Healthcare and Urban Poor: A View From Pakistan

Second in a six-part series, entitled “The Future of the Urban Poor”

A talk by

By Dr Asher Hasan
(Founder and CEO, Naya Jeevan, Karachi)

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Ideas and Action for a Better India

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Newsletter

Deepa Dinesh and Radha Viswanathan
The Observer Research Foundation Mumbai (ORF) and Intellecap jointly organised their second event in the six-part Speaker Series titled ‘The Future of the Urban Poor’ on Wednesday, 24th August 2011. The guest speaker on the occasion was Dr. Asher Hasan, founder and CEO of the Karachi-based Naya Jeevan, a not-for-profit social enterprise dedicated to providing low-income families throughout the emerging world with affordable access to quality healthcare. He was joined in conversation with Ms. Rupa Subramanya, an economist and columnist who participated as a panelist at this event.

This speaker series looks at equitable and sustainable development of cities in India, Pakistan and Bangladesh - a region that is home to nearly 25% of the world population, comprises 3% of its land area and significantly, 45% of the world’s poor.

A View from Pakistan

Before going on to present his unique ‘Robin Hood’ model for ensuring good healthcare privileges accessible for the urban poor, Dr. Hasan introduced the healthcare quagmire of Pakistan to the audience through his experience in establishing and running Naya Jeevan. Drawing up stark similarities between Pakistan, India and Bangladesh, he mentioned the following facts:

- Public expenditure on healthcare in Pakistan is less than 3% of total expenditure.
- More than 70% of basic health units are without doctors or nurses.
- More than 50% of rural health centres suffer the same fate.
- The private sector caters for 70% of Pakistan’s population or 40 million low-income households and 99.3% of this population are not covered by health insurance.
- Like in India, medical calamities can lead to generational poverty and debt among millions of poor people in Pakistan.

Pakistan has witnessed rapid urbanisation and currently 38% of the population of lives in urban areas. Its cities are experiencing increasing influx of economic migrants who come from rural areas in search of jobs. Even within the urban setup, there is vast inequality in healthcare accessibility between the non-poor and poor. “The urban poor, starved for resources are even worse off than their rural counterparts,” Dr. Hasan said, terming this disparity between the haves and the have-nots as socio-economic “apartheid”. He attributed this phenomenon to the lack of social conscience of the affluent and privileged people who live in cities, which he said, “resonates in the juxtaposition of slums and the affluent, glistening, glass buildings and residential bungalows in cities like Mumbai and Karachi”.

He recounted the plight of the Swat Valley refugees at refugee camps in Peshawar, “who suffer greatly due to poor drinking water and sanitation facilities which have resulted in large scale outbreak of infectious diseases” and compared them with living conditions present in the shanty towns / urban slums in the mangrove swamps of Karachi. These slums, he said, are “illegally occupied” by 700,000 people living in conditions of abject poverty. Since these are unauthorised dwellings, the government does not provide them with even the most basic healthcare services, an unfortunate reality in common to Pakistan, India and Bangladesh.
Alarmingly, total lack of access to healthcare has created a situation in Pakistan where infant mortality rate in rural areas is almost the same as that of the urban poor (around 63/1000 live births/year according to the CIA world factbook). Percentage of women receiving pre-natal or post-natal care among the urban poor was worse than the 20% women who receive this care in rural areas in 2006. The worst infant (under 5 years of age) mortality among the SAARC countries is in Pakistan (101 infants out of every 1000 will die before the age of five in Pakistan whereas the SAARC average is 85 out of every 1000). Sri Lanka has made significant headway in public health measures be it in immunisation, infant mortality rate or maternal mortality rates. “In 2011, 15 million kids will die of preventable diseases in South Asia, which is a sinful waste of human resources,” Dr. Hasan said.

He maintained that provision of affordable or free basic education and healthcare to every citizen by the state should be the social obligation of the governments. “However, governments in the South Asian region are spending dismally low amounts on public health and even this negligible amount is mostly siphoned off by corrupt bureaucrats. The state’s healthcare infrastructure is currently dilapidated, under-resourced and overwhelmed. At the current pace of reforms, this inefficiency will take at least two or three decades to be effectively removed and we simply cannot wait that long,” he remarked.

He said that to overcome these inefficiencies, Naya Jeevan had come up a unique participative health insurance model which could potentially create easy access for the urban poor in South Asia to good healthcare.

### WHO National Health Accounts

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<th>Total expenditure on health as % of GDP</th>
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### The Naya Jeevan model

So should we wait for the system to reform itself? Or should the private sector and the NGO sector step in to create change that is beneficial for all stakeholders? Four years ago, Dr. Hasan along with a bunch of students from California came to India and Pakistan and conducted surveys on the private and public healthcare systems. Their objective was to find out what is the best way to finance and deliver healthcare to lower income groups. One interesting outcome of this survey was that only one million people had access to private healthcare system, and these worked mainly in the corporate sector (esp. multinationals), while nearly 20 million did not have proper access to health care.

