EDITORIAL

Transitioning to social health insurance in Pakistan: The experience of Sehat Card Plus in Khyber Pakhtunkhwa province

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Following the experience of many low- and middle-income countries (L&MICs),[1] there has been a gradual transition in Pakistan towards public sector financed health insurance, primarily for providing in-patients care. This change has particularly been seen in the provinces of Punjab and KP as well as at the federal level.[2] Historically, public sector financing in health has predominantly relied on tax-based financing in Pakistan.[3] The health system has remained chronically underfunded with public sector funding hovering around 1% of the GDP and financing has largely relied on direct out of pocket (OOP) payment by the households.[4]

Khyber Pakhtunkhwa (KP) province embarked on a health insurance reform in 2013, starting in four districts, targetting people living below poverty line as defined by Benazir Income Support Programme (BISP) criteria.[5] In 2015, it evolved into a flagship publicly funded social health insurance scheme, Sehat Sahulat Programme, implemented through the State Life Insurance Corporation (SLIC), providing inpatient services, free at point of care, at empanelled hospitals. This was a move away from OOP payments, and promised enhanced financial protection for the beneficiary households.[4] In April 2020, the KP government extended the coverage to all households in the province, irrespective of poverty status, and renamed it the Sehat Card Plus (SCP) programme. SCP claims to provide an annual cover of up to PKR 1 million per family with over 7 million enrolled households.[5]

On the request of the KP government, the Aga Khan University accepted to undertake an independent evaluation of the SCP in 2022-23, which comprised a three-tiered assessment supported by GIZ.[6] This special issue of JPMA presents a series of 8 papers that summarize the results of the SCP Programme evaluation. To the best of our understanding this is the first comprehensive evaluation of any health insurance programme in Pakistan.

This comprehensive in-depth evaluation has demonstrated several strengths of SCP that need to be commended and reinforced. We found significant reduction in out-of-pocket expenditure among SCP users, compared to SCP non-users across all wealth quintiles. The level of catastrophic health expenditure was also found to be significantly lower among SCP users (14%) compared to SCP non-users (35%), leading to higher perceived economic well being among SCP users. The reduction in the financial burden among beneficiaries is a hallmark of the SCP. This accomplishment, within a relatively brief time frame is commendable. In addition, we found a high cumulative readiness of tertiary care hospitals included in our assessment (in the range of 80-98%), to provide clinical services for Accident & Emergency, Critical Care, General Surgery, Gynaecology and Obstetrics. It is also worth noting that 94% SCP users, interviewed at the time of exit from the hospital, expressed satisfaction with the quality of health under the programme. The evaluation also highlights other strengths of SCP such as high level of political commitment, strong parliamentary legislation, availability of financial resources to expand SCP, and its electronic management information systems and high level of awareness about the SCP among the general population.

Concurrently, our analysis shows that SCP is confronted with several challenges that need to be addressed to ensure long term sustainability and impact on health outcomes. For instance, the inpatients benefit package can be revisited to be evidence informed along with the inclusion of primary care and preventive interventions. We would also like to advocate for improving readiness of secondary hospitals, especially in remote districts, which would enable the beneficiaries to receive services without travelling long distances.

We also recommend strengthening the capacity of the Directorate of Social Health Protection within the Department of Health. This would reduce reliance on SLIC for hospital empanelment, information sharing, and monitoring, and enhance programmatic efficiency by reducing the high administrative cost. Further, and along the lines of similar programmes in other L&MICs, the SCP Policy Board should include representation of private providers and beneficiaries, which is not the case currently.[7] While, there has been a proliferation of the private health market to compete for empanelment under SCP, something which was not possible before; enhanced

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transparency in the grading of hospitals and setting of tariffs would alleviate the concerns of some large private hospitals. Another important though contentious issue for the consideration of the government is to continue to implement this programme through SLIC or to establish under a statute of the parliament a truly independent and autonomous health insurance organization (HIO) as has been the case in many L&MICs. Finally, going forward, the benefits of expanding the programme from previously covering the population below poverty, to the entire population of the province, should be weighed against available fiscal space.

Despite these challenges, SCP is a real 'game changer' in the province and can provide valuable experience to other provinces in Pakistan and countries at similar level of development. Pakistan, and KP can also benefit from the experience of other L&MICs that have launched and scaled up public sector financed health insurance programmes for their populations. Prominent among these are the Indonesian Social Insurance Administration Organization's Badan Penyelenggara Jaminan Sosial-Kesehatan or BPJS-K,[8] the Philippine Health Insurance Corporation's Konsultasyong Sulit at Tama,[9] National Health Insurance Agency Morocco's Régime d'Assistance Médicale[10] and India's National Health Authority, which runs Pradhan Mantri Jan Arogaya Yojana.[10] Thailand has been among the leading countries that achieved universal health coverage (UHC) in 2002, when the uncovered population was brought under the fold of the Universal Coverage Scheme. Evidence from Thailand has shown favourable outcomes in terms of improved access and financial risk protection with reduction in catastrophic health spending and impoverishment.[11]

Our evaluation unveils the great potential of social health insurance in Pakistan to advance health equity. This reform needs to be sustained by revisiting its service package, strengthening governance arrangements and monitoring capacity, and ensuring financial sustainability.[12] Health insurance programmes are a major shift from the traditional 'supply-side' to the more inventive 'demand-side' programmes, where the beneficiaries, especially the poor have a voice and are not just 'eligible' but are 'entitled' to receive essential services, where passive purchasing of services is replaced by strategic purchasing that employs innovative methods of provider payment to get the best return on investment.[13] While it may take some time to build more indigenous capacities for delivering such programmes, it is hoped that the new democratic government in Pakistan would continue on the path to support health insurance programmes in the country while reinforcing their strengths and effectively addressing the gaps. If done well, health insurance can be the prime vehicle for achieving UHC in Pakistan.

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