement. Typically, the IPA health plan contracts with a network of independent practitioners to arrange for the delivery of medical care to the plan's members. These physicians are then listed as plan providers from whom members may select their doctors. The quality, geographic accessibility, and quantity of such participating physicians influences how attractive the plan is compared to its competitors.

Operations

Often the management of services for individual patients is done by their primary care physicians who are on contract not only to deliver care to patients, but also to monitor and coordinate any services they refer patients to. Typically, the physicians are paid fees for service, but part of their fees are held back and returned at year-end only if the plan meets the budget. This form of risk sharing motivates the physicians to deliver and manage services at low cost.

Through its payment terms, risk-sharing arrangements, selection of providers, and measurement of the costs and quality of services delivered, the health plan plays a critical role in ensuring that most providers actively manage services in the best long-term interests of the plan's membership.

There are numerous variations on these two general types of managed-care health plans.

4.3. Issues and Suggestions for Managed Care

Managed care is a tool for influencing the cost, quality, and accessibility of medical care services for an enrolled population. Insurers and some employers who were interviewed by HFS health insurance experts acknowledged their inability to control yearly escalation of costs. However, most of the employers interviewed did not see cost reduction as one of their most urgent concerns. Given the business environment in Pakistan, particularly in Karachi, satisfying labor unions' concerns about the quality of medical care was a higher priority than controlling health care costs. In the initial interviews conducted by the HFS technical experts, virtually all of the interviewees expressed their preference for obtaining greater value for health care expenditures by improving the quality of care delivered and reducing "abuse." Abuse, in this case, refers to such issues as beneficiaries fraudulently arranging benefits for their uninsured friends.

The following responses from interviewees might be helpful in developing a model for a managed-care health insurance product for Pakistan.

- More emphasis needs to be put on training and retaining general practitioners.
- Referral systems from generalists to specialists need to be established for particular conditions and interventions.
- Poly-pharmacy practices need to be discouraged and a control system established for prescribing and dispensing drugs.
- Ways need to be found to reduce "abuse" by beneficiaries and/or providers. In particular, padding of hospital bills by providers, admitting patients without justifiable cause, or reimbursing the medical expenses of ineligible people needs to be stopped.

4.4. The Potential for Managed Care

It appears that there is greater potential for managed care in Karachi than in Islamabad because of the more competitive nature of Karachi's labor market and provider economy. In addition, the prevalence in Karachi of large, progressive private sector employers (especially multinational and semi-autonomous companies) is an asset. At the same time, Islamabad is growing rapidly and, as it adds health care resources and private employers, it may become more hospitable to managed care. Nonetheless, initiating managed-care plans in either city would not be easy, and success is far from assured.

Karachi also looks like a good place to market managed-care insurance because it has decent hospitals and specialists who provide quality services. These institutions and individuals compete vigorously for paying patients. If promised a steady flow of such patients through a managed-care plan, providers might well be interested. In particular, there are more private and semi-private hospital rooms in Karachi than there are patients, so hospitals would be very responsive to a scheme that fills them.

In terms of the target market, managed-care health insurance plans should initially focus on multinational and state-owned organizations. These organizations have more generous benefits and are more conducive to introducing change.

4.4.1. Potential Managed-Care Providers

Baqai Foundation

Among potential sponsors other than insurance companies, only the Baqai Foundation has indicated a determination to start its own Health Maintenance Organization (HMO)-type health insurance program in the near future (Kingsdale, 1992). The Baqai Foundation is headed by Dr. Farid Baqai. Besides operating Baqai hospital, the Foundation also owns and operates Baqai Medical College. Dr. Baqai has made at least one presentation to the officials of FMOH in which he has indicated the Foundation's intention to purchase and/or build four additional hospitals in Karachi and to use them as part of an HMO-style health insurance effort. He expects this health insurance plan and the five hospitals to become operational in the near future. The Baqai Foundation's managed-care program seems still to be in the planning stages, however, Dr. Baqai has offered to host a workshop in Karachi focusing on private managed-care health insurance in Pakistan to follow up on HFS's work.

The Aga Khan University Hospital (AKUH)

The AKUH in Karachi seems to be the most qualified and capable organization to start a HMO-type insurance plan, but it currently is focusing its resources on developing its provider capacity. Based on its excellent reputation and its strong position in the marketplace, AKUH in the future may plan to launch a health insurance scheme on its own or in association with other providers.

Shifa International Hospital

A multispecialty group in Islamabad sponsored by Pakistani physicians in North America is currently building a 200-bed hospital. The group has also expressed an interest in developing its own HMO health insurance plan to serve Islamabad, Rawalpindi, and the surrounding areas. It is too early to evaluate the group's capacity to do this.

4.4.2. Resources Required for the Development of Managed Care

To successfully introduce a private managed-care health insurance plan, some of the resources required will be:

- Credible sponsorship by prestigious, progressive organizations such as the Aga Khan University Hospital (provider) and/or the Habib Bank (employer).
- Expertise in medical management in the Pakistani context.
- Good primary care physicians.
- Interested employers and employees who are conscious of benefits derived from high-quality health services (such as lower absenteeism due to the emphasis placed by managed-care providers on preventive care and on high-quality curative care).
- Substantial start-up capital to create the managed-care organization, provider arrangements, and administrative systems. Initially, a reserve fund will also be needed to cover medical expenses that may exceed the collected premiums as a result of underpricing due to insufficient data.

4.4.3. Major Obstacles to Developing Managed Care

Based on its research and its knowledge of managed care, HFS found the following obstacles to developing private managed-care health insurance in Pakistan:

- The lack of good generalist physicians to coordinate care for plan members and the consequent absence of a referral system built upon generalists.
- The tradition of employees' expecting a relatively small cash allowance for medical care.
- The informal method by which some large domestic employers manage employee health benefits. The current system would have to be replaced by delegating management functions to a managed-care health insurance plan. Such delegation would erode the paternalistic "credit" and control that employers enjoy on a case-by-case basis as they determine the benefits for serious illness.
- The relative dearth of sophisticated, capable, non-profit organizations interested in sponsoring managed-care health insurance plans.

- Illiteracy and infrastructure problems that inhibit ready communication about medical issues, as well as problems related to patients finding transportation to preferred providers.

- An abundance of labor, reducing the need for generous, well-managed health care benefits that attract employees.

4.5. A Managed-Care Insurance Model for Pakistan

Synthesizing these findings, the potential for managed care in Pakistan is limited by the constraints of the current health care system environment and the responses of employers, employees, and providers to managed-care incentives. Consequently, the initial managed-care insurance efforts cannot fulfill all aspects of the standard managed care definition. They can, however, reflect managed-care principles that, if successful, will evolve into a full-scale managed-care organization that delivers cost effective health care at a reasonable price. The Appendix to this volume describes in more detail a conceptual model for private health insurance with managed-care principles that could operate in Pakistan. Further development would be based on actual experience. The system would have the following features:

- The system would operate simply and rely more on the selection of competent physicians than on any sophisticated monitoring of physician behavior through data systems, due to Pakistan's current unfamiliarity with managed care.

- Managed-care benefits would be introduced in two phases. The first phase would cover only inpatient and specialty services with the establishment of co-payments to discourage the use of specialists and to encourage the use of primary care physicians. In the second phase, primary care physician referrals would be required for coverage of inpatient and specialist care.

- The provider network would be limited in Phase 1 in order to ensure the selection of committed providers and to test administrative and financial systems.

- Due to the lack of adequate data to predict reliable capitation figures and due to the unfamiliarity of the concept to providers, care givers would first be reimbursed on a fee schedule. To encourage risk sharing, a certain amount of the fees charged would be held back by the managed-care organization and paid to providers after a year-end reconciliation.

- Successful implementation of managed-care principles will require skilled managers. Significant training may be necessary if management resources are not presently available in the country.

