Implementation of Sehat Sahulat Cards – A Social Safety Net

October 2011 – September 2012

Lasbela, Balochistan

brac

CONTECH INTERNATIONAL
Health Consultants

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Section I: Context

Pakistan has lagged behind many of it neighbors regarding health and population outcomes. Poor and marginalized communities are underserved along whole continuum of care because the poor are more likely to live in rural and remote areas with little access to healthcare services. Interagency estimates show that of urban dwellers, 99 percent had access to health care, 96 percent to safe water, and 62 percent to sanitation, while of rural dwellers, only 35 percent had access to health care, 71 percent to safe water, and 19 percent to sanitation.[1] These inequities have implications for the population that is economically vulnerable and face a lot of social hardships.

Dwindling financial allocations with less focused investment in health of rural population, inadequate care at public facilities with questionable quality, poor accountability system for staff, fragmentation of care and lack of referral system, and issues of accessibility and affordability are major hindrances in delivery of healthcare services in rural and remote areas. Although public health services aim to make health care accessible and affordable for the poor and marginalized, but it has largely failed to do so. Such inequitable patterns of healthcare provision both reflect and entrench the social exclusion faced by the poorest and the most marginalized groups and help explain why health indicators show marked socioeconomic variations in Pakistan.

1.1 Developing a healthcare financing model

Financing quality health care is a global challenge for industrialized and developing countries alike. Although there are no internationally agreed thresholds on minimum per capita total spending, the Countdown to 2015 initiative has estimated that per capita spending of less than US$ 45 is insufficient to provide quality basic health care services. Among the 68 priority countries lagging behind achievement of health-related Millennium Development Goals (MDGs) identified by the Countdown to 2015 initiative (including Pakistan), 21 have spending of less than US$45 per capita.[2] Public expenditure on health can be a key determinant of health system capacity.

Countries with low rates of spending per capita may be associated with poor health outcomes, gaps in staffing, and weak investment in healthcare infrastructure and logistics. In 2004, the

[1] UNDP. Human Development Report, 2009.
[2] Bryce, Jennifer, Requejo J. H. Tracking Progress in Maternal, Newborn & Child Survival: The 2008 report, Countdown to 2015, United Nations Children's Fund, New York.

average expenditure on public health was just 2.6 percent of gross domestic product for low- and middle-income countries as a whole, in sharp contrast to the near 7 per cent of GDP spent by high-income countries. South Asia had among the lowest rate of spending, at just 1.1 per cent of gross domestic product. Countries and donors are increasingly recognizing the pivotal importance of delivering essential health care in equitable social and economic development. Many governments, even in low-resource areas, are exploring different strategies for helping families manage the costs of routine and emergency healthcare. Various options are possible, including reducing or eliminating direct user charges; implementing social protection initiatives such as cash transfers and vouchers on either a conditional or unconditional basis, introducing national or community health insurance and subsidizing private provision of health care for poor households.[3] To be truly effective and sustainable, however, these interventions must take place within a development framework that strives to strengthen and integrate programs with health systems and an environment supportive of communities' rights.

1.1.1 Eliminating user charges

A key area of debate in health financing is direct user charges, which are an important barrier to accessing health services, particularly for poor people. Removing user fees has the potential to improve access to health services, especially for the poverty-stricken. Several countries across the developing world have already abolished, or are in the process of eliminating, some or all direct charges and it is often with encouraging increases in access to healthcare services. No systematic evaluation of user fee removal has taken place so far in Pakistan. Preliminary evidence suggests that in countries where user fee removal was not supported by other policy measures, such as increased national budgets for health care or careful planning and deliberate implementation strategies, health system problems tended to increase and performance weakened. In countries where fee removal was carefully planned and managed, however, there are signs of increased utilization of services and indications that the poor may have benefited most, although the incidence of catastrophic expenditures among the poor did not fall.[4]

It should be emphasized that user fees are not the only barriers that the poor face. Other cost barriers include informal fees; the cost of medicines, laboratory and radiology tests not supplied in public health facilities; travel, food and accommodation; and charges in private healthcare facilities. These costs generally make up a significant proportion of the total costs that households face and disproportionately affect the poor. In addition, cultural barriers must also be overcome before the poor can access adequate health services. The evidence indicates that these non-barriers disproportionately affect the poor. Although user fees are only one of many barriers facing the poor, they are among the most amenable areas for policy action. Recent experience from Uganda has shown, the policy process of fee elimination has a catalytic effect in allowing

[3] Borghi J.O. Mobilizing Financial Resources for Maternal Health. The Lancet, 2006; 368(21):1457-1465.

[4] Gilson, Lucy, McIntyre D. Removing Fees for Primary Care in Africa: The need for careful action. British Medical Journal, 2005; 331:762-765

governments to confront other issues, such as drug supply and procurement, budget allocation or financial management, which pose further barriers to progress. It should be noted that the context for user fee removal is critical, and no blanket policy is likely to address the needs of communities. Careful analysis of the situation, the equity implications of alternative financing and delivery strategies along with multiple financial and non-financial barriers to access is required to support decisions on the most appropriate course of action.

1.1.2 Insurance, cash transfers and cost sharing

Health insurance schemes can increase access for the poorest women to antenatal and delivery care. Yet these forms of financing are hard to expand in countries with limited formal sector employment and low incomes. Community health insurance schemes, which operate more informally and on a smaller scale than social insurance schemes, had increased institutional delivery rates by 45 per cent in Rwanda and by 12 per cent in the Gambia. Similarly, cost-sharing scheme in an urban district of Burkina Faso increased the number of emergency referrals from 84 to 683 in a year.[5] It may be difficult to expand such schemes for wider coverage, as they require government or donor support because they may not be self-financed and are dependent on effective community mobilization.

Conditional cash transfers and voucher schemes are also effective in generating demand for specific services among the poor. Cash transfers have increased antenatal care during the first trimester among poorer women in Mexico by 8 per cent and in Honduras by 15–20 per cent.[6] India has provided financial incentives for deliveries in facilities for women from marginalized groups in priority districts of Gujrat province. While these initiatives have increased access to healthcare services, effective improvements in maternal health outcomes may not be realized without concomitant improvements in quality of services. Continued monitoring and evaluation of these financing innovations are required to inform appropriate scale-up by policymakers.

