Social Health Protection Health Insurance Programme, Pakistan

(Ref No: BMZ 2009 66 168)

Progress Report (January to June 2020)

Final Draft

29th August 2020

About Oxford Policy Management

Oxford Policy Management is committed to helping low- and middle-income countries achieve growth and reduce poverty and disadvantage through public policy reform.

We seek to bring about lasting positive change using analytical and practical policy expertise. Through our global network of offices, we work in partnership with national decision makers to research, design, implement, and evaluate impactful public policy.

We work in all areas of social and economic policy and governance, including health, finance, education, climate change, and public sector management. We draw on our local and international sector experts to provide the very best evidence-based support.

Table of Contents

[Executive Summary 9](#_Toc49550207)

[1 Context 10](#_Toc49550208)

[1.1 Impact of COVID-19 in the Country 10](#_Toc49550209)

[1.1.1 The COVID-19 Pakistan Preparedness and Response Plan (PPRP) 12](#_Toc49550210)

[1.1.2 Economic impact of COVID-19 and the relief package 12](#_Toc49550211)

[1.2 International Partners Funding Agencies and Donors 12](#_Toc49550212)

[2 Financial Report 14](#_Toc49550213)

[2.1 Updated Overall Financial Report 14](#_Toc49550214)

[2.2 Organisational Development (OD) Funds: 17](#_Toc49550215)

[2.2.1 Khyber Pakhtunkhwa: 17](#_Toc49550216)

[2.2.2 Gilgit Baltistan 18](#_Toc49550217)

[3 Developments in Health Insurance Programmes in Pakistan, Khyber Pakhtunkhwa and Gilgit-Baltistan 20](#_Toc49550218)

[3.1 Health Insurance Schemes funded by the Government in Khyber Pakhtunkhwa 20](#_Toc49550219)

[3.1.1 Sehat Sahulat Program (Federal) 20](#_Toc49550220)

[3.1.2 Sehat Sahulat Program (Govt. of Pakhtunkhwa funded - Phase IV) 20](#_Toc49550221)

[3.1.3 Sehat Sahulat Program (100% Coverage) 20](#_Toc49550222)

[3.2 Health Insurance Schemes funded by the Government in Gilgit Baltistan 21](#_Toc49550223)

[3.2.1 Federal Government funded Sehat Sahulat Programme 21](#_Toc49550224)

[3.2.2 Government Employees Health and Life Insurance Scheme 22](#_Toc49550225)

[3.2.3 Religious Clerics Health Insurance Scheme 22](#_Toc49550226)

[4 Enrolment of Beneficiaries in Government / KfW Funded SHPI in KP 24](#_Toc49550227)

[4.1 Programme Enrolment in the Four Districts 24](#_Toc49550228)

[5 Enrolment of Paying Beneficiaries in KP 26](#_Toc49550229)

[6 Empanelment of Hospitals (Secondary Service Providers) in KP 29](#_Toc49550230)

[7 Empanelment of Hospitals - Tertiary Services Providers in KP 31](#_Toc49550231)

[8 Utilisation of Services in KP 32](#_Toc49550232)

[8.1 Chitral 34](#_Toc49550233)

[8.2 Kohat 34](#_Toc49550234)

[8.3 Malakand 35](#_Toc49550235)

[8.4 Mardan 36](#_Toc49550236)

[8.5 Public, Private & Gender Wise Admissions 36](#_Toc49550237)

[8.6 Utilisation by Secondary and Tertiary Services. 37](#_Toc49550238)

[8.6.1 Why is utilisation closer to 1% than 2%? 37](#_Toc49550239)

[8.6.2 Design Considerations 38](#_Toc49550240)

[8.6.3 Evidence from other schemes 38](#_Toc49550241)

[8.6.4 Age Structure and Utilisation 38](#_Toc49550242)

[8.6.5 Hospitalisation and Scheme Utilisation 41](#_Toc49550243)

[9 Premiums and Costs in KP 43](#_Toc49550244)

[9.1 Top Admissions and Average Cost since Inception and during reporting 43](#_Toc49550245)

[9.1.1 Top Five Procedures for Admissions for Women During Reporting Period 44](#_Toc49550246)

[9.2 Length of Stay 45](#_Toc49550247)

[10 Developments in Health Insurance Programmes in GB 47](#_Toc49550248)

[10.1 KfW funded Social Health Protection Initiative 47](#_Toc49550249)

[10.1.1 Extension of Phase-I of SHPI in GB 48](#_Toc49550250)

[11 Enrolment of Eligible Beneficiaries in GB 49](#_Toc49550251)

[11.1 Programme Area and Population 49](#_Toc49550252)

[11.2 Enrolment of Eligible Population 49](#_Toc49550253)

[12 Enrolment of Paying Beneficiaries in GB 52](#_Toc49550254)

[13 Empanelment of Hospitals in GB 53](#_Toc49550255)

[14 Utilisation of Services in GB 54](#_Toc49550256)

[14.1 Admissions 54](#_Toc49550257)

[14.2 Quarterly Trend of Admissions 55](#_Toc49550258)

[14.3 Utilisation of Services by eligible population by Union Councils 57](#_Toc49550259)

[14.4 Hospitals visited by the Insured 58](#_Toc49550260)

[14.5 Influence of COVID-19 pandemic on the scheme in Gilgit district 59](#_Toc49550261)

[14.6 Age and Gender Distribution by Eligible and Wider Enrolled 60](#_Toc49550262)

[14.7 Readmission cases 62](#_Toc49550263)

[14.8 Length of Stay 62](#_Toc49550264)

[15 Premiums and Costs in GB 64](#_Toc49550265)

[16 Other Matters within the SHPI Phase I Project 66](#_Toc49550266)

[16.1 Khyber Pakhtunkhwa 66](#_Toc49550267)

[16.1.1 Issues in Management of the Schemes 66](#_Toc49550268)

[16.1.2 Revision of Empanelment Criteria and Process 66](#_Toc49550269)

[16.2 Gilgit Baltistan 67](#_Toc49550270)

[16.2.1 Cards Distribution 67](#_Toc49550271)

[16.3 Key Activities – July to December 2020 68](#_Toc49550272)

[17 Conclusions 69](#_Toc49550273)

[18 Recommendations 70](#_Toc49550274)

List of Tables

[Table 1: Corona Virus Cases in Pakistan 10](#_Toc48591573)

[Table 2: Disbursement of Programme Funds During Reporting Period (in Euros) 14](#_Toc48591574)

[Table 3: Financial Position of Disbursements In Khyber Pakhtunkhwa (in Euros) 15](#_Toc48591575)

[Table 4: Financial Position of Disbursements In GB (in euros) 16](#_Toc48591576)

[Table 5: Key components of OD Funds in KP 18](#_Toc48591577)

[Table 6: Key Features of different insurance schemes (in Pak Rupees) 21](#_Toc48591578)

[Table 7: Updated Enrolment Status of Sehat Sahulat Programme in GB 21](#_Toc48591579)

[Table 8: Number of beneficiaries enrolled as at end June 2020 24](#_Toc48591580)

[Table 9: Distribution of enrolled beneficiaries by Gender and by Age Group 25](#_Toc48591581)

[Table 10: Status of enrolled families, admissions and claims 27](#_Toc48591582)

[Table 11: Empanelled Hospitals in KP 29](#_Toc48591583)

[Table 12: Empaneled Tertiary-level Hospitals in Khyber Pakhtunkhwa 31](#_Toc48591584)

[Table 13: Gender-wise Utilisations of Services by type of hospital (Jan-Jun 2020) 36](#_Toc48591585)

[Table 14: Utilisation Rate by Secondary & Tertiary Services 37](#_Toc48591586)

[Table 15: Secondary vs Tertiary Admissions in Public & Private Hospitals 37](#_Toc48591587)

[Table 16: Annualised half year utilisation in 4 Districts, 2018 to 2020 39](#_Toc48591588)

[Table 17: Average utilisation rate for 5 half years by age group 39](#_Toc48591589)

[Table 18: Enrolled populations and reported admission rates 40](#_Toc48591590)

[Table 19: Estimation on enrolment figures 40](#_Toc48591591)

[Table 20: Average, minimum and maximum disbursement for top 10 admissions. 43](#_Toc48591592)

[Table 21: Top five Admissions among the female population 44](#_Toc48591593)

[Table 22: Length of stay SHPI Phase I 45](#_Toc48591594)

[Table 23: Enrolment of Beneficiary and Wider Populations 47](#_Toc48591595)

[Table 24: Enrolment of Eligible Population by Union Council 50](#_Toc48591596)

[Table 25: Distribution of eligible beneficiaries by Gender and Age Group 50](#_Toc48591597)

[Table 26: Enrolment of wider population since inception of SHPI 52](#_Toc48591598)

[Table 27: Distribution of enrolled wider population by Gender and Age Group 52](#_Toc48591599)

[Table 28: Empanelled Hospitals in GB 53](#_Toc48591600)

[Table 29: Non-surgical Admissions 54](#_Toc48591601)

[Table 30: Surgical Admissions 55](#_Toc48591602)

[Table 31: Overall Number of enrolled households, individuals and quarterly admissions (Eligible Population) 57](#_Toc48591603)

[Table 32: Service Utilisation of Eligible Population by Union Council 57](#_Toc48591604)

[Table 33: Admissions in each Hospital (Jul-Dec 2019) 58](#_Toc48591605)

[Table 34: Distribution of admissions by age group, gender and type of enrolment 61](#_Toc48591606)

[Table 35: Average length of stay by each hospital (Jul-Dec 2019) 62](#_Toc48591607)

[Table 36: Number of Admissions by Length of Stay by Type of Beneficiaries 62](#_Toc48591608)

[Table 37: Top Ten Diagnoses of One Day Admissions 62](#_Toc48591609)

[Table 38: Claimed Amount against top 10 & all Non-surgical Admissions (Jan-Jun 2020) 63](#_Toc48591610)

[Table 39: Claimed Amount against top 10 & all Surgical Admissions (Jan-Jun 2020) 63](#_Toc48591611)

List of Figures

[Figure 1: COVID-19 Cases by Province, Pakistan, to June 2020 10](#_Toc48591463)

[Figure 2: Number of cases of COVID 19 by District, Khyber Pakhtunkhwa to June 2020 11](#_Toc48591464)

[Figure 3: Enrolment by 6-month periods 2016 to 2018 24](#_Toc48591465)

[Figure 4: Enrolment January to June 2019 27](#_Toc48591466)

[Figure 5: Visits and admissions (February 2019 - June 2020) 28](#_Toc48591467)

[Figure 6: Admissions SHPI I 2020 32](#_Toc48591468)

[Figure 7: Admissions SHPI KP Phase IV 2020 33](#_Toc48591469)

[Figure 8: Admissions under Sehat Sahulat Programme 2020 33](#_Toc48591470)

[Figure 9: Utilisation rate by year and cumulatively to date 34](file:///C:\Users\jzimmermann\Dropbox%20(OPML)\Health%20-%20OPM%20Europe\A2459%20KfW\Implementation\Reports\Progress%20report%20Jan%20-%20June%202020\OPM_Six%20Month%20Report_January%20to%20June%202020_final%20draft.docx#_Toc48591471)

[Figure 10: Utilisation rate by year and cumulatively to date 34](file:///C:\Users\jzimmermann\Dropbox%20(OPML)\Health%20-%20OPM%20Europe\A2459%20KfW\Implementation\Reports\Progress%20report%20Jan%20-%20June%202020\OPM_Six%20Month%20Report_January%20to%20June%202020_final%20draft.docx#_Toc48591472)

[Figure 11: Utilisation rate by year and cumulatively to date 35](file:///C:\Users\jzimmermann\Dropbox%20(OPML)\Health%20-%20OPM%20Europe\A2459%20KfW\Implementation\Reports\Progress%20report%20Jan%20-%20June%202020\OPM_Six%20Month%20Report_January%20to%20June%202020_final%20draft.docx#_Toc48591473)

[Figure 12: Utilisation rate per year and cumulatively to date 36](file:///C:\Users\jzimmermann\Dropbox%20(OPML)\Health%20-%20OPM%20Europe\A2459%20KfW\Implementation\Reports\Progress%20report%20Jan%20-%20June%202020\OPM_Six%20Month%20Report_January%20to%20June%202020_final%20draft.docx#_Toc48591474)

[Figure 13: Map of Gilgit District with its Union Councils 49](#_Toc48591475)

[Figure 14: Quarterly trend of Admissions 56](#_Toc48591476)

[Figure 15: Impact of COVID-19 on total admissions from insured population 60](#_Toc48591477)

[Figure 16: Impact of COVID-19 on total admissions in Public Sector Hospitals in Gilgit 60](#_Toc48591478)

List of Abbreviations

|  |  |
| --- | --- |
| ADB  AKDN  AKF  COVID | Asian Development Bank  Aga Khan Development Network  Aga Khan Foundation  Corona Virus Disease |
| DoH | Department of Health |
| EAD | Economic Affairs Division |
| FY | Financial Year |
| GB | Gilgit Baltistan |
| HDU | High-Dependency Unit |
| ICU | Intensive Care Unit |
| IMF | International Monetary Fund |
| JLI  KfW | Jubilee Life Insurance  Kreditanstalt für Wiederaufbau |
| KP | Khyber Pakhtunkhwa |
| LHW | Lady Health Worker |
| M&E | Monitoring & Evaluation |
| NO | No Objection |
| OD | Organisational Development |
| OPM | Oxford Policy Management |
| PPRP | Pakistan Preparedness and Response Plan |
| SHPI | Social Health Protection Initiative |
| SLIC | State Life Insurance Company |
| TA | Technical Assistance |
| UK | United Kingdom |
| UN | United Nations |
| WHO | World Health Organisation |

Executive Summary

This is the six monthly report on the KfW supported social health protection initiative in 4 Districts of Khyber Pakhtunkhwa and one District in Gilgit-Baltistan in Pakistan. It covers the period from January to June 2020. The overall purpose of KfW in supporting this initiative is the testing of demand-side approaches to enhance access to health services of good quality amongst poorer populations and to protect poor households from income shocks caused by ill health. The specific form of the initiative – insurance for hospitalisation - was determined through appraisal, design and tendering processes also supported by KfW with technical assistance from Oxford Policy Management.

Whilst the financial support of KfW has remained focused on these 5 Districts, the attractiveness of the approach to government has led to a more general adoption of such health insurance approaches in all the Provinces of Pakistan and particularly in Khyber Pakhtunkhwa and the Punjab. In this respect, technical assistance is extended with the support of KfW to aspects of the more general adoption in KP and G-B and in this report the wider aspects of adoption are also reported upon.

It will be appreciated that during this six month period the health system in Pakistan has been severely affected both by covid-19 and the responses of government to the pandemic. Throughout the period the insurance arrangements remained in place but the actual ability to access services was constrained by restrictions on services imposed by government to create capacity for response to an anticipated surge of patients. These restrictions were eased towards the end of the reporting period.

Financial Reporting

As has been reported for some time, the most significant financial issue is the considerable underspend anticipated for the initiative in the four Districts of KP. In this respect whilst proposals have been made consistent with the objectives of the initiative for the use of “unspent funds”, these will not be sufficient to match the scale of the anticipated underspend.

Enrolment

Enrolment for the beneficiary populations (premium paid by government with support from KfW) in the 5 Districts remains unchanged – as would be expected since the enrolment exercise was substantially completed in 2016 and 2017. The design of the initiative specifically included incentives for the insurance organisations (SLIC and AKDN-JLI) to offer similar low cost insurance products to the wider population who would pay their own premiums. This process has continued in Gilgit with over 7,000 households now enrolled. In KP, in the face of government decisions to pay premium for 100% of the population, an early successful start to such enrolment has been abandoned.

In both KP and G-B the main concern in relation to enrolment in the under-representation of infants and young children in relation to their share of the population.

Empanelment

There have been no changes in the hospitals empanelled in this period. The greatest concern relates to Kohat where the lack of hospitals perceived by the population as providing quality services may be one reason for low utilisation of the insurance scheme.

Utilisation

In the preparation of this report additional attention has been given to matters related to utilisation with the participation of the expert actuary who was involved in the original design. In Gilgit utilisation remains at predicted levels although with notably higher utilisation by the wider / paying population compared to the beneficiary population combined with a clear preference in the wider population for use of private facilities and in the beneficiary population for government facilities. Thus the market is developing into two quite distinct segments.

