ORIGINAL ARTICLE

Sehat Card Plus in Khyber Pakhtunkhwa: Confronting challenges, strengthening governance, ensuring financial sustainability

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Abstract

Objective: To conduct an in-depth policy analysis of the Sehat Card Plus (SCP), focussing on its governance, financing structures, achievements, and long-term sustainability.

Methods: A three-tiered framework was employed. At the micro-level, over 4,000 households were surveyed; at the meso-level, readiness assessments were conducted at 38 empanelled hospitals; and at the macro-level, a policy and strategic review of the SCP was conducted. The policy review examined (i) programme governance and coordination, including third-party administration by SLIC; (ii) current status of legislative and regulatory aspects; (iii) financing trends and sustainability; (iv) service delivery mechanisms, including beneficiary enrollment, empanellment and reimbursement mechanisms; and (v) monitoring and evaluation systems. A mixed-methods approach was used, combining literature review, technical reports, and budgetary documents with in-depth interviews conducted with provincial and federal officials, health system experts, and stakeholders. Data from interviews was collected between October and November 2022 underwent thematic deductive analysis.

Results: Six thematic areas were identified: (i) Governance: Strong legislative commitment through the UHC Bill 2022, but with limited citizen representation in decision-making bodies; (ii) Organizational arrangements: Limited staff and dependence on SLIC limit monitoring and strategic management; (iii) Financing: Unplanned expansion challenges financial sustainability in economic crisis, as SCP is fully funded by provincial revenues; (iv) Service purchasing: State Life Insurance Corporation (SLIC) manages hospital empanellment and claims processing, though lack of involvement of health authorities; (v) Monitoring & evaluation: Independent monitoring systems are needed for transparency and quality assurance (vi) Communication and User Satisfaction : Beneficiary engagement and feedback mechanisms in SCP need improvement.

Conclusion: SCP has expanded inpatient care and improved financial protection, but challenges remain in quality, financial sustainability, and equity, crucial for achieving UHC in Pakistan.

Keywords: Universal Health Coverage (UHC), Sehat Card Plus (SCP), Khyber, Pakhtunkhwa (KP), Publicly Funded Health Insurance, Social Health, Protection Initiative (SHPI). (JPMA 74: S-3 [Suppl. 11]; 2024)

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Introduction

Achieving Universal Health Coverage (UHC) is an overarching target of the Sustainable Development Goals (SDGs), especially SDG3, the goal of health and wellbeing.[1] Almost every country in the world, rich or poor, has committed to achieving UHC by the year 2030. UHC is defined as the aspiration that all people receive quality health services they need without suffering financial hardship as a result of seeking healthcare.[2] Every country, especially the low- and middle-income countries (L&MICs), must take the necessary steps now to advance progress toward UHC by the year 2030, which is jointly monitored by the World Health Organization (WHO) and World Bank biennially.[3] Pakistan's National Health Vision (2016-25) unequivocally commits to providing a responsive unified direction to overcome health challenges, while ensuring adherence to UHC as the ultimate goal.[4]

Any UHC scheme in L&MICs, that delivers an essential package of health services (EPHS) requires a well-thought out health financing strategy to transition from high-levels of out of pocket payments (OOP) to a pre-payment arrangement thereby enhancing risk pooling, ensuring financial risk protection (FRP), and protecting households from catastrophic health expenditure and impoverishment. Many L&MICs have successfully embarked on UHC schemes, while others have launched similar initiatives to accelerate progress towards UHC.[5-7] The health care financing landscape in Pakistan, like many other L&MICs is dominated by OOP payments, which is estimated to be 53% of the current health expenditure[8] and 13.2% of the population is vulnerable to financial catastrophe due to healthcare payments.[9] Hence, there is a critical need for

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Pakistan to shift towards prepayment arrangements to enhance FRP for its citizens.

Launched towards the end of 2015, the Prime Minister's National Health Insurance Scheme, also known as the Sehat Sahulat Programme (SSP), has been providing FRP to the poor against health problems that require inpatients treatment.[10] SSP is a major health reform launched by Pakistan's federal government and three of the four devolved provincial governments – Khyber Pakhtunkhwa (KP), Punjab and most recently Balochistan in response to the health financing pillar of the National Health Vision 2016-2025.

Launched as a publicly funded health insurance programme, SSP KP was implemented by the State Life Insurance Corporation (SLIC) to improve access to quality inpatient health services and enhanced FRP to the poor population through reduction in OOP payments. In April 2020, the KP government announced extending the coverage to all households in the province, irrespective of poverty status, and renamed it the Sehat Card Plus (SCP).[11]

This document is among a series of papers following a comprehensive evaluation of the SCP in KP that was undertaken in the year 2022-23. It presents a policy review and strategic analysis of the SCP and focuses on its governance including legislative, organizational, and financing arrangements with emphasis on building its institutional capacity and medium- to long-term financial sustainability.

