Benefits of Health Insurance among the poor insured people of Balochistan

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Benefits of Health Insurance among the poor insured people of Balochistan

A Master's thesis submitted to the Graduate School of Public Health, Yonsei University in partial fulfillment of the requirements for the degree of Master's in Global Health Policy and Financing Capacity building

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Individual Research Paper

By

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A paper submitted to the Faculty in fulfillment of the requirements of the Master's Degree Program. The contents of this paper are the end product of my own efforts and research and reflect my own personal views and are not necessarily endorsed by any other entity.

Signature:

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Date:

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LIST OF ABBREVIATIONS

BHU	Basic Health Unit
CD	Civil Dispensary
RHC	Rural Health Center
MCH	Mother and child health center
DHQ	District Head Quarter
CH	Community Hospital
THQ	Tehsil head Quarter
SHS	School Health Services
SHC	Sub Health Center
T.B.C	T.B Clinic
MD	Mobile Dispensary
LC	Leprosy Clinic
LH	Leprosy Hospital
HOSP	Hospital
HAU	Health Auxiliary Unit
THOS	Tertiary Hospitals
F	Functional
NF	Non functional
PMNHIP	Prime Minister's National Health Insurance Program
PMU	Project Management Unit

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF GRAPHS

LIST OF CHARTS

ABSTRACT

The Province of Balochistan is the poorest province of Pakistan with very limited resources of healthcare facilities mostly in respect of healthcare providers due to which the population is suffering with lack of healthcare services throughout the region. The Government of Pakistan initiated a health insurance program for the people living with less than 2 dollar per day income to provide healthcare services to such people who are not able to have the healthcare services through their own income and mostly were pushed towards death due to unaffordability in respect of out of pocket expenditures. The five districts among 33 districts were selected in the initial phase of this program to insure such people from the province of Balochistan in 2016. The state life corporation of Pakistan (Insurance Company) was awarded the mandate by the federal government for the health insurance services. Articles reviewed regarding health insurance schemes in different developing countries for knowledge attitude where it has come to knowledge that the health insurance has well resulted in many countries among the insured people who availed the benefits of insurance policy, some studies expressed that people were not aware of benefits of health insurance system due to lack of knowledge about insurance plans and some even didn't knew about the health insurance system. The awareness plays a vital role to such people to get the benefits of insurance schemes. The secondary data obtained from the Health Department Government of Balochistan for this study and analyzed via Microsoft Excel 2010 and SPSS. The measures found the percentages of the insured people among the population and the people who got treatments against the health insurance. The data included all of those people who were inpatients in the same district hospital and other district hospitals as well. It has been found that the head of the families (card holder) had the treatment with 65.2%, the wives 20.5%, the child with 8.5%, son/daughter 5.6% and the husbands with 0.2 % among the beneficiaries. This health insurance for poor people was a good initiative, the ratio of beneficiaries who were facilitated and availed of treatments through insurance companies among the insured population was very low, and the stakeholders said that lack of awareness was the main

cause of the low ratio of treated people within the insured population. The delay in payments of premiums from the federal government to the insurance company also played a role for fewer beneficiaries, this caused the delay payments to healthcare providers and the health care providers lost the interest to provide services to the insured people. Private hospitals do not take interest in special care treatments to the insured. The same disappointed the insured people and avoided treatment against the insurance scheme. The decisions were centralized at federal level and lack of coordination also found in between federal and provincial level.

The Health Insurance schemes are highly helpful for developing and low income countries where the health services provision is very difficult due to financial hardship as well as lack of skilled human resource, communications, and proper referral system. The Province of Balochistan is needed to implement health insurance in the entire province to provide healthcare services to the scattered population. The pilot phase gave low results but there is an opportunity to increase the beneficiaries of the health insurance scheme with proper awareness of communities and with good governance to save many lives who can suffer due to non-availability of services.

Keywords:

Government of Balochistan, health department, tertiary care hospitals, health insurance Balochistan, health service delivery, diseases, poverty

I. INTRODUCTION

The workforce and infrastructure have recorded an increase in public health activities in the past which shows an enormous number of hospitals comprising of 1201, consisting of 5518 BHUs (Basic Health Units), adding more rural health centers which are 683, moreover, civil dispensaries numbering 5802, there are many maternity and child health centers those are 731, all these health facilities have 123394 beds in total. Furthermore, there are around 95000 human resources available in the form of LHWs (Lady Health Workers) who provide their services in their assigned health houses.

The Balochistan province has 33 districts with 25 DHQ Hospitals, 8 Hospitals of 50 bed, 4 THQ Hospital, 8 Civil Hospitals, 3 Tertiary care hospitals in Divisional Headquarter and including the Provincial Headquarter with 5 tertiary care hospitals. Balochistan population is 12 million according to census report 2017 and there are about 3500 doctors working in the public sector, in this continuation there is one doctor for 3400 people, due to the scattered population this ratio is unable to provide services to the population. It is important to mention here that about 2000 thousand doctors are working in the provincial headquarter in different public hospitals and offices of the health department or under training for post-graduation. Among remaining doctors 150 are enrolled in districts but undertraining in other provinces. So it is calculated that only about 1350 doctors remain for the rest of the district population (source data of payroll from Accountant General Office Balochistan).

Demographically Balochistan shares 47% of the land mass (347,190 Sq. Kilometers) of Pakistan. The province holds a sufficient number of natural resources and plays a very important role in meeting the overall country's demand for natural gas, both for the household and business purposes. In addition to natural gas, the land owns significant stores of coal, gold, copper, chromite and other minerals. However, with the wealth of these resources, the province is comparatively very much behind the acceptable level of health services and other indicators of development. For improving the accessibility to

healthcare services and providing essential services, performance of health sector is very important. The health services are available in few District Head Quarters and rest of the population is mostly under the risk along with the out of pocket expenditure with regard to the health services. The constitution of Islamic republic of Pakistan 1973 provides social security to everyone living in Pakistan (mentioned in article38)

Due to the vast area, scattered population and poor communication the access to the health care delivery services is very poor as compared to the rest of the country. There has been recorded improvement in Balochistan since 1990 regarding the health facilities though previously due to poor data collections it was not easy to make accurate results. Balochistan also falls behind in National Health indicators. Balochistan still needs to develop its health facilities regarding epidemiological transition, adding many more diseases which are commonly found in child bearing women and children. Balochistan has shown very improvement in minimizing the child mortality rate which also includes its achievement in millennium development goals.

Balochistan health outcomes are unsatisfactory and this is depicted in the health indicators which show huge disparities compared to rest of the country i.e. Maternal Mortality Ratio (MMR) in Balochistan is 785/100,000 than the national MMR value 272/100,000 and similarly the less than five year age mortality rate (U5MR) of Balochistan is 111/1000 compared with national value of 89/1000. Concluding, Balochistan's health facilities have been improved but still they have many loopholes.

However, the federal and provincial assets and resources should be used in a proper way through which the maximum number in population would be protected from financial risks that is only possible if both federal and provincial stakeholders form a model which benefits both of them. Firstly, the targeted population should be below the poverty line and it should also include a transparent method for its achievement. In order to develop such a system, one must keep some key points in mind while regulating this system that it should be practically applicable in society, especially for the poor.

Table 1.1: Health services of Government of Balochistan

List of Health Facilties		
of Balochistan 2020		
S.No	**Health Facilities**	Total
1	Tertiory Care Hospitals	7
2	Hospitals 50 Bedded	8
3	DHQH	28
4	Tehsil Head Quarter Hospital	4
5	Civil Hospitals	8
6	Rural Health Center	106
7	Basic Health Unit	761
8	Civil Dispinsery	501
9	Mother & Child Health Center	91
10	School Health Services	7
11	Sub Health Center	1
12	T.B.Clinic	8
13	Mobile Dispinsery	4
14	Leprosy Clinic	5
15	Leprosy Hospital	2
16	Health Auxiry Unit	15
TOTAL		**1556**

As per statistics available, the usual out of pocket expense is made on purchase of medicines, doctors fee and transportation costs, therefore, the proposed strategies for social health insurance through federal and provinces a insurance program should be initiated mutually that will be providing the basic health facilities to the citizens via government like: outreach and primary care.

In the earthquake of 2005, Pakistan not only faced issues in basic infrastructure but as well as human life loss too. Such areas still have impacts today as well. The country is extremely in a challenging situation to cope with problems regarding social protection. Adding more, the natural disasters like floods which gave birth to new chronic diseases

that were found in the affected area, led to an increase of 7% in different chronic diseases. However, the government allocated 5% of the total budget for the health sector. These findings imply that social protection strategy is much needed for those which are most vulnerable to the effects of catastrophic spending. Only a quarter of the population in Pakistan is entitled to healthcare benefits to a varying degree and 74% (mostly poor and rural) pay out of their own pocket for health expenditures. The 25% or more of the total population falls below the line of poverty, that led them to easily fall in a trap of medical poverty and they might not get any facility. The extreme level expenditure is done in rural areas over health, mainly on women and others who are above 60 years old.

I.1. Background

Balochistan shares 47% of the land mass of Pakistan. For improving the accessibility to healthcare services and providing essential services, performance of the health sector is very important. The health services are available in few District Head Quarters and rest of the population is mostly under the risk along with the out of pocket expenditure with regard to the health services. Commitments on improving its health indicators and reducing the out of pocket expense for health care coverage, the government of Pakistan has embarked on the mission of initiating social health coverage with a clear vision of ensuring universality of health cover till year 2024. The federal and provincial governments run national health insurance programs for the poor with joint responsibilities. The Prime Minister’s office was leading the process with a vision of covering 100 million populations, in a phased manner.

