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Research Article

The German Development Bank as a policy entrepreneur for social health protection: a case study of the development and implementation of the 'Sehat Sahulat Programme' in Khyber Pakhtunkhwa, Pakistan

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Background

The German Development Bank (KfW) supported the Government of Khyber Pakhtunkhwa (GoKP) to design and implement its first social health protection (SHP) scheme, named the Sehat Sahulat Programme (SSP). We described the role of KfW in the evolution of SSP with a view to identifying transferrable lessons for international development agencies working on similar initiatives in socioeconomically comparable contexts.

Methods

We employed a qualitative instrumental case study design approach. First, we obtained and analysed key programme documents to describe the chronology of events and policy changes. We then undertook in-depth interviews to understand factors influencing policy changes. Finally, we carried out non-participant observations to understand how policy decisions were made and implemented. We employed maximum variation sampling to recruit participants and conducted a thematic analysis of data.

Results

SSP was described by GoKP officials as an innovative financing strategy and a flagship project of the government formed by the Pakistan Tehreek-i-Insaf (PTI). First, programme officials reported that KfW was instrumental in both designing and financing SSP, which had plans to provide free health insurance to low-income families and raise revenue through paid enrollment of the wealthy (solidarity). Second, GoKP deviated from this model and covered the entire population of KP free of cost. Through SSP, GoKP envisaged service provision through private hospitals (subsidiarity). In the third year, GoKP included public sector hospitals in the programme. Although planned supplementary insurance products might result in inequitable utilisation, KfW continued supporting SSP and committed funding for piloting outpatient department services for two years, 2023 and 2024.

Conclusions

This in-depth case study has highlighted the potentially positive role of international development assistance in introducing innovative financing strategies to promote universal health coverage. However, development partners might have limited control over how things evolve.

Sehat Sahulat Programme (SSP), a Social Health Protection (SHP) scheme managed by the Government of Khyber Pakhtunkhwa (GoKP), aimed to improve the health status of people in Khyber Pakhtunkhwa (KP) and reduce poverty.[1] According to the International Labor Organization, SHP is a series of public or publicly mandated private measures that protect against the cost of necessary medical treatment and the socioeconomic distress arising from ill-health.[2]

SSP was designed as an inpatient health insurance programme that aimed to improve access to quality health care services and confer financial protection.[1] SSP addressed the high out of pocket (OOP) expenditure on health care and its

resulting poverty. Solidarity in financing and equity in access were the key tenants of SSP.[1] Solidarity entails paying according to financial ability, and equity in utilisation is the ability to use services as needed, irrespective of the ability to pay.[2]

SSP saw rapid growth in a limited period (2015-2021). In Phase 1 (2015), only 2% of the population of KP was covered by SSP. Coverage increased to 100% by Phase 4 (2020). The disease coverage was enhanced from secondary (2015) to tertiary care (2018) and organ transplantation (2021).[3] In Phase 1, families were covered up to 240,000 Pakistani Rupees (PKR) per year, while in Phase 4, the coverage was enhanced to PKR 600,000/per family per year.[4]

KP, the north-western province of Pakistan bordering Afghanistan, has been prone to natural disasters, armed conflicts, and terrorism.[5] These underlying factors made KP a priority area for development assistance from the German Federal Ministry for Economic Cooperation and Development (BMZ).[5] On behalf of BMZ, the German Development Bank (KfW) was active in KP and supported SSP.[6] In this paper, we describe the role of KfW in the evolution of SSP and the challenges they faced with a view to drawing transferrable lessons for international development agencies working on similar initiatives in socioeconomically comparable contexts.

In a previous paper, we contextualised SSP in the broader efforts of GoKP to achieve UHC in the province. We described its progress on World Health Organization's (WHO) UHC Box Framework.[3] Improving access to health services is a fundamental pillar in achieving UHC, and we will describe SSP's access-related accomplishments and challenges in a separate paper. In another paper, we will describe SSP's role in GoKP's COVID-19 response to draw inferences for the potential role of SSP and similar programmes in promoting global health security.