Methods

The SCP evaluation followed a three-tiered framework - micro-level, which surveyed over 4,000 households; meso-level, which assessed the readiness of 38 empanelled hospitals; and macro-level, which comprised the policy and strategic review of the SCP, which is the focus of this paper. This entails of the: (i) programmatic governance and coordination including arrangements related to third party administration of SCP by SLIC; (ii) current status of legislation and regulatory aspects of SCP; (iii) trends in financing of the SCP including analysis of its sustainability; (iv) operational aspects of SCP related to service delivery, beneficiary enrollment, benefits package, empanellment of health facilities, and billing and reimbursement mechanisms; and (v) monitoring and evaluation of SCP. A mixed method approach was applied including review of literature and in-depth interviews of stakeholders.

We reviewed published literature and technical reports prepared by the provincial government, SLIC, and development partners and budgetary documents, though range of documents available was limited. In addition, a team of national and international health system and social health insurance experts visited the province and engaged in meetings and interviews with multiple stakeholders including the minister of health and finance, senior government management, and autonomous and regulatory institutions in health. Deductive analysis by theme in the interview guide was applied for information gathered from in-depth interviews

The team held extensive deliberations with staff at the Directorate of the Social Health Protection Initiative (SHPI) and the manager of Regional Office of SLIC. The assessment team also visited and interviewed with managers of several public and private hospitals in Peshawar. In addition, meetings were held with development partners, and at the federal level with staff and consultants of the Ministry of National Health Services Regulations and Coordination (MONHSRC) and federal SSP. The data collection was done between October and November 2022.

Results

Sehat Card Plus (SCP) is the flagship programme of the KP Government to advance towards UHC by providing inpatients care to almost 40.8 million population of the province 2. The Programme, led by the then minister of health, is overseen by the SHPI Directorate of the Department of Health, KP. The implementation of SCP has been outsourced to SLIC through an open national competitive bidding process.

The policy and strategic review of SCP identified several challenges and opportunities. Six thematic areas emerge from our analysis: (i) governance, legislative and regulatory aspects; (ii) organizational arrangements of SCP KP; (iii) financing and financial sustainability of SCP KP; (iv) purchasing of services and the critical role of SLIC; (v) monitoring and evaluation arrangements; and (vi) communication channels and user satisfaction.

Governance, Legislative and Regulatory aspects of SCP

A Policy Board, as the oversight and governing body of SCP, was established subsequent to the passage of UHC Bill 2022. Chaired by the provincial Minister of Health, it is well represented by eight relevant public sector departments. The Chief Minister of KP nominates three representatives from the non-governmental sector who are mostly retired civil servants, health professionals, health insurance or financial management experts, or philanthropists. There is no provision in the Bill to have members that represent the voice of citizens or beneficiaries. The Policy Board approves all policy matters concerning the benefit package, provider payments, caps on benefits, annual plans and financial allocations to the SCP. At the time of the assessment, the

Policy Board had the unique advantage that the Minister of Health was also the Minister of Finance in KP who has a major say in budget approval for SCP KP.

SCP and its Directorate have been given an autonomous status through enactment of the Khyber Pakhtunkhwa Sehat Insaf Card Bill, 2018,[13] and its financing has been transferred to regular budget of the government. However, the rules and regulations of SCP are yet to be framed. Legislating UHC Bill demonstrates strong political and legislative commitment towards UHC through SCP.

Although, SLIC does not have a legal status in the UHC Bill 2022 some of its clauses explicitly make it the preferred third party. For instance, the Bill that states – "Expansion of Sehat Card Plus to all population of the province done during 2020 and 2021, through State Life Insurance Corporation, shall be deemed to have been done under this Act". This legally endorses the de facto status of SLIC. Though a competitive bidding process is required, prior experience reveals that managing health insurance gives SLIC gives greater advantage than its competitors. It also expresses the legislative intent to implement SCP through an independent third-party arrangement in the medium to long term instead of establishing an autonomous provincial health insurance organization.

Organizational arrangements of SCP KP

The Social Health Protection Initiative (SHPI) Directorate has been entrusted with the task of managing SCP by the KP government. Under the 2022 Bill UHC, the SHPI Directorate is autonomous, reports to the Policy Board, and works directly with the Minister of Health led by its Chief Executive Officer. It is also the Directorate that works closely with SLIC to ensure programme implementation, while staying away from direct implementation.

The shortage of technical staff and logistical support due to limited operational budget hampers the capacity to monitor programme performance independent of SLIC. Hence, the SHPI lacks its own information system and is entirely dependent on SLIC for receiving information about SCP, especially on implementation related matters, which results in a conflict of interest. This compromises its legal mandate in safeguarding the interest of beneficiaries and health care providers. Figure 1 illustrates the organizational arrangement of SCP at the policy and implementation level.

