Health-Care Delivery System and Reimbursement Policies in Pakistan

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Introduction

Today, Pakistan stands as the sixth most populous country in the world with a projected population of around 162 million people [1]. Around one-third of these people live below poverty level. There are four provinces that are further divided into districts that make up the local government. With the current devolution of power plan, the district governments have been given funds to manage community health programs [1–6].

Pakistan is seeing an epidemiological transition; traditionally thought to be an agricultural country, it is now in the phase of industrialization. Previously, the main burden of disease was the communicable diseases (49%) but now, the noncommunicable diseases (41%) are predicted to overtake the former [7]. This puts Pakistan in a unique predicament, where the underprivileged strata of the society suffer from both in alarming proportions. This makes health-care planning and delivery a complex task [8]. The national action program for the prevention of noncommunicable diseases has been set forth to tackle this menace [9,10].

Health-Care Expenditures, Plans, and Policies

Over the past 60 years, health-care progress has been slow and gains achieved have been offset by a boom in the population. The expenditure on health as a percentage of the gross domestic product is lower than any other country (public health expenditure is 0.9% and private 3.2%). Forty-three percent of the gross domestic product (GDP) is spent in debt servicing; this hampers the quality of care at the primary level, which remains poor [11]. Historically, the government policies have failed to address this inequity. National health planning began with the Second Five-Year Plan (1960–1965) and continues to the 10th plan. There have been three health policies (1990, 1997, and 2001). The country has made improvements in health indicators but when compared to other developing countries this outcome remains wanting. The average annual population growth rate has remained at 2.5%, the highest among South Asian countries [12,13].

Pakistan is signatory to both the Alma Ata 1978 and Millennium Development Goals 2000 and is currently behind schedule for meeting the goals.

The Health-Care Delivery System [6]

The districts have been given comprehensive administrative and financial autonomy to make health delivery efficient. The role of the federal government is in policymaking, coordination, technical support, research, training, and seeking foreign assistance. The system is run by the Ministry of Health through the respective provincial health departments. The other major institutions like the nongovernmental organizations (NGOs), the parastatals, etc., run in parallel. These institutions run their own funded institutions. The other major players are the private institutions based mostly in the urban areas and are primarily focused on curative care.

The Public Sector

The public sector provision has two components, a curative component and a preventive component. The curative care in turn is divided into three tiers, namely the primary, secondary, and tertiary care.

Primary care [6]. The Basic Health Units (BHUs) and the Rural Health Centers (RHC) make up the primary care setting. The BHU covers a population of 20,000 and has one medical officer, one lady health visitor (LHV), and a dispenser providing outpatient care only. The RHC serves a population of up to 100,000 and provides both inpatient and outpatient services. There are 10 to 12 beds in such facilities and is staffed with two to three medical officers, nurses, dispensers, LHVs, dental technicians, and vaccinator. It also houses basic diagnostic facilities. On paper, this looks comprehensive but because of variability in the terrain, population concentration, and political will, only a few centers are functional. A dearth of funds has rendered these facilities redundant. The primary care facilities are “underutilized” as 40% of patients attending secondary/tertiary care hospitals have primary care issues. BHUs are run in dilapidated conditions. Geographical access and absenteeism is a major problem. The average attendee pays a high average cost per visit and occasionally out-of-pocket
payment for free service. The people have thus turned away from these setups to seek substandard private care in rural areas.

Secondary care [6]. The secondary care is provided through the Tehsil Headquarters hospitals and the District Headquarters Hospitals (DHQs). These hospitals have full-scale services specialists and serve more than 1 to 2 million people and comprise of 100 to 400 beds and deal with most major medical problems. Not all DHQs are equally equipped.

Tertiary care [6]. The tertiary care setup comprises of the teaching hospitals, which are attached to medical colleges and are placed in the major cities of the country. The standard in these institutions has also lagged behind the private institutions providing similar care facilities.

Preventive Care
It is a paradox that the preventive care setup, which is the need of the country, is rudimentary. The preventive care services are mostly taken care of by the vertical programs [6,12].

Vertical programs. The vertical programs are run by the federal government and comprise the maternal and child health care, tuberculosis control program, National AIDS control program, Expanded program on immunization, malaria control program, and women health project. Though run centrally, there is an overlap in the provision of care at the community level [6,12].

