Sehat sahulat: A social health justice policy leaving no one behind

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Introduction

The World Health Organization states "[Universal Health Coverage] UHC means that all individuals and communities receive the health services they need without suffering financial hardship."[1] In Pakistan, where it is well-documented that healthcare expenditures are responsible for aggravating economic shock in poor families (see Box 1), the room for population health improvements is clear.[2,3] In recent years, Pakistan has joined the likes of emerging markets in pushing towards UHC.[4] While simultaneously grappling with the COVID-19 pandemic, since late 2020 the Khyber Pakhtunkhwa (KPK) province expanded coverage for all its 30.5 million residents[5] for inpatient care up to 1 million Rs per family each year in over 500 public and private hospitals across the country through its Sehat Sahulat program (SSP).[6] The program, first adopted by the provincial government in 2016 to cover its population living below the poverty line, aims to transform healthcare in the country and progress towards UHC in recognition of the importance of health and wellbeing to the functioning of society. Former Pakistani Prime Minister Imran Khan commended the SSP, and efforts to expand healthcare coverage for residents of other provinces, including Islamabad Capital Territory (ICT), Punjab, Azad Jammu Kashmir (AJK), Gilgit Baltistan (GB), and Tharparkar-Sidh are underway.[7] Endeavors to improve coverage in the region are laudable, and have helped segments of the population in getting the care they need: as of 1 July 2022, 35,866,110 families had been enrolled under the program and 4,392,734 hospital visits had been covered since the SSP's establishment.[7] However, coupled with the successes of the program, there are a number of challenges that have arisen – especially with the change in administration in Pakistan in April 2022.[8] In this commentary, we aim to outline both the progress of the program thus far and the opportunities for improvement in the future; in particular, we ask whether the benefit package can better set the foundation towards UHC?

Background on the SSP in KPK

Historical underfunding of the Pakistani health system has exacerbated population health challenges in the country. The government of Pakistan is one of the lowest spenders on health amongst lower-middle income countries (LMICs) globally, and in the region, which often results in high out-of-pocket costs for healthcare services.[9] Over one fifth of Pakistan's population lives below the poverty line, and it is well-documented that healthcare expenditures are responsible for triggering catastrophic health expenditures which push families into further economic ruin (see Box 1).[2,10]

Recognizing the need for increased access to healthcare, in recent years there has been a significant drive at the national and provisional levels to develop and fully subsidize programs aimed at mobilizing government financial resources to purchase medical services from both public and private providers, targeting the poor and those with catastrophic conditions. The SSP is a mechanism to do just that. The SSP can be viewed as an insurance mechanism, but the idea is that premium contributions are fully subsidized by the government. It covers secondary care and tertiary care for conditions including accidents and emergencies, diabetes, kidney diseases (including dialysis and transplant), Hepatitis B and C, cancers, and heart and vascular diseases. Additionally, it provides financial assistance under certain conditions for wage loss during treatment,

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Pakistan is the world's fifth largest country and has long lagged behind the rest of the globe on several health-related indicators.

- Health expenditure around 3.2% of GDP (2018 estimates).
- Less than 1 physician for every 1000 people (2018 estimates).
- Total life expectancy at birth below 70 years (2021 estimates).
- 55.26 deaths/1000 live births (2021 estimates).
- 23.1% children under 5 years are underweight (2017/18 estimates).
- Ranked 17/227 countries for highest infant mortality rates in the world (2022 estimates).
- Poor access to education for many school-aged children.
- Poor access to safe drinking water and natural gas as a clean cooking fuel.
- About 1/4 (2015 estimates) of the country's approximately 243 million population (2022 estimates) live below the poverty line.
- 2018–2019 estimates suggest that about 20% of all households living below the poverty line in Pakistan were driven to these circumstances by catastrophic health expenditure (health expenditure accounting for 10% of all a household's expenditures).

