***Journal of Religion & Society* (JR&S)**
Available Online:
https://islamicreligious.com/index.php/Journal/index
Print ISSN: 3006-1296Online ISSN: 3006-130X
Platform & Workflow by: Open Journal Systems

A Comparative Analysis of Evolution and Developemnt of Financing Models in Public Sector Health System

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Abstract
This study presents a brief overview of evolution and development of health financing models being followed across the world. Since health expenditures constitute a significant part of the household and government budgets, there have been several initiatives to provide health financing in optimum way. From pure tax funded models to contributory health insurance system, there have been several experiments across different regions to provide necessary finance for the health sector. This study comparatively studied the health financing models developed across Asia, Africa and Latin America with a view to identify financing source, coverage for patients, managing agencies etc. Along with this, the Pakistan specific health insurance model, the Sehat Card scheme is also discussed to examine its financing structure and identify comparative financing options by benchmarking worth other global health financing schemes.

Introduction:

Historically, there are different healthcare financing models developed mostly in the Western Countries. The first model is the Bismarck model named after Otto von Bismarck, the German chancellor . The objective of this model was to meet the healthcare needs of working class through a contributory system. In this model, private insurance organizations, also referred to as sickness funds, work as non-profit organizations in which both employers and their employees contribute funds. However, these non-profits organizations do not financially benefit from the provision of healthcare. The Govt. maintains a strict overview on the health care system and ensures the equitable provision of healthcare system. Germany, Japan, Belgium and some other countries have adopted this model for healthcare.

The second healthcare model adopted in different countries is the Beveridge Model, which is named for its British developer, William Beveridge. In this system, healthcare is provided for every citizen by the government through funds collected in the form of taxes. It is also referred to as a single-payer national health service as it is paid for exclusively by the government and is provided on a national scale. The countries that adopted this healthcare model are UK, Spain, New Zealand, Cuba and some Scandinavian countries.

The third model is the national health insurance model which is sometimes known as a blend of the Beveridge and Bismarck models. Like the Beveridge model, this model also has the government working as the single payer for insurance policies, though all citizens contribute financially for the program. Just like the Bismarck model, however, the private insurance organizations under the national health insurance model are not solely profit-driven and cannot deny insurance claims. In this model, patients can choose their own healthcare providers and are generally not financially burdened by the cost of care. South

Korea, Taiwan and Canada have this type of healthcare models.
The fourth model is the Out-of-Pocket Expenditures Model which requires the payment of healthcare procedures and medicines through own means. Mostly, this model is practiced in under-develop countries where Govt. generally lack the funds and resources for above said healthcare models for their population. In this model, patients pay for their health services without any contribution from the Govt. directly to the healthcare providers. However, in some developing countries govt. has developed healthcare facilities for lower-income groups but affluent class still approach the private sector hospitals and pay for their treatment.

Evolution of Sehat Card Scheme in Pakistan:

The Federal Government of Pakistan launched its social health protection initiative, named Sehat Sahulat Program (formerly known as Prime Minister's National Health Program), in 2015, which envisioned improving access to healthcare for the lower income segments. The program initiated a social health insurance scheme named as the Sehat Card that aimed to provide free of cost healthcare services to the poorest population in targeted 34 districts (Two districts of each Azad Jammu & Kashmir & Gilgit Baltistan, six districts of ex-FATA, Islamabad District, five districts of Sindh, five districts of Baluchistan, thirteen districts of Punjab and four districts of KPK) in Pakistan. Initially, the maximum financial coverage limit per family per year was PKR 300,000 (Rs. 250,000 for priority care treatment and Rs. 50,000 for secondary care treatment) with a coverage of same amount as excess of loss coverage financed by Pakistan Bait Ul Mal.
The operating mechanism of the Sehat card scheme was to pay a fixed premium to a health insurance company and selection of the hospitals for treatment of the beneficiaries. The government paid a premium of Rs.1,299.98/- per year per family to the State Life Insurance Corporation of Pakistan which reimbursed the treatment expenditures to the hospitals. During its 1st phase (pilot-testing) around 500 public and private hospitals across the Pakistan were empanelled to provide the healthcare services to the poorest population of the country. The data of beneficiary families were provided by the BISP from its National Social Economic Registry database 2009-10 (NSER). The NADRA also played a vital role in composition and real-time verification of the household data of BISP into families database.
The second phase of the Sehat Card was started in 2018 in which entire population of ex-FATA and AJK were included in the beneficiaries list through 700 plus hospitals across country thereby moving towards the Universal Health Coverage (UHC). In this stage, KPK and Punjab were handed over the financial and administrative operations of their respective districts. In the third phase of the Sehat Card scheme beginning in 2022, the entire population of AJK, GB, ex-FATA and Tharparkar District of Sindh were covered in the Sehat Card scheme with treatment from 100 plus hospitals across Pakistan. The Govts. of Punjab and KPK are managing the financial and administrative aspects of the Sehat Card scheme from their own resources. At present, the federal government is providing the technical and administrative support to these provincial governments on need basis. The financial contribution of federal government on account of health insurance premium till 2022-23 is about Rs. 14 billion (Rs. 3 billion related to below poverty population and Rs. 11 billion related to Universal Health Coverage).
Pakistan has implemented the Sehat Card scheme within the ambit of the social health insurance. However, compared to the regional peers, Pakistan has made a late entry in the social health insurance model. The social health insurance coverage was started in Thailand in 2012, in Indonesia in 2014, in 1983 in Singapore, in 1984 in Malaysia. Pakistan, with its, 250 million population is the fifth largest country of the world and has historically relied on the crowded and poorly funded govt. run hospitals for providing

health services to the population.

Pakistan, being a developing country, had historically spent less than 1% of its GDP on health. The Govt. of Pakistan has mostly relied on govt. run hospitals for managing the health-related issues. These hospitals were often located in urban and semi-urban areas with fewer facilities and crowded patient wards. The high-income groups have relied on private hospitals for health treatment across the country. As the construction of new govt. run hospitals were a time-taking and a costly option, the govt. considered the option of social health insurance models. The Sehat Card scheme, being a mixture of the Bismark & Beveridge model, was designed to provide social health insurance to the wider segments of the society through private sector hospitals located in various cities.

Literature Review:

Many researchers have studied the health financing scheme in multiple perspectives. Some experts have worked on assessing the doctors' responses, patients feedback and other end users' perspectives while others have evaluated the impact of scheme on meeting patients' needs. For example, McIntyre et.al. (2003) examined the design features of the social health insurance schemes in the South Africa and reported that mere launching of social health insurance schemes is not enough if their design and administration is not carefully made. Apart from financing mechanism, the administrative and service delivery concerns of the social health insurance schemes need to be examined to promote equity and sustainability.

World Health Organization (2004) in its discussion paper on social health insurance has called for developing a comprehensive social health insurance scheme to achieve the universal coverage. The paper called for designing social health insurance schemes by examining the local conditions; health infrastructure, financing patterns, capacity of insurance companies, stakeholders' dialogues, and political factors for ensuring sustainability and fairness. Similarly, Hsiao & Shaw (2007) worked on designing and implementation of social health insurance programs in developing nations and called for observing the fiscal space, health infrastructure, income level, quality of insurance firms and selection criteria for the beneficiaries. They also called for checking political willingness among different political parties and other stakeholders' participation levels for effective management of health insurance schemes.