1.2 Experience of social safety nets in Pakistan

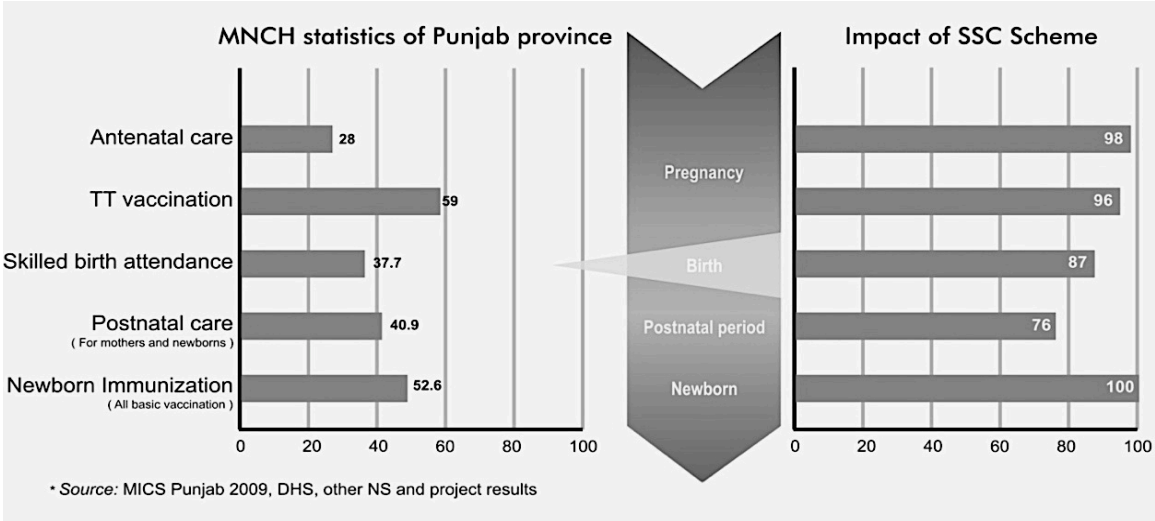
Sehat Sahulat Cards (SSCs) scheme was implemented on a pilot basis in districts of Kasur and Rawalpindi through a public private partnership between Contech International and Punjab Devolved Social Services Programme, funded by Asian Development Bank. Under this scheme, social safety nets were provided to pregnant women living below poverty line in rural union councils of these districts for ensuring free and quality MNCH services. The selection of beneficiaries was made on the basis of poverty scoring of pregnant ladies in catchment areas. Besides providing the resources, community awareness was also emphasized in this initiative as in Pakistan, particularly in the rural areas, women were constrained in seeking healthcare for

[5] Richard F. Reducing Financial Barriers to Emergency Obstetric Care: Experience of cost- sharing mechanism in a district hospital in Burkina Faso. Tropical Medicine and International Health, 2007; 12(8):972-981.

[6] Morris S.S. Monetary Incentives in Primary Health Care and Effects on Use and Coverage of Preventive Health Care Interventions in Rural Honduras: A cluster randomized trial. The Lancet, 2004; 364(9450):30-37.

themselves and their children on account of low mobility and restrictions imposed in the name of religion or culture.[7] Findings of the pilot revealed substantial improvement in health indicators (Figure 1). A third party evaluation was also commissioned which validated the impact of the scheme[8] and scaling up of the initiative for achieving maximum impact was proposed by the Asian Development Bank[9].

Figure 1: Outcomes of piloting SSC Model on MNCH services



[7] Aslam A. Health-Related Millennium Development Goals: Policy Challenges for Pakistan. Journal of Pakistan Medical Association, 2004; 54(4):175-81.

[8] Punjab Economic Research Institute, Planning and Development Board. Sehat Sahulat Cards Scheme: Report of Third Party Evaluation, 2010.

[9] Asian Development Bank. Report and Recommendation of the President to the Board of Directors, 2010.

Section II: Implementation of SSC

Barriers such as distance, lack of transportation infrastructure and cost of transport services, limited supplies of medicines and poor staff attitudes hold back people from seeking care in public sector hospitals, whereas high out-of-pocket payments in private sector health facilities have limited their access among the poor. Therefore, there is a coverage gap of 37 percent between the poorest and the richest wealth quintiles in Pakistan. This situation demands immediate steps for identification of innovative and effective approaches that have been subjected to rigorous scientific evaluation for provision of 'hard' evidence to determine their effectiveness for ensuring optimal utilization of resources.

Given the situation, a scaled-up model of SSC scheme has been proposed for implementation. Basic idea behind introduction of SSCs is to subsidize demand among the poor for specific health services of known cost-effectiveness, whilst allowing a competitive market for its provision. It is expected to enhance access and coverage of essential healthcare services for the poor and marginalized communities. It is more beneficial than using same resources to subsidize supply and will also bring improvements in overall health outcomes, reduction in poverty, and also foster towards meeting the Millennium Development Goals commitment of Pakistan. Contech International and BRAC has started the implementation of social safety nets through SSCs to provide direct benefits to poor and marginalized communities in selected Tehsils of Lasbela district of Balochistan province. Key objectives are as follows:

