HEALTHCARE ECOSYSTEM IN PAKISTAN

SECP

SECURITIES AND EXCHANGE COMMISSION OF PAKISTAN

INSURANCE DIVISION
SECP

Disclaimer: This report is a work of research utilising the publicly available sources and direct submission by the insurance companies, the references to which have been provided in relevant sections.

The findings given in the report are based on the analysis of information collected directly from the insurance companies and takaful operators. It should be noted that the ideas, opinions, and recommendations thereto belong to the author of the report and do not necessarily reflect the official stance of the SECP.

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CONTENTS

ACRONYMS

ACO	Accountable Care Organizations
AJK	Azad Jammu Kashmir
CISSII	Centralized Information Sharing Solution for Insurance Industry
CNHI	Centre for National Health Insurance
COHI	Compulsory Occupational Health Insurance
DCP 3	Disease Control Priority 3
DRAP	Drug Regulatory Authority of Pakistan
EPHS	Essential Package of Health Services
FED	Federal Excise Duty
GB	Gilgit Baltistan
GDP	Gross Domestic Product
HIC	Health Insurance committee
HSA	Health Services Academy
HTA	Health Technology Assessment
ICD	International Classification of Diseases
ICT	Islamabad Capital Territory
KP	Khyber Pakhtunkhwa
KSA	Kingdom of Saudi Arabia
MNHSRC	Ministry of National Health Services, Regulation & Coordination
MSDS	Minimum Service Delivery Standards
NADRA	National Database & Registration Authority
NFIS	National Financial Inclusion Strategy
NEP	National Efficient Price
NHA	National Health Accounts
NIH	National Institute of Health

ACRONYMS

OOP	Out of Pocket
PAEC	Pakistan Atomic Energy Commission
PBS	Pakistan Bureau of Statistics
PHRC	Pakistan Health Research Council
PMDC	Pakistan Medical & Dental Council
PSDP	Public Sector Development Program
SCI	Service Coverage Index
SCP	Sehat Card Plus
SDG	Sustainable Development Goals
SECP	Securities & Exchange Commission of Pakistan
SLA	Service Level Agreement
SLIC	State Life Insurance Corporation of Pakistan
SOPs	Standard Operating Procedures
SSP	Sehat Sahulat Program
TAT	Turnaround Time
TCI	Technical Committee on Insurance
TPA	Third Party Administrator
UHC	Universal Health Coverage
UN	United Nations
VBH	Value-based Healthcare
WB	World Bank
WHO	World Health Organization

CHAIRMAN'S MESSAGE

The five-year strategic plan "Journey to an Insured Pakistan" sets out the vision of SECP for insurance sector development. Formulated through broad-based stakeholder consultation, it lays out key priority areas such as financial stability, ease of doing business, modernization of legislation, access to capital, reinsurance optimization, policyholder protection, digitalization and engagement with stakeholders, among others. One of the operational outcomes envisioned by the SECP is to "foster the growth of private health insurance premiums to represent more than 15% of the total premium".

Healthcare is a social imperative, a fundamental right enshrined in Pakistan's constitution, and a barometer of societal equity. Despite healthcare being a constitutional right, Pakistan has one of the highest levels of out-of-pocket medical expenditures indicating inadequate focus on healthcare which results in self-funding of healthcare by majority of population.

The health insurance is a bridge to extend financial protection, provide quality healthcare access to the population, and catalyze strengthening of country's healthcare capability. However, the potential of this important area remains underutilized for a variety of reasons. While the government sector Sehat Sahulat Program has moved the needle in terms of access to basic healthcare benefits through the State Life Insurance Corporation, the long-term sustainable development in the private health insurance sector requires concerted efforts of private sector, insurance companies, medical practitioners and the policy- makers.

To address the unique issues and bottlenecks in the health insurance growth, this study explores the broader ecosystem of healthcare sector, specific role of health insurance in healthcare delivery, the shortcomings on the supply-side and challenges on the demand side, and sets out the recommendations for improvements in the specific areas. Fostering digital transformation, product innovation, inclusive market development and compulsory insurances are the key focus areas.

The healthcare benefits can be amplified through sector-wide integration, in terms of amalgamation of primary healthcare with the universal health coverage through participation of public sector and private sector. The universal healthcare can be complemented by employer-based health insurance and further enriched through the individual top-up coverage to create a comprehensive healthcare benefit package for the individuals including the long-term primary, secondary and tertiary care. The role of technology through digital health and telemedicine is critical.

A vision is presented for a robust healthcare sector comprising of integrated institutions and seamless operations powered by technology and standardization, and governed in-line with international best practices. With specific focus on health insurance, the idea of health insurance information exchange is presented, which can enable resourceful and efficient healthcare service delivery and contribute to financial protection for the public and the government. The international disease coding, standardizing the adjudication of claims, and integration of key stakeholders for real-time information exchange are the prerequisites.

I urge all stakeholders in the insurance sector and healthcare sector to join hands and work together for creating an adequate healthcare sector which is able to serve the healthcare needs of public, and contribute to fulfilling the constitutional responsibility of provision of medical relief to the citizens of Pakistan. We remain committed to provide all necessary assistance to contribute to important area of healthcare sector in Pakistan.

AKIF SAEED
CHAIRMAN

COMMISSIONER'S MESSAGE

One of the key governance challenges is fragmented authority over a single subject or area of work. This stands true for the subject of insurance, the ownership of which lies with different ministries and governmental departments. The fragmented ownership contributes to the bottlenecks in effective decision-making & policy implementation. Another area in which this challenge manifests, is the healthcare sector in Pakistan, of which, health insurance is an essential component.

After the 18th amendment to the constitution of Pakistan, the subject of health was devolved to the provinces, among other subjects such as agriculture, transport, and taxation departments. The healthcare sector is governed through the federal ministry, and provincial health departments, in-tandem with the varying institutions with specific mandates such as, Pakistan Medical & Dental Council (PMDC), provincial Healthcare Commissions, Pakistan Health Research Council (PHRC), National Institute of Health (NIH), among others. While the dedicated institution for specific purposes is expected to foster development in each focus areas, none can operate in silos and integration and robust coordination among these is prerequisite for achieving the sector-level objectives.

It is in this backdrop, I am pleased to present a detailed report on healthcare ecosystem in Pakistan highlighting the state of healthcare ecosystem, the relevant stakeholders, role of health insurance, market dynamics and performance along with key challenges in the way of sector development and recommendations for optimization of healthcare benefits for the public.

Providing the quality healthcare and medical relief to all citizens is enshrined in the Article 38 of Constitution of Pakistan, hence, a priority area for the country. It is also one of the sustainable development goals (SDG) of the United Nations (UN) and key focus of bilateral and multilateral development agencies. Accordingly, health insurance sector development is one of the operational outcomes of the five-year strategic plan of the SECP launched in December 2023 titled "journey to an insured Pakistan".

The share of accident & health insurance premiums in the total gross written premium of the insurance sector is a meagre 6% in 2023 excluding Sehat Sahulat Program. The SSP constitutes 54% of SLIC's premium and 29% of the total insurance industry premium as per annual financial statements, 2023. First universal health coverage program in Pakistan, the SSP's experience over the years and performance is presented in the light of international standards along-with the recommendations such as enhancement of actuarial and technical involvement in program design. The private health insurance market majorly comprises of corporate/ group health insurance while share of retail market/ individuals in the total private health insurance premium is a meagre 1% (as per 2023 financial statements). The number of individuals covered is not encouraging being less than 10 million in a country of over 240 million people. There is a pressing need to reconsider the group health insurance business model as well as evaluate the market priorities for the retail segment, particularly in terms of potential market expansion and pricing basis.

The health insurance products in Pakistan mostly cover inpatient treatment and exclude doctor's consultation/outpatient, dental, optical, and pharmacy or lab costs. There is significant potential for improvement in terms of coverage for primary care, long-term care products, health insurance products for elderly persons, and simplification of products with minimal exclusions.

For sustainable and comprehensive reforms in the sector, a broad-based holistic national level strategy is required with ownership of all relevant stakeholders. Along with products, underwriting, conduct and administration, development is also needed in terms of integration of healthcare sector through digitalised solutions. A blueprint of digital information exchange is presented in the report as a starting point for stakeholders to deliberate, solidify and proceed towards its materialization.

I would like to re-emphasize that it is a prerequisite to shift the focus on wellness, primary healthcare, convenience and value for money for the common man. Only then the health insurance will serve the purpose of provision of medical relief as enshrined in the constitution of Pakistan.

In the end, I would like to commend the efforts of the Chairman SECP for his focus on health insurance and the Insurance Division, with special thanks to the team behind this report, Mr Falak S. H. Soomro (Advisor Insurance), Ms Sabahat Ul Ain (Additional Joint Director) and Ms. Esha Imran for a comprehensive report on this important area.

MUJTABA A. LODHI
COMMISSIONER INSURANCE

EXECUTIVE SUMMARY

Article 38 of the Constitution of Pakistan enshrines the provision of medical relief to all citizens along with other necessities. However, the public sector expenditure as a percentage of total health expenditure in Pakistan is one of the lowest among the developed and developing countries whilst the country ranks one of the highest in out-of-pocket spending for health expenditures. Overall public health spending remains a meagre 1% of the GDP of Pakistan, with PSDP allocation to the health sector in 2023 set at Rs.25 billion against the total PSDP allocation of Rs.1,150 billion.

Multiple public sector stakeholders in Pakistan's healthcare sector have been working on reforms and improvements in the sector in variable areas such as the Ministry of National Health Services, Regulation & Coordination (MNHSRC), Pakistan Medical & Dental Council (PMDC), provincial health departments and Healthcare Commissions, Pakistan Health Research Council (PHRC), National Institute of Health (NIH), among others. A sound and efficient healthcare ecosystem needs to be built to ensure access to quality healthcare services, management of insurance and financial risks, and alignment of interests of all stakeholders including the government and policymakers, regulators, insurers, hospitals and private sector stakeholders, and the general public.

The primary insurance law allows underwriting of health insurance under the "accident & health" class of business to all entities registered as life and non-life insurance companies under the Insurance Ordinance, 2000. The share of accident & health insurance premiums in the total gross written premium of the insurance sector is a meagre 6% in 2023 excluding Sehat Sahulat Program (SSP), Pakistan's largest health insurance scheme which is funded by the federal and respective provincial governments. This public sector health insurance scheme administered by the State Life Insurance Corporation of Pakistan (SLIC) comprises 54% of SLIC's premium and 29% of the total insurance industry premium as per annual financial statements, 2023.