METHODS

We employed an instrumental case study design approach.[7] When a researcher intends to develop an in-depth understanding of a case (an event, programme or activity), Cresswell and Poth described case study design as the most appropriate approach.[8] Instrumental case study is an approach when 'a case' is used as an instrument to understand the broader issue or concern.[7,9] We selected SSP as an instrumental case to draw inferences for SHP programmes initiated by the provincial Government of Gilgit-Baltistan (GB) and the Federal Government of Pakistan (GOP). The GB and GOP programmes had replicated SSP in different geographical areas, and at the time of our enquiry, SSP was the only programme having 100% population coverage.

DATA COLLECTION

DATA SOURCES

We used three data sources. First, we used the programme documents in the public domain. Second, we conducted in-depth interviews with key stakeholders, and third, we undertook non-participant observations at the SSP policy level meetings and hospital-based SSP implementation desks.

TIMELINE AND ETHICS

We collected data over nine months (March 2021 - December 2021). We had ethics approval from the University of Edinburgh (UK) and the Khyber Medical University (Pakistan). Written informed consent was taken from the study participants.

SAMPLING AND RECRUITMENT

Documents were acquired from the SSP head office and its official website(s) (https://sehatsahulat.com.pk/ and https://sehatcardplus.gov.pk/). The included documents were either authored or commissioned by GoKP, including Planning Commission Form 1 (PC1) and the contracts. PC1 is a standard planning document for all new projects and programmes undertaken by the provincial or Federal Government in Pakistan.

We used maximum variation purposive sampling for the stakeholders' interviews. We conducted interviews at policy (n=30) and implementation levels.[10] At policy level, we interviewed officials from GoKP (n=6), the insurance company (n=5), hospital executives (n=6), representatives of international development agencies (n=8) and patient/public advocacy groups. At implementation level, we interviewed eight persons each at public and private hospitals with equal distribution in secondary and tertiary care levels. We recruited participants through direct verbal or email invitations or indirect invitations through an open display of invitation posters at the stakeholder offices. All participants were provided with participant information sheets and written informed consent was taken before data collection. Interviews were collected in a combination of Urdu and English by the first author and transcribed in English.

For collecting non-participant observations, we used the same maximum variation sampling. To have maximum variation, we collected observations on both the policy and the implementation levels. The policy level observations were collected in meetings convened under the SSP head office. Implementation level observations were collected at the SSP desks in the network hospitals. We collected observations at six public (i.e., three each at secondary and tertiary level) and six private sector hospitals (i.e., three secondary and three tertiary) to have maximum variation. The SSP Director served as the gatekeeper and facilitated access to the meetings and the SSP desks.

TYPES OF DATA CAPTURED

The programme documents helped us capture the chronology of events in SSP. The theoretical underpinnings of the Multiple Streams Theory (MST)[11] and the Health Systems Strengthening (HSS) Framework[12] guided our sampling and analysis. We were able to identify problems that led to the initiation of SSP and the issues that emerged during its implementation.

Through the in-depth interviews, we teased out the tensions between different policy assumptions of SSP (targeted subsidy, private provision, equitable access), deviation from the policy assumptions and the potential impact of such variations on the programme's outcome. Through the observations, we tried to understand how policy decisions were made at the SSP head office and implemented (or not implemented) at the grass-root level, i.e., SSP hospital desks.

DATA ANALYSIS

We conducted thematic data analysis with the help of NVivo 12. We devised a coding framework under different headings of the MST and the HSS. Then we sorted data into the coding framework; and added newer codes as we went through the data analysis. The ongoing data analysis improvised our coding framework, refined our themes, and informed our ongoing data collection. Finally, we organised the codes under four distinct themes of solidarity, subsidiarity, equity and ongoing support of KfW for the programme as a vehicle for promoting Universal Health Coverage (UHC).