The SHPI Directorate also lacks a multi-institutional programme management committee to help the CEO in strategic management, planning, and supervision of SCP. Advantage has not been taken to mobilize public sector autonomous bodies to support the work of SHPI Directorate. Prominent among these are the: (i) Health Care Commission (HCC), an autonomous body responsible for the regulation of public and private health care establishments in KP; (ii) Health Foundation that is mandated to develop innovative health care delivery

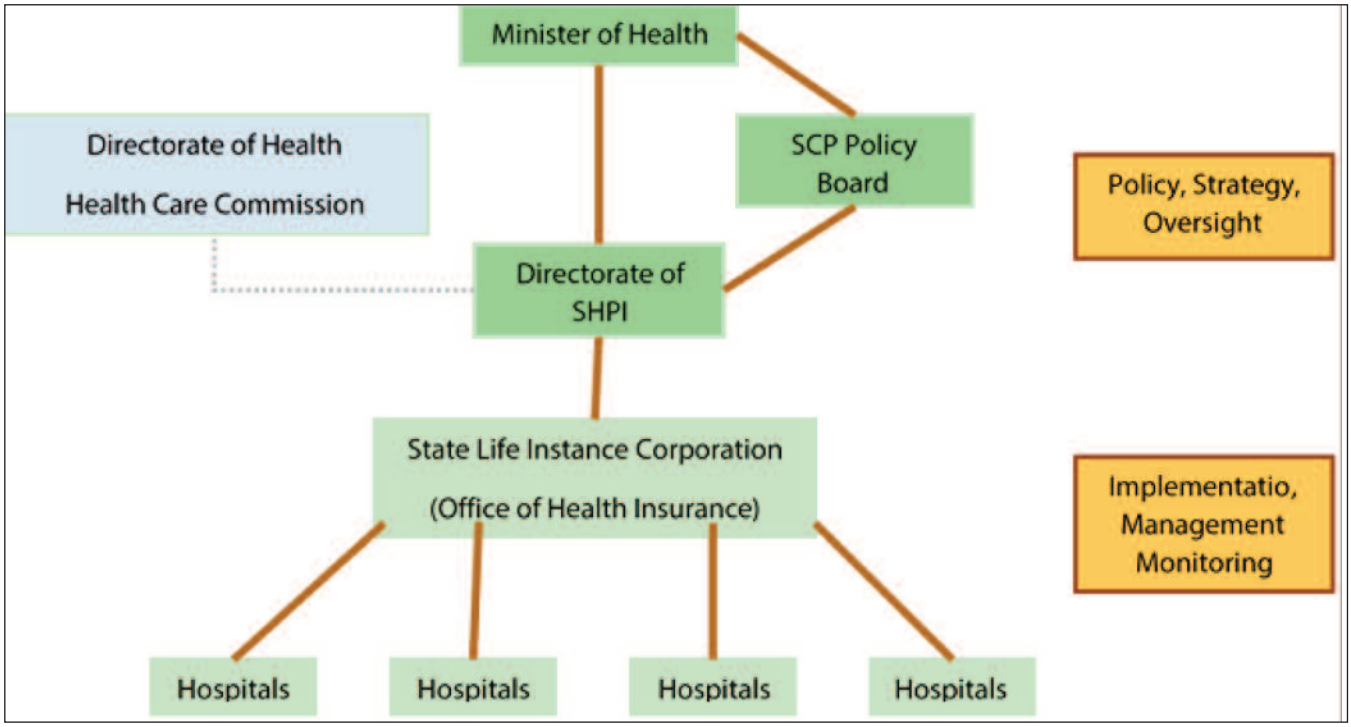

Figure-1: Existing Organizational Arrangement of Sehat Card Plus.

models through public private partnership arrangements,[14] (iii) Independent Monitoring Unit (IMU) within the DOH with almost 200 staff can independently monitor the performance of SCP; and (iv) Provincial Health Services Academy for capacity development related disciplines. The capacities of these institutions need to be tapped better than has hitherto been done.

Financing and Financial Sustainability of SCP

Pakistan currently faces a complex economic crisis. The continued devaluation of the Pakistani rupee, high levels of inflation, depleting foreign exchange reserves, and a less than satisfactory economic growth rate pose challenges to the financial sustainability of SCP. Considering the change in policy from targeting the poor to the fully subsidized entitlement for all by SCP has posed a major challenge, as it is always difficult for any government to withdraw such a political commitment. Although SCP can be applauded from any equity perspective, its unplanned expansion to cover the entire population threatens its financial sustainability.

Further, SCP is not based on contributions but on entitlements and is fully funded by the provincial government. The role of tax-based financing and entitlement-based approach is increasing in L&MICs since collection of contributions from the informal sector is difficult. However, the absence of any financial transfer by the federal government contrasts with other L&MICs where it is usually shared between the state and federal governments.

The annual budget of the SCP KP is approved as part of overall budget by the Provincial Assembly and disbursed on quarterly basis by the Finance Department to SHPI from where it is transferred to SLIC for payment to contracted health care providers through reimbursement claimed by the empanelled hospitals. Allocations to SCP KP for the years 2021/22 and 2022/23 are illustrated in Table 1 and Figure 2, although recently non-payment or delayed release of payments by Finance Department have been major concerns. Additionally, the government had allocated PKR 1.0 billion for high-cost interventions such as liver and renal transplantation with little evidence of their cost effectiveness, which further questions the efficiency and financial sustainability of SCP.

Table-1a: Government Allocations for the Year 2021/22 and 2022/23 to SCP (PKR billions).