***Box 1*: The health context in Pakistan.**[2,3]

transportation costs, maternity allowances, and funeral expenses in case of death during hospital admission.[11] As mentioned above, the SSP provides coverage of up to Rs 1 million a year per family, however only under special circumstances; for most families, the SSP covers Rs 460,000 per year.[12] In the first phase of implementation, families in KPK below the poverty line (earning less than ($2/day) with a poverty mean test score less than or equal to 32.5 were eligible to enroll in the program. However, with the commendable expansion of the program over time, currently all permanent residents of KPK, ICT, Punjab, AJK, GB and District Tharparker are eligible to enroll.[7]

Financing for the program is raised through provincial taxes, and these funds cover State Life Insurance Corporation (SLIC) premiums for all eligible families in the province.[13] Because of these arrangements, the federal government does not have as much administrative control over the program. In theory, SSP beneficiaries should receive covered inpatient services completely free of charge, without any out-of-pocket payments. For families which do not make any claims in a year, 90% of their premiums are reimbursed to the national exchequer.[13]

Coverage extends to services in both public and private facilities. This recognizes that over 70% of people in Pakistan seek healthcare from private hospitals – both in rural and urban settings.[14] A small minority of private hospitals refuse to accept patients for certain conditions or services under the SSP because of their high overhead costs[12]; in these circumstances, this gives public hospitals the opportunity to absorb these patients and bring in additional funds.

A key component of the SSP is its "fund retention formula" which was approved in 2016.[15] The formula enables public hospitals to retain a percentage of the income generated by their treatments under the program – of this amount, 25 percent goes towards the provincial government, and the other 75 percent is kept by "the hospital for service quality improvement, and doctors' share."[15] As many medical professionals practice in both private and public settings, ideally, this formula helps deter them from always referring patients to private facilities under the scheme by creating extra financial incentive for public hospitals and providers.[15] Since SLIC offers fixed packages for the number of inpatient days and the types of procedures, hospitals are disincentivized to keep patients longer than needed or overprescribe medications or diagnostic tests because this would result in losses for the hospital.

Successes of the program thus far

So far, the SSP has made significant progress in increasing access to necessary healthcare and reducing financial hardship caused by healthcare costs. With the recent expansion, over 7.2 million families in KPK province are covered under the program (and across all provinces in Pakistan, over 10 million families are covered).[16] Overall, the SSP costs the KPK province about 2% of its budget, and given the well-documented economic gains that can be triggered by better population health, these are worthwhile investments.[16,17] Estimates suggest that over 600,000 individuals would use the SSP in the 2021-22 year (based on YTD averages in Nov 2021) – a 10-fold increase compared to utilization of the original SSP card (for less than 65,000 individuals) before it was universally rolled out in 2020.[16] And while utilization is ten times the amount it was before universal roll out of SSP, the claims have increased by about 4-5 times.[16]

With the closure of out-patient services and the halt of elective surgeries in the early phases of the COVID-19 pandemic, care covered by the SSP increased because of its primary focus on inpatient care. Additionally, it is important to note that COVID-19 inpatient care is covered under the SSP.[18]

The Government of KPK has outlined the utilization of services from 1 July to 31 October 2021 under the SSP based on total expenditure (PKR Mn) and total activity (Table 1).

One feature of the program which highlights its importance for UHC is that the total amount of financial coverage offered under the SSP (Rs 1 million) is adequate for most families dealing with most procedures in KPK. For instance, a package for Coronary Artery

Services	Utilization of services based on total expenditure (PKR Mn)	Utilization of services based on total activity (#)
Cardiology	1721	14,470
General Surgery	696	35,002
Gynecology	556	31,412
Medical Cases	347	25,386
Multiple	317	5081
Orthopedic	303	12,742
Urology	268	9109
Oncology	198	7867
Throat	194	11,270
Dialysis	166	36,617
Ophthalmology	174	11,993
Total	5257	214,267

***Table 1*: Utilization of SSP Services in KPK from 1 July – 31 October 2021.** Recreated based on SLIC dashboard data obtained through personal communication of Dr. Riaz Tanoli, CEO, Sahat Sahulat Plus Program, Khyber Pakhtunkhwa.[19]

Bypass Surgery negotiated with SLIC is Rs 280,000. Thus, even after the costs from a major operation, a family would still be able to receive other inpatient care coverage without paying out of pocket that year.

