**[Road to UHC](https://www.dawn.com/news/1831146/road-to-uhc)**

[Zafar Mirza](https://www.dawn.com/authors/9300/zafar-mirza) Published May 3, 2024

MAPS are important for destinations. But travelling on the road to universal health coverage, we first need to understand the destination itself.

The [WHO’s definition](https://www.who.int/health-topics/universal-health-coverage) of UHC is: “when all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.”

Let’s take Khyber Pakhtunkhwa as an example. How we can reach the destination where all the people of KP can use the quality health services they need without suffering financial hardship?

First things first. Do we clearly understand from which point we are embarking on this journey? In a nutshell, KP has a population of 40.85 million living in 5.88m households spread over 35 districts. Eighty-five per cent of the people live in the rural areas and the province has a population growth rate of 2.38pc, which means that every year around a million people are added to the population and poverty is again on the rise.

All of these people need healthcare, ie, protection from risks to health and diseases (preventive health services); health education to avoid risky behaviour (promotive health services); treatment for those already sick (curative services); assistance for those suffering or recovering from disabling conditions including inborn defects, injuries and diseases (rehabilitative services); and care for the terminally ill (palliative services).

The path to universal health coverage in KP is being paved.

The UHC Service Coverage Index for 2022 in KP was 51.1 (the range runs from one to 100). The UHC SCI is calculated on the basis of only 14 basic health services and aspects of access and system capacity covering four key health domains: reproductive, maternal and child health, infectious diseases, NCDs, and health service access and capacity. The WHO and World Bank are jointly conducting UHC tracking biannually across the world since 2015. Pakistan has also been undertaking the exercise for the last few years.

The state of access to a mere 14 essential health services indicate the overall state of health service coverage in society. In the case of KP, UHC SCI was 36.2 in 2015 and it went up to 51.1 in 2022, ie, 41.21pc increase in seven years. The global target is 80 by 2030.

According to National Health Accounts, out of a total health expenditure of Rs200.5 billion in the province in 2019-20, around 65pc was being spent by people out of their own pockets. Government spending was only 30pc. This is despite the fact that there is government-financed universal [health insurance](https://www.dawn.com/news/1819946) (UHI) available for hospitalisation, ie, secondary and tertiary healthcare.

Of the 30pc the government spends on health, around 70pc goes to secondary and tertiary healthcare and only around 30pc to primary healthcare. This lopsided spending is responsible for weak PHC, especially in the rural areas, for the majority of the population through public-sector health facilities. Because of this, people have to go to the cities and make out-of-pocket payments as private healthcare is concentrated in the cities.

In this situation, what actions must the KP government take to advance UHC?

First and foremost, UHC, and not just the financial protection of hospitalised patients [through the Sehat Card](https://www.dawn.com/news/1830971), should be established as a destination and this has to be done at a political level. (For an explanation of UHC versus UHI, see my last article on these pages.)

Once the destination is decided then the above-mentioned situation and the existing knowledge about which health service makes the greatest difference at what level of healthcare, and which sections of society need prioritised financial protection will dictate the priorities for the travel towards UHC.

The WHO says that up to 90pc of healthcare can be provided at the PHC level. We know that the most cost-effective healthcare, ie, preventive healthcare, which all people need, is also provided at the PHC level and when we know that 85pc of KP’s population lives in the rural areas we don’t need to be Aristotle to work out where the focus of healthcare should be.

In this connection, to the credit of the KP government, a very well-worked-out essential package of health services with localised evidence was developed in 2021, which contains 98 services to be delivered at the district level. The package was also costed. At the current exchange rate, it requires around $18 (Rs5,000) per capita per year. Currently, the KP government is spending only around $5 per capita, so there is a glaring gap of $13. The UHC SCI and the current state of PHC services for 85pc of the population reflects this gap.

Filling this gap, removing huge inefficiencies and delivering an essential package of health services to KP’s rural areas is the key to meaningfully advance UHC. In urban areas, tertiary and secondary care for hospitalised patients is already universalised through the state-financed Sehat Sahulat programme by empanelling hundreds of private and public hospitals.

Without debating the universalisation part, this has provided protection to poor families in KP against catastrophic and impoverishing expenditures. However, to further lower out-of-pocket expenditures by poor people seeking healthcare in the private sector, the Sehat Sahulat programme needs to be extended to PHC.

The road to UHC is fed by many small passages that pass through various areas of the health system, other than health services and financing, and include, but are not limited to, the health workforce, medicines and technologies, digital management of health information, etc.

All such projects and efforts to strengthen various aspects need to be explicitly aligned with the goal of achieving UHC.

So, the road to UHC in KP is being paved. Some important steps have already been taken. Huge financing gaps need to be filled, which seems like a Herculean job but is not impossible. Public-private partnerships in rural KP, especially with an expanding not-for-profit health sector in Pakistan would be the key. More on PPPs in the health sector another time.

*The writer is a former SAPM on health, and professor of health systems at Shifa Tameer-i-Millat University.*

**zedefar@gmail.com**

*Published in Dawn, May 3rd, 2024*