Object/Head	Budget Estimate 2021-22	Revised Budget Estimate 2021-22	Budget Estimate 2022-23
Regular Districts of KP			
Annual Insurance Premium	21.0	21.0	23.5
Inclusion of liver transplant & other services	1.0	1.0	1.5
Premium under group insurance (Total)	22.0	22.0	25.0
Merged Districts			
Premium under group insurance	1.0	1.0	3.5

Table-1b: Cumulative and Year wise Budget Allocation, Release, and Expenditure by SCP.

Year	Allocation	Release	Expenditure
2019-20	3,611,274,538	3,611,274,538	3,611,274,537
2020-21	13,717,455,804	13,717,455,804	13,692,066,708
2021-22	22,200,795,000	13,852,974,719	13,852,974,719
2022-23	25,228,628,000	19,039,646,628	19,026,895,147
	64,758,153,342	50,221,351,689	50,183,211,111

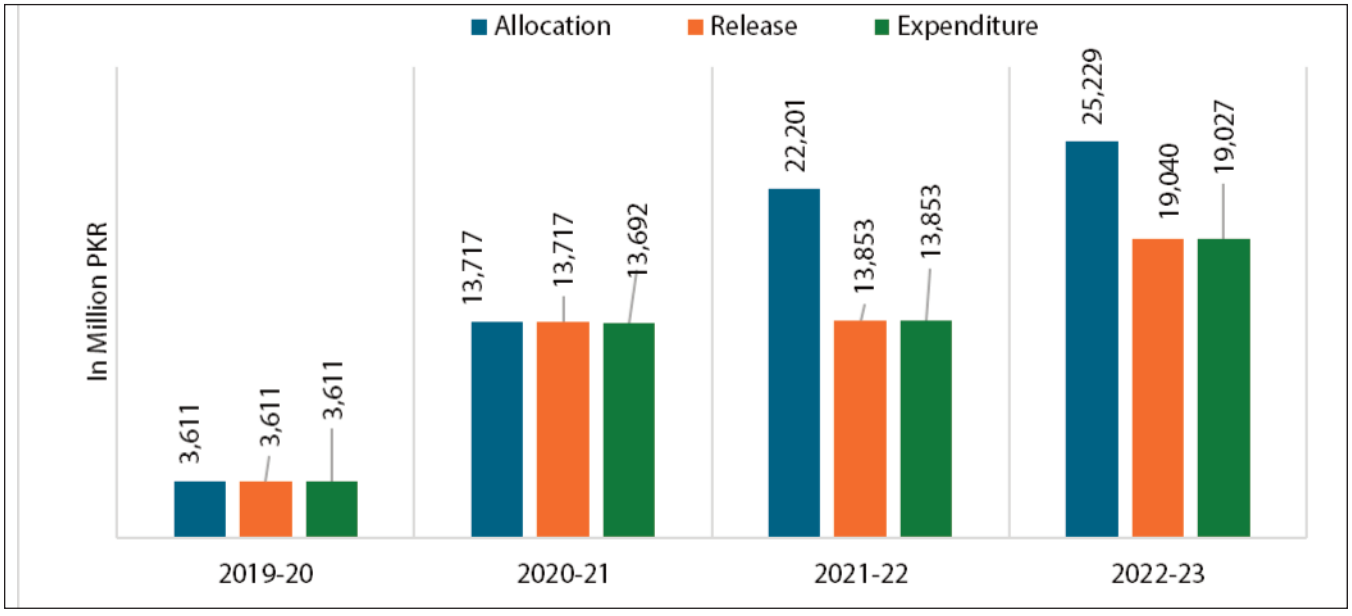

Figure-2: Budget Allocation, Release, and Expenditure by SCP.

The premium for the registered families, which is entirely paid by the SCP, is set at PKR 2,849. Family-based coverage, instead of individual coverage, has accelerated expansion of SCP. The premium does not seem to be based on actuarial estimation but as an input to the bidding process. SLIC, which in the current round has been contracted for a period of three years receives 11.27% of premium as administrative overheads for implementing SCP. Further, in case of non-utilization, 85% of the premium goes back to the government and 15% remains with SLIC in the current risk sharing arrangement. Benefits ceiling has been introduced to protect financial sustainability of SCP but increases the risk of exposing households to financial hardship. The benefits ceiling needs to be increased in the long run, otherwise it would create the dilemma of introducing co-payment and reducing financial protection that SCP currently offers.

Purchasing of Services: The critical role of SLIC

The implementation of SCP has been outsourced to SLIC that includes: (i) hospital empanellment and grading for differential tariffs; (ii) pre-authorization of patients for admission through verification with NADRA database; (iii) claims processing, review, approval, and suspension; (iv) consumer rights protection through complaint monitoring and redressal; and importantly (v) the decision to admit patients under SCP. SLIC has its own staffs in empanelled hospitals, and - health facilitation officer (HFO) and district medical officer (DMOs) who facilitate services and verify membership in NADRA's online computerized database. In the short run, this has been a useful measure to rapidly establish and roll out the programme. By March 2023, SCP had registered more than 7.2 million families in KP, with 3.1 million outpatient visits and 2.1 million hospitalizations. Since implementation commenced 4.95 million enrollment Sehat Cards were issued till the SCP became universal, renamed as SCP, and Sehat Card replaced by the Computerized National Identity Card (CNIC).