Table 1.2: Health services of Government of Balochistan

Facility Acronym	Target Districts			
	Lasbela	**Gwadar**	**Kech**	**Loralai**
BHU	44	23	39	22
CD	26	15	39	20
RHC	4	3	13	1
MCH	4	3	4	2
DHQ	1	1	0	1
CH	1	0	0	0
THQ	0	0	0	0
SHS	0	1	0	0
SHC	1	0	0	0
T.B.C	0	1	0	1
MD	0	0	0	1
LC	0	2	0	1
LH	0	1	1	0
HOSP	1	0	0	0
HAU	1	0	0	1
THOS	0	0	0	0
F	83	45	80	45
NF	0	5	16	2
Closed	0	0	0	3
Total	83	50	96	50

The joint program was to ensure the efficacious use of available resources by utilizing economies of scale while negotiating costs of the premiums with the insurance companies. The initial phase includes a good connection to the poor population for getting better

medical facilities adopting a health protection approach through a health insurance program. The health insurance program covers expenditures of hospitalization That includes childhood diseases, births and other necessary surgeries and injuries., coverage for limited tertiary care and medical ailments, and to improve access to improve the availability of medical facilities for the poor population by providing benefits in financials and enhancing the quality of medical services. The main aim of this project was to improve medical services for the population that includes 5 districts of a province, the main focus was on primary and secondary diseases.

It was in line with the National Health Vision and Provincial Health Sector strategy to provide Universal Health Coverage to the population primary and secondary diseases.

This insurance project aimed to provide free access to the poor for getting treatment of primary and secondary diseases without any cost. This program included the districts of Balochistan which were Quetta, Kech, Lasbela, Gwadar and Loralai. Mainly the targeted population fell below the line of poverty.

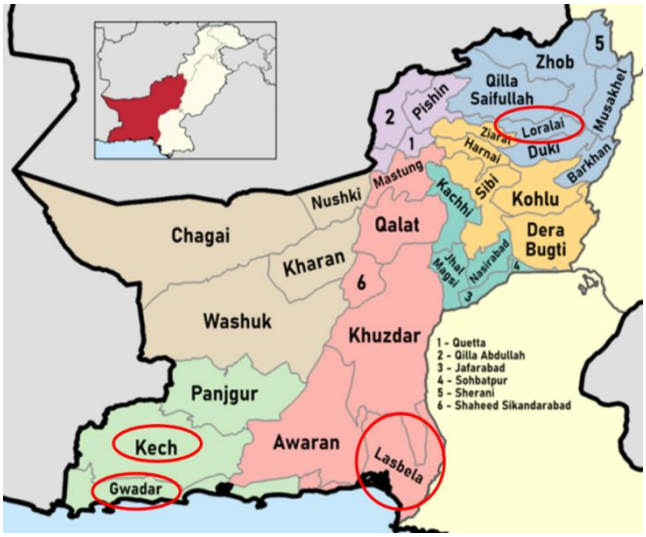


Figure 1.1. Map of Balochistan province

Figure 1.2. Pakistan Health Card for Health Insurance

This program only targeted the poor families of the above-mentioned districts which benefited from it in the form of 2$ every day. A survey was also conducted by Benazir Income Support Program in 2010 of all districts of Pakistan. All of the data of BISP was given to the Prime Minister National Health Insurance Program which included many families having income of 2$ or below, all of these families were given insurance cards when they were identified in some selected districts.

Only those families enrolled in Prime Minister National Health Insurance Program (PMNHIP) whose name is present in Benazir Income Support Program (BISP) poverty database of Proxy mean test (PMT) 32.5 and below. A family is defined as a group of people with head of the family that is (1) husband, wife and unmarried dependent children, (2) a couple with no children, (3) divorced or separated woman or man, widow or widower with or without dependent children, Single man or woman living alone, with parents or relatives, (4) parents are not included in family but will they can form a their own family separately if all are using same residence. All married children of a beneficiary family were also excluded from the list until and unless BISP enter them in their list of poverty (equal or less than PMT 32.5).In PMNHP each family were insured up-to Pak Rupees: 60,000/ year for secondary care treatment and up to Pak Rupees:

300,000/- per year for tertiary/priority care treatment. PMNHP wasn't dealing with the cash payments, the beneficiaries were not awarding or facilitating any kind of cash payments, only the beneficiaries who referred to other cities for treatment could get travelling allowances. An indoor healthcare service provides all necessary apparatus for diagnostics and equipment for the laboratory.in addition, it needs a period of 5 days after discharge for having regular checkups of a patient while if a patient has diabetics should be given a supply of one-month injectable insulin after discharge.

The program was implemented through State Life Insurance Corporation hired after a single bid process as per PPPRA (Pakistan Public Procurement Authority) rules by the Ministry of National Health Services Regulation & Coordination Islamabad and approved by the Steering committee. Services were delivered to the beneficiaries by empaneling secondary care and tertiary/ priority care level healthcare provider/ private hospitals, in all districts where the program initiated. The hospital is empanelled by the State Life insurance corporation based on hospital empanelment criteria set forth in the project documents. The shortlisting and penalization of the hospital was accorded approval by the Federal PMU, though in principal consultation with provincial Health Department was required, but it was taken on board after empanelment of hospital.

The option of inter-district portability is present in the program which enables / allows the resident of one district, with limited level of health care facilities, to access health care facilities of other districts, program focused or non-focused, health care facilities. The option of inter-provincial portability was also present for panel hospitals.

I.2. Purpose

The purpose of this study is:

1. To assess and describe the benefits of Health Insurance among the insured poor people of the pilot phase in four districts out of five districts of Balochistan.

2. Feasibility of health insurance scheme for provision of tertiary and secondary health care services to the poor masses of districts in Balochistan where the health services are unavailable or all the districts.
3. To explore the impact of extending health care insurance to the entire province

I.3. Literature Review

There is a need for a health insurance scheme in urban areas, against collection of micro payments which can prevent the financial risk of the low-income people who will not face financial hardship for payment of premium and getting treatment benefits. In developing countries, the health facilities are limited due to financial constraints and cannot fulfill the needs of the people's health, so the health insurance can help in such scenarios for provision of health services to those who cannot receive the services. The most required services may be covered in the package like emergency care, hospitalization, outpatient department, consultation, diagnostic tests and transportation. This should be preferred amongst low-income masses. (Habib & Zaidi, 2021).

Due to lack of health insurance or medical treatment vouchers /receipts decrease the chances of contact with the healthcare system rather than other social demographic characteristics. Moreover, MISA without health insurance has a lower risk of ever conducting HIV tests than people who are insured can conduct more tests to ensure the more appropriate care, all migrants in Germany must get easy access to the health insurance companies with low cost for the citizens for getting better healthcare services. (Müllerschön et al., 2019)

In Myanmar the people are facing very hardship regarding their income and which is one of the main causes for nonpayment of the insurance premiums. However, this affects the Insurance system, but the government in support to their people pays the premium without having share from the people due to the financial condition of the

people for better provision of healthcare services to the population without financial hardship.(Myint et al., 2019)

A cluster from a population may not have any awareness regarding the health insurance schemes, due to this lack of knowledge about social health insurance, people suffer from the non-availability of the healthcare services, and even they do not have any information that what services are being provided by the health insurance, the lack of knowledge makes the people obstructive and defensive, this factor is limiting the access to healthcare services who are already suffering the inequality in this regard. The findings in the study highlights the sensitive and clear information for the coverage. (Green et al., 2017)

Every convention in the world has some sort of barriers similarly the National Convention had also some limits that took place between the reformist doctors and health insurance funds. According to this study, it should be kept in mind that this convention should provide satisfaction to the doctors in order to achieve the principles of MHI, however they need to understand to use the financial funds in such a way that it should not get disturb and should be available for the insured.

The renewal of national convention commitment of the doctors to Collaborate with bungling procedures should be renewed and rationalize the expenditure, negotiations between rational national convention management and liberal doctors reveal and confrontation of powers and interests.(Zegraoui et al., 2018)

Hypertension is a major health threat in China which has not been efficiently controlled over the period of time, despite awareness and effective treatment access. Most probably, it suggests a problem is being faced in the treatment quality, treatment observance and patient's knowledge. An improvement step requires to be taken in the management of disease, health care and awareness to the patients who are at risk and health insurance package provision is required.(Liao et al., 2016)

The lack of awareness in the people regarding national health insurance, somehow they had limited knowledge about the health insurance but having no appropriate knowledge that how it works so it is necessary for the government to provide awareness sessions to the people, informing them about the benefit of the insurance that provides cost efficient and good healthcare services by utilizing health insurance.(Mulupi et al., 2013)

Many people are unaware of the benefits of health insurance; the government needs to provide awareness to the population regarding health insurance. Furthermore, studies are also required to fill the niche on knowledge of health insurance for further improvement in the healthcare sector.(Obse et al., 2015)

Knowledge regarding infusion security, healthcare insurance and belief in healthcare insurance needs to be expended in Cambodia through data spread. Progressing people's health education may be imperative to engage better choice making towards healthcare. This study also points to the limits of communication campaigns focusing on the health insurance system in the country. It is very vital to take steps for the changes in healthcare quality which will be executed, guaranteeing that there is a strong legitimate and arrangement system that enables individuals to require advantage of health insurance plans in Cambodia and that there is a clear path to achieve universal health coverage. (Ozawa et al., 2018)

To continue NHIS operations in Ghana there are some threats in respect of financial and operational life: cost increase, political pressure, insufficient technical capability, spatial distribution of health facilities and health service providers, poor monitoring setups, wide benefits package, huge exemption groups, lack of client education, and limited community engagement. Adding more, low quality of healthcare in NHIS which resulted in the reduction of patients in health centers. The NHIS continues to play a grave part towards reaching universal health coverage in Ghana though facing the above difficulties which can highly breakdown the health insurance scheme. Avoiding this possible dilemma it will be highly depended upon the intensive efforts of the key stakeholders

such as health insurance administration, healthcare service providers, insurance subscribers, the government policy makers and the politicians.(Alhassan et al., 2016).