Under the SSP program, 164 million persons are covered as of 2023 across the country including multiple regions and provinces comprising Azad Jammu Kashmir, Gilgit Baltistan, Baluchistan, Tharparkar district of Sindh, Punjab, Islamabad and Khyber Pakhtunkhwa. The baseline UHC SCI (an indicator of universal health coverage by the World Bank and World Health Organization) was very low at 40 percent for Pakistan in 2015, indicative of poor access and use of essential health services and data issues/ challenges. It has reached a score of 45 in 2021 but remains significantly lower than the average score of 58 amongst lower middle-income countries according to the latest available data in 2021.

The assessment of the private health insurance market reveals that 99% of the health insurance market comprises corporate/ group business and only 1% with the individual/ retail market in terms of gross written premium for the year ended December 31, 2023. Only 31 thousand persons are covered under individual health and 6.5 million persons are covered under group health insurance as per information compiled for the year 2023. The health insurance distribution primarily relies on a direct sales force, or corporate agents and/ or brokers in the group as well as individual health segments while the distribution through digital channels such as mobile network operators, or web aggregators remains minimal.

The group health insurance, primarily distributed by direct sales force and corporate agents/ brokers, is signified by competitive pricing strategies, and above 100% loss ratio throughout the period under review (2019 – 2023). Also, the number of persons covered under group health insurance has decreased from 8.2 million in 2019 to 6.5 million in 2023. There is a pressing need to reconsider the group health insurance business model, particularly in terms of potential market expansion and pricing basis.

Individual health insurance appears financially feasible as the combined ratio (computed as the sum of claims ratio, expense ratio and commission ratio) was 77.2% in 2019, rose to 101.8% in 2022 and settled back to 97.1% in 2023. The insurance companies' interest towards individual health insurance remains minimal as indicated by only a 1% market share of the individual health insurance in the total health insurance market. This may be attributed to insurers' belief that if any person is purchasing health insurance, he may be primarily sick and anti-selecting against the insurer, hence low market share.

The health insurance products in Pakistan mostly cover inpatient treatment and associated costs. This may or may not include maternity coverage after the waiting periods, while the doctor's consultation/outpatient, dental, optical, and pharmacy or lab costs are not covered except during the inpatient treatment and pre/ post hospitalization of up to 30 days. The gaps in health insurance products include the limited policy term (generally one-year), lack of coverage for primary/preventative care, absence of long-term care products, unavailability of any types of health insurance products for elderly persons, long waiting periods, and complicated exclusions specifically the pre-existing conditions.

A standard product with simple terms and minimal or no exclusions needs to be designed for the retail market with a focus on wellness, primary healthcare, convenience and value for money for the common man. Also, products for the elderly and long-term care need to be developed as there is huge unserved market. This can be considered through top-up/add-on products over the standard policy under SSP and employer-employee scheme (group) health insurance products.

In addition to considerations of products, claims administration is an important area in the delivery of healthcare services. The lack of standard operating procedures, absence of standard coding of diseases, variable prices of treatments at different hospitals and healthcare providers, reliance on laborious manual documentation and stringent conditions for seeking treatment such as pre-authorisation and waiting periods, hamper the efficient delivery of service to the policyholders and covered persons. The SECP has undertaken multiple initiatives to improve the health insurance market such as the formulation of Third-Party Administrators for Health Insurance Regulations, 2014, the development of a group health insurance register in CISSII, and submitting a proposal to the Finance Division for the development of Compulsory Occupational Health Insurance (COHI). The joint contribution of market players in every development is a prerequisite to moving the needle.

Healthcare is a priority area for the Government of Pakistan, as well as for bilateral and multilateral development agencies, being one of the sustainable development goals (SDG) of the United Nations (UN). To instigate transformative change in the state of healthcare services and the health insurance market, there is a need for a national-level joint strategy to be developed in collaboration with provincial bodies and ancillary stakeholders. Progress tracking and evaluation for any project or reform initiative should be conducted from a centralised forum. The transformation of the health

For the health insurance sector, the option to establish the digital information exchange is to be explored by the insurance companies and healthcare providers to remove administrative inefficiencies from the current health insurance claims administration. The system will serve as an information exchange on which information of all covered persons, policies and claims will be available with standardised coding and classification. The integrated Healthcare Information Exchange is expected to connect healthcare providers (hospitals, laboratories, registered clinics), payers (government, insurance company, other entity) and beneficiaries (as needed) for sharing and accessing information relating to covered persons, eligibility, pre-authorisation, and health insurance claims to improve administration and bring efficiency therein.

At a later stage when the integrated healthcare exchange system has reached a certain level of maturity and user experience has developed, the scope of the system can be enhanced through ownership of Federal and provincial policymakers on the lines of casemix usage in other jurisdictions and recent value-based healthcare initiative of the KSA, as illustrated in the report.

The report is concluded with recommendations in the area of product development, conduct and claim administration and the actions required from the regulators and policymakers. A tentative action matrix is also presented to engage the insurance industry stakeholders and health sector policymakers for collaboration on a joint strategy for reform initiatives.

1. HEALTHCARE ECOSYSTEM IN PAKISTAN

1.1 BACKGROUND

Three key principles of any healthcare policy globally are:

1. Better healthcare for patients
2. Improved health of the population
3. Lower Per Capita Costs and Financing for Healthcare Services.

These objectives are often in conflict with each other for various stakeholders in the ecosystems. For instance, the government and policymakers want better healthcare, improved health of the population and lower costs, but the insurance companies and other healthcare providers may be more focused on cost reduction and commercial success. The population, on the other hand, want to reduce healthcare costs whilst looking for the best healthcare services. A sound and workable ecosystem needs to be built to ensure access to quality healthcare services, management of insurance and financial risks, and alignment of interests of all stakeholders.

Ensuring public health is essential for building a thriving society and driving economic prosperity. Under Article 38 of the constitution of Pakistan, the Government of Pakistan is required to secure the well-being of the people and provide the necessities of life including medical relief. However, the public health expenditure remains a meagre 1% of the GDP of Pakistan and PSDP allocation to the health sector was set at Rs.25 billion against the total PSDP allocation of Rs.1,150 billion. (Pakistan Economic Survey, 2023 - 24). The public sector expenditure as a percentage of total health expenditure in Pakistan is one of the lowest among the developed as well as developing countries whereas Pakistan ranks one of the highest in out-of-pocket spending for health expenditures. The synopsis of a few comparable countries is as follows:

COUNTRY	Public Spending on Health	Out-of-Pocket Spending
GERMANY	80%	10%
CANADA	71%	15%
INDONESIA	52%	33%
CHINA	55%	33%
MALAYSIA	50%	38%
INDIA	39%	46%
SRI LANKA	40%	40%
PAKISTAN	38%	47%

Source: Global health expenditure database of the World Health Organization (2022)

1.2 STATE OF HEALTHCARE ECOSYSTEM IN PAKISTAN

The Healthcare ecosystem is a complex network of interconnected stakeholders with distinct roles in the provision of healthcare services. Each stakeholder in the healthcare system plays a significant role in ensuring accessibility, affordability, and quality of healthcare systems for individuals and communities.

Year	No. of Hospitals	[1]BHUs	Maternity & Child Centres	Rural Health Centres	TB Health Centres	Total Beds	Registered doctors	Registered Nurses
2019	1282	5,472	752	670	412	133,707	233,261	112,123
2020	1289	5,561	752	719	410	147,112	245,987	116,659
2021	1276	5,559	781	736	416	146,053	266,430	121,245
2022	1284	5,520	798	697	417	151,661	282,383	127,855
2023	1284	5,520	798	697	417	151,661	299,113	127,855

Source: Pakistan Economic Survey, 2023-24 (Table 11.1 and 11.2)

A synopsis of multiple stakeholders and their responsibilities can be summarized in the table below, however, the roles and responsibilities need to be thought through in an interconnected approach to ensure that the ecosystem can be integrated to achieve the three broad objectives of any healthcare policy.

Stakeholder	Responsibilities
POLICYMAKERS/ REGULATORS[2]	• Healthcare Regulator: Ensure consumer protection, fair practices, and compliance with healthcare laws • Insurance Regulator: Establish and enforce laws, regulations, and guidelines for the insurance industry • Monitor and evaluate the performance and quality of the health insurance companies
HEALTHCARE PROVIDERS – HOSPITALS, LABORATORIES, PHARMACIES, BLOOD-BANKS	• Deliver medical services and treatments to patients • Verify insurance coverage, submit claims, and receive payments • Adhere to regulatory guidelines and protocols.
INSURANCE COMPANIES	• Provide health insurance plans to individuals and employers • Determine coverage levels, premiums and network of providers • Process claims, handle reimbursements, and manage financial risks.

[1] Basic Health Unit (BHU) is a public sector facility that provides primary health care (PHC) services in rural Union Council and serves 5,000 to 10,000 people over an area of 15-25 square miles.
[2] Federal and provincial policymaking/ regulatory bodies including the Ministry of National Health Services, Regulations and Coordination, Provincial Health Departments, Provincial Healthcare Commissions, Drug Regulatory Authority of Pakistan, Pakistan Medical and Dental Council etc.

TECHNOLOGY PROVIDER - NADRA, PAKISTAN BUREAU OF STATISTICS, TELEHEALTH SERVICES AND PLATFORMS, ETC.	• Support innovation and digital transformation in the health insurance sector • Develop and maintain software solutions for processes, such as claims management, data analytics, customer portals, and global healthcare monitoring systems such as Health Insurance Networks and Claims Exchanges etc. • Improve efficiency, accuracy and transparency for insurance operations
EMPLOYERS	• Offer health insurance benefits to employees • Select insurance plans, negotiate premiums, and educate employees on coverages • Administer enrollment, manage premiums and contributions, and facilitate claims processing
PATIENTS	• Purchase health insurance plans and pay premiums • Seek medical care from healthcare providers • Understand their coverage, rights, and responsibilities

After the 18th Constitutional Amendment, the health sector was devolved to the provincial governments, but the federal government still funds sector projects through PSDP. The Federal government funds the healthcare sector projects to be implemented by the Ministry of National Health Services, Regulation & Coordination (NHSR&C), the Defense Division, the Pakistan Atomic Energy Commission (PAEC)[3] , and federal projects of a provincial nature and special areas by the respective provinces. Presently, the Ministry of NHSR&C is sponsoring 40 health sector projects with an estimated total cost of Rs 148 billion[4] .