Empanellment of hospitals according to criteria defined by SLIC is essential before becoming eligible for reimbursement under SCP. The empanelled facilities are graded and entitled to different tariffs, which are reimbursed on submission of claim. SLIC is responsible for hospital empanellment with little involvement of the DOH, SHPI Directorate or the HCC. There is lack of clarity as to how the tariffs are estimated, and which cost items are covered such as cost of diagnostics and treatment, and adjustment to current inflation rates.[15]

Once empanelled, SLIC enters into a contractual arrangements with hospitals. At the time of the assessment, almost 200 public and private hospitals had been empanelled by SLIC (Table 2). Political interference plays a part in the process of empanellment, which SLIC claims to have resisted successfully. Recently SLIC dis-empanelled 48 hospitals, all from the private sector, due to non-performance. This is indicative of the lack of capacity of hospitals to deliver quality services, and of SLIC's limited capacity at the time of empanellment. There are few initiatives to continuously monitor the quality of care offered. SLIC conducts some level of monitoring to counter supplier induced demand, particularly for surgical procedures such as appendectomies, cataracts, and Caesarean-sections.

Table-2: Breakdown of Hospitals Empanelled by SLIC in KP.

Hospital Level	Public	Private	Total
Secondary	28	124	152
Tertiary	21	20	41
Total	49	144/	193

The current benefits package of SCP is for inpatient care although it covers 1 day before and 5 days after admission mostly on medicines. In addition to basic treatment package which covers secondary care services up to PKR 200,000 per family per year, the SCP also covers advanced treatment up to PKR 400,000 per family per year, and an additional coverage of certain high-cost treatments such as chemotherapy, radiation and surgical treatment for cancer, kidney transplantation, accident and emergency and ICU care up to a maximum of PKR 400,000 per family per year. (Figure 3). Considering that even a small amount of direct payment can be a financial burden to access for the poor and the vulnerable, no copayment under SCP has been introduced.

Benefits package decisions are not based on cost effectiveness and other considerations such as social acceptability, equity, medical ethics, and budgetary impact. The exclusion of primary care in the benefits package is not based on evidence of cost effectiveness and major disease burden of NCDs which requires regular outpatients' treatment. Currently SCP pays providers based on case-based payment, which is a wise policy choice to start with. More systematic research and development is required to assess this and consideration be given to move incrementally towards a Diagnostic Related Group based payment system. Furthermore, regular clinical auditing is required to detect supplier induced demand or clinical justification for repeated admissions for the same medical condition.

It is difficult to assess the adequacy of tariffs without rigorous analysis of costs for each condition. Tariffs for some services may be too high and for others too low compared with the actual cost, with differential profitability of individual cases, which can cause distortions in the optimal

