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Making Sehat Sahulat Programme Sustainable

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Today, millions of people in low-income countries lack access to health services due to accessibility and affordability issues. Health financing refers to the "function of a health system concerned with mobilising and allocating money to cover health needs. There are various healthcare financing models around the globe; the two broader ones are;

(i) The supply-side models provide free-of-cost health services in public hospitals, i.e., *Canada, Taiwan, South Korea, etc.*
(ii) The demand-driven models encourage citizens to purchase health insurance, the government only partly finances the premium for marginalised segments, i.e., USA, UK, and many others.

The Sustainability Issues of Sehat Sahulat Programme (SSP)

Pakistan has a mixed health financing system where the private sector dominates. Before the SSP's emergence, the country faced a twofold burden: only 0.6 percent of the health budget as percentage of GDP, and more than two-thirds of the financing by households themselves.

The federal government took a major initiative in 2015 by launching the Sehat Sahulat Programme (SSP) in a few districts (excluding the KP province) to provide free in-door health services to poor and vulnerable segments having poverty scores up to 32.5 in the BISP database. At the same time, the Khyber Pakhtunkhwa (KP) government independently started it in four districts. Until 2020, the programme served only marginalised segments by using the BISP data. However, the KP government declared it universal in 2020, and the same approach was followed by the federal government in 2021. There are settled package rates against each sickness; however, the federal and KP vary over premium rates and treatment packages.

There are five stakeholders to run the programme; the primary stakeholder is the State Life Insurance Company (SLIC), which is responsible for all operational activities, including; on-board empanel hospitals, providing free-of-cost in-door health services, and addressing all service-related grievances. So far the programme has enrolled 43 million families by covering 190 million population of country. More than 14.6 million individuals have used in-door health facility in empanel hospitals (till November 2023).

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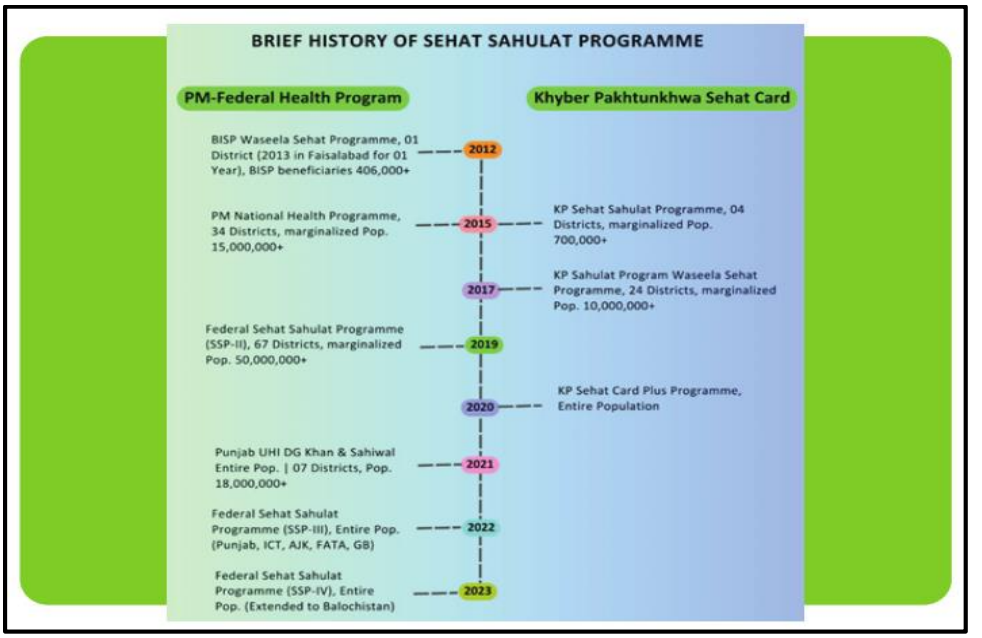
Table 1