REFLEXIVITY

Reflexivity, i.e., awareness of one's standpoint and potential biases, is important for objective writing. SAK, who had worked at SSP as a Deputy Director, was at risk of biased interpretation of the stakeholders' views. Through constant member checks with AS and KC, these biases were minimised. On the one hand, this personal affiliation had upped the risk of biased interpretation, but on the other hand, it helped with access to the case study sites and data collection.

RESULTS

Our final dataset comprised of 20 documents (Appendix 1-supplementary document), 62 interviews (Appendix 2-supplementary document) and 63 hours of observations (Appendix 3- supplementary document). The official documents and websites enabled us to understand the BMZ and KfW mandates and how these were reflected in the programmatic policies of SSP. Through interviews, we explored the stakeholders' views about the programme's design. We identified solidarity, subsidiarity and equity as key design features and explored how these were upheld or abandoned. By attending the policy and implementation level meetings, we were able to understand the tensions between different policy options and their implementation. The rest of the paper will present an overview of the Pak-German partnership, stakeholders' views on KfW's role in SSP and how the envisaged design elements were (or were not) practised.

THE PAK-GERMAN PARTNERSHIP OF SEVENTY YEARS

The Islamic Republic of Pakistan and the Federal Republic of Germany were founded in 1947 and 1949, respectively. Diplomatic relations between the two countries started in 1951. Development cooperation between them started in 1961, the year BMZ was founded. Key priority areas of BMZ work in Pakistan were sustainable economic development, energy, and governance (including health care).

The BMZ priorities were reflected in the developmental engagement of KfW. The key objective of KfW's work in Pakistan, stated on its website, was to "stabilise the country".[5,6] KfW was engaged in good governance, clean energy and health care. According to the GoKP and KfW respondents, SSP was considered an outcome of the long-standing development assistance BMZ provided to Pakistan through KfW.

The PC1 mentioned two overarching goals for SSP. These were to improve the people's health status and reduce poverty levels associated with poor health and health care costs. In the PC-1, there were three stated objectives for the programme: (1) to improve access to health care services; (2) to improve the quality of these health services; and (3) to reduce the financial barriers to seeking health care. These objectives aligned with the aspirations of UHC and the country priorities of BMZ and KfW.

SSP goals and objectives reflected the consciousness of the low coverage access to health care at the policy level. Programme officials suggested that support for launching the programme existed among key bureaucrats and decision-makers in KP's Department of Health. GoKP and development partners, including KfW and the WHO highlighted the appetite and hope for strategic innovation to bring effectiveness and efficiency to the health system. GoKP officials suggested insurance was the best strategy for bringing efficiency into the health system, and they noted that the financial and technical support from the German Government enabled GoKP to initiate SSP:

> *"I think the key enablers were key officials' willingness and the financial and technical support from KfW and GIZ. The government is more willing to experiment new things if no public money is involved." [Respondent 1: GoKP official]*

KFW WAS THE POLICY ENTREPRENEUR FOR SSP PLANNING, BUT COULD NOT RETAIN THE INITIAL POLICY DIRECTION OF SSP

SSP initiation was largely attributed to the persuasion of GoKP by KfW officials. One of the senior programme officers shared that SSP resulted from long drawn advocacy and negotiation efforts between GoKP and KfW since 2010. On 9 January 2015, a service agreement was signed between the GoKP and KfW, followed by a public launching ceremony on 15 December 2015. Four districts (out of 28), namely Chitral, Kohat, Malakand and Mardan, were included in the pilot project in 2015. For the pilot project, 88% of the required funds came from the KfW and 12% from the provincial Government of KP (SSP PC1).

The BMZ website and the programme officials had the same narrative that the German Government was interested in working in Pakistan's health sector, particularly KP. One of the respondents, who had considerable experience of

working at SSP, squarely attributed the design of the SSP to the KfW's consulting experts by saying:

> *"...they selected the most effective and feasible option of social health protection or insurance...they designed the scheme in March 2011, and the Government of KP approved that...This is how the social health protection initiative started". [Respondent 1: GoKP official working at SSP]*

The willingness of KfW to offer financial and technical assistance made SSP possible.