There seems to be a market for expanding private health insurance. This can be encouraged by addressing some of the concerns related to current private health insurance products by:

- Improving eligibility systems to eliminate coverage for false claimants.

- Improving quality assurance systems to eliminate poly-pharmacy practices.

- Improving systems to monitor provider fraud and abuse.

There may also be an opportunity to increase private managed-care health insurance by working within the context of current medical benefits plans. For large employers that are already using provider panels, co-payments, and utilization reviews, the inclusion of managed-care principles into their plans may be feasible. This possibility should be investigated.

5.0. A MARKET SURVEY OF EMPLOYERS

The FMOH and HFS agreed that a systematic survey of employers' interest in managed care would provide important data to this study. A market survey of selected employers in Karachi and Islamabad could indicate their interest in a managed-care product; this interest might stimulate interested insurers to develop plans. A survey would also demonstrate the commitment and support the FMOH is willing to provide in introducing a managed-care product in Pakistan. The details and findings of the survey that was conducted are presented in this section.

Specific objectives developed for the survey of employers were:

- To obtain information on current health benefits provided by employers in the two cities surveyed.

- To ascertain the most recent year's expenditures of these organizations on employee medical care.

- To assess employers' reactions to and views about a managed-care health insurance product, and their interest in acquiring this type of insurance were it available in their local market.

- To provide potentially interested insurers with a model of a managed-care health insurance plan which could be marketed in Pakistan.

This study was a market survey and did not seek to be representative of all businesses in Karachi and Islamabad.

To help surveyed employers understand what was meant by a managed-care health insurance product, HFS gave them a concept paper on such a product prior to the survey interviews. This paper can be found in the Appendix. Briefly, the services and benefits described to employers were:

- Ambulatory services including primary care, specialist care, diagnostic services, and drugs.

- Inpatient professional services including surgery, obstetrics, anesthesia, and psychiatry.

- Health promotion services including family planning and health education.

- Exclusions: dental, eye wear, non-prescription drugs.

In order to price this product, an interested insurer would have an actuarial projection performed based on reasonably comparable experiences in using medical services.

5.1. Methodology of the Survey

A list of organizations to involve in this survey was prepared based on "reasoned selection." They included organizations already visited by HFS technical experts as well as others selected randomly. A total of 52 organizations were short-listed; 32 based in Karachi and 20 in Islamabad. Out of the 52 organizations, 38 responded to the questionnaire. The response rate was best for international organizations and was lowest for Pakistani state-owned enterprises. This could be an indication that international organizations may be more interested in managed-care health insurance plans than are state-owned enterprises. The survey information presented in this section is based on the responses received from these 38 organizations.

The survey was conducted by having HFS technical experts schedule an interview with a responsible official of the company, normally a Human Resources Director or an Administrative Manager. Each respondent was given a specially prepared information and survey package which contained:

- An introduction to the HFS project.
- A basic description of managed care.
- A proposed summary of benefits (model care plan).
- The survey questionnaire.

5.2. Findings and Analysis of the Employer Survey

The findings and the analysis are presented in two parts. The first part is a profile of the employers surveyed and their current health benefits programs. The second part is employers' opinions about the hypothetical managed-care health insurance program described in the Appendix. A commentary after each table describes the survey findings.

5.2.1. Employers' Profile and Review of Current Health Benefits

This section briefly describes the employers who participated in the survey, indicating the type of ownership, the number of management and non-management (unionized) personnel, and information about their eligible populations, current benefits, contracts with providers, rankings of hospitals, and recent medical expenditures.

5.2.1.1. Responding Organizations by Type of Ownership

Exhibit 2 provides information on the ownership of the responding organizations.

EXHIBIT 2
Organizations Surveyed
By Type of Ownership
(N = 38 of 38)

Ownership	Karachi	Islamabad	Total
Multinational or Foreign	10	4	14
State Owned	6	5	11
Private (Pakistani)	7	6	13
Total	23	15	38

Commentary:

Four state-owned organizations (Habib Bank Ltd., the National Bank of Pakistan, the Pakistan National Shipping Corporation, and the State Bank of Pakistan) initially agreed to be interviewed for the survey, but were not willing to provide information without a specific request in writing by the Director General, Health. Even after getting this approval, however, these organizations failed to provide the information requested. This is an indication of the difficulties and obstacles facing potential insurers in dealing with organizations. The above-named organizations are still included as part of the 38 respondents.

5.2.1.2. Management and Unionized (Non-management) Personnel

EXHIBIT 3
Division of Personnel
in Organizations Surveyed
(N = 17 of 38)

	Karachi	Islamabad	Total # of Employees
Management	4,423	2,852	7,275
Unionized	6,411	7,656	14,067
Total	10,834	10,508	21,342

Commentary:

Staff classification information was made available for only 45 percent (17 out of 38) of the organizations surveyed. Personnel classified as management represented 34 percent (7,275 out of 21,342) of the employees.

5.2.1.3. Eligible Populations

Exhibit 4 shows who within the respondent organizations is eligible to receive health benefits provided by or paid for by the organization.

EXHIBIT 4
Populations Eligible to Receive Health Benefits
(N = 34 of 38)

Eligible Population	Number of Organizations
1. Employee only	4
2. Employees and Dependents (spouse and children)	17
3. Employee and Dependents (spouse, children, parents)	12
4. No Health Coverage Provided	1
Total	34

Commentary:

The majority of the organizations responding to this question (85 percent: 29 of 34) provide medical care to employees and their dependents; in some cases, this includes the parents of the employees.

5.2.1.4. Current Benefits

Exhibit 5 shows the nature of the health services provided by or paid for by responding organizations.

EXHIBIT 5
Medical Benefits
By Type of Services Provided by Employers
(N = 28 of 38)

Type of Services	Number of Organizations	
	Management Personnel	Unionized Personnel
Hospitalization (including specialty care)	27	27
Outpatient (including spec. care, diagnostic services, and pharmacy)	27	27
Max. ceiling in Rs./ Hospitalization	15*	15
No maximum ceiling	12	12
No health benefits provided	1	1

** In thousands. ($1.00 U.S. = 25 rupees in 1992).*

Commentary:

These data could be helpful in designing a managed-care benefits package. The organizations surveyed pursue an even-handed policy in providing medical care benefits to their employees. While all organizations responding to this question provide some form of both inpatient and outpatient services, there are differences in the level of services provided to the staff based on their classification and grades. It is noteworthy that 54 percent (15 out of 28) of the organizations have stipulated some form of capping system to limit their risk. The ceilings ranged between Rs. 25,000 to Rs. 35,000 per year per employee. This could offer a distinctive marketing advantage to a prospective insurer

since, under a managed-care health insurance plan, the maximum ceiling would probably be much higher. However, this is countered by the No Maximum Ceiling policy pursued by 43 percent of surveyed employers (12 of 28), mostly belonging to the state-owned category. Since state-owned organizations provide liberal health benefits, they are not able to control cost escalation; the major advantage for these organizations under a managed-care health insurance plan would be the incentives given to providers to control costs.

5.2.1.5. Contracts with Health Care Providers

Exhibit 6 shows the number of responding organizations that maintain contracts with either hospitals, specialists/consultants, and/or general practitioners.

EXHIBIT 6
Number of Organizations Which Contract With Providers for Medical Services
(N = 34 of 38)

	Yes	No	Did Not Respond	Total
Maintain Panel of Hospitals	17	9	8	34
Maintain Panel of Specialists/Consultants	8	8	18	34
Maintain Panel of GPs*	9	7	18	34

** General Practitioners*

Commentary:

These data indicate that many of the employers surveyed already use some form of managed-care principles by directing employees and their dependents to contracted providers. The majority of respondents (17 of 26) contract with hospitals to provide inpatient care to their employees and dependents. Half (8 of 16) of those responding said that they maintain panels of specialists and general practitioners. It may be possible to improve these provider arrangements by introducing additional managed-care principles such as risk sharing, quality assurance, and utilization reviews while also addressing benefits. Employers who have contractual arrangements already in force may be candidates for initiating private managed-care health insurance.

