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CONTEXTUALISING SEHAT SAHULAT PROGRAMME IN THE DRIVE TOWARDS UNIVERSAL HEALTH COVERAGE IN KHYBER PAKHTUNKHWA, PAKISTAN

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ABSTRACT

OBJECTIVES: To describe the evolution of the Sehat Sahulat Programme (SSP), a large-scale health insurance scheme launched by the provincial government of Khyber Pakhtunkhwa, Pakistan and to contextualise it in the national discourse around Universal Health Coverage (UHC).

METHODS: This review was based on peer-reviewed publications and publicly available grey literature over the last five years (2016-2020). We employed a combination of deductive and inductive approaches informed by the World Health Organisation's (WHO) UHC box framework.

REVIEW: SSP was launched on 15 December 2015. It has been implemented in four phases, with a gradual expansion in the population, services and cost coverage. In 2015, SSP covered the poorest 21% of the population in four pilot districts. On 20 August 2020, the coverage was expanded to 100% of the population of Khyber Pakhtunkhwa. SSP conferred free access to an expanding list of inpatient, secondary and tertiary care services. The scheme covered all expenditures during hospital admission, with a defined upper ceiling. The ceiling for secondary and tertiary care has improved, with marked changes in tertiary coverage, from PKR 0 in Phase I PKR 400,000 in Phase 4. Despite the progress, SSP did not cover key health-related targets under Goal 3 of the Sustainable Development Goals (SDGs) and partially covered Pakistan's UHC benefits package.

CONCLUSION: SSP coverage of population, disease and financial protection has expanded over five years. However, SSP coverage was not aligned with the national UHC priorities and the SDGs.

KEYWORDS: Sehat Sahulat Programme (Non-MeSH); Insurance (MeSH); Insurance, Health (MeSH); Universal Health Coverage (Non-MeSH); Disease Control Priority Volume 3 (Non-MeSH); Social health protection (Non-MeSH); Sehat insaf (Non-MeSH); Khyber Pakhtunkhwa (Non-MeSH); Pakistan (MeSH).

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INTRODUCTION

Under the Sustainable Development Goals (SDGs) commitment, all member states (193 countries) of the United Nations have agreed to achieve Universal Health Coverage (UHC) by 2030.¹ UHC is an inspiration to enable all people to have access to health care of sufficient quality to be effective, irrespective of their ability to pay at the point of service.¹ Like many economically developing countries, Pakistan does not have UHC.² Low government spending

on health care has been one major barrier in achieving UHC.³

In 2014-15, around 24.0% of Pakistan's population (~50 million people) lived under the national poverty line. The national poverty line was defined as an income of 3,250 Pakistani Rupees (PKR) or 15.3 Great Britain Pounds (GBP) per adult equivalent per month.⁴ In 2015-2016, 57.6% of the health care expenditure in Pakistan was out-of-pocket (OOP).⁵

In the wake of the SDGs and the resulting global push for UHC, the

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Federal and Provincial Governments in Pakistan launched three large-scale social health protection (SHP) schemes. These schemes conferred free health insurance, covering inpatient care for families living under the national poverty line.^{6,7} Launched by the Government of KP, SSP was the first and the largest of the SHP schemes.⁸

In this review paper, we will describe the evolution of SSP since 2015. We will contextualise SSP in the national discussion around UHC and discuss the opportunities and challenges facing the programme to inform the future strategy to achieve UHC.

METHODS

This review is based on peer-reviewed publications as well as publicly available grey literature. We searched for the literature using Google, Google Scholar, PakMediNet and PubMed. The keywords were "Sehat Sahulat", "social health protection", "Universal Health Coverage", "Sehat Insaf Card", and different variants of these keywords, along with their combinations, using the Boolean characters of [AND] and [OR]. The search was limited to 1 January 2015 to 1 January 2021. No geographical restrictions were applied to the searches. Papers and documents published in either English or Urdu were included.