> *"...Pakistan, especially Khyber Pakhtunkhwa, had a willing partner, i.e., the German Development Bank (KfW), to experiment with social health protection and that paid off". [Respondent 12: Development sector's representative]*

The German partners described SSP as a success and took pride in being the force behind it. A KfW official shared that the seed money and basic design had come from the KfW, fully owned and expanded by the Government of KP:

> *"I think Social Health protection was one of the rare successes. The Prime Minister owns it, and leadership's heart lies in the programmes". [Respondent 15: KfW official]*

Another KfW representative suggested that the SSP's innovative financing approach had a cascade effect, across the country, as described in the following quote:

> *"...I mean, we [KfW] can already show the [KP] success story...the federal government also decided to adopt this scheme and to extend to other provinces in Pakistan". [Respondent 16: KfW official]*

GoKP and SLIC officials viewed the German Health Insurance System as a role model and noted that SSP was based on learning from the German experience.

SSP WAS ORIGINALLY BASED ON THE PRINCIPLE OF SOLIDARITY, BUT THIS WAS ABANDONED MIDWAY.

The programme officials expressed confidence in the German Insurance Model and its core principle, i.e., solidarity. The basic idea of SSP, as proposed by KfW, was based on solidarity. SSP PC1 had plans to provide free health insurance to the poorest 21% of families in the pilot districts through cross-subsidisation by selling a voluntary, commercial insurance product to another 30% of the KP population. Hence, the PC1 envisaged SSP as a sustainable insurance fund.

> *"The insurance product will also be marketed for others...who are willing to purchase the same voluntarily". [SSP PC-1 document]*

The GoKP and KfW officials, however, noted that this cross-subsidisation did not materialise. KfW officials reported, and the programme officials confirmed that GoKP deviated from the solidarity-based, sustainable model and extended SSP coverage to the entire population of KP (around 6.6 million families or 36 million individuals) through a non-targeted subsidy.

GoKP called the rapid expansion testament to political ownership and GoKP's resolve to protect the population's health. But, a senior GoKP official said that due to the politically driven removal of the voluntary insurance component, the programme lost the possibility for the rich to subsidise the poor and establish a sustainable health fund.

> *"The hallmark of the social health insurance is the concept of solidarity...where is the element of solidarity in this system? Nowhere". [Respondent 23: Senior GoKP official]*

A KfW respondent showed disappointment with the GoKP failure to implement the voluntary insurance product and noted that SSP strained the already limited fiscal space. KfW saw this as a concerning development due to the rising premium costs and the limited fiscal space:

> *"The government has taken over 100% of the population...due to the limited fiscal space...we are a bit concerned...". [Respondent 16: KfW representative]*

The Pakistan Economic Survey (FY 2020-21) showed that around 2.2 million Pakistani individuals and businesses were active taxpayers in 2021.[13] The tax-to-Gross Domestic Product (GDP) ratio was 9.6% for the same period. In comparison, the tax-to-GDP ratio of India was 11.7%, and the average tax-to-GDP ratio for countries in the Organisation for Economic Cooperation and Development in 2020 was 33.5%.[13,14] With such a low tax-to-GDP ratio and the 100%, population coverage with a 100% subsidy was deemed unwise by the development sector officials:

> *"Social health protection is for the poor, not for 100%". [Respondent 12: a health systems specialist working with GoKP]*

Programme officials defended the 100% population coverage as good if properly implemented. However, representatives from the advocacy groups strongly objected to the 100% population coverage with a 100% subsidy. They considered it akin to the poor subsidising the rich.

> *"With the regressive taxation in Pakistan, 100% population means the poor are paying the premium for the richer people". [Respondent 22: Representative of a cancer support group]*

A financial sector expert from a development organisation highlighted that Pakistan had a regressive tax structure. According to the expert, the poor paid a greater portion of their income as taxes than the rich.