5.2.1.6. Hospital Rankings

Exhibit 7 indicates, in descending order, the quality of hospitals in the view of the respondents.

EXHIBIT 7
Ranking of Hospitals
by Employers

Rank	Karachi	Islamabad
1	Aga Khan University Hospital	PIMS*
2	Liaquat National Hospital	FGSH**
3	Ziauddin Memorial Hospital	Capital Hospital
4 (tie)	Baqai Hospital Orthopedic Medical Institute	
6	Medicare Hospital	

** PIMS = Pakistan Institute of Medical Sciences*
*** FGSH = Federal Government Services Hospital*

Commentary:

The rankings given to the hospitals listed are based on the perceptions of the employers surveyed. From a managed-care viewpoint, this information is helpful in developing a short list of hospitals which could be considered by a potential insurer as having considerable support and following among users. These rankings only serve as a guideline for identifying the perceived leading hospital in a city. A prospective insurer should select providers also based on quality of care standards, cost of treatment, and geographical location. For example, in a city like Karachi, managed-care health insurance contracts could exist with 5 to 7 hospitals as a way of providing accessibility to a majority of plan members. Other hospitals mentioned positively by respondents were the National Institute of Cardiovascular Diseases, Mideast Hospital, and some other smaller hospitals in Karachi.

5.2.1.7. Medical Care Expenditures

Exhibit 8 shows data on expenditures by responding organizations, by type of organization, and by city.

EXHIBIT 8
Total Annual Expenditure for Medical Care
by Organizations Surveyed
(N = 27 of 38)

Type of Organization	# of Orgs. Responding	# of Employees	Total Annual Cost (Rs. in Millions)	Avg. Exp. Per Employee (Rs.)
a. Multinational/ Foreign Agency	12	8,100	44.3	5,469
b. State Owned	7	28,584	182.4	6,381
c. Private	8	9,075	124.3	13,697*
Total:	27	45,759	351.0	7,670
Karachi	15	35,258	287.2	8,146
Islamabad	12	10,501	63.8	6,076

** Muslim Commercial Bank (MCB) accounts for Rs. 100 million of Rs. 124.3 million total expenditures for private organizations. Without MCB expenditures, the average cost per employee for private organizations comes to Rs.4,119.*

Commentary:

Caution should be used in interpreting the data presented in Exhibit 8. This information is based on a company's best estimate for the most recent year. In most cases, the total expenditure data included both hospitalization and outpatient costs. Total expenditures also include cash benefits provided by some companies for medical care. Information relating to the state-owned organizations is lopsided because of the presence of some very large companies such as Pakistan International Airways with 19,319 employees and Rs. 120 million in annual expenditures.

From a potential insurer viewpoint, however, these data are helpful in assessing the level of financial commitment made by the organizations surveyed to their medical care programs. This information can be used as a guideline in determining the premium-paying capacity of employers. Based on the data given in Exhibits 5 and 8, it is possible to extract information to use in designing a managed-care product which reflects employers' preference in level of coverage desired and inability to pay. The total health expenditure of this sample of employers of Rs. 351 million offers an attractive potential market for a prospective insurer. It is broken down as Rs. 287 million for Karachi-based employers and Rs. 64 million for Islamabad employees. Prospective insurers are advised to use the information given in these exhibits as baseline data to be built upon.

5.2.2. Employer Response to Managed-Care Plan and Benefits

In the second part of the survey, the questions were based on how a proposed managed-care health insurance plan might work in Pakistan using the model described in the Appendix. The intent in preparing this model was to test the concept of such a plan on the employers and to assess their interest in purchasing this service if it were available in the market. Employers were told that the plan could be modified by the prospective insurer to include amendments and additions requested by the employers. The findings and analysis of this model-based survey are summarized on the following pages.

5.2.2.1. Employers' Expression of Interest in a Managed-Care Health Insurance Product

The first survey question asked employers to express their interest in offering a managed-care health insurance plan such as the model in place of their existing medical benefits. Their responses were:

EXHIBIT 9
Employers' Expression of Interest
in a Managed-Care Health Insurance Product
(N = 33 of 38)

Interest	Number of Organizations
Responses received	33
Organizations that wished to provide the model managed-care plan to both management and unionized staff	23
Organizations that wished to restrict the plan to management staff only	7
Organizations not interested in managed care (satisfied with their existing arrangement)	3

Commentary:

The model managed-care health insurance plan found a strongly favorable response with 91 percent (30 of 33) organizations interested. Of these employers, 77 percent (23 of 30) expressed their desire to offer such a plan to both their management and unionized staff. Only 23 percent (7 of 30) stated that they would restrict the availability of this plan to their management cadre.

5.2.2.2. Organizations Interested in Considering the Purchase of this Plan for Their Employees

Employers were asked to rank on a scale of 1 to 5 their interest in receiving pricing information as a way of considering purchase of this plan for their employees. Their responses are shown in Exhibit 10.

EXHIBIT 10
Organizations Interested in Considering Purchase of This Plan for Their Employees
(N = 34 of 38)

Ranking	# of Organizations
1 Not Interested	3
2	-
3	4
4	2
5 Very Interested	25

Commentary:

The employers surveyed were very interested in receiving pricing information about this plan; 74 percent (25 of 34 organizations) expressed deep interest in the product. A prospective insurer may want to initiate the process of pricing such a product since the employer market may be receptive to considering purchase of a managed-care health insurance plan, provided the price is right.

5.2.2.3. Willingness to Pay More for Managed-Care Health Insurance

Respondents were asked to indicate if the prospective managed-care health insurance plan needed to cost less than their existing health benefit program in order to interest them further. They were also asked if they would be willing to pay more for managed care.

EXHIBIT 11
Willingness to Pay More for Managed Care
(N = 31 of 38)

	Yes	No	Total
Plan must cost less than existing costs	13	18	31
Willing to pay more	18	13	31

Commentary:

While only 42 percent (13 of 31) of the respondents felt that the managed-care plan must cost less than their current health coverage, 58 percent (18 of 31) were willing to consider this plan even if it costs more than their existing health care.

5.2.3. Features of the Model Managed-Care Plan That Were Liked and Disliked by the Respondents

Fourteen percent of the employers surveyed felt that the co-payment feature of the managed-care health insurance plan would be helpful in controlling costs and reducing the abuse of medical benefits. Other features which employers felt were helpful were the availability of preventive and outpatient services.

Fourteen percent of the employers also indicated their dislike for the concept of co-payment, feeling that it might be difficult to implement in their environment. There also was some resistance to the idea of not funding inpatient private rooms as well as to the idea that managed care restricts the freedom to choose health care providers.

The mixed response on co-payments, private room availability and physician choice indicates that insurers may need to tailor products to employers' individual needs. Managed-care health insurance products including no co-payments, private rooms, and greater choice (preferred providers) would have to be priced higher.

5.2.4. Additional Services Recommended by Employers

Dental coverage was cited by most employers as a service which should be included as a standard feature of managed-care health insurance plans, with 30 percent of the respondents requesting addition of this service. Other services that could be considered for inclusion were treatment abroad for selected medical conditions, prescriptions for eyeglasses, inclusion of parents as part of dependent coverage, and enlisting *hakims* (traditional practitioners) and homeopaths as part of the managed-care health insurance plan.

One of the major pharmaceutical companies interviewed in the course of this study replied that it is required by law to pay 2 percent of its pre-tax profit to the government every year for a Workers' Welfare Fund and 5 percent towards a Workers' Participation Fund. The general idea is to use these funds to give workers and their families better education, health care, and other social services. The company felt that these monies were not being used for the purpose for which they were collected. A review of these funds and their use could be undertaken as a way of assuming that more of them get applied to improving health and other services for employees.

