Health Insurance claims in Hospitals of Sargodha: A Case Study of Prime Minister National health Programme

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CERTIFICATE

This is to certify that this thesis entitled: "*Health Insurance Claims in Hospitals of Sargodha: A Case Study of Prime Minister National Health Programme*" submitted by Mr. Mohammad Hishaam Muzaffar Qureshi is accepted in its present form by the Department of Development Studies, Pakistan Institute of Development Economics (PIDE), Islamabad as satisfying the requirements for partial fulfillment of the degree in Master of Philosophy in Development Studies.

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Abstract

The Sehat Insaf Card, an innovation of the last decade, is becoming increasingly popular nationwide as the Sehat Sahulat Card. This research is an attempt to critically look into the health insurance programme launched by the Government of Pakistan, and recognize the link of patient satisfaction level with the rejection of insurance claims in this programme. The major part of this research took place in Sargodha; however, representatives of this programme from different cities were also interviewed. Mixed method approach was used to look at the quantitative aspect of insurance claim rejections, and weigh its importance, while examining the implications with the in-depth approach of the qualitative method during interviews. It was found that insurance claim rejections for hospital treatment in Sargodha had an adverse impact on patient satisfaction, which led to confusion, decline in efficiency of hospitals and increased shifting of doctors away from those hospitals.

Key Words: Insurance claims, hospitals, patients, satisfaction, rejection, *Sehat Sahulat*, Insaf, Health Card.

Chapter 1

INTRODUCTION

Pakistan is a country firmly committed to achieving Health for All (HFA) (S.Z., 2000). Outreach of universal healthcare to people who live below the poverty line is, however, fairly difficult, especially in developing countries, which is mainly because of non-existence of the health insurance system as a step towards universal cover age as well as the absence of quality health services in many areas(Shaikh Hussain R. H., 2018).

Pakistan is the riskiest place in which to be born as indicated by the high rates of its newborn mortality as well as infant mortality. For every 1000 babies born, 46 die in the first month (UNICEF, 2018). Improving the access to health services for achieving the widest population coverage is an essential step for bringing down the mortality rates (maternal mortality, infant mortality, also mortality of adults) in the country. According to the same UNICEF report, the quality of care is defined as the extent towards which health-care services improve the desired health outcomes. It also brings to light a remarkable and yet unrecognized finding - that financial resources for managing strong health systems in Pakistan do exist; but there is a dire need for strong political will to re-direct these investments to achieve quality of service that is wide-ranging enough, and reaches where it is needed most, particularly the underprivileged. Health is the fundamental responsibility of the government, though a neglected one. Even Article 25 of the Universal Declaration of Human Rights 1948statesthat "everyone has the right to a standard of living adequate for the health and well-being of himself and his/her family, including food, clothing, housing and medical care" (Iqbal, 2019). The Lancet study that ranked Pakistan 154thamongst the 195 countries in accessibility and quality of healthcare, unfortunately, had little impact on stimulating rapid corrective action.

A factor of great concern regarding the limitations that apply to public sector health care is that no major public sector general hospital had been established since 1985to 2018(Fatima Khaliq, 2018) while the population has almost tripled since the 1980's(Pakistan Bureau of Statistics, 2017). In this regard, the 2018 *State Bank Notes* emphasize the need to recognize the obvious, namely, that in order to have a meaningful outcome in the health sector with comparable parameters, the priority should be to follow the international best practices.

Clearly, no quick fix can be achieved by undertaking large expenditures, bringing foreign aid, investing in infrastructure, if standards in human capital are not enhanced and maintained at the desired level (Fatima Khaliq, 2018). Health policy-making is firmly guided by the

principle of subsidiarity, i.e. the central authority has a subsidiary function only; health care systems stem from specific political, cultural, historical and socio-economic traditions(Dr.Elke Jakubowski, 1998). Furthermore, health care need, while fundamental to social well-being and economic growth, is at best reflected in incomplete policy analysis around the causes of death, overshadowed by the frightening phenomena of stunting and polio within population groups. A major aspect that remains overlooked is the impact of ageing on health care expenditure – rather a complex issue, particularly in developing countries. In numerous European Union (EU) countries it was found that expenses in the health care domain multiply between the ages of 65 to 75 compared to those on the younger age groups. However, it did seem that the younger old - rather than the very old - need more expensive medical care, since the increased demand and costs of the very aged (80 and older) fall more on other sectors of social care.

It is significant that the World Bank seems less confident regarding its approach to health sector in Pakistan than it does in Bangladesh or India. Complexities of the problem, together with inadequacy of effort, seem to explain why Pakistan has been falling behind the averages for health indicators of low income countries (Abbasi, 1999).

In Pakistan, while the status of health has improved in the past three decades, the pace of improvement has not been satisfactory because of poverty, low levels of education (especially of women and their low social status), and inadequate attention to sanitation and potable water facilities (Abbasi, 1999). Pakistan's doctor-to-population ratio is amongst the lowest in South Asia, with one attendant for nearly a thousand population (Hussain, 2019).

On the other hand it is unarguably true, and accepted, that nutrition and health are vital contributions for economic development of the country; healthy people are energetic, lively and effectively contribute to economic progress(Pakistan Economic Survey 2017-18). This compelling truth is seldom, if at all, reflected in public policy. Vision 2025 provides a guideline which includes the importance of addressing inadequacies in primary/secondary healthcare facilities and ensuring availability, affordability and quality of medical facilities. Under the 18th Constitutional Amendment, health service delivery (always a function performed by provincial governments) was transferred as constitutional responsibility to the provinces in 2010. There remain, however, questions about the extent to which the enhanced expectations have been met adequately from vastly increased share in national resources transferred to the provinces in implementation of the 18th Constitutional Amendment.