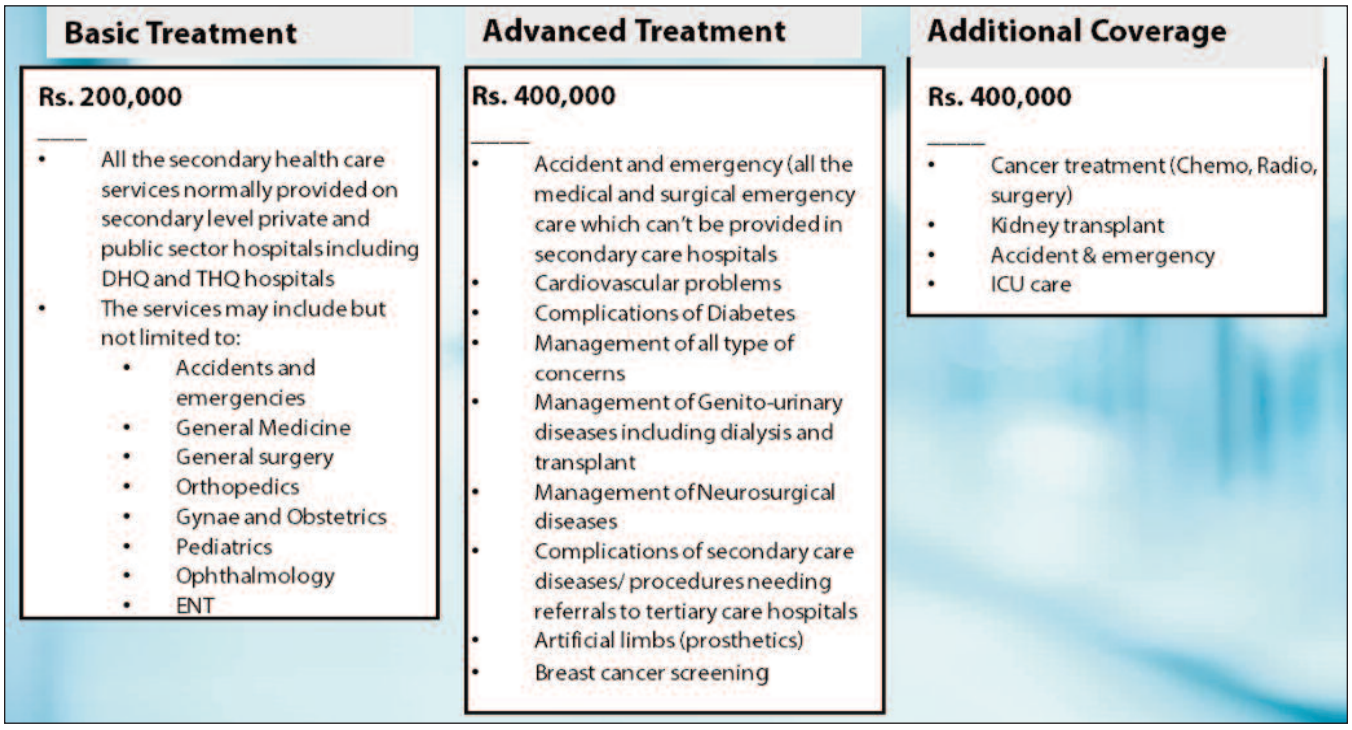

Figure-3: SCP KP Basic and Advanced Treatment and Additional Package.

case mix with over-provision of high-margin cases and under-provision of low-margin ones. The tariffs are adjusted based on the grading of hospitals, which is based on the level of technical sophistication of the facility, although its definition and means of measurement are lacking.

Public hospitals benefit significantly from the SCP since the legislative provision encourages dual financing sources from annual budget allocation, and additional revenue generated from reimbursement by the SCP - the double dipping phenomenon. From the private providers' perspective, this is not a levelled playing field as their earnings come only from the SCP and other out-of-pocket payment services provided. The government should consider transferring the state budget allocations to public hospitals for better financial coverage and adequate tariffs as an incentive to public hospitals to improve performance. This change in funding flow will provide a levelled field for fair competition between public and private hospitals as has been practiced in Thailand since 2002.

Over time, SLIC has increased its technical capacity for claim processing, and most get reimbursed within a month. SLIC can further improve its capacity as a strategic purchaser beyond efficiency in billing, fraud detection, supplier induced demand, and management of grievance. The most important performance measure of SCP is its contribution to FRP of patients. Clinical data is fundamental for the review and audit for quality of care improvement, however, currently this aspect is lacking.

The number of empanelled hospitals in each district is critical in ensuring universal access to care in the province. Table 3 provides information on the number of enrolled families, empanelled hospitals, enrolled family per hospital and discrepancy index across 38 districts in KP. Nine districts, those recently merged in KP, did not have empanelled hospitals, which requires patients to travel to neighbouring districts for admission or to pay out-of-pocket to receive services. Analysis of SLIC data shows in 2022 that 32% patients had to travel to another district to seek treatment.

A high level of supplier induced demand by both public and private empanelled hospitals was also observed. For instance, there was a high intervention rate of Caesarean section, appendectomy, and tonsillectomy. The tariff for Caesarean section at grade 5 hospitals is PKR 30,000 as compared to PKR 16,500 for normal delivery. This sends a perverse incentive for hospitals to opt for Caesarean section, although SLIC has adequate staff as service navigators in hospitals who monitor such practices. Hence, close monitoring of clinical indicators and regulatory interventions for non-adherence is required,[16] It was observed that admission rate of ambulatory care sensitive conditions (ACSC), such as bronchial asthma, was relatively high. Either patients demand inpatient treatment for such

Table-3: Number of enrolled families, empanelled hospitals, and discrepancy index by districts in KP.

District	Families Enrolled	No. of Empanelled Hospitals	Enrolled Families per Empanelled Hospital	Discrepancy Index	District	Families Enrolled	No. of Empanelled Hospitals	Enrolled Families per Empanelled Hospital	Discrepancy Index
Abbottabad	460,471	10	46,047	0.93	Madan	660,625	20	33,031	0.67
Bajaur Agency	298,982	5	59,796	1.21	Mohmand Agency	172,584	1	172,584	3.48
Bannu	310,933	4	77,733	1.57	N Waziristan Agency	230,704	1	230,704	4.65
Batagram	161,736	8	20,217	0.41	Nowshera	376,060	9	41,784	0.84
Buner	242,602	3	80,867	1.63	Orakzai Agency	110,584		NA	
Charsadda	451,651	9	50,183	1.01	Peshawar	816,814	31	26,349	0.53
Chitral	130,059	3	43,353	0.87	S Waziristan Agency	225,077	---	NA	---
D. I. Khan	366,428	5	73,286	1.48	Shangla	218,250	5	43,650	0.88
Hangu	142,301	2	71,151	1.43	Swabi	482,342	15	32,156	0.65
Haripur	334,597	4	83,649	1.69	Swat	658,691	23	28,639	0.58
Karak	214,808	3	71,603	1.44	T A Adj Bannu	10,984	---	NA	---
Khyber Agency	291,663	2	145,832	2.94	T A Adj D.I.khan	17,410	---	NA	---
Kohat	269,330	5	53,866	1.09	T A Adj Kohat	32,688	---	NA	---
Kohistan	93,646	1	93,646	1.89	T A Adj Peshawar	12,791	---	NA	---
Kurram Agency	182,981	---	NA	---	T A Adj Tank	13,389	---	NA	---
Lakki Marwat	216,107	3	72,036	1.45	T.A Adj Lakki Marwat	5,538	---	NA	---
Lower Dir	358,636	10	35,864	0.72	Tank	89,557	1	89,557	1.81
Malakand P Area	197,222	5	39,444	0.80	Tor Ghar	37,135	---	NA	---
Mansehra	555,912	4	138,978	2.80	Upper Dir	267,694	4	66,924	1.35
Total KP	9,718,982	196	49,587	1.00					