Reliance on a regressive tax regime, according to advocacy groups and development sector representatives, made the SSP revenue stream inequitable and went against the spirit of UHC. When asked if KfW had cautioned GoKP against the non-targeted subsidy, their respondent said:

> *"With the government's high level of ownership and financial allocation, KfW did not have much leverage to define the programme's course". [Respondent 15: KfW official]*

As per a KfW official, if the bank had leverage, they might have insisted on sticking to the original plan, i.e.,

purchase of insurance by the rich and cross-subsidisation for the poor

SSP HAD AN ELEMENT OF SUBSIDIARITY TO IMPROVE EFFICIENCY AND QUALITY OF SERVICES WITH MIXED RESULTS.

SSP also had an element of subsidiarity, i.e., transferring authority to a lower level for efficiency and responsiveness. Through SSP, GoKP sought to divest its roles in the health system. In the SSP PC1, the payer role was assigned to GoKP, purchasing to the insurance firm and service provision to private hospitals.

GoKP officials hoped that these subsidiary roles would improve efficiency and quality of care. The development sector representatives, including KfW, agreed that SSP would improve quality and efficiency in the health system. However, an insurance representative said it was akin to resuscitating an ailing health system through insurance. The insurance manager suggested that GoKP should make reforms through its regulatory function and not leave reforms to an insurance intervention.

The insurance and KfW representatives considered the public sector hospitals too weak for starting SSP and informed that the SSP design envisaged empanelling only private hospitals. However, in Year 3, public sector hospitals were also included in the programme:

> *"Of course, it is quite a weak system. And this is why the scheme first targeted the private hospitals, and it was only the second step that also the public hospitals enrolled in the scheme". [Respondent 16: KfW representative]*

Then why did KfW push for an insurance programme instead of supporting the existing supply-side arrangements? As per their response, it was optimism with the demand and pessimism with the supply side arrangements:

> *"Before the insurance programme, the German Government and KfW mainly supported the supply side, i.e., supporting the primary care and construction of hospitals. The outcome was not satisfying. It is why there was a change in the perspective". [Respondent 16: KfW representative]*

In the face of such pessimism from supply-side arrangements, a private sector respondent found it intriguing that SSP engaged the same public sector hospitals as service providers. The insurance manager shared that public sector hospitals were included in the SSP panel in Year 3 for three main reasons:

> *"[i] The major reason was the government's interest in spending and retaining public money in public sector hospitals. Another reason was [ii] to make the public sector hospitals competitive with the private sector...and [iii] make customers so that the open-funding [budget-side] provided to the public sector could be curtailed". [Respondent 4: Manager at the insurance company]*

The premise of making the public sector competitive by including them in SSP was challenged by many. For example, a development agency's representative questioned the plausibility of curtailing the supply side financing, as around 90% of hospitals' expenditures were incurred on salaries, which were legally protected.

> *"Unfortunately, most of our health care spending is either on the construction of buildings or the salaries. It is often the life-saving medicines or medical appliances that are neglected. [Respondent 10: Cardiologist from a public sector tertiary hospital]*

A development sector representative called the public sector inclusion (which already got a budget) double-dipping and termed it against the efficient utilisation of limited resources. A technical advisor of SSP said that the programme was supposed to cure inefficiencies and not amplify them, as in the case of double-dipping in the public sector.

A private hospital's manager referred to the public-private mix as unfair competition, where the private sector competed with the highly subsidised public sector, especially in tertiary care. Another private sector respondent shared that the insurance company had barred some services in the private sector, like cancer care, which was harming patients.

> *"I must say that forcing cancer patients to the public sector just to cut cost is criminal. The public sector does not emphasise infection prevention or close monitoring needed for cancer patients". [Respondent 9: Private hospital's administrator]*

A manager from the insurance company shared an initial rejection of SSP in the public sector. Later, under GoKP pressure, the officials said that the public sector half-heartedly adopted the programme in secondary care. A senior official of SSP suggested that the public sector hospitals had capacity issues and needed support:

> *"Insurance is a novel idea. We are not taught insurance, health finances or health economics in our medical education and management sciences. There is no knowhow of insurance or managerial law—this a challenge". [Respondent 1: GoKP official]*

Whether SSP had the right approach is debatable as there were arguments in favour and against the SSP approach. For example, a senior official cherished the SSP approach of engaging private hospitals, like the German Insurance System. However, a hospital manager argued that Pakistan had a legacy, mixed health system, whereas, in Germany, there were only private hospitals.