6.0. LEGAL ISSUES RELATED TO PRIVATE HEALTH INSURANCE

The HFS study team examined the legal framework that currently exists in Pakistan related to private health insurance. The study found that health insurance programs can be developed by private individuals and organizations in Pakistan under existing laws, including the Companies Ordinance, the Partnership Act, and the Insurance Laws. Although the latter legislation gives permission to sell health insurance policies, most of its provisions deal with life and general insurance. At this time, there is no formal statutory private health insurance law and no machinery is available to enable a consumer to go to a designated authority and seek redress on insurance issues.

For discussion of the overall legal issues relevant to health sector reform and the other initiatives in this study, see summary Volume I. The study team decided that three things need to be done in the area of insurance: (1) laws must be written that would foster the development of private insurance along the lines of managed care, and (2) the Employee Social Security Insurance system needs to be improved, and (3) an oversight organization needs to be created to monitor the development and performance of private insurance programs. Recommendations are made below in each of these areas.

6.1. Creating a Legal Framework for Private Insurance

Laws need to be created that make it possible for individuals or their agents (such as employers, cooperatives, or other group representatives) to purchase managed-care-style medical coverage for themselves and their dependents. Eventually, insurance coverage could be made compulsory for some groups such as for employees of enterprises employing a certain number of employees.

These laws should also provide that insurance companies be subject to financial regulation. Among other things, they should be required to have minimum reserves or re-insurance coverage in relation to potential actuarial obligations.

Further, the new laws may wish to favor insurance which features managed-care types of organizations (groups which have prospective payments for services on a capitation basis). This approach is expected to help control costs of care, promote the use of preventive services, encourage healthy lifestyles, and reduce fraud and abuse. Methods for favoring such approaches could include offering favorable tax treatment of premiums paid for such coverage or of profits earned by insurers.

6.2. Improving the Employee Social Security Insurance (ESSI) System

Any new insurance laws should allow provincial governments to index the wage ceiling for eligibility for ESSIs to an official measure of the inflation rate. They also should provide that ESSIs be permitted to enter into capitation-type contracts with provider organizations for the provision of services to members. Finally, these laws should permit provincial governments eventually to allow employers to opt out of ESSI if they provide their employees with alternative services of equal or better quality and scope.

6.3. Establishing a Government Entity to Monitor Performance of Insurance Programs

Consideration should be given to creating a government entity to monitor the financial and quality-of-care performance of managed-care health insurance plans. This idea seems to have value, but needs to be explored further.

7.0. RECOMMENDATIONS

Private health insurance has become a mechanism for financing health services in many countries. This could also be true in Pakistan. To facilitate the development of health insurance and managed-care health insurance in Pakistan, the HFS study offers the following recommendations:

Near-Term Government Actions:

- *Conduct workshops for potential insurance organizations, employers, and health care providers in Karachi and Islamabad to present the findings of this study*. The HFS study report would be made available to the participants. The report's implementation plan could serve as a strategic plan for potential insurers.

- *Help potential insurers acquire technical training in designing and operating managed-care plans.* The FMOH could ask donors to provide technical training to interested insurers as part of their programs in health care for Pakistan. This would both stimulate private insurers and also demonstrate the government's commitment to helping introduce private health insurance along managed-care lines in this country.

- *Encourage selected health care providers in Karachi and Islamabad to initiate their own managed-care health insurance plans.* The Pakistan Institute of Medical Sciences (PIMS) is already used by government employees. If the government agrees to refer its employees to PIMS on a capitation basis, this would enable the hospital to amplify its revenue source while also gaining experience in managing its own health insurance plan. Depending on the success of such a plan, this approach could be expanded to other cities.

- *Provide financial incentives to potential insurers for investing in a managed-care health insurance plan.*

  Private sector employers could be stimulated to purchase health insurance by extending to them a temporary tax break to offset a part of the expenditure incurred in making the first purchase of one of these new products. This tax break could be a temporary way to "break the ice" to induce employers to try out the concept. Once employers enroll in a managed-care plan, the benefits could be expected to keep them there without the tax incentive.

- *Arrange for a government-backed demonstration of a managed-care plan.* The GOP or Provincial Governments should consider showing off the attractive feature of managed care

by contracting with private health insurers that use managed-care principles to provide services for a selected group of government employees.

Near-Term Insurer Actions:

- *Revise the HFS managed-care model to incorporate employer feedback*. The views of the employers surveyed in Karachi and Islamabad regarding the strengths and weaknesses of the model would be helpful in structuring a benefits package that would be attractive to them and their counterparts. Some of the features they suggested are dental care, benefits for parents of plan members, and access to treatment abroad, when appropriate. HFS recommends that, first, a basic package be priced. Then, each of the desired add-ons could be individually priced. Adding together the cost of the basic package and the prices of chosen add-ons would give employers the total price of the specific package they desire.

- *Conduct a feasibility study for introducing a managed-care health insurance product.* The survey conducted during this study shows that employers are very interested in considering managed-care health insurance options as an alternative to their current system of health benefits. Ninety-one percent of the respondents wanted to know more about the model managed-care health insurance plan. Seventy-four percent asked to receive pricing information on the model.

  The size of the potential market (Rs. 351 million: Rs. 287 million for Karachi and Rs. 64 million for Islamabad) in annual expenditures for 45,759 employees for the 27 respondents alone should make this market an attractive proposition for any interested insurer.

- *Market managed-care plans to multinational/foreign and state-owned organizations.* Based on the survey findings, interest among employers for a managed-care product is quite high. The findings also indicate that while organizations provide medical coverage for most of their employees, multinational/foreign and state-owned organizations tend to furnish more liberal and extensive health benefits. Therefore, these organizations may be more inclined to participate in a managed-care health insurance plan; this should be part of the initial marketing strategy of a prospective insurer.

Long-Term Government Actions:

- *Enact national legislation to provide the framework for managed-care insurance programs.* Such legislation could allow for the revision of Employment Social Security Insurance, and the establishment of a national body to oversee insurance issues in Pakistan.

- *Revise the policy on Employee Social Security Insurance (ESSI).* There are a number of areas that government can intervene in the ESSI program to improve its effectiveness. These include:

  - Raising the income ceiling of ESSI-eligible employees and indexing it to inflation (i.e., have it increase annually by the rate of inflation). Also, employees who pierce this ceiling should be allowed to stay in the program if they so desire.

  - Making all non-supervisory employees eligible for enrollment in the ESSI program.

  - Encouraging employee contributions on a monthly basis to further improve ESSI-provided services.

  - Contracting with private providers on a capitation basis.

  - Permitting employers to opt out of ESSI by selecting alternative insurance programs.

- *Conduct a study to assess the advantages and disadvantages of compulsory health insurance coverage for employers.* Study the impact of such a policy on employment and competitiveness. New legislation could cause a reduction in employment and a loss of competitiveness in export markets. Before enacting any such legislation, the impact of these consequences should be estimated and alternatives considered.

8.0. IMPLEMENTATION PLAN

The details of an implementation plan to introduce managed-care health insurance in Pakistan are laid out in Exhibit 12. This plan begins with introducing managed-care health insurance to insurers, employers, providers, and the Department of Health in Karachi and Islamabad. This could be done in workshops that would present and discuss the findings contained in the HFS report. The plan also includes offering financial incentives, initiating a study of the effects of compulsory insurance, beginning a dialogue with providers about starting their own managed-care health insurance plans, conducting a feasibility study, and submitting the ESSI recommendations to provincial governments.

The second stage of this plan would be to implement model managed-care health insurance plans in Karachi and/or Islamabad and would be followed by monitoring and evaluating those efforts. Assuming that pilot programs go well, managed-care health insurance could then be introduced, first, in other selected cities and, then, nationwide.