The official websites of SSP (<https://sehat-sahulat.com.pk/>), the KP Health Department (<http://www.healthkp.gov.pk/>) and Pakistan's Ministry of National Health Services, Regulation and Coordination (MNHSR&C) (<http://www.nhsr.gov.pk/>) were also searched for content in English as well as Urdu.

A mix of deductive and inductive approaches was adopted in the review. The chronology, policy parameters and political dimensions of SSP were explored using the inductive approach. The UHC box framework guided the deductive approach. The findings of this review are presented under three headings, namely: (I) The evolution of SSP, (II) SSP in the national discourse on UHC, (III) opportunities and challenges.

REVIEW

We found several documents, which helped us to contextualise the SSP in the discussion around UHC in Pakistan.^{9,12} The official documents were useful in describing the evolution of SSP in terms of the population, services and financial coverage.^{6,8,13,14} Several peer-reviewed publications and unpublished research studies helped us in reflecting on the opportunities and challenges facing the SSP.¹⁵⁻¹⁹

The KP Government launched SSP on 15 December 2015.⁸ The overall objective was "to improve access to health services by the poorest population groups in the programme region by reducing financial barriers and strengthening the quality of health service provision".⁸ It was a pre-pooled health care financing scheme to be managed through an insurance firm. SSP has been implemented in four phases, increasing the population, services and cost coverage.^{6,8,13} Table I summarises the date of initiation, geographical coverage, source of funding, total financial cost and premium for each phase. In the following pages, we will briefly reflect on the population, services and cost coverage under the SSP, along the three dimensions of the UHC box framework.^{20,21}

I. The Evolution of SSP (UHC Box Framework)

Population Coverage (Phases I 4)

In Phase I of SSP (2015-16), the poorest 21.0% of households in four districts (approximately 2.0% of the province population) were eligible. Poverty score on the National Socio-Economic Registry defined the eligibility for enrolment. The enrolled households had a proxy means testing (PMT) score of 16.7 or less.⁸ PMT testing calculates

the financial means based on proxy measures like the ownership and structure of the house and the consumption patterns.²²

In Phase 2 (2016-17), the target was to enrol households with a PMT score of 24.5 or below.¹³ Around 51.0% of the households in the province met this criterion. In Phase 3 (2018-19), the enrollment unit was changed from household to family.⁶ A family comprised of a wife, husband and their unmarried children. In one household, there could be multiple families. The cut-off for enrollment under Phase 3 was a PMT score of 32.5 or below.⁶ In Phase 4 (2020), the population coverage under SSP was extended to 100% of the permanent residents of KP.¹⁴ Hence, the eligibility for SSP enrollment changed from poverty to residence status.

Services Coverage (Phase I Phase 4)

In Phase I, SSP provided inpatient, secondary health care services.⁸ Secondary services were defined as any service provided at a district headquarter (DHQ) hospital. The panel hospitals, i.e. a network of selected public and private hospitals at the district level, would provide the services.⁸ In Phases 2 and 3, coverage of tertiary care for some priority diseases was introduced.^{6,13} The tertiary care covered under Phase 2 and 3 included:

1. Accident and emergencies
2. Cancer treatment
3. Cardiovascular diseases, including congenital heart problems
4. Coverage for treating organ failure, but excluding organ transplant
5. Management of cerebrovascular accidents
6. Treatment for viral Hepatitis B and C complications
7. Treatment of diabetes complications

In Phase 4, the tertiary coverage was expanded to:¹⁴

1. Breast cancer screening
2. Complications of secondary care diseases needing referral to tertiary care
3. Management of genitourinary diseases, including dialysis
4. Management of neurosurgical diseases

5. Prosthesis/artificial limbs

Pre-existing conditions were covered. Screening for diseases, e.g. breast cancer and rehabilitation elements, appeared for the first time in the programme. However, these services were under tertiary care instead of primary and rehabilitation services.¹⁴ SSP had excluded mental health services, contraceptive treatment/devices, treatment for substance abuse, sexually transmitted diseases, and attempted suicides.¹³ Though treatment for complications arising from diabetes mellitus and viral Hepatitis B and C are covered, their primary treatments were not.