An important step to overcome some of these handicaps was taken when Ministry of National Health Services, Regulations and Coordination (NHSRC), Government of Pakistan, together with the Provincial Governments, started the Prime Minister's National Health Program in 2015, now known as the *Sehat Sahulat Programme*. It is an innovative scheme designed for the most poor communities in the country, enabling them to gain access to health-care services of quality from the public or private sector according to their choice, thus opening up a large area of social advancement without burdening them with any financial constraints (Federal Ministry of National Health Services, 2019). The *Sehat Sahulat Programme* provides comprehensive cover to entitled beneficiaries, treating patients from low income segments with free-of-cost hospitalization, emergency and in-patient services (Riaz, 2019). Low income families selected after intensive scrutiny under Benazir Income Support Programme (BISP) criteria (approved after professional review) are covered for two levels of health care benefits that are very substantial. The expenditure incurred on this account can be as much as Rs. 300,000 per family for Priority Disease Treatment and Rs. 60,000 per family for Secondary Care Treatment. A large number of hospitals (from the public and private sector) are empaneled after extensive scrutiny by teams of professionals in terms of the capacity and suitability of each hospital. The entitled families can choose to access any hospital from the panel for indoor treatment. At the same time, the option of inter distrcit portability – unusual feature in any programme, particularly in public sector programmes, and not easy to implement -allows the enrolled families to access indoor hospital services from any empanelled hospital, located anywhere in the country, whether in private or public sector.

Several innovations have been made to ensure that the treatment of low income patients in public and private sector hospitals is managed independently and in a fully transparent manner. A health insurance scheme for low income communities has been introduced. Families borne on the BISP database are made eligible for free treatment; premium is paid by the government; the insurance company is selected through competitive bidding, which in turn empanels the hospitals; and no cash re-imbursement is made to low income patients for their medical treatment. The only exception is Rs. 1,000 per discharge, for a total of 3 discharges per year, for transportation from residence to hospital and back.

Coverage under the scheme is not of individuals but of families. A family (based on NADRA family registration certificate) can be husband, wife and unmarried children; or husband and wife without any children; or divorced / separated woman / man, widow / widower with or without unmarried children, living alone or with her parents / relatives. Parents are not included in a family, if living in same household, but will form a separate family unit.

The Prime Minister's National Health Program (PMNHP), an innovative social health protection initiative, is recognized as an important opening with far reaching implications to achieve 'National Health Vision 2016-2025' (PMNHP, 2018). A major step towards the achievement of that vision, the *Sehat Sahulat Programme*, is being implemented in a phased manner. Its coverage expanded gradually and is addressing management problems as they arise.

It has also taken a giant step in furtherance of the other initiative by the government for improvement of services to persons with disabilities (Ikram Junaid, 2019). Support for the disabled, started in the 1980s, had progressed for a few decades, and has now been more than revived. The scheme meets the medical requirements of "special persons" and does so in an unusually liberal manner. It has opened to them all empanelled facilities without subjecting them to the eligibility criteria of financial scrutiny that other beneficiaries have to undergo. Thus every person with disability, irrespective of his or her financial capability, is eligible for free medical cover under the *Sehat Sahulat Card*.

As of 9th March 2019 a total of 3,237,660 families (out of the total 27 million families registered by BISP)were enrolled for high quality health coverage and more than 117,726 families were treated for numerous illnesses at 157 empanelled hospitals across Pakistan(PMNHP, 2018). The impact of *Sehat Sahulat*, placed in its proper context, is startling. According to the *Economic Survey 2017-18*, the cumulative health expenditure budget catering to the total population was Rs.384.57 billion in the last fiscal year, which is less than 1% of Pakistan's Gross Domestic Product (GDP).That is much too small an amount for health cover that could make substantial impact. On the other hand, the *Sehat Sahulat Programme* provides comprehensive cover to entitled beneficiaries, treating patients from low income segments with free-of-cost hospitalization, emergency and in-patient services (Riaz, 2019). The expenditure incurred on this account – (allowing as much as Rs. 300,000 per family for Priority Disease Treatment and Rs. 60,000 per family for Secondary Care Treatment)– makes a very substantial addition to the cumulative health budget. Further, it stands out as a unique and finely targeted support to and, indeed, investment in, citizens that are most in need. Above all, it has raised the range of health cover, as well its quality, to levels far beyond what the health system supported by the budget of Rs.384.57 billion could provide.

While the service it provides is good by all accounts, there are awkward aspects too, mainly on account of the innovation of bringing insurance into financial management of a service for low income people. This is a new element from the private sector that managers of health

services of the public sector were not familiar with. Car owners and people in business would be familiar with rejection of claims. Under *Sehat Sahulat* the contact of patients is with hospitals. But payments to hospitals are made by the insurance company; and when payment is delayed or refused, hospitals become difficult towards the patients. Insurance claim rejections have thus emerged as an important phenomenon of this very important health programme. This phenomenon, though not so widespread at present, can become more problematic if not managed with care and can have adverse effects on the programme at large. Patients as well as managers have come to know that claim denials and rejections – two distict categories of complaints - are the two biggest obstacles in getting the claims accepted for scrutiny and then processed. Both, the insurer and the insured, face problems when insurance claim rejections become frequent or numerous. If the risk of claim rejections is not addressed efficiently, it can lead to misgivings and dampen the satisfaction levels of patients significantly. However, the revenue of the insurance company might perhaps improve in the short run with these claim rejections, but the harmful affect it will have in the long run will become serious. The insurance company rejecting the claims creates precisely the dilemma which the policy makers desire to prevent.