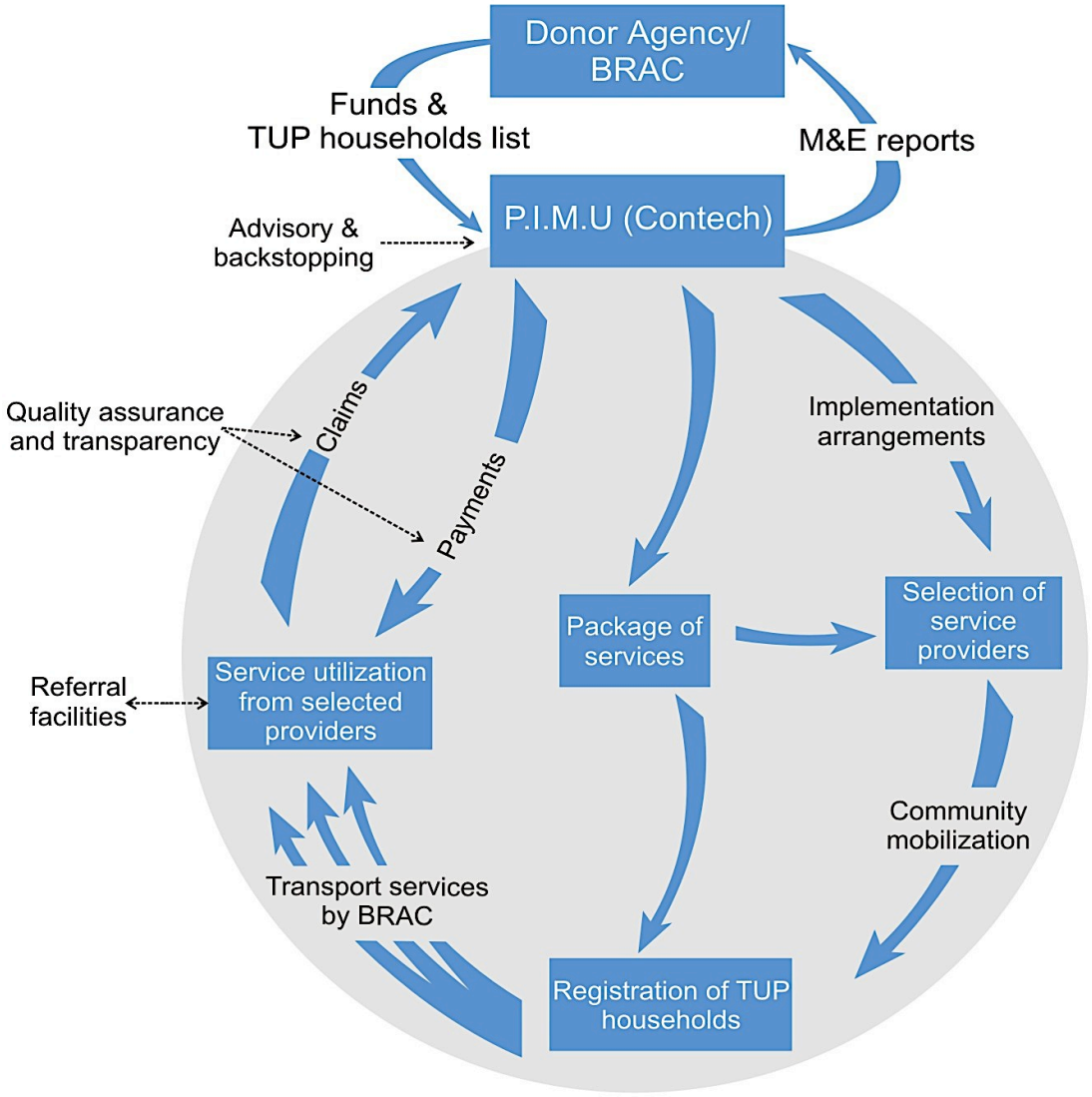
1. To initiate a social safety nets project for incentivizing families living below poverty line, giving them access to free health care services
2. To identify and upgrade willing and appropriate health care providers for provision of services to selected families
3. To form a strong linkage between the public and private sector for managing better health care services to those underserved in the targeted areas.
4. Establishing a social safety net for families living below poverty line, giving them access to free healthcare services

2.1 Conceptual framework

A framework of implementation (Figure 2) is developed for operationalizing the SSC scheme in district Lasbela. While BRAC provided the financial assistance, Contech implemented the project by adopting an integrated and comprehensive approach comprising of reliable fieldwork,

supportive assistance, effective monitoring, cross-validation and timely feedback. Frequent team interactions are carried out to bring in quality, reliability and credibility to the activities. After finalizing package of services that shall be provided to the beneficiaries, beneficiaries are identified and registered. Simultaneously, willing and appropriate healthcare providers are identified.

Figure 2: Conceptual framework of Sehat Sahulat Cards – a social safety net



2.2 *Area of intervention*

The project is implemented in district Lasbela of Balochistan, which comprises of 5 Tehsils. Total population of the district is 449,451 and 63 percent of the population resides in rural areas. Three Tehsils including Bela, Hub and Uthal is selected for implementation of the project and total of 19 Union Councils (UCs) are selected from these Tehsils (Table 1).

Table 1: Description of selected Tehsils and Union Councils in district Lasbela

Tehsil	Number of UCs	Name of UCs
Bela	5	Bela, Gadore, Kahore, Welpat Janobi, Welpat Shumali
Uthal	7	Karaj, Khenwari, Lahra (Tehsil Lakhra), Liari (Sub-Tehsil Liari), Sheh Karaj, Khenwari, Uthal, Wayara
Hub	7	Allahabad, Baroot, Gaddani (Sub-Tehsil Gaddani), Pathra, Sakran, Sonmiani (sub-Tehsil Sonmiani), Winder (sub-Tehsil Sonmiani)
Total Number of Tehsils = 3 and Total UCs = 19		

2.3 Implementation arrangement

A centralized project implementation and management unit (PIMU) is established at Contech's head office to oversee all technical, managerial and administrative aspects. A team lead by Project Manager is put in place, which is support by an advisory and backstopping team consisting of senior specialists. At the district level, field team is constituted, headed by a Field Coordinator, for overall management and supervision of the activities. Field Coordinators are positioned to: 1) maintain liaison and correspond with Contech office, 2) facilitate the beneficiaries, and 3) take care of necessary documentation involved in the process. These coordinators take guidance from BRAC focal person for health for carryout activities. They are paid salary and Contech also releases a facilitation amount for patient transportation etc. being spent by the coordinators. All the technical and financial issues are handled at the PIMU for ensuring uniformity whereas the logistics management is decentralized to provide flexibility. However, a strong and consistent coordination is maintained between the PIMU and field staff.

2.3.1 Package of services

Recently, quality care has expanded from an exclusive focus on biomedical outcomes to a more inclusive approach that also takes into consideration patient rights and satisfaction, standards, equity, and the responsibilities and rights of healthcare facilities and their workforce. Prime objective of SSC is to provide quality healthcare to communities living in straitened circumstances. Providing a good quality care to all the beneficiaries of SSC included a minimum level of care to all the men, women and children, with capacity of attending to those requiring emergency or more specialized services. It is aimed to obtain the best possible medical outcome; satisfy providers, patients, and families; maintain sound managerial and financial performance; and developing linkage with the beneficiaries for brining a change in their behavior. The novelty of SSC is the set of services covered under this social safety net, which also encompasses provision of transportation through coordination with ambulance services of BRAC in the catchment areas, besides the clinical checkups and medical procedures, hence providing a greater

opportunity for investment to save lives of mothers and children. Following package of services is covered in this project.