In this study the author elaborates the result that the community is not willing to pay the premium amount because of unawareness about the community-based health insurance schemes. Hence this was one of the big hurdles that people are unaware about the benefits of the scheme. The author emphasizes that the people can avail all the benefits of health insurance through community-based healthcare insurance schemes by only spreading awareness among the people. (Sana et al., 2020)

CBHI awareness, family health status, community cohesion, health facility service quality, and family health have been the most important factors affecting whether or not registered in the system. As a result, in detail and long-term awareness campaigns on the scheme; stratification premiums based on home economic status; and the integration of social power factors, great emphasis cohesion in scheme execution, are all essential to ensuring long-term registration. Because perceived family health status and the prevalence of chronic disease were also determined to be significant factors of registration, the government may have to look at making the scheme compulsory to the population which can definitely help for reaching the desired goals for universal health coverage.(Mirach et al., 2019)

In Ghana a study found and confirmed that health insurance is good for financial protection in the health sector. The result shows a good effect on the poor people among the general population. The consequences are fruitful for many low income countries that are running the same healthcare insurance schemes. Ghana's practice also displays that establishing insurance by itself is not suitable to remove completely the out-of-pocket payment for health. Further efforts are desired to discourse the source side's inducements and quality of care, so than the people who are insured by these schemes can better revel in the full benefits of insurance.(Nguyen et al., 2011)

This study says about the objective of universal coverage which can be seen in two extents, Private healthcare services plays a significant role in coverage by generating

revenue from profits gainers for health services better than the role of government healthcare service providers and associated subsidizations. South Africa is the best example which shows how regulation and deregulation occurs in natural deepening. It also highlights how inadequate regulation of established private institutions can significantly weaken this role and reduce outcomes to degree of social protection that are below what is achievable. The established South African system has proven its responsiveness to regulating design and its ability to adjust quickly to both positive and negative modifications. When threat pools methods are implemented, coverage is enhanced and becomes more reasonable and sustainable. When expenses grow and those with low health status are routinely excluded from coverage, the system becomes less stable and fair. As a result of this vulnerability to regulation, policymakers have the chance to fulfill social protection goals through smart market governance instead of relying solely on less responsive systems based on tax-funded direct supply. This is particularly important because private healthcare markets are unavoidable, reducing policy options to a choice between functional and dysfunctional systems.(van den Heever, 2012)

The benefits of the Integrating of Social Medical Insurance (ISMI) program for health care utilization in rural China were assessed in this article. The ISMI policy had a favorable impact on inpatient health services utilization (IHSU), but not on outpatient health services utilization (OHSU). This is consistent with the policy's initial aim, which was to focus on inpatient services rather than outpatients in order to achieve its main goal of avoiding catastrophic health costs. The ISMI policy had a good impact on OHSU inequity reduction but a negative impact on IHSU inequality reduction. This adjustment will require more investigation to confirm. This research examined the effects of policy integrating implementation could be informative to regulators, and it has significant policy implications for many other developing countries experiencing comparable obstacles on the route to universal health coverage.(Fan et al., 2021)

To fasten the universal health coverage, Nigeria's National Health Insurance Scheme (NHIS) devolved the execution of government health insurance to the individual states in 2014. The states initiated the legalization of health insurance schemes specially Lagos, to increase the benefits of health insurance behind the few people enrolled in community based health insurance programs CBHIP. Effective negotiating and compliance with standards of healthcare providers are required for government insurance plans in developing countries to be effective. According to the health care facilities, the regular payments to the healthcare providers, the development of the infrastructure and the social awareness about health insurance schemes can play a vital role in the health insurance system enhancement. (Shobiye et al., 2021)

This is a cross sectional study about awareness of benefits among the foreigner in the Kingdom of Saudi Arabia. A face to face interview was conducted by the author with the Foreigners in which the author found that most of the foreigners do not understand or are not aware about the health insurance system and they do not have any awareness of how to estimate the expenditure which they made for health services. Understanding of their health insurance coverage is extremely low, highlighting the significance of adopting a policy to improve this knowledge among Saudi Arabian foreign residents. The information was available in Arabic and English only and most of the foreigners who were working did not understood both of these languages which was a big communication gap between Saudi government and the foreigners. (Alkhamis, 2017)

The insured people who have poor and lack of information regarding the national health system and the people who are registered show satisfactory reports from the insurance scheme. However, people can avail as many benefits as a national insurance scheme provides them by just spreading awareness among them, which will be only possible through health education and awareness campaigns for the required population. Such campaigns will help people of a country to get the maximum benefits from the insurance scheme (Abiola et al., 2019).

A recent study investigated the feasibility of health insurance scheme for the metropolitan city of Karachi, Pakistan and interest of poor women for availing such a scheme. This study was descriptive and focused on the populations who were enrolled in Benazir Income Support Program (BISP), which is a state run social welfare project from the Federal Government of Pakistan. The study found that most of the expenses occurred in OPD services (93.4%) followed by hospitalization (11.9%). The study designed an insurance system based on copayment method to cover OPD, hospitalization, and medicines. 53% of the participants chose a comprehensive package which would cover all aspects of health care such as emergency, hospitalization, OPD, medical tests and travelling expenses to hospital. 49.4% of participants opted for the package which would cover 50% of OPD expenses whereas 25.9% opted for a package which would cover hospitalization expenses. This study reported the high success rate of the comprehensive health insurance system in poor people of Karachi. (Habib & Zaidi, 2021)

1.4. Factors Associated with Health insurance

Factors include age, sex and dependency and level income among others in the population. The provision of primary and secondary healthcare services to the rural area people who live beyond the poverty level. The factors associated with the beneficiary district and hospital district among the poor insured people for the pilot phased four districts of Balochistan.

2. RESEARCH METHODOLOGY

2.1. Design

This is a Cross-sectional exploratory study, by using Secondary Data obtained from Health Department Government of Balochistan.

2.2. Data Collection

The secondary data was obtained from PIU Prime Minister's Health Insurance Program, Health Department Government of Balochistan. Due to COVID-19 situation and spread of delta type virus in Pakistan it was not possible to collect the primary data from the target districts for advance analysis therefore the secondary data is considered and collected for this study. Data contains details of those people who were insured by the government and avail the benefits of medical insurance for tertiary care treatment without any expenditure out of their pocket.

2.3. Data set

The target population of this study is the insurance card holder (Insured people) and the patients (dependents) who took benefits against the insurance policy.

2.4. Inclusion and Exclusion Criteria

The inclusions are those patients insurance card holder who were admitted in the hospital for treatment of tertiary care from the target districts and the exclusions those patients who having insurance card had treatment of secondary care and visits the outpatient department OPD against the insurance benefits and provincial headquarter (Quetta) insured people.

2.5. Definitions of the key terms

- Government of Balochistan: The Provincial Government of the province Balochistan.
- Health Department: The Provincial Health Department of the province Balochistan.
- Tertiary care hospitals: Specialized care provider.

- Health insurance Balochistan: Covers the medical expenses which arise due to an illness for poor people of Balochistan.
- Health service delivery: That delivery of healthcare services to meet the health needs of the population.
- Diseases: Abnormal condition of a person.
- Poverty: having not enough money to meet basic needs.

2.6. Sampling

This study is for among those insured people who were insured by the Government of Pakistan with criteria that their daily income is less than $2 per day in four district of Balochistan i.e. Gwadar, Keach, Lasbela and Loralai. That population is being taken from inpatients that availed the tertiary care and secondary care treatment against the insurance among the data available.

2.7. General Characteristics

General characteristics of participants consisted of 06 items: District, relationship with card holder, hospital name, hospital district, diagnosis and treatment.

2.8. Data Analysis

Data analysis was performed using Microsoft Excel 2010 The following describes the data analysis in detail.

2.9. Interview

2.9.1. Participants

The ex-Provincial Coordinator, Focal Person for the insurance program and the Staff officer to the Secretary Health Department Government of Balochistan was telephonically interviewed for the questions.

The low income people from public and private sector equally interviewed for question

2.9.2. Interview questions

Questions from stakeholders
What was the main reason for the low number of beneficiaries who availed the benefits of the health insurance scheme even though it was totally free of cost for them?
Is the budget released timely?
What was the response of the health service provider?
What do insured people think about health insurance after treatment?
What efforts PMNHIP PMU Balochistan initiated for such a problem?
What was the role of district health administration in the health insurance program?
Question from low income people
What is your age?
What is your monthly income?
Do you know about health insurance?
Are you satisfied with services providing the public health facility centers?
What do you think about health insurance after awareness?
Should the Government pay the premium or you will pay or you?
If the government medically insured you and in future not be able to pay the premium in future then will you continue with the health insurance by paying the premium amount by yourself?