In KP overall utilisation continues to fall well below 1% and is dragged down by the particularly low utilisation in Kohat; whereas in Chitral utilisation continues, after a slow start, to make incremental improvements.

The report considers a number of potential contributory factors to low utilisation whilst recognising that these can only be explored fully through the utilisation study now being commissioned by KfW. These include the low utilisation for maternity services; the low enrolment of infants and children; and, the low number of hospitals empanelled. The actuary suggests, from international experience, other matters that may be contributing. These include trust and mistrust in the hospital system; distance to empaneled hospitals; other household costs associated with hospitalisation; effectiveness of advocacy and communication.

**Conclusions**

Government restrictions imposed on public and private hospitals as part of the response to COVID-19 caused what will probably be a temporary reduction in admissions in both the four KP Districts and in Gilgit. With the easing of restrictions for the time being it can be expected that activity will return to previous levels.

The most significant financial issue remains that of a potential underspend on the KP Phase 1 scheme of near to Euros 3M. Proposals discussed to date will not absorb this in full. The remaining amount will be revisited in the last one week of December 2020 after which proposals will be shared with Government of Khyber Pakhtunkhwa and KfW in first week of January for use of the funds.

Under representation of children remains the most significant issue in enrolment in KP. This requires urgent attention by government and SLIC so as to find practical solutions which do not undermine the integrity of the scheme.

The short experience in KP of extending insurance products to a paying population was showing great promise and the learning from this experience should be retained, particularly as health expenditures come under greater pressure.

The limited number of hospitals empanelled in Kohat and the perception of their quality in the population seems to be a significant problem causing low utilisation of the scheme and requires addressing by government and SLIC as a matter of urgency.

Whilst some of the specific causes of underutilisation of the scheme can be identified with reasonable certainty (the Kohat Supply issues; the low enrolment of children; the lack of demand or supply related to hospital deliveries), the general level of utilisation at considerably less than 2% is not yet explained adequately. However, there are a number of reasonable hypotheses that require attention in the forthcoming utilisation study.

In advance of the study and what might flow from it, it would be reasonable to test the impact of a good quality medical transport service.

The range in costs for services in KP continues to look reasonable and still best left to the operation of the market rather than the subject of further intervention.

The capacity of government to give sufficient attention to issues specifically related to issues in the 4 KfW supported Districts is inadequate

The range in costs in GB is much greater and probably deserves some more attention by government and AKDN.

In G-B there are similar issues in respect of the under enrolment of children and practical solutions need to be found

The continuing significant difference in utilisation by the “eligible” and “wider” populations again should be given further attention

**Recommendations**

Based on discussions with government, OPM to propose to KfW further uses of the “unspent funds” consistent with the overall objectives of the initiative and including the testing of innovations with potential for future scale-up.

Governments to request SLIC and AKDN to propose measures with any associated costs for increasing the enrolment of infants and children.

SLIC and AKDN to enter into discussions with empaneled hospitals to identify practical measures and associated costs to increase the attractiveness of maternity services.

OPM to support SLIC and AKDN in the development of terms of reference for a good quality medical transport service, the impact of which to be tested as soon as possible in at least one of the 4 Districts in KP.

KfW to request government in KP to identify a senior officer in the PMU to be the focal point for matters related to the 4 Districts.

AKDN to be requested to give consideration to the implications of the market segmentation in Gilgit.

# Context

During the last 6 months the health context has been dominated by planning and response to COVID-19 and we focus upon this in this section.

## Impact of COVID-19 in the Country

In Pakistan, the first COVID-19 case was reported on 26th February 2020, with a slow rise in infected patients till 15th March, after which the cases increased exponentially. The first death was reported on 19th March. Till 15th June, 144,478 patients with COVID-19 have been confirmed, with the largest number of cases in Punjab, 54138. Large metropolitan cities like Lahore and Karachi being the worst affected. Women comprise 28% of confirmed cases.

Table 1: Corona Virus Cases in Pakistan

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Region | Confirmed Cases | Active Cases | Deaths | CFR | Recoveries | Recover Rate |
| KPK | **18013** | **12799** | **675** | **3.75%** | **4539** | **25.20%** |
| Punjab | 54138 | 35397 | 1031 | 1.90% | 17710 | 32.71% |
| Sindh | 53805 | 27368 | 831 | 1.54% | 25606 | 47.59% |
| Baluchistan | 8177 | 5233 | 85 | 1.04% | 2859 | 34.96% |
| Islamabad | 8569 | 6454 | 78 | 0.91% | 2037 | 23.77% |
| AJK | 647 | 380 | 13 | 2.01% | 254 | 39.26% |
| GB | 1129 | 397 | 16 | 1.42% | 716 | 63.42% |
| Total (Pakistan) | **144478** | **88028** | **2729** | **1.89%** | **53721** | **37.18%** |

Figure 1: COVID-19 Cases by Province, Pakistan, to June 2020



The government of Pakistan started COVID-19 response from mid-January 2020. A coordination committee, headed by the Special Assistant to the Prime Minister on Health, was constituted at National level. Similar committees were constituted at all provincial level. In line with the World Health Organisation (WHO) advice the initial strategy was of confinement.

Government of Khyber Pakhtunkhwa declared Provincial Emergency on 3rd February 2020. Immediately after which an emergency fund of Rs.100 Million was approved and released.

To monitor the situation, a 24/7 Control room was established in the DG Health office in Peshawar. The department of Health (KP), established Rapid Response Teams at each district level. Surveillance system has been initiated with daily reporting including zero reporting mechanism. ICUs, HDUs, Isolation Hospitals/centres/rooms have been established in all districts, including many in private sector hospitals.

Pakistan has low incidence of confirmed cases compared to some other countries. Multiple explanations are explored for low incidence of cases, such as early adoption of measures of social distancing and lockdown such as closures of educational institutions, large markets and public transport before large numbers of locally transmitted cases started appearing. Closure of Chinese and Iranian borders and screening of all arrivals on airports from 23rd February may also have led to the slow spread of the epidemic. Pakistan also suspended all international operations from 21st March 2020, except for repatriation of its citizens from other countries. Although the lockdown is only partially observed in many towns, there are no reports about large number of severely ill patients with symptoms of COVID-19 infections or related deaths.

Another explanation of low number of cases is that there is insufficient testing and many cases are being missed and not reported.

Figure 2: Number of cases of COVID 19 by District, Khyber Pakhtunkhwa to June 2020



### The COVID-19 Pakistan Preparedness and Response Plan (PPRP)

The COVID-19 Pakistan Preparedness and Response Plan (PPRP) was formulated jointly by government of Pakistan staff, the UN agencies staff and other partners and launched by the Minister of Foreign Affairs on 27th April 2020. The Plan is meant to ensure a coordinated international support to the Government of Pakistan including, the Ministry of Health Services, Regulations and Coordination, National Disaster Management Authority and Provincial governments, to stop transmission of COVID-19. The PPRP is focused on public health needs in Pakistan. The Plan is costed at US$ 595 million for a period of 9 months till December 2020.

### Economic impact of COVID-19 and the relief package

Ministry of Finance, Ministry of Planning and the State Bank of Pakistan are monitoring the impact of the virus on economy of Pakistan and are also trying to provide short term relief to people as well as develop strategies to deal with long effects of the situation arising after the pandemic.

The Ministry of Planning has estimated that 12.3 million to 18.5 million people in the country will lose their jobs and the economy will sustain Rs 2 trillion to Rs 2.5 trillion (US$ 12 billion) losses in just three months due to “moderate to severe shocks from the coronavirus outbreak”. The government has assessed the losses on the basis of the impact of the restrictions – imposed to stop the COVID-19 from spreading – on business, tax revenue, international trade and cost of unemployment for three months.

## International Partners Funding Agencies and Donors

Most of the donors, technical and financing agencies have diverted their funding and financial assistance towards COVID-19 response from March 2020 onwards. Funds already committed for various areas of support have also been reprogrammed to help Pakistan in its response to the COVID-19 pandemic and its effects in the country.

Pakistan has received an emergency loan of $1.39 billion from the International Monetary Fund (IMF) to cope with the coronavirus pandemic.

The World Bank has approved a $200 million package to help Pakistan take effective and timely action to respond to the COVID-19 pandemic by strengthening the country’s national healthcare systems and mitigating socioeconomic disruptions. This support includes appropriating $38 million from eight existing projects for procurement of urgently needed medical equipment and supplies. Part of this assistance is being used to help the poor and vulnerable to cope with the immediate impact of the pandemic through social protection measures (BISP and EHSAS programme), food rations, and remote learning education.

The Asian Development Bank (ADB) has made a commitment to provide $800 million (Rs129 billion) for COVID-19. The ADB has provided financial assistance of $2.5 million as a grant and re-purposed $50 million for the procurement of equipment related to the COVID-19 response in Pakistan.

The government of UK has announced, 2.67 million pounds support to Pakistan to support its efforts to manage the covid-19 outbreak.

WHO is supporting “Family Practice Approach” in two districts of Khyber Pakhtunkhwa – Swabi and Haripur. The Family Practice Approach plans to organise health care delivery by family physicians supported by teams who would be providing health care services to a defined population. The Family Practice clinics/physicians may be paid on capitation basis and will be part of a referral system. Government may use these family physicians as part of the insurance scheme to be used as gatekeepers.

According to the monthly bulletin of Foreign Economic Assistance by Economic Affairs Division (EAD), Pakistan received around $4.758 billion as foreign economic assistance from bilateral and multilateral development partners on concessional terms with longer maturity in the ten months (Jul-April) of Financial Year 2020.

During, ten months (Jul-April) of Financial Year 2020 the collective disbursement from bilateral donors amounted to $850 million.

A breakup of the funds received from bilateral sources shows that Pakistan received $487 million from China, followed by $128 million from the United Kingdom, $94 million from Korea, $59 million from the United States during ten months (Jul-April) of Financial Year 2020.

Foreign assistance obtained by Pakistan through multilateral sources during Jul-April FY20 totalled $3.68 billion. Amongst the multilateral development partners, Asian Development Bank provided $2.253 billion, Islamic Development Bank $879 million, and World Bank $505 million.

# Financial Report

## Updated Overall Financial Report

According to the initial documents and C&F table as well as the original contract implementation of the scheme was for a period of five years from January 2015 to December 2020. As such most of the payable amounts have been disbursed. Since the amount of funds under each activity in the separate agreement was allocated on assumptions there is a difference between the allocated amount and the actual amount as per contract.

The premium of PKR 1700 per annum per household was reduced in the second year onwards as a consequence of lower premium for the government funded scheme for the wider population. Similarly, after detailed analysis of the OD plan submitted by SLIC the amount of allocated OD was reduced. Funds allocated for the yearly audit proved to be much higher than the bids received through the procurement process and these were far below the allocated amounts. This resulted in savings of over Euros 3 million in the allocated funds. During the period under report the position of disbursements of program funds is given in the following table.

Table 2: Disbursement of Programme Funds During Reporting Period (in Euros)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Premium | Separate Agreement | Contractual | Disbursed | Payable | Saving/ Excess |
| Year 1 | 1,366,504 | 1,224,186.37 | 1,219,820.37 | 0.00 | 146,683.63 |
| Year 2 | 1,294,582 | 925,136.07 | 925,136.07 | 0.00 | 369,445.93 |
| Year 3 | 1,222,662 | 862,394.62 | 843,099.62 | 0.00 | 379,562.38 |
| Year 4 | 1,150,741 | 734,701.97 | 720,437.97 | 0.00 | 430,303.03 |
| Year 5 | 1,078,820 | 705,820.00 | 650,489.00 | 41,959.00 | 428,331.00 |
| Total | 6,113,309 | 4,452,239.03 | 4,358,983.03 | 41,959.00 | 1,712,366.97 |
| Audit | | | | | |
| Year 1 | 110,000.00 | 2,842.04 | 2,842.04 | 0.00 | 107,157.96 |
| Year 2 | 110,000.00 | 2,000.10 | 2,000.10 | 0.00 | 107,999.90 |
| Year 3 | 110,000.00 | 1,844.00 | 1,844.00 | 0.00 | 108,156.00 |
| Year 4 | 110,000.00 | 2,800.00 | 0.00 | 2,800.00 | 107,200.00 |
| Year 5 | 110,000.00 | 5,000.00 | 0.00 | 6,000.00 | 104,000.00 |
| Total | 550,000.00 | 14,486.14 | 6,686.14 | 8,800.00 | 534,513.86 |
| M&E | | | | | |
| OPM | 450,000.00 | 1,337,373.00 | 917,580.00 | 0.00 | -467,580.00 |
| RSPN | 0.00 | 173,770.64 | 173,770.64 | 0.00 | -173,770.64 |
| RSPN | 0.00 | 182,003.14 | 182,003.14 | 0.00 | -182,003.14 |
| Total | 450,000 | 1,693,146.78 | 1,273,353.78 | 0.00 | -823,353.78 |
| OD | 1,500,000 | 1,045,312.93 | 1,045,312.93 | 0.00 | 454,687.07 |
| Contingency | 1,386,691 | 0.00 | 0.00 | 0.00 | 1,386,691.00 |
| Total | 10,000,000 | 7,206,790.88 | 6,682,941.88 | 50759.0 | 3,264905.12 |

Premium for all the 5 years has been disbursed except for the 5th year’s premium in GB. Payments to OPM for the 5 years contract period have been disbursed. Payments on account of Audits for 3 years in both KP and GB have been disbursed. Audit for 4th year in KP was delayed because of the COVID-19 lockdown and suspension of services in the hospitals. Audit has now been completed and audit report will be submitted to KfW shortly. Audit for years 4 and 5 in GB and year 5 in Khyber Pakhtunkhwa are not yet due. The entire approved OD funds have been disbursed to SLIC and AKDN.

Since implementation of the scheme started earlier in KP the entire amounts due, except for the 2 years audits, has been disbursed. The following table depicts disbursement of funds in KP.

Table 3: Financial Position of Disbursements In Khyber Pakhtunkhwa (in Euros)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Premium | Separate Agreement | Contractual | Disbursed | Payable | Saving/ Excess |
| Year 1 | 1,282,954.00 | 1,145,493.37 | 1,145,493.37 | 0.00 | 137,460.63 |
| Year 2 | 1,215,430.00 | 865,904.07 | 865,904.07 | 0.00 | 349,525.93 |
| Year 3 | 1,147,906.00 | 798,964.62 | 798,964.62 | 0.00 | 348,941.38 |
| Year 4 | 1,080,383.00 | 675,681.97 | 675,681.97 | 0.00 | 404,701.03 |
| Year 5 | 1,012,859.00 | 650,489.00 | 650,489.00 | 0.00 | 362,370.00 |
| Total | 5,739,532.00 | 4,136,533.03 | 4,136,533.03 | 0.00 | 1,602,998.97 |
| Audit | | | | | |
| Year 1 | 88,000.00 | 1,596.04 | 1,596.04 | 0.00 | 86,403.96 |
| Year 2 | 88,000.00 | 1,303.10 | 1,303.10 | 0.00 | 86,696.90 |
| Year 3 | 88,000.00 | 1,147.00 | 1,147.00 | 0.00 | 86,853.00 |
| Year 4 | 88,000.00 | 1,300.00 | 0.00 | 1,300.00 | 86,700.00 |
| Year 5 | 88,000.00 | 3,000.00 | 0.00 | 3,000.00 | 85,000.00 |
| Total | 440,000.00 | 8,346.14 | 4,046.14 | 4,300.00 | 431,653.86 |
| M&E | | | | | |
| OPM | 360,000.00 | 998,750.00 | 757,247.00 | 0.00 | -397,247.00 |
| RSPN | 0.00 | 154,122.64 | 154,122.64 | 0.00 | -154,122.64 |
| RSPN | 0.00 | 157,027.14 | 157,027.14 | 0.00 | -157,027.14 |
| Total | 360,000.00 | 1,309,899.78 | 1,068,396.78 | 0.00 | -708,396.78 |
| OD | 1,200,000.00 | 804,688.93 | 804,688.93 | 0.00 | 395,311.07 |
| Contingency | 1,260,468.00 | 0 | 0.00 | 0.00 | 1,260,468.00 |
| Total | 9,000,000.00 | 6,259,467.88 | 6,013,664.88 | 4,300.00 | 2,982,035.12 |

Contract between the GoKP and SLIC for implementation of the scheme was signed in January 2015 for provision of services for a period of 5 years but actual provision of services in the four districts started in March 2016. The provision of services under the contract will therefore continue till February 2021. The DoH KP approached KfW for extension of the contract as well as Technical assistance till June 2021. The rationale for extension till June was that the financial year of the government ends in June and also that after the end of the project there would still be activities like procurement of audit firm, finalisation of audit report and end of the project report. The KfW mission during its visit to Peshawar agreed with this proposal and asked OPM to submit addendum to its contract for the extension. OPM has submitted this extension request to KfW for additional amount of Euros 226,357 for the period March 2020 to June 2021.