- Outpatient curative care
  - General Curative Care
  - Treatment of RTI/STDs
  - DOTS -Treatment of TB
  - Treatment of Malaria
  - Management of Diarrhea
  - Management of ARI
  - Adolescent RH care
  - NCDs care
- Inpatient curative care
  - General medical care
  - Minor Surgical Care
  - Obstetric/Gynecologic Care
  - Pediatric Care
  - Emergency Care
- Diagnostic services
  - Lab investigations
  - Ultrasonography
  - X-rays
- MNCH services
  - Antenatal Care
  - Natal Care (both normal delivery and Caesarean section)
  - Post Natal Care (First 40 days)
  - New-born Care (First month)
  - Immunization
  - Family planning services

2.3.2 Identification and registration of beneficiaries

In district Lasbela, only those areas are included in the project where BRAC is currently working. A list of target ultra-poor (TUP) households is developed by BRAC, which ultimately forms the beneficiaries of the SSC. Female family head (mother of household) represents each selected household and an ID card (Attached at annex 2) is issued, which includes names of all the beneficiaries from that household. On average, there are 5 to 6 beneficiaries registered through one SSC. Total of 1,500 households are selected and registered for SSCs from three Tehsils of district Lasbela.

2.3.3 Selection of service providers

The original concept of SSC involves both public and private sector healthcare providers. However, in target area, private providers are selected as the public facilities are found non-functional and inaccessible, and where functional they are either unwilling or lacking qualified staff and equipment for delivery of quality healthcare services. However, referral linkages are developed with higher level of facilities. Initially, a mapping exercise is undertaken to identify private-sector service providers available in the target area. An assessment of these service providers is carried out by joint visits of technical teams from Contech and BRAC. Service providers are selected based on qualifications of service providers, availability of skill-mix at their facilities, relevant requirements of physical infrastructure and acceptability among the community. A memorandum of understanding (MOU) is signed with each of selected service provider (List of service providers is attached at annex 1 and template of MOUs are attached at annex 2 and 3).

2.3.4 Fostering social mobilization

In rural communities of Pakistan, entrenched cultural attitudes and beliefs often surround health-seeking behavior. Supply-side measures cannot be successful without strengthening demand for quality healthcare at the level of households and communities. Social inclusion must be prioritized, and individual families and communities must be included and treated as partners in healthcare provision. Unconventionality of SSC Scheme is to enlist communities through inclusion rather than coercion. Community awareness activities are carried at three stages during the project: 1) at first contact of the household with BRAC team during registration; 2) during distribution of SSC ID Cards by Contech's District Coordinator, they are informed about available services and benefits; 3) during health communication sessions conducted by BRAC in the target areas refreshed community awareness on availability of free and quality healthcare services. Achievement of service deliverance targets can be much attributed to these awareness strategies.

2.4 Development of information system

A comprehensive information system comprising of following recording and reporting tools is developed and finalized after field-testing and approval by technical team of BRAC.

2.4.1 SSC ID Card

It is issued to the beneficiary and included complete information about the household. A unique code is issued to each beneficiary household, which includes information regarding Tehsil, household and family member. This unique code is used as reference for recording and reporting purposes (Attached at Annex 4).

2.4.2 Prescription Form

These forms are provided with the service provider to record the patients' findings, prescribed medicines and laboratory investigations (Attached at annex 5).

2.4.3 Patient Reporting Form

These forms are provided with the service provider for recording the details about services availed by the beneficiary (Attached at annex 6).

2.4.4 Prescription Monthly Summary Form

These forms are provided at the selected pharmacies for preparing summary of all the prescriptions to submit quarterly claims (Attached at annex 7).

2.4.5 Reimbursement Bill Form

This form is used by the service provider to submit quarterly claims for reimbursement (Attached at annex 8).

2.5 Service utilization and reimbursement

Beneficiaries of SSC have been utilizing healthcare services from selected service providers. After arrival at the healthcare facility, service provider uses Prescription form for documenting diagnosis, required management including laboratory investigations and prescribed medicines. Details of the visit are also entered on the beneficiary's SSC ID Card. It was initially expected that the information shall be duplicated in the Patient Reporting Form provided at the facility but selected providers were unwilling to fill this form. This problem is rectified by support provided by Field Coordinators, who enters the information about services provided in the Patient Reporting Form after validating it from Prescription Form. After consultation, beneficiary takes the Prescription Form to the selected laboratory if investigations are prescribed and then to the selected pharmacy where medicines are issued and Prescription Form is kept for record. Based on Prescription Form and Patient Record Form, claims are submitted on Reimbursement Bill Form to the head office on quarterly basis.