SSP AIMED TO IMPROVE EQUITY, BUT SOME DEVELOPMENTS INSTITUTED WERE CONTRARY TO THIS AIM.

SSP officials claimed that the programme would promote equitable access to health care services. Hospital managers agreed that was the case initially, but things had changed rapidly, as according to them, the insurer discouraged access to several services under SSP. For example, the per diem rates, as shared by a paediatrician, were so low that

they made it impossible for doctors to treat children under the scheme.

The latest PC1 of SSP showed that the enrollment criteria in SSP changed from poverty to residence status. This change made the poor and the rich members of the same pool without any contribution and safeguards for the poor. The advocacy groups feared that the rich would crowd out the poor due to their understanding and connections in the health care system. A development sector respondent had similar views:

> *"Due to their connection in the health care, the rich are more likely to get services through SSP than the poor". [Respondent 43: Development sector's representative]*

The programme official suggested that including the poor did not exclude the poor. This argument was, however, not accepted by a financial sector expert working at a development agency, who thought access to health care was rivalry and exclusionary, i.e., if the poor and rich are competing for a single bed available, one of them could have it.

> *"If the poor do not get access, while richer people could find their way to get the services under the programme, then it is the poor outcome and a huge challenge". [Respondent 37: Development sector's representative]*

Additionally, with 100% population coverage, SSP has now planned to offer supplementary insurance products to the rich and civil servants. SSP officials explained that the supplementary insurance would enable the enrollees to access fast-paced executive services, enhanced limits and better benefits. This went against the notion of UHC and was flagged in the UHC guiding document (2017):

> *"The equity principles reflected in UHC imply that health services should be made available to people based on need - and should therefore not differ according to membership in a particular scheme". [UHC guiding document]*

A member of a patient advocacy group suggested that the supplementary policy would create a for-poor and for-rich SSP. They feared an internal brain drain with the supplementary product, positing that the best doctors would serve those with the supplementary insurance in anticipation of better pay-outs.

A KfW official shared mixed feelings regarding supplementary insurance. They supported it in the hope of raising revenue but did not like it for the risk of creating a poor and rich divide, which the programme had sought to bridge.

KFW ENGAGEMENT COULD STILL IMPROVE SSP IN THE PURSUIT OF UHC

KfW respondents shared mixed feelings about the rapid expansion of SSP. On the one hand, they labelled SSP as a success story, as the government accepted their idea and took complete ownership of its expansion. On the other hand, they considered the health system too weak and the fiscal space too narrow to serve the entire population through non-targeted subsidies.

KfW officials took pride in their contribution to SSP, and the programme officials genuinely acknowledged their role. There were some limitations, though. A KfW respondent informed that health was no longer a KfW priority sector for Pakistan. And therefore, SSP was facilitated under the KfW governance area.

Despite these deviations from the critical design features of SSP, KfW continued supporting SSP. KfW has now committed funding to pilot outpatient department (OPD) services under SSP in four districts (Chitral, Kohat, Malakand and Mardan) by mid-2022. The KfW team was optimistic and had high hopes for the OPD scheme:

> *"Phase II [of KfW support] will be a leap forward towards Universal Health Coverage. Under Phase II, we will be piloting OPD services". [Respondent 13: KfW manager]*

DISCUSSION

SUMMARY OF THE KEY FINDINGS

KfW supported GoKP to launch SSP. KfW served as the policy entrepreneur and strove to diffuse the German learning of Social Health Insurance (SHI) in KP through promoting SSP based on solidarity, subsidiarity and equity.[15–17]

Over the years (2015-21), the programme grew faster and larger than the expectations of the policy entrepreneur. Though appreciative of the government's ownership of the programme, the actions deviated from the core foundational principles. The policy entrepreneurs mobilised government resources towards a global health goal, i.e., promoting UHC, but could not make the government maintain a commitment to solidarity, equity and subsidiarity (bifurcation of responsibilities).