3. RESULTS

Table: 3.I. Tertiary Care treatment for three years

	Kech 2016-2019	Gawadar 2016-2019	Lasbela 2016-2019	Loralai 2016-2019
Insured People	27270	19727	44059	29086
Tertiary Treatment	82	9	206	235
population-2017	909116	263514	574292	397400
%age of insured people among the population	3	7.49	7.69	7.32
Beneficiaries among total insured-(%)	0.37	0.05	0.47	0.81

In the above table Kech district population is 909116 and insured population is 27270, the %age of insured population among total population is 3.0 %. The beneficiaries who availed treatment with the number of 82 for tertiary care services, the percentage among the insured population is calculated 0.37 %. The Gwadar district population is 263514 and insured population is 19727, the %age of insured population among total population is 7.49 %. The beneficiaries who availed treatment with the number of 9 for tertiary care services, the percentage among the insured population is calculated 0.05 %. The Lasbela district population is 574292 and insured population is 44059, the %age of insured population among total population is 7.69 %. The beneficiaries who availed treatment with the number of 206 for tertiary care services, the percentage among the insured population is calculated 0.47 %. The Loralai district population is 397400 and insured population is 29086, the %age of insured population among total population is 7.32 %. The beneficiaries who availed treatment with the number of 235 for tertiary care services, the percentage among the insured population is calculated 0.81 %.

Table: 3.II. Secondary care treatment for three years

	Kech 2016-2019	Gawadar 2016-2019	Lasbela 2016-2019	Loralai 2016-2019
Insured People	27270	19727	44059	29086
Secondary Treatment	434	40	1709	436
Population-2017	909116	263514	574292	397400
%age of Insured among total population	3	7.49	7.67	7.32
Beneficiaries among total insured (%)	1.59	0.2	3.88	1.59

In the above table Kech district population is 909116 and insured population is 27270, the %age of insured population among total population is 3.0 %. The beneficiaries who availed secondary care treatment with the number of 434, the percentage among the insured population is calculated 1.59 %. The Gwadar district population is 263514 and insured population is 19727, the %age of insured population among total population is 7.49 %. The beneficiaries who availed treatment with the number of 40 for secondary care services, the percentage among the insured population is calculated 0.2%. The Lasbela district population is 574292 and insured population is 44059, the %age of insured population among total population is 7.69 %. The beneficiaries who availed treatment with the number of 1709 for secondary care services, the percentage among the insured population is calculated 3.88%. The Loralai district population is 397400 and insured population is 29086, the %age of insured population among total population is 7.32 %. The beneficiaries who availed treatment with the number of 436 for secondary care services, the percentage among the insured population is calculated 1.59 %.

Table: 3.III. Tertiary & Secondary care details for District Gwadar Year vise

Gwadar			
	July 2016-June 2017	**July 2017-June 2018**	**July 2018-June 2019**
Secondary	0	25	15
Tertiary		4	5
Total	0	29	20
Grand Total			49
Total insured	19727	%age year wise	
Total population-2017	263514	7.49	
Growth rate	1.86		
Total population-2018	268415	7.35	
Total population-2019	273408	7.22	
	Beneficiaries among total insured- (%)		
	July 2016-June 2017	**July 2017-June 2018**	**July 2018-June 2019**
	0.00	0.15	0.10

Table: 3.IV. Tertiary & Secondary care details for District Kech Year vise

Kech			
	July 2016-June 2017	July 2017-June 2018	July 2018-June 2019
Secondary	81	240	113
Tertiary	19	38	25
Total	100	278	138
Grand Total			516
Total insured	27270	%age year wise	
Total population-2017	909116	3.00	
Growth rate	4.23		
Total population-2018	947572	2.88	
Total population-2019	987654	2.76	
	Beneficiaries among total insured- (%)		
	July 2016-June 2017	**July 2017-June 2018**	**July 2018-June 2019**
	0.37	1.02	0.51

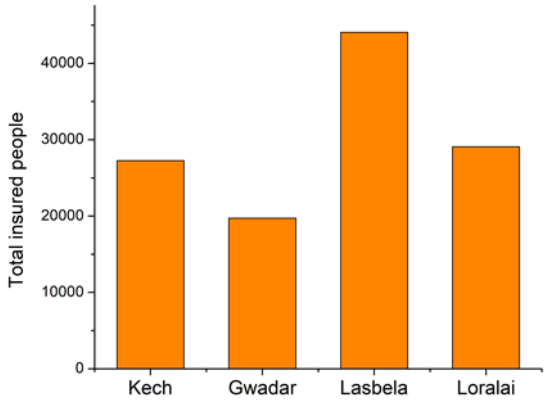
Table: 3.V. Tertiary & Secondary care details for District Lasbela Year vise

Lasbela			
	July 2016-June 2017	**July 2017-June 2018**	**July 2018-June 2019**
Secondary	622	694	393
Tertiary	73	67	66
Total	695	761	459
Grand Total			1915
Total insured	44059	%age year wise	
Total population-2017	574292	7.67	
Growth rate	3.24		
Total population-2018	592899	7.43	
Total population-2019	612109	7.20	
	Beneficiaries among total insured- (%)		
	July 2016-June 2017	**July 2017-June 2018**	**July 2018-June 2019**
	1.58	1.73	1.04

Table: 3.VI. Tertiary & Secondary care details for District Loralai Year vise

Loralai			
	July 2016-June 2017	**July 2017-June 2018**	**July 2018-June 2019**
Secondary	159	207	106
Tertiary	86	98	51
Total	245	305	157
			707
Total insured	29086	%age year wise	
Total population-2017	397400	7.32	
Growth rate	2.46		
Total population-2018	407176	7.14	
Total population-2019	417193	6.97	
	Beneficiaries among total insured- (%)		
	July 2016-June 2017	**July 2017-June 2018**	**July 2018-June 2019**
	0.84	1.05	0.54

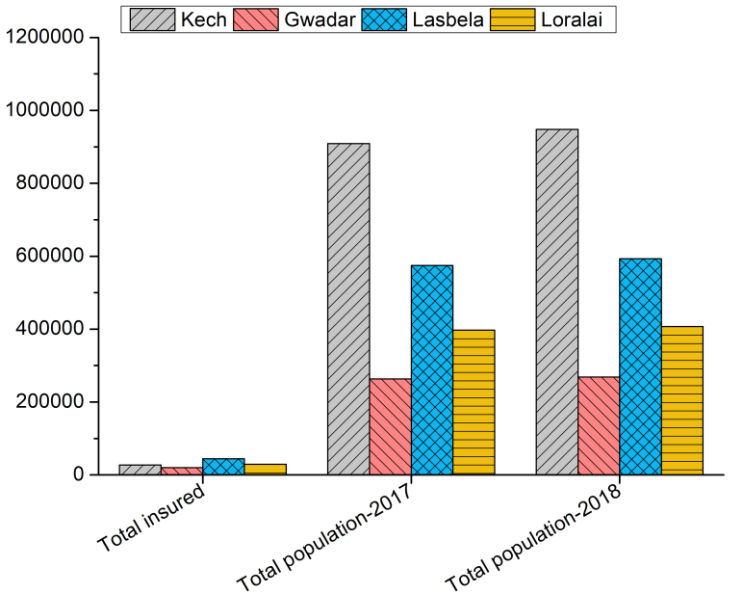
The graph below is showing the insured population of the target districts.



Graph: 3.I. Total Insured People

The Gwadar district insured population is 19727, The percentage of insured population is 7.49 %, 7.35 % and 7.22 % for the year 2016-2016, 2017-2018 and 2018-2019 respectively The kech district insured population is 27270, The percentage of insured population is 3.00 %, 2.88 % and 2.76 % for the year 2016-2016, 2017-2018 and 2018-2019 respectively the Lasbela district insured population is 44059 The percentage of insured population is 7.67 %, 7.43 % and 7.20 % for the year 2016-2016, 2017-2018 and 2018-2019 respectively The Loralai district insured population is 29086. The percentage of insured population is 7.32 %, 7.14 % and 6.97 % for the year 2016-2016, 2017-2018 and 2018-2019 respectively

The graph below is showing the total population and the ratio of insured population of the target districts as per national census report of 2017 with growth rate per annum. The Gwadar district population is 363514 growth rate of 1.86 , The kech district insured population is 909116 growth rate of 4.33, the Lasbela district insured population is 574292 growth rate of 3.24 and the Loralai district insured population is 397400 growth rate of 2.46.



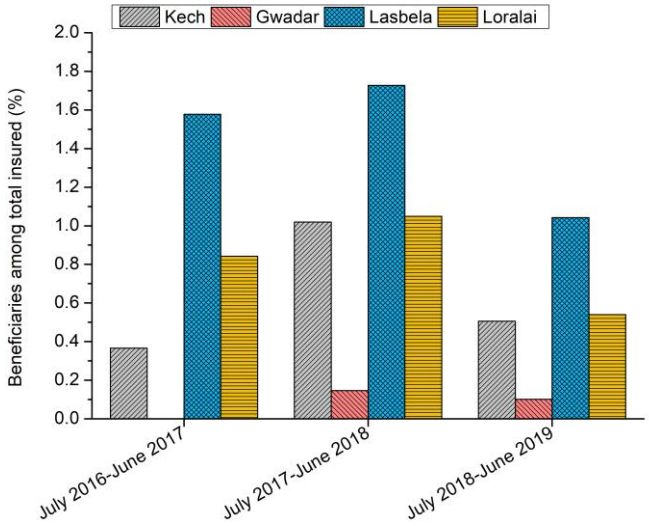
Graph: 3.II. Total Population and Insured People

The Kech district population got treatment with the number of 81 for secondary and 19 tertiary care services with the total 100 patients, the percentage among the insured population is calculated 0.37 % in 2016-2017. The population got treatment with the number of 240 for secondary and 38 tertiary care services with the total 278 patients, the percentage among the insured population is calculated 1.02 % in 2017-2018. The population got treatment with the number of 113 for secondary and 25 tertiary care services with the total 138 patients. The percentage among the insured population is calculated as 0.51 % in 2018-2019.

The Gwadar district population could not get treatment due to unknown reasons in the year 2016-2017. The population got treatment with the number of 25 for secondary and 4 tertiary care services with the total 29 patients, the percentage among the insured population is calculated 0.15 % in 2017-2018. The population got treatment with the

number of 15 for secondary and 5 tertiary care services with the total 20 patients. The percentage among the insured population is calculated as 0.10 % in 2018-2019.