Premium for all the 5 years has been disbursed and there is a saving of over Euros 1.6 million in the premium consequent to the revision of premium due to increased enrolment of population. After disbursement of all the funds related to the present activities there is a saving of Euros 2.982 million. When informed about the savings KfW asked OPM to suggest options for its disbursement. Different options were considered and after many rounds of written and verbal discussion KfW suggested extension of the same scheme to the four districts for another period of two years. Various components on which the unspent amount is proposed to be spent are as under.

* Premium
* Audit
* OPM TA for extension up to June 2021.
* Anticipated TA for two years July 2021 to June 2023.
* Utilisation study
* Awareness raising through LHWs
* Safe Medical Transportation
* Learning Activities
* Contingency

The following table depicts disbursement of funds in GB.

Table 4: Financial Position of Disbursements In GB (in euros)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Premium | Separate Agreement | Contractual | Disbursed | Payable | Saving/ Excess |
| Year 1 | 83,550.00 | 78,693.00 | 74,327.00 | 0.00 | 9,223.00 |
| Year 2 | 79,152.00 | 59,232.00 | 59,232.00 | 0.00 | 19,920.00 |
| Year 3 | 74,756.00 | 63,430.00 | 44,135.00 | 0.00 | 30,621.00 |
| Year 4 | 70,358.00 | 59,020.00 | 44,756.00 | 0.00 | 25,602.00 |
| Year 5 | 65,961.00 | 55,331.00 | 0.00 | 41,959.00 | 24,002.00 |
| Total | 373,777.00 | 315,706.00 | 222,450.00 | 41,959.00 | 109,368.00 |
| Audit | | | | | |
| Year 1 | 22,000.00 | 1,246.00 | 1,246.00 | 0.00 | 20,754.00 |
| Year 2 | 22,000.00 | 697.00 | 697.00 | 0.00 | 21303.00 |
| Year 3 | 22,000.00 | 697.00 | 697.00 | 0.00 | 21303.00 |
| Year 4 | 22,000.00 | 1,500.00 | 0.00 | 1,500.00 | 20,500.00 |
| Year 5 | 22,000.00 | 2,000.00 | 0.00 | 3,000.00 | 19,000.00 |
| Total | 110,000.00 | 6140.00 | 2640.00 | 4500.00 | 102860.00 |
| M&E | | | | | |
| OPM | 90,000.00 | 338,623.00 | 160,333.00 | 0.00 | -70,333.00 |
| RSPN | 0.00 | 19,648.00 | 19,648.00 | 0.00 | -19,648.00 |
| RSPN | 0.00 | 24,976.00 | 24,976.00 | 0.00 | -24,976.00 |
| Total | 90,000.00 | 383,247.00 | 204,957.00 | 0.00 | -114,957.00 |
| OD | 300,000.00 | 240,624 | 240,624.00 | 0.00 | 59,376.00 |
| Contingency | 126,223.00 | 0.00 | 0.00 | 0.00 | 126,223.00 |
| Total | 1,000,000.00 | 947,323.00 | 669,277.00 | 46459.00 | 282870.00 |

Contract between the GoGB and AKDN Consortium for implementation of the scheme was signed in April 2015 for provision of services for a period of 5 years but actual provision of services started in August 2016. The provision of services under the contract was therefore to continue till July 2021. Premium for 4 years has already been disbursed. Withdrawal application for payment of premium for the 5th year will become due in July 2020. Audit fee has been paid for 3 years. Audit for year 4 will become due in August 2020. Payment to OPM has been made for the entire period of 5 years ending March 2020. After disbursement of all the funds related to the present activities there is a saving of Euros 0.282 million.

KfW asked OPM to suggest options for disbursement of this amount. But during KfW mission visit to Gilgit and meeting the GB government officials an understanding was reached between GoGB and KfW that in Gilgit district the GB government will continue to provide both secondary and selective priority care services to population below 32.5 PMT with KfW funding. KfW agreed to allocate additional funds for the extended phase of SHPI in Gilgit Baltistan. A Separate Agreement (SA) in this regard was signed between KfW and Deportment of Health GB on 18 August 2019. According to this SA KfW committed to allocate Euro 2.6 million for the extended phase including piloting of coverage of Outpatient Services and funding the existing SHPI for two years in Gilgit district.

Based on this SA, DOH GB prepared a PC-1 for this extended phase of SHPI for a period of three years with enhanced population and benefit package. The population coverage will be increased from 16.17 to 32.5 PMT score and benefit package will include priority tertiary care. The cost of premium of IPD services (Secondary and priority tertiary care hospitalisation) for this coverage during the initial two years will be co-financed by KfW and Government of GB and for last year all premium cost will be borne by the GB Government. PC-I for the extension is pending approval of the Federal government and its approval and procurement process for the implementing partner is likely to be completed by December 2020.

## Organisational Development (OD) Funds:

The entire amount of approved OD funds for both KP and GB has been disbursed.

### Khyber Pakhtunkhwa:

While reporting on the expenditure in OD funds SLIC anticipated that some funds may remain unspent at the completion of the plan, while some modification in the proposed OD plan is also required due to changes in the overall SHPI plans while some emerging needs have also been identified. The anticipated savings and proposed modifications in the approved plan were discussed thoroughly with SLIC and DoH and proposal for revision and extension in the approved OD Plan was submitted to KfW for approval. After many iterations and modifications KfW finally gave a No Objection (NO) for the modified OD plan on 25th March 2020. The main components of the revised plan are as follows.

Table 5: Key components of OD Funds in KP

|  |  |  |  |
| --- | --- | --- | --- |
| Particulars | Duration | Rate PKR | Total |
| Treatment Protocols and Operational Manual | | | |
| Hiring of Consultant for Treatment Protocols | 6 months | 400,000.00 | 2,400,000.00 |
| Preparation of Training Manual & Training | 6 months | 300,000.00 | 1,800,000.00 |
| Hiring of Content Writer | 1 year | 175,000.00 | 2,100,000.00 |
| Training Sessions (Office) TOT |  |  | 800,000.00 |
| Hospital, HFO, DMO Training |  |  | 1,000,000.00 |
| Total |  |  | **8,100,000.00** |
| Total in Euros |  |  | **49,090.91** |
| Awareness raising activities with focus on use of LHWs |  |  | 5,008,000.00  Euros 30,351.52 |
| Preparation of Empanelment Criteria/ Training of staff on empanelment |  |  | 2,625,000.00  Euros 15,909.09 |
| Training workshops for Public/Private/MTI hospitals on SoPs and Operations Manual |  |  | 2,644,500.00  Euros 16027.27 |
| Monitoring visits and Review meetings |  |  | 1,500,000.00  Euros 9090.91 |
| TOTAL EXPENDITURE |  |  | **Rs. 19,877,500.00**  **Euros 120,469.70** |

Preparatory work on the new OD plan components have been finalised in consultation with SLIC and DoH but the implementation and field work were delayed because of the lockdown due to COVID-19 and the absence of a permanent Chairman SLIC. These activities will be completed by the first quarter of 2021.

### Gilgit Baltistan

During reporting period there was total spending of PKR 985,253 out of the OD fund on running cost of Social Mobilisation and Coordination. The advertisement for the procurement of consultancy services for three major components of OD Fund plan namely (a) preparation of a Video documentary on SHPI in Gilgit, (b) carrying out a field assessment to document the effects of health insurance on beneficiary population and (c) development of Management Information System for SHP-Micro Health Insurance was done in March 2020.

However, the COVID-19 pandemic delayed the further process. A committee comprising representatives of PMU (DOH-GB), AKDN and OPM has started the finalisation of consultancy firms, which is expected to be completed in August. Once the committee finalise its recommendations then these will be submitted to KfW for its NO before awarding the services.

# Developments in Health Insurance Programmes in Pakistan, Khyber Pakhtunkhwa and Gilgit-Baltistan

There are at least two government funded health insurance schemes in Gilgit Baltistan and three such schemes in Khyber Pakhtunkhwa.

Currently four schemes are being implemented in Khyber Pakhtunkhwa. One is federal scheme (in erstwhile FATA), whereas rest of the three schemes are funded by government of Khyber Pakhtunkhwa.

## Health Insurance Schemes funded by the Government in Khyber Pakhtunkhwa

### Sehat Sahulat Program (Federal)

The Scheme is being implemented in newly merged districts (erstwhile FATA) of Khyber Pakhtunkhwa. The scheme is based on “Family Model”, with coverage to Family Head, Spouse and unmarried children. The secondary coverage is Rs. 60,000 for whole family and Tertiary coverage of Rs. 300,000. The scheme also has an “Excess of Loss” feature, under which in life threatening situations during treatment both secondary and tertiary coverage could double and even triple if required. A transportation cost of Rs, 1000 is paid to all the patient (maximum three times annually). Funeral charges of Rs, 10,000 is also paid to the family of beneficiaries in case the patient dies during treatment while admitted under the scheme.

### Sehat Sahulat Program (Govt. of Pakhtunkhwa funded - Phase IV)

This scheme has been implemented in all the districts of Khyber Pakhtunkhwa. The beneficiaries are with PMT score of 32.5 under BISP criteria. This scheme is also family based with secondary coverage of Rs. 40,000 and tertiary coverage of Rs. 400,000. A reserve fund has also been created for coverage of cost that exceeds the secondary and tertiary limits. Kidney Transplant is also covered under the reserve fund.

Agreement was signed between State Life and Govt of KP for a period of three years from July 2020 to June 2023. But with introduction of coverage of 100% population under the new scheme this phase would continue till the implementation of the new scheme.

### Sehat Sahulat Program (100% Coverage)

Khyber Pakhtunkhwa government advertised RFP for coverage of 100% population of Khyber Pakhtunkhwa. State Life has won the bid for the implementation of the scheme for which the agreement is yet to be signed. The scheme is broadly identical to Phase IV although there some differences in details. The major difference being that coverage has been increased to 100% population and benefit limits enhanced while the unit for payment of premium is changed to “family” rather than “household”.

Table 6: Key Features of different insurance schemes (in Pak Rupees)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Project | Premium | | | Secondary Coverage | Tertiary Coverage |
| **Basic Premium** | **Reserve Fund** | **Total** |
| Sehat Shaulat Program (Federal) | 1998 | 0 | 1998 | 60,000 (per family floating) | 300,000 |
| Sehat Sahulat Program, KP (Phase I) | 1549 | 0 | 1549 | 30,000 (per member) | 300,000 |
| Sehat Sahulat Program, KP (Phase IV) | 1998 | 40 | 2038 | 40,000 (per member) | 400,000 |
| Sehat Sahulat Program (100% coverage) | 2849 | 40 | 2889 | 40,000 (per member) | 400,000 |

## Health Insurance Schemes funded by the Government in Gilgit Baltistan

### Federal Government funded Sehat Sahulat Programme

The Federal Government of Pakistan, in 2015, launched a health insurance scheme under the name of “National Health Programme” in 23 districts across four provinces, the Capital Territory of Islamabad, erstwhile Federally Administered Tribal Areas, Azad Jammu and Kashmir **and Gilgit Baltistan**. This scheme is managed by the Federal Programme Implementation Unit and planned to roll out to all districts of GB. However, upon request of Provincial Government, Gilgit district was excluded where the KfW supported programme is being implemented. By end of July 2020, a total of 51,961 families have been enrolled in this scheme in four districts of GB against the target of 73,783 families as shown in the following table:

Table 7: Updated Enrolment Status of Sehat Sahulat Programme in GB

|  |  |  |  |
| --- | --- | --- | --- |
| District | Target Households | Cards Distributed | Total Hospital Admissions so far |
| Skardu | 24,955 | 21,119 | 2693 |
| Diamer | 19,764 | 17,148 | 853 |
| Ghizer | 16,313 | 4,854 | Cards distribution started in July 2020 |
| Hunza Nagar | 12,751 | 8,840 | 10 |

Furthermore, Sehat Sahulat Program has recently recruited a Deputy Director and M&E Officer for GB and will be placed in GB for smooth implementation of Project in GB.

### Government Employees Health and Life Insurance Scheme

In order to provide better health care facilities to the Government employees, Gilgit Baltistan Assembly has passed an act namely “The Gilgit-Baltistan Civil Servants Health and Life Insurance Act, 2019” through which around 50,000 government employees and their entitled family members will be provided with Health and Life Insurance Coverage. For this purpose, an advertisement was published in newspapers. The procurement process for hiring of Insurance Company is in its final stages.

### Religious Clerics Health Insurance Scheme

Another health insurance scheme to provide health insurance coverage to the Imams/heads of all Mosques/religious places of Gilgit Baltistan. Government of GB has allocated PKR 65 million for this scheme in its Annual Development Programme. The PC-1 for this scheme will be prepared and after its approval Request for Proposals will be floated later this year.

Part 1: Khyber Pakhtunkhwa

# Enrolment of Beneficiaries in Government / KfW Funded SHPI in KP

## Programme Enrolment in the Four Districts

Enrolment in the KfW supported Social Health Protection Initiative in the four districts of Khyber Pakhtunkhwa currently stands at 784,718 individuals or 95,405 households (averaging around 8.2 members in a household). The enrolment drive in the four districts was primarily undertaken in first half[[1]](#footnote-2) of 2016 while the remaining was undertaken in first half of 2017.

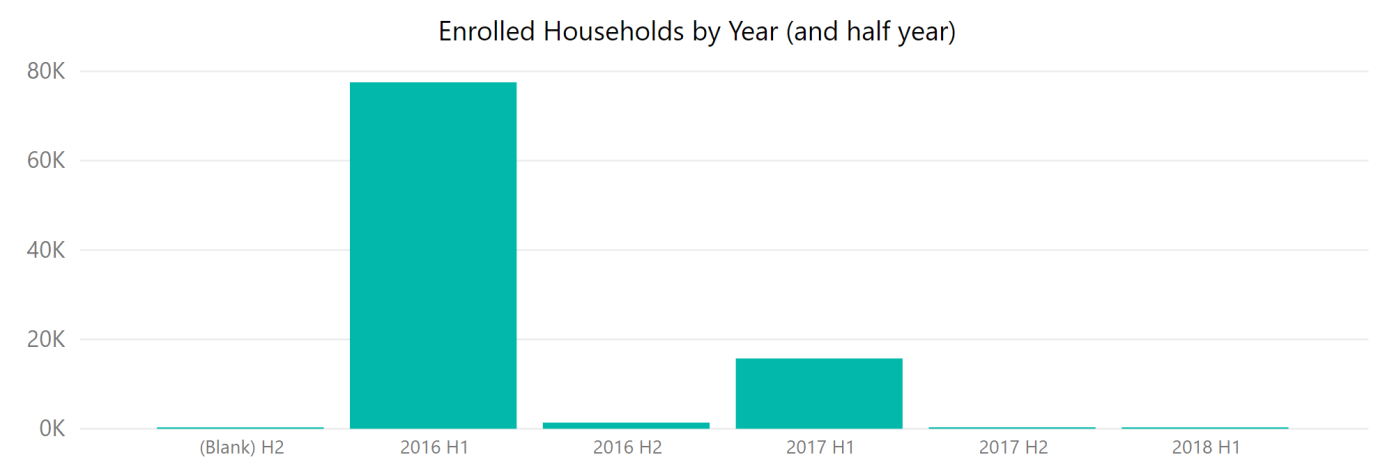
Table 8: Number of beneficiaries enrolled as at end June 2020

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| District | Households enrolled | Individuals enrolled | Households (Census 1998) | % Enrolled | Households (Census 2017) | % Enrolled |
| Chitral | 8645 | 78024 | 45,228 | 19.1% | 61,619 | 14.0% |
| Kohat | 19760 | 157335 | 113,461 | 17.4% | 121,344 | 16.3% |
| Malakand | 18000 | 146202 | 82,495 | 21.8% | 91,414 | 19.7% |
| Mardan | 49000 | 403350 | 230,502 | 21.3% | 311,868 | 15.7% |
| Total | 95,405 | **784911** | 471,686 | 20.2% | 586,245 | 16.3% |

While premium for the beneficiary households are paid on annual basis, the cards distributed to the beneficiaries are valid for five years of the program period.