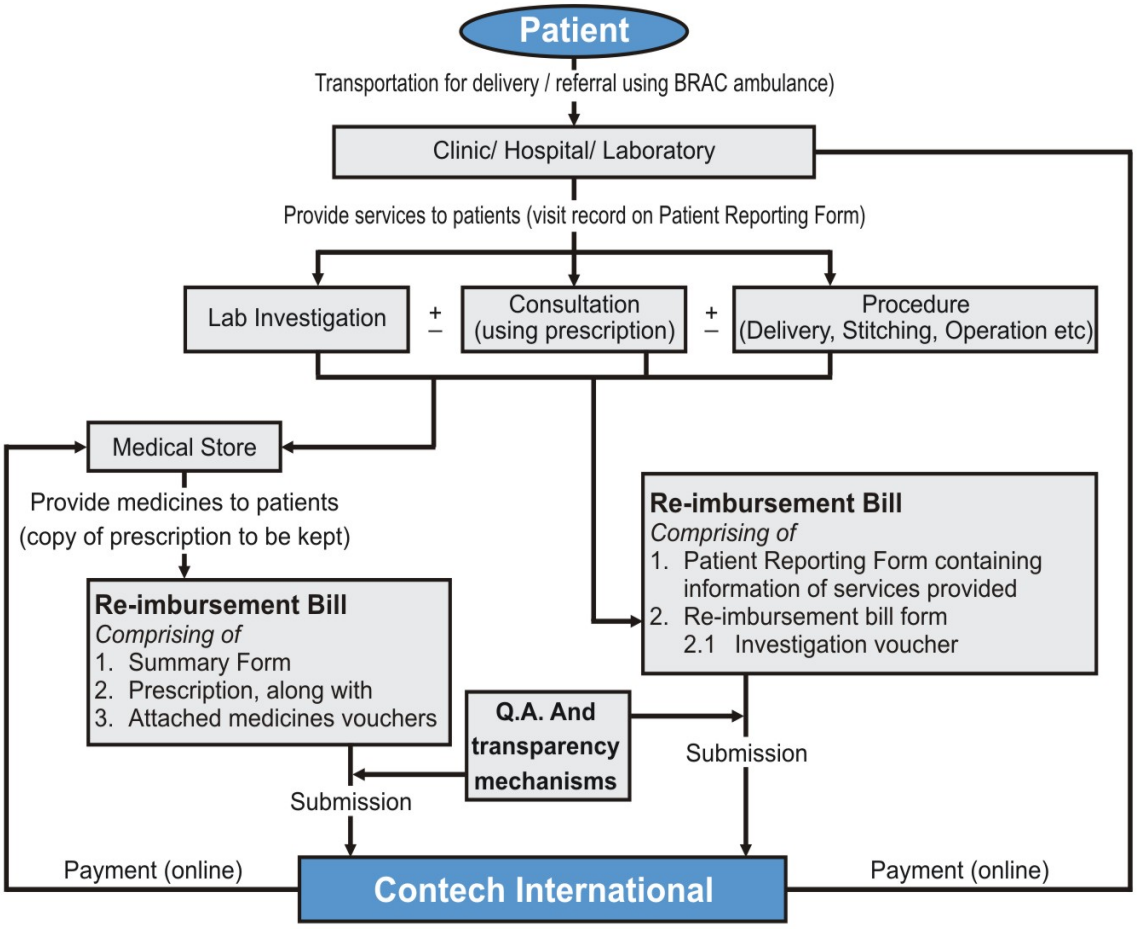
Contech Coordinators collect and forward necessary documents to the head office, relating to the record of services availed by beneficiaries. Contech team scrutinizes the documents and then process data using computer software. A reimbursement detail of each service provider is prepared separately for processing payment. Initially payments were made through cross-cheques in the name of concerned healthcare provider. But, local bank used to take considerable time in clearing these cross-cheques. In order to cut short this time, the Contech made efforts and succeeded in making arrangements for online transfer of payments. Account details were received with the support of Field Coordinators (See figure 3 on the process). BRAC's technical team is constantly kept informed during above course of events.

2.5.1 Automation of database

Computer software is developed on MS Access to automate database for this project. All the information regarding utilization services is entered in this database and reimbursement claims are linked with unique code given on each SSC ID Card. It contained drop-down menus for multiple-choice responses and help perform consistency checks with entry of date for services availed at the facility. Treatment and expenditure record of each beneficiary is maintained on this database. Automated receipts are generated for making quarterly payments to providers.

Another use of automated database is to prepare quick summaries of service utilization and healthcare outcomes of the beneficiaries. These summaries are used for analysis as well as sharing progress and invoicing with BRAC.

Figure 3: Working arrangements for service utilization and reimbursement



2.5.2 Provision of transportation services

Plans for health infrastructure development should consider the best means of improving transportation systems to aid communities in accessing routine and emergency care. Lack of transportation infrastructure in target areas of district Lasbela is a major constraint in accessing healthcare facilities both for routine and emergency healthcare. Therefore, beneficiaries of SSC

are supported through developing a liaison with BRAC community ambulance services for transportation of patients. Transportation rates are agreed on per-kilometer basis and Contech reimburses cost of services to BRAC.

2.6 Monitoring quality of care

Monitoring and evaluation mechanisms are set forth during the design phase of the project. Careful consideration is accorded to identify indicators, activities and outputs required for monitoring. A key aspect of monitoring is quality of care and two aspects of quality of care are monitored including technical quality and human quality. Technical quality related to quality of care provided at the health facility is ensured by selection of service providers meeting set criteria regarding qualification, skill-mix and physical infrastructure. Further, quality of laboratory services and brands of medicines dispensed are also monitored to ensure quality of care. Human quality of care, which is related to patients' satisfaction with rendered services, is also monitored. Field coordinators are present at the facilities for ensuring quality of care provided and have been in constant link with the beneficiaries to assess their feedback about the services.

2.7 Quality assurance and transparency

Legitimate concerns about potential abuses of the SSCs can take on exaggerated proportions of available funds. Monitoring and quality assurance mechanisms are put in place to ensure quality of services, transparency, detecting and avoiding any misuse of SSC and services. Following measures are taken in this context.

2.7.1 Preventing counterfeit

In order to avoid counterfeiting, multiple low-cost measures are adopted, which are described as follows.

- A printed SSC ID Card is issued to each of the TUP beneficiary
- A unique code is assigned on each card, which denotes information about Tehsil, household and member
- In each card comprises of sections and multiple colors are fonts are used
- Each card is stamped with a date of expiry
- Contech's Field Coordinators directly distributed the cards at the houses of TUP beneficiaries

2.7.2 Impeding fraudulence and collusion

A key aspect of transparency is fraudulence regarding voucher distribution. In order to avoid this, various measures are taken including development of TUP beneficiaries list by BRAC's social mobilizers and issuance of ID Cards from Contech's head office.

Another issue of transparency is collusion between field teams and service providers. It is tackled

through constant supervision of field teams by Contech's technical team and strong coordination with BRAC's District Coordinator.

2.7.3 Prohibiting over-servicing

There is a tendency in such schemes that service providers are tempted to shift patients to higher-paying categories as different sums are paid based on patient characteristics, even if it means providing services the patients do not merit according to the management protocol. This possibility, called "moral hazard" (or "over-servicing"), is well known to health insurance schemes. Following measures are used to prohibit over-servicing and ensuring rational use of services.

- A unified fee for consultation is agreed with the service provider irrespective of the type of patients presenting in OPD.
- Automated of reimbursement claims and generation of automated receipts are used to review the services provided by individual providers to TUP beneficiaries. Software is programmed to accept claims from only those SSC IDs that have been produced and distributed.
- All individual claims are scrutinized to assess management prescribed for presenting complaints of the patients and cost variation is monitored in similar cases.
- Medical expert at Contech's head office cross-validates claims of pharmacy and laboratory services to assess their rationality.
- Although availability of competitive service delivery environment by providing choice to beneficiary about selection of service providers is of hallmark importance, it could not be implemented due to limited number of service providers available for inclusion in the scheme.

