REVIEW ARTICLE

SOCIAL PROTECTION STRATEGIES AND HEALTH FINANCING TO SAFEGUARD REPRODUCTIVE HEALTH FOR THE POOR: MAKING A CASE FOR PAKISTAN

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Globally, a billion people cannot seek appropriate and timely healthcare because they are not covered under any social protection and health insurance system. Countries where government financing for health care is meagre, the situation is even worse. Pakistan with its slowly improving indicators of maternal and child health makes a classical case for instigating a social protection mechanism for the poor segments of population. The Government safety nets are unable to cater the large proportion of poor population. NGOs partially cover the rural areas where majority of the vulnerable population lives but need to expand their scope of work. Donors have presented variety of models and frameworks which were seldom considered in the concerned quarters. All stakeholders ought to strategise their plans to adopt and scale up the successful interventions (vouchers, cash transfers, micro-credits, community based insurance etc) which have been operating but on a very small scale or for other types of health services, but none for reproductive health care *per se*. Adoption of risk pooling mechanisms and provision of accessible and quality reproductive health services seems feasible through a meaningful and integrated public private partnership in the times to come.

Keywords: Social protection, Health financing, Reproductive health, Health System

BACKGROUND

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

With a maternal mortality ratio of 276/100,000 live births, stagnating contraceptive prevalence rate of 29.6% and only 39% deliveries attended by the skilled birth attendants, Pakistan ranks 65th in Gender Inequality Index with an overall Human Development Index ranking of 125th over the last 3 years.[4] Around 25,000 women die each year due to pregnancy-related complications. With an infant mortality rate of 78 per 1000 live births, at least 300,000 infants (including 160,000 neonates) die annually in their first year of life. About 37% of married women do not want to have more births after three children, yet do not protect themselves against unwanted pregnancies because of limited availability of quality family planning services. This results in approximately 890,000 induced abortions annually in Pakistan.[5] The indicators specific to the millennium goals 4 and 5 have progressed very slowly since past few years despite the presence of MCH specific service delivery interventions with skilled birth attendants (SBAs), the lady health workers (LHWs) and a three tiered health care system with basic and comprehensive Emergency Obstetric Care (EMOC) services. Maternal and obstetrics complications prevail due to insufficient number of SBAs, lack of competency and affordability issues while seeking care in basic and comprehensive EMOC facilities.[6] A reduction in the maternal mortality ratio (MMR) can only be envisaged if major focus on universal coverage of vulnerable population, such as women of reproductive age, is developed with the identification of diverse healthcare financing options, particularly in the rural parts of Pakistan.

While seeking RH care even of a mediocre quality, the poor quintiles have always confronted the threat of catastrophic expenditure. Meagre budget, imbalance in allocations, mismanagement of finances, and poor governance has resulted in a worrying state of health indicators in Pakistan.[7] Around 0.6% of GDP and least developmental expenditures on health have been incurred over the last two decades in Pakistan. Most of the proportion in the allocation has gone to recurring

costs mainly of hospitals, serving hardly 15% of the urban population. Out of total health expenditures in Pakistan, government spends only US$4 out of US$17 per head per year, and US$13 is out of pocket private expenditure.[8] Direct taxation and out of pocket payments are the predominant modes of healthcare financing in the county. Other modes of financing in the country are private insurance, Employees Social Security Institution (ESSI), social protection funds such as *Zakat*[*] and *Bait ul Maal*[†], which cover small segments of the population.[4,9] Various options and modes of financing for healthcare have never been thought out for PHC services, a decisive point for attaining the universal coverage for the vulnerable population. OECD countries present a case where direct payments have been replaced by various forms of prepayments such as social, community based and commercial private insurance.[10] At this point in time, when health sector in Pakistan is facing reforms, streamlining of the alternative financial arrangements to lessen financial hardship faced by the poor in the restrained resource settings is critical.

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

Existing state of affairs

Beside direct taxation and out of pocket payments, other modes of heath financing in Pakistan include Employer's contribution (5.07%), donors (1.64%) and philanthropy (0.92%). Though various forms of social protection mechanisms are there on ground to cater the health needs of the impoverished population, however there is no explicit safety net to cover the expenses incurred on the reproductive health services. The main impediments in this scenario are quite obvious: overall low spending, dependency on existing modes of financing with fewer alternative options, issues with fund mobilization and utilization.[11] Recent reforms in Pakistan allow provinces to govern the health related subjects as laid down in the devolution framework. Setting priorities and identifying health financing options for the poor are now primary responsibilities of the provinces. Unfortunately, the provinces have a history of investing more in the secondary and tertiary care facilities as compared to the primary health care which is supposed to serve a large proportion of the population.