Private Sector
The private health sector includes all actors outside the government. This setup in the country has filled up the hiatus of the much wanted advanced facilities. Many substandard setups, however, have cropped up because of a lack of regulation. The private sector has also embarked on provision of medical education where again, a wide variation is noted. A proper ambulance service for shifting of acutely ill patients is nonexistent. Some NGOs and welfare trusts have started services but these are meant mostly for logistic purposes and not for acute prehospital care [6,12].

Traditional Medicine and Practice
The rural population use more traditional medicine because of underutilization of the primary care facilities and escalating private care cost. This is divided into three major forms. The Islami Tibb (Greco-Arab), homeopathy, and Ayurvedic (herbalists). There are 45,799 registered practitioners of Islami Tibb, 84,000 registered homeopathic practitioners, and 600 herbalists in the country. There are 130,000 registered practitioners of traditional medicine and 83 recognized homeopathy colleges versus 103,535 registered doctors and 53 medical schools. The Tibb-e-Unani, Ayurvedic, homeopathic, herbal, and other non-allopathic Drugs Act of 2005 had been promulgated and a National Policy on Traditional Medicines is in its final stage [6,11,12].

Modes of Financing
The principal mode of health-care finance is out-of-pocket payment and tax-based revenue; however, the tax net is not efficient and broad-based. The other constituents are the donor funds (4–16% of health sector allocation), employee’s social security schemes (cover 3.06% of the workforce in the formal sector), and safety nets like the Zakat (religious) fund (covers 0.3–3% of total health expenditure). The role of community cofinancing and philanthropic grant is not well established and remains undetermined [6,12].

Health Insurance
Pakistan has a small private health insurance industry (State Bank of Pakistan review 2003 puts Pakistan’s private insurance industry to be the smallest compared to other developing countries). Only one offers individual health insurance. These companies are based in the urban areas and work through private institutions where cost of care is high, thus leaving the rural areas totally uncovered [6].

Employees Insurance Scheme
The employees’ social security scheme is the only comprehensive health coverage system for the labor force. It is an autonomous system of fund generation that is disbursed through a self-owned health-care infrastructure. A total of 1.2 million individuals in the force are insured (small proportion). Forty-eight percent of the workforce in the agriculture sector is excluded from this net.

Social health insurance. Zakat is the mandatory religious donation that is submitted annually and this goes in to a separate fund and distributed among the needy. In 2003, 152 million rupees were disbursed, which make only 2.6% of the total Zakat fund for the year 2003. The rest of the amount could not be put to use because of an infrastructure that is not capable of the disbursement of the entire amount needed in a timely and equitable manner [6].

Provider reimbursement. Physicians and hospitals are reimbursed through individual out-of-pocket payments. There is no limit on provider fee in the private setups. In the public sector, however, the providers get a fixed pay but private practice after working hours is not discouraged. A minority of providers are reimbursed through entitlement [6].
Research and evaluation. There is a wide gap in implementation of health care and evaluation of strategies in the local setup. Pakistan recognized the need for research and formed the Pakistan Medical Research Council in 1954. Currently, there exists a well-developed infrastructure of institutions but the results have been suboptimal [6,13].

Regulation of health care. The Pakistan Medical and Dental Council formed in 1962 is the only autonomous regulatory organization that has fallen short of its mandate in not addressing the vital issues of ethical practice, quack-run setups, and professional negligence. It registers doctors but further credentialing procedure is nonexistent [6].

Conclusion
Pakistan is an emerging economy lumbered with a double burden of disease and a high population growth rate [14]. The health-care infrastructure on paper looks perfect but it is plagued by understaffing, absenteeism, lack of drugs and significant logistic issues, which make the operational capability weak and lethargic. A countrywide facility-based Health Management Information System has been implemented and the initial data have been used in decision-making [15]. There appears to be a rejuvenation of political will with an ongoing review of the health policy for a positive change [6]. The basic “right to life,” a fundamental right, is part of the constitution of Pakistan. Primary health care and preventive strategies are the needs of the day. For development, poverty needs to be alleviated and it can be done through better health care. To guide future policy and for the evaluation of plans, health outcomes research is cardinal and needs to be developed. Learning from the experience of others through collaboration and developing linkages appears the prudent way forward.

References