Roles and Responsibilities of SSP Stakeholders

Department	Role in SSP Operation
Federal SSP	• Overall custodian of programme through policy formulation and provision of technical assistance
Provincial Health Departments	• Provincial custodian of programme by supervising all operational activities
NADRA	• Provide updated family level data, and manages an out-bound call centre to acquire feedback from discharged patients
State Life Insurance Corporation (SLIC)	• Sole insurance company to manage all operational responsibilities including hiring of empanel hospitals, manages front desk in hospitals, resolve all grievances related to enrolment and treatment, manages an in-bound call centre to address queries of public and register complaints.
Empanel Hospital	• Provide in-door health services on agreed packages by charging no money on admission, lab tests, surgery, doctor fee, medicine etc. Also, provides transport fare (PKR 1,000) at discharge and 05 days medicine.

The programme seems revolutionary in improving the accessibility and affordability of healthcare services. However, it is largely politicised overtime with less attention is made to make it modest and financially sustainable. The government entirely pays the premium of enrolled families. This commitment led to several duplications, making it financially unsustainable when, at the same time, the government was paying a premium to SLIC and financing the public hospitals.



The programme is facing following broader design and operational issues:

(i) There is yet to be a consensus among provinces about the programme's future. Sindh is yet to opt for it, whereas AJK and GB rely on the federal government for premiums.

(ii) The programme restricts the treatment only to those having CNIC/B-form. Many of the population need more documentation and automatic record updation to avail indoor health services. Sixty million children lack birth registrations in the country, and around 18 percent of the adults lack CNIC (10 percent male and 26 percent female).

(iii) The government still needs to be able to create competition among insurance providers. Only one vendor (State Life) holds a monopoly and has no health-related experience. As a result, there is underutilisation of in-door health services due to limited empanelled hospitals, poor quality of services provided by them, and denial of services by various hospitals as they opt for a 'pick and choose behaviour' by offering services only in treatments that are more profitable.

(iv) The government is paying premium for even those citizens who can afford healthcare on their own, making the universal health insurance model unsustainable.

(v) The programme led to duplications in public health spending. The federal and provincial governments spend more than PKR 600 billion on public health infrastructure annually, and logically, the in-door services in public hospitals after the inception of SSP should be financed from the programme and not the annual health budget. Second, health entitlement to citizens by various other initiatives must be stopped to avoid duplications, e.g., government employees and their families, including army, that have their own healthcare systems, various other social protection initiatives, etc.

POLICY GUIDELINES TO MAKE SSP SUSTAINABLE

The SSP model seems too ambitious and unrealistic as no developing country has a universal health insurance scheme. Some co-payment formulas can optimise public resources. For example, the government should pay the premium for the poor and vulnerable segments, whereas the economically stable households pay themselves. Again, the role of government is crucial as being a regulator to promote healthy competition in the insurance market by allowing multiple service providers. The following recommendations may help in improving efficiency, effectiveness, and sustainability of programme.

(a) Limit the Mandate Only for Poor and Promote Health Insurance Competition

The country is facing a huge debt burden where more than half of the budget goes to finance interest payments. The economic growth is sluggish, whereas social safety net expenditures are rising day-by-day, mainly due to the donor push. All such spending without economic growth and job creation are meaningless. The idea of universal health insurance in a country like Pakistan is unviable. We strongly recommend limiting the

programme's mandate to only the poor and marginalised segments (i.e., BISP beneficiaries) rather than all citizens. The government must promote fair competition, as a single health insurance company cannot provide an innovative solution. The government must involve multiple insurance service providers to create fair competition so insurance companies compete on services and citizens can choose the better service provider.

(b) Development of a National Health Financing Framework

Making the programme apolitical requires national consensus on the *health financing framework* across provinces and regions. The framework must provide the guiding principles and roadmaps for federal and provincial governments. The framework must focus on the following policy actions:

- What healthcare financing model should the country follow to make healthcare affordable for the poor citizens?
- How can the health insurance model be competitive in the country?
- Effectively use the insurance programme in public hospitals to finance in-door services, instead of relying on the annual health budget. It is not easy keeping in view the existing red-tapism, doctors unions, and vestige interests by politicians and bureaucrats.