Political support and ownership were vital for scaling up the donor-supported initiative. However, over-politicisation damaged institutionalisation and sustainability. Therefore, the policy entrepreneurs have a role in presenting a policy image and preventing deviant or counterproductive steps during the implementation.

STRENGTHS AND LIMITATIONS

The strengths of our study were using the instrumental case study design, using three data sources and selection of SSP as the case. We used a single-case study design which enabled us to have an in-depth understanding of the programme. Our findings were potentially transferable to the GOP and GB programmes as these programmes had used the SSP design in different geographical areas. All three programmes have similar sociopolitical and health system contexts. Additionally, like SSP, the GB programmes had technical and financial contributions from KfW. If KfW supports similar programmes in other countries with similar contexts, for example, Bangladesh, it might face similar problems as the programme evolves. A key limitation of our work was the absence of direct patient and population voices. Although solidarity has appeared as a key design feature, but could not ascertain the ability and willingness of the population to pay insurance premiums. Nonetheless,

we captured the views of patient support groups regarding the programme.

INTERPRETATION IN VIEW OF THE BROADER LITERATURE

Many authors have described SSP as a leap forward in making health care accessible in Pakistan.[18–20] Some called it an effective step to actualise Target 3.8 of Sustainable Development Goals (SDGs),[19] while others considered it a successful development partnership between Pakistan and the Federal Republic of Germany.[18,21] These views reflected considerable support for SSP. However, important questions still remained, namely whether SSP was the best option for the mixed health system of Pakistan or if it could be sustainable?

SSP was designed to provide free insurance to the poor. There were plans to enrol the rich on a contributory basis. But, as noted above, the element of solidarity was scrapped. It was difficult to call it SHP as a key element, i.e. solidarity was no more.[22] The programme officials insisted that it still was social protection, arguing that the poor were still covered. Contradicting this notion, experts have reported that in a poor-rich pool, it is highly likely that the rich would crowd the poor, as the rich have better understanding and connections in the formal health care system.[23]

The enthusiasm of the SSP and KfW officials that the German Model of SHI might work in KP needed careful reevaluation. The German SHI had a strong statutory backing and a solid contribution from employers and employees. More than 90% of the working population was covered under the SHI Fund.[17] On the contrary, less than 30% of Pakistan's job market had formal employment.[13] Considering the ground realities, even if the element was solidarity was allowed to stay, the cross-subsidisation might be an uphill task for two reasons: (i) collecting premiums from non-salaried people would have been difficult; and (ii) the formal employees already had health coverage, reducing the prospects of bringing them under SSP.[24]

Pakistan has a mixed health system, and the assumption that insurance would bring efficiency and improve quality is yet to be proved. Despite an extensive network of public sector health facilities, the utilisation in the private sector outweighed that in the public sector.[25] Therefore, engaging the private sector under SSP was pragmatic, but imposing the public sector hospitals on the programme defeated its purpose, i.e. hampering efficiency and quality. Though SSP officials were hopeful that the public sector would improve its service quality to make revenue from the programme, there were broad system-wide problems.[26,27] As shared by a respondent in our study, an insurance programme cannot resuscitate an ailing system.

A population-based survey found that SSP did not increase the consumption of health care (number of admissions); the number of people choosing the private sector over the public had increased.[28] The study concluded the shift might be due to the perceived higher quality of care in the private sector.[28] This is in keeping with the programme's policy assumption that the private sector had better quality. But, other researchers have reported a multitude of SSP-related implementation barriers, especially in the public sector.[29] The patient's verification, admission authorisation, low package rate, the reluctance of specialist doctors, and delayed claims payment all contributed to the public sector's reluctance to participate in SSP.[29] These problems were not unique to SSP in Pakistan. A study on the Indian Pradhan Mantri Jan Arogya Yojana reported similar implementation barriers, suggesting that international experience could provide valuable, transferrable lessons.[30]

