POLICY BRIEF

An overview of the policy design and development for the Social Health Protection Initiative-II in Khyber Pakhtunkhwa, Pakistan

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KEY MESSAGES

1. Various actors were involved in the Social Health Protection Initiative Phase-II (SHPI-II) design, who engaged in intense deliberations to conceptualize different aspects of the scheme
2. Originally planned for August 2022, the scheme launch has been delayed owing to a combination of reasons such as political uncertainties and bureaucratic procedures
3. Scheme design decisions favored options that promised greater alignment of the SHPI-II pilot with strengthening healthcare systems and PHC in the long run
4. Although Pakistan's political and economic scenario has changed over the course of the design phase, posing uncertainties for the scheme designers, the drive for a successful SHPI-II pilot among all program actors is strong

BACKGROUND & MOTIVATION

The Government of Khyber Pakhtunkhwa (KP) is striving to achieve Universal Health Coverage (UHC) for its population. KP's flagship healthcare scheme "Sehat Card Plus" has played a vital role in making inpatient care accessible to the KP population. Going forward, KP with support from the German government, is gearing towards setting up an outpatient (OPD) care scheme, the Social Health Protection Initiative phase II (SHPI-II).

A consortium of German and Pakistani researchers has been tasked to produce evidence that will inform the design and implementation of the OPD scheme. This brief narrates the early phases of the SHPI-II, to highlight strengths and opportunities of the program design process. In doing so we introduce the achievements of the SHPI-II so far, to audience beyond the program actors, as well as summarize the challenges for the program actors to reflect upon for the next stages of the program.

METHOD

We used data from interviews with 10 key stakeholders closely involved in the SHPI-II design and development, and a further 11 stakeholders from the broader health sector. We formally interviewed stakeholders at two time points: Jun-Aug 2022 and Jan-Mar 2023, supplemented by a review of policy documents and by consistent interaction with relevant policy stakeholders.

We present the synthesis of our analysis according to four core thematic elements - actors, processes, context, and content - reflecting a conceptual approach useful in policy analysis proposed by Gilson and Walt.

RESULTS

Actors – the program architects

• The **main actors and their roles** are summarized in Fig 1. The KfW, is the first central stakeholder, funding 85% of the program costs, formally co-signing program documents, and monitoring funds and project. The SHPI Program Management Unit (PMU) shares the responsibility for the management of the SHPI inpatient scheme and the design and implementation of the SHPI-II pilot, on behalf of the KP Health Department.
management4health (m4h) has been selected through bidding as an implementation consultant tasked with supporting the project executing agencies and the project implementation units. Moreover, organizations like the GIZ, OPM and national health experts have been invited to dissemination meetings held by m4h and by the scientific research team coordinating with the central actors to offer research support.

• The **insurance provider** (fund manager) will suggest modifications to the scheme design, only after the bidding process has been completed to avoid any potential conflict of interest.

• Stakeholders pointed out that beyond the institutions in place, **political representatives** continued to play a decisive role in all decision-making.

• Our analysis revealed that the actors were involved in **intense deliberations during the design phase**, as preferences on the different scheme attributes sometimes contrasted. Agreements were sought and found through discussion.

• **Alignments** in relation to how the responsibility of scheme monitoring and evaluation will be shared among multiple actors, level of autonomy of the insurance provider, and perceived length of the cooperation were open areas for discussion among the actors at the time of writing this brief.

• The need to **strengthen the capacity of the PMU** was considered from the conception of the pilot and m4h was mandated to consult the PMU in this regard. Specific aspects to build capacity were human resources, monitoring and evaluation capacities, and expertise for actuarial analyses.

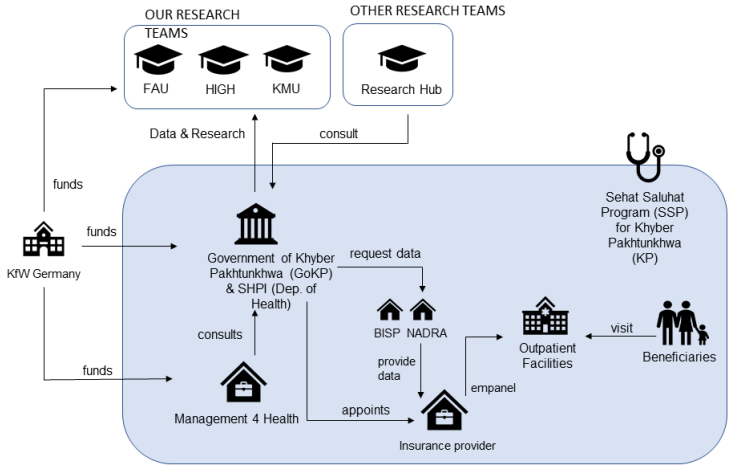

Fig. 1 Stakeholder Mapping Phase II – Outpatient Service (for KP)

Process – a race against time

• **The lack of OPD care coverage** in the Sehat card Plus scheme, linked to its low utilization catalysed initial discussions for SHPI-II. Positive results of a feasibility study for an OPD scheme were presented in 2017. Stakeholder discussions framed Primary Healthcare (PHC) as the focus for the SHP-II after this.

• **The scheme launch was planned for August 2022**, which shifted to January 2023, January 2024, and finally May 2024 according to our latest interactions with key stakeholders.

• Stakeholders lamented that the **overall timeframe** for planning and launching the pilot was too short given the intricacies involved in the scheme design.

• Although a general sense of frustration due to the delay is inevitable, key stakeholders also recognise the role played by drawn out **legal formalities and extensive bureaucratic procedures**.