EXHIBIT 12
PRIVATE MANAGED-CARE HEALTH INSURANCE
IMPLEMENTATION PLAN

OBJECTIVES	ACTIVITIES	DURATION IN MOS.*	START/ END MO.	WHO/WHAT	BUDGET RESOURCES	COMMENTS
INTRODUCE MANAGED-CARE HEALTH INSURANCE IN KARACHI AND ISLAMABAD	CONDUCT WORKSHOP IN KARACHI AND ISLAMABAD TO PRESENT HFS STUDY FINDINGS TO INSURERS, EMPLOYERS, PROVIDERS & DOH	1	1-1	FMOH, DOH, INS, EMP, PROVIDERS & TA	FMOH, DONOR & INSURER	FMOH MAY REQUEST PROSPECTIVE INSURER TO SPONSOR WORKSHOP
	DEVELOP FINANCIAL INCENTIVES FOR POTENTIAL SPONSORS & PARTICIPANTS INCLUDING LEGAL FRAMEWORK	18	1-18	FMOH, DOH, INS, EMP & TA	FMOH & DONOR	CONSIDER FORMING A WORKING GROUP AND REVIEW INCENTIVES GIVEN TO OTHER INDUSTRIES
	BEGIN STUDY OF COMPULSORY HEALTH INSURANCE	18	1-18	FMOH,DOH, INS, EMP & TA	FMOH & DONOR	LEGISLATION SHOULD CONSIDER DISADVANTAGES OF COMPULSORY INS. LAW, FORM WORKING GROUP
	BEGIN DIALOGUE WITH PROVIDER(S) TO START THEIR OWN MANAGED-CARE HEALTH INSURANCE PLAN	6	3-9	FMOH, DOH, PROVIDERS, TA	FMOH & DONOR	IDENTIFY ONE PROVIDER EACH IN KARACHI & ISLAMABAD
	SUBMIT ESSI RECOMMENDATIONS TO PROVINCIAL GOVERNMENTS	12	3-15	FMOH, DOH	FMOH	FINALIZE HFS RECOMMENDATIONS
IMPLEMENT MANAGED-CARE HEALTH INSURANCE PLAN(S) IN KARACHI AND/OR ISLAMABAD	HELP INTERESTED/CAPABLE PARTIES TO START A MANAGED-CARE HEALTH INSURANCE PLAN INCLUDING A FEASIBILITY STUDY	18	6-24	FMOH, INS, PROVIDERS, EMP, TA	FMOH, INSURER, PROVIDERS, EMP, DONORS	BEGIN IMPLEMENTATION, STEP BY STEP
MONITOR & EVALUATE PERFORMANCE AT KARACHI & ISLAMABAD	GATHER INFORMATION ON EXPERIENCES IN KARACHI & ISLAMABAD, EVALUATE, THEN MODIFY APPROACHES	MONITOR: 24 EVALUATE: 2	MONITOR: 24-48 EVALUATE: 36; 48	FMOH, DOH, INS, EMP, PROVIDERS & TA	FMOH & DONOR	DRAW LESSONS, MODIFY AND CONSIDER FOR ADDITIONAL IMPLEMENTATION

**From start of process.*

FMOH: FEDERAL MINISTRY OF HEALTH DOH: DEPARTMENT OF HEALTH (PROVINCE)
TA: TECHNICAL ASSISTANCE
INS: INSURER EMP: EMPLOYER

EXHIBIT 12
PRIVATE MANAGED-CARE HEALTH INSURANCE IMPLEMENTATION PLAN (CONTINUED)

OBJECTIVES	ACTIVITIES	DURATION IN MOS.*	START/ END MO.	WHO/WHAT	BUDGET RESOURCES	COMMENTS
CONSIDER IMPLEMENTATION OF MANAGED-CARE HEALTH INSURANCE TO OTHER SELECTED CITIES	DEVISE PLANS BY CITY/PROVINCE FOR INTRODUCING MANAGED-CARE HEALTH INSURANCE BASED ON EXPERIENCES OF OTHER CITIES	24	48-72	FMOH, DOH & TA	FMOH, DOH & DONOR	IN CONSULTATION WITH PROVINCES, IDENTIFY OTHER CITIES FOR IMPLEMENTATION
MONITOR & EVALUATE PERFORMANCE AT OTHER LOCATIONS	GATHER DATA ON PERFORMANCE INDICATORS, EVALUATE, THEN REVISE APPROACHES	MONITOR: 24 EVALUATE: 2	MONITOR: 72-96 EVALUATE: 84, 96	FMOH, DOH & TA	FMOH, DOH & DONOR	LEARN LESSONS FOR MODIFYING INSURANCE MODEL BEFORE FURTHER IMPLEMENTATION
INTRODUCE MANAGED-CARE HEALTH INSURANCE ON A NATIONWIDE BASIS	DEVISE/IMPLEMENT A LONG-TERM PLAN (10 YEARS) FOR NATIONWIDE IMPLEMENTATION	120	84-204	FMOH, DOH, INS/EMP/TA	FMOH, DOH & DONOR	COMPLETE MAXIMUM POPULATION COVERAGE

**From start of process*

FMOH: FEDERAL MINISTRY OF HEALTH DOH: DEPARTMENT OF HEALTH (PROVINCE)
TA: TECHNICAL ASSISTANCE
INS: INSURER EMP: EMPLOYER

9.0. MONITORING AND EVALUATION PLAN

Ongoing monitoring and evaluation activities are included within the implementation plan described in the preceding section. Once managed-care initiatives are developed and implemented by providers, an evaluation will have to be done of the impact of these programs on all parties: employers, employees, providers, insurers themselves, and the Government of Pakistan. Monitoring and evaluation activities that are additional to the ones mentioned in the implementation section are:

- Observing insurers' responses to government actions aimed at fostering managed care.
- Obtaining feedback from employers using the new insurance services.
- Evaluating the experiences and level of satisfaction with managed-care services of employees of participating government departments compared with previous practices.
- Reviewing insurers' plans for expanding health insurance coverage to the uncovered population of the country.
- Conducting recurrent reviews with providers regarding the performance of health insurers.
- Considering the formation of a "watchdog committee" in each of the provinces to oversee the conduct of both insurers and providers and to protect the interests of users.

These activities would be carried out in addition to any regulatory activities the government might undertake as a result of establishing a legal framework for managed care within the country.

EXHIBIT 13
PRIVATE HEALTH INSURANCE
MONITORING AND EVALUATION PLAN

OBJECTIVES	MONITORING INDICATORS	EVALUATIONS
INTRODUCE MANAGED-CARE HEALTH INSURANCE IN KARACHI & ISLAMABAD	OBSERVE POTENTIAL INSURERS RESPONSE TO FMOH INITIATIVES	ONGOING
MEASURE CONSUMER SATISFACTION	EMPLOYER/USER SURVEY GOVT. EMPL/USER SURVEY	ANNUAL ANNUAL
DEVELOP AN EXPANDING PRIVATE HEALTH INSURANCE MARKET	INSURERS MEMBERSHIP ENROLLMENT	ANNUAL
INSURANCE AS AN ALTERNATE SOURCE OF HEALTH FINANCING	PARTICIPATING PUBLIC & PRIVATE SECTOR REVENUE INCREASE	ANNUAL
NATIONWIDE HEALTH INSURANCE COVERAGE	INCREASING INSURANCE MEMBERSHIP TO ADDITIONAL CITIES & RURAL AREAS	ONCE EVERY TWO YEARS

APPENDIX

CONCEPT PAPER:
FEATURES, BENEFITS, AND PROCESSES
FOR MANAGED-CARE HEALTH INSURANCE IN PAKISTAN

APPENDIX

CONCEPT PAPER: FEATURES, BENEFITS, AND PROCESSES FOR MANAGED-CARE HEALTH INSURANCE IN PAKISTAN

INTRODUCTION

The following concept paper is intended to be a preliminary design for a Pakistani managed-care health insurance plan. Using as a base a plan organized and operated in the United States, this paper proposes modifications for the Pakistani context. Due to the newness of managed-care concepts in Pakistan and to the radical changes such plans bring about in provider relationships, it is clear that a Pakistani managed-care plan will need to be altered significantly from the American model.