(c) Autonomy of Public Sector Hospitals and Abolish Duplication

As mentioned earlier, the SSP programme was initiated without devising a public health spending framework having agreement among various governmental tiers. Resultantly, it led wastage of public resources as the public health spending drastically increased (from Rs. 470 billion in 2017 to Rs. more than 800 billion in 2023) due to additional-financial burden allocated to the SSP (Table 2). Ideally the health spending for in-door health services in public hospitals should be stopped; however, no such regulatory framework was devised by the federal/provincial governments to make the hospitals financially autonomous. Many of the public hospitals gathered more than 40 million revenues from the SSP premium (as paid by the State Life), however, they were clueless how to utilise insurance-generated revenues. Resultantly, the government.

Table 2

Annual Premium Cost for 2023

Province	Families (in Millions)	Premium Cost (in Billion Rs.)
KPK	10	30
Punjab	32	139
Balochistan	2	6
Federal Administered Areas*	2.5	11
Total	46.5	186

*This includes payment against the AJK, GB, ex-FATA, and Tharparker beneficiaries.

The provincial governments must amend the regulatory framework to make public hospitals autonomous, where each hospital -finances its in-door services from insurance revenues. The government should -finance only the outpatient services in public hospitals.

Overall the health insurance model is cheaper if the government diverges resources from hospital-financing to premium payments, even in the case of universal health insurance; however, currently, there is duplication in health payments by paying premiums on one side and -financing the public sector hospitals on the other side (Table 2 & Table 3). The government must decide about the health entitlements of public sector employees, including both civil and military.

All other initiatives under the social protection umbrella (i.e., zakat, social security, etc.) should also be the part of the SSP. There is, thus, a need to abolish all duplications in health-financing by stopping health entitlements to public sector employees, and through other social protection programmes if a person is part of the SSP.

Table 3

Health Spending and Estimated Amount Required for Health Premium

Province	Govt. Spending on Health in 2017 (in Billion Rs.)*	Total Health Spending in 2017 (in Billion Rs.)*	Expected Number of Families (in Million)	Estimated Cost Annual at Various Premium Trajectories (in Billion Rs.)	
				Current Rs. 4,350 pr Family	Estimated Rs. 6,000 per Family
KPK	64.8	173.6	10.0	43.5	60.0
Punjab	240.4	612.6	32.0	139.2	192.0
Sindh	95.7	276.6	10.0	43.5	60.0
Balochistan	5.5	71.9	2.0	8.7	12.0
GB	0.6	0.6	0.4	1.6	2.0
AJK	N/A	6.1	1.5	6.7	9.2
ICT	1.1	9.7	0.3	1.2	1.6
Unregionalised	61.4	61.4	–	–	–
Total	**469.5**	**1212.5**	**56.2**	**244.3**	**337.0**

*Govt. spending includes federal and provincial, armed forces, local government, public sector zakat, etc.

A limited number of hospitals are empanelled—(22 percent of public and 11 percent of private). To incentivise, the treatment packages must be market-based so every hospital has an incentive to participate in the programme and avoid fake admissions. Second, the provincial regulatory framework must ensure that every registered private hospital must be empaneled. Third, every government hospital must be empaneled and manage the in-door services from the insurance budget.

Table 4

Empanelled Hospitals in SSP by Province

Province	Population (in Million)	Public Empanelled Hospitals (Numbers)	Private Empanelled Hospitals (Numbers)	Total Public Hospitals (Numbers)	Total Private Hospitals (Numbers)	% of Public Empanelled Hospitals	% of Private Empanelled Hospitals
Punjab	110	124	411	317	4,000	39	10
KP	36	42	119	214	400	20	30
AJK*	4	9	10	25	23	36	43
GB**	1	5	5	41	25	12	20
ICT	2	2	9	9	16	22	56
Balochistan	12	0	0	83	10	0	0
Sindh	48	2	14	146	502	1	3
Total	**212**	**184**	**568**	**835**	**4,976**	**22**	**11**