Context – A dynamic scenario

• **Pakistan's political and economy scenario** changed over the course of the design phase posing uncertainties and exacerbating delays. A change in government took place both at the national and provincial levels, breaking the continuity of the political backing which SHPI-II had enjoyed before. Economic woes raised questions about all future development projects.

• **The SHPI-II's contextual strengths** are the German development cooperation's successful collaboration in KP, the ongoing momentum for UHC in Pakistan with millions covered under publicly funded schemes (Sehat card Plus, 2016 and National Sehat Saulat Program, 2019), and political attention towards UHC. Stakeholders recalled that all main political parties had clearly formulated health goals in their election manifestos in the 2018 national elections.

• Public appreciation of the SHPI and the structural provisions of the **KP UHC Bill 2022** further add to SHPI-II's security, even though in its current form, the Bill formally only protects inpatient services.

Content – multiple dilemmas

• Initially planned for four **districts**, the actors agreed in summer 2022 to initially pilot the scheme in only one district i.e., Mardan, and then gradually expand to the other three. The decision was prompted by the consideration of high OPD utilization (hence costs) and was reached with high consensus.

• All actors noted that the interest to include coverage for non-communicable disease (NCD) in the **benefit package** was present from the conception of the scheme, strongly supported by the provincial government. The decision, however, was taken to orient the benefit package towards the Pakistan Essential Package of Health Services to offer broader coverage, leaving open the question as to what extent coverage for NCDs, and especially NCD medications, will effectively be included as only a 3-day drug coverage is being discussed. Many actors continue to express concern over the real potential of the scheme to enhance financial protection among people with NCD.

• The idea that the scheme could be implemented through a **third-party fund manager**, possibly entrusted to a healthcare provider network, emerged during the first round of interviews. Stakeholders across the board suggested that given the payment modality under consideration, capitation, would technically free the insurer of the risk-management function, the scheme could also be managed by a non-insurance fund manager. In the end, however, no provisions were made for it, and the decision emerged to manage the upcoming scheme through the same insurance partnership model as the inpatient scheme.

• Provider empanelment and contracting presented the challenge of choosing the **level of care** at which to deliver the concerned OPD services. The PMU expressed interest in enrolling secondary and tertiary level facilities to offer higher quality care,

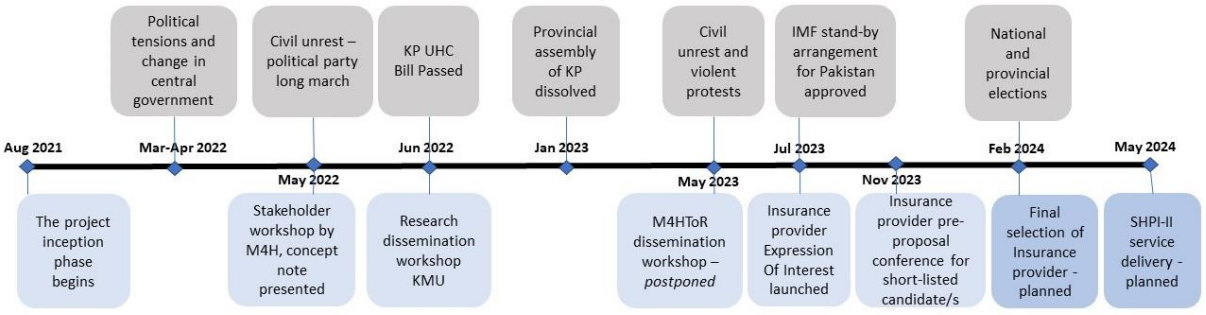

Fig. 2 A timeline of SHPI-II development within a changing political and economic context

while m4h favoured the primary level, to build referral and gatekeeping mechanism toward overall longer-term health system strengthening. The actors decided in favour of the latter for a higher alignment with the PHC concept.

• In 2022 m4h respondents did not appear keen to contract private facilities. By 2023, this decision was reversed and there was an intention to empanel and contract both **public and private providers**, as also suggested in the initial tender engaging m4h. This decision appears to be driven by a desire to increase the potential reach of the programme to geographic locations that are not serviced by public sector facilities, and to offer choice of provider to the program beneficiaries.

• Coming to an agreement on a **provider payment mechanism** was particularly challenging. If on the one side, actors recognised the suitability of per-capita payments to facilities registering the patient, on the other side, they were also aware that neither the insurance agents nor the healthcare providers have any experience with such prospective payment mechanisms. Moreover, the challenge presents itself of implementing a single payment mechanism model against the wish to contract both public, and hence also partially funded, and private facilities. A blended mechanism, combining capitation and case-based payments was proposed by m4h to push for a PHC model with the added consideration that all lower-level facilities may not be fully equipped to allow beneficiaries to receive all required services in relation to a particular illness event in a single facility.

Conclusion – an optimistic future

The design process for the SHPI-II was long and complex, and continues at the time of writing this brief. The program actors are discussing ways towards an optimum scheme within the available resources, and despite delays and political uncertainties their drive remains strong. To support them, we offer a few recommendations below.

RECOMMENDATIONS

Based on the observation of the early development phase and in the light of the upcoming implementation phase, which we expect to pose additional challenges, we encourage program actors to:

- Continue to periodically re-align goals and priorities to help streamline roles in the wake of a rapidly changing context.
- Further expand participation to include a wider variety of stakeholders into design and implementation discussions. This could be done by convening idea-exchange events inviting public and private sector providers, bureaucrats, health organizations, and even potential beneficiaries.
- Engage in a collective excercise to prepare program timelines to be sensitive to standard operating procedures, consultative processes, and reflect contingency planning.

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