It will be appreciated that the validity of cards will soon be expiring. SLIC is developing an approach to extension of validity and awareness of this within eligible households will form part of Lady Health Worker (LHW) activities under planning.

Figure 3: Enrolment by 6-month periods 2016 to 2018



The Table below describes distribution of enrolled beneficiaries by age group and gender.

Table 9: Distribution of enrolled beneficiaries by Gender and by Age Group

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Age Group | Eligible | | Total | % by Age Group |
| **Male** | **Female** |
| Less than 1 | 2130 | 1880 | 4010 | 0.5% |
| 1 to 04 yrs. | 279 | 238 | 517 | 0.1% |
| 5 to 14 yrs. | 70580 | 69050 | 139630 | 17.8% |
| 15 to 49 yrs. | 259465 | 264016 | 523481 | 66.8% |
| 50 to 69 yrs. | 51969 | 41062 | 93031 | 11.9% |
| 70 yrs. & above | 12100 | 11061 | 23161 | 2.9% |
| Total | **396523** | **387307** | **783830** | **100.00** |

As reported previously, the major concern related to enrolment is the under representation of young children and infants. The reasons suggested for this include:

The enrolment priority process, as in the design and requirement, was not followed properly with adults within a household given preference over children (perhaps in the belief that adults would have greater need for hospital services with common childhood illness typically being dealt with at primary level at low cost)

That infants and young children could only be enrolled if their birth had been registered and thus proof that they were part of the household.

It is likely that non-enrolment has also led to under-utilisation in these age groups, the potential impact of this is returned to in the section on utilisation below, and this will be a matter to be addressed in the utilisation study currently being commissioned by KfW.

# Enrolment of Paying Beneficiaries in KP

Contract for implementation of SHPI signed between Provincial Government KP and SLIC in January 2015 provided that in addition to the 21% population whose premium was paid by the government through KFW funds an additional 29% population was to be insured by SLIC by offering a similar product. During the initial phase of the program implementation this activity could not be initiated as certain prerequisites such as preparation of the model for implementing wider enrolment, hiring of the NGOs and approval of product took considerable time due to the technical nature of the activity and unawareness of SECP involved in approval of the product.

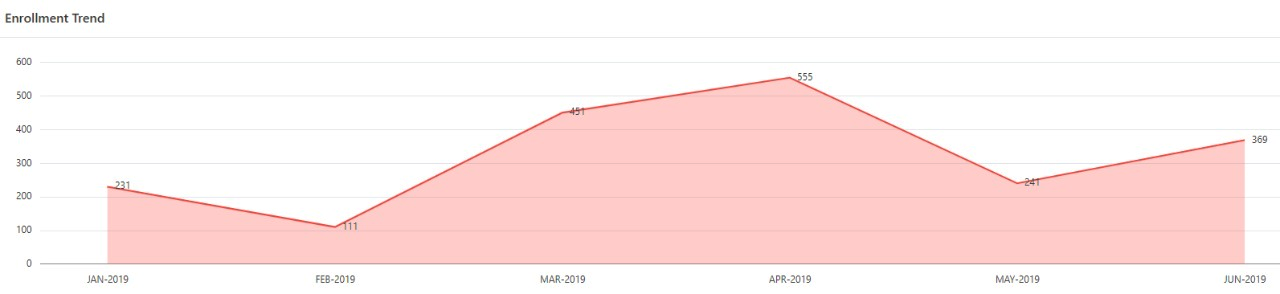
In meanwhile the Govt launched another scheme where the insurance coverage was not only spread to all the districts of the Province but the threshold for enrolment was also raised to 25 PMT instead of 16.17, later increased to population under PMT Score of 32.5. Implementation of this new project was a challenging task which was achieved successfully but the attention from the implementation of wider enrolment was also temporarily deviated.

The Wider enrolment was finally launched in the second half of 2019 and due to the huge popularity of the Sehat Insaaf Card, the introduction of the scheme was a success. This scenario changed due to the provincial government’s decision of extending the coverage to 100% population in 2020. The decision was announced in June 2019 following which the situation and its implications for wider enrolment were discussed. Initially the wider enrolment was frozen for a three months period till September 2019 and later it was decided to stop offering the insurance product for voluntary purchase as the Provincial Govt would be extending the coverage to 100% population of the province.

The target for the first year was 12,500 households, out of which 1,958 households were enrolled in two districts (Mardan & Malakand) comprising 8547 individuals. In short period of time 15 groups with enrolled families ranging from 100 to 120 were enrolled. Though no enrolment activities were carried out from Jan to June 2020 but the beneficiaries who had valid cards kept getting health care services under the scheme. A total of 60 admissions took place, costing Rs. 900,000.

The scheme was very successful in Mardan which accounted for 70% of the enrolment followed by Malakand district. In district Kohat the spade work had been completed and Chitral was planned to be launched in July 2019. The following figure depicts the enrolment trend of the voluntary insured families during the 6 months. In Mardan 1469 and in Malakand 489 families were enrolled consisting of 8567 individuals.

Figure 4: Enrolment January to June 2019

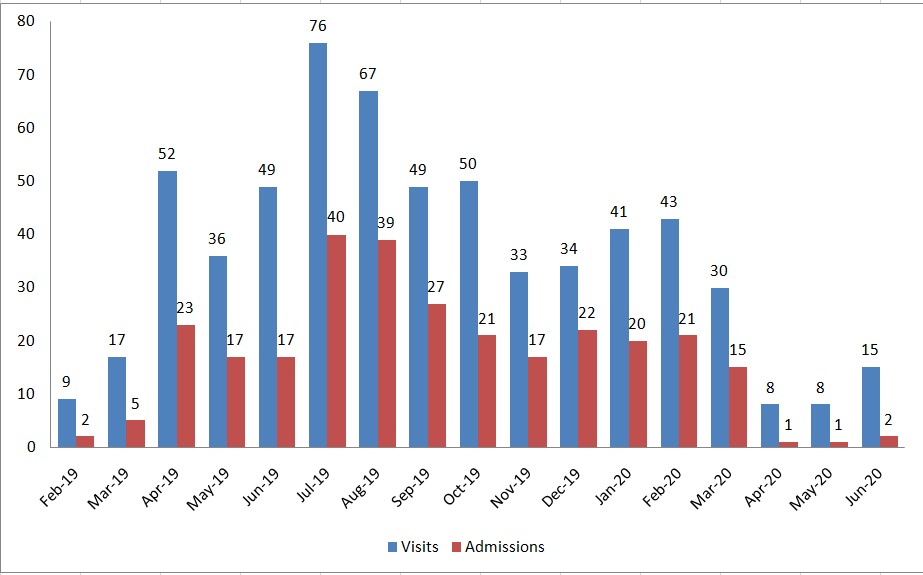


The following table reflects the figures of enrolment (families were enrolled in groups and not as individual families to avoid adverse selection), admissions and claims.

Table 10: Status of enrolled families, admissions and claims

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| District | Groups | Families Enrolled | Admissions | Claims Incurred | Claims Paid | Paid %age |
| Mardan | 13 | 1,469 | 234 | 3,223,336 | 3,022,336 | 93.76 |
| Malakand | 4 | 489 | 54 | 699,145 | 590,245 | 84.42 |
| Total | **17** | **1,958** | **288** | **3,922,481** | **3,612,581** | **92.10** |

Figure 5: Visits and admissions (February 2019 - June 2020)



Utilisation in the initial two months was a little low but it gradually started picking up reaching its peak in July 2019. The lower utilisation in the months of April, May and June 2020 is because of the suspension of services in both public and private hospitals because of COVID-19.

Utilisation rate in these families was much higher than the utilisation in the government funded beneficiaries. In just over a year, 617 members of these families visited the hospitals for seeking advice and 288 got admissions and utilised the services for the claimed amount of over PKR 3.9 million. The average utilisation was a little less than 3%. The high rate of utilisation in this population could be attributed to a number of factors but probably the main difference was the awareness created by NRSP, the NGO hired for enrolment and awareness; and that the formation of groups in itself may have had a positive influence on awareness of the value of the scheme.

This experience in Khyber Pakhtunkhwa suggests that the perceived value of the insurance scheme to those whose premiums were paid spilled-over to a more general understanding that health insurance was worth paying-for (a key proposition of the design). In order to continue with the recognition amongst population, it was decided that an alternative strategy would be developed under which not only awareness for use of the health card would be provided to the beneficiaries of government funded scheme, but efforts for improvement of utilisation would also be carried out. Information would be disseminated to the public regarding availability of top up products on payment of premium if someone wishes to avail additional health insurance cover.

In this regard proposals for awareness raising activities have been developed and part of the activities will be implemented in collaboration with the LHWs’ Programme. SLIC has developed some health insurance products that are in process of approval by the Securities Exchange Commission of Pakistan (SECP).

# Empanelment of Hospitals - Secondary Service Providers in Khyber Pakhtunkhwa

The service provider network for SHPI includes hospitals that have been empanelled for providing cashless inpatient hospital services to enrolled members of beneficiary households. The PMU, OPM and State Life Insurance Corporation periodically review performance of service providers, removing underperforming hospitals and adding hospitals. Currently 18 hospitals are empanelled in the four districts. Of these 6 are public, 9 are private, and 3 operate as public private partnerships.

Table 11: Empanelled Hospitals in Khyber Pakhtunkhwa

|  |  |  |  |
| --- | --- | --- | --- |
| No | Hospital | District | Type |
| 1 | Aga Khan Medical Centre Booni | Chitral | Private |
| 2 | Rural Health Centre, Shagram | Chitral | Public Private Partnership |
| 3 | Rural Health Centre, Mastuj | Chitral | Public Private Partnership |
| 4 | THQ Garamchashma | Chitral | Public Private Partnership |
| 5 | DHQ Chitral | Chitral | Public |
| 6 | Frontier Hospital | Kohat | Private |
| 7 | KDA Hospital | Kohat | Public |
| 8 | Liaqat memorial Hospital | Kohat | Public |
| 9 | Sajida Islam Hospital | Mardan | Private |
| 10 | Junaid Medical Centre | Mardan | Private |
| 11 | District Headquarter Hospital | Mardan | Public |
| 12 | Al Sayyed Hospital | Mardan | Private |
| 13 | Shiekh Yaseen Hospital | Mardan | Private |
| 14 | Gul Medical Centre | Malakand | Private |
| 15 | Siraj Shaheed Hospital | Malakand | Private |
| 16 | Bahader Khan &Roze Khan | Malakand | Private |
| 17 | DHQ Malakand | Malakand | Public |
| 18 | THQ Dargai | Malakand | Public |

Apart from these hospitals other hospitals empanelled under the larger Govt financed scheme and Federal scheme are also available for treatment to the beneficiaries under portability option, where any patient can get services from any hospital empanelled by State Life. There are more than 250 hospital across Pakistan (including Azad Jammu Kashmir and GB) where the services could be availed.

Majority of the hospitals are those that were empanelled in 2016. Later some of the hospitals were depanelled. The total number of secondary hospitals in the four districts is 18 whereas one tertiary hospital (MTI) is empanelled in district Mardan.

The most significant current concern relates to the availability and reputation of hospitals in Kohat. The Military Hospital is widely regarded as the institution offering the best quality services and efforts have been made but without success to enrol this hospital. This is returned to in the section on utilisation.

# Empanelment of Hospitals - Tertiary Services Providers in Khyber Pakhtunkhwa

Most of the hospital in the KfW supported districts are secondary care hospital. Only one hospital in District Mardan is tertiary care hospital (Medical Teaching Institute). Mardan Medical Complex was enrolled to provide both secondary and tertiary level services to the beneficiaries. In order to get tertiary care services other tertiary hospital located outside the four districts are providing services which include both public and private hospitals. Following is the list of the tertiary hospitals located in Khyber Pakhtunkhwa, where tertiary care services could be availed.

Table 12: Empaneled Tertiary-level Hospitals in Khyber Pakhtunkhwa

|  |  |  |  |
| --- | --- | --- | --- |
| S No | Tertiary Hospital | Type | District |
| 1 | Ayub Teaching Hospital, Abbottabad | MTI | Abbottabad |
| 2 | INOR (would start services shortly) | Atomic Energy Commission (Semi-Autonomous public) | Abbottabad |
| 3 | Khalifa Gul Nawaz Medical Complex, Bannu | MTI | Bannu |
| 4 | Mufti Mehmood Memorial Teaching Hospital, DIK | MTI | D.I.Khan |
| 5 | Qazi Hussain Ahmad Medical Complex, Nowshera | MTI | Nowshera |
| 6 | Lady Reading Hospital, Peshawar | MTI | Peshawar |
| 7 | Khyber Teaching Hospital, Peshawar | MTI | Peshawar |
| 8 | Hayatabad Medical Complex, Peshawar | MTI | Peshawar |
| 9 | Maqsood Medical Centre | Private | Peshawar |
| 10 | Fauji Foundation Hospital | Public Private Partnership | Peshawar |
| 11 | Pak Medical Centre | Private | Peshawar |
| 12 | IRNUM | Atomic Energy Commission (Semi-Autonomous public) | Peshawar |
| 13 | Kuwait Teaching Hospital | Private | Peshawar |
| 14 | Swat Medical Complex | Private | Swat |
| 15 | SINOR (would start services shortly) | Atomic Energy Commission (Semi-Autonomous public) | Swat |

Treatment Services across Pakistan are also available to the beneficiaries under portability of services.

# Utilisation of Services

Annualised utilisation rates overall for the four districts were around 0.5% in first half of the 2020. This shows a decrease of 0.2% over the second half of 2019. Utilisation remained highest in the second half of 2016 and first half of 2017, after which a gradual decrease was recorded over the years.

The reason for the current decrease was mainly due to the response strategies for COVID-19. Majority of public and private hospitals were instructed by government authorities to limit the admissions to emergency or urgently required procedures and delay the cold or non-emergency cases due to which a sharp decline was observed. The cut down in admissions started at the end of March 2020. The statistics shows that the annualised quarterly utilisation from Jan to Mar 2020 was 0.8%. After the protective measures adopted in line with government instructions, the annualised quarterly utilisation dropped to 0.3%.

Isolation wards for those affected by covid-19 were established in public hospitals both secondary and tertiary level hospitals. In some districts, such facilities were established in Rural Health Centres (RHCs). OPDs were closed in the public hospitals. Soon afterwards the local govt officials also issued notices to the private hospital for closure of their facilities for safeguarding the patients against COVID-19. The private hospitals remained closed for the whole month of April and May and started opening towards end of June. The public facilities are still restricted and may be opened after the Eid Ul Adha (Muslim Holy festival) around 5th August which should result in normalising or even increase in the utilisation.

The outbreak of COVID-19 had significant effect over the utilisation of services under all the programs. As a response to covid-19 pandemic, access to hospitals was heavily controlled from 23rd March 2020. The admissions for January and February and three weeks of March 2020 were in line with previous years, but admissions took a dip after 23rd of March 2020.

Figure 6: Admissions SHPI I 2020

This trend could also be noticed in the bigger programme of Khyber Pakhtunkhwa where almost 1.8 million families have been enrolled.

Figure 7: Admissions SHPI KP Phase IV 2020

Under the Federal Scheme (implemented in FATA, Sindh and Punjab) where more than 6 million families are covered the reduction in utilisation was identical to that of the trend in Khyber Pakhtunkhwa schemes.