Few of the federal and provincial stakeholders entrusted with healthcare sector development, policy-making and reforms are as follows:

Entity	Role
MINISTRY OF NATIONAL HEALTH SERVICES, REGULATION & COORDINATION (MNHSRC)	Federal health ministry
PAKISTAN MEDICAL & DENTAL COUNCIL (PMDC)	Regulator of medical education, medical and dental practitioners & medical students countrywide (doctors & dentists)
PAKISTAN HEALTH RESEARCH COUNCIL (PHRC)	Conducts and promotes research in public health and medical sciences to support evidence-based policymaking

[3] The PAEC is actively involved in cancer awareness, prevention, diagnosis and treatment including establishment of cancer hospitals nationwide equipped with advanced technology.
[4] PES, 2023 - 24

NATIONAL INSTITUTE OF HEALTH (NIH)	Provides multi-disciplinary technical, administrative and health facilities such as disease surveillance, research, and training in health-related fields
HEALTH SERVICES ACADEMY (HSA)	Provides postgraduate education and training in public health, conducts research, and advises on health policies
DRUG REGULATORY AUTHORITY OF PAKISTAN (DRAP)	Oversees the registration, quality control, and regulation of drugs & medical devices
HEALTH DEPARTMENTS IN THE PROVINCES	Healthcare policy-making in the provinces
HEALTHCARE COMMISSIONS IN THE PROVINCES	Hospitals regulator in the provinces
PROVINCIAL HEALTH DEVELOPMENT CENTRE	Train healthcare workers and support the implementation of health programs at the provincial level

As per NHA 2021-22 issued by the Pakistan Bureau of Statistics (PBS), there are four main types of financing for healthcare: Government (through taxes), social insurance (through payroll, taxes or direct contributions), private insurance and out-of-pocket (OOP). The first three types are pre-paid financing mechanisms and have some form of risk pooling. OOP is the most inefficient, inequitable and regressive form of healthcare financing. However, it is the most crucial component of healthcare financing in most developing countries. The health financing mechanism mainly depends on the country's economic status. The poorer the country, the more dependent it is on out-of-pocket payments.

In Pakistan, out of total health expenditures, 47% is made by general government agents which include the social security, Zakat, Baitul Mal and Autonomous bodies/Corporations' health expenditures as well. Private expenditures constitute 52.6% of total health expenditures in Pakistan, out of which 89% are households' OOP spending. The share of development partners/donor organizations in total health expenditures is almost 0.4%.

The total public sector spending on healthcare during the last year is as follows:

2023-24 Spending	Amount in PKR Million
FEDERAL	**35,892**
PUNJAB	**450,610**
SINDH	**204,632**
KP	**122,348**
BALUCHISTAN	**29,697**
PAKISTAN	**843,179**

Multiple public sector stakeholders in Pakistan's healthcare sector have been working on reforms and improvements in the sector in variable areas. A few important work areas by the important stakeholders need to be mentioned here:

1. National Health Vision 2016-2025 by the Ministry of NHSRC
2. Essential Package of Health Service (EPHS) prepared in 2020 by the Ministry of NHSRC with technical assistance from WHO and Disease Control Priority 3 (DCP3)
3. Health-related Intersectoral Interventions Action Plan 2021-30 by the Ministry of NHSRC
4. National Digital Health Framework 2022- 2030 by the Ministry of NHSRC

The National Health Vision 2016 – 2025 states the vision statement as follows:

To improve the health of all Pakistanis, particularly women and children by providing universal access to affordable, quality, essential health services which are delivered through a resilient and responsive health system, capable of attaining the Sustainable Development Goals and fulfilling its other global health responsibilities.

Box 1: The National Health Vision 2016 - 2025 builds its narrative on eight thematic pillars to ensure access, coverage, quality, and safety— essential requisites for achieving the ultimate goal of universal health coverage (UHC) in Pakistan. These will form the basis of the over-arching technical support from the federal government towards the provinces to achieve the national health vision.

1. Good governance of federal and provincial health authorities encompassing building, stewardship, innovative management and strategic planning and accountability mechanisms
2. Health financing from the federal as well as provincial government along with fiscal discipline and resource mobilisation so as to meet the needs of healthcare priorities, pro-poor social protection initiatives, universal health coverage.
3. Packaging of health services to be improved by widening of essential service packages and improvement of coverage and functionality, which is also disaster resilient.
4. Focus on human resources in health by improving the medical and health related education including development of comprehensive national HR, nursing, and allied health work force strategies.
5. Health information system and research by use of innovative technologies for creating health database which can enable evidence-based decision-making and resources allocation including development of central hub for information repository, integrated disease surveillance and response system and collaborative mechanism for high-quality research on national priority areas.
6. Focus on essential medicines and technology through developing health technology assessment (HTA) capacity at federal and provincial levels and develop standard treatment guidelines based on international standards including drug pricing policy.
7. Creating cross sectoral linkages by promoting the concepts of "One Health" and "Health in all Policies" and develop a common vision and framework with variable stakeholders such as population, education, food security, agriculture and livestock, housing, sanitation, water, environment, and disaster management.
8. Global heath responsibilities to be pursued and reflected in all health policies including the sustainable development goals (SDG), integrated disease surveillance and response, polio eradication, among others.

However, the degree of progress in pursuance of this vision at the end of 2024 can be deliberated by the Ministry of NHSRC or the health departments in the provinces.

1.3 OBJECTIVE

In this backdrop, the report is expected to address the following areas:

- To illustrate the health insurance market performance in terms of market share distribution, premium, claims, loss ratios, pricing
- To identify issues in the health insurance products – coverage, benefits and propose solutions thereto
- To explore the conduct issues in health insurance and propose solutions vis-à-vis claims management SOPs
- To explore gaps and issues in healthcare ecosystem management/ integration and propose tangible solutions including digital integration thereof

2. HEALTH INSURANCE MARKET IN PAKISTAN

The Insurance Ordinance, 2000, the primary insurance law, allows underwriting of health insurance under the "accident & health" class of business to all entities registered as life and non-life insurance companies. The share of premiums in accident and health class of business out of total industry premiums stands at a meagre 6% in 2023, excluding Pakistan's largest health insurance scheme which is funded by the federal and respective provincial governments. The public sector health insurance scheme administered by the State Life Insurance Corporation of Pakistan (SLIC) comprises 54% of SLIC's premium and 29% of the total insurance industry premium as per year-end 2023 financials.

Gross Premium	Non-Life		Life Insurance		
(PKR billion)	ACCIDENT & HEALTH	TOTAL	ACCIDENT & HEALTH*	STATE LIFE (SSP)	TOTAL
2023	25	227	14	181	404
2022	22	178	7	147	372

*private sector life insurance

As health insurance is offered by both, the major private sector market share is captured by Jubilee Life, Adamjee Insurance and EFU Life. The only dedicated health insurance company, EFU Health Insurance Company has been acquired by and merged into EFU Life in April 2024 to offer a full suite of life-related insurance products, resulting in no dedicated health insurance company operating in Pakistan.

2.1 SEHAT SAHULAT PROGRAM

The Sehat Sahulat program in KP, Punjab, Sindh, Balochistan, Gilgit Baltistan (GB) and Azad Jammu Kashmir (AJK) offers health insurance benefits through the State Life Corporation of Pakistan, comprising basic health coverage to families in defined provincial jurisdictions. The program started in 2015 in KP in selected districts and expanded to cover the entire population of the province in 2020. Under this program, residents can avail the treatment of up to Rs. 1 million per family per year in all the empanelled public and private hospitals of the KP. The program was also launched in Punjab in 2016 in 13 districts and later expanded to all districts of Punjab in 2021. The per family limit for secondary and priority care for 8 priority diseases is approximately 1 million in Punjab though the coverage is expanded from low-income persons to all permanent residents of Punjab in 2022. The program is also implemented on limited scale in Islamabad, Sindh, AJK, Gilgit Baltistan and Balochistan.

Province	Coverage	Enrolled People
AZAD JAMMU KASHMIR	Only low-income population	5.03 million
SINDH	Tharparker (low-income)	1.27 million
GILGIT BALTISTAN	Only low-income population	0.94 million
BALOCHISTAN	Only low-income population	8.11 million
ISLAMABAD	Only low-income population	0.89 million
KHYBER PAKHTUNKHWA	Covers 100% of the population	38.61 million
PUNJAB	All permanent residents of Punjab	109.30 million
Total		**164.15 Million**

Source: (State life submitted data)

Providing universal health coverage to the entire population in a resource-constrained country is an ambitious and less practical choice as the vulnerable population remains underserved due to resource allocation which is equal but not equitable.

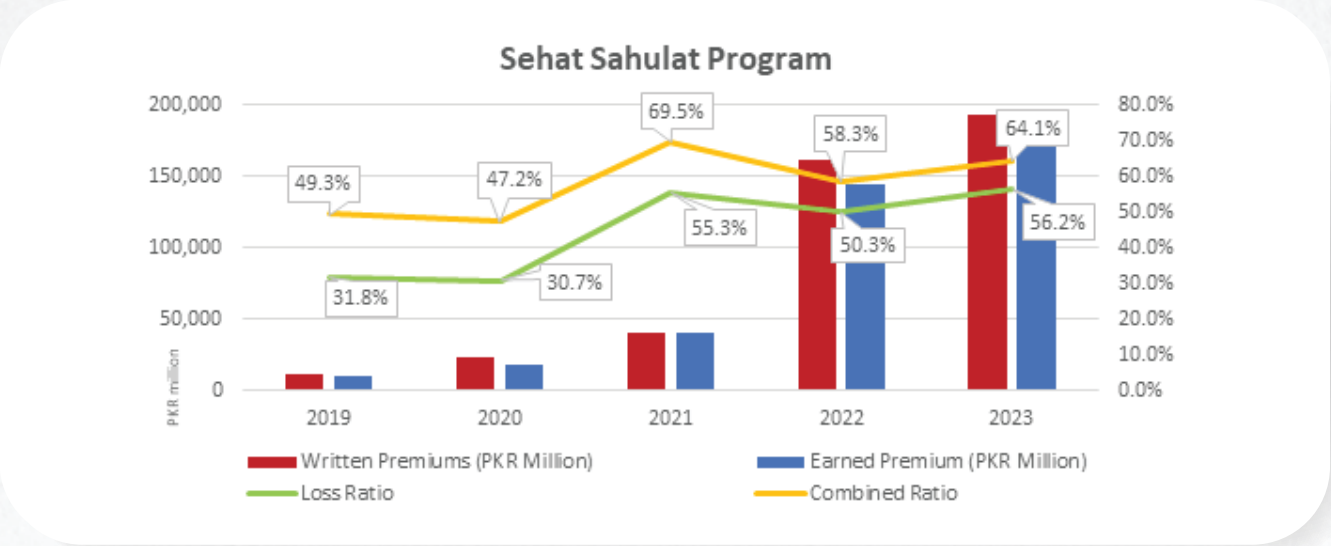
Box 2: The universal health coverage (UHC) prioritizes four groups of integrated essential health care services at all five levels of health care delivery system (i.e., community, primary healthcare centre, first level hospital, tertiary hospital and population levels) and through both public and private sectors, to address the burden of diseases in an effective and efficient way. An indicator of universal health coverage is UHC Service Coverage Index (SCI) which is a composite indicator and is defined as the average coverage of essential health services based on sixteen tracer interventions in four groups that include

a) Reproductive, maternal, new-born, child and adolescent health & nutrition
b) Infectious diseases
c) Non-communicable diseases
d) Service capacity and access

According to the WB and WHO, the baseline UHC SCI for Pakistan in 2015 was very low at 40 percent, indicative of poor access and use of essential health services and data issues/ challenges. It has reached score of 45 in 2021 but remains significantly lower than the average score of 58 amongst lower middle-income countries according to latest available data in 2021.
Source: Health Financing Progress Matrix assessment Pakistan 2023 by the WHO

As per the annual financial statements of the State Life Insurance Corporation (the "SLIC"), the experience refund premium amounts to Rs. 69 billion for the year 2023 which means that out of the total gross written premium, Rs.69 billion was returned by the SLIC to the government as per the agreement.