Section III: Accomplishments

After one years of implementation, the project has shown promising results regarding health-related outcomes, impact on equity and poverty reduction. Although, poverty impact analysis and cost-effectiveness is difficult to ascertain after implementation for a short period but it has definitely saved people from catastrophic healthcare expenditure.

3.1 Utilization of services

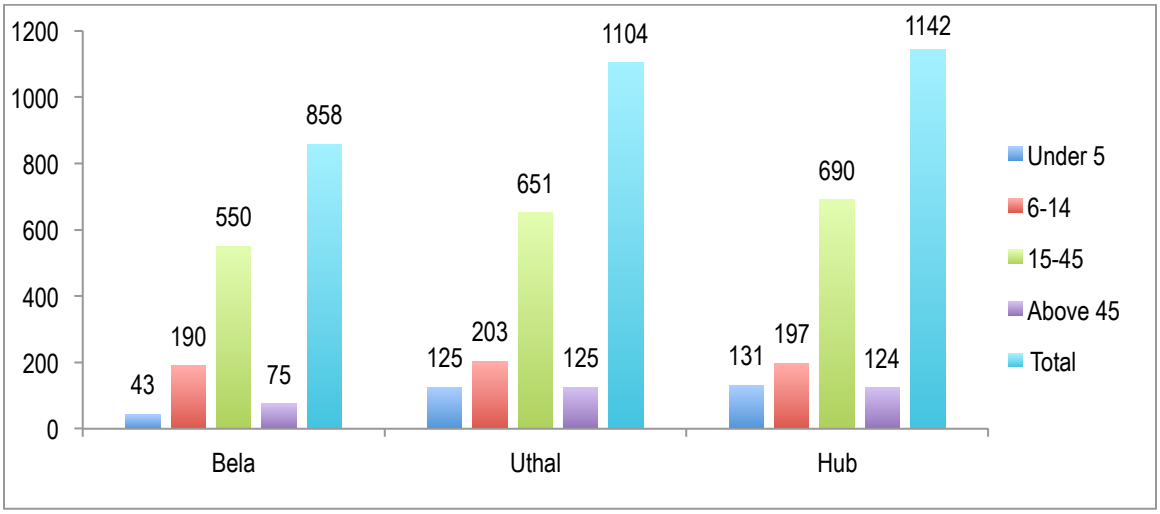
During the first two quarters of service delivery to TUP beneficiary, overall service utilization remained at 71.33 percent, ranging from 68 percent in Tehsil Hub and 75 percent in Tehsil Uthal. A Tehsil-wise breakup of beneficiaries' service utilization is given in table 2.

Table 2: Overall utilization during first two quarters of project implementation

Name of Tehsil	Total number of TUP households	Households utilizing services	
		Number	Percentage
Bela	451	321	71 %
Uthal	550	410	75 %
Hub	499	339	68 %
Total	1500	1070	71 %

Total of 3104 beneficiaries utilized healthcare services during first two quarters of the project starting from October 2011 to March 2012. Analysis of utilization data reveals that majority of services is utilized by beneficiaries of 15 to 45 years of age (Figure 4).

Figure 4: Age-wise break up of TUP beneficiaries utilizing healthcare services



Review of disease patterns are also analysed for beneficiaries from all three Tehsils of district Lasbela. In Tehsil Bela, total of 858 TUP beneficiaires has utilized the services and most common cause of consultation includes PUO (29 percent) followed by ARI (12 percent) and diarrhoea (7 percent) as described in figure 5.

In Tehsil Hub, total of 1142 TUP beneficiaries has utilized the services and most common cause of consultation includes PUO (28 percent) followed by ARI (9 percent) and Osteo-Arthritis (6 percent) as described in figure 6.

In Tehsil Uthal, total of 1104 TUP beneficiaries has utilized the services and most common cause of consultation includes PUO (31 percent) followed by ARI (11 percent), Diarrhoea (7 percent) and Scabies (4 percent) as described in figure 7.

Figure 6: Most common consultations in tehsil Bela

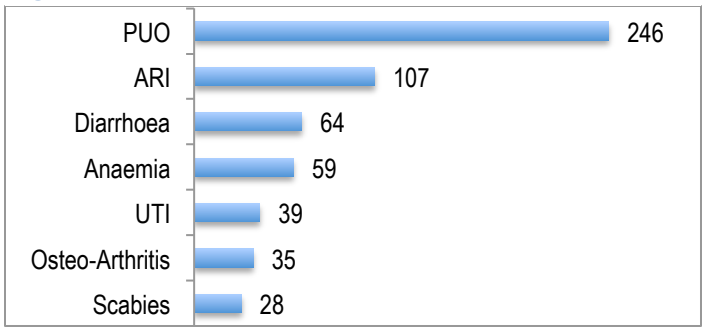


Figure 5: Most common consultations in Tehsil Hub

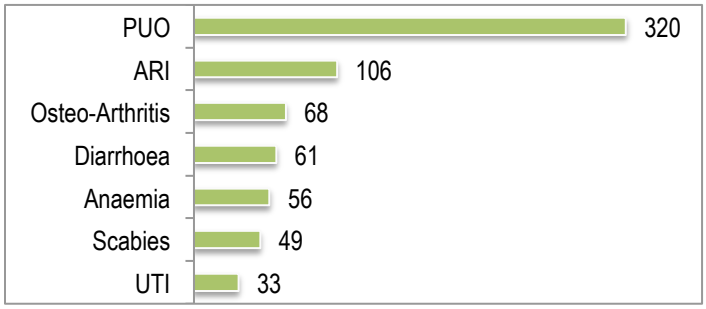
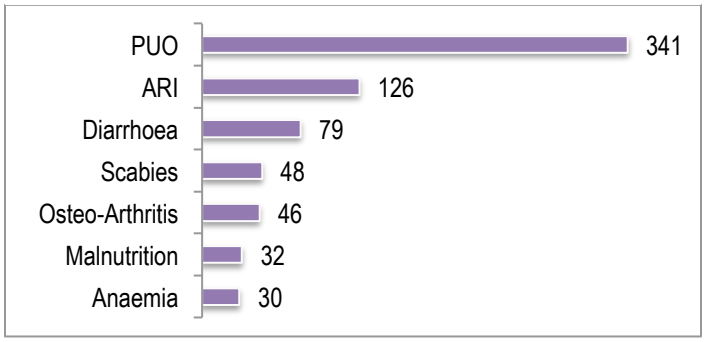