Generally, health care providers undertake to provide health care to patients and then collect revenue from the payers by submitting a “bill” (from the provider's perspective) or “claim” (from the payer's perspective). For a faster claims payment, the health care providers submit the medical bills to health care payers, in quite a repetitive pattern. Therefore, it is vital to implement claim processing methods that are efficient and fast, and which minimize the number of medical claims that are "rejected” by the payer (Rao, 2005).

Health providers are the hospitals – who want their bills to be paid quickly and in full. The payer is State Life Insurance Company, selected after competitive bidding. They scrutinize every bill, and reject all those that fail to meet the criteria. Beneficiaries who suffer on account of delays or rejection of claims are the patients from entitled families who were given the *Sehat Card* and got admitted to the hospital but were, later, found to be (a) either not entitled, or (b) were given services beyond their entitlement.

Hence, we see an intertwined canvas of the insurance claim rejections of the *Sehat Sahulat Health Card* in the National Heath Programme of Pakistan, in a direct relation with patients’ satisfaction level. This is examined in this research study.

1.1. Statement of the Problem

While the *Sehat Sahulat Programme* has made significant advances, and is considered unique in terms of the many successes it achieved over a short duration, Insurance Claim Rejections under this programme are considered to be on the rise mostly in the less developed areas of Pakistan. This is of particular importance as the programme is implemented to support those in need and targets the families living below the international poverty line of $2 per day. The data on which the populations under the programme are covered was collected by Benazir Income Support Program (BISP) through a household socio-economic survey, the results of which have been reviewed by the World Bank and recognized as credible beyond reproach.

These rejections – even if small and relatively insignificant at the moment - have an impact on the overall performance of the programme. This has two-fold consequences: it affects the poor, who need the service but couldn't pay for it and were enabled by *Sehat Sahulat* to get quality service but came to be frustrated when quality of service went down on rejection of the claim; it affects also economics of the programme when full utilization of the amount available in the Health Card is compromised. The link between insurance claim rejections and satisfaction level of patients is self-evident and, therefore, well recognized by the patient. It is also significant for the service provider as well as the insurer. Insurance claim rejections is a distinctly measurable indicator of the satisfaction level of patients.

1.2. Research Problem and its Operationalization into Research Questions and Objectives

Operationalization is the process of strictly defining variables into measurable factors. The process defines concepts, particularly when these are fuzzy, and allows them to be measured, both empirically and quantitatively. It involves a process of conceptual reduction where the concepts and variables employed in a research exercise are further reduced to measurable indicators (Sudatta Ranasinghe, 1998).

The Insurance Claims Rejections – State Life not paying the bill of the low income client - have impact on the programme's money flow, satisfaction level of patients, and the performance of hospitals. An increased level of insurance claim rejections results in lower level of patient satisfaction rate of hospitals. Insurance claim rejections, patient satisfaction rate along with the performance of hospitals were assessed to gauge the impact on one another and determine the resulting pattern of relationships.

1.3. Research Questions

A research question provides a clear statement of what the researcher wants to know and seeks to find out. The question forces the reader to be more explicit about what is to be investigated (Bryman, 2008).The research questions pursued were:

(a) Why are the hospital insurance claims rejected by the insurance company?
(b) What is the patient satisfaction level in those hospitals?
(c) What is the link between the rejections of insurance claims of hospitals and the patient satisfaction level?

1.4. Objectives of the Research

The objectives of this research undertaking were as follows:

1. Find out the reasons of insurance claim rejections and assess their significance
2. Find out the levels of patient satisfaction in the particular hospitals.
3. Investigate the link between the rejection of insurance claims and patient satisfaction level.
4. Actions that can eliminate or minimize the increasing Insurance Claim Rejections of the hospitals.
5. Actions that can enhance the conditions of the poor which the PMNHP targets (the needy sought to be helped who get affected by Insurance Claim Rejections).
6. Evaluate the reasons of Insurance Claim Rejections from the supply side (insurance providers) and from the demand side (hospitals).

1.5. Hypotheses

A hypothesis is an educated guess about the solution of a problem, which can be defined as a rationally conjectured relationship between two or more variables expressed in the form of testable statements (Sekaran, 1984)

H0: Insurance claim rejections have no impact on patient satisfaction level of hospitals

H1: Rejection of Insurance Claims leads to a lower Patient Satisfaction Level.

1.5. Explanation of Key Terms/Concepts

Prime Minister's National Health Programme:

The Prime Minister's National Health Programme (PMNHP) that was launched in 2015aims to provide health services to the under-privileged citizens of Pakistan. The programme is using the National Socio Economic Registry (NSER) 2010/11 data, collected by Benazir Income Support Programme (BISP), identifying the potential beneficiaries of the programme. The eligibility criterion is to target the families having Proxy Mean Test (PMT) Score up to 32.5with the assumption that the particular households have income of less than $ 2 a day. BISP carried out a nation-wide poverty census by using the Poverty Score Card (PSC) (BISP, 2019). This census collected information regarding the numerous aspects of the households including its assets[1]. It created a reliable registry, measuring the socio-economic status of about 27 million households across Pakistan (BISP, 2019).

The Prime Minister Health Programme was initially launched in 23 districts and under Phase II, its services were expanded to 40 districts, covering 14 million families. (Pakistan Economic Survey 2017-18). This programme is a milestone in the journey to social welfare reforms, and is eminently successful in ensuringthat the underprivileged citizens around the country are able to avail health care of quality in a dignified manner without any financial obligations (Pakistan Economic Survey 2017-18). Rs. 15 billion was allocated in the Public Sector Development Programme (PSDP 2017-18) for two phases of the programme. Expenasion in benefits, both geographically and in numbers, has been phenomenal: for example 1,655,657 enrolled families (and 56,000 families treated by 125 empanelled hospitals across the country) in January 2018 (Pakistan Economic Survey 2017-18)increased to 3,237,660 enrolled families (and 117,726 families treated at 157 empanelled hospitals) by March 2019 (PMNHP, 2018). This shows that - assuming a family to have seven (7) members – the coverage of 11.5 million population in 2018 increased two-fold to 22.5 million entitled persons in 2019. The forward march continues and further enrolement of 7.2 million families indicates solid health cover of quality for the hitherto voiceless 54 million. At the same time, the option of inter distrcit portabilityallows enrolled families to access indoor hospital services from any empanelled hospital, located anywhere in the country, both in privateand public sector.