The Lasbela district population received treatment with the number of 622 for secondary and 73 tertiary care services with a total 695 patients, the percentage among the insured population is calculated as 1.58 % in 2016-2017. The population got treatment with the number of 694 for secondary and 67 tertiary care services with a total of 761 patients, the percentage among the insured population is calculated as 1.73 % in 2017-2018. The population got treatment with the number of 393 for secondary and 66 tertiary care services with a total 459 patients. The percentage among the insured population is calculated as 1.04 % in 2018-2019.



Graph: 3.III. Beneficiaries among Insured People

The Loralai district population got treatment with the number of 159 for secondary and 86 tertiary care services with the total 245 patients, the percentage among the insured population is calculated as 0.84 % in 2016-2017. The population got treatment with the number of 207 for secondary and 98 tertiary care services with a total of 305 patients, the percentage among the insured population is calculated as 1.05 % in 2017-2018. The

population got treatment with the number of 106 for secondary and 51 tertiary care services with the total 157 patients. The percentage among the insured population is calculated as 0.54 % in 2018-2019.

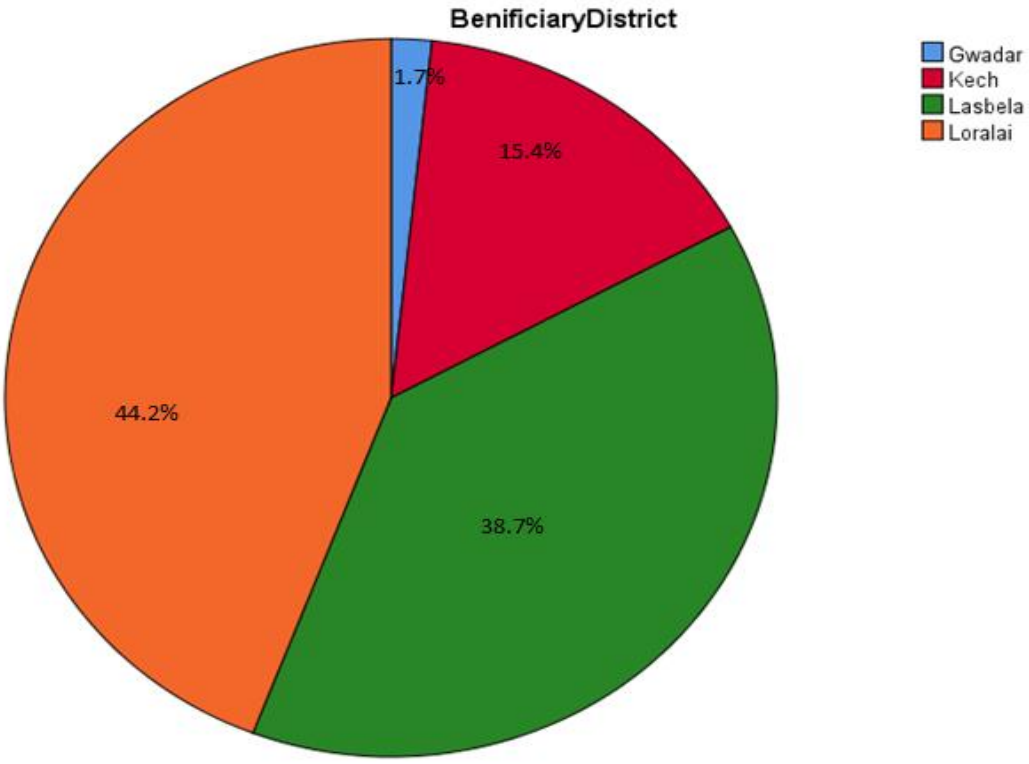


Chart.3.1 Beneficiary District

This pie chart is showing the beneficiaries of the districts in which the district Gwadar is at the lowest position with 1.7% among the insured people having treatment against the insurance. Gwadar is the farthest district of the province and facing lack of any kind of facilities. The district does not have a private hospital, insured people had to travel nearby districts for treatments and all the beneficiaries were taken treatment from other districts,

travelling, unawareness and long distances affected the output of the insurance scheme. Kech district is second lowest with 15.4% beneficiaries among the insured people, Kech is also far from any other district where the patients can reach easily because there are some private hospitals providing services to people. Lasbela district is the third lowest with 38.7 among the beneficiaries among the insured people, this district is bordering with the province of Sindh and capital of the province Karachi, this district having private health service providers being nearby to Karachi the most populated and business city of Pakistan. The highest beneficiaries among the insured people are from Loralai district with 44.2% among those insured people who availed the insurance benefits, this district is near to the provincial headquarter and most of the patients had treatments in Quetta district.

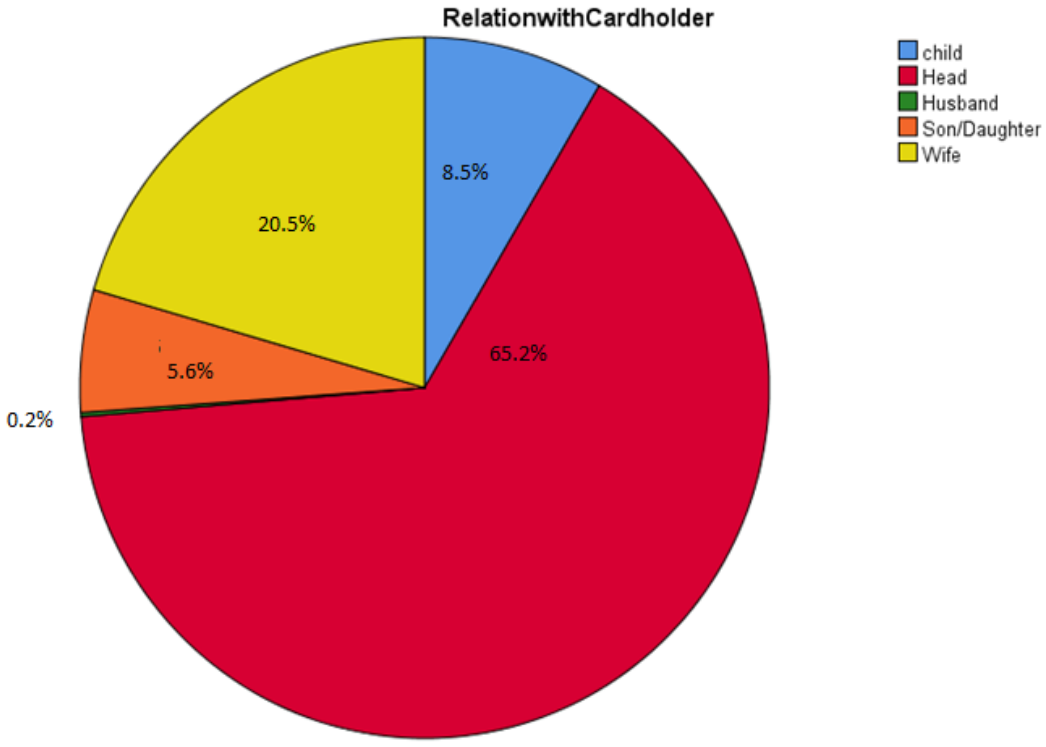


Chart.3.II Relationship of Patient with card holder:

In this chart it shows that head of the families (card holder) had the more treatment with 65.2% among the beneficiaries, remaining patients are the relatives of the card holders, the wives of card holders with 20.5% than child with 8.5% after that son/daughter with 5.6% and at last husband of some card holder women with 0.2 % among the beneficiaries.

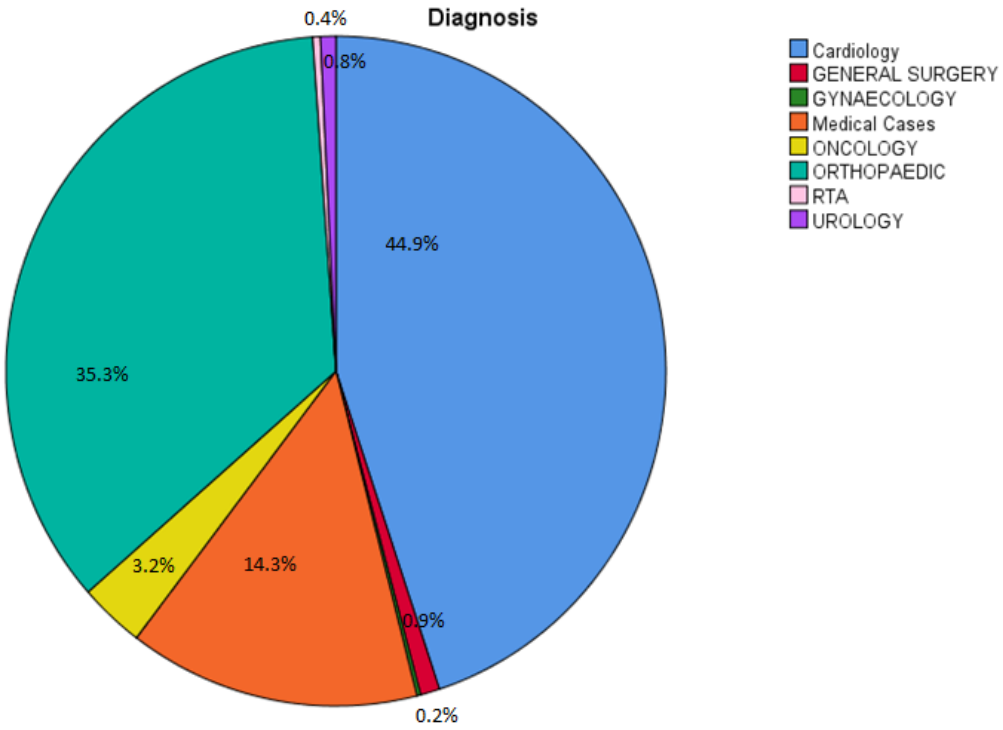


Chart. 3.3. Diagnosis of insured people or dependents.