Source: https://sehatcardplus.gov.pk/enrollment/ access 4 January 2023

conditions to seek coverage under SCP, or hospitals have a perverse incentive to admit such patients and get it reimbursed from SLIC. There is a need to do a differential analysis of the causes of admission of ACSC.[17] Interview with SLIC senior management revealed that the spending rate increased from 45% of total premium in 2015 to almost 100% in 2021 due to increased utilization rate and potential supplier-induced demand.

Monitoring and Evaluation Arrangement

SLIC has developed and maintained a robust management information system (MIS) for SCP, which provides live information on inpatient registrations/services and claims through a customized dashboard. This application is also connected with NADRA database and is used for instant verification of CNIC. It provides a hierarchical and customized access to SLIC users based on their roles and responsibilities at the facility, district, provincial and regional office levels. Table 4 summarizes some of the strengths and gaps of the SCP MIS.

Building independent monitoring and evaluation (M&E) system is a critical governance and management tool for decision makers to determine the outputs and outcomes of SCP. Although, routine operations are well supported by the MIS, result-based monitoring of SCP remains weak. There are certain process-level indicators used for monitoring through customized dashboard (e.g., claims raised and settled, beneficiaries registered etc.), however the critical need to identify KPIs for the SCP remains.

Table-4: Strengths and Gaps and Challenges of the SLIC Management Information System.

Strengths	Weaknesses
Electronic information management system (inpatient services and claim management – partially)	Does not record data on patient wealth status/poverty score
Provides live reporting through customized dashboards	Utility of MIS information is primarily driven by traditional activity-oriented approach
Collects information on patients' vital statistics, disease, date of admission and discharge, treatment outcome, expense details	Limited dashboard/customized reports for HFO, DMO and Zonal in-charge, and to the Directorate of Social Health Protection Initiative (SHPI)
Record patient diagnosis based on International Classification of Diseases (ICD-10)	Limited use of result-based and outcome-level data beyond customized reports
Hierarchical access of MIS to its users based on needs (HFO, DMO, Zonal head, and Provincial head, and central headquarter in Islamabad)	The selection of indicators to be included in dashboard lack clear strategic purpose and operational definitions
Password protection and restrictive access to users to ensure data safety and security	The SLIC HMIS system is not integrated with hospital HMIS

Consumer protection: Management of complaints and their redressal

SCP requires an effective communication and dissemination strategy. Preliminary information revealed that the SHPI Directorate conducts sporadic awareness campaigns to promote and advertise SCP through television, FM Radio, newspapers, billboards, banners, posters and streamers. SLIC has established Facilitation

Desks at prominent places in empanelled hospitals, which are properly branded, equipped, and have the necessary human resources. Information elicited from the household survey suggested over 90% knowledge of the SCP, however knowledge of its different components was less than 50%. The most common source of information about SCP was through the 'word of mouth', which can often lead to misinformation.

SLIC claims to monitor user satisfaction regularly, the redressal is immediately taken up by DMOs and HFOs who are present in empanelled hospital. Posters are displayed at empanelled hospitals at notable points to reinforce the messaging and explaining how to lodge a complaint. The mechanism for complaint registration by the beneficiaries at the empanelled facilities presents a conflict of interest as those that register complaints at the facility level (i.e., HFO) are employees of SLIC and local hospital staff. From the interviews with healthcare providers, they were confident that there is no extra billing or under the table payments by the patients, which was substantiated by patient during the exit interviews.

Discussion

The SCP is a flagship initiative of the KP government that provides coverage of in-patient's services to a large segment of population. SCP is overseen by a Policy Board, while its implementation has been outsourced to SLIC. While this arrangement has worked well in the short run, the establishment of an independent health insurance organization or a similar statutory body with adequate capacity to manage such a complex scheme needs consideration in the long run.