[1]Many BISP beneficiaries were recently found to be owning valuable assets, including cars. Stern and expeditious action was taken to exclude them and disciplinary measures were also to be taken.

The *Sehat Sahulat* model is the vanguard of Pakistan's commitment to Universal Health Coverage (UHC) by 2030 (Hussain, 2019). This commitment is part of the third Sustainable Development Goal, with its 3.8 target achieving the UHC through "financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and afforable essential medicines and vaccines for all". It is significant that indicator 3.8.1 on "Coverage of essential health services"(UN, 2019) is largely fulfilled by *Sehat Sahulat*.

The *Sehat Sahulat* Program is now providing services in 43 districts cross Pakistan, stretching from areas of difficult geographic terrain in the north, to vast expanses in the Punjab and Sindh. Rs. 190 billion has been alloted for this programme(year 2019-20), and the card holders can get free of cost treatment in any of the 280 hospitals of these districts. (Kashif Abbasi, 2019). Enrolement of 7.2 million families signifies that 54 million people below the poverty line, who earn less than $2 (Rs. 300) per day, benefit(Riaz, 2019). In these facilities free treatment is available for a wide-range of treatments, and the amount that can be utilised by each family has also been increased to a total of Rs 720,000which is the equivalent of 4,500 Euros (AsiaNews, 2019). Moreoever, additional finance has also been held in reserve for more serious ailments: if an enroled family member catches a major disease which requires more expensiveprocedure, the treatment will not be stoppedif funds are exhausted, and in that case the government would further provide Rs. 360,000 per annum per family to enable completion of the treatment(Riaz, 2019). Dr. Mehdi Hasan, anoted Pakistani left-wing journalist, emphasizes the value of the *Sehat Insaf Card*, by stating that 40% of the population that lives below the povery line (less than $ 1.5 a day), find it imposssible to meet health expenditure without assiatnce of the kind now made avilable. (AsiaNews, 2019).

According to one school of thought, it is understood that *Sehat Sahulat*'s origin was derived from Rashtriya Swasthya Bima Yojana (RSBY) – India's 2008 Insurance Programme (Hussain, 2019). The Indian government also aimed to enhance the access of people Below Poverty Line (BPL) to in-patient medical care at both public and private sector institutions (Hussain, 2019). Considering that socio-economic and urban-rural dynamics of India are quite similar, the Sehat Sahulat team found RSBY Programme to be the most compatible model for Pakistan to follow. The government of Pakistan adopted RSBY's model of out-of-pocket payment reduction (which included a decrease in the personal costs on healthcare) among India's poor; Pakistan further strengthened it by introducing the provincially-approved "funds retention formula" along with cross-sectoral public-private health partnerships (Hussain, 2019).

The objectives of the programme (PMNHP, 2018) go well beyond the overall objectives and expected outcomes of the social sector of the country. Generally the Plans seek to enhance the health status of the population in the country by ensuring access to quality health care, especially improving access and coverage to secondary health care and reduce catastrophic events as a result of tertiary care. Most of that, unfortunately, has not happened, and where it did, the occurrence was occasional and to limited extent. PMNHP is exceptional in ensuring access to quality health care to the most vulnerable segments of society. It is also an important thematic pillar of "National Health Vision" on which all provinces and regions have agreed, despite different approaches adopted by each province for other components of the Health programme after devolution of Health to the provinces in 2010.

The Specific objectives of the program are as follows:

(a) 60% of the poorest families are covered by health insurance scheme to access quality health care.

(b) 60% reduction of out-of-pocket expenditure of enrolled beneficiaries for in-patient care.

(c) 60% reduction in episodes of catastrophic health expenditures for in-patient hospitalization of enrolled families.

The Prime Minister's National Health Program is being implemented through State Life Insurance Corporation of Pakistan, which is hired through a transparent and open bidding process. The services are delivered to the beneficiaries by empanelling tertiary and secondary level health care facilities, both private and public sector, in all metropolitan cities and focused districts of the country. The hospitals are empanelled by the insurance company based on hospital empanelment criteria set forth in the project documents. Approval of all empanelled tertiary health care facilities are being given by Federal Project Management Unit (PMU) of PMNHP in consultation with provincial Project Management Unit of the respective province (PMNHP Comprehensive Brief 2018).

Insurance:

The history of Social Health Insurance is as old as mankind, the first country instituting it being Germany in 1883 (Shaikh, May 2008).Social Health Insurance has been used as an approach to enhance efficiency of healthcare system, reduce financial burden on disadvantaged groups and achieve consumer satisfaction in provision of healthcare services. Several developed countries have successfully planned and implemented insurance models, addressing issues of equity while providing almost universal coverage (Shaikh, May 2008). Health insurance helps to pay for partial or entire costs of healthcare, thereby protecting the insured persons from paying expensive treatment costs during an episode of sickness.

Insurance has also been a part of the current government's Health Vision, including healthcare for all (Insaf). In the context of its five point health agenda, health insurance is seen as a major part of the Health Vision.

Community-based health insurance schemes allow many people's resources to be pooled for covering the costs of unforeseen health-related events. They protect individuals and households from the risk of catastrophic medical expenses in exchange for regular payments of premiums.(Ranson, 2002).