This chart about the diagnosis of the insured people, it is shown here that most of the beneficiaries were causing the cardiac diseases with 44.9% and which are life risk disease among these diagnoses, at second the orthopedic diagnoses treated with 35.3 % among the beneficiaries, at third physiology related diagnosis got the treatments with 14.3%

among the beneficiaries. Furthermore oncology 3.2%, Surgery department 0.9%, urology department 0.8%, RTA/Trauma department 0.4% and Gynecology department 0.2 %.

The treatment ratio among the insured population is very low, owing to which the Government has faced a huge amount of finances but the population who avail the insurance policy saved their lives because the treatment they needed were almost major diseases and the facilities were not available in the area concerned. The services received were very beneficial to the population and must be continued in the same districts as well as may be enhanced throughout the province, most of the districts are facing the shortage of skilled hands and equipment to cope with such diseases. The target population was below the poverty line and not able to spend out of pocket expenditure for their treatment which could cause most of these patients death.

A representative of expenses covered by this health insurance scheme for treating cardiac related diseases of insured people is given below in Pakistan rupees (PKR) and USD. The average expenses incurred on a single patient for cardiac treatments was around $ 731.13 USD, which is very hard to be paid for a poor people whose daily income is $ 2. It would take around 365 days for a poor man with the daily income of $2 to make the above amount ($731.13). This table shows the effectiveness of this health scheme for providing basic health facilities to poor people.

Table 3.VII.Expenses covered by health insurance company for cardiac related disease treatment among the insured people (three years)

Department	**Treatment**	**Charges in Private Hospitals PKR**	**Charges in Private Hospitals USD (A)**	**Number of Patients Treated (B)**	**Expenses (C=A*B)**
Cardiology	Angioplasty - 1 Bare Metal Stent	150000	882.3529	1	882.35
Cardiology	Angioplasty with single stent (Drug eluted)	250000	1470.588	6	8823.52
Cardiology	ASD Repair	300000	1764.706	1	1764.70
Cardiology	AVR one Valve	350000	2058.824	1	2058.82
Cardiology	CABG	350000	2058.824	20	41176.48
Cardiology	Cor. Angio Plasty with 1 stent (BMS)	150000	882.3529	58	51176.46
Cardiology	Cor. Angio Plasty with 2 stent (BMS)	200000	1176.471	30	35294.13
Cardiology	Coro Angiography with all inclusive	40000	235.2941	114	26823.52
Cardiology	Mitral Valve Replacement (MVR)	200000	1176.471	2	2352.94
Total					170352.95

3.1. Interviews of stake holder.

The ex-Provincial Coordinator, Focal Person for the insurance program and the Staff officer to the Secretary Health Department Government of Balochistan was telephonically interviewed and they were asked about the reason of low percentage of insured people who availed the benefits of health insurance their reply:

Question: What was the main reason for the low number of beneficiaries who availed the benefits of the health insurance scheme even though it was totally free of cost for them?

Reply: They said that the low ratio of treated people among the insured population the main reason was lack of awareness. The three districts Law and Order Situation was not good in the past.

Question: Is the budget released timely?

Reply: The payment of premium was always delayed from the Federal Government side to the insurance company so that insurance company payment was also slow to the health care service providers which caused lack of interest for insured people.

Question: What was the response of the health service provider?

Reply: Special care was not provided in many private hospitals to the insured people who were poor. The hospitals avoided to attain such a case due late clearance of the bills from the insurance company, which resulted in lack of interest of health service providers for such patients.

Question: what do insured people think about health insurance after treatment?

Reply: They faced trouble and disappointment during visits to the hospital because of unawareness of the benefits, the procedure for free treatment and services against the health insurance scheme.

Question: what efforts PMNHIP PMU Balochistan initiated for such a problem?

Reply: All the matters were dealt at federal level and the provincial office was not taking on board, the federal office was not taking action against the raising issues which were facing the insured people. The PMU Balochistan was facing shortage of funds for frequent travel to the target districts and conduct health insurance awareness activities.

Question: What was the role of district health administration in the health insurance program?

Reply: The local health administration was totally unaware about the health insurance program and insured people so their health educational awareness activities were exiled from health insurance awareness to the public.

3.2 Interview of low income people:

For the perception of low income general population of ten people from public sector lower level employees and ten from private sector telephonically interviewed with few question which are as under:

1. What is your age?

The minimum age of interviewee was 23 years and the maximum age 65 years.

2. What is your monthly income?

The monthly income of the interviewees was between 35USD to 235USD.

3. Do you know about health insurance?

90% of the people were unaware of the health insurance schemes and 10 % knew about health insurance.

Table. 3.VIII. Percentage of People comments on questions

Comments	**Awareness about health Insurance**	**After awareness comments about health insurance**	**Satisfaction public health facilities**	**Premium Pay by Government**	**agree for pay premium if not by Government**
	%	%	%	%	%
Yes	10	0	5	95	20
No	90	0	95	0	10
Don't Know	0	30	0	5	0
Can't afford	0	0	0		70
Good	0	70	0	0	0

Among these 90%, the 90 % of public servants and 10 % from the private sector were unaware and 10% who knew about health insurance 50% from the public sector and 50% from the private sector.

4. Are you satisfied with services providing the public health facility centers?

Only 5% of the people were satisfied with public sector health facilities and 95% people were not satisfied with the services of public sector health facilities.

Among these 95% the 100 % of public servants were not satisfied with health service facilities and 90 % from the private sector were unaware and 10% were satisfied with public sector health facility services.

5. What do you think about health insurance after awareness?

The people interviewed and 90% of those people were not aware about the health insurance they were briefly told about the health insurance and then asked their view about it, 70% of the people were admired that this will be very good for us and 30% replied that they don't know that will the health insurance be good or not for them.

Among these 70% the 100 % of public servants said that it will be a good initiative for us and 60 % from the private sector said that they don't know that will it be god or not for us and 40% said that this will be good for us.

Table. 3.IX. Percentage of People comments on questions working category vise

Interviewee	Comments	Aware-ness about H I	After awareness comments about HI	Satisfaction public health facilities	Premium Pay by Government	agree for pay premium if not by Government
Public Servant		%	%	%	%	%
	Yes	10	0	0	0	40
	No	90	0	100	100	20
	Don't Know	0	0	0	0	0
	Can't afford	0	0	0		40
	Good	0	100	0	0	0
	Not Good		0			
Private					0	0
	Yes	10		5	90	0
	No	90		95	0	0
	Don't Know	0	60	0	10	0
	Can't afford	0		0	0	100
	Good	0	40	0	0	0

6. Should Government pay the premium or you will pay or you?

95% of the people were replied that Government should pay the premium amount and 5 % said that they don't know anything about this. Among these 95% the 100 % of public servants and 90 % from private sector were said that Government should pay the premium amount and 10 % from private sector said that they don't know.

7. If government medically insured you and in future not be able to pay the premium in future then will you continue with the health insurance by paying the premium amount by yourself?

70% of the people said that they cannot pay the premium due low income and non-availability of savings with them, 20% were agreed to continue the health insurance and pay the 100 % premium out of their pocket and 10 % said no they will not continue the health insurance scheme if they have to pay the premium amount.

Among above 70% the 29 % of public servants said that they cannot afford the premium amount due to low income and don't having opportunities for saving money and 71 % from private sector also said that they cannot afford the premium amount due to low income. Among the 20% who were willing to pay the premium amount if the Government suspend the payments against premium all of these were public employees. Among the 10% who said they will not pay the premium amount if the government suspended the payment all were public servants.

SWOT analysis

Strength

Performance of service delivery to the poor masses cannot afford the out of Pocket expenditure with in their districts and received the treatments at the other districts where the services are available, and the burden on the health department which was already facing pressure of non-availability of budget as well as Skill hand for treatment of serious disease patients was diverted to the other district hospitals where the tertiary care and secondary care services were available like cardiovascular diseases, orthopedics oncology and RTAs etc. the insured people received the treatment through health insurance. The

health insurance program saved thousands of people's lives during the years 2016 to 2019 from the target districts.

Weakness

Unawareness of people about the health Insurance, people were willing to receive the treatment from panel hospitals but delay in reimbursement reduced the interest of the service provider which disheartened the people for treatment through health insurance, non-availability of service providers in the same district for the insured people. Non-involvement of the provincial program management in decision making progress and not taking the district health management on loop who was the most reliable tool for implementation of policy on the ground level in respect of the health sector. Long distance also plays a role in not accessing the beneficiaries of one district to other districts for treatment.

Opportunity

In case of extending the program, the rest of the districts of the province will save the lives of those who cannot afford the out of pocket expenditures for healthcare services which are not available in the districts. The provincial government can initiate self-operated health insurance company to avoid the financial loss in the shape of premiums payment to private health insurance company. The deduction of health insurance yearly premium from the salaries of the government employees as per category of employees to generate revenue and survival of self-operated health insurance company. The hospital where the service provision rate is very low can be privatized for upgrading of the service provision of the people and availability of maximum health services for coverage of health insurance within the districts. Most of the people are unaware of the health insurance system, who receive free of cost treatment for tertiary care and secondary care, next time most of them will try to arrange a premium amount.