Figure 8: Admissions under Sehat Sahulat Programme 2020

## Chitral

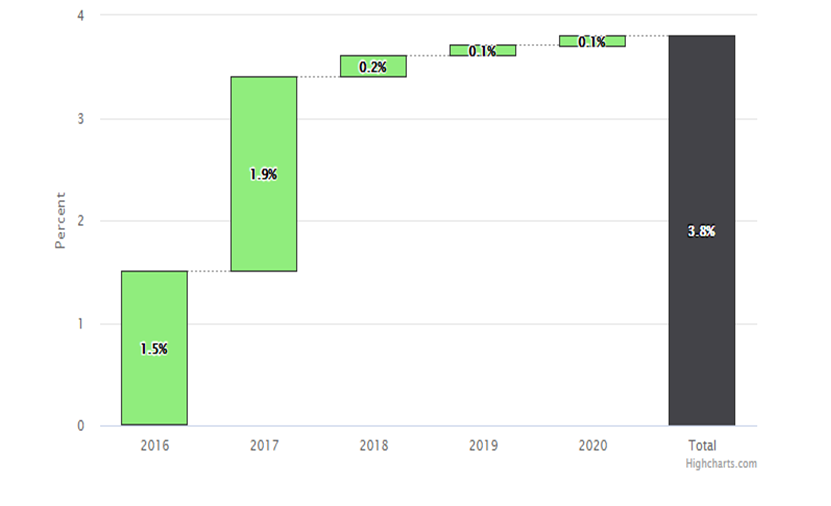
Figure 9: Utilisation rate by year and cumulatively to date

Chitral has gradually recorded increase in utilisation over the years. From 0.1% in 2016 to 0.8% in 2019. In 2019 0.3% increase was recorded over 2018%. The utilisation in 2018 was 0.5% which increased to 0.8% in 2019. The increase from 2017 to 2019 is due to the contribution of District Headquarter hospital. Before the operations of DHQ under the scheme, all the empanelled hospitals were in upper Chitral with the main Chitral city without any service providers. Efforts were made to make the DHQ Hospital operational which has brought an increase in the utilisation rate.

However, in the first six months of 2020 a decrease of 0.1% has been observed due to COVID-19 pandemic and its effect on hospital operations.

## Kohat

Figure 10: Utilisation rate by year and cumulatively to date



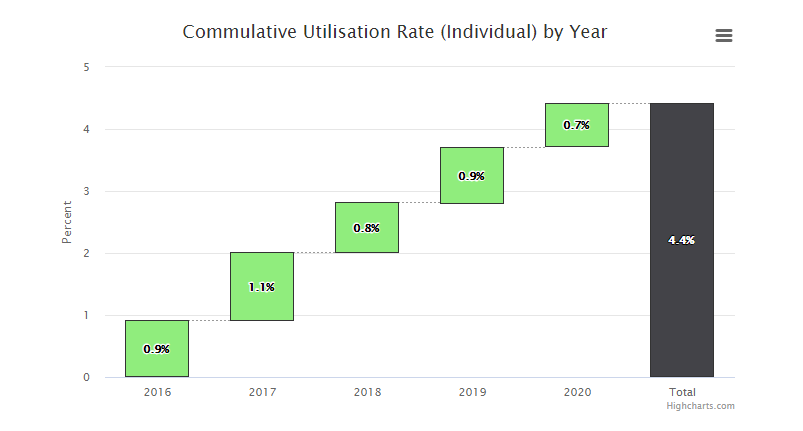
Kohat is recording a decrease in utilisation over the years. The statistics for 2016 and 2017 were unreliable due to bad practices in one of the hospitals which was disempanelled. Kohat is clearly now an outlier amongst the 4 Districts. This requires urgent attention by government and SLIC. The components of this action would include:

Empanelment of quality hospitals with good reputation in the community. OPM team has visited Kohat and met with senior management at the military hospital in Kohat as well as some other hospitals. it was agreed that SLIC team will seek approval for reimbursement of costs if treatment is taken in Combined Military Hospital (CMH) Kohat, where a large segment of population in Kohat prefer to get healthcare services. Similar arrangements can be followed in other cities. It was also agreed that SLIC team will visit Kohat to empanel more hospitals in Kohat. This could include the women and children hospital being managed by Family Planning Association of Pakistan (FPAP) in Kohat.

This might be usefully combined with a reinforcement of awareness campaign in Kohat particularly through use of Lady Health Workers.

## Malakand

Figure 11: Utilisation rate by year and cumulatively to date

In the district Malakand the utilisation was highest during 2017 after which it dropped to 0.8% in 2018 and remained same in 2019. There are 5 hospitals in the Malakand district, but the major chunk of admissions is in private sector.

The effect of COVID-19 is also visible in Malakand district which recorded a decrease of 0.2% in the 2020.

## Mardan

Figure 12: Utilisation rate per year and cumulatively to date

Mardan shows a consistent 0.7% utilisation for the last three years with the first year (2016) utilisation of 0.8%. The only public sector Tertiary level hospital is also located in District Mardan. With major chunk of enrolled population of 49,000 households. Mardan accounts for highest number of admissions among the four districts.

The utilisation in the first quarter 2020 (Jan to Mar) was 0.9% which dropped to 0.4% in second quarter of 2020 (Apr to Jun). Out of this 0.4% utilisation, almost 0.2% were End stage dialysis which is life-saving procedure and continued even during the COVID-19 closure.

## Public, Private & Gender Wise Admissions

The private and public and gender wise distribution reveals that almost 53% admissions were recorded in public sector whereas 47% were in private sector. Gender wise distribution shows that 4% more females went to private sector 14% more females visited public hospitals.

Table 13: Gender-wise Utilisations of Services by type of hospital (Jan-Jun 2020)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type of Hospital | Eligible | | Total | %age of Females Admissions |
| Male | Female |
| Private Hospital | 608 | 613 | 1221 | 50.20% |
| Public Hospital | 443 | 455 | 898 | 50.66% |
| Total | **1051** | **1068** | **2119** | **50.4%** |

Thus overall, there is no concern about this distribution.

## Utilisation by Secondary and Tertiary Services.

The Services availed under secondary care are several folds more than tertiary care. In 2016 there was no tertiary care available but afterwards there has been a consistent rate of tertiary care since 2017.

The secondary admissions almost halved during Jan to June 2020 whereas the tertiary care remained unchanged. The drop-in secondary care services could be attributed to COVID-19. Under tertiary care the emergency and dialysis remained unchanged as these were lifesaving treatments and continued despite COVID-19 issue.

Table 14: Utilisation Rate by Secondary & Tertiary Services

|  |  |  |
| --- | --- | --- |
| Period | Secondary | Tertiary |
| Jan-Jun 2016 | 0.6 | - |
| Jul-Dec 2016 | 1.2 | - |
| Jan-Jun 2017 | 1.1 | 0.1 |
| Jul-Dec 2017 | 0.6 | 0.1 |
| Jan-Jun 2018 | 0.5 | 0.1 |
| Jul-Dec 2018 | 0.4 | 0.1 |
| Jan-Jun 2019 | 0.4 | 0.1 |
| Jul-Dec 2019 | 0.6 | 0.2 |
| Jan-Jun 2020 | 0.3 | 0.2 |

Table 15: Secondary vs Tertiary Admissions in Public & Private Hospitals

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type of Hospital | Admissions | | Total | %age of Secondary Admissions |
| **Secondary** | **Tertiary** |
| Private Hospital | 794 | 434 | 1228 | 64.65% |
| Public Hospital | 481 | 428 | 909 | 52.91% |
| Total | **1275** | **862** | **2137** |  |

This overall pattern does not give cause for concern. Earlier concerns that a rapid increase in use of tertiary care services could threaten the financial viability of the scheme have not been fulfilled but this remains something to be monitored carefully.

### Why is utilisation closer to 1% than 2%?

As the programme has developed utilisation rates has become the matter of greatest concern to KfW. Whilst the ambition of testing innovations in a demand side approach was being achieved, was the programme also fulfilling the ambition of increasing access to hospital services and particularly for the poor. In this report we have given more consideration to this issue and drawn upon some of the insights of Denis Garand, actuary and health insurance expert, who was closely involved in the original design.

### Design Considerations

The original model and assumptions were based on experience from Pakistan, India and Bangladesh for similar hospitalisation schemes. For Pakistan we had information on the program with Jubilee insurance for Aga Khan Foundation in Gilgit area. From India, we had information from Vimo SEWA, Yeshasvini, Healing Fields Foundation and others. In Bangladesh we had information from Sajida, BRAC, Grameen and others.

We did see a variety of hospitalisation rates in these schemes, ranging from 0.5% to 4.0% of covered clients. Based on our analysis we determined that a plan that is understood by clients on access and coverage and is medically managed to provide correct services should have 2% utilisation rate.( The feasibility study used 3% instead of 2% to create some margin. A margin was wise as there is a wide variation in utilization is schemes studied. 2% utilization is a best guess of what is the ideal utilization.)

When utilisation was low in other schemes, we found poor knowledge of access and benefits from clients, issues with getting help due to concerns with loss of daily wages, distance from empanelled hospital, and other additional costs (In other such scheme that are supposed to be cashless to client, some clients have to make payments to health facilities for a variety of reasons, including speed money) to get treatment. There was also a pattern of low utilisation at start up, with rates increasing over time.

High utilisation was found when there was adverse selection, abuse by health providers in billing, abuse by health provider in doing surgeries and treatment that were not necessary.

It was assumed the population distribution in all the selected cases would be similar to the country population.

The final assumption of 2% utilisation was an educated guess of a well-managed and communicated plan, with public health information that was monitored, and had an information system to provide timely information.

Note – in the financial modelling for the scheme 3% utilisation was assumed. This was set deliberately high to ensure that the scheme would be financially viable even at higher levels of demand.

### Evidence from other schemes

Three ILO commissioned reports indicated:

* Pakistan Federal Sehat Salut Scheme – 0.93% and 0.65% (2016 and 2017 respectively)
* Yeshasvini India scheme – increasing from 0.56% to 2.57% from 2003 to 2008
* RSBY India 2014 – 1.7%

### Age Structure and Utilisation

It is apparent that the age structure of a population will impact on anticipated hospital utilisation. The very young and very old will require a higher level of hospitalisation. In the design the locations chosen had similar age structures so in itself this does not provide explanation for the apparent low utilisation.

The table below provided by SLIC shows the annualised utilisation rate for five half years of the enrolled individuals in age groups and for males and females.

Table 16: Annualised half year utilisation in 4 Districts, 2018 to 2020

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Age Group | 2018 H1 | | 2018 H2 | | 2019 H1 | | 2019 H2 | | 2020 H2 | |
| **M** | **F** | **M** | **F** | **M** | **F** | **M** | **F** | **M** | **F** |
| Less than 1 | 1.70 | 0.75 | 1.04 | 0.43 | 1.04 | 0.75 | 1.13 | 0.32 | 1.13 | 0.56 |
| 1 to 04 yrs. | 1.29 | 0.73 | - | 0.73 | 1.29 | 0.73 | 2.57 | 1.47 | 5.28 | 0.75 |
| 5 to 14 yrs. | 1.48 | 2.28 | 1.11 | 1.71 | 1.03 | 1.75 | 1.26 | 2.28 | 1.08 | 1.64 |
| 15 to 49 yrs. | 0.09 | 0.07 | 0.07 | 0.06 | 0.08 | 0.07 | 0.11 | 0.09 | 0.08 | 0.06 |
| 50 to 69 yrs. | 2.12 | 1.99 | 1.56 | 1.77 | 1.82 | 1.78 | 2.01 | 2.29 | 2.31 | 1.42 |
| 70 yrs. & above | 2.90 | 1.92 | 1.84 | 1.01 | 2.50 | 1.22 | 2.00 | 1.64 | 1.80 | 1.65 |

Summarising this for the whole period, this makes up the following:

Table 17: Average utilisation rate for 5 half years by age group

|  |  |  |
| --- | --- | --- |
| Age Group | Average utilisation rate for 5 half years | |
| **Male** | **Female** |
| Less than 1 | 1.21 | 0.56 |
| 1 to 4 | 2.56 | 0.88 |
| 5 to 14 | 1.19 | 1.93 |
| 15 to 49 | 0.09 | 0.07 |
| 50 to 69 | 1.96 | 1.85 |
| 70 and over | 2.21 | 1.49 |

The overall pattern is roughly as might be predicted.

Amongst the younger child groups reported utilisation is higher amongst males and females but since the numbers are small this may not be significant and reverses in the 5 to 14 group.

In the 15 to 49 group utilisation is very low as would be expected in the healthiest age group. However, a higher utilisation for females would be expected if the hospitals were attracting a significant number of normal and complex deliveries (which currently they are not).

Among the over 70s the increase in hospitalisation for over 70s is not as steep as would be expected compared to the 50 to 69 group (but again with relatively small numbers this may not be significant).

Table 18 below is a model of the current situation based on enrolled populations and the reported admission rates.

Table 18: Enrolled populations and reported admission rates

|  |  |  |  |
| --- | --- | --- | --- |
| Age and Gender | Enrolled Population | Admission Rate | Admissions |
| M 1 and less | 2130 | 1.21 | 26 |
| F 1 and less | 1880 | 0.56 | 11 |
| M 1 to 4 | 279 | 2.56 | 7 |
| F1 to 4 | 238 | 0.88 | 2 |
| M 5 to 14 | 70580 | 1.19 | 840 |
| F 5 to 14 | 69050 | 1.93 | 1333 |
| M 15 to 49 | 259465 | 0.09 | 234 |
| F 15 to 49 | 264016 | 0.07 | 185 |
| M 50 to 69 | 51969 | 1.96 | 1019 |
| F 50 to 69 | 41062 | 1.85 | 760 |
| M 70 and over | 12100 | 2.21 | 267 |
| F 70 and over | 11061 | 1.49 | 165 |
| TOTAL | 783,830 | 0.62 | 4,849 |

We see that the scheme rate is 0.62 but appreciate that this is being dragged down by factors mainly of supply in Kohat. If Kohat was taking its 20% share of these admissions, then there should be about 960 admissions or an increase of about 800.

A scheme to encourage hospital admissions, say through good medical transport as in the Punjab, might add conservatively about 1000 female admissions for deliveries across the enrolled hospitals in the 4 districts. In Pakistan in 2018 the annual birth rate was 28.25 per 1000; so in the enrolled population of nearly 800,000 about 22,600 births would be anticipated, making 1000 a very conservative number. In fact, as indicated in the table in section on premiums and costs, there have been less than 400 normal deliveries in total since the scheme inception.

What might the impact be of the enrolment of higher numbers of under 1s and 1 to 4s in the scheme? The table below provides reasonable estimates of the enrolment figures assuming that the age cohorts are similar to those aged 5 to 14 (about 7,000 per each one-year group).

Table 19: Estimation on enrolment figures

|  |  |  |  |
| --- | --- | --- | --- |
| Age and Gender | Enrolled Population | Admission Rate | Admissions |
| M 1 and less | 7058 | 1.21 | 85 |
| F 1 and less | 6905 | 0.56 | 39 |
| M 1 to 4 | 28232 | 2.56 | 723 |
| F1 to 4 | 27620 | 0.88 | 243 |
| M 5 to 14 | 70580 | 1.19 | 840 |
| F 5 to 14 | 69050 | 1.93 | 1333 |
| M 15 to 49 | 259465 | 0.09 | 234 |
| F 15 to 49 | 264016 | 0.07 | 185 |
| M 50 to 69 | 51969 | 1.96 | 1019 |
| F 50 to 69 | 41062 | 1.85 | 760 |
| M 70 and over | 12100 | 2.21 | 267 |
| F 70 and over | 11061 | 1.49 | 165 |
| TOTAL | 783,830 |  | 5893 |

If we add to the 5893, the 800 for resolving Kohat supply factors and 1000 for attracting hospital deliveries the total admissions would be about 7,693. Utilisation would then be close to 1%.

Clearly, whilst a significant improvement on the current situation, this would still fall well short of the 2% that Denis Garand would still regard as a reasonable expectation based on international experience. He has suggested other factors that might be possible explanations:

* Mistrust in hospital: Does the population have mistrust in the hospital system?
* Other available service: Population is using the government system, primary system or using local mid-wives/traditional birth attendants
* Distance to empaneled hospital. Studies of BRAC in Bangladesh did show lower utilisation rates by clients that lived farther from the health centre.
* Other cost such as loss of daily wage, additional transport cost, and cost of food can be an impediment to going to the hospital (Study by Vimo Sewa) and using health services. This can be overcome with additional daily stipend per day hospitalised and transport benefit.
* Communication: The Yeshasvini plan in India had low take up rate in the first 3 years. ILO did a survey among known clients that had the plan and found that many did not know they had coverage or how to access
* Trust: Over time when clients hear and see people getting covered for ailments successfully utilisation does increase.