The numbers provided by the SLIC reflect adequate margins and hence experience refund is made to the government.



The claims ratio computed based on information provided by the SLIC, has increased from 31.8% in 2019 to 56.2% in 2023 while the expense ratio has decreased from 17.5% in 2019 to 7.9% in 2023. As there are no commissions in the SSP, the combined ratio only comprises of claim ratio and expense ratio. The claims and expense ratios reflected here are determined before the consideration of experience refunds.

In view of ensuring the efficient implementation, benefits improvements, and enhanced utilization amidst the continuation of the program, independent monitoring and evaluation of the program in terms of administration, governance, utilization as well as coverage and pricing needs to be done on a regular basis. To optimize the benefits for public under the health insurance, the private sector participation could be encouraged through the top-up/add-on coverage over the standard policy under SSP and employer-employee scheme (group) health insurance products.

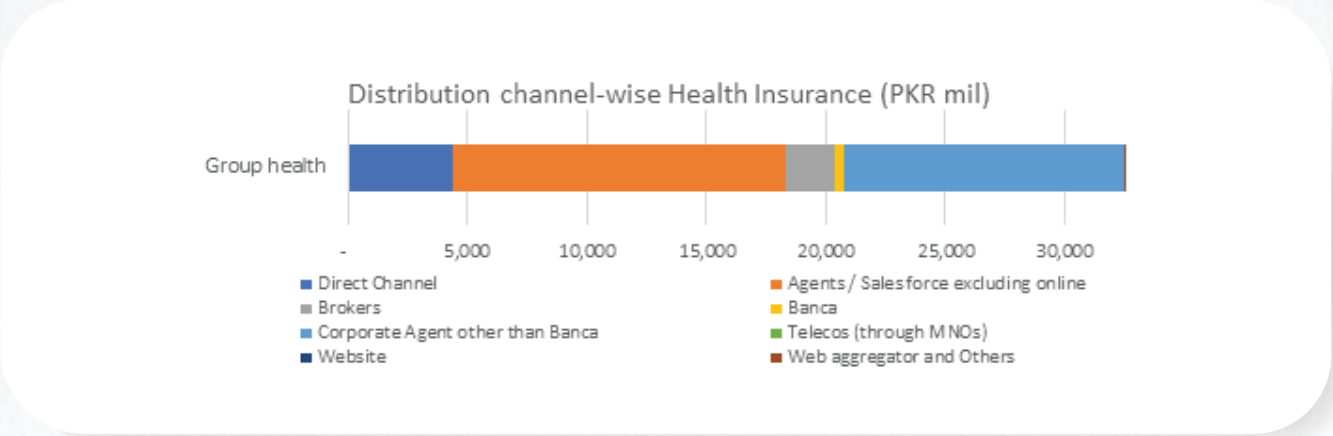
2.2 PRIVATE HEALTH INSURANCE MARKET

Information on the health insurance business was collected from the life and non-life insurance companies writing the health insurance products for the 5 years spanning 2019 to 2023. In this analysis, we have included 6 life companies and 14 non-life companies based on their market share in terms of gross written premium and also based on the availability of information from the companies. The companies included in the analysis comprise 90% of the market share in terms of premium in the total accident and health class of business for the year 2023 (excluding the Sehat Sahulat program).

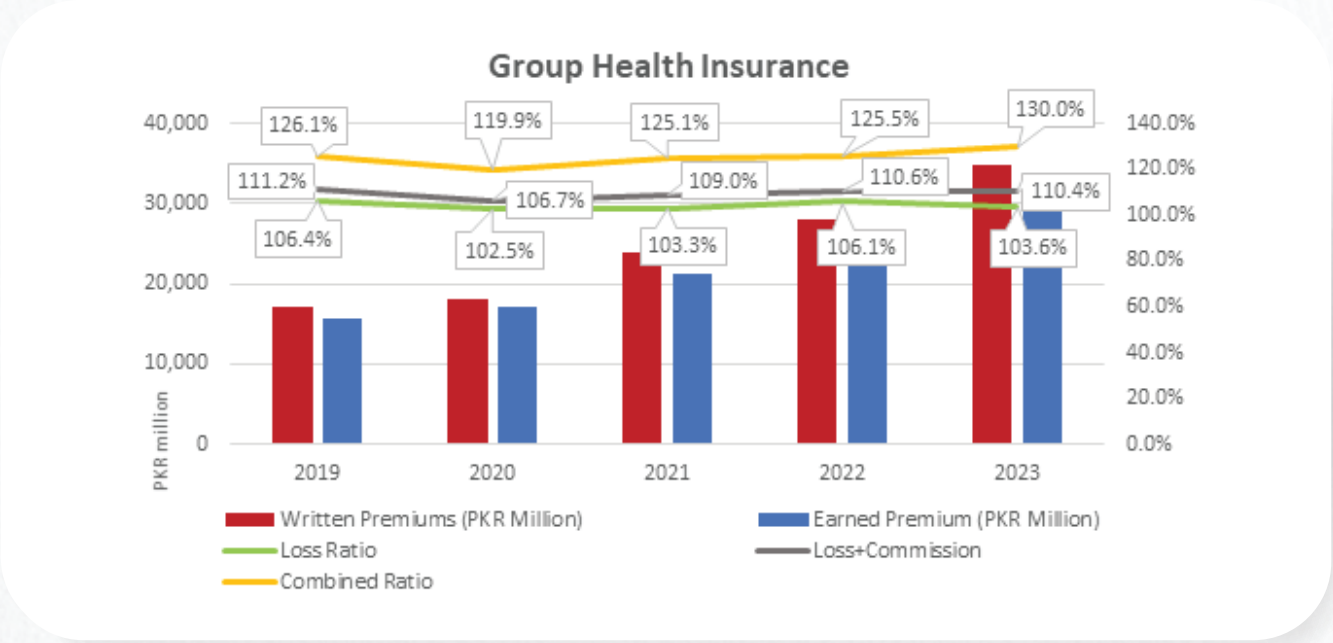
Based on the information collected, 99% of the health insurance market comprises corporate/ group business and only 1% with the individual/ retail market in terms of gross written premium for the year ended December 31, 2023. The premium written under individual health is Rs.328 million and the premium written under group health insurance is Rs.34,877 million for the year 2023. Only 31 thousand persons are covered under individual health and 6.5 million persons are covered under group health insurance as per information compiled for the year 2023. The number of persons covered under group health insurance has decreased from 8.2 million in 2019 to 6.5 million in 2023. Though the group insurance premium has increased from Rs.17.1 billion in 2019 to Rs.34.8 billion in 2023, the increase is only inflationary due to the rise in the cost of healthcare services/ treatment and eventually the health insurance premium.

2.2.1 GROUP HEALTH INSURANCE

The group health insurance distribution primarily relies on a direct sales force, or corporate agents and/ or brokers while the distribution through digital channels such as mobile network operators, or web aggregators remains minimal. The details as per 2023 information are illustrated below.



Source: Information submitted by the industry under Circular 31 of 2021
"Performance Information on Annual Basis"



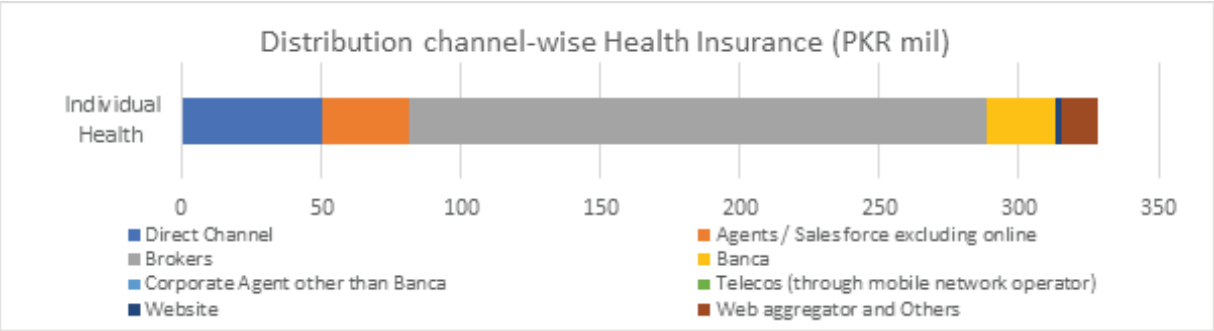
Source: as per information collected from the insurance companies

As per the assessment, the loss ratio over 5 years has slightly decreased from 106.4% in 2019 to 103.6% in 2023 in the group/ corporate health insurance. The expense ratio has witnessed an increase from 14.8% in 2019 to 19.7% in 2023. The group health business has been loss-making for the insurance companies as reflected in the graph above. This may be attributable to packaging of health business with other lines of business by the insurance brokers and cross-subsidization of the premiums resultingly leading to inadequate premium rates for health segment being charged. .. However, unlike individual/ retail health insurance, the major contributor to a combined ratio in the group health insurance business is claim cost and the expenses and commissions worsen this further.