Figure 7: Most common consultation in tehsil Uthal



3.2 Poverty impact analysis

Such analysis is necessary to assess the proportion of TUP beneficiaries who have been protected by the SSCs from becoming impoverishes or reduction in income inequalities in health outcomes. Currently, with a utilization data of two quarters, it is difficult to ascertain impact of the project on poverty. However, an endline analysis shall be conducted to examine the service outputs like receipt and utilization through SSCs, in terms of the socioeconomic profile of the beneficiaries. Similarly, assessment about the equity impact of the project shall be made by comparing differences in outcomes by socioeconomic status of the beneficiaries. Appropriate measure such as concentration coefficients or the index of relative inequality shall be employed for endline assessment.[10]

[10] Wagstaff, A, E. V. Doorslaer. On the Measurement of Inequalities in Health. Social Science, 1991; 33:545-557.

3.3 Cost-effectiveness analysis

Assessment of cost-effectiveness is one of the most challenging enterprises in public health. However, social safety nets like SSCs simplify this process by accurately measuring cost and health outcomes. At small scale of intervention, technical, and management cost shall mislead the cost-effectiveness analysis and this cost shall be sufficiently decreased at scaled up level.

3.4 Way forward

3.4.1 Lessons learnt

During the pilot implementation of SSCs in district Lasbela, various strategies are modified and based on the results of implementation and some new strategies are adopted according to the lessons learnt from the field. These changes are not viewed as a failure but as a chance to rethink and improve process for ensuring success.

- Initial design was focused on both public and private sector providers but due to non-availability of public sector providers as per quality specifications for selection, project selected only private sector providers.
- Continuous link with the community is essential for enhancing confidence of the beneficiaries and uplifting credibility of the project.
- Service quality is linked with careful selection of service providers as such project expects both clinical as well as managerial expertise. Building expertise on recording and reporting tools is essential for service providers.
- Lack of transport infrastructure is a major hindrance in accessing healthcare facilities by TUP beneficiaries. However, linkage is formulated with BRAC's community ambulance services for overcoming this barrier. It highlights the importance of patients' transportation mechanisms, which should be put in place in addition to providing free quality healthcare for rural population.
- Limited availability of service providers in intervention area is a major constraint in building a competitive service delivery environment. This resulted in limited cooperation by service providers in utilizing all the MIS tools provided at their facilities. However, it is tackled by assigning this responsibility to field coordinators.
- Social safety nets are not sufficient – availability of services, mainly at the doorsteps for scattered population in areas is necessary. Other modalities like operationalizing mobile health units are necessary to enhance the access and coverage.
- Institutionalization of such forms of social safety nets are necessary for bringing improvement in health outcomes of poverty-stricken rural communities of Pakistan. However, it is important not to streamline all aspects of such projects and continuous technical assistance should be sought in the process of institutionalization.

3.4.2 Scaling up

Ideally, social safety nets should be scaled up at two levels, first as small-scale pilot and then applying it to full target population, and second as full geographical expansion. Similarly, SSC was initially piloted on a small scale covering below poverty line population with only MNCH related services. Given the promising results in terms of improved health outcomes and equality, this scaled up to cover a larger population group with wide range of healthcare services. Now it is time to enhance the scale of coverage to bring sufficient impact on poverty reduction as well as cost effectiveness. Efficiency shall also be enhanced through scaling up as there are certain relatively fixed administrative costs inherent in the implementation of such projects like expenditures on technical assistance provided by the implementing agency. As the project is scaled up, numerous initially established systems like computer software for database, MIS tools, training materials, contract negotiation skills, etc. shall be employed to reduce cost.

Section IV: Annexes

Annex 1: List of service providers

Tehsil Bela

S/No.	Clinic/ Hospital/ Medical Store	Service Package	Payment Heads
1.	BRAC Clinic	· PHC services, including · Basic laboratory tests	· Consultation · Medicines · Investigation
2.	Fatima Helping Hand Charity Hospital	· PHC services, including · Laboratory tests	· Consultation · Investigation · Services
3.	Tanisha Medical Store, Main Bazar Bela	Provision of prescribed Medicines and Consumables	· Medicines

Tehsil Hub

S/No.	Clinic/ Hospital/ Medical Store	Service Package	Payment Heads
1.	BRAC Clinic	· PHC services, including · Basic laboratory tests	· Consultation · Medicines · Investigation
2.	Fatima Helping Hand Charity Hospital	· OPD service · Natal services, including · Laboratory tests	· Consultation · Investigation · Services
3.	Zahid Medical Centre & Maternity Home	· Specialized services for referred patients including Operation theatre, paediatric nursery, etc. · Emergency and accident services, · Laboratory tests not available at BRAC Clinic	· Consultation · Investigation · Services (delivery, procedures etc) · Medicines (medical store within this health facility)
4.	Tanisha Medical Store	Provision of prescribed Medicines and Consumables	· Medicines

Tehsil Uthal

S/No.	Clinic/ Hospital/ Medical Store	Service Package	Payment Heads
1.	BRAC Clinic	· PHC services, including · Basic laboratory tests	· Consultation · Medicines · Investigation
2.	Shahbaz Clinic	· OPD services	· Consultation
3.	Tanisha Medical Store	Provision of prescribed Medicines and Consumables	· Medicines

Annex 2: Template of MOU signed with service provider

MEMORANDUM OF UNDERSTANDING

Sehat Sahulat Scheme (Family Health Insurance)

The MOU is made for provision of health care services under Sehat Sahulat Scheme (Family Health Insurance) (SSS-FHI), being implemented with the financial assistance of the BRAC Pakistan, between the Contech International Lahore and _____ District Lasbela Balochistan.