### Hospitalisation and Scheme Utilisation

Beneficiaries have access to a large number of the available institutions offering tertiary services in Khyber Pakhtunkhwa; but with the exception of Mardan, these are located at some distance from the populations.

However, for secondary level services it is apparent that between 3 and 5 hospitals per District is a small proportion of hospital provision both public, including military, and private. Such hospitals are attracting patients even though there will be direct costs to the household both formal and informal and no transport allowances will be paid.

Thus, at the heart of the **“1% to 2%”** question are the various factors that make using alternative providers to those enrolled in the scheme the rational choice.

In the last report we provided information on utilisation by Union Council. That is, to begin exploring the question as to whether the time, lost income, transport, and accommodation costs of accessing an enrolled hospital were such that it would make sense to use a more local provider even though fees or informal charges would be made for services. The initial data was inconclusive.

There may also be judgments about risk and inconvenience of a household member travelling to a location at significant distance from the home. For this reason, experimentation with a good quality medical transport service would seem worthwhile and has been proposed in use of unspent funds.

It is also apparent that judgments are being made about quality of service available. At a simple level, why would I take a child for hospitalisation in a hospital where a paediatrician was not available 24 / 7? Such factors certainly seem to be important in Kohat where the most respected hospital (the military hospital) is not available to card holders.

The issue of communication, knowledge, and advocacy may be important. Our review of the scheme in the Punjab did not indicate that this was a particularly significant factor. For example, the lack of an OPD benefit was seen as more significant. However, to the extent that it is a matter to be tackled what was clear was that the involvement of trusted community members (and particularly health workers) was much more effective than other approaches.

Clearly, all of these factors point to the need for a well-designed utilisation study with survey instruments and targets carefully associated with the different hypotheses.

# Premiums and Costs in KP

## Top Admissions and Average Cost since Inception and during reporting

Please see below the average reimbursement for the top 10 diagnoses / procedures, and highest and lowest cost.

Table 20: Average, minimum and maximum disbursement for top 10 admissions.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Most common causes of admissions for Jan-June 2020 | | | | | | | | | |
| S No | **Treatment** | | **Admissions** | | **Avg Claimed Amount** | | **Max (PKR)** | | **Min (PKR)** |
| 1 | End Stage – Dialysis | | 320 | | 4,190 (PKR) | | 5,000 | | 2,500 |
| 2 | Non Surgical | | 159 | | 4,614 (PKR) | | 2,200 | | 1,800 |
| 3 | Appendicectomy | | 147 | | 14,769 (PKR) | | 29,000 | | 12,000 |
| \*4 | Chemotherapy - Per sitting | | 130 | | 23,272 (PKR) | | 144,053 | | 720 |
| 5 | Tonsillectomy – Bilateral | | 106 | | 14,656(PKR) | | 16,500 | | 12,000 |
| 6 | Hysterectomy – abdominal | | 91 | | 21,802 (PKR) | | 25,000 | | 16,000 |
| 7 | Coro Angiography with all inclusive | | 57 | | 18,035 (PKR) | | 22,000 | | 14,000 |
| 8 | Cholecystectomy | | 53 | | 22,102 (PKR) | | 30,000 | | 18,000 |
| 9 | Haemorrhoidectomy | | 47 | | 14,280 (PKR) | | 16,000 | | 12,000 |
| 10 | Cataract with IOL Phacoemulsification – Unilateral | | 38 | | 20,763(PKR) | | 22,000 | | 16,000 |
| Most common causes for admission since Inception | | | | | | | | | |
| S No | **Treatment** | **Admissions** | | **Avg Claimed Amount** | | **Max (PKR)** | | **Min (PKR)** | |
| 1 | Non Surgical | 8,917 | | 2,032 (PKR) | | 2,200 | | 1,800 | |
| 2 | Tonsillectomy – Bilateral | 1,872 | | 14,359 (PKR) | | 16,500 | | 12,000 | |
| 3 | Appendicectomy | 2198 | | 13,843 (PKR) | | 29,000 | | 12,000 | |
| 4 | End Stage – Dialysis | 1,123 | | 4,188 (PKR) | | 5,000 | | 2,500 | |
| 5 | Hysterectomy – abdominal | 665 | | 21,959 (PKR) | | 25,000 | | 16,000 | |
| 6 | Haemorrhoidectomy | 607 | | 14,108 (PKR) | | 16,000 | | 12,000 | |
| 7 | Coro Angiography | 466 | | 15,957 (PKR) | | 22,000 | | 14,000 | |
| 8 | Cataract with IOL Phacoemulsification – Unilateral | 431 | | 22,239 (PKR) | | 22,000 | | 16,000 | |
| 9 | Cholecystectomy | 426 | | 2,1439 (PKR) | | 30,000 | | 12,000 | |
| 10 | Normal Delivery | 354 | | 11,374 (PKR) | | 22,000 | | 16,000 | |

Most of the procedures in top 10 list are secondary care services with Angiography, Chemotherapy and Dialysis from the tertiary list. This is because Chemotherapy and Dialysis require repeated visits by the patients which could range between 60 to 80 per year per patient. Under secondary procedures Tonsillectomy and Appendectomy continue to be on the top of the list both for January to June 2020 and for overall scheme since inception.

Disparity could be noticed and high and low rates of the procedures. Detail of procedure where the rate disparity is on higher side is given below:

**Dialysis:** Under dialysis the public hospitals have lower rates which is Rs. 2,500 whereas in private sector the rates range from 4000 to 5000.

**Appendectomy:** The average rate for appendectomy ranges between 12000 to 16000 depending. Rs. 29000 is an outlier which pertains to the AKHS, P Boni Medical Centre, Chitral. Since there is no other hospital in upper Chitral therefore the high rates have been accepted for provision of services to the beneficiaries.

**Chemotherapy:** There is a big gap between maximum and minimum rates for chemotherapy. This is because the quantity and number of medicines used in chemotherapy is different for each patient. Due to this reason the rates of chemotherapy are services based and not under the package rate. There is a single service provider for providing services of chemotherapy.

**Hysterectomy:** The rate for hysterectomy ranges between 20,000 to 25,000, with Rs. 16,000 as an outlier for LMH (Liaqat Memorial Hospital), which is a public sector hospital in District Kohat.

**Coro angiography:** The cost of Coro angiography ranges between 20,000 to 22,000. The MTI hospitals of LRH and HMC are providing these services at much lower cost of Rs. 14,000 and 15,000 respectively, which could be categorised as outliers.

**Cholecystectomy:** The cost of Cholecystectomy ranges between 18,000 to 24,000 in different hospitals. The rate of Pak Medical Centre, Peshawar is Rs. 30,000 which could be categorised as outlier.

### Top Five Procedures for Admissions for Women During Reporting Period

Table 21: Top five Admissions among the female population

|  |  |  |
| --- | --- | --- |
| No | Treatment | Admissions |
| 1 | End Stage – Dialysis | 105 |
| 2 | Hysterectomy – abdominal | 90 |
| 3 | Non-Surgical | 90 |
| 4 | Caesarean delivery | 29 |
| 5 | Normal Delivery | 22 |

The most frequent treatment among the females is dialysis. This is due to the fact that a single patient requires repeated treatments which could range up to 80 per year.

Hysterectomy and non-surgical are followed by caesarean and normal deliveries.

As discussed above, it is apparent that the use of the scheme for deliveries is very low. The value of a properly supervised delivery and management of risk factors in increasingly recognised by the Pakistan population. It is therefore important to understand the motivations and behaviours underlying these decisions and should be included in the upcoming utilisation study.

## Length of Stay

More than half of admissions are for one day stay in hospitals. This is because some procedures which do not require admission in hospitals for longer periods. Dialysis sessions, chemotherapy or radio therapy sessions for cancer treatment and Angiographies (without angioplasties) are covered as part of the benefits package under “priority care” which can be done as day care.

Table 22: Length of stay SHPI Phase I

|  |  |  |  |
| --- | --- | --- | --- |
| January to June 2020 | | | |
| No | **Days** | **Admissions** | **%age** |
| 1 | 1 Day | 1189 | 55.66 |
| 2 | 2 to 3 Days | 544 | 25.47 |
| 3 | More than 3 Days | 403 | 18.87 |

PART 2: Gilgit Baltistan

# Developments in Health Insurance Programmes in GB

The political government in Gilgit Baltistan completed its five-term in June 2020. A care-taker setup is governing GB currently. New elections, previously schedule to be held in August 2020 have been postponed by Chief Court, GB and now expected to be held in October 2020.

## KfW funded Social Health Protection Initiative

Government of Gilgit Baltistan, with financial support of Government of Germany through KFW, is implementing a health insurance scheme in Gilgit District under the Social Health Protection Initiative Pakistan (SHPI).

Under SHPI a Health Insurance scheme is being implemented that entails compulsory enrolment of 21% of the poorest families in programme district as per the Poverty Means Testing (PMT) scores maintained by Benazir Income Support Programme (BISP). The cut-off PMT score of poorest population of Gilgit district is 16.17. The premium of this population is paid by the Department of Health GB out of the programme funds created by KfW and Government of GB, the share of the latter is being scaled up annually from the initial 5% contribution as a step towards long term sustainability of the scheme.

In addition to increasing the contribution of Government of GB share in payment of premium payment, another important step taken in the design of the scheme for long term viability is mandatory enrolment of 29% population of the programme district amongst population with PMT scores of above the cut-off value over the life of the project. Considering that, two segments of population in Gilgit District are currently being insured for Health insurance under Social Health Protection Initiative:

* The poorest population group in the project area, whose premium will be paid by Department of Health GB out of the programme funds committed by German Government through KfW and Government of GB. (Benazir Income Support Programme (BISP) data was used for enrolling the eligible households).
* The population (7567 HHs equivalent to 29%), obtaining the insurance voluntarily by paying insurance premium themselves from population in Gilgit district.

Aga Khan Development Network (AKDN) Consortium, comprising Aga Khan Foundation Pakistan, Aga Khan Rural Support Programme and Jubilee Life, is implementing the scheme of MHI in Gilgit District under a contract with DOH-GB for five years since August 2016.

The following table shows the updated status of this scheme in Gilgit district as of 30 June 2020.

Table 23: Enrolment of Beneficiary and Wider Populations

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Enrolment: Target vs. Achievement | | | | | |
| District Gilgit | **Target** | | **Achievement** | | **Percentage Achieved** |
| **Households** | **Population** | **Households** | **Population** |
| Insured from eligible  population | 5480 | 38360 | 5340 | 35667 | 97% |
| Insured from wider population | 7567 | 52973 | 7101 | 34805 | 94% |

### Extension of Phase-I of SHPI in GB

A Separate Agreement was signed on August 18, 2019 between KfW and Department of Health Gilgit Baltistan on financial support for allocating financial resources for extension of Phase-I for two years i.e. from August 2021 to July 2023. During this extended phase tertiary level services will also be included in the benefit package of health insurance under SHPI in Gilgit district and coverage will also be extended to population living up to 32.5 PMT Score.

OPD services will also be piloted with KfW financial support during this extended phase. A new PC-1 was developed for implementation of the scheme for the extended period of three years. In this PC-1 the Government of GB committed allocation of additional funding from its own resources for paying 100% of premium of population below 32.5 PMT score during year-3 of the scheme. This PC-1, after approvals at GB level, was submitted to Planning Commission of Pakistan for approval of Federal authorities. The Planning Commission raised a few queries on the PC-1, OPM worked with PMU-GB in responding to those queries.

Pre Central Development Working Party (CDWP) was held in last week of July 2020 and Planning Commission decided to convene a joint meeting of SHPI and Federal Sehat Sahulat programme in Islamabad to develop a consensus on some of the features given in SHPI revised PC-1 during 2nf half of August 2020 before CDWP meeting. PMU-GB expects that after approval of PC-1 and concluding tendering process, the services under the Extension Phase could be started from January 2021.

# Enrolment of Eligible Beneficiaries in GB

## Programme Area and Population

The health insurance scheme under SHPI is being implemented in Gilgit district of GB. Gilgit district consists of 11 union councils and one Municipal Committee, spread over an area of 4,208 square kilometres with a population of 193,100, at the time of signing of contract in 2016. The census 2017 findings have not yet been released by the Government for Gilgit Baltistan.

Figure 13: Map of Gilgit District with its Union Councils



## Enrolment of Eligible Population

As per contract between DOH-GB and AKDN consortium, the unit of enrolment for insurance is ‘household’ with a maximum of ‘seven’ members. The total number of households in 21% of the poorest population in Gilgit district is 5,480. These households are termed as eligible household and their enrolment is mandatory for the project implementing organisation - AKDN. BISP data was used to identify and enrol eligible households using PMT scores; the cut-off value of the poorest 21% house is 16.17.

The insurance premium of these eligible households is being paid by DOH out the programme funds committed by KFW and Government of GB. AKDN used a multi-pronged strategy to reach and locate the households. AKRSP being an organisation having extensive links with community-based forums like Village Organisations, Women Organisations and LSOs/CSOs were tasked to locate, enrol and deliver insurance cards and MHI related awareness material. The following table shows the updated status of enrolment amongst eligible population against the set targets in the contract between DOH-GB and AKDN Consortium.

Table 24: Enrolment of Eligible Population by Union Council

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Sr.# | Name of UC | Target # household | Achieved # household | Population  Covered |
| 1 | Bagrote | 267 | 332 | 1660 |
| 2 | Chakarkote | 453 | 422 | 2110 |
| 3 | Damote | 1050 | 969 | 9690 |
| 4 | Daniyor | 362 | 302 | 2114 |
| 5 | Gilgit Municipal Area | 1182 | 1035 | 7245 |
| 6 | Haramosh | 363 | 363 | 1815 |
| 7 | Jalalabad | 538 | 525 | 2625 |
| 8 | Nomal | 180 | 245 | 1225 |
| 9 | Rahimabad | 219 | 326 | 1630 |
| 10 | Sakwar | 240 | 231 | 1423 |
| 11 | Shakiyot | 626 | 590 | 4130 |
| Total | | **5,480** | **5,340** | **35667** |

Overall, 97% of the target of enrolment of households has been achieved. In three union council – Bagrote, Nomal and Rahimabad the number of enrolled households are more than the initial target. It was due to migration of families and also there were errors in the addresses of the beneficiaries in data provided by BISP that was later rectified by the field workers of AKRSP who visited door to door in these union councils.

Table 25: Distribution of eligible beneficiaries by Gender and Age Group

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Age Group | Eligible | | Total | % by Age Group |
| **Male** | **Female** |
| less than 1 | 92 | 82 | 174 | 0.5% |
| 1 to 04 yrs. | 926 | 839 | 1765 | 4.9% |
| 5 to 14 yrs. | 6977 | 6543 | 13520 | 37.9% |
| 15 to 49 yrs. | 6976 | 6366 | 13342 | 37.4% |
| 50 to 69 yrs. | 3261 | 2832 | 6093 | 17.1% |
| 70 yrs.& above | 354 | 419 | 773 | 2.2% |
| Total | **18586** | **17081** | **35667** | **100%** |

In the enrolled population, 48% are women beneficiaries.

Children under five years of age comprise about 5% of the beneficiaries enrolled. Generally, the percentage of children under five years of age is around 15% in population. A possible explanation for lower proportion of enrolment of children is that most families do not have formal registration documents (Form B / Bay Form) from NADRA for their children. Such documentation is necessary to certify that the children are members of the household.

Another reason was that beneficiary households preferred to enrol grown-up people as they expected older members of the family to have need for hospitalisation.

For new-borns the data in the list of individual beneficiaries gets added by insurance company only when delivery has taken place through hospitalisation services availed through SHPI, or a new-born is admitted in the hospital by the enrolled household.

# Enrolment of Paying Beneficiaries in GB

In addition to compulsory enrolment of ‘eligible’ households, AKDN, under the contract, is bound to enrol 29% of households from the remaining 79% population with PMT scores of above 16.17 over a period of five years. Enrolment for this section of population is called as “wider enrolment”. Jubilee Life with the help of AKRSP marketed a health insurance product for wider enrolment to be purchased by households voluntarily for their household members.

The following table gives the enrolment of self-paying beneficiaries in the programme population.