Managed care must be developed in phases. Progress can be determined and efforts redirected based on initial experiences. Additional analysis would need to precede the development of an implementation plan.

This paper presents the key features of a model plan. Consideration is given to the composition of the provider network, operation of referrals among physicians, reimbursement of providers to encourage cost effectiveness, and benefits coverage. Information also is included on a dozen key administrative processes that are essential to the operation of a successful plan.

FEATURES

Simplicity

In light of Pakistan's current unfamiliarity with managed-care concepts and programs, its partial literacy rate (16-18 percent nationally, higher in urban areas), other social and economic support system deficiencies, and the relatively low price of medical services, it is critical that any managed-care program operate relatively simply. Any such programs should have minimal administrative overhead and relatively elemental requirements for communication among health care personnel, employers, employees (and their dependents), participating physicians, and other providers. Therefore, plan designs must rely more on the selection of competent, motivated providers and on clear financial incentives to reinforce cost-effective service delivery than on sophisticated monitoring and regulation of provider behavior based on claims or other data analyses. Perhaps the claims payment mechanism (whereby the insurance system pays the patient or provider for the service rendered), subject as it is to abuse, delay, and confusion, should be kept as uncomplicated as possible.

Minimizing claims payments without reverting to a simple cash allowance is a challenge. Because transferring payments is complicated for a widespread Independent Practice Association (IPA) network, a pre-paid group practice (PPGP) model may be more practical in the Pakistani context. Alternatively, if a patient's freedom to choose practitioners is not crucial to market appeal, then an IPA with relatively few hospitals and physicians participating, or one hospital with specialists on salary and a small network of highly qualified primary care physicians (called "generalists" in the Pakistani context) may be both administratively feasible and attractive to the market.

In order to simplify the flow of money, primary care physicians might eventually be paid by "capitation" (i.e., so many rupees per covered member per month). A single, sophisticated hospital and affiliated specialists in each city could provide all other services. In a large market such as Karachi, however, multiple hospitals would be needed in order to ensure access of many people to care and to give individuals a choice of care providers. Each member and PCP could be linked either by geography or by choice to one hospital with its associated specialists.

To keep the system manageable as it begins (Phase I), the program could initially be largely limited to inpatient and specialty services. Later, in Phase II, such services as outpatient care and pharmaceuticals could be offered.

Fee Schedule

A managed-care health plan would need to develop a fee schedule that would pay specialists and primary care providers fees-for-service with some portion withheld as a way of sharing risks. Employer fee schedules are common and very simple (e.g., one fee for a visit to the generalist, one or two fees for specialist visits, and surgical procedure fees). Any plan would need to call for pre-authorization of all non-emergency hospital admissions and of continued visits to specialists (e.g., more than five on a single referral or during an episode of care). Pre-authorization and concurrent review for inpatient and outpatient specialty care are familiar practices in Pakistan, but the withholding and capitation concepts are foreign. The acceptance of the latter ideas on the part of providers must be tested. (The British National Health Service's "honorarium" is known to some of the more sophisticated Pakistani physicians.)

Primary Care Providers

Generalist practitioners are central to a managed-care insurance plan and must be carefully selected. This is the weakest professional link in Pakistani medicine, yet the most important management device (the "gatekeeper") in managed care where the generalist is expected to restrict unnecessary utilization of

services. In Phase I, a managed hospital care plan would cover inpatient and specialist services only, allowing time to establish and train a network of general practitioners to centerpiece the system in Phase II.

Selection of generalist physicians should involve site visits and substantial input from qualified specialists. Selection should also be reinforced on a continuing basis by intensive training and education. Consideration may have to be given to using a non-gatekeeper managed-care plan design if Pakistan's primary care physicians prove simply to be too weak to manage referrals effectively.

In Phase II, plan members would be free to select a general practitioner from the participating panel and would then be required to use that physician for all generalist services as well as for referrals to specialists. Specialists would not be reimbursed by the plan unless services were rendered as a result of a proper referral from the patient's core physician.

Co-Payments

In order to keep patients interested in obtaining services at the primary care level and to keep the primary care physician interested in providing this care, patients should pay a small but not a token amount (a co-payment of perhaps Rs. 10) for visits to their own primary care physicians. A more sizeable co-payment would be required to see specialists. This co-payment should be a fixed amount per visit (possibly Rs. 50 so that the fee works as a real disincentive to overuse specialists for trivial visits). Co-payment is a foreign concept, so market acceptance may dictate that the plan phase this in, starting with only the co-payment on specialty care in Phase I and adding co-payment on primary care physician services in Phase II.

Pharmaceuticals

Because pharmaceutical services might well be the single largest cost (perhaps 25 to 50 percent) of a comprehensive plan, this aspect of a care plan must be tightly managed to keep down costs and to reduce poly-pharmacy (excessive prescribing). Outpatient drugs should require a co-payment and should be dispensed only from carefully selected and professionally run pharmacies. This may mean that the health plan has to start its own central pharmacy and formulary.

Management of a pharmacy, reduced use of specialists for minor complaints, and decreases in unnecessary hospitalizations for relatively minor complaints may prove to be the most fruitful forms of cost containment in Phase II.

Benefits

Any plan for the administration of managed-care health programs is affected by the menu of medical services being proposed. A first cut at a package of benefits is shown below. Following the menu are some preliminary ideas on the administration of managed-care insurance plans. These ideas take into consideration the different administrative demands of Phase I and Phase II.

Covered Services

In Phase I, the package would not cover any physician, hospital, or ancillary service (other than eye exams) not performed at the hospital with which the member of a plan is associated. Repeat visits, admissions, and same-day surgery would have to be pre-authorized by the health plan. (Emergency services would have to be authorized within 24 hours of their being incurred.)

In Phase II, the package would not cover any physician, hospital, or ancillary service (other than eye exams and Ob/Gyn services) not performed by the member's primary care physician, by a specialist to whom the primary care provider referred the patient, or pre-authorized by the health plan. (Again, emergency services would have to be authorized within 24 hours of receiving the care.)

OUTPATIENT SERVICES		
SERVICE	COVERAGE	CO-PAY/QUALIFICATION
PCP** Office Visits	Unlimited*	Rs. 10/visit
Specialist Consults in Med/Surg/Peds/ Ob-Gyn	Unlimited*	Rs. 50/visit, W/PCP referral, up to 5 visits
Psychiatry	10 Visits/yr*	50% co-pay
Laboratory tests	Unlimited	No co-pay
Diagnostics Radiology	Unlimited	No co-pay
Other Diagnostics	Unlimited	No co-pay
Outpatient Hospital	Covered on same basis as individual PCPs and specialists	
Prescription Drugs	Unlimited at Plan Pharmacy*	Rs. 10/prescription
Eye Exam	One per year	No co-pay
INPATIENT SERVICES		
Surgeon	Unlimited	No co-pay (pre-auth.)
Obstetrician	Unlimited	No co-pay
Anesthesia	Unlimited	No co-pay
Psychiatry	30 Days	50% co-pay
Other Specialist	Unlimited	No co-pay

** These items would be covered only in Phase II, and then, perhaps, as a rider.*
*** Primary Care Physician*

HOSPITAL FACILITY		
SERVICE	COVERAGE	CO-PAY/QUALIFICATION
Obstetrics	1 Day/normal del. Add'l Days for C-section	No co-payment if pre-authorized
Medical/Surgical	Unlimited	No Co-pay (pre-auth.)
Psychiatric	30 Days/year	No Co-pay (pre-auth.)

HEALTH PROMOTION
Family Planning Services, including IUD insertion, pill, and contraceptives (but co-payment may be required to avoid abuse)
Patient self-care and plan procedures guidebook
Quarterly newsletter on health promotion and preventive techniques, including precautions during epidemics (meningitis, flu, etc.)

