State of the Art Lecture

Universal Healthcare

Sania Nishtar[1]

[1]*Chairperson, Benazir Income Support Programme*

Ladies and gentleman, Assalam-o-alaikum, good morning and congratulations to the organisers of the King Edward Medical College symposium, both for convening this event and for giving it such a befitting theme. Universal health coverage has become the central pillar in the global health discourse. It is the unifying thread in goal three of the sustainable development agenda. It has become the number one policy choice of governments all around the world and for very good reason, because universal health coverage can create avenues to fix broken health systems, it can help to save lives, it can avert death and disability, it can be a vehicle for achieving programmatic goals and most importantly, if it is delivered effectively, it could become the 21 st century welfare contract between the state and the citizens, a state's promise to its people. But what does it mean in public policy terms for a country like Pakistan, a country of two hundred million people with a large mixed health system and with the highest and the worst newborn mortality rate in the world. Well, first to put things in context, we have to bring to bear that Pakistan has many health systems and not one. The revenue funded armed forces health system; the self-sustaining Fauji Foundation systems health establishment; the Employee Social Security Institute, financed through compulsory social security contributions; the health services delivered by Pakistan's autonomous parastatal organisations; the state's entitlement; social protection and insurance systems, in other words the card based systems. All of these together according to my early estimates cover more than 21 % of the country's population, of course in financial access terms. This is more than 50 million people, five times the population of Sweden which is considered the bastion of welfare services. So my first message to you is that we must disaggregate data when we talk about universal health coverage in financial access terms in Pakistan's context because there is some good news too and it is to be expected that health outcomes for those covered through these systems would be much better, but we have actually never disaggregated data health systems wise in Pakistan to be able to document that. But as opposed to this missed good news there is a lot of bad news as well. Outside of these vertical systems which I referred to a moment ago, there is a large mixed health system with private health providers predominating where out-of-pocket expenditures are the major means of health financing. As you know, ladies and gentleman, universal health coverage is about three things, it is about geographic access, it is about financial access and it is about quality and we have a long way to go in all three areas. In geographic access terms our services are concentrated in urban areas. For a very long time, we have been striving to improve access in rural areas. Of course, there has been some progress over the last fifteen years, but a huge gap remains to be filled. In financial access terms more than 79% of the population of the country is not fully covered, that is a huge number. These individuals run the risk of spending catastrophically on healthcare and they run the risk of being pushed into poverty, and in terms of quality we know that barring exceptions, there has been little attention to service quality regulation over the last 70 years. We know that collusion is well-institutionalised in medical education regulation and human resource regulation and in drug regulatory arrangements. All these are critical gaps because

without quality universal health coverage is an empty vessel, which is what we also outlined in the United States National Academy of Sciences and Medicine report on the quality of healthcare which was released earlier this year and which I had the honour and privilege of co-chairing.

So what are our options in terms of the way forward and here I would like to make three quick points. My first point is about the importance of changes in overall governance and fight against corruption. These are critical for making quantum strides in the health sector. Health reform is not a sectoral phenomenon. It is interlinked with macroeconomic management which is needed to create fiscal space for universal health coverage. Effectiveness of governance can deeply impact the performance of the health system. I strongly believe rule-based control on government functioning, respect for merit, integrity, ethical conduct, accountability and transparency, I believe oversight of discretionary powers and safeguards against conflict of interest are the basic foundations to enable that. It is critical to appreciate that government openness, strong audit institutions, laws relevant to white collar crime, citizens' empowerment and right to information are some of the most important investments to improve health systems and we must understand why there is a lack of incentive or even a disincentive in the public system to embrace these attributes. To change behaviours we must change the design of institutions and the incentive structures that drive them. I strongly believe that improvement in overall governance can have a massive impact on the performance of hospitals. It can tum around Pakistan's over twelve hundred primary healthcare centres and we have seen isolated examples of that in a few provinces over the last ten years. I believe improvements in governance can be the key ingredient to reform regulatory bodies and not just that, but it will also help engage the private sector which has to be part of the universal health coverage solution. Without leveraging the outreach of the private sector, we simply cannot achieve universal health coverage in Pakistan. So, governments have no option but to go the strategic purchasing route. This has to be adopted as a political choice, as a health reform lever, but it is impossible to tum this around in a collusive context. I can tell you that technical reform approaches for universal health coverage is not what is the issue. It is how they are implemented which is where the constraint is and that cannot be fixed without good governance. I strongly believe and especially in resource mobilisation terms because after all universal health coverage costs and we all may cause for increased spending, so within that context I strongly believe that there are also potential synergies to be exploited with the current anticorruption and anti-tax evasion drives as these could potentially plug the diversion of resources which can then be made available for universal health coverage and other similar welfare initiatives. That is the first point which I wanted to make strongly.

My second point is about the importance of disruptive reform. We cannot wait forever for governance to be fixed, people are dying today and action has to begin now and here it is important to draw on lessons from other developing countries who have embraced universal health coverage. If you reflect back in history, in all those settings where universal health coverage was adopted, there has either been a balance between population size and resources or the power of strong institutions to draw reform or a contribution of a constitutional entrenchment to the right to health and strong civil society institutions that have capitalised onjudicialisation of health rights. Any of these three policy levers have been at play whenever universal health coverage has been enabled anywhere in the world and we have to appreciate that we have none of these conditions at play, which is why we need to use disruptive reform approaches. Fortunately technology provides an unprecedented opportunity to do that. These opportunities have been tapped by the private sector and have created islands of progress in the public system. The critical question is, will governments both federal and provisional governments, be able to harness them to bring about the quantum change that is desperately needed in the health sector of Pakistan today. So even in Pakistan when you seek online services today, fast food chains and online taxi such as Careem will deliver on the objective oftrackability, efficiency, transparency and accountability. The same technological capabilities which underpin these service delivery mechanisms, if strategically deployed, I strongly believe could support the development of public sector digital ecosystems and health and that is critical for universal health coverage. There is no reason why we should