Various forms of health financing mechanisms to safe guard poor have been introduced by the government, private sector and donor organizations in Pakistan. These initiatives though operational in the country for quite some time now, but they insure only a very small proportion of the population and provide limited services coverage.

a. Government Initiatives

Existing government owned social protection and safety net arrangements are *Zakat* and *Bait-ul-Mal* which primarily help in getting exemption for poor who are seeking care in the public hospitals. Federally administered *Bait-ul-Mal* significantly contributes toward the poverty alleviation through providing a window opportunity for the poorest of the poor to seek high cost diagnostic and invasive procedures, not covered under *Zakat*, for instance. Micro-financing options such as Individual Financial Assistance for destitute, Girl child nutrition support program and a Disability care are core functions of *Bait-ul-Mal*.[12] Similarly, *Zakat* certificate authorized by the local government entitles poor to seek free healthcare in the government health care facilities. *Zakat* fund also facilitates micro financing for the poor through grants and stipends. However, these safety net arrangements add up only 0.45% to the total health expenditure regardless of having structured institutional arrangements.[8] Another initiative is the National Rural Support Programme (NRSP) in 54 out of 138 districts of Pakistan, working for rural development and poverty reduction through offering micro health insurance schemes. NRSP microfinance poverty program has enabled the rural men and women with knowledge and skills to seek timely and appropriate healthcare.[13] Similarly, Benazir Income Support Program (BISP) is another safety net arrangement by the federal government which uses targeting process to identify poor for offering microcredit options, exclusively for the rural women in Pakistan. BISP has recently decided to include a health insurance program for the beneficiaries.[14] At the provincial level, the Punjab Health Sector Reform Programme (PHSRP) aims to improve quality and coverage of reproductive health

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

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

services at PHC facilities with introduction of the health cards in three districts of Pakistan.[15] PHSRP provides other micro financing options too, in addition to medication and hospitalization for the poor.

b. NGO sector initiatives:

Social protection is considered as a collective social responsibility, encompassing public as well as the privately governed programs, especially for the vulnerable population. NGOs have significantly contributed in the social sector by investing in reproductive health, education, women development, community mobilization and micro-credit schemes. Some of these NGOs offer social protection mechanisms and community based insurance for the women of reproductive age. Marie Stopes Society, Health and Nutrition Development Society and Greenstar Social Marketing have adopted client centred approach by using the private provider model to provide affordable and quality reproductive health and family planning services in Pakistan.[16–18] Moreover, pre-paid vouchers in this regard have resulted in considerable uptake of institutional deliveries as well as other services such as antenatal checkups, family planning and child immunization. These NGOs use principles of social marketing to create demand for RH and FP services among the couples looking for quality services at their doorsteps. However, these franchised networks have been limited to the urban centers or at the most peri-urban segments of population. Other notable example of health care financing is by creating community based saving groups supported by Aga Khan Rural Support Programme in northern areas of the country, thus enabling the women to overcome the financial constraints in accessing quality pre and post natal care, delivery at the facility and care of neonates.[19] Last but not the least, Heartfile's Health Financing initiative has established a health equity fund to safeguard the poor from medical impoverishments caused because of heavy expenses incurred on chronic diseases treatment.[20] Health equity fund facilitates cash transfers to protect the poor through using appropriate validation mechanisms with integration of National Database Registration Authority and uses transparent criteria for identifying poorest of poor.

c. Donor Initiatives

Fundamental challenge for the development partners is to help the developing countries in strengthening the social sector, which is by and large, informally organized. With regards to social protection strategies, German Technical Cooperation (GIZ), World Health Organization (WHO) and International Labor Organization (ILO) have recently established a consortium in Pakistan for ascertaining social protection mechanisms in the economically deprived communities.[2] GIZ has contributed actively in interprovincial coordination and facilitation between the different federal and provincial institutions, already working on social protection for the poor in Pakistan.[21] Development partners have tried to prioritize equity and financing issues of MNCH, as investment case in the developing countries of Asian region. Few years back, the Asian Development Bank presented a framework and financial outlay for initiating SHI in Pakistan.[22] UNICEF and World Bank's Marginal Budgeting for Bottlenecks (MBB), is a tool aimed at estimating marginal resources required for overcoming the health system constraints. MBB helps in planning and estimating cost and impact of investments in order to scale up coverage and quality of MNCH related interventions.[23] This tool is being used to strategize the action plans for the health sector of Pakistan.

What are the options for scaling up social protection strategies?