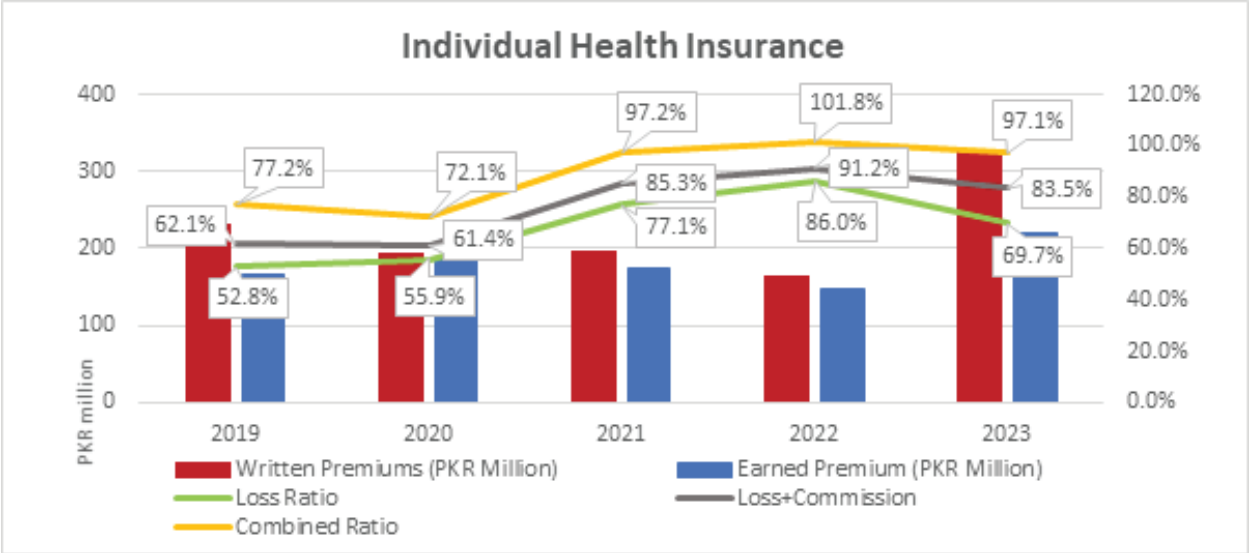
On the claims side, 78,066 claims are outstanding in the group health insurance business compared to 822,830 settled claims as of the year ended 2023. This indicates that outstanding claims are approximately 9.5% of the settled claims, reflecting a high settlement rate through quick claims development and payment patterns along with efficient processing for the majority of claims. On the contrary, there are 431 outstanding claims compared to 1,420 settled claims in the individual health insurance.

2.2.2 INDIVIDUAL HEALTH INSURANCE

Individual health insurance distribution primarily relies on a direct sales force, or brokers while distribution through digital channels such as websites, mobile network operators, or web aggregators remains minimal. The details as per 2023 information are illustrated ahead.



Source: Source: Information submitted by the industry under Circular 31 of 2021 "Performance Information on Annual Basis"



Source: as per information collected from the insurance companies

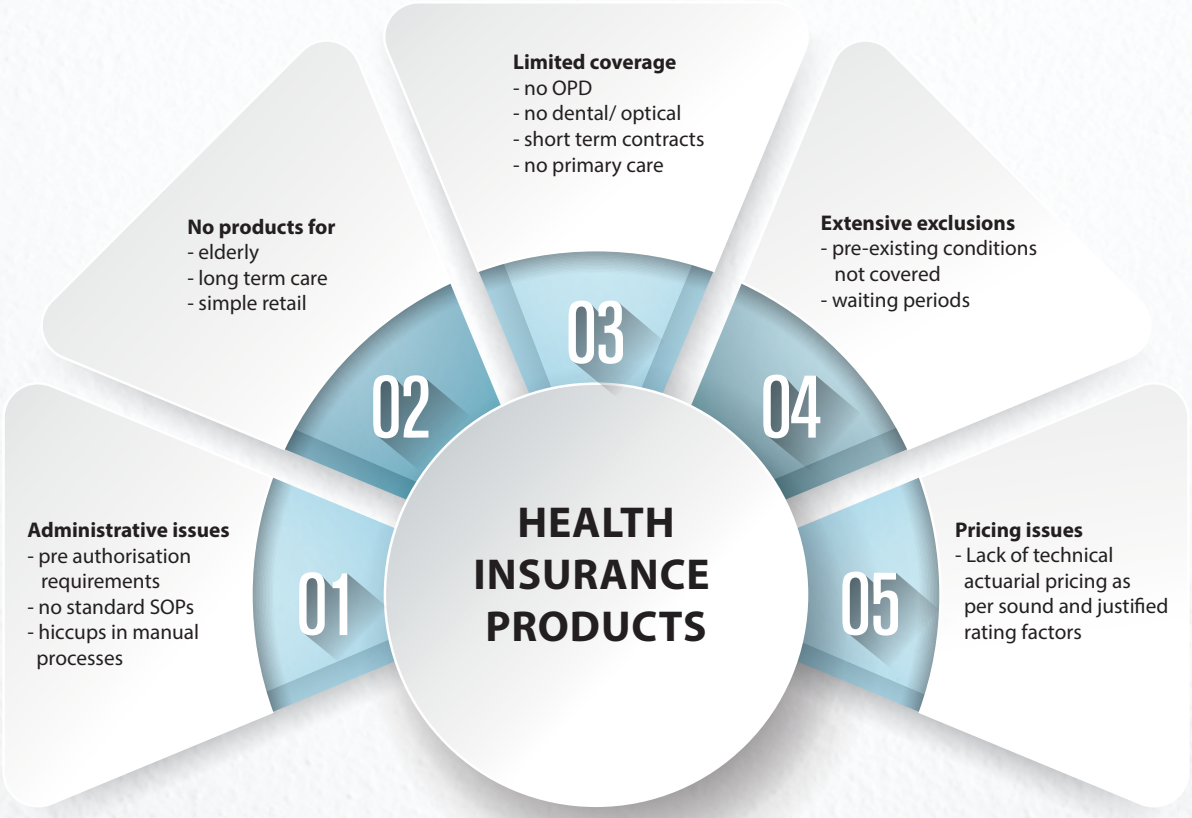
The combined ratio computed as the sum of claims ratio, expense ratio and commission ratio, was 77.2% in 2019, rose to 101.8% in 2022 and settled back to 97.1% in 2023. The major component of the combined ratio is the loss ratio which has increased from 52.8% in 2019 to 69.7% in 2023 due to rising medical and drug inflation costs. Though the expense ratio, loss ratio and combined ratio in individual health insurance are lower in comparison to the group health insurance (because of adequate utilization), the insurance companies' interest towards individual health insurance remains minimal as indicated by only 1% market share of the individual health insurance in the total health insurance market.

The following conclusions are made based on the above analysis:

1. The retail market is disadvantaged and underserved in the dynamics where the insurance companies do prudent pricing, and have adequate margins though the share of individual health insurance premiums in total industry premiums is a meagre 1%.
2. Group health insurance loss ratios have consistently exceeded 100% (103.6% in 2023), indicating that claims exceed premiums.
3. While the group health insurance business model relies on large volumes and risk pooling, sustained losses question its long-term feasibility. Insurers must revisit pricing strategies to align premiums with burning costs and focus on organically growing the group health insurance market in a sustainable manner.

Generally, all the health insurance products need to be in sync with one another, starting from universal health insurance (such as SSP) offering basic health care products on a sustainable basis and covering basic health care services, group insurance products providing sustainable but better health care products for the employees, putting the lowest burden on the retail products which shall cover the individual health care coverage at the optimal benefits structure according to affordability of population.

2.3 HEALTH INSURANCE PRODUCTS IN PAKISTAN



Health insurance products in Pakistan mostly cover inpatient treatment and associated costs only with a minimum in-hospital stay. This may include maternity cover after the waiting periods while the doctor's consultation/ OPD, and pharmacy or lab costs are not covered except during the inpatient treatment and pre/ post hospitalization of up to 30 days max. The dental and optical coverage products are minimal. However, primary care in the form of preventative care/ disease prevention, general physician consultation and all outpatient costs are excluded. This is applicable both in the case of private sector health insurance products as well as the public sector Sehat Sahulat program and its extensions in the provinces. Also, the health insurance products are mostly one-year contracts renewable on an annual basis and therefore, lack the long-term focus on health and wellness as there are not many long-term health insurance and care products available in the market, leading to a disconnected relationship between policyholder and insurer.

Critical illness coverage is available generally in the form of riders with life insurance products, and also on a standalone basis though the element of long-term care is missing. Another issue is the exclusion of pre-existing conditions from most products which is aggravated by lack of multi-year or long-term contracts. Even if pre-existing conditions are covered, there is a waiting period of 30-90 days which makes it difficult for policyholders/ covered persons to avail of benefits and improve their health.

Another issue is the difficulty in obtaining health insurance for elderly persons as there is an age limit of up to 60 years for most products. This population segment is restricted in Pakistan, despite increased longevity and need for health insurance coverage as mostly higher ages are generally charged higher rates according to insurance cost curves as per international experience.

The retail health insurance products prices range from Rs.9,000 to 15,000 per person for an annual cover limit of Rs.250,000 to 500,000 however, the exclusion of pre-existing conditions, extensive waiting periods, absence of primary care and short-term nature of product significantly dilute the benefits for the beneficiaries/ policyholders. Some terms and conditions of insurance companies are specifically cumbersome and less practical such as the requirement to inform the insurance company 48 hours before admission to the hospital which is not doable in most cases due to urgency arising out of the health condition of patients. Though telehealth or digital health solutions like Sehat Kahani, Webdoc etc. have contributed to filling the gap for primary healthcare by providing digital consultation with doctors, the utility of these solutions for consumer wellness and the impact in terms of reduction in the burden of disease is yet to be explored.

The above analysis of health insurance products suggests that consumer benefits and wellness considerations often take a back seat, rather than serving as core drivers in the design, coverage, and overall value of these offerings.. . The value proposition could be one of the reasons for low interest in the retail market for health insurance products as individuals are not able to see value for the money that they need to pay to purchase the health insurance product. The complicated and extensive exclusions further trim down the benefit that consumers seek. Furthermore, there is a substantial need to introduce no-claims discounts to promote the health insurance product, reduce the premiums and maintain health coverage for those in good health hence maintaining policyholder retention.

Another area of focus is technical actuarial pricing according to sound and justified rating factors to attract policyholders from different areas of pricing according to socio-economic factors (product segmentation and class and business segmentation), demographics (urban and rural distinction, male-female differential rating, age-group segmentation), treatment level and various other rating factors, which are non-prevalent in the market. There is a need for inclusive and comprehensive coverage health insurance product which focuses on wellness with the provision of primary healthcare including outpatient coverage, disease prevention as well as long-term care in case of critical illness. Also, the simple and standard product for individuals/ retail market needs to be designed with a focus on wellness, primary healthcare, convenience and value for money for the common man.

2.4 HEALTH INSURANCE CLAIMS ADMINISTRATION & CONDUCT ISSUES

In addition to the complicated and extensive exclusions, stringent policy terms and waiting periods, and lack of focus on primary care, one of the major hiccups in the delivery of healthcare is the cumbersome and lengthy paper-based process of claims. Though most of the insurance companies have panels of hospitals for the cashless delivery of healthcare services, complicated forms, long waiting times, pre-authorization requirement and lack of standardization in claim process create difficulty for the individuals during their health emergencies. The service quality and conduct considerations are elaborated in the section below.