Threats

The scattered population can possibly result in difficulties for the program to provide the health education of people, the political wings of the doctors and paramedical staff will not agree for privatization of the public health facilities, generation of funds for payment of premium can be a threat for the government due financial constraints of the provincial government. The religious stakeholders can interfere in the process of insurance to use the religious law and ethics. The poor communication and coordination of stakeholders is also a drawback for successfulness of the program.

4. DISCUSSION

This is the ever first study from Balochistan, which can contribute in feasibility of policy making or amendments for health insurance scheme for the low-income people and employees of the government of Balochistan It also been examined that how much people of among the insured people received the treatments against the health insurance and how much they got relief financially due to the insurance scheme, It also been examined that for tertiary care treatments how much expenses could be occur if the low income insured people received the treatment out of pocket expenditure. The disease which was examined was life threatened and if the insured person did not receive the treatment could die. The open heart surgery was also performed with the expenses borne by the health insurance company and it was about 731 USD, and all the insured were those people whose daily income was not more than 2 USD, for treatment out of pocket it would take 365 days income. It was impossible for such people to save an amount which could occur on their treatment. As a result they lost their lives while receiving treatment. This study findings indicate that most of the low-income people are not aware of the health insurance, such people do not have any sources for treatment of tertiary care or even secondary care treatments due to non-availability savings and nor they can save money in their current situation of earnings. If the rest of people who were insured through this scheme were given awareness at the initial stage then in these three years most of the ill people could utilize the health insurance benefits. The main drawback was found that the decision making was centralized at the federal level and no such monitoring and evaluation activities were conducted in three years to improve the beneficiaries' number, which resulted in the wastage of public funds and may be lives. Most of the Balochistan province districts are facing the shortage of specialist doctors and some where even doctors, in this situation the health insurance program can play a fruitful role to save lives and many low income people can receive the tertiary and secondary healthcare services without paying OOP.

with the previous rate of receiving services against the health insurance was near to 3%, the possibly reason was low literacy for health insurance schemes among the insured population, the scheme wasn't supporting the outpatient and primary healthcare services and the panel hospitals number was also low in the target districts even sot private hospital available in some districts. In some studies it has also been found that Iran, India, and Kenya have identified lack of outpatient coverage as a resulting weakness of insurance schemes in these countries [19], the same faced in Balochistan as well. Thus the people of Balochistan need the health insurance schemes initially in the districts where specialists are not available at the rate of 100%.The people have the right to have the health services without OOP expenses but the government is responsible to provide the health services to them at their doorstep, it is not possible in current situation i.e. non availability of skilled human resource, essential machinery and equipment for entire the province, the health insurance is a bright way to cope with this problem and provide the health services to whole population without OOP expenditure

5. CONCLUSION AND SUGGESTIONS

5.1. Conclusion:

This study conducted various experiments and it is concluded that the Government of Pakistan has initiated as pilot project of health insurance for the poor masses of the five districts of Balochistan province, though it was a good initiative but the ratio of beneficiaries were not higher who were facilitated and avail the treatments through insurance company among the insured population. This research presented that the number of beneficiary is very low but as per available data the treatments were all about to the major diseases. The patients who availed this opportunity mostly get cured and expressed their satisfaction with the insurance services. It is a good sign that insured people had the benefits of treatment of those diseases which were not available at their districts health facilities. The reason behind low output of beneficiaries may have to be properly studied by the health reformers policy makers and cope with the barriers to facilitate more population based on the ground realities. The current situation of the province regarding health facilities and human resource availability of machinery equipment and medicine, it is very difficult to provide the services to the population of the province, so the health insurance is an ideal system to cope with situation and make easy to the people for access of healthcare services with in districts or other districts. It will be worthwhile for the people of Province if the health insurance scheme is continued not only in these five districts but throughout the province to cover maximum population phase wise. Parallel to the extension of this scheme, the creation of public awareness about this service is necessary, the interview of low income people shows that the awareness about the health insurance, 90% of the interviewee with low income both from public sector and private poor worker were not aware about the health insurance. The awareness will play a fruitful role for successful results and divert the population in large scale towards the health insurance instead of non-availability of services in most of the districts of the province. The awareness can be generated by the community meetings,

broadcastings through radio Pakistan, news channels and newspapers. The political involvement in transfer posting of the doctors and paramedical staff also affects the service provision to the people, most of the districts do not have the facilities for the health providers like residence children education and other basic needs are not available in many districts which is also a cause of refusing service provision in such districts. The pilot phase of this project was successful as all the patients who were served treatment through the insurance company were having the diseases which could not been treated at their districts due to all of them were earning less than $2/ day and most of them could die due to unaffordability and to be referred for required healthcare services. The local district administration is the main tool for such activities but unfortunately the district health administration was totally unaware of the health insurance scheme as well as the activities done by the PMNHIP in the target districts, if the district health administration would involve in this program the results definitely would be changed.

5.2. SUGGESTIONS

It is suggested that after treatment the expenditure incurred must be shared with the patient or attendant who can help for further awareness of community which will create interest among the insured population that the insurance company is bearing the huge amounts for the treatment of insured population. The health educator may be deputed to those people to conduct awareness sessions among the insured people regarding health insurance benefits. The health department may convene meetings with the panel hospitals administration to discuss the maximum service provision to the insured people. The Provincial Government should be executing the health insurance through its Project Management Unit (PMU). The program was implemented initially in the 5 focus/ designated districts of Balochistan. In next phase, it should be expanded to include whole province. In order to assist the Provincial PMU, technical support should be provided by the Federal M/o HSR&C Pakistan, GIZ, WHO or any other such body. This technical support to the provincial PMU should be for the planning, implementation, coordination, supervision and monitoring & evaluation and specially for sustainability of the health

insurance program.

The annual financial audit of the program should be carried out by an external financial auditor for fair accountability and high-lighting the financial gaps. Annual assessments including spot checks of financial records at all levels using random sampling to ensure that transferred funds had arrived as stated and the services provided to clients as claimed. MIS should be established for the data of insured people with in the province. Proper Grievance readdress committee should be notified to readdress the complaints of Health Service Provider, Insurance companies and the beneficiary's at least divisional level.

5.2.I. Capacity Building for Provincial PMU:

The Provincial PMU should be strengthened in its capacities to perform its designated functions,

Capacity building of the HR involved in the program shall be arranged with the collaboration of the technical partners.

5.2.II. Capacity Building for Implementing Agencies (Insurance Companies):

The implementing partners who would be expected to invest in the area of capacity development out of their own resources. The extent to which they propose to do this will be a criterion in the selection of the implementing partners.

5.2.III. Financial Arrangement:

The PPIU should be strengthened by funding for timely response to the insurance companies premiums and further payments to the health care providers to avoid any inconvenience to the beneficiaries.

5.2.IV. Provincial Government owned establishment of Insurance Company:

The provincial Government should establish its own insurance company for health sector which will be highly helpful to cope with the financial risk factor, The Government of Balochistan having more than 0.3 million employees, if the insurance scheme introduced to employees by deducting a specific share from their salary on monthly basis than it would be big financial support to the government against health insurance.

5.2.V. Introducing Public Employees insurance mechanism:

The Government of Balochistan public employee's treatment is the mandate of the Government without any deductions from their salary. The Government should establish a mechanism through which all the employees would be insured, the premium amount should be paid from both the employees and the employer that is Government of Balochistan. It will help the reduction of overburdened budget against the payments of medical reimbursement bills as well as the employees who could not get any reimbursement due reason one and another also get treatments for free of cost through insurance scheme.

5.2.VI. Mandatory Health Insurance scheme for Private sector:

Most of the population is working with private companies, Banks Schools business developers etc. should be mandatory insured for health services by the employers, the payment of premium may be payable from both the employee and the employer.

5.2.VII. Privatization of Public Hospitals:

The Provincial Government should initiate privatization of public hospitals and public private partnership for the health facilities to increase the service capacity of the facilities and provision of maximum health care services to the beneficiaries.

Many districts do not having private sector well established health facilities but the public sector infrastructure is available entire the province in shape of District Headquarter Hospital, Tehsil Headquarter Hospital, Rural Health Center, Rural Health Center plus, Basic Health Unit plus and Basic Health Unit with trained hospital staff deployed and equipped with needed equipment with certain exceptions where improvement will be required in public sector.

5.2.VIII. Benefits and analysis of Health Insurance:

5.2.VIII.a. Financial:

Social Health Protection being a social sector plan would not have any financial benefits other than public sector hospitals having an alternative mechanism for financing their operations. This health insurance in entire the province can directly contribute to poverty

alleviation as health care cost can push people to poverty and exacerbate poverty. A Country may find it difficult to improve its health services but still it's a big hurdle in its way for productivity. As if country's health sector is at its best it will be very easy for it to coup every problem in its way for productivity, essential for socioeconomic development. As if a country faces lack of providing medical facilities to its citizens like, low health facilities access and diseases are not treated at its best, all these will affect a country's productivity which will cause many instabilities in economy of the country. This lack of health facilities will also have its impact on international market of the country regarding its competitiveness.

5.2.VIII.b Social benefits with indicators:

It is expected that through health insurance the poor cluster in a population can easily avail the best services of health that will automatically overlap every financial barrier and the poor can get the best services. Furthermore, this will result in many social developments and providing economic stability.

The Health Insurance can support for health system strengthening by clearly bifurcating the purchaser, provider and regulator.

5.2.VIII.c. Employment generation (direct and indirect):

As a result of the health insurance implementation, job opportunities unemployed persons in various cadres will be created as a direct recruitment. The companies in order to implement the health insurance are expected to hire around thousands of people for all districts which would be indirect employment generation.