Rural poor households are far more subjected to financial adversity while coping with out-of-pocket healthcare costs.[24] A system based on pre-payment and financial risk pooling is desirable that ensures equitable access to the quality health services at affordable prices in which contributions to the system are based on ability to pay and benefits needed.[25] Though some pro-poor health strategies have been tested; nevertheless, limited attempt has been made to scale up such strategies, particularly focusing mortality and morbidity due to the preventable reproductive health problems e.g. complicated pregnancy, unsafe abortions, reproductive tract infections, fistula etc. These issues are confronted by the poor on daily basis in this country and while coping with these challenges, out of pocket payments further exacerbate inequity and poverty. Presently, social security schemes available for the formal sector are not practicable means of financing for the informal sector which comprises large proportion of population working on daily wages and contractual employments. Inability to shell out taxes from the informal sector and inability of the government to make contributions for this enormous segment of the poor rural population need attention. However, it can be suggested that if there is an integrated approach, not only among these private enterprises but also with the government, social health insurance can be scaled up for ensuring a universal coverage for providing RH services to the poor.[26]

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

tested for identifying, enrolling and validating poverty status for those receiving assistance in informal sector.[20]

Better allocation to health facilities has shown to improve the utilization of maternal health services.[27] Public sector financing, therefore, has to be increased in order to cover the lag in achieving MDGs.[28] With government's own meager resources, the future roadmap for healthcare financing of RH services could be based on integration between the government health services at the basic and secondary healthcare facilities in close liaison with the private sector. The former being strong by virtue of its vast infrastructure and human resource, whereas the latter might contribute in terms of investment, thus promoting public private partnership. Such an agreement of cooperation can improve accessibility, equity and quality of RH care among deprived population.[29] Recent reforms have also enabled provinces to be autonomous in taking such policy decisions. This sort of mixed health system arrangement can virtually tackle the RH issues, particularly in seeking antenatal, obstetrics and postnatal care. Lastly, the donor contributions through the performance based funding mechanisms can further strengthen this public private partnership for scaling up a community based insurance and the social security arrangements in low income groups.[30]

Private sector and some of the NGOs' initiatives suggest solutions for addressing the limitations of the larger health systems. Some of the successfully implemented initiatives are pre-paid voucher schemes, community based insurance and micro finance programs. Health equity fund is also an efficient strategy for risk pooling in the informal sector.[24] This fund is able to address catastrophic out-of-pocket payments through providing exemption systems in health facilities and direct cash transfers. Such funding mechanism can be adopted within the scope of *Bait-ul-Mal's* work to transfer cash to the poor. It has been demonstrated that the electronic database of NADRA can be used for validation of economic status of the poor and needy population. Further advancement in the electronic database to continuously update the status of low socio-economic groups shall promote fairness and equity in funds distribution. This can be scaled up to safeguard the vulnerable women for providing them with essential reproductive health services in the government facilities. Similarly, vouchers schemes have shown to overcome the financial impediments faced while seeking antenatal, postnatal and institutional care, hence preventing a catastrophic spending on health.[9,31,32] Combined with the social marketing strategies, vouchers have proven to be an effective instrument in uptake of reproductive health services in resource constraint settings and therefore must be experimented in the public sector too.[33]

Community based insurance and micro financing programmes are scalable through the development of community based saving groups organized by the local women.[34] Social mobilization on RH issues and sensitization on the micro financing options are quite practical solutions with the help of the community based health workers in the two national programmes. Around 110,000 LHWs and 15,000 community based midwives are committed to the mandate of decreasing the maternal and under five mortality rate.[35,36] These two cadres can actually ensure community involvement in the identification, prioritization and management of resources made available through community based micro financing programmes.

In Pakistan, private franchised service providers have been able to improve the access and quality of RH care through performance based financing.[37] Moreover, identification and prioritization of demand side issues resolve impediments in seeking antenatal, institutional deliveries and postnatal care. To attain these objectives, scaling up franchising of RH services is quite an optimistic modality for making the health system of Pakistan more responsive.[38] Franchised private service providers have very aptly used a client centered approached such as demand-side financing mechanism to promote the RH services utilization by the poor women of reproductive age.

CONCLUSION

Within the ambit of the government health facilities and institutionalisation of public social security arrangements, social safety nets must be introduced in collaboration with the private sector. It is further suggested to merge various government funds from *Zakat, Bait-ul-Mal* and other pools into one to create a reasonable fund for social protection at the national level. Private sector must be encouraged to scale up its initiatives and need full support of the government to serve the poor communities. Donors must fill in the interface between the public and private sector by plugging in the financial gaps. With limited fiscal space, narrow tax base and allocation of resources skewed towards other sectors, adoption of risk pooling mechanisms and provision of accessible and quality reproductive health services seems feasible through a meaningful public private partnership in times to come.

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