Financial Coverage (Phases I 4)

SSP started with limited coverage of PKR 25,000/- per household per annum. There was no tertiary coverage.⁸ Figure I shows changes in the financial coverage under SSP over the last five years. The financial coverage for tertiary care has continuously risen. In contrast, coverage for secondary care had an initial rise and then fell.

In all four phases of SSP, the KP Government paid the insurance premium on behalf of the insured population. There were no co-payments, deductibles or compulsory contributions.^{6,8,13} Table I summarises the premium and coverage amount of SSP under the four phases. The scheme planned to introduce voluntary health insurance (VHI) products for those who could afford, to cross-subsidise the poor.⁸ However, the VHI product never took off.¹⁵ In Phase 4, however, a supplementary product was introduced on a commercial basis.²⁴

The provider-user interaction in SSP was cashless. The users got the required services at the panel hospitals. The provider submitted a claim to the insurer. The insurer paid the claimed amount to the provider on a case-based approach.^{6,8,13,24} If a patient exhausted their coverage during a hospital admission, an additional amount came from a reserve fund. The reserve fund was established by pooling PKR.50 per family per annum in the first three phases. It was capped at PKR.40/- per family per annum in Phase 4.^{6,8,13,24} As provided in Table I, in Phase 2 and

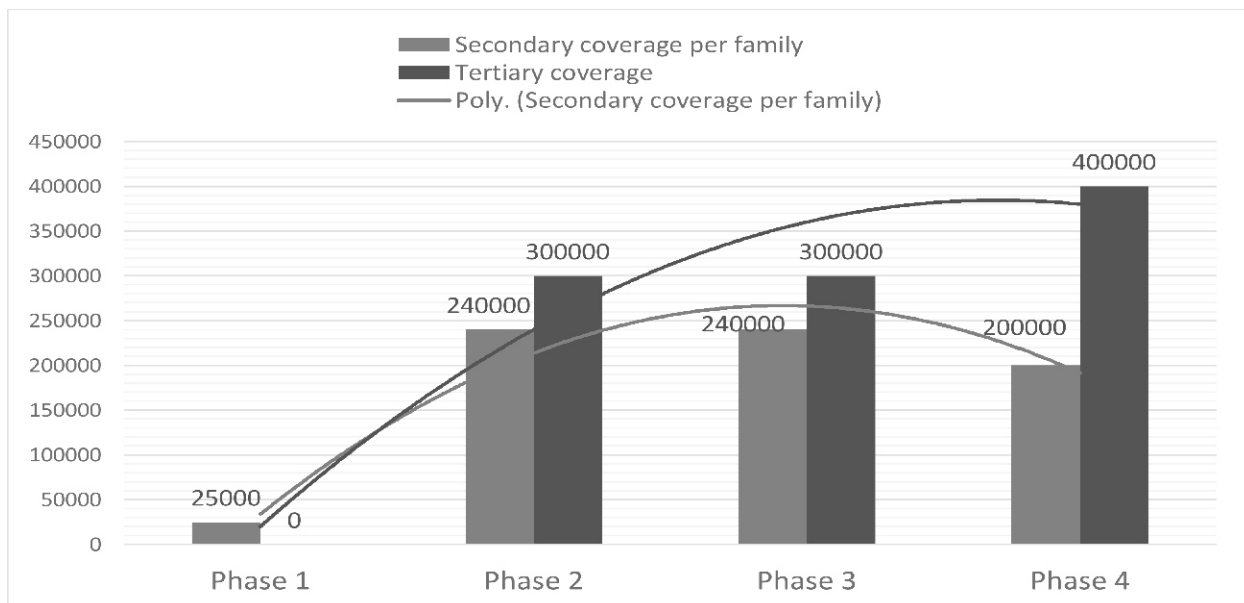


Figure 1: Evolution of SSP: Financial coverage (Phase I-Phase4)