Table 26: Enrolment of wider population since inception of SHPI

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Period | Household Enrolled | Population | Cumulative Household Enrolled | Cumulative Population | Achievement against Target (7567 HHs) |
| Jan-Dec 2017 | 733 | 4142 | 733 | 4142 | 10% |
| Jan-Jun 2018 | 2422 | 10928 | 3155 | 15070 | 42% |
| Jul-Dec 2018 | 2015 | 10014 | 5170 | 25084 | 68% |
| Jan-Jun 2019 | 135 | 358 | 5305 | 25442 | 70% |
| Jul-Dec 2019 | 1693 | 8848 | 6998 | 34290 | 92% |
| Jan-Jun 2020 | 103 | 555 | 7101 | 34845 | 94% |

Table 27: Distribution of enrolled wider population by Gender and Age Group

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Age Group | Wider | | Total | % by Age Group |
| Male | Female |
| **Less than 1** | 620 | 612 | 1232 | 3.5% |
| **1 to 04 yrs.** | 1424 | 1454 | 2878 | 8.3% |
| **5 to 14 yrs.** | 2917 | 3074 | 5991 | 17.2% |
| **15 to 49 yrs.** | 7007 | 7370 | 14377 | 41.3% |
| **50 to 69 yrs.** | 2604 | 2593 | 5197 | 14.9% |
| **70 yrs.& above** | 2604 | 2526 | 5130 | 14.7% |
| **Total** | **17176** | **17629** | **34805** | **100%** |

It is apparent that the strategy of using the benefits of insurance in the beneficiary population to demonstrate the value of insurance to the wider population has been a considerable success. Whilst there are some specific factors favouring such acceptability in the Gilgit population, this is still a considerable achievement.

# Empanelment of Hospitals in GB

AKDN consortium in collaboration with the Programme Implementation Unit (PIU) of DOH-GB has empanelled five secondary level hospitals in Gilgit Districts. A Memorandum of Understanding (MoU) was signed by Jubilee Life with each hospital after agreeing on the prices of services covered under the SHPI insurance scheme. These hospitals along with the total number of beds available include:

Table 28: Empanelled Hospitals in GB

|  |  |
| --- | --- |
| Empanelled Hospital | Number of Beds |
| District Headquarter Hospital Gilgit – Public Sector | 210 |
| City Hospital, Kashrote, Gilgit – Public Sector | 110 |
| Aga Khan Medical Centre, Gilgit – NGO – AKHSP | 46 |
| Family Hospital Gilgit – NGO – Family Planning Association of Pakistan | 20 |
| Sehat Foundation Hospital Daniyore, NGO – Sehat Foundation | 30 |
| Total available beds | 416 |

Considering that the total insured population in Gilgit district is 70,472, the average insured population per bed comes to 169 i.e. 5.9 beds per 1000 insured population.

All the empanelled hospitals are secondary level hospitals. Though the Combined Military Hospital (CMH) Gilgit has not been empanelled due to procedural issues, however, few patients avail services from there too on reimbursement basis.

# Utilisation of Services in GB

## Admissions

During the reporting period (Jan to June 2020), 572 admissions including 152 (27%) from eligible and 420 (73%) from wider population were reported in different public and private empanelled hospitals. No patient with Corona infection was reported during this period from the insured beneficiaries. The overall utilisation during the first six months of 2020 declined by 46% compared to last six months of 2019 when total admissions were 1063. This decline is more marked during the 2nd quarter (April to June 2020) when total admissions were only 180 compared to 392 admissions during first quarter. More discussion on effects of the COVID-19 pandemic on utilisation of services is given in relevant sections below.

The utilisation of services during this quarter too was higher in wider population than the eligible population and the possible reason might be that in wider population, purchasing insurance is a well informed and voluntary decision by the family, indicating the higher level of education, health awareness, having more information about health insurance products and tendency of using more healthcare services. Sixty six percent (379) of admitted cases were of female patients. Among the admitted cases 56% (320) were reported to be non-surgical cases and 44% (252) surgical cases.

The following table shows the major causes of non-surgical admissions.

Table 29: Non-surgical Admissions

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Non-Surgical/Obstetric Treatment | Public Hospitals | | Private Hospitals | | Total |
| **Eligible Population** | **Wider Population** | **Eligible Population** | **Wider Population** |
| Upper Respiratory Tract Infections | 0 | 0 | 0 | 40 | 40 |
| Urinary tract infection, unspecific/pyuria | 2 | 0 | 1 | 31 | 34 |
| Chronic Obstructive Pulmonary Disease, NOS | 13 | 0 | 0 | 19 | 32 |
| Gastroenteritis | 1 | 0 | 1 | 23 | 25 |
| Asthma (all types) | 9 | 2 | 0 | 12 | 23 |
| Fever, Unspecific | 1 | 0 | 2 | 13 | 16 |
| Hypertension, benign | 2 | 1 | 0 | 11 | 14 |
| Pneumonia, unspecific | 0 | 0 | 0 | 12 | 12 |
| Cardiovascular Accident (CVA), late effect, unspecific | 1 | 0 | 0 | 9 | 10 |
| Sepsis, Neonatal | 0 | 0 | 0 | 6 | 6 |
| All other non-surgical cases | 12 | 0 | 4 | 92 | 108 |
| Total | **41** | **3** | **8** | **268** | **320** |
| Percentage | **93%** | **7%** | **3%** | **97%** |  |

The data of non-surgical admissions shows that 271 (65%) patients from wider population were admitted for non-surgical health problems, among these, 99% (268) were admitted in private hospital and only 1% (3) visited public hospital. On the other hand, only 49 patients from eligible population visited the health care facility for non-surgical treatments, among that 16% (8) visited private hospital and 84% (41) visited public hospital. The major diagnosis of hospital admissions under non-surgical illness was Pneumonia/Upper Respiratory Tract Infection (URTI) that accounted for 13% (40) in total admissions.

The following table shows the causes of surgical admissions.

Table 30: Surgical Admissions

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Surgical/Obstetric Treatment | Public Hospitals | | Private Hospitals | | Total |
| **Eligible Population** | **Wider Population** | **Eligible Population** | **Wider Population** |
| Appendicitis/Appendectomy | 40 | 4 | 0 | 5 | 49 |
| Lower Segment C-Section | 11 | 1 | 0 | 21 | 33 |
| Spontaneous Vaginal Deliveries | 5 | 0 | 2 | 24 | 31 |
| Abdominal pain, unspecific | 2 | 0 | 0 | 10 | 12 |
| Fracture lower arm, healing, aftercare | 5 | 1 | 0 | 3 | 9 |
| Renal insufficiency, acute | 0 | 0 | 0 | 9 | 9 |
| Cholelithiasis, NOS | 6 | 0 | 0 | 2 | 8 |
| Calculus, ureter | 1 | 0 | 1 | 4 | 6 |
| Head injury, NOS | 4 | 0 | 0 | 0 | 4 |
| Pancreatitis, acute | 0 | 0 | 1 | 3 | 4 |
| Others | 21 | 1 | 4 | 61 | 87 |
| Total | **95** | **7** | **8** | **142** | **252** |
| Percentage | **93%** | **7%** | **5%** | **95%** |  |

The above information indicates that most of the patients (93%) amongst the eligible population got surgical treatment from public sector hospitals whereas the majority of patients (95%) from wider enrolment availed services from private hospitals. The reasons of this pattern of utilisation may include that most of the enrolled households in wider population belongs to catchment population of Aga Khan Health Service, where there is preference to use services from Aga Khan Medical Centre Gilgit (GMC), beneficiaries from eligible population prefer services from particular physicians and surgeons working in public sector hospitals as revealed in exit interviews from patients discharged from public sector health facilities in 2019.

## Quarterly Trend of Admissions

The following graph shows the quarterly trend of admissions. The admissions have fallen during the reporting period. Admissions data revealed that in first quarter of 2020 (Jan-Mar) 392 beneficiaries were admitted in the hospitals and in second quarter (April-June) admissions declined sharply, as only 180 clients visited the hospitals.This could be attributed to COVID-19 pandemic to ensure social distancing and government imposed measures like lockdown restricting movement, closure of services offered by health facilities for a period of time, ban on public transport and people themselves also avoided to visit hospitals for other illness due to fear of getting infection. The following graph depicts trend of quarterly admiisions from Jan 2018 to June 2020.

Figure 14: Quarterly trend of Admissions

Table 31: Overall Number of enrolled households, individuals and quarterly admissions (Eligible Population)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Quarter, Year** | **HHs enrolled (Cumulative)** | **Lives Insured** | **Admissions** | **Quarterly** | **Annual Utilisation Rate (%)** |
| **(Cumulative)** | **(In the quarter)** | **Utilisation Ratio (%)** |
| **Quarter 1, 2017** | 5334 | 35622 | 72 | 0.2 | 1.65 |
| **Quarter 2, 2017** | 5334 | 35622 | 241 | 0.68 |
| **Quarter 3, 2017** | 5334 | 35622 | 123 | 0.35 |
| **Quarter 4, 2017** | 5340 | 35671 | 151 | 0.42 |
| **Quarter 1, 2018** | 5340 | 35671 | 199 | 0.56 | 2.35 |
| **Quarter 2, 2018** | 5340 | 35671 | 251 | 0.7 |
| **Quarter 3, 2018** | 5340 | 35671 | 243 | 0.68 |
| **Quarter 4, 2018** | 5340 | 35671 | 147 | 0.41 |
| **Quarter 1, 2019** | 5340 | 35671 | 178 | 0.5 | 1.86 |
| **Quarter 2, 2019** | 5340 | 35671 | 216 | 0.61 |
| **Quarter 3, 2019** | 5340 | 35671 | 147 | 0.41 |
| **Quarter 4, 2019** | 5340 | 35671 | 122 | 0.34 |
| **Quarter 1, 2020** | 5340 | 35671 | 115 | 0.32 | 1.18\* |
| **Quarter 2, 2020** | 5340 | 35671 | 37 | 0.10 |

\*Shows annualised Utilisation Rate for last four quarters (3rd and 4th quarters of 2019 and 1st and 2nd quarter of 2020)

The utilisation rate in eligible population was highest in 2018, since then it is dropping, AKDN planned to have awareness campaigns including medical camps in union councils in 2020 however due to COVID-19 epidemic this plan could not be executed.

## Utilisation of Services by eligible population by Union Councils

Table 32: Service Utilisation of Eligible Population by Union Council

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| UC Name | Eligible Population | (Jan-Dec) 2018 | | (Jan-Dec) 2019 | | (Jan-June) 2020 | |
| **No.of Admissions** | **Utilisation Rate** | **No.of Admissions** | **Utilisation Rate** | **No.of Admissions** | **Utilisation Ratio\*** |
| Bagrote | 1660 | 32 | 1.9% | 27 | 1.6% | 14 | 0.84% |
| Chakarkote | 2110 | 144 | 6.8% | 31 | 1.5% | 12 | 0.57% |
| Damote | 9690 | 78 | 0.8% | 127 | 1.3% | 33 | 0.34% |
| Daniyor | 2114 | 41 | 1.9% | 18 | 0.9% | 6 | 0.28% |
| Gilgit | 7245 | 84 | 1.2% | 121 | 1.7% | 42 | 0.58% |
| Haramosh | 1815 | 78 | 4.3% | 70 | 3.9% | 2 | 0.11% |
| Jalalabad | 2625 | 114 | 4.3% | 60 | 2.3% | 10 | 0.38% |
| Nomal | 1225 | 67 | 5.5% | 21 | 1.7% | 4 | 0.33% |
| Rahimabad | 1630 | 73 | 4.5% | 107 | 6.6% | 13 | 0.80% |
| Shakiyot | 4130 | 83 | 2.0% | 66 | 1.6% | 9 | 0.22% |
| Sakwar | 1423 | 46 | 3.2% | 15 | 1.1% | 7 | 0.49% |
| Total | **35667** | **840** | **2.4%** | **663** | **1.9%** | **152** | **0.43%** |

\* For Jan to June 2020, it is half yearly **utilisation ratio** not Annual Utilisation Rate

## Hospitals visited by the Insured

During the reporting period Aga Khan Medical Centre, Gilgit (GMC) remained the most utilised health facility and got 72% share in total admissions. Most of the admissions in GMC were from amongst the wider population who had purchased insurance on voluntary basis. This could possibly be due to the fact that the segment of population that had been purchasing private health insurance have been using the GMC for seeking hospitalisation service as private health insurance has been in place in Gilgit for about five years prior to SHPI. Public sector hospitals were not empanelled in the private health insurance schemes implemented earlier. The City Hospital and DHQ were also utilised by patients from eligible population, as being economical secondary healthcare facilities. The utilisation of Sehat Foundation Hospital and Family Health Hospitals remained low these facilities provide comparatively limited range of healthcare.

The following table gives hospital-wise admissions from eligible and wider populations.

Table 33: Admissions in each Hospital (Jul-Dec 2019)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Hospitals | Wider | Eligible | Total | Percentage |
|
| Gilgit Medical Center | 399 | 11 | 410 | 72% |
| City Hospital | 4 | 78 | 82 | 14% |
| DHQ | 6 | 58 | 64 | 11% |
| Sehat Foundation Hospital | 2 | 4 | 6 | 1% |
| Family Health Hospital | 9 | 1 | 10 | 2% |
| Total | **420** | **152** | **572** | **100%** |

The City Hospital and DHQ hospital catered 90% of the 152 admissions from the eligible population. During the reporting period 25% of all admissions were in public sector hospitals. In terms of admissions from eligible population, 51% clients utilised City hospital, 38% DHQ hospital, 7% Gilgit Medical Centre, 2% Sehat Foundation and 1% utilised Family Health Hospital, Gilgit. The City Hospital catered the highest number of eligible admissions (78), while the Gilgit Medical Centre got the highest number of wider admissions (399). An exit interview of admitted patients from eligible population conducted in 2019 revealed that patient utilise services of health facility due to a particular physician or surgeon.

## Influence of COVID-19 pandemic on the scheme in Gilgit district

The exponential rise in the number of confirmed COVID-19 cases in Pakistan till June 2020 and the under-resourced health systems, and political and economic instabilities are adversely affecting the communities especially in the remote and rural areas of the country. A high level of uncertainty prevails among the target communities due to restricted mobility, economic downturn and rising unemployment rates. In District Gilgit as of June 2020, there have been 1630 confirmed cases and 36 deaths reported in project area in Gilgit District. Since early March, the local government imposed strict lockdown which resulted in restricted mobility, economic and social activities in the district.

In the context of the COVID‑19 crisis, service utilisation under SHPI scheme was suffered unfavourably during the reporting period. Following project activities were affected during COVID-19 pandemic and lockdown.

**Wider enrollment campaign** adversely influenced during the reporting period, resulting only 103 new families enrolled in the scheme.

**Outreach activities** such as awareness session with WOs/LSO/Vos, community meetings, medical camps and experience sharing workshop to inform individuals regarding insurance products and its benefits could not be executed as per plan during the reporting period.

**OD Fund utilisation:** The lockdown and mandatory work from home delayed in procurement of services planned under OD Fund and initiation of capacity building activities as well. It is expected that these activities will now be initiated in August 2020.

**Hospital admissions** declined (46%) compared to admissions during the previous reporting period (Jul-Dec 2019). Only 572 patients hospitalised during the reporting period. The average number of admissions per day remained 3.1 from Jan to June 2020 compared to 6.1 admissions per day during the period July to December 2019. The decline in admissions was markedly increased after the lockdown was implemented in March in the district. It is evident from the fact that there were 392 admissions in first quarter (Jan to March) which dropped to 180 admissions during the period from April to June 2020. The possible reasons of decline in admission include restrict mobility and difficulty faced by community in finding transportation to go to hospitals located in Gilgit town, the perception that hospitals are not providing services to non-coronavirus patients and the fear among the community that they will be get infected by visiting to the hospitals. The administration of Gilgit District also banned entry into Gilgit city for two weeks in May 2020.

The COVID-19 pandemic not only adversely affected the services provision for insured population, but it also led to decline of utilisation of all healthcare services provided by public and private healthcare providers. The following graphs show the impact of COVID-19 on overall admissions in public sector hospitals (DHQ and City Hospital Gilgit) and on admissions of all insured beneficiaries.

Figure 15: Impact of COVID-19 on total admissions from insured population

Figure 16: Impact of COVID-19 on total admissions in Public Sector Hospitals in Gilgit

## Age and Gender Distribution by Eligible and Wider Enrolled

During the reporting period 66% of all admitted patients were female. This trend of higher proportion of female beneficiaries was noticed both in public sector (75% female admissions) and private sector (63%) hospitals as well as among beneficiaries from the eligible and wider populations (74% and 63% female admissions respectively). The following table shows the distribution of admitted patients by gender and by different age groups from eligible and wider populations.