Although the SSP and KfW officials had confidence in the private sector's quality of care, it was not that good either. A review of the KP Health System by the Asian Development Bank (ADB) concluded no quality standards or accreditation systems were in place in the province. The private sector was unregulated, and no clinical guidelines or standard operating procedures existed that were implemented across the province.[27]

The political leadership, including the Health Minister of KP[31] and the (former) Prime Minister of Pakistan *(Imran Khan)*[32] likened SSP to UHC and the establishment of a welfare state. In our study, respondents highlighted the positive role of political ownership, but this level of political branding could make such programmes a turf for political manoeuvring. Considering the collapse of Imran Khan's government, which had supported 100% coverage in KP and its expansion to the rest of the country, the programme's future is uncertain. After all, many pro-poor and welfare programmes have been discontinued in the past.[10]

CONCLUSIONS

There are five key messages from this analysis. First, international development assistance and policy entrepreneurship can play a vital role in catalysing initiatives to promote global health objectives like UHC. The programme objectives of improving access, quality and financial protection resonated with the UHC objectives. However, achieving these needed SSP to include prevention, promotion, palliation, and rehabilitation services.

Second, while promoting innovative interventions, e.g., demand-side financing in a supply-side health system, the policy entrepreneurs might have limited control over approaches to implementation. Policy entrepreneurship could shape national and subnational health policies, albeit within limits. For instance, the SSP aspirations were a bit divorced from reality, and the programme's basic premise, i.e., solidarity, did not work out.

Third, the institutionalisation of an innovative intervention is shaped by the constraints of the implementing system. SSP was a diffusion of the German health insurance ideals, constrained by the socioeconomic realities of Pakistan. SSP did not evolve in a vacuum, but in a legacy health system with many countervailing forces like the lack of HRH,[33] weak stewardship,[34] and low public spending on health care.[24] This should serve as a cautionary note for others involved with trying innovative financing ideas. This experience is potentially likely to be transferable to countries with similar fragile contexts and underperforming health systems, e.g., Afghanistan, Bangladesh and the

Central Asian Republics, as BMZ is involved in these regions too.[35–37]

Fourth, policy entrepreneurs need some kind of policy levers – for example, disbursement linked indicators, to ensure that the reform process does not deviate from the envisaged policy parameters. In this case, the envisaged policy direction (which was abandoned) included developing a sustainable insurance fund, improving health services quality, and making the private sector accessible to people.

Fifth, KfW mobilised the government's will and resources for social protection. This inquiry raises three important questions for KfW - - (i) with the 100% population coverage through 100% subsidy, is SSP still a social protection programme? (ii) how would the programme treat the poor at par with the rich, both being members of the same pool? and (iii) would the supplementary insurance products take the programme towards or away from UHC. As the policy entrepreneur of SSP, KfW needed to engage its Pakistani partners in a constructive discussion on these key policy questions.

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DISCLAIMER

Our work does not include any potential identifiers of our participants, and we had the consent of the participants to publish our work based on their participation. We did not use any copyrighted material in this paper.

ETHICS STATEMENT

We had ethics approval from the Ethics Committee at the University of Edinburgh and local ethics approval from the Khyber Medical University. We have complied with the ethics regulation of the approval bodies at all stages of the research and have maintained a written record of informed consent for the study participants.

DATA AVAILABILITY

The datasets used and analysed during the current study are available from the corresponding author on reasonable request.

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AUTHORSHIP CONTRIBUTIONS

SAK developed the research plan and led the data collection, analysis and write-up. KC and AS contributed to refining the study design advised on the data collection, analysis, and interpretation, and helped refine the manuscript. All authors read and approved the final document.

DISCLOSURE OF INTEREST

The authors completed the ICMJE Disclosure of Interest Form (available upon request from the corresponding author) and disclose no relevant interests.

ADDITIONAL MATERIAL

The appendices are attached as online supplementary documents.

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Online Supplementary Document

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