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a. District Wise Government Health Facilities in Balochistan

S.No	Districts	BHU	CD	RHC	MCH	DHQ	CH	THQ	SHS	SHC	T.B.C	MD	LC	LH	HOSP	HAU	THOS	F	NF	Closed	Total
1	Kalat	16	13	2	3	1	0	0	1	0	0	0	0	0	0	0	0	34	2	0	36
2	Kharan	22	4	0	2	1	0	0	0	0	0	0	0	0	0	2	0	31	0	0	31
3	Khuzdar	45	30	4	1	1	2	0	1	0	1	1	1	0	1	0	0	86	2	0	88
4	Lasbella	44	26	4	4	1	1	0	0	1	0	0	0	0	1	1	0	83	0	0	83
5	Mastung	24	6	6	2	1	0	0	0	0	0	0	0	0	1	0	0	30	10	0	40
6	Awaran	7	17	2	1	1	0	0	0	0	1	0	0	0	0	0	0	24	5	0	29
7	Washuk	28	12	2	0	0	0	1	0	0	0	0	0	0	0	0	0	43	0	0	43
8	Gwadar	23	15	3	3	1	0	0	1	0	1	0	2	1	0	0	0	45	5	0	50
9	Panjgur	29	11	6	4	1	0	0	0	0	1	1	1	0	1	0	0	45	10	0	55
10	Keich (Turbat)	39	39	13	4	0	0	0	0	0	0	0	0	1	0	0	0	80	16	0	96
11	Jaffarabad	19	20	1	3	1	1	0	0	0	1	0	0	0	1	1	0	47	1	0	48
12	Kachhi (Bolan)	12	19	5	3	1	2	0	0	0	0	0	0	0	0	0	0	42	0	0	42
13	Naseerabad	18	9	3	3	1	0	0	1	0	0	0	0	0	0	1	0	36	0	0	36

14	Jhal Magsi	14	11	3	2	1	0	0	0	0	0	0	0	0	0	0	0	29	2	0	31
15	Chagai	15	11	4	4	1	0	0	0	0	0	0	0	0	0	0	0	34	1	0	35
16	Pishin	34	11	9	4	1	0	1	0	0	0	0	0	0	0	0	0	60	0	0	60
17	Quetta	40	6	4	14	0	0	0	1	0	0	0	0	0	2	1	7	70	3	2	75
18	Killa Abdullah	38	13	5	2	1	2	0	0	0	1	0	0	0	0	0	0	53	8	0	61
19	Nushki	14	14	2	2	1	0	0	1	0	0	0	0	0	0	0	0	33	0	1	34
20	Dera Bugti	34	26	1	3	1	0	0	0	0	0	0	0	0	1	0	0	63	1	2	66
21	Kohlu	40	30	3	1	1	0	0	0	0	0	0	0	0	0	4	0	79	0	0	79
22	Sibi	15	15	3	4	1	0	0	1	0	0	0	0	0	0	0	0	38	0	1	39
23	Ziarat	15	7	5	3	1	0	1	0	0	0	0	0	0	0	0	0	29	3	0	32
24	Harnai	7	8	1	1	1	0	0	0	0	0	0	0	0	0	0	0	18	0	0	18
25	Barkhan	10	9	0	2	1	0	0	0	0	0	0	0	0	0	2	0	24	0	0	24
26	Killa Saifullah	17	14	5	2	1	0	1	0	0	0	0	0	0	0	0	0	36	1	4	41
27	Loralai	22	20	1	2	1	0	0	0	0	1	1	1	0	0	1	0	45	2	3	50

28	Musa Khail	20	14	1	2	1	0	0	0	0	0	1	0	0	0	0	0	39	0	0	39
29	Zhob	22	17	4	2	1	0	0	0	0	1	0	0	0	0	0	0	47	0	0	47
30	Sherani	8	7	2	1	0	0	0	0	0	0	0	0	0	0	0	0	18	0	0	18
31	Surab	27	6	1	1	1	0	0	0	0	0	0	0	0	0	0	0	36	0	0	36
32	Sohbatpur	23	15	0	4	0	0	0	0	0	0	0	0	0	0	2	0	40	4	0	44
33	Duki	20	26	1	2	1	0	0	0	0	0	0	0	0	0	0	0	47	2	1	50
TOTAL		761	501	106	91	28	8	4	7	1	8	4	5	2	8	15	7	1464	78	14	1556

B. QUESTIONNAIRE USED FOR SELECTION OF PANEL HOSPITAL

HOSPITAL GENERAL INFORMATION						
SECTION A: HOSPITAL ACCOMODATION						
1.0 ACCOMODATION	**NUMBER OF BEDS/ ROOMS**	**M**	**F**	**ROOM COOLER**	*AIRCONDITIONING*	**REMARKS (ANY ADDED PERKS)**
1.1 GENERAL WARD WITH 4-6 BEDS						
1.2 GENERAL WARD WITH 7-10 BEDS						
1.3 GENERAL WARD WITH MORE THAN 10 BEDS						

1.4 SEMI PRIVATE WITH 2 BEDS						
1.5 SEMI PRIVATE WITH 4 BEDS						
1.6 PRIVATE WITH 1 BED						
1.7 PRIVATE WITH 2 BEDS						
1.8 PRIVATE A/C						
1.8 DELUXE						
1.10 VIP						

OTHER ESSENTIAL SERVICES		M	F
1.11 BATHROOM IN WARDS	Y / N		
1.12 BATHROOM IN SEMI PRIVATE	Y / N		
1.13 BATHROOM PER ROOM	Y / N		
1.14 RUNNING WATER	Y / N		
1.15 DRESSING CART/TRAY PER FLOOR	Y / N		
1.16 CRASH CART PER FLOOR	Y / N		
1.17 IS CLEAN LINEN AVAILABLE FOR PATIENTS ON A DAILY BASIS	Y / N		
1.18 DO YOU HAVE 24/7 AVAILABILITY OF MEDICAL OFFICERS	Y / N		
1.19 DO YOU HAVE 24/7 AVAILABILITY OF NURSING CARE	Y / N		

SECTION B: OPERTATION THEATER SALON / RECOVERY ROOM							
NO. OF OPERATION THEATERS							
S.NO	**CARDIAC MONITOR**	**PULSE OXIMETER**	**AUTOCLAVE**	**LAPROSCOPIC EQUIPMENT**	**MOBILE X-RAY**	**C-ARM (ILLUMINATOR)**	**CARDIAC DIFIBRILLATOR**
OT 1	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
OT 2	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
OT 3	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
OT 4	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

0T 5	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
OT 6	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
OT 7	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
OT 8	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
OT 9	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
TOTAL							
DO YOU HAVE A SEPARATE LABOR ROOM? Y/N							
IS THE LABOR ROOM SUPPLIED WITH OXYGEN? Y/N							
IS THE LABOR ROOM CONNECTED WITH THE MAIN THEATRE? Y/N							
IS THE LABOR ROOM EQUIPMENT STERILIZED? Y/N							

IS THE LABOR ROOM CONNECTED WITH A RECOVERY ROOM? Y/N
IS THE LABOR ROOM EQUIPPED WITH ☐ Anesthesia Ventilator ☐ Suction machines ☐ NIBP ☐ Cardiac monitor ☐ Pulse oximeter☐ Cardiac defib
DO YOU HAVE AN OPERATION THEATRE DEDICATED FOR DAY CARE SURGERY? Y / N
DO YOU HAVE A CSSD DEPARTMENT? Y/N
DO YOU HAVE ENDOSCOPY EQUIPMENT? Y/N
DO YOU HAVE BRONCHOSCOPY EQUIPMENT? Y/N
DO YOU HAVE INTENSIVE CARE UNIT (ICU)? Y/N
IS THERE A DOCTOR AVAILABLE IN ICU 24/7? Y/N

ARE THE BEDS IN ICU EQUIPPED WITH: ☐ CARDIAC MONITOR ☐ DEFIBRILLATOR ☐ NIBP / OXIMETER
DO YOU HAVE NEONATAL ICU? Y/N
IS THERE A VENTILATOR IN NEONATAL ICU? Y/N

3.0 SECTION C: RADIOLOGY	**X-RAY MACHINE**	**FLOUROSCOPY**	**4.0 SECTION D : SONOLOGY**	
100 MA MACHINE	Y/N	Y/N	**ULTRA SOUND**	Y / N
200 MA MACHINE	Y/N	Y/N	**ECHOCARDIOGRAM**	Y / N

300 MA MACHINE	Y/N	Y/N	**DOPPLER COLOUR**	Y / N
500 MA MACHINE	Y/N	Y/N	**DOPPLER B&W**	Y / N
640 MA MACHINE	Y/N	Y/N	**5.0 SECTION E: INVASIVE RADIOLOGY**	
780 MA MACHINE	Y/N	Y/N	**COMPUTERIZED TOMOGRAPHY (CT SCAN)**	Y / N

1000 MA MACHINE	Y/N	Y/N	**MAGNETIC RESSONANCE IMAGING (MRI)**	Y / N
DO YOU PERFORM IVP STUDIES?		Y/N	**CATHODE LAB (ANGIOGRAPHY)**	Y / N
DO YOU PERFORM BARIUM MEAL STUDIES?		Y/N	**RADIOTHERAPY (NUCLEAR MEDICINE)**	Y / N

6.0 SECTION F: LABORATORY	
AUTO. HAEMATOLOGY CELL ANALYSER	Y / N
MICROLAB 200	Y / N
MICROLAB 300	Y / N
OTHER BIOCHEM. MACHINE	Y / N
URINE ANALYSER	Y / N
ELECTROLYTE ANALYSER	Y / N
AB GASES MACHINE	Y / N
ELISA	Y / N
STRIP READERS FOR HbsAg, HCV, HIV	Y / N