The _____ will be responsible to:

- ensure availability of quality health care services as referral hospital,
- provide quality health care services / advice to the beneficiaries of SSS after confirming:
  - identity from SSS card, and
  - referral slip from authorized clinic / hospital,
- maintain treatment record of each beneficiary using 'Patient Reporting Form',
- maintain contact with Contech's Tehsil/District Coordinator,
- charge the services, as per user-charges – annex-1,
- prepare monthly re-imbursement bill on the letter-head, duly supported with treatment / operation notes, vouchers etc.-annex-2,
- hand over re-imbursement bill to Contech's Tehsil Coordinator,

Contech International will be responsible to:

- provide list of referring clinics / hospitals,
- maintain constant liaison with partner in smooth implementation of the scheme,
- pay monthly reimbursement bill in favour of signatory of this MoU,
- Contech shall monitor performance through its Tehsil / District Coordinator and authorized representative of head office,

Timeline

Both allies will abide by the timeline starting from **_____, *2011*** to **_____, *2012***.

Commitment to Partnership

1. The collaboration service area includes District Lasbela Balochistan, Pakistan.
2. We, the undersigned have read, agree with and approve this MOU.
3. Partners retain the right to terminate this MoU subject to one month notice.

By _____
Name:
_____
Ph: 0853-363115
Zahid Medical Center & Maternity Home,
Main RCD Road, Hub - Lasbela Balochistan
Date _____

By_____
Dr. Naeem ud Din Mian,
CEO, CONTECH INTERNATIONAL,
2-G, Model Town Lahore Pakistan.
Ph: 0423-5888798-9
Email: contech@brain.net.pk
Date _____

Annex 3: Template of MOU signed with pharmacy

MEMORANDUM OF UNDERSTANDING

Sehat Sahulat Scheme (Family Health Insurance)

The MOU is made for provision of medicines under Sehat Sahulat Scheme (SSS), being implemented with the financial assistance of the BRAC Pakistan, between the Contech International Lahore and TANISHA MEDICAL STORE at Main Bazar Bela, District Lasbela Balochistan.

The Tanisha Medical Store will be responsible to:

- ensure availability of properly stored required quality drugs and consumables,
- provide drugs and / or consumables to the beneficiary of SSS after confirming:
  - identity from SSS card, and
  - prescription from authorized clinic / hospital,
- prepare separate voucher for each beneficiary, bearing 'Household (H.H.) No. of Targeted Ultra Poor (TUP) and date,
- keep record of each item provided to the beneficiary in the attached 'Voucher Register' format,
- handover prescription and original voucher/s to 'Contech's Tehsil Coordinator' along with summary, and get receiving signatures on voucher register,

Contech International will be responsible to:

- maintain constant liaison with partner in smooth implementation of the scheme,
- pay monthly reimbursement bill in favour of signatory of this MoU,

Timeline

Both allies will abide by the timeline starting from _____***, 2011*** to _____***, 2012***.

Commitment to Partnership

4. The collaboration service area includes Tehsil Bela, District Lasbela Balochistan, Pakistan.
5. We, the undersigned have read, agree with and approve this MOU.
6. Partners retain the right to terminate this MoU subject to one month notice.

By _____
Name:
_____
Ph:_____
TANISHA Medical Store Bela
District Lasbela, Balochistan
Drug Sale License No.
_____
Date _____

By_____
Dr. Naeem ud Din Mian,
CEO, CONTECH INTERNATIONAL,
2-G, Model Town Lahore Pakistan.
Ph: 0423-5888798-9
Email: contech@brain.net.pk
Date _____

Annex 4: SSC ID

Visit Record

Date	Clinic/Hospital Name	H.M.No.

Name of Household Head: ____________

Family Members

H.M.No.	Name	Age
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		

Date of Issue: ____________

Issued by: ____________

Valid upto: ____________ Stamp:

Contech International

brac

Sehat Sahulat Scheme

(Family Health Insurance)

District LASBELA

FAMILY PROFILE

Name of TUP: ____________

Household No: ☐☐☐☐

Goth: ____________

Tehsil: ____________

Visit Record

Date	Clinic/Hospital Name	H.M.No.

Visit Record

Date	Clinic/Hospital Name	H.M.No.

Visit Record

Date	Clinic/Hospital Name	H.M.No.

Annex 5: Patient Prescription Form

Sehat Sahulat Scheme (Family Health Insurance)
BRAC Pakistan
District Lasbela, Balochistan

Name of Clinic/ Hospital: _____

Patient Name: _____

H.H. No. _____ H.M. No. _____ Date: _____

Diagnosis/ Service	Rx	Test Advised
1. Ante-natal		
2. ARI		
3. COAD		
4. C- Section		
5. Dermatitis		
6. Diabetes Mellitus		
7. Diarrhoea		
8. Dysentery		
9. Ear Infection		
10. Family Planning		
11. Hypertension		
12. Malnutrition		
13. Minor Injuries		
14. Normal Delivery		
15. Osteo- Arthritis		
16. Post-natal		
17. PUO		
18. Scabies		

Annex 6: Patient Reporting Form

Contech International

PATIENTS' REPORTING FORM

Sehat Sahulat Scheme (Family Health Insurance) BRAC Pakistan - District Lasbela, Balochistan

brac

Name of the Health Facility: _____ **Tehsil:** _____ **Month:** _____ **/201__**

Date of visit	H.H. No.	H.M. No.	Patient Name	Age (D/M/Y)	Sex (M/F)	Diagnosis	Investigations Advised	Treatment (Write all medicines provided)

Prepared by: _____

Name: _____

Annex 7: Prescription Summary Form

MONTHLY SUMMARY

Sehat Sahulat Scheme (Family Health Insurance) - BRAC Pakistan

Tanisha Medical Store, _____

District Lasbela, Balochistan

Month _____ 201__

Date	Number of Prescriptions	Number of Vouchers	Cost (PKR)

Signatures: _____

Date: _____

Annex 8: Reimbursement Form

Reimbursement Bill for the Month of_____, 201__ Page _____ of _____

_____ - District Lasbela Balochistan

Date of visit	H.H. No.	H.M. No.	Patient Name	Cost of Services (PKR)					Total Charges (PKR)
				1.Consultation	2.Medicine	3.Investigations	4.Procedures	5.Others (specify)	

Prepared by:

Signatures:_____
Name:_____
Date:_____

Verified by *(Contech's Tehsil / District Coordinator)*:

Signatures:_____
Name:_____
Date:_____

Documents attached:

1. Treatment notes/prescription, 2. Medicine voucher, 3. Lab. test voucher, 4. Operation notes, 5. others (specify please)