not be using simple things such as distribution chain security coupled with mass serialisation to combat the menace of spurious drugs. No reason why we should not be using video surveillance to monitor and counter absenteeism in basic health units across Pakistan's infrastructure of over twelve hundred primary healthcare centres. There is no reason why we should not use last mile solutions such as drones to deliver blood products to haemorrhaging woman in labour in far flung areas just like Rwanda has done. No reason why we should not use integrated interoperable information systems across the public and private sector health systems. We know the potential for increasing digitisation and we know what cell phones and digitisation can do to disrupt the global health landscape, and to usher in these innovations we must partner with entities other than the health sector. Today, health systems are being re-engineered not by ministries of health but by financial institutions and organisations involved in online retailing. They are disrupting in redesigning healthcare all over the world and we need to learn how to leverage that potential. I believe we could usher in a transformation even with our constraints and that is the second point I wanted to make. I strongly believe we could usher in a transformation with the use of digital disruptive technologies that are currently being used by the private sector and in isolated settings in the public system.

Ladies and gentleman, my third point is about future health systems. Today, I would like to challenge you to re-imagine healthcare in our lifetimes. In 2030, a woman in a rural setting anywhere in Pakistan with diabetes could potentially be able to manage her conditions from her smartphone in a context where artificial intelligence could make up for workers shortages. Her wearable sticker could monitor blood glucose and sweat. The internet of medical things could gather this and other information from a microchip in her PIN and upload information to her blockchain secured electronic health record in a cloud. In 2030, the same woman will be able to take her own retinal image on a smartphone and artificial intelligence algorithm could analyse it and book an appointment with a doctor automatically if it is abnormal. It could also order a Careem for her automatically to take her there, deducting money from a mobile wallet saving account and it could send her an SMS alert. The doctor on the other hand before she arrives would have tested the laser therapy on her digital twin before she checks in to see what works best. The woman would be able to order medicines through Amazon, print pills at a local pharmacy, verify their authenticity through a text message and have her Insulin delivered to her doorstep by a drone. You are probably smiling by now because you think I am going into science fiction. This is not science fiction, even today each one of these solutions exist in isolation and efforts are underway all over the world to knit them together at a health systems level. When you view this in the overall context of changes in the market the potential for a massive quantum shift in the near future is evident. There are other massive transformations in health underway also, which will be commercially available in Pakistan regardless of what governments do or do not do. Healthcare will be transformed very soon in our lifetimes and we can re-imagine health even in a country like Pakistan, we can re-imagine for it to deliver on the premise of quality and equity if we make the right public policy investments now. But alongside these governance and normative imperatives are also emerging in the wake of these paradigm shifts and we need to invest in developing new rules, new norms and standards, ethical patient safety, human resource and institutional capacity issues need our urgent attention. The issue of capacity is a critical issue because when the first industrial revolution came, it increased the demand for unskilled workers, but today's fourth industrial revolution is calling for investments in human capital. So profound is this realisation that very soon the international financial system will stop pegging the borrwoing costs of countries like ours with their human capital rankings. So we need to accord attention to umbrella policy like universal health coverage not because they are right based, but also because they make good economic sense.

So to summarise my three points, we must build capacity to tap opportunities that are around the comer, but we must also make for use of disruptive technologies that can make a difference today alongside efforts to ride the broader anticorruption drive to free up resources for health and welfare and to make systems more effective and responsive.

Ladies and gentleman we must appreciate that the needed changes have to be adopted by federal and

provincial governments in a context where legislative lists have outlined respective roles of the federal government, the federation and provisional governments and these are three different layers at the inter-provincial interface and I am not even talking about further down. It is imperative that at all levels governments think beyond the horizons of their five year terms so that universal health coverage can be isolated from policy vacillations that are inherent to change in government. We need an all-party consensus on directions for a universal health coverage policy reform. We need a sustained effort to build institutional capacity to conceptualise and implement reform and build the evidence base to make course corrections. This is a commitment which will traverse decades and statesmanship is needed to broker this. Universal health coverage can be a state's promise to its people and I hope we can get on the way to laying the foundations for a transformation very soon because we have no other choice.

I thank you.

Further Reading:

1. Framework for assessing governance of the health system in developing countries: gateway to good governance
Siddiqi S, Masud TI, Nishtar S, et al. Health Policy, 2009; 90: 13–25.

2. Choked Pipes: Reforming Pakistan's Mixed Health System
Nishtar, Sania, Hardcover – 18 Feb 2010, OUP Pakistan; 1 edition (18 Feb. 2010), ISBN-10: 0195479696, ISBN-13: 978-0195479690

3. Crossing The Global Quality Chasm,
Improving Health Care Worldwide.
A Consensus Study Report of the National Academies of Science, Engineering and Medicine, 2018
https://www.nap.edu/catalog/25152/crossing-the-global-quality-chasm-improving-health-care-worldwide
Accessed on line, 28/7/2019
Delivering quality health services: a global imperative for universal health coverage
ISBN 978-92-4-151390-6 WHO
ISBN 978-92-64-30030-9 (PDF) OECD
© World Health Organization, OECD, and International Bank for Reconstruction and Development/The World Bank, 2018
https://www.oecd-ilibrary.org/social-issues-migration-health/delivering-quality-health-services-a-global-imperative_9789264300309-en
Accessed on line, 28/7/2019