2.4.1 AGREEMENT BETWEEN HOSPITALS AND INSURERS

One major issue is the lack of standardization in service level agreements (SLAs) relating to the quality of service and costs of treatments for different diseases between insurance companies and hospitals. There is no national-level standardization in service delivery standards. Though the provincial Healthcare commissions have issued the minimum service delivery standards (MSDS), these do not address the cost of treatments and the degree of compliance thereto remains ambiguous.

The Punjab Healthcare Commission issued the (draft) Pricing of Healthcare Services Regulations 2021 for public comments which state, among other things, the following:

1. Establishment of pricing cell/ department in the healthcare commission
2. Notifying framework for conducting the activity-based costing for healthcare services
3. Requirement for hospitals to undertake activity-based costing for all healthcare services provided by it
4. Limit of 25% profit margin to the cost determined through the activity-based costing
5. Requirement to obtain approval of cost of healthcare services by each hospital/ healthcare establishment
6. Power of the healthcare commission to require the hospital to charge any price determined by it, if deemed appropriate and revision of such price from time to time

However, the information on the enactment of these Regulations is not found. Similar requirements are stated in the (draft) Islamabad Healthcare Regulatory Authority Regulations, 2022 issued for public comments, but there is no information on the promulgation thereof. The same is the case with Sindh, Baluchistan and KP Healthcare commissions/ Departments.

Variable service quality, different or speculative costs, and minimal checks on quality and pricing not only affect the pricing of health insurance products but also the quality of service that the patients receive and eventually, their wellness levels.

There is a pressing need for the development of a simple, standardized product with minimal or no exclusion, and a straightforward claims process with no waiting or prior intimation/ pre-authorization requirements.

2.5 TAXATION ISSUES

The Sales Tax on services was devolved to provinces vide the 18th constitutional amendment in 2010. Before this, life and health insurance were exempt from the sales tax and the Federal Board of Revenue (FBR) also encouraged purchasing insurance by allowing the tax rebate on life insurance premiums. However, after the devolution of sales tax to the provinces, life and health insurance became subject to sales tax despite efforts of the SECP for the continuation of historic exemptions. The Sindh Revenue Board (SRB) had been issuing annual exemptions for life and health insurance until the withdrawal of exemptions in 2023-24. Other provinces also levied sales tax such as 15% in Baluchistan and KP while the Punjab levied sales tax of 16%. Meanwhile, the KP and Punjab issued exemptions for the social health insurance services vide notification issued in 2016 and 2018 respectively, though for private insurers, the sales tax remains applicable. At present, the sales tax is applicable on health insurance as follows (tax year 2024-25):

Region	Applicable Tax
BALUCHISTAN	15% on both individual and group health insurance
SINDH	15% on group health insurance, certain relaxations to individual category
KHYBER PAKHTUNKHWA	10% on all health insurance including the Sehat Card Plus
PUNJAB	16% on group health insurance; individual health insurance exempt
ISLAMABAD (ICT)	NIL
FEDERAL GOVERNMENT	Life & health insurance are specifically exempt from Federal Excise Duty

The SECP regularly submits tax proposals to the tax authorities with recommendations to exempt personal lines insurance from the sales tax including health insurance. The Insurance Reforms Committee formed by the Ministry of Commerce and headed by Dr. Shamshad Akhtar, ex-Finance Minister, also recommended the removal of tax on health insurance as it increases the cost of insurance and eventually, makes healthcare expensive for the population. An extract from the report of the Insurance Reforms Committee prepared in CY2020 reads as follows:

"Health insurance serves as an alternative to government-sponsored welfare programs. In developing countries like ours where the government faces various challenges on other fronts, the private sector comes forth to assist in some of the government's objectives and health insurance is one of those areas.

Health insurance relieves pressure on the social welfare system by insurance companies coming forward to provide hospitalization benefits to the policyholders. By far and large, governments around the world acknowledge this by granting tax benefits to the health insurance policyholders."

Variable service quality, different or speculative costs, and minimal checks on quality and pricing not only affect the pricing of health insurance products but also the quality of service that the patients receive and eventually, their wellness levels.

There is a pressing need for the development of a simple, standardized product with minimal or no exclusion, and a straightforward claims process with no waiting or prior intimation/ pre-authorization requirements.

2.6 SECP INITIATIVES RELATING TO HEALTH INSURANCE

2.6.1 THIRD-PARTY ADMINISTRATOR FOR HEALTH INSURANCE REGULATIONS, 2014

The SECP issued the Third-Party Administrator for Health Insurance Regulations, 2014 to formalize the third-party claim administrators and regulate the conduct of business in health insurance claims administration. At present, there are five (5) third-party administrators registered under the TPA for Health Regulations, 2014 though the impact on the health insurance market in terms of improvement in quality of services and convenience in customer journey could not be found. The health insurance expenses particularly for individual policyholders have remained significant throughout the 5 years under review (2019 – 2023) and the share of the retail market remains a mere 1% in the total health insurance market.

2.6.2 GROUP HEALTH INSURANCE CLAIMS REGISTER IN CISSII

The Centralized Information Sharing Solution for Insurance Industry (CISSII) was formed through the regulatory impetus of the SECP in 2014 to enable insurance companies to make informed decisions in terms of underwriting, pricing and fraud prevention based on information relating to group life claims experience, declined and postponed risks, agents' register, and early death claims.

The CISSII was expanded to include the group health insurance claims register which enables access to industry-wide information on accounts/ policies with a group size of at least 1000 lives and a loss ratio of 90% or above. This was aimed to bring transparency in pricing and prevent price manipulation in group health insurance. All life and non-life insurance companies engaged in underwriting group health insurance business were required to be part of this solution and share information thereon. The required group size was reduced to 500 lives and the cut-off moved from 90% to 80% pure loss ratio in 2021.

As the CISSII was envisioned as an industry-based forum to facilitate insurance companies in making informed decisions, the SECP does not monitor information reporting on the system or the accuracy thereof. However, the industry's contribution and use of this facility remains dubious as the information is not regularly reported by the insurance companies and predatory pricing in group health insurance continues.

The SECP may reconsider the voluntary reporting and use of information on the CISSII register and may notify, as part of pricing and underwriting requirements and practices for health insurance and include affirmations from all stakeholders involved including the policyholders, to include the last three years' historical experience of the account in the pricing and ensure underwriting, not below the burning cost based on historical experience as reported on the CISSII. The approach to such actions would be to mandate all parties involved in underwriting, i.e. the group customer/client, insurance brokers, the current insurer and the prospective insurer, to give an undertaking that information shared between the parties is final and accurate, according to past three years' experience, and in the desired format of the SECP instructions, such that information is not falsified and misquoted,

carrying weight of legal repercussions on all stakeholders in case of such activities are found to be true. This practice is not new and is prevalent in developed group insurance markets such as KSA (covering motor, health and group life protection) resulting in market stabilisation and growth.

Further, the information to be reported on the CISSII may be enhanced to include other relevant information fields as follows:

Category	Data Fields
DEMOGRAPHIC & COVERAGE DATA	1. Industry/ Sector 2. Age distribution of insured members 3. Gender distribution 4 .Benefit holder categorization: main covered person, spouse and dependents 5. Benefit structures & Coverage tiers 6. Geographic location(s) of employees 7. Employee turnover rate 8. Waiting periods & exclusions
CLAIMS & MEDICAL UTILIZATION DATA	1. Historical claims frequency & severity 2. Average claim cost per employee 3. Clinical codes for treatments 4. Top disease categories (e.g., diabetes, cardiovascular, musculoskeletal, other) 5. Hospitalization rates 6. Outpatient vs. inpatient claims ratio 7. Chronic illness prevalence
UNDERWRITING & RISK FACTORS	1. Medical underwriting results (if applicable) 2. Pre-existing condition disclosures 3. Occupational risk factors (if high-risk industry) 4. Smoking/alcohol usage trends
PRICING & RENEWAL TRENDS	1. Premium rates charged (banded to avoid anti-competitive issues) 2. Renewal rate changes (YoY) 3. Loss ratios (aggregated to avoid sensitive disclosures) 4. Deductibles & co-pay structures
FRAUD & ABUSE INDICATORS	1. Anonymized fraud case patterns 2. Common misrepresentation trends 3. High-utilization member red flags (without PII)
BENCHMARKING & INDUSTRY TRENDS	1. Market-wide claim inflation trends 2. Emerging health risks (e.g., cardiac issues claims' surge) 3. Regional healthcare cost variations

2.6.3 Data Privacy & Compliance Considerations

- **Anonymization:** Ensure no personally identifiable information (PII) is shared.
- **Aggregation:** Share data in bands (e.g., age groups, claim ranges) to prevent reverse identification.
- **Regulatory Cover:** it is essential to provide regulatory cover to information sharing so as to avoid any unprecedented legal and regulatory risks.

The information sharing as envisaged above is aimed at achieving the following objectives

- Better risk pooling insights
- More accurate pricing models
- Early detection of claim fraud trends
- Improved product design based on industry needs

2.6.4 PROPOSAL TO INTRODUCE COMPULSORY OCCUPATIONAL HEALTH INSURANCE

The Government of Pakistan launched the National Financial Inclusion Strategy (NFIS) in 2015 and The Government of Pakistan launched the National Financial Inclusion Strategy (NFIS) in 2015 and entrusted different entities with governance of technical committees on specific focus areas. The SECP was entrusted with governing the NFIS Technical Committee on Insurance, which presented its recommendations in the NFIS Steering Committee meeting chaired by the Finance Minister in 2019. One of the key recommendations was the introduction of Compulsory Occupational Health Insurance (COHI), an employer-funded health insurance scheme for all industrial and commercial establishments which can provide basic healthcare benefits for employees and their dependents. The COHI proposes to make employers responsible for providing health insurance to its employees thereby reducing the burden on the national exchequer and provincial resources to provide health coverage under the Sehat Sahulat Program or any other social welfare scheme. Simultaneously, the COHI can be made attractive for employers by providing tax benefits in the form of tax credits and/or exemptions.

As resolved by the NFIS Steering Committee, the proposal to introduce the COHI was sent to the Ministry of Inter-provincial Coordination (MOIPC) through the Finance Division for input and for developing consensus thereon. The proposal comprises healthcare benefits as well as the proposed legal amendments in the relevant laws of the provinces. The SECP has been regularly following up with the Finance Division to seek updates thereon and to expedite the proposal.