TABLE I: PHASE-WISE DETAILS OF SSP IN TERMS OF POPULATION, SERVICES AND COST COVERAGE

	Salient Features	SSP Phase1 (2015-16)	SSP Phase 2 (2016-17)	SSP Phase 3 (2017-19)	SSP Phase 4 (2020 and onward)
Area		Four districts	Entire province, i.e. 26 districts	Entire province, i.e. 26 districts	Entire province, i.e. 26 districts
Source of Funding		KFW + Government of KP (88.0%:12.0%)	Government of KP (general revenue)	Government of KP (general revenue)	Government of KP (general revenue)
Total Funding		PKR. 1.4 billion (GBP 6.5 million)	PKR.5.4 billion (GBP 25.2 million)	PKR. 6.5 billion (GBP 30.4 million)	PKR. 18 billion(GBP 86.4 million)
Premium		PKR.1661/- household (GBF 7.8)	PKR.1549/- per household. (GBP 7.2)	PKR.21,00/- per family	PKR. 28,49/- per family
Project Launching		15 December 2015	31 August 2016.	30 November 2017.	20 August 2020
Duration of Project		ADP scheme for five years	ADP scheme for two years	Ongoing programme	Ongoing programme
Who is Covered?	Enrollment criteria	PMT Score of 167 or less	PMT Score of 2.45 or less	PMT Score of 3.25 or less	Entire population
	Percentage of population	21.0% bottom population	51.0% poorest population	69.0% population of the province	100% population of the province
	Enrollment unit	Household	Household	Family	Family
	Maximum members per unit	Seven persons	Eight persons	Unlimited	Unlimited
	Total population covered	0.1 million households	1.8 million households	2.4 million family	Around 6.1 million families
What is Covered?	Type of services	Inpatient services only	Predominantly inpatient Services	Predominantly inpatient services	Predominantly inpatient services
	Outpatient Cover	Maternity services only	Maternity services and cancer care	Maternity services and cancer care	Maternity services and cancer care
	Secondary Diseases	All inpatient secondary care.	All inpatient secondary care.	All inpatient secondary care.	All inpatient secondary care.
	Tertiary Conditions	None	Limited tertiary cover	Limited tertiary cover	Enhanced tertiary cover
	Primary health care	Not covered	Not covered	Not covered	Not covered
What amount of expenditure is covered?	Insurance mechanism	Demand-side financial support	Demand-side financial support	Demand-side financial support	Demand-side financial support
	Beneficiary/provider interaction	Cashless	Cashless	Cashless	Cashless
	The upper limit for secondary care	PKR.25,000/- per person per year(GBP 116.6) PKR. 175,000/-household/year (GBP 816.5)	PKR.30,000/ person/ year (GBP 140) PKR.240,000/ household/ year (GBP 1,119)	PKR.30,000/ person/ year (GBP 140) PKR.240,000/ household/year (GBP 1,119)	PKR.40, 000/ person/ year (GBP 186) PKR.200, 000household/ year (GBP 932.6)
	The upper limit for tertiary care	None	PKR.3000,00/household/ year (GBP 1,400)	PKR.300,000/household/ year (GBP 1,400)	PKR.400,000/family/year (GBP 1,866)
	Wage replacement	None	PKR.250/- per day for three days (GB 1.12)	PKR.250/-per day for three days (GB 1.12)	PKR.250/- per day for three days (GB 1.12)
	Tertiary transportation	None	PKR.2000/-at hospital discharge (GB 9.3)	PKR.2000/-at hospital discharge (GB 9.3)	PKR.2000/-at hospital discharge (GB 9.3)
	Maternity transportation	None	PKR.2000/-at hospital discharge (GB 9.3)	PKR.2000/-at hospital discharge (GB 9.3)	PKR.2000/-at hospital discharge (GB 9.3)
	Burial allowance	None	PKR.10,000/-in hospital death (GBF 46.7)	PKR.10,000/- in hospital death (GBF 46.7)	PKR.10,000/- in hospital death (GBF 46.7)
	OPD voucher	None	One OPD voucher for follow-up	One OPD voucher for follow-up	One OPD voucher for follow-up