Table 34: Distribution of admissions by age group, gender and type of enrolment

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Age Group | Male | | Female | | Total | | Percentage | |
| Wider | Eligible | Wider | Eligible | Male | Female | Male | Female |
| less than 1 | 9 | 0 | 10 | 0 | 9 | 10 | 5% | 3% |
| 1 to 04 yrs. | 18 | 0 | 13 | 0 | 18 | 13 | 9% | 3% |
| 5 to 14 yrs. | 13 | 11 | 23 | 15 | 24 | 38 | 12% | 10% |
| 15 to 49 yrs. | 51 | 12 | 124 | 76 | 63 | 200 | 33% | 53% |
| 50 to 69 yrs. | 27 | 11 | 55 | 16 | 38 | 71 | 20% | 19% |
| 70 years & Above. | 36 | 5 | 41 | 6 | 41 | 47 | 21% | 12% |
| Total | **154** | **39** | **266** | **113** | **193** | **379** | **100%** | **100%** |

The information in the table above shows that the highest number of admissions i.e. 92 (16%) were from the age group of 30 to 39 years followed by 85 (15%) admissions of patients aged 19 to 29 years. There were 54 (9.4%) admissions of under the age of 5 years children.

Table 35: Utilisation Ratio[[2]](#footnote-3) during reporting period by Age Group, Gender and type of Enrolment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Age Group | Male | | Female | | Total | | Total |
| Wider | Eligible | Wider | Eligible | Male | Female |
| **Less than 1** | 1.45% | 0.00% | 1.63% | 0.00% | 1.26% | 1.44% | 1.35% |
| **1 to 04 yrs.** | 1.26% | 0.00% | 0.89% | 0.00% | 0.77% | 0.57% | 0.67% |
| **5 to 14 yrs.** | 0.45% | 0.16% | 0.75% | 0.23% | 0.24% | 0.40% | 0.32% |
| **15 to 49 yrs.** | 0.73% | 0.17% | 1.68% | 1.19% | 0.45% | 1.46% | 0.95% |
| **50 to 69 yrs.** | 1.04% | 0.34% | 2.12% | 0.56% | 0.65% | 1.31% | 0.97% |
| **70 yrs.& above** | 1.38% | 1.41% | 1.62% | 1.43% | 1.39% | 1.60% | 1.49% |
| **Total** | **0.90%** | **0.21%** | **1.51%** | **0.66%** | **0.54%** | **1.09%** | **0.81%** |

## Readmission cases

For the current reporting period, there is no readmission case in public or private hospitals within 30 days of initial admission.

## Length of Stay

During the reporting period, out of 572 admissions (420 wider and 152 eligible), 23% of patients stayed for 1 day or less, 56% of patients stayed 2-3 days, and 13% of patients stayed for 4-5 days and 8% patients stayed longer than 5 days.

The length of stay in government hospitals had an average of 3.5 days, whereas the length of stay in private hospitals was 2.5 days. The average length of stay (ALOS) in other micro and community-based insurance schemes could not be traced out, the ALOS in NHS hospitals England was 4.5 days in 2018-19[[3]](#footnote-4).

Table 36: Average length of stay by each hospital (Jul-Dec 2019)

|  |  |  |
| --- | --- | --- |
| Hospital | Average Length of Stay | |
| **Eligible** | **Wider** |
| City Gilgit | 3.5 | 4 |
| District Head Quarter | 3.5 | 3 |
| AK Medical Centre (GMC) | 1.5 | 2.5 |
| Sehat Foundation Hospital | 1 | 1 |
| Family Health Hospital | 1 | 1 |
| Overall Average | 3 | 2.5 |

The table above shows that the average length of stay for clients from eligible population was 3 days, and patients from wider enrolment stayed for an average of 2.5 days.

Table 37: Number of Admissions by Length of Stay by Type of Beneficiaries

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Length of stay | Eligible | Wider | Total | Percentage |
| 1 day | 16 | 118 | 134 | 23% |
| 2 to 3 days | 83 | 237 | 320 | 56% |
| 4 to 5 days | 29 | 45 | 74 | 13% |
| 5 days and above | 24 | 20 | 44 | 8% |
| Total Admissions | 152 | 420 | 572 | 100% |

The following table gives the top ten diagnoses of one day admissions.

Table 38: Top Ten Diagnoses of One Day Admissions

|  |  |
| --- | --- |
| **Diagnosis** | **Number, (%)** |
| Normal Delivery | 26 (19%) |
| Urinary Tract Infections | 16 (12%) |
| Gastroenteritis | 15 (11%) |
| Renal insufficiency, acute | 9 (7%) |
| Abdominal Pain, Unspecific | 8 (6%) |
| COPD, Asthma | 7(5%) |
| Upper Respiratory Tract Infections | 6 (4%) |
| Fractures/Injuries | 4 (3%) |
| Peptic Ulcer Disease | 5 (3%) |
| Abortions and other Pregnancy Complication | 4 (3%) |
| Other Diagnoses | 34 (25%) |
| **Total** | **134** |

One fifth of all one day admissions were for normal deliveries.

# Premiums and Costs in GB

There were claims against admissions for common ailments. The following tables provide details of claimed amount for top 10 surgical and non-surgical admissions with average, minimum and maximum amounts:

Table 39: Claimed Amount against top 10 & all Non-surgical Admissions (Jan-Jun 2020)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Non-Surgical/Obstetric Treatment | Admissions # | Average Claimed Amount  (PKR) | Minimum  (PKR) | Maximum  (PKR) |
| Upper Respiratory Tract Infections | 40 | 14,348 | 2,603 | 33,167 |
| Urinary tract infection, unspecific/pyuria | 34 | 13,281 | 2,643 | 40,000 |
| Chronic Obstructive Pulmonary Disease, NOS | 32 | 13,103 | 2,599 | 40,000 |
| Gastroenteritis | 25 | 11,106 | 2,125 | 40,000 |
| Asthma (all types) | 23 | 9,143 | 873 | 21,031 |
| Fever, Unspecific | 16 | 11,238 | 3,887 | 22,313 |
| Hypertension, benign | 14 | 16,919 | 3,615 | 40,000 |
| Pneumonia, unspecific | 12 | 17,755 | 4,691 | 34,061 |
| Cardiovascular Accident (CVA), late effect, unspecific | 10 | 25,410 | 6,504 | 40,000 |
| Sepsis, Neonatal | 6 | 14,591 | 6,989 | 26,060 |
| All Non-Surgical admissions | **320** | **13,655** | **873** | **40,000** |

Table 40: Claimed Amount against top 10 & all Surgical Admissions (Jan-Jun 2020)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Non-Surgical/Obstetric Treatment | Admissions # | Average Claimed Amount  (PKR) | Minimum  (PKR) | Maximum  (PKR) |
| Appendicitis/Appendectomy | 49 | 8,759 | 2,764 | 30,000 |
| Lower Segment C-Section | 33 | 17,847 | 5,117 | 24,000 |
| Spontaneous Vaginal Deliveries | 31 | 10,360 | 2,487 | 12,000 |
| Abdominal pain, unspecific | 12 | 7,004 | 2,261 | 15,978 |
| Fracture lower arm, healing, aftercare | 9 | 20,568 | 3,033 | 40,000 |
| Renal insufficiency, acute | 9 | 6,746 | 2,014 | 17,490 |
| Cholelithiasis, NOS | 8 | 21,559 | 7,179 | 40,000 |
| Calculus, ureter | 6 | 9,597 | 4,293 | 25,000 |
| Head injury, NOS | 4 | 12,935 | 3,339 | 25,000 |
| Pancreatitis, acute | 4 | 21,714 | 15,481 | 25,000 |
| All Surgical Admissions | **252** | **14,207** | **1,751** | **40,000** |

The above tables show that there is no marked difference between average claim for non-surgical (PKR 13,655) and surgical admissions (14,207). There are also cases when the admitted patients exhausted the capped amount (PKR 25,000 for eligible population and PKR 40,000 for wider enrolment).

# Other Matters within the SHPI Phase I Project

## Khyber Pakhtunkhwa

### Issues in Management of the Schemes

Members of the PMU-SHPI as well as SLIC are overwhelmed by ever expanding scope of the scheme in the province. Matters related to KfW funded scheme usually receives little attention due to other competing tasks. I t has therefore been suggested that there is a need for a Focal Person in PMU-SHPI dedicated to KfW funded activities. Similarly, there is a need for a small and dedicated team in SLIC office Peshawar for KfW supported program activities.

It is also important to have a separate empowered team in SLIC to handle the SHPI Khyber Pakhtunkhwa.

SLIC should share detailed management plans for implementation of activities in Khyber Pakhtunkhwa as per the proposals submitted in response to RFPs.

Human Resources and other resources to be placed on fast track basis in Peshawar for Khyber Pakhtunkhwa.

### Revision of Empanelment Criteria and Process

A review of the empanelment criteria and the process has been initiated to further refine the empanelment criteria and assign scores with a broader range. There is a need to develop suggest criteria for tertiary care hospitals separately. The review is aimed at making process for empanelment of hospitals further transparent so that there is clear and accountable process for application by hospitals interested in getting empanelled. A key strategy to ensure transparency in the process would be to establish an online process for application for empanelment by insurance company. Key elements of such a process would be:

* Application forms for empanelled to be filed by the hospitals would be made available free of charge with open access to hospitals online.
* Once any application is submitted to the insurance company, the PMU will automatically receive an alert &/or a copy of the application which it can then track.
* The insurance company will be bound to inspect the hospitals for empanelment within one month of lodge of applications.
* In case of delay beyond this period the PMU will send a notice to the insurance company.
* Further delay (without adequate explanation) would lead to penalising the insurance company by imposing fines or any other means.
* DoH will establish a mechanism to check process of empanelment of hospitals through periodic visits by a team of trained assessors

After receiving the application, SLIC team would visit the hospitals for assessment. Hospitals that meet the criteria will be selected for further negotiations on prices, process and services.

Scores on various service areas in the hospitals will be linked to levels of pricing for the services. This will be a step towards rationalisation of prices charged by hospitals for different procedures covered in the benefits package.

## Gilgit Baltistan

### Cards Distribution

#### Cashless Cards Distribution Status

Total 5202 cashless cards were distributed out of 5340 cards during the months of January and February. The 138 cards remained undelivered due to lockdown in March, which will be delivered in July 2020.

#### Wider Enrolment

During the reporting period, 103 new household were successfully enrolled with their willingness to purchase the health product of Jubilee Health Insurance Scheme. In addition, 115 families renewed their health insurance. Overall, 97% cards have been distributed through different LSO’s and WO’s.

During the reporting period only five awareness sessions/meeting could be conducted in two union councils Gilgit and Daniyore and a total of 30 people (5 male and 25 female) participated in these sessions. Wider enrolment campaigns were badly affected. Any kind of planned awareness raising activities such as meeting with LSOs/WOs, medical camps, experience sharing sessions with targeted communities were completely stopped due to restricted movement within the district during the COVID-19 pandemic. Resulting project was not able to announce the wider enrolment in March 2020. As an alternative way project staff initiated the wider enrolment in the month of June through telephonic calls and by sending the SMs to beneficiary families.

Standard Operating Procedures for Case Management Section (the SOP) lays down the procedures as to how a case is managed after it has been approved by JLI Approval Centre.

## Key Activities – July to December 2020

|  |  |  |  |
| --- | --- | --- | --- |
| Activity | | Responsibility | Timelines |
| 1 | Support to PMUs in KP & GB for review & finalisation of implementation of activities for 2020 – 2021 | MN,  IGK , Abid, Akram & SZA | Aug. – Sept. 2020 |
| 2 | Support to PMU-SHPI in procurement/contract management for hiring of insurance company for expanded scheme in GB. | MN,  IGK , Abid, Akram & SZA | Oct. – Nov 2020 |
| 3 | Support to experts hired by SLIC in revision of Empanelment criteria & review of empanelled hospitals | IGK & SZA | August 2020 |
| 4 | Support to experts hired by SLIC in preparing operations manual for SHPI | IGK & SZA | November 2020 |
| 5 | Support to SLIC in implementation of Awareness raising activities through LHWs in KP | Dr Fauzia (Trg. Expert), SZA | Sept – Oct 2020 |
| 6 | Support to SLIC in Training of staff empanelment process and Quality monitoring | IGK, SZA and Abid Hussain (AH) | October 2020 |
| 7 | Support to SLIC in improvements in transport facilities for beneficiaries | SZA, IGK | Sept. – Oct 2020 |
| 8 | Support to PMUs in Monthly Review Meetings (KP & GB) | IGK, SZA, Dr Akram & AH | July – Dec. 2020 |
| 9 | Support to PMUs in Steering Committee Meetings for KP & GB | IGK, SZA, AH & MN | As required. |
| 10 | Ongoing monitoring/tech support | SZA, AH, Dr Akram IGK & MN | July – December 2020 |
| 11 | Review of the utilisation reports, claims for assessment of proposals for enhancement of premium by the two insurance companies | SZA, IGK, AH & MN | 25th Dec 2020– 15th Jan. 2021 |
| 12 | Support to PMU in KP in finalising Treatment Protocols | SZA, IGK, AH | October 2020 |

# Conclusions

Government restrictions imposed on public and private hospitals as part of the response to COVID-19 caused what will probably be a temporary reduction in admissions in both the four KP Districts and in Gilgit. With the easing of restrictions for the time being it can be expected that activity will return to previous levels.

The most significant financial issue remains that of a potential underspend on the KP Phase 1 scheme of near to Euros 3M. Proposals discussed to date will not absorb this in full. The remaining amount will be revisited in the last one week of December 2020 after which proposals will be shared with Government of Khyber Pakhtunkhwa and KfW in first week of January for use of the funds.

Under representation of children remains the most significant issue in enrolment in KP. This requires urgent attention by government and SLIC so as to find practical solutions which do not undermine the integrity of the scheme.

The short experience in KP of extending insurance products to a paying population was showing great promise and the learning from this experience should be retained, particularly as health expenditures come under greater pressure.

The limited number of hospitals empanelled in Kohat and the perception of their quality in the population seems to be a significant problem causing low utilisation of the scheme and requires addressing by government and SLIC as a matter of urgency.

Whilst some of the specific causes of underutilisation of the scheme can be identified with reasonable certainty (the Kohat Supply issues; the low enrolment of children; the lack of demand or supply related to hospital deliveries), the general level of utilisation at considerably less than 2% is not yet explained adequately. However, there are a number of reasonable hypotheses that require attention in the forthcoming utilisation study.

In advance of the study and what might flow from it, it would be reasonable to test the impact of a good quality medical transport service.

The range in costs for services in KP continues to look reasonable and still best left to the operation of the market rather than the subject of further intervention.

The capacity of government to give sufficient attention to issues specifically related to issues in the 4 KfW supported Districts is inadequate

The range in costs in GB is much greater and probably deserves some more attention by government and AKDN.

In G-B there are similar issues in respect of the under enrolment of children and practical solutions need to be found

The continuing significant difference in utilisation by the “eligible” and “wider” populations again should be given further attention

# Recommendations

Based on discussions with government, OPM to propose to KfW further uses of the “unspent funds” consistent with the overall objectives of the initiative and including the testing of innovations with potential for future scale-up.

Governments to request SLIC and AKDN to propose measures with any associated costs for increasing the enrolment of infants and children.

SLIC and AKDN to enter into discussions with empaneled hospitals to identify practical measures and associated costs to increase the attractiveness of maternity services.

OPM to support SLIC and AKDN in the development of terms of reference for a good quality medical transport service, the impact of which to be tested as soon as possible in at least one of the 4 Districts in KP.

KfW to request government in KP to identify a senior officer in the PMU to be the focal point for matters related to the 4 Districts.

AKDN to be requested to give consideration to the implications of the market segmentation in Gilgit.

1. H1 = Period between January and June, H2 = Period between July and December [↑](#footnote-ref-2)
2. It is the ratio of admissions during the reporting period (Jan to June 2020) to the population in that age group, gender and type of enrolment. It is not the annualised Utilisation Rate. [↑](#footnote-ref-3)
3. <https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers> [↑](#footnote-ref-4)