2.7 CONCLUSION

In a nutshell, the primary reasons for health insurance business losses include the rising costs of medical treatments due to inflation and currency depreciation, exaggerated bills of the insured population from private hospitals, and delayed claims management at the time of renewal and pricing, lack of product innovation and standardization, infrequent and inconsistent monitoring on underwriting practices, fraudulent claims reporting and varied third-party claims administrators practices along with inadequate automation and digitized processes, and lack of reinsurance support are some of the key causes of health insurance business in Pakistan.

3. INTEGRATION OF HEALTHCARE ECOSYSTEM

As it is said, Pakistanis are one hospital bill away from the poverty line. The current healthcare system in Pakistan has multiple challenges such as varying standards of services, quality issues, inconsistent accountability, limited resources and access issues. The healthcare services vary significantly for public and private hospital networks as our public hospitals are stretched due to under-funding, leading to additional financial strain of self-funded private hospital treatment for better services. In such circumstances, the health insurance business offers tremendous opportunities for the population, employer-funded schemes and patients (i.e. policyholders).

One of the major issues in the healthcare sector is the lack of coordination among different stakeholders starting from regulator/ policy-making bodies to providers and insurance companies. Though there is support from multi-lateral bodies such as the World Bank, Asian Development Bank, German Development Cooperation and the World Health Organization (WHO) on multiple initiatives, the escalation and consistent implementation of various initiatives is left half-way or remains ambiguous owing to variable reasons. A few examples include the Sehat Sahulat Program, the financial and administrative feasibility of which is ambiguous and utilization is a meagre 2.6% while the interventions recommended in the EPHS are not implemented[5], the pricing regulations of the provincial healthcare Commissions, which were issued as a draft but not enacted/ implemented, National Health Vision 2016 – 25, the progress on which is not known, among others.

STAKEHOLDERS IN THE HEALTHCARE SECTOR

[5] Third party evaluation by AKU with support of GIZ

In the absence of clear, consistent and committed advocacy for progress on the planned measures, the healthcare and other service providers operate in traditional ways with a lack of focus on the efficiency and wellness of the population. The hospitals/ laboratories and insurance companies have arduous manual processes in place. The records are mostly decentralised and in paper-back form due to which, the processing is administratively cumbersome and delayed. The result is poor quality services for the patients and policyholders.

3.1 NATIONAL CASEMIX AUTHORITY, AUSTRALIA

As in many developed countries, information on patients and healthcare services is maintained through a country-level integrated healthcare ecosystem solution. This means record maintenance at a service provider level (i.e. hospitals and clinics, laboratories, blood banks and all those in the health ecosystem) to assess the information at the seriatim-level on individual policyholder, to network, to district and to national level by various risk classification criteria. The information is then processed and analysed by multiple stakeholders for decision-making and optimal resource allocation which contributes to consistent service quality and improved financial management on the policymakers' and service providers' side collectively. For instance, the policymakers and government use it for budget allocation, the hospitals use it for the availability of healthcare services which are needed for patients of respective profiles, the insurance companies use it for pricing and underwriting etc, and the policyholders for making sound and financially conducive decisions. It helps understand the range and complexity of care provided in a certain hospital which can also affect resources needed and the costs associated with it.

One such example is the National Casemix Authority established in the 1980s in Australia with the objective of activity-based costing. Casemix adopts an activity-based costing system which helps in fair funding as costs are associated with the complexity and types of cases treated. This means that the hospitals having groups with more complex treatments get more funds. It helps in resource management since a mix of patients makes it easier for the hospitals to understand and plan resources accordingly.

This mechanism is also used for reporting on patient activity information i.e. to ensure healthcare providers are paid for the services they deliver, to support studies and service planning, and for benchmarking and performance management. The stakeholder-wise usage of the Casemix is given in the table on next page

Stakeholders	Description
HOSPITALS AND SERVICE PROVIDERS	• Use case-mix data to manage resources • Plan services according to the mix
GOVERNMENT AND POLICY MAKERS	• Use case-mix data to allocate funds and resources • Design healthcare policies
INSURANCE COMPANIES	• Use data to set a relevant premium • To negotiate contracts and services with healthcare providers
REGULATORY AUTHORITIES	• Use data to regulate the quality of services provided
DOCTORS/NURSES	• Use the case-mix data to come up with treatments according to the segregated groups
RESEARCHERS	• Use data to understand trends associated to each mix • Use it to develop new or more efficient treatments accordingly

The variants of Casemix are being used in UK, USA, New Zealand, Germany, Japan, South Korea & others.

3.2 CENTRE FOR NATIONAL HEALTH INSURANCE, KSA

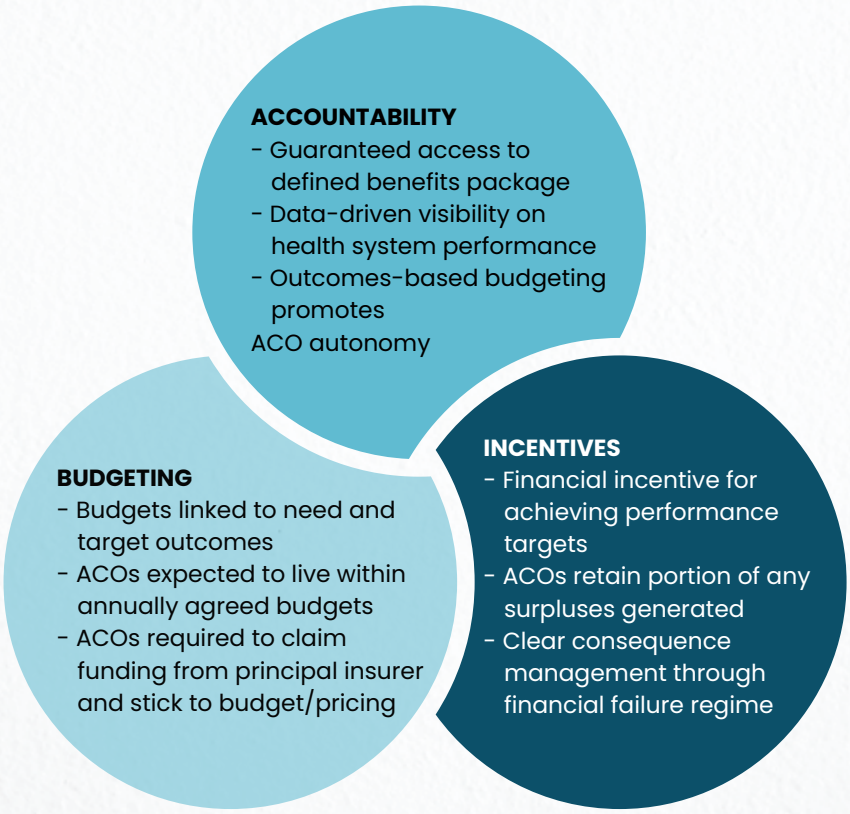
The Kingdom of Saudi Arabia (KSA), as part of its Vision 2030 has embarked on a transformation of its healthcare sector aiming at improving the patients' outcomes and allocation of financial resources. The reform envisages a shift from a model that rewards healthcare providers primarily for treating illnesses to one that incentivizes maintaining the population's health i.e. "value-based healthcare" (VBH). Under the VBH, budgeting is directly correlated with improving patient outcomes to ensure that spending delivers the best value for patients and the healthcare system itself [6].

The KSA citizens primarily rely on the government-funded healthcare system, which provides free medical services at public hospitals. Private insurance is optional for them unless covered through employer-funded schemes in the private sector. Minute details such as benefits of Saudi Nationals could be different to expatriates working in the Kingdom.

To implement the VBH reform, the Centre for National Health Insurance (CNHI) was established which has a distinct and key role in the implementation of value-based healthcare. The synopsis of the model is presented as follows:

1. 21 Accountable Care Organizations (ACOs) are responsible for bringing together various healthcare providers—such as hospitals, clinics, and specialists—to collaborate on delivering patient-centred care, with shared responsibility for improving outcomes and reducing unnecessary expenses.
2. The Centre for National Health Insurance (CNHI), operating under the Ministry of Health, KSA and regulated by Insurance Authority KSA, will act as custodian of health system sustainability – putting in place the funding and incentives for providers, through the ACOs to deliver a defined set of outcomes and establishing transparency and accountability on delivery.

The CNHI is aimed at governing the healthcare sector on the basis of following principles in each area of operation.



[6] https://abmagazine.accaglobal.com/global/articles/2024/aug/public/saudi-overhauls-healthcare-financing.html

Each of the 21 ACOs will be responsible for a respective cluster comprising specific geographic areas, aiming to address population health needs comprehensively including preventative/ primary care. The ACOs will also focus on quality improvements and cost savings through data-driven decision-making and shared accountability among providers.

The provider payment strategy describes CNHI approach to purchasing healthcare in a way that promotes value through improved patients' outcomes and the long-term financial stability of all stakeholders. The budget allocation is at the heart of VBH and is designed such that each ACO will receive a risk-adjusted budget, based on two sets of calculations:

1. The characteristics of their population and local context, such as the beneficiaries including spouse and dependents, their age, gender, and health risk status, region and city, socio-economic status of the population, classes and co-pay structures.
2. The efficient total cost of care for delivering the health benefits package, informed by national and international benchmarks for total utilization, distribution of activity by care setting, unit costs

The pre-requisite for budgeting includes the activity-based costing through the Casemix system comprising of accurate classification of patients, diseases and treatments in a certain geographical area, based on which the National Efficient Price (NEP) is computed i.e. cost for treatment of each person in a particular cluster. The budgets will be allocated based on NEP for the population in each cluster.

The sharing of patients' health information between healthcare providers as well as sharing financial data between insurance companies has been made possible through the digital platform "Nphies" which serves as a basis for the digital transformation of the healthcare sector in Saudi Arabia. The Nphies enables patient eligibility check and claims processing in terms of insurance solutions, while it facilitates integrated medical record for coordinated user experience, cost effectiveness and unified healthcare serves in terms of clinical solutions.
The systemic shift in Saudi Arabia's healthcare system involves the expansion of private-sector investments and a greater scope of services in the healthcare sector. These will create a significant demand for financial professionals in a range of fields including roles in financial analysis and strategy focusing on value-based healthcare and risk-adjusted budgeting, among others[7].

3.3 DEVELOPMENT OF INTEGRATED HEALTHCARE EXCHANGE SYSTEM IN PAKISTAN

Given issues and bottlenecks in the delivery of healthcare services with a special focus on funded healthcare i.e. by insurance companies, there is a pressing need for healthcare sector transformation through clear vision, consistent and concerted efforts and engagement of all relevant stakeholders. Needless to mention, the ownership of the initiative from the Federal Ministry of NHSRC and provincial health departments is a prerequisite.