onward, the programme started coverage for indirect costs as well.^{6,8,13,24}

I. SSP and the national discourse on UHC

Pakistan's national health vision is "to improve the health of all Pakistanis, particularly for women and children, through universal access to affordable quality essential health services".¹⁰ The action plan developed by MNHSR&C

sets advancing UHC as a strategic priority.⁹ In consonance with the national health vision and action plan, MNHSR&C designed a UHC benefit package.^{12,25} The draft UHC benefits package was planned to be implemented by the four provincial health departments, with interventions spreading across five levels of care (platforms) and five [disease] clusters.^{12,25}

In 2019, the MNHSR&C reviewed the

essential universal health coverage (EUHC) services availability in Pakistan. EUHC is a model benefit package that all middle-income countries should target to achieve by 2030.²⁶ In total, 135 (62.0%) of the EUHC interventions were implemented in Pakistan. The review concluded that the level of services was not sufficient to make considerable progress towards UHC.¹²

II.SSP in the context of UHC; opportunities and challenges

The financial resources of SSP and its panel hospitals present an opportunity to deliver the EUHC services/interventions. All the tertiary care and most of the district-level hospitals in KP render services under SSP.¹⁵ Most of the EUHC interventions were available at the tertiary and the district level hospitals.¹² Similarly, the UHC benefits package provides an impetus for SSP to streamline its services.^{12,25} The national health vision and the action plan provided a framework for SSP to contribute towards achieving UHC in KP and the country.^{9,10} However, aligning the SSP with the national benefits package and the national health vision would be challenging.

The challenges were political, technical and financial. Politically, SSP is a hailed step. The Prime Minister of Pakistan, Imran Khan, labelled the 100% population coverage as the first step towards a welfare state.^{27,29} The political leadership has branded SSP as universal health insurance, but this was contested.^{27,29} With limited hospital-centric scope, SSP could not be the foundation of UHC in KP. The rapid expansion has complicated the institutionalisation of SSP.¹⁵ It has compromised a transition towards comprehensive coverage for the most vulnerable.^{15,30} The working hypothesis of SSP was that primary health care (PHC) is free and accessible. However, it was neither free nor accessible.^{12,25}

Technically speaking, SSP was a health care financing reform to address the high OOP expenditure, inaccessibility, inequity and faltering quality of health care.⁹ However, inequitable utilisation persisted even with the SSP.¹⁶ Service utilisation under the SSP by younger adults (20-35 years of age) outweighed the utilisation by the vulnerable groups, i.e. children, women and senior citizens.¹⁶

The SSP utilisation data have shown inequitable utilisation by sex as well.¹⁶ When controlled for obstetric services, utilisation by men was significantly higher than women.¹⁶ Also, higher utilisation in the private sector and the central districts compared to the lesser developed districts of KP was reported under the SSP.¹⁶

The official indicators for measuring the progress of SSP were very limited, including (i) the number of families enrolled, (ii) reduction in OOP expenditure on health, (iii) reduction in poverty associated with health costs, and the (iv) insurance card utilisation rates.^{6,13} The SSP progress indicators were more aligned with poverty alleviation than a health-centric initiative.^{6,13}