The government of KP allocates PKR 25 billion (USD 89 million) annually to SCP, which given the prevailing macroeconomic situation raises questions on its long term financial sustainability. The decision to expand coverage to the entire population instead of targeting the poor, poses a huge financial burden on SCP and mitigates against the principle of progressive universalism.[18]

Programmes that provide large scale health coverage based on social health insurance are relatively new in Pakistan. The health sector has predominantly been financed by tax-based revenue and OOP expenditure. SCP is not a classical health insurance rather a fund management initiative, since the premium on behalf of the entire population is paid by the government instead of payroll taxes and the programme is managed by an autonomous health insurance agency or SLIC. This seems appropriate as a significant segment of the population lives below poverty line and there is a huge non-tax paying informal sector in the country. Similar health insurance schemes have been successfully implemented in several L&MICs and have contributed to achieving UHC.[5-7] These schemes have been termed national health insurance programmes that collect from both taxes and non-tax revenues.[19] These are distinct from the classical social health insurance programmes in economically developed countries, which rely on payroll taxes.[20]

The SCP has several strengths that need to be capitalized and include the high level of political and financial commitment, the obligation to provide financial protection against catastrophic expenditure, make inpatients services accessible to a large segment of the population, and expand services expeditiously by outsourcing the management to SLIC. At the same time, SCP is confronted with several shortcomings that include, among others, the challenge of financial sustainability, high administrative costs (11.3% of the total premium receipt from the government) and an insufficient premium (PKR 2,849 per family); decision to cover the entire population without proper planning and forecasting; over-reliance on SLIC for hospital empanellment, strategic purchasing, and monitoring, and limited capacity of the SHPI Directorate to oversee and independently monitor SCP; and the critique that offering a package of inpatients services only many of which are not proven to be cost-effective compared to many primary care interventions.

While the SCP provides a fairly generous package of inpatients care, it goes beyond by selectively covering some high cost interventions such as organ transplants and implants. It is unclear how the policy related to organ transplant and implants was developed and what evidence was used. At the same time it does not extend coverage to primary care interventions despite the existence of a well-defined, cost effective and evidence informed Essential Package of Health Services for KP. The latter includes 98 interventions, based on global and local evidence, at the community, primary care and district hospital level at a reasonable cost of US$ 17.60 per person.[21] This is essential as outpatients care is equally responsible for causing catastrophic expenditure, especially as the disease burden shifts towards NCDs and other chronic diseases.

Though decision to expand SCP to the entire population posed a huge financial burden, while targeting the poor might not have been politically appealing. A few policy choices that could be considered include a) targetting the poor and scaling up the entire population once fiscal capacity allows, b) scale up to whole population while adjust down funding support by the government and introduce co-payment while exempting the poor. Further challenges will still lie ahead if the SCP will cover ambulatory care in the light of fiscal constraints.

If implemented well, SCP KP could become the forerunner towards UHC in KP and in Pakistan. It can equally benefit from the experience of similar programmes that are more advanced and being implemented in several L&MICs. For instance, the Badan Penyelenggara Jaminan Sosial-Kesehatan (BPJS-K) in Indonesia,[22] Pradhan Mantri Jan Arogaya Yojana (PM-JAY) in India,[23] or the Universal Healthcare Coverage Scheme in Thailand.[24] The BPJS-K aims at providing universal health coverage to its citizens covering around 250 million people, globally it is one of the most extensive insurance system.[22] Similarly, the PM-JAY is the largest health assurance scheme in the world provides a health cover of INR 500,000 per family per year for secondary and tertiary care hospitalization to over 120 million people living below the poverty line and vulnerable families that form the bottom 40% of the Indian population.[23] The latter successfully targets the poor to access inpatients services.

The SCP can be a potential game changer for health in KP and other provinces can benefit from its experience as they consolidate Sehat Sahulat Programmes. However, for implementing this, urgent measures are essential. Notwithstanding the challenges to its financial sustainability, the SCP needs a robust and independent information system that monitors key performance indicators, degree of health protection offered, health and services outcomes, costs of care, beneficiary satisfaction, and most important whether it is serving the poor segments as was originally envisaged. Similarly, issues related to empanellment and grading of hospitals, setting of tariffs for different treatments, delivery of care and monitoring quality, provider payment modalities, claims review and reimbursement, and monitoring and evaluation need to be identified and adequately addressed. SCP has yet to introduce rigorous auditing systems and legal actions to address supplier-induced demand and improve efficiency. Further, there is an urgent need to strengthen the human resource and infrastructural capacity of SHPI Directorate along with the involvement of other public sector agencies in monitoring SCP implementation.

In addition, SCP should have a policy and systems research, including implementation operational research, function that provides evidence on topics such as costs and price setting of interventions, differential utilization by population groups, quality of care, and user satisfaction. Alternatively, academic institutions can be invited to undertake such studies till in house capacity is developed within SCP. Such evidence, can be presented to the Policy Board for decisions that benefit SCP and are in the interest of the population in general.

Conclusion

The SCP in KP province has made significant achievements in a short period of seven years by extending coverage and utilization of inpatients care and enhancing financial risk protection to the population. While the KP governments needs to be commended for this achievement, there are many challenges along the way, which need to be addressed if SCP is to be sustained and institutionalized with favourable outcomes notably access to quality care, financial protection, and ensuring equity. It is indeed a tall order, nevertheless if done well SCP will be the pioneer in contributing to UHC in Pakistan.

Disclaimer: Limited findings from this study have previously been discussed in a report titled "Third Party Evaluation of Sehat Card Plus Khyber Pakhtunkhwa" which was conducted by the Department of Community Health Science at the Aga Khan University, Karachi, Pakistan.

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