At the outset, a digital information exchange for patient treatment eligibility and claims processing is to be developed by insurance companies and healthcare providers to remove administrative inefficiencies from the current health insurance administration. With a focus on funded healthcare services, the objective is to devise a mechanism for streamlining coordination between multiple stakeholders engaged in the provision of healthcare services to individuals covered under any program of government, insurance company or any other relevant entity, as applicable.

[7] https://abmagazine.accaglobal.com/global/articles/2024/aug/public/saudi-overhauls-healthcare-financing.html

The integrated healthcare exchange system is expected to connect healthcare providers (hospitals, laboratories, registered clinics) payers (government, insurance company, other entity) and beneficiaries (as needed) for sharing and accessing information and improving administration of health claims.

At the second stage when the integrated healthcare exchange system has reached a certain level of maturity and user experience has developed, the scope of the system can then be enhanced through ownership of Federal and provincial policymakers on the lines of case-mix usage in other jurisdictions and recent value-based healthcare initiative of the KSA, as illustrated above.

3.3.1 PHASE 1

In phase 1, the integrated healthcare exchange system is proposed to enable smooth coordination between insurance companies and healthcare providers i.e. hospitals, laboratories, pharmacies etc. without manual intervention. The repository of all health insurance policyholders and their claims records will also enable status checks, eligibility, fraud prevention etc.

The details of services which can be availed by each stakeholder through this proposed system are given in the table ahead. The system is aimed to bring standardization, simplification and efficiency in health claims filing and processing, enabling improved service for the beneficiaries and administrative and cost efficiency for the healthcare providers and payers. The relevant ministries and regulators at federal and provincial levels, need to be engaged for contributing and streamlining this idea so that it can be steered towards execution.

Stakeholders	Description
HOSPITALS	Checking eligibility and seeking automated pre-authorisation for certain procedure/ admission/ benefit based on policyholder/ patient record, without manual intervention
LABORATORIES	Eligibility check for tests/ procedures
INSURANCE COMPANY/ TPA	Approval on admission/ claim confirmation with TAT of 5 minutes max
PATIENTS	Check eligibility prior to admission/ service to panel and out-of-panel hospital
PATIENTS	Claim submission for out-of-panel hospitals and discharge request for panel hospitals Lodge complaint or seek review of insurance company decision for partial coverage or rejection thereof

1. Simplified information search i.e. information should be available with a single CNIC number search
2. Targeted TAT of 5 minutes for admission to the hospital/ access to the service or acceptance/ rejection thereof
3. Hospitals to be trained on usage of information exchange and one person to be appointed for each hospital
4. Quick assistance facility to be formed at the insurer's end until system and process becomes seamless
5. System efficiency/ technology infrastructure requirements to be complied

3.3.2 PHASE 2

Through the digitalised repository of the insurance policyholders and updated repository of health claims records, the information can be segmented and analysed for resource allocation and other benefits, in the likes of casemix example elaborated above. The policymakers in the healthcare sector need to develop a framework for introducing the patients, diseases and treatments clustering based on which, activity-based costing can be done and efficient resource allocation can become possible, coupled with improved patient outcomes.

At present, multiple initiatives relating to this concept are underway in the healthcare sector, a few of which are mentioned in the former part of this report such as:

- **National Health Data Centre:** The National Institute of Health, Pakistan (NIH) manages and maintains the central database for all diseases in Pakistan
- **National Health Accounts (NHA):** A tool that helps policymakers understand and improve health systems prepared and managed by the Pakistan Bureau of Statistics to estimate health expenditures in the public and private sectors.
- **Pakistan Health Information System (PHIS):** An integrated and analytical dashboard developed by the Ministry of NHSRC.
- **District Health Information System (DHIS)**
- **eHealth strategy as mentioned in the Digital Pakistan Policy, 2018** where the Ministry of IT and Telecommunication proposed to facilitate the M/o NHSR&C to accelerate the use of telemedicine; promote digitization and automation of existing hospitals; share information for preventive care of dominant disease groups in local languages, and set eHealth service providers accreditation and requisite protocols and standards.
- **Digitization** of more than 4 million records for Drugs Regulatory Authority Pakistan (DRAP) supported by the USAID[8]
- **National Digital Health Framework 2022 – 30 by the** Ministry of NHSRC in which, certain action points are mentioned as follows:
    - Develop **costed action** plan for implementation of Digital Health Framework
    - Develop and implement **legislation for digital health** including data security, privacy, storage and engaging private sector to name a few
    - Rules and regulations need to keep pace with rapidly changing technology
    - Develop rules for the **governance of health services** provided through the digital medium
    - Establish a mechanism for **collective decision-making based on shared data between** different sectors on indicators affecting health.
    - Develop guidelines, SOPs, and **regulatory framework for streamlining digital health services**

[8] Digital Health Framework 2022 - 20

4. RECOMMENDATIONS

In view of the state of the healthcare sector and health insurance market in Pakistan over the last 5 years specifically, certain areas for improvement are suggested. The idea is such that a systematic process is elaborated for technical engagement and discussions, alignment of various stakeholder interests and growth and improvement of the health insurance and healthcare sector. It would touch upon key areas in the Health insurance Ecosystem of Pakistan, reflecting upon the need to consider the overall integration and digitization of the same, outlining the missing links, developing systematic engagements, and ensuring smooth, systematic and successful synergies of all the stakeholders.

Product Innovation & Inclusivity			
RECOMMENDATION	**PURPOSE**	**RESPONSIBLE ENTITY**	**TIMELINE**
Develop basic, simple, standard and affordable products for the retail health market with minimal or no exclusions, focusing on wellness and long-term policyholder relationships	To improve public comfort, trust and access to health insurance	Insurance companies, SECP	Short term
At least one simple, standard & affordable health product for retail customers to be offered by all insurance companies in conventional as well as takaful category	To improve access of health insurance to retail market	Insurance companies, SECP	Short term
Develop long-term, comprehensive care products for the elderly and critically ill persons	To address the gap in elderly and long-term care insurance, and promote inclusive health insurance market	Insurance companies, SECP	Medium term
Develop medical malpractice products and create a market	Provide legal and financial protection to healthcare professionals	Insurance companies, SECP	Medium term
Explore cost-efficient distribution mechanisms for the retail market	Cost efficiency and business sense for retail health insurance	Insurance companies	Medium term

Conduct & Administration			
RECOMMENDATION	**PURPOSE**	**RESPONSIBLE ENTITY**	**TIMELINE**
Simple, minimal and standard pre-authorisation requirements and SOPs for all panel hospitals	Improve patients experience and reduce delays in patients' treatment	Insurance Companies, hospitals	Short term
Standard Operating Procedures (SOPs) to be agreed for claim lodging and payment, along with benchmarking for specific treatments in terms of cost and service quality	Improve patients experience and service quality	Insurance Companies, hospitals	Medium term
Standard classification of diseases and treatments on the lines of International Classification of Diseases (ICD) and Casemix	Administrative efficiency, improve patients experience and service quality	Insurance Companies, hospitals	Medium to long term

Pricing & Underwriting			
RECOMMENDATION	**PURPOSE**	**RESPONSIBLE ENTITY**	**TIMELINE**
Health insurance products pricing and underwriting mechanism to be introduced in alignment with the healthcare services pricing and demographic factors and specific attributes of the covered persons such as: •Age •Gender •Geographic location •Pre-existing condition disclosures •Occupational risk factors (if high-risk industry) •Smoking/alcohol usage trends (if anonymized) •Medical underwriting results (if applicable) •Benefit structure, limits and offerings	Ensure fairness and transparency in insurance underwriting, pricing and coverages	SECP, Healthcare Commissions, Health departments in the provinces	Medium term

Standardised pricing/ costing benchmarks for different treatments/ services by healthcare providers	Enable consistent pricing across the sector and reduce disputes in insurance claims	Federal & Provincial Healthcare Commissions, health departments	Medium term
To counter the rate under-cutting, the requirement to certify the claims history for all corporate accounts by the insurer for preceding twelve – twenty-four months, the policyholder, the current and the new insurer who will underwrite the business for next twelve months	Transparency in pricing, promote responsible underwriting and curb unfair pricing practices in corporate/ group health insurance	SECP, Insurance Companies	Medium term

Oversight & Monitoring			
RECOMMENDATION	**PURPOSE**	**RESPONSIBLE ENTITY**	**TIMELINE**
Healthcare regulatory bodies to monitor hospitals, labs, and providers for compliance with applicable framework including minimum service delivery standards	Improve service quality and regulatory compliance across healthcare providers	Provincial Healthcare Commissions and health departments	Short term
SECP to strengthen the reporting and monitoring of insurance companies to include performance reporting of health insurance business envisaging frequency, severity, exposed policyholders, allocated expenses, commission, expenses, along with segregation in further demographic factors, benefit packages etc.	Improve regulatory compliance across insurance sector	SECP	Medium term
Monitoring and evaluation of Pakistan's largest health insurance program (administered by SLIC)	Ensure effective service delivery, cost control, and program transparency	Federal & provincial health departments	Short term

Digitalization and Systems Integration			
RECOMMENDATION	**PURPOSE**	**RESPONSIBLE ENTITY**	**TIMELINE**
Improve usage of CISSII (Centralized Information Sharing Solution for Insurance Industry) health insurance register and expand its scope as envisaged in 2.6	Enable efficient data sharing, reduce fraud, and improve underwriting	SECP, Insurance Association of Pakistan (IAP)	Medium term
Engagement with insurance and healthcare sectors for development of a Health Insurance Exchange and enhancing digital integration of the healthcare ecosystem (inspired by KSA, Australia, etc.)	Create a unified digital platform for seamless interaction between payers, providers, and policyholders	SECP, insurance companies, Federal and Provincial Health departments, hospitals	Medium term

Other			
RECOMMENDATION	**PURPOSE**	**RESPONSIBLE ENTITY**	**TIMELINE**
Encouragement of private sector for participation in the Sehat Sahulat programme through the top-up/add-on coverage over the standard policy under SSP and employer-employee scheme (group) health insurance products	Promote competition, broaden access to quality healthcare and ease the burden on public infrastructure	Ministry of National Health Services, State Life, Private Insurers	Short term
Encourage the insurers to focus on wellness in product development and policy administration	Shift toward preventive healthcare and reduce long-term healthcare costs by improving population wellness	SECP, Ministry of National Health Services, insurance companies	Long term
Form a committee comprising of insurance companies underwriting health insurance/ IAP and other relevant stakeholders as agreed by the Committee	To deliberate on the execution of aforementioned recommendations and action plan thereof	SECP Insurance Association of Pakistan	Medium term

SECP

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