“We decided to create a model for providing healthcare for these underprivileged classes by using the resources provided by the affluent class through co-financing,” he said, terming this practice as a “Robin Hood” theory of socio-economic justice. “This does not mean stealing from the rich, but just
cross-subsidising the basic services for the lower income groups in a way in which the affluent stakeholders are also benefitted,” he explained.

Dr Asher Hasan and Mr Shri Kumar

Dr Asher Hasan and Ms Rupa Subramanya

The Naya Jeevan healthcare plan, for just about USD 2 per month, ensures curative healthcare and regular health check-ups for infectious and contagious diseases that become an integral part of preventive care in a country that is still battling avoidable diseases like polio, malaria and hepatitis. Hundreds of employers are signing up for insurance for their low-wage employees, he said. Among other facilities Naya Jeevan has a 24x7 toll-free number which directs people to authorised surgeons/clinics who guide them with proper medical advice.

Naya Jeevan provides health care for three groups of people:

1) Low income households – making less than 20,000 rupees per month and also are domestic help
2) Uninsured contract workers or factory workers
3) Kids studying in NGO schools and their families

To illustrate this concept, Dr. Hasan portrayed the scenario of the distribution channel of the FMCG giants Unilever and P&G, how products from their factories reach the last buyer in cities, towns and villages. More often than not, the small retailers themselves and the people employed by them at the end of the distribution chain belong to the low income category. In Pakistan, Naya Jeevan has started a loyalty programme financed by Unilever and P&G to provide health insurance, as a sales incentive to these small retailers and the people employed by them.

He also gave another example. “If you consider 800 officers and managers who work at P&G, there are about 20,000 low income workers and their children directly or indirectly employed by them. They could be anyone – domestic help, drivers, dhobis, gardeners etc. The health insurance of these people can be taken care of by buying of bulk health insurance from large insurers like Allianz with a major contribution from the employers and minor contribution from the low income people who are employed by them. This can be scaled up significantly by bringing in more and more middle and upper management employers into the fold. By increasing the risk pool and amplifying the number of insured people from one million to 20 million, the cost of insurance is lowered and subsidised for
all stakeholders and the people at the lowest rung of the employment ladder get access to good healthcare,” Dr. Hasan explained.

Besides medical coverage, services offered by Naya Jeevan under this plan also extend to teaching employable skills in the urban environment in the areas of the multi-national companies’ strategic interests such as sanitation, child care etc. “The services could also include donor-funded rescue for catastrophes not covered by traditional insurance. We emphasise on providing preventive health services and leverage technology to spread health awareness. The ultimate goal is social impact,” he said.

During the Q&A session which followed the talk, Dr. Hasan said that making the poor familiar with the nebulous idea of insurance and getting them to contribute could be facilitated by giving them an opportunity to experience the tangible benefits of health insurance. “On the other hand it is also important to convince the employers of the cost benefits if they expanded the base. Companies have strategic interest in empowering consumers of the future. So investing through the supply chain is effective for them, as it becomes a conduit for enrolment. In return, the company tries to sell its entire range of products through the retailer. So it is mutually beneficial. Aggregating large pools of low income group, Naya Jeevan acts as an aggregator, catalyser and value enhancer,” he said.

However, Dr. Hasan did agree that as of now, the plan has some limitations. It is specifically targets the urban poor and it’s only available in three major cities in Pakistan. Also it is solely reliant on the cooperation of conscientious employers. Scalability is possible only through franchises or PPPs. The organisation is currently in talks with the federal and provincial governments in Pakistan to adopt its schemes for industrial workers.

In his opening remarks, Mr. Shri Kumar, CEO, Intellecap, said that attempts at making PPP models viable in resolving social problems in South Asia, has made the region a “veritable laboratory of the world in this regard”. The rest of the world is looking at this populous region to draw some lessons on market-based models or public private partnerships that can deliver better results than many of the older models for providing basic health care services, he said.

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About The Future of the Urban Poor Series: The “Future of the Urban Poor”, a six-part series hosted jointly by the Observer Research Foundation and Intellecap—and supported by the Rockefeller Foundation, aims to advance knowledge sharing on urban issues that impact the poor. The series will bring together key stakeholders, experts and practitioners, from India, Pakistan and Bangladesh, working on innovative development initiatives in the urban context to inspire new ideas and work towards action. Future topics will include healthcare, urban planning, gender and development, technology and participatory governance.

About Observer Research Foundation Mumbai: ORF is a public policy think tank that aims to influence policy formulation for building a strong and prosperous India. ORF pursues these goals by providing informed and productive inputs, in-depth research and stimulating discussions. The foundation is supported in its mission by a cross section of India’s leading public figures, academics and business leaders.

About Intellecap: Intellecap is a global advisory firm which provides intellectual capital to catalyze businesses with positive social and environmental outcomes. Intellecap also offers Business Consulting to clients positioned at the intersection of inclusive and mainstream sectors, including agriculture, food and rural business; clean energy; education; financial inclusion; healthcare, water and sanitation; and technology for development.

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