Tien et. al. (2011) checked the health financing patterns of Vietnam focusing on social health insurance and identified the issues in institutional design and organizational practice of health financing. They surveyed the existing health financing mechanism and identified the potential issues in the system. The suggested to develop a contributory system of health financing for Universal Health Coverage by pooling funds and devising suitable social health insurance schemes. Knaul et. al. (2012) examined the universal health coverage in Mexico and reported that transition towards universal health coverage through social health insurance has been a challenging task. With the passage of time, health coverage, financial mechanism, service delivery concerns and satisfaction of patients have increased. Atun et. al. (2015) examined the health reform and universal health coverage in Latin America and reported that since 1990s governments across the continent are struggling to manage both supply side and demand side factors for enhancing the health coverage to the vast segments of population. Within this context, social health insurance models can play a significant role if their design and structure is thoughtfully planned and executed. In the African context, Ogundeji et. al. (2019) developed a checklist for designing health insurance programmes for Nigerian states and identified six key areas to be considered for designing a social health insurance scheme. These areas include sources of finance, benefit package, provider payment mechanism, contributing population and level of contribution, pooling of funds and administration and

management.

Within the context of the Sehat Card scheme in Pakistan, different researchers have worked on the financial and non-financial aspects of the scheme. For example, Hasan et. al. (2022) discussed the Sehat Sahulat Program of Pakistan found that it's a good program for provision of health services. However, with its expansion across Pakistan, there is a risk of delays in claims settlement and funds deficiency that requires dynamic risk management tools. This requires a consensus among the key stakeholders to arrange funds for the provision of healthcare facilities to every segment of population in an affordable manner. Similarly, Forman et. al. (2022) examined the Sehat Sahulat Program and appreciated the efforts of the Govt. for launching a health insurance model on a larger scale. The authors highlighted the role of health insurance as a tool to enhance the access of health facilities across the country. However, they asked for conducting an in-depth study on the actual recipients and the overall program structure to address the short-comings and enhance the health support mechanism specially for lower income groups.

To check awareness of the Sehat Card scheme among local population, Din et. al. (2022) worked in District Rawalpindi. Using questionnaire, they found that on majority of card holders receive the information on Sheat Card through word of mouth and the local political party. Another key finding was that 72% recipients used the Sehat Card for curative purposes. A positive finding of the study was that almost 90% respondents felt no discrimination in accessing the health facility through Sehat Card. The authors recommended that there is a greater need to widely circulate the benefits of Sehat card so that maximum number of people can use this facility. Another useful brief study by Farooq & Kunwal (2022) with the title of potential role of Sehat Sahulat Program (SSP) in reducing catastrophic health expenditures suggested that the present mechanism of Sehat Card only covers the in-door treatment of the patients while the major share of out of pocket health spending is made on OPD treatment. Therefore, they suggested that some limited funds may be allocated in the Sehat Card scheme for OPD treatment. Similarly, they argued for coverage for patients with chronic diseases which also require a lot of expenditures.

Shahbaz et. al. (2023) conducted a study on knowing the public perception and satisfaction with the Sehat Card in Punjab. Through a questionnaire, they collected data from 350 recipients and found that majority of persons were satisfied with the facilities provided under the Sehat Card scheme. They also observed that Sehat card has also divided the burden of patients among the govt. and private sector hospitals enhancing access for the poor and reducing load on Govt. run facilities. In a similar way, another study by Shahbaz et. al. (2023) on Sehat Card with a view to explore the health professional perceptions in Lahore. They collected data from 200 healthcare professionals in Lahore and found that the Sehat Card scheme has increased job-specific burden on the healthcare professionals with increased administrative and compliance hours. They also observed lower job satisfaction and slow procedure in reimbursement rates under the Sehat Card scheme. The authors suggested to effectively manage the workload of the healthcare professionals for better treatment quality.

Research Methodology:

This study used a comparative analysis method for examining the features of different health financing models followed in various parts of the world. For this purpose, this study selected health financing models being followed in 12 different countries of Asia, Africa and Latin America. The selection of these healthcare financing models for this study was based on the similar economic and social features of these countries. This study excluded healthcare financing models of Europe, USA, Australia, Canada etc. as they have different economic conditions. For selected countries, this study examined the coverage limit,

budgetary spendings, administrative agency and other key features of the healthcare financing model. A brief overview of the comparative analysis of healthcare financing models in selected countries is provided below;