Patient satisfaction surveys in KPK indicate high levels of satisfaction with the SSP overall, and despite some challenges with the program (described below), reports suggest the majority of the population has benefited from it and praise it.[7]

Opportunities for improvements and expansion

Extending coverage to outpatient care and investing in prevention

Despite this progress, there are still opportunities for improvements. To date, the SSP mainly covers inpatient/emergency care, but some diseases like mental health disorders and hypertension have high disease burdens and high costs from services and medications outside of inpatient care. Considering that outpatient expenditures account for most (up to 80%) of the catastrophic health expenditures that Pakistani households face,[20] the SSP could benefit from coverage expansion to outpatient care.

Furthermore, most inpatient care services are designed to address states of ill health which arise at advanced stages of disease, rather than preventing the diseases from occurring in the first place. For example, access to revascularization procedures for those with severe coronary artery disease or dialysis are high-cost solutions for people with advanced renal disease. But there are existing mechanisms to prevent heart disease and kidney disease altogether, including screening programs, risk factor prevention and diabetes management. Relative to revascularizations and dialysis, these interventions are less intrusive, less expensive and can often impact larger numbers of people, and represent cost-effective mechanisms to reduce human suffering and improve population health.[21] Across many of the disease areas covered under the SSP, a similar pattern is seen. Thus, in addition to hospital services which aim to meet the increasing demand for secondary and tertiary treatments, the SSP could benefit from preventative services which seek to reduce risk factors and drivers of disease and increase population health and wellbeing overall.

Couple coverage expansion efforts with efforts to extend healthcare access

For most of the vulnerable people whom the program was initially designed for, barriers towards accessing inpatient services covered under the scheme also should be assessed. Dialysis services, for example, even if they are free of charge, are often limited to urban settings in many LMICs. Thus, schemes to increase coverage for these services should be coupled with efforts to improve access to facilities in rural and remote locations.[21,22]

To address some of the above challenges, the Provincial Government of KPK is planning to cover outpatient services in a pilot program in four districts.[23] We believe expansion of a wide range of outpatient and preventive services will align well with the goals outlined under UN Sustainable Development Goal (SDG) 3.8 to achieve UHC through financial risk protection, access to quality essential healthcare services, and access to safe, effective, and affordable essential medicines and vaccines for all.

Avoid adverse selection and ensure no one is left behind

In this drive, it is important to remain cognizant that while health insurance schemes can improve health care utilization and financial protection for their members, they can also risk compromising equity by excluding high-risk and/or vulnerable individuals. Since its early stages, KPK's SSP has taken pragmatic steps to ensure greater dividends with increasing "awareness" and "enrolment," especially for vulnerable groups.[11] But because the program makes special effort to include vulnerable individuals, it must also take steps to avoid adverse selection of those who may be more likely to be covered under the scheme, including elderly and chronically ill, and those who seem in need of frequent health care services. To ensure equity and inclusion of all groups, mandatory scheme enrolment, enrolment at the household level or introduction of a waiting period can be considered. Ongoing surveillance is also needed to ensure that resources are distributed equitably.

Vulnerable subpopulations may need additional assets and services to meet the broader goals of "leaving no one behind." In this regard, simple indicators such as those adopted by the UN Statistical Commission to monitor progress towards the UN SDGs, including coverage of essential health services and the proportion of households with CHE can be considered.