Knowledge about Causes of Insurance Claims Rejection:

A denied claim is one that has been determined by an insurance company to be not payable, usually because of common billing errors, missing information, or sometime even based on questions regarding patient coverage (Medical Billing and Coding Online, 2018).

A rejected claim occurs because of a wide range of errors – mostly in the information entered about patients, insurance company, or mismatch in treatment, diagnosed codes and its details. The information needs to be accurate in order to be accepted and processed correctly. Some common billing errors on denied claims include not having access to Explanation of Benefits (EOB), not verifying a patient's insurance coverage, duplicate billing and sloppy documentation (Medical Billing and Coding Online, 2018).

Difficulties with regard to human resource, administrative capacity, technical, and working environment challenges were seen leading to delays in submission of claim by providers, their vetting and payment by managers of schemes.(S. SODZI-TETTEY, December 2012)

Patients' Satisfaction Rate:

This relates to the patients' level of satisfaction with facilities of the hospitals, and also to the attitudes and manners of the doctors towards patients. These aspects become visible when the insurance claims of hospitals are rejected by the insurance companies, adversely affecting the satisfaction level of patients in those hospitals.

1.7.Units of Data Collection (UDC)

UDC1: Patients with Health Card who got their treatment.

UCD2: Hospital employees (Front Desk Officers) who deal with the patients of Health Insurance

UCD3: Insurance Company representatives who deal with Insurance Claims of Hospitals

Chapter 2

RESEARCH METHODOLOGY

It is the framework connected with a particular set of paradigmatic assumptions that is used to carry out research, i.e. ethnography, scientific method, action research (O'Leary, 2004). The procedures followed by researchers in undertaking their work, and described to explain how these were used to compile data and predict the phenomena, are called research methodology.

Phenomenology is described as a study of phenomena as they present themselves in direct experience (O'Leary, 2004). The phenomenological studies are highly dependent on individuals (O'Leary, 2004).

Phenomenology is a research method that is used to illustrate how human beings experience a certain phenomenon (CIRT, 2010). According to the Centre for Innovation in Research and Training, phenomenological study attempts to set aside biases and predetermined assumptions about human experiences, responses and feelings to a particular situation. It allows the researcher to delve into the understandings, perceptions, perspectives, and feelings of those people who have actually experienced or lived the phenomenon or situation of interest. Therefore, phenomenology can be defined as the direct investigation and description of phenomena as consciously experienced by people living those experiences (CIRT, 2010). Phenomenological research is normally conducted through the use of in-depth interviews of small samples of participants. By studying the perspectives of multiple participants, a researcher can begin to make generalizations about what it is like to experience a certain phenomenon from the point of view of those that have lived the experience (CIRT, 2010).

2.1 Research Strategy

The researcher intended to use Mixed Methods. Mixed Methods is the concept of mixing different methods originated in 1959 when Campbell and Fisk used multi-method to study validity of psychological traits (Creswell, 2009).

The qualitative research emphasizes the understanding through closely looking at the people's actions, records and words (Pamela Maykut, 1994).

The quantitative or traditional approach to research looks beyond these actions and words, and records their mathematical importance. This traditional approach quantifies the results of

these observations (Pamela Maykut, 1994). The major difference between the two approaches is the meaning brought to the behaviors, words and documents, which are interpreted through quantitative analysis, as opposed to numerous patterns of meaning which come out from the data and also in the participants' own words (Pamela Maykut, 1994). The goal of qualitative research is to discover patterns emerging after careful documentation, thoughtful analysis and close observation of the research topic.

The qualitative aspect was helpful in capturing the actual grass-root facts and the level of their occurrence. The quantitative strategy was important for understanding the significance of Insurance Claim Rejections along with the finances involved and rotated in this procedure. Merging of these two methods helped the researcher progress towards a true picture of the relationship and assesses the factual reality of the relationship between insurance claim rejections with that of the patient's satisfaction level.

During the initial stages of this research, it was also recommended by experts to carry out the mixed method approach, so that the quantitative data along with the in-depth reality of this project can both be gauged.

Descriptive statistics were used to describe and summarize the basic features of the data in a study, using the quantitative descriptions in an intelligible and manageable form (O'Leary, 2004).

2.2 Research Design

Research designs are plans and procedures for research that span the decisions from wide-ranging assumptions to in-depth methods of data collection and analysis (Creswell, 2009).

A research design provides a framework for the collection and analysis of data, reflecting decisions about the priority given to a range of dimensions of the research process (Bryman, 2008). Research design can also be described as a framework encouraging the researcher to answer basic questions about his research objectives.

Experimental research engenders considerable confidence in the robustness and honesty of causal findings. True experiments tend to be very strong in terms of internal validity. (Bryman, 2008),and often used as a benchmark against which non-experimental research is assessed.

The Case Study Design entails detailed and intensive analysis of a single case. Case study research is concerned with the intricacy and particular nature of the case in question. (Bryman, 2008). The most common use of the term 'case' associates its study with a location, such as a community or organization. The emphasis tends to be upon a rigorous examination of the setting. Exponents of the case study design often favour qualitative methods, such as participant observation and unstructured interviewing, because these methods are viewed as predominantly helpful in the generation of an intensive, detailed examination of a case. However, case studies are frequently sites for the employment of both quantitative and qualitative research. (Bryman, 2008)

Qualitative approach was used for primary data collection through interview guides and checklists, to assess the patients' satisfaction level. The reimbursement rates and value of rejected claims were calculated with the quantitative method and depicted graphically, applying methods of Descriptive Statistics.

