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**Health solutions**

The government of Khyber Pakhtunkhwa has extended the Sehat Card Plus program to more than 30 million population of the province. This is a commendable job, given the fact that each year tens of thousands of households across Pakistan are pushed into poverty due to catastrophic health expenditures.

Lack of access to health pushes people into a vicious cycle of poverty and ill health, which end up consuming savings and destroying the sources of sustenance of the impoverished. Malnutrition results in stunting and underperformance in learning and productivity.

An unhealthy population becomes a liability for the public budget and developmental progress as productive sectors get ignored. Spending on health is therefore a much-needed investment. But in developing countries, including Pakistan, health spending is mostly directionless, ill planned and without regard to value for money. It is more important how the money is spent rather than how much money is spent.

The government claims that Sehat Card Plus is universal health coverage (UHC). In universal health coverage, all individuals and communities receive the needed health care services without suffering financial hardships. It covers the full spectrum of essential health services – ranging from treatment, rehabilitation, and palliative care to promotive and preventive care. According to the WHO definition, health is a complete state of physical, mental and social well-being, not merely the absence of disease or infirmity. On the contrary, Sehat Card Plus only covers a limited number of diseases, ignoring all other crucial aspects of health services. Promotion of health and prevention of diseases, outpatient care and supply side financing are not part of this package.

The Sehat Card Plus financing model is not based on international standard best practices and is flawed in many respects. The Khyber Pakhtunkhwa government is the single provider of funds, while services providers are both public and private, and State Life Insurance Corporation is the private for-profit insurer. A financing model based on taxpayers’ money where taxation is indirect and essentially regressive in nature will potentially hit the poor and salaried classes.

In essence, for all practical purposes, this scheme subsidizes all and sundry, including the rich, through the tax money coming from the poor and salaried classes. A better model would be the pooling of resources to cross-subsidize the poor and marginalized segments of society.

The government’s calculation of Rs18.024 billion is simplistic, unrealistic and naive, and not based on scientific data and study. In such an amount even the poorest countries would achieve UHC. A request for proposal was asked by the government from interested insurance companies and the minimum amount quoted per family was Rs2849 with Rs40 as reserve per family. It has been multiplied by a total number of 6.135 families with 300 million added as the PMU annual operational cost. If it had been that simple, no one in the world – from Sub Saharan Africa to Latin America – would have been without insurance.

At the operational and implementation side, the government has already started facing ghost treatment, with the collusion of beneficiaries and other actors, defrauding the public exchequer. Surgeries are reportedly being done by unqualified doctors who charge a minimum fee from the employer whereas employers are paid a full amount by the government. Surgeries are also alleged to be done on paper only with the connivance of those involved in the process. Manipulation of record and misuse of the scheme are becoming an open secret.

It is common sense that people will throng to neat and clean private-sector hospitals leading to cost escalation, unnecessary treatment, collusion, corruption leakage with a resultant failure of the insurance scheme. All this gets more painful considering that the money comes from the poor who pay a plethora of indirect taxes on almost every item they consume. This flawed model has all the recipe to further aggravate life conditions for the poor and jack up poverty.

Another sad aspect of the Sehat Card Plus scheme is that almost 64 percent of funds are already going towards the private sector. The government's own statistics show that two-thirds of patients’ funds were expended in the private sector last year. This figure will expand further with the passage of time, leading to under-utilization of public-sector hospitals, and hence their ultimate collapse. This scheme is enriching and strengthening the private sector – to the detriment of public-sector hospitals, that too at the cost of taxpayers' money.

Quite anomalously, the government remains the purchaser and supplier simultaneously. This model is not sustainable, both in theory and practice. The advantage of contract negotiations has been lost. The private sector is eyeing this windfall gain, not caring for the long-term implementations of the scheme. The licensing part of the hospitals have not been started. During the MMA government, an international health insurance company agreed to provide health insurance to public-sector employees, with only three percent service charges while all savings were to return to the government

There is no transparent mechanism for selection of health facilities, where the Healthcare Commission should play its major mandated role. The cost of treatment is determined by the insurance company and resultantly gets maximum benefits. The government is expanding this program to the whole of Pakistan without evidence and assessment of effectiveness and sustainability.

Universal health coverage is Pakistan’s international commitment under SDG 3. Moving towards universal health coverage is, therefore, an important obligation. But half-cooked reform initiatives which are not based on informed decision-making process, and backed by scientific data, will be abortive, prematurely killing all serious moves towards universal health coverage in the future.

The government should ensure that the KP model is made an all-inclusive, sustainable and equitable solution. It must be given a few more years to test and validate its efficacy and long-term sustainability, after rectifying its systemic faults. Hasty, ill-planned and thoughtless policy prescriptions are part of our problems; they cannot become a recipe for our lingering problems of poverty and ill-health.

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