Increase surveillance and learning efforts to monitor progress and maximize dividends from investment

Parallel surveillance efforts must be conducted to assess the impact of this unique social protection program on the utilization of care, its quality, and the effects on CHE and health outcomes for those who are prone to increased utilization of health services. For example, there needs to be critical attention paid to evaluating the cost of health insurance and medical benefits, the level of financial protection, whether health insurance schemes satisfy the needs of specific subpopulations, the quality of care covered by and the affordability and sustainability of the program.

Several challenges and risks related to disparities in quality and services provided at public versus private hospital facilities need to be addressed and mitigated. Evidence from June 2021 suggested that in the previous five years — despite the fund retention formula — private hospitals had received 78% of the funds paid out through the SSP and government-run facilities had only received 22%.[24] Several reports have also suggested that hospitals were denying shares to their staff.[16] Moreover, there is a risk that the SSP, with its fee-for-service payment system, may become inadequate to cover ever-increasing overhead fees and treatment costs with the projected increase in enrollments and claims.[25] Furthermore, since there is only one large insurer — the SLIC — the program could be exposed to potential risks for fraudulent activities such as inflated bills or creation of ghost hospitals and patients.[25] However, the Government of KPK has not reported any major issues related to misuse, and there are strict punitive measurements in cases of irregularities.[16] Surveillance efforts of the SSP should continue to capture issues like these which are preventative to the success and sustainability of the program. It is important to incorporate strict risk mitigation strategies by setting early warning indicators to control costs and prevent leakage and fraud.

Lessons can be learned from our group's prior similar efforts assessing impact of progress towards UHC in other countries, including both national and subnational analyses.[26–28] These continued insights will help refine region-specific policies and impact evaluations can be used to promote benefit-inclusion and equity in particular health insurance schemes. Clearly, progressing towards equal health outcomes is not a short-term endeavor, and long-term commitment from governments is required. In the end, surveillance efforts and impact measurements can support budget planning for healthcare providers or purchasing agencies; they can reduce fragmentation in pooling to enable greater financial protection; and they can enhance equity in the distribution of resources and services.

Conclusion

Despite some challenges with the SSP, Pakistan's recent investments in healthcare coverage are laudable, especially when considering that much wealthier countries have not been able to achieve this sort of coverage for their populations. We also must recognize that this program emerged in a region where there was little prior experience with health insurance, and thus the exponential expansion in KPK from a small pilot project to a program implemented at the entire provincial level is a substantial achievement. Further, it reflects a changing environment in which political figures recognize the importance of health for financial prosperity and social wellbeing at both the individual and the population levels. We believe that this social protection program is important not just for poverty reduction, but also for pushing towards poverty prevention by reducing the incidence of CHE. However, there is more work to be done and considerations to be made regarding what is covered, who gets these services and how they can access them under a government-sponsored scheme like this. It is likely that more health gains are possible if additional funding is invested into preventive measures and outpatient care, if the program is actively monitored and adjusted based on impact evaluation results, and if there is particular concern paid to equity issues to ensure that no one is left behind.

Ultimately, to guide future reforms and improvements to the program, it is imperative that there are proper analyses conducted to evaluate the SSP in depth. It will be key to measure enrolment and uptake patterns over time, coverage rates, the split of private versus public hospital utilization, the costs, the benefits, patient satisfaction, and the quality of care provided through the SSP. Furthermore, research should examine the lessons that can be learned and the characteristics and qualities in Pakistan which have enabled or prohibited progress towards UHC in Pakistan; particularly reflecting upon why other countries (including wealthier ones) have had less success in their UHC efforts. This research can then drive evidence-informed policy changes to improve access to quality healthcare, reduce disparities in health, and push further towards successful and sustainable UHC in Pakistan and beyond.

Contributors

K.N., E.M., and R.F. designed the study. R.F. and K.N. produced the first draft of the manuscript. All authors

subsequently added to and critically revised the manuscript for important intellectual content.

Data sharing statement

Data related to references 16 and 19 are available from Dr Shah on request. All other data referred to in the study is publicly available online.

Declaration of interests

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