2.3 Methods of Data Collection

These are the techniques used to collect data, i.e. observation checklists, questionnaires, interview schedules. (O'Leary, 2004)

For several, data collection represents the key aspect of any research project, in which the researcher establishes a broad outlook of what he wants to explore, and designs research instruments according to his implementation (Bryman, 2008).

Questionnaire is one such instrument through which the researcher is able to establish what he wants to find out, and seek answers to the research questions which drive the project, allowing the relevant data to be collected (Bryman, 2008).

Focus Group Discussions were helpful in tracing out the characteristics and processes of the group members in the hospitals and in the insurance companies. The researcher learnt the relationship of Insurance Claims with that of the Patient's Satisfaction level. This was helpful in the hospitals at Sargodha, during meetings with Health Facilitation Officers and District Monitoring Officers. During these meetings, experienced professionals of the hospitals dealing with health insurance were also present.

Interviews are a method used in both – qualitative as well as quantitative research. Interviews are widely used amongst the masses to recognize and analyze people's perceptions, views, feelings and experiences, and relating them to the reality. The researcher used Unstructured Interviews to speak to patients and the hospital staff to recognize the link between insurance claim rejections and patients' satisfaction level. The research method of semi-structured interviewing helps the researcher keep an open minded approach towards what he wants to find out, encouraging the concepts and theories to emerge from the data (Bryman, 2008). Unstructured interview was particularly helpful for the researcher when he interviewed the Health Facilitation Officers; these interviews were informal and, consequently, the researcher succeeded in grasping the in-depth knowledge of the programme and the prevailing issues which require attention and critical review.

Telephonic interviews: these were helpful to trace patients who got their treatment with the facility of the health card, and gauge their perceptions, views and analysis about the experience. These patients mostly had come from far off rural areas, and telephone was the only mode easily available to reach out to those whose contact details were shared by the hospital management.

2.4 Sampling

In order to generalize the findings, we look for samples to be representative and far from being a disorganized activity. Sampling is a process that is always tactical and sometimes mathematical(O'Leary, 2004). In studies with goals of generalizability, sampling involves using the most realistic procedures possible for fathering a sample that best 'represents' a bigger population.

Stratified Random Sampling for UDC 1

Stratified Random Sampling involves dividing the population into various subgroups and then taking a simple random sample within each one subgroup. (O'Leary, 2004). Here the population, whichever could easily be made available and whose details was shared, was divided into strata from which each stratum was drawn. Numerous sample groups (patients from different hospitals) were selected, and were accessed over the telephone for a brief discussion about the health insurance programme and their satisfaction level.

During the visit of the hospitals in Sargodha, the researcher was also allowed to visit the patients who were admitted in two hospitals (Munir Hospital and Sadiq Hospital). About 18

patients in total who were available were met in person, and they themselves along with their family members responded to the questions of the researcher. The 18 patients were those who were admitted and in process of being treated. The researcher was able to meet 12 other patients also, who were in waiting for treatment, and also those who had got their treatment and were about to leave from the hospitals.

Purposive Sampling for UDC 2 and UDC 3.

A purposive sample is a non-probability sample that is selected based on characteristics of a population and the objective of the study. Purposive sampling is also known as judgmental, selective, or subjective sampling. This helps to select and judge cases relevant to the research objectives along with the research questions. This helped to select cases which were particularly relevant, informative and helpful in accordance with the particular field and specific area.

The researcher used this technique to carry out the interviews of the health facilitation officers, and district monitoring officers of State Life Insurance Company. The provincial monitoring officer was also interviewed using the same approach.

2.5 Locale

Sargodha (Punjabi and Urdu: سرگودھا) is the 12th largest city in Pakistan. It is also an administrative hub of Sargodha Division located in the Punjab province, Pakistan and one of the fast-paced growing cities in Pakistan. (Sargodha).

In the Prime Minister National Health Programme, this city is considered to be having significant issues in the performance of this programme, which the researcher looked into from the perspective of claim rejections and patients' satisfaction level.

Sargodha is a city where commuting from various locations in which people live does not take very long, and everything appears to be close-by from everywhere. Consequently, in this city, most of the people know one another, and especially everyone knows the business giants too. These businessmen also include owners of the private hospitals, including Sadiq Hospital and Mubarak Medical Complex, to name a couple.

When the researcher started work, there were initially eight hospitals of Sargodha on the panel of Prime Minister National Health Programme. With the poor performance of the hospitals, criticism of policies being pursued and dissatisfaction with coverage by the Health