The programme did not measure and report on the 16 tracer indicators mentioned in the WHO UHC monitoring framework.³¹ The SSP indicators were also out of step, with the 23 indicators published under the effective UHC coverage index.³² The funding stream of SSP was not stable.¹⁶ Initially, SSP had a policy of covering the poorest through subsidy and enrolling the affluent families on a commercial basis.⁸ Both the subsidised and non-subsidised groups were to have the same benefits package.¹⁵ The proposal went unheeded.¹⁵ On the contrary, SSP introduced a supplementary coverage plan for richer families.³⁰ The supplemental plan will entitle those willing to pay a premium to executive services and provider choice, including access to top-notch private hospitals.¹⁴

The financial implications of SSP have increased. From Phase 2 onward, the premium has persistently hiked, despite a larger pool and a reduced size of the enrolment unit.¹² This trend hinted towards a lack of strategic purchasing in SSP. The financial sustainability argument is crucial, keeping in view Pakistan's narrow tax base (limited fiscal space).³⁴ In Pakistan, tax revenue made only 12.9% of the GDP.³⁴ The premium cost of SSP was paid from the general tax collection.³³ At the same time, the government continued to fund the supply side.³³ SSP, instead of raising revenue through the premium collection, has further strained the limited fiscal space.^{15,30,33} The provincial government did not adjust the supply-side, and therefore, double-dipping has occurred, wasting the limited resources.

DISCUSSION

Summary of Findings

SSP was launched in 2015 to improve access to health services by the most impoverished population. In five years,

the population coverage has expanded from a mere 2.0% (0.1 million) to 100% (6.6 million) of the KP families. The KP government paid the entire population's premium to the insurer from general government revenue. The insurer purchased services from a mix of public and private hospitals. Services were limited to inpatient care at secondary and tertiary level hospitals. SSP had a list of exclusions, denying access to essential services, mentioned under Goal 3 of the SDGs. The MNHSR&C UHC benefits package and the benefits package of SSP were not aligned.

The indicators for measuring the progress of SSP did not include any of the indicators mentioned in the UHC coverage tracer indicators or the UHC effective coverage index. Therefore, the SSP progress could not be effectively gauged and reported on national and international levels. By aligning SSP with the national UHC benefit package and incorporating health-outcome indicators into its monitoring and reporting, SSP might serve as a vehicle in the UHC journey in Pakistan in general and the province of KP in specific.

Strengths and Limitations

The current review has shed light on the evolution of SSP since its inception. The review presents the first commentary on SSP in the broader discourse around UHC. This review provides limited insights into the equity and quality aspects of services provided under SSP. This is due to the paucity of empirical studies or grey literature on these vital aspects of the programme.

Interpretation in the Light of the Wider Literature

The progress made by SSP was huge but not without challenges. SSP has emphasised high-cost, hospital-based care over a community-based PHC approach. A PHC led approach is proven to be cost-effective, with better health outcomes.^{35,36} SSP focused on high-cost services yet lacked a revenue-raising plan for sustainability. Pooling and purchasing functions are inherently dependent on a prudent revenue-raising function of health care financing⁽³⁷⁾

SSP might need a hybrid financing model

befitting KP's resources and constraints.^{36,39} As a hybrid arrangement, many economically developing countries have either established a contributory arm in their insurance programmes or limited the population coverage per their fiscal space.^{36,39} For example, PhilHealth offers insurance to richer families in the Philippines on contribution, passing the subsidy to the poor.⁴⁰

Under Phase 3, the enrollment unit changed from household to family, decreasing the number of members per unit.⁶ In Phase 4, the population coverage under SSP extended to 100% of the permanent residents of KP.²⁴ The large heterogeneous pool with fewer people per unit should have reduced the premium or considerably enhanced the benefits package.³⁸ The opposite has happened at SSP. It hinted towards a lack of strategic purchasing at SSP.³⁹