A Comparative Analysis of Health Financing Models

Scheme	Country	Year Launched	Coverage Limit	Financing Model	Estimated Annual Budget / Spending	Population Coverage	Provider Network	Administration / Implementing Agency	Key Features
Sehat Sahulat Program	Pakistan	2015 (KP), national expansion 2019	Up to PKR 1 million per family annually	Government-subsidized social health insurance	~PKR 40–45 billion	~44 million families (varies by province)	Public & private hospitals	Government of Pakistan with State Life Insurance	Cashless hospitalization, digital health card, coverage for major diseases and surgeries
Ayushman Bharat (PM-JAY)	India	2018	₹500,000 per family annually	Joint central and state government financing	~$7 billion	~500 million beneficiaries	Public & private hospitals	National Health Authority	One of the world's largest publicly funded health insurance programs
Universal Coverage Scheme	Thailand	2002	Comprehensive healthcare (no fixed monetary limit)	General taxation	~$6–7 billion	~75% of Thai population	Mainly public hospitals	National Health Security Office	"30-Baht Scheme"; strong primary healthcare network
National Health Insurance Scheme (NHIS)	Ghana	2003	Comprehensive essential health services	Payroll taxes, VAT levy, premiums	~$1–1.5 billion	~60% of population	Public & private providers	National Health Insurance Authority	Social insurance model aimed at reducing out-of-pocket expenses
Aasandha Universal Health Insurance	Maldives	2012	Comprehensive services including overseas treatment	Government-funded national insurance	~$150–200 million	Nearly entire population	Public and international hospitals	Aasandha Company Ltd.	Covers medicines, diagnostics, specialist care, and treatment abroad

Seguro Popular / INSABI	Mexico	2003 (reformed 2020)	Comprehensive basic health services	Federal taxation and public budget	~$15–20 billion	~50 million previously uninsured citizens	Public hospitals	Ministry of Health	Designed to expand coverage to uninsured population
Sistema Único de Saúde (SUS)	Brazil	1988	Universal health services	Federal, state, and municipal taxes	~$100+ billion	Entire population (~214 million)	Public hospitals and contracted private providers	Brazilian Ministry of Health	One of the world's largest universal public health systems
Seguro Integral de Salud (SIS)	Peru	2001	Free essential healthcare services	Government-funded insurance	~$1–2 billion	~60% of population	Public hospitals	Peruvian Ministry of Health	Focus on poor and vulnerable groups
Programa SUMAR (Plan Nacer)	Argentina	2004	Maternal and child healthcare coverage	Federal government financing	~$500 million	~15 million beneficiaries	Public healthcare facilities	Ministry of Health Argentina	Results-based financing to improve maternal and child health
Mutuelles de Santé (Community Health Insurance)	Rwanda	1999	Basic healthcare services	Household premiums + government subsidies + donor support	~$300–400 million	~80–90% of population	Local health centers and hospitals	Rwanda Social Security Board	Highly successful community-based health insurance model
National Health Insurance Fund (NHIF)	Kenya	1966 (major reforms 2015)	Hospitalization and outpatient services	Payroll contributions + government subsidies	~$600–800 million	~20–30% population (expanding)	Public and private hospitals	National Health Insurance Fund	Gradual expansion toward universal health coverage
Seguro Universal Materno Infantil (SUMI)	Bolivia	2002	Free maternal and child healthcare	Government funded	~$200 million	Pregnant women and children under five	Public healthcare facilities	Bolivian Ministry of Health	Targeted program to reduce maternal and infant mortality

Conclusion:

This study provided evolution and comparative analysis of different healthcare financing models being practiced across Asia, Africa and Latin America. With limited budgetary support and household income, the governments of these countries have adopted less costly healthcare financing models. This study presented a brief comparative analysis with a view to examine other financing options which can be adopted in Pakistan in Sehat Card and other healthcare initiatives. Since every financing model has its own limitations, the option to localize the structure and processes can help the healthcare system of Pakistan to provide adequate coverage to entire population.

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