EXCLUSIONS *(unless added as a rider with additional premium)*
Routine dental, other than trauma
Eye wear
Non-prescription drugs

KEY PROCESSES

The following processes are considered critical in delivering value to managed-care health insurance consumers, especially in Phase II.

1. Underwriting

2. Pricing and Budgeting of Premiums

3. Marketing

4. Enrollment and Collection of Premiums

5. Membership Identification

6. Customer Service

7. Processing and Payment of Claims

8. Management of Financial Risks

9. Selecting, Credentialing, and Contracting With Providers

10. Provider Relations, Medical Management, and Quality Assurance

11. Determination and Interpretation of Benefits

12. Data Collection and Analysis of Prices and of Utilization of Services

1. Underwriting Guidelines. Initially, underwriting guidelines should target sizeable firms (ones that have over 50 subscribers) in order to reduce marketing costs. Subscribers should be full-time employees not otherwise eligible for ESSI (i.e., they should have wages at least in excess of Rs. 3,000 per month). When legal changes allow conversion of ESSI contributions to private plans, it may become feasible to extend eligibility to lower-paid employees.

If employees are asked to contribute to their premiums (not unreasonable if, as seems likely, the managed-care health insurance plan will be more expensive than current plans), under no circumstances should premium contribution from employees exceed 50 percent. In Phase II, employers should give their eligible employees a choice between traditional benefits (such as cash or indemnity) and the managed-care health insurance plan. Plan pricing should reflect the preference for replacement rather than option coverage. Some minimum participation level (e.g., 50 percent of eligible employees) would be required, even in an option situation. In Phase II, how the employer structures the choice of health plan or the rider for medicine (the relative benefits and costs to the employee) will be critical to the plan's market appeal and to its cost performance.

2. Pricing and Budgeting Premiums. This will be inexact at first. Provider capitation arrangements for payment would fix the payor's risk, but the initial paucity of credible utilization data will make determining such capitation amounts fairly problematic. At first, perhaps all physician and hospital payment arrangements should be fee-for-service with a withholding of 15 to 25 percent with settlement on a plan-wide basis. This would provide a large retention fund (reserves). With experience over time, each hospital and specialist grouping should be budgeted

separately for its own members, and primary care physicians should be capitated for their own members.

Specifically, each hospital and its associated specialists would be budgeted for expected expenses per member month. Hospitals could be paid discounted charges at first and, eventually, a comprehensive per diem plus operating theater rate. General practitioners could be paid by claim with an amount withheld until such time as their panel reaches 100 plan members. This would allow the plan to gain some experience before setting global payment rates; it would also protect providers from getting too many sick people under a capitation payment scheme.

3. <u>Marketing</u>. Developing a marketing plan will be a learning experience. It would be smart to start with some form of "sponsorship" from a foreign partner and with backing from opinion leaders in the local business community. If the product were to target managers and junior managers (sometimes as many as half the employees in a firm), it could cater to their status ambitions. For example, having a prestige name for the plan, offering a special membership identification card, and providing access to special benefits such as semi-private accommodations would play to this image and market niche.

The "sale" of a managed-care health plan will have to be made at the highest level of a business in order to have the support needed to institute radical innovations. As the concept is so new to Pakistan, intensive sales force training will be required and enrollment must be preceded by extensive education of the potential membership.

Reliance must be placed largely on local expertise to get the marketing on track. Preliminary meetings, including ones with the general managers of target companies and with prestigious medical personnel could help smooth the way for follow-up sales calls. Getting a few opinion leaders in the business community to take this project under their wing or to try it on a low-risk pilot basis may also be helpful.

4. <u>Enrollment, Billing, and Collection of Premiums</u>. These activities will require careful controls. Advance billing would be safer for the plan. Apparently, this is common practice by insurers in Pakistan. However, for employers who are sensitive to the time-value of money, billing could be made quarterly. At a minimum, the plan must have strict policies for terminating services for non-payment of premiums.

Enrollment, disenrollment, and reconciliation of premiums would be complicated by high turnover rates. In a work force with very low turnover, this should not be a problem. Nevertheless, enrollment and disenrollment should be possible only at time of hiring or at an annual offering date. All additions and

terminations of members must be done prior to the start of the eligibility period in order to allow time for activities such as producing identification cards and updating providers' membership lists.

5. Membership Identification A system of member identification must be "tight" to avoid abuse. Some employees currently carry work-related identification (I.D.) cards, with their pictures and the names and ages of their dependents. Most Pakistani adults also carry a pictured I.D. card with a unique national I.D. number. At a minimum, the managed-care health plan should give each adult member an insurance card which lists his or her national identification number and all enrolled dependents (with age, sex and other identifiers). Members would have to present their health plan and that national I.D. cards to get service. Production and distribution of these cards will require careful planning and management to minimize costs and abuse. For example, employers must agree to return an employee's card upon termination of employment. In Phase II, on a monthly basis the plan should provide each primary care physician with a list of plan members (subscribers and dependents) on his/her panel. As long as a way is found to discourage abuse, the referral system and card combination should eliminate the problem of covering non-members.

6. Customer Service. Providing high quality customer service will be an extremely complex task, depending on the plan's ability and the employer's willingness to educate and train members and providers about the plan's processes and procedures. On-site training of employers and employees by plan sales personnel must be extensive and comprehensive. Since in-house medical officers currently provide annual check-ups and other clinical services, an attractive feature might be to offer, as a benefit, having the plan's medical officer routinely visit work sites in order to educate employees, do physicals, and handle customer service issues.

Assuming that the higher-paid employees in Pakistan are generally literate, each subscriber could receive a health-plan handbook as a benefit of joining the plan and as a training device. If read and consulted, such a handbook could become a critical tool in customer relations, a vehicle for health education, and a very attractive marketing device. This handbook could counsel members on self-limiting symptoms, on a few simple and effective home remedies, on when and how to access plan providers and on simple preventive measures such as smoking cessation.

7. Processing and Payment of Claims. This may be done on a relatively simple basis compared to the U.S. because: (1) payers now use relatively few fees (as stated before, one for generalists and two for specialists, plus procedures, tests, and hospital charges), and (2) primary care and pharmacy services could be delayed until Phase II and then paid on something other than

fee-for-service. Comprehensive hospital per diems appear to be practical, with a standard per diem set for all secondary-care facilities in a city and another for tertiary-care referrals.

Hospital accommodations and charges almost always vary by the patient's socio-economic status, and some accommodation to this norm will be required. The plan may have to process hospital and related-specialty claims on a two-tiered or three-tiered schedule of payments and be able to check a member's eligibility file and the account's plan type in order to pay at the appropriate accommodation level.

Pre-authorization for hospitalization can be performed by telephone or fax and concurrent review of extended hospital stays and repeat specialty visits can be done by medical officers. In Phase II, management of specialty referrals could be the trickiest piece from a claims-processing and communication perspective. To monitor for abuse in referrals, the plan would audit the primary care provider's records of referrals against referral slips submitted by specialists during the plan's annual inspection and review of primary care physicians prior to contract renewal (see #9 below).

In Phase II, the plan could supply duplicate referral slips and ask the primary care physician to retain one copy for the patient's medical record. The other copy would go with the patient to the specialist who, in turn, would send it with the claim to the plan. It would need to specify member data, date, the condition for which the primary care physician referred the patient, diagnostic information, and recommended treatment. Each referral form would need to be numbered for auditing purposes.

The plan should own/manage its own pharmacy(s) in Phase II and should fill only official prescriptions containing the following information: physician's name, member's name and health plan I.D. number, condition/diagnosis, name and quantity of drug, renewal information, and the day's date. Special prescribing pads (duplicate) will generate a copy for the member to give to the pharmacy and a copy for the prescribing physician to keep as part of the patient's medical record. It will be critical for the plan to collect these prescriptions from any participating private pharmacy as a pre-condition for payment, both because of the threat of abuse and because of the need for data on drug use.