The programme might become more inequitable with 100% population coverage. The eligibility for enrollment in SSP has changed from poverty to residence status.¹⁴ The poor and the rich became part of the same pool, with no safeguards. By switching the entitlement from poverty to residence, the poor are at risk of exclusion.³⁸ Additionally, Phase 4 has introduced a supplementary policy, which will confer fast-tracked executive services for those able to pay a premium.¹⁴ It may lead to fragmentation within SSP, leaving the poor to long queues and low-quality care.³⁸ Profits from the supplementary coverage might drive high-quality service providers to serve the rich. This phenomenon of internal brain drain might negatively affect the poor.³⁸

The list of exclusions put SSP at odds with the targets and indicators under Goals 3 of the SDGs, i.e. access to mental health services, controlling HIV/AIDS, treatment and rehabilitation of substance abuse and control of sexually transmitted diseases.²³ Sticking to the current inpatient policy image of SSP might contradict the established notions that comprehensive PHC is more foundational in achieving UHC and improving the community's health.^(7,9,37)

Implications for Policy, Practice and Research

The policy implications of this review

are four-fold. First, the progress made under this health care financing reform (SSP) needs institutionalisation, i.e., legal protection, to ensure things do not roll back. Second, SSP has focussed on only one goal of UHC, i.e. financial protection. The programme needs to focus on the other two goals, i.e. quality assurance and equitable utilisation. Third, to gauge the contribution of SSP towards UHC in KP in specific, and Pakistan in general, its benefits package needs alignment with the UHC package developed by the MNHSR&C. Fourth, SSP needs to revise its target indicators. With its current financial indicators, it needs to incorporate health-outcome indicators. The progress indicators should be aligned with the UHC tracer indicators and the effective UHC index indicators for global comparison.

The programme presents a plethora of applied questions on which research is needed. SSP is a flagship programme, injecting billions of rupees through a demand-side intervention. However, we did not find any published literature on econometrics, cost-benefit analysis, cost-effectiveness studies or actuarial studies supporting the programme's expansion. Also, the programme has recorded more than 200,000 admissions so far, but no studies measuring the health outcome and patients' satisfaction were available. Last but not least, we did not find any peer-reviewed or grey literature measuring the programme's core indicators, i.e. reduction in OOP expenditure or poverty alleviation in the covered population.

In view of the foregoing, we recommend that:

1. The progress made under SSP should be institutionalised.
2. The programme should consider a revenue-raising component and adopt strategic purchasing.
3. The supplementary policy should be discouraged. Emphasis should instead be placed on complementary policies to move towards comprehensive coverage.
4. The SSP service coverage and exclusion list should be revised to conform with the targets under Objective 3 of the SDGs and the

national UHC benefits package.

5. SSP should consider the use of internationally available UHC progress indicators.
6. SSP should leverage its data to inform midcourse reforms, engage in research and adopt evidence-based decisions.

CONCLUSION

SSP has rapidly evolved since 2015. It became the first insurance scheme in Pakistan with 100% population coverage. The cost and services coverage has also expanded. With the rapid expansion, the institutionalisation of the scheme suffered, resulting in inequitable service utilisation. It remained a hospital-centric programme, covering high-cost treatments, making the programme financially unsustainable.

SSP has overlooked the revenue-raising component and overstretched the limited fiscal space. The strategic-level political support for SSP is not coupled with a pragmatic design and prudent implementation at the tactical and operational levels, respectively. The national health vision and the national strategy provide the policy framework around which SSP and other provincial schemes could be anchored.

The UHC benefit package developed by the MNHSR&C is quite extensive. The SSP can serve as a vehicle to contribute towards the Maternal, Neonatal and Child Health (MNCH) and the non-communicable diseases NCDs cluster of the national UHC benefit package at the first level care facilities and the tertiary care hospitals.

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AUTHOR'S CONTRIBUTION

Following authors have made substantial contributions to the manuscript as under:

SAK: Conception & study design, analysis and interpretation of data, drafting the manuscript, approval of the final version to be published

KC & AS: Acquisition, analysis and interpretation of data, drafting the manuscript, critical review, approval of the final version to be published

Authors agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

CONFLICT OF INTEREST

Authors declared no conflict of interest

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