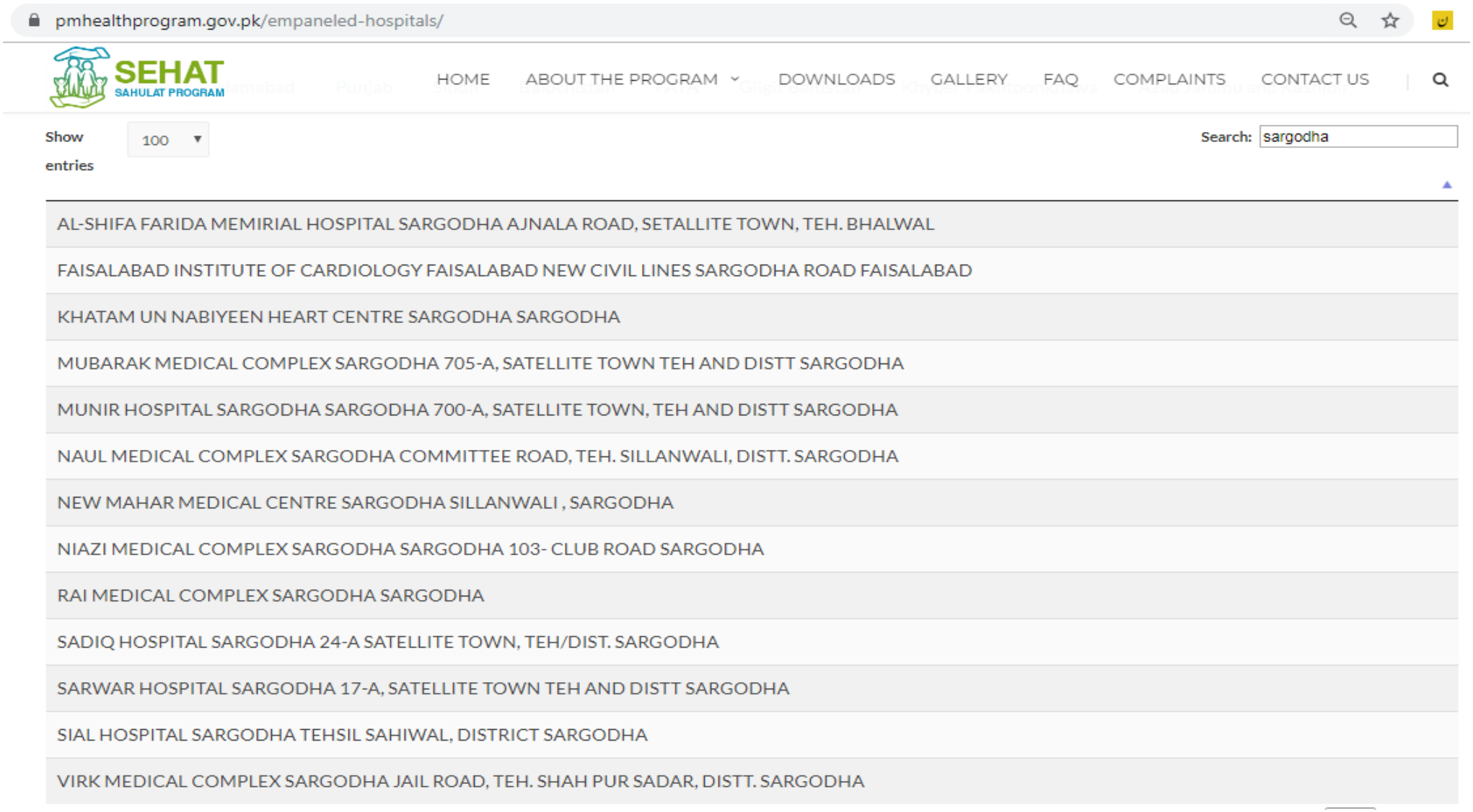
Card, along with issues with State Life Insurance Corporation, the status of the empanelment of these hospitals has varied – changes being made from time to time.

During the time of data collection, an updated list of a total of twelve empanelled hospitals was found from the official website. These are:

1. Al-Shifa Farida Memorial Hospital Sargodha Ajnala Road, Setallite Town, Teh. Bhalwal
2. Khatam Un Nabiyeen Heart Centre Sargodha Sargodha
3. Mubarak Medical Complex Sargodha 705-A, Satellite Town Teh And Distt Sargodha
4. Munir Hospital Sargodha Sargodha 700-A, Satellite Town, Teh And Distt Sargodha
5. Naul Medical Complex Sargodha Committee Road, Teh. Sillanwali, Distt. Sargodha
6. New Mahar Medical Centre Sargodha Sillanwali , Sargodha
7. Niazi Medical Complex Sargodha Sargodha 103- Club Road Sargodha
8. Rai Medical Complex Sargodha Sargodha
9. Sadiq Hospital Sargodha 24-A Satellite Town, Teh/Dist. Sargodha
10. Sarwar Hospital Sargodha 17-A, Satellite Town Teh And Distt Sargodha
11. Sial Hospital Sargodha Tehsil Sahiwal, District Sargodha
12. Virk Medical Complex Sargodha Jail Road, Teh. Shah PurSadar, Distt. Sargodha

However, at the time of the grassroots survey, the researcher could find the record of only eight empanelled hospitals of Prime Minister National Health Program in Sargodha. (Ministry of National Health Services Regulations and Coordination, 2019).

Website Screenshot of Empanelled hospitals of Sargodha



Chapter 3

REVIEW OF LITERATURE

Despite the success this national programme has achieved, and also despite the geographical and financial interactions it has involved, very little research on the programme has taken place to date. Hence, the literature available is very limited, especially related to difficulties encountered in Pakistan.

None of the EU countries provide a wholly public sector service and, in fact, the inclination has been towards a reduction in the state's role in service provision (Dr.Elke Jakubowski, 1998). The main common problems were inefficiency of systems to cope with changing disease patterns, providing equitable access to services, maintain control over costs and utilizing health care resources efficiently with high quality medical care. It was only in1992 that general disease prevention measures were added to the legal mandate of the social insurance system.

Public health expenditure in Pakistanis meager, as is the case in many developing countries, and modest initiatives for increasing it have been taken up as experiments in some provinces (Shaikh, May 2008). Although Social Health Insurance is just one aspect of social protection strategy, if suitably structured, it can eradicate many equity issues in healthcare provisions across the country. Given the constraints and institutional capacities, operationalizing any government funded Health Insurance scheme on a national level that ensures universal coverage is an enormous challenge (Shaikh, May 2008).

In a number of developing countries, access to universal healthcare for people living below poverty line is not easy, mainly due to the nonexistence of health insurance for universal coverage (Shaikh Hussain R. H., March 2018). Pakistan is facing numerous challenges as far as its healthcare financing and resource allocation are concerned. The major issue is inability of low income families to afford the catastrophic healthcare expenses. Every country on the globe has designed a customized version of healthcare system borrowed from elsewhere in an attempt to provide universal access to healthcare services. Pricing of healthcare products varies widely among regions and countries.