Special emphasis must be placed on guarding against such abuses as buying medicines under the plan for non-members, "lending" the ID number to friends, and fee-splitting between the primary care physician and the specialist. A separate fraud/audit team may be needed to send a strong signal that such practices are being monitored and will be punished. To discourage fraud and abuse, criminal action against providers or members may be required.

8. Management of Financial Risks. This may be eased by the apparent lack of concern that most payers have about catastrophic claims. The style of medicine and patient expectations in Pakistan do not indicate the need for high-impact case management or individual stop-loss protection. (Of course, these conditions may change, especially if private insurance becomes more viable.)

Nevertheless, pricing and budgeting will be hit-or-miss at first. Because of this, it is probably prudent to initially collect a withholding, wherever possible, from specialists, primary care physicians, and hospitals, and to return this whole or in part at year-end settlement uniformly across the relatively small network in each market. This practice will obviate the need for having a fixed budget per member month and will allow for benefit variations without generating a new budget for each benefit level. Acceptance of financial risk by providers is key and must be tested.

After gaining experience and membership, the plan would evolve into a system of separate budgeting, retention funds, and settlement for each provider unit (i.e., each hospital and associated specialist as a single provider unit). Specialists can be in more than one provider unit, in which case they will be subject to multiple settlements, but members must be allocated to only one such unit. Hospitals without full secondary-care services would have to be grouped with other hospitals offering complementary services. Specialty hospitals, such as eye hospitals, could serve all members and be settled on a plan-wide basis.

9. Selecting, Credentialing, and Contracting With Providers. These activities may be the most important managements tool for the plan. The key to provider selection may be to start with a well-organized, prestigious, committed group of specialists. As multispecialty groups do not currently exist in Pakistan, finding such a group becomes a critical challenge. Large hospitals are the other option, such as the Aga Khan and Baqai Hospitals in Karachi or PIMS and Shifa International hospitals in Islamabad. Specialists enjoy prestige in Pakistan and will be the fulcrum for market appeal. Their willingness to participate in managed-care plans must be tested.

In smaller cities, a single, good hospital and associated specialists may suffice and would simplify administration and control of any plan. Discussions with providers and employers in Karachi indicate that a minimum of five geographically dispersed secondary-care hospitals and one tertiary-care facility would be required. If confirmed, then the plan should design its network so that each hospital has its own service area, specialists, and associated network of primary care providers.

In Phase II, the network of practitioners must be carefully selected, with substantial input from specialists. This selection should be based on interviews, on site visits, and on objective minimum standards. Examples of the standards could be that the primary care physician has an examining table, uses lab tests and x-ray in diagnosis, keeps medical records, has a minimum of one-year house officership and three years of subsequent experience or has actually done some additional residency in general medicine or primary care specialties, and arranges for coverage when he or she is not available. Primary care provider capitation or fees could be increased for generalists who meet these procedural standards and have post-graduate training in a primary-care specialty. The plan could provide training and aides (such as medical record folders on its members) to encourage such practices. Ideally, other providers in a service region would form one or more coverage groups for plan members. Continuing medical education and support by the plan, matched by requirements that the providers achieve these standards within a specified number of years after joining, will be critical to quality improvement.

10. Provider Relations, Medical Management, and Quality Assurance. In order to monitor practice, audit records, and stay in close contact with providers, a rotating committee comprised of specialists, providers, and the plan's managing physician should visit each provider's office annually prior to contract renewal in order to observe practice, review records, and get the provider's thoughts.

Although the primary care providers initially need to be paid fees-for-service with a withholding as soon as actuarial experience and membership is built up, they could be switched to capitation. Any adjustment to capitation would have to be proven by medical records indicating frequency of visits. The annual review should capture such data, which is also useful for actuarial projections and budgeting.

Each managed-care plan will need a full-time medical director. Fortunately, many large employers have such personnel to manage their own in-house clinics or to provide gatekeeper services, referral management, utilization review, and quality assurance functions for their in-house plan of benefits. These Senior Medical Officers, as they are called, would make perfect candidates for the managed-care plan's post. They are accustomed to performing telephone review of a sort, to interviewing and selecting generalists and specialists for their panels, and to negotiating fee levels and referral patterns.

Monitoring for under-use will be required for the primary care providers on capitation payment. In addition to auditing their records annually, the plan should develop protocols for encouraging and following-up on member grievances, especially regarding under-service by providers. The threat of termination

ought to prove a powerful incentive to good service once the practitioner has acquired 100 or more plan members on his/her panel.

Many generalists practice in pairs (often, both a female and a male physician) and there is a growing prevalence of family practices (i.e., a family of physicians in practice together who must be treated as a single provider unit for plan purposes). Problems may arise if the family includes specialists or if solo practitioners share an office with specialists, as some of the better ones do. Measures will be needed to guard against abuse of the referral system in such contexts. It may be that provider capitation will present too strong a temptation to many primary care providers to make too many referrals, in which case a fee-for-service with withholding approach would be preferable. Again, the key lies in choosing reputable, honest, and competent primary care physicians and specialists.

In addition to monitoring over-referral to specialists, medical management should focus on physicians' prescribing patterns, on the need for secondary-care hospitalizations, and on inpatient lengths of stay. These are all areas frequently identified as subject to waste. Follow-up specialty visits are another area of concern, although this may be a tough one to monitor.

Quality improvement should focus on continuing medical education and on training to a standard of practice management such as keeping elementary medical records, the norm for ambulatory care in the West.

11. Determination and Interpretation of Benefits. This determination must, of course, reflect local expectations and practices. Beneficiaries are accustomed to employers making relatively informal, paternalistic decisions about extending limited cash benefits in special circumstances. As a result, there may be a substantial problem of members and/or providers trying to stretch the interpretation of covered benefits or trying to upgrade patient accommodations with the active concurrence and support of client employers. Clearly, hospitals will want to fill their private and semi-private rooms at higher rates, so guidelines in this area must be both socially acceptable and firm.

Other issues may include access to tertiary out-of-country care facilities, interpretation of eligibility for certain dependents, and resort to homeopaths and other non-panel practitioners in special circumstances.

12. Data Collection and Analysis of Prices and of Utilization of Services. This may be somewhat simpler than in the U.S. because units of service are more global in Pakistan. Moreover, the problem of over-reliance on high-tech or even on

rudimentary diagnostic procedures is not yet relevant in Pakistan. For purposes of assuring quality in diagnoses, counts of lab tests and x-rays would be helpful. As most practitioners must refer out for such services, the plan should be able to track their utilization of claims data.

The relevant units of analysis for Phase II are:

- Drug Prescriptions
- Generalist Office Visits
- Specialists Office Visits
- Hospital Admissions and Days
- Surgical Procedures

For purposes of quality assurance and utilization review, claims-based data should be aggregated by member, by provider unit, and by primary care physician. (For capitated providers, claims data should be supplemented by annually collected medical records data.) Some data should be analyzed by specialists. This would be easy to do in non-tertiary care specialties where each participating hospital has one participating specialist with an assigned membership base. Physicians and hospitals should be profiled annually and compared with their peers in order to identify those providers who refer their members to specialists more than twice as often as the average provider, those members who use more than five times the average number of prescriptions per year, and those hospitals with high average lengths of stay.

For purposes of budgeting and premium projection, both utilization and fee data will be required, mainly on a per-member, per-month basis. Also, administrative overhead must be kept within bounds. (Employers and insurers need to be queried in greater detail on how much they currently spend to administer their own health benefits.)

Although more complex and administratively rigorous than current benefit plans, a managed-care health insurance plan would enjoy substantial economies over in-house employer benefit programs in terms of provider selection, contracting, claims payment, and other aspects of medical management. If administrative costs prove overly burdensome, there may be little choice but to contract with single, comprehensive provider entities such as the Aga Khan Hospital and Community Health Center, and simply pay them a capitation fee for all services rendered to enrolled members. Such a plan would have to be offered as an option to a reasonably comprehensive indemnity benefit package.

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