PMNHP is a public funded health insurance scheme that is free of cost for its user at the point of service delivery. In some cases transport charges are also provided to users. The programme provides universal healthcare access to people living below the poverty line (Shaikh Hussain R. H., March 2018).

The Prime Minister's National Health Programme is a strong public sector initiative, especially for the poor, ensuring access to quality care. But it requires strong political support and active participation of the provincial and regional governments (Khattak, 2019).

The health-financing trend over the last five years portrays a considerable jump in the health investment, doubling the capital outlay on the development side and tripling the non-development expenditures (Khattak, 2019).

One of the main areas of intervention of the Punjab Health Initiative Management Company (PHIMC), which was established under the Companies Act 2017, is the implementation agency of Prime Minister National Health Program, now known as the Sehat Sahulat Program(GOP, 2019-2028). This Health Initiative Management Company is mandated by the specialized healthcare and medical management department for the implementation and execution of the Sehat Sahulat Program, improving access of the poor to quality medical services by providing a micro health insurance scheme (GOP, 2019-2028).

Pakistan desires to improve the health of all Pakistanis, especially women and children, through universal access to affordable quality essential health services, and delivered through durable and responsive health system, ready to attain Sustainable Development Goals and fulfill its other global health responsibilities(NATIONAL HEALTH VISION Pakistan 2016-2025). Pakistan has a mixed health system, which includes government infrastructure, para-state health system, private sector, civil society and philanthropic contributors. The health system faces challenges of vertical service delivery structures and low performance accountability within the government, creating efficiency and quality issues (NATIONAL HEALTH VISION Pakistan 2016-2025).

Moreover, the National Health Vision has objectives of a unified vision for improving health with ensuring political autonomy and diversity, building coherence into Federal and Provincial efforts towards consolidating progress, synchronizing commonality across international treaties, coordinating for regulation and foundational basis for implementing and charting the Sustainable Development Goals.

Governance of sustainable health system included coordination amongst institutions, non-governmental organizations, the private sector, community organizations, individuals and research and academic community. The State's role is to guarantee equity of access, ensuring functions to Frame Policy for a sustainable health system involving community, ensuring continual vigilance, protecting health, innovation in science and technology and capacity building of human resources for health – all this performed at the highest level of quality for all the peoples (Hakim, 2001).

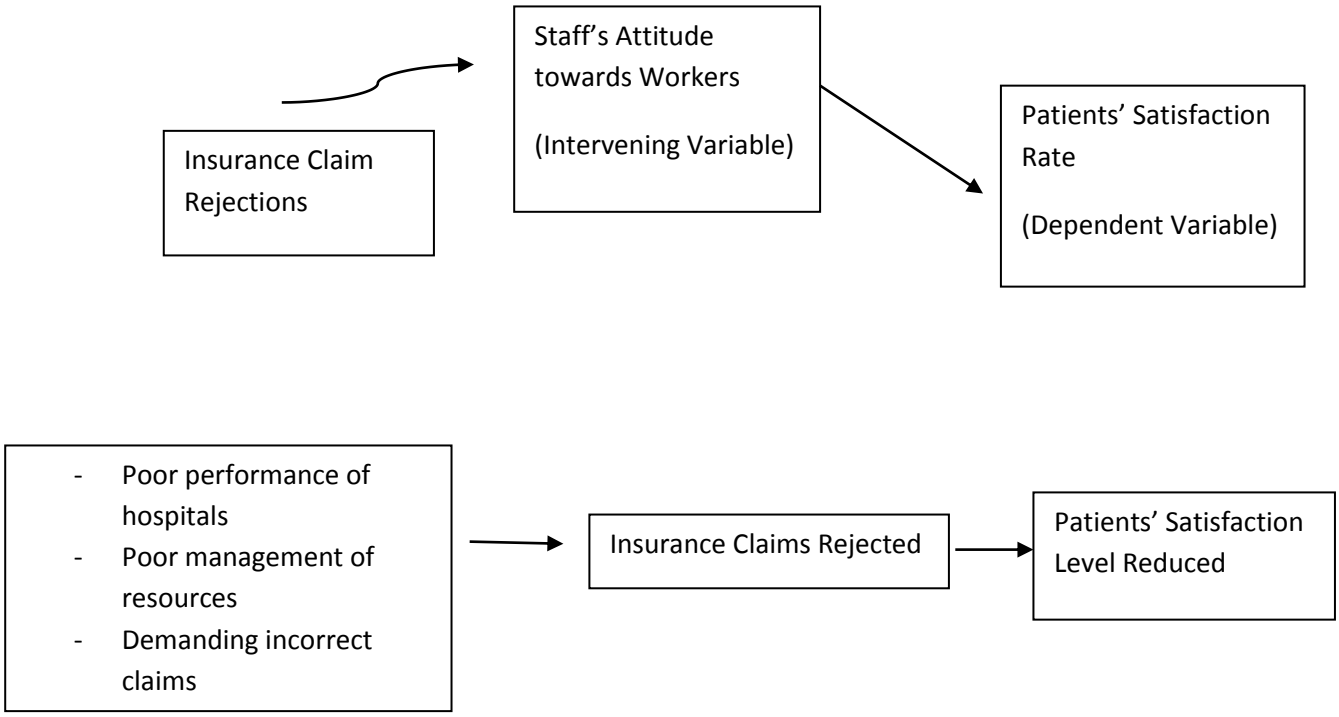
The World Health Organization (WHO) defines health as "the state of complete physical, mental and social well-being, and not merely as the absence of disease disability". It sees health as a human right, it being "a societal issue as the conditions which promote health or cause ill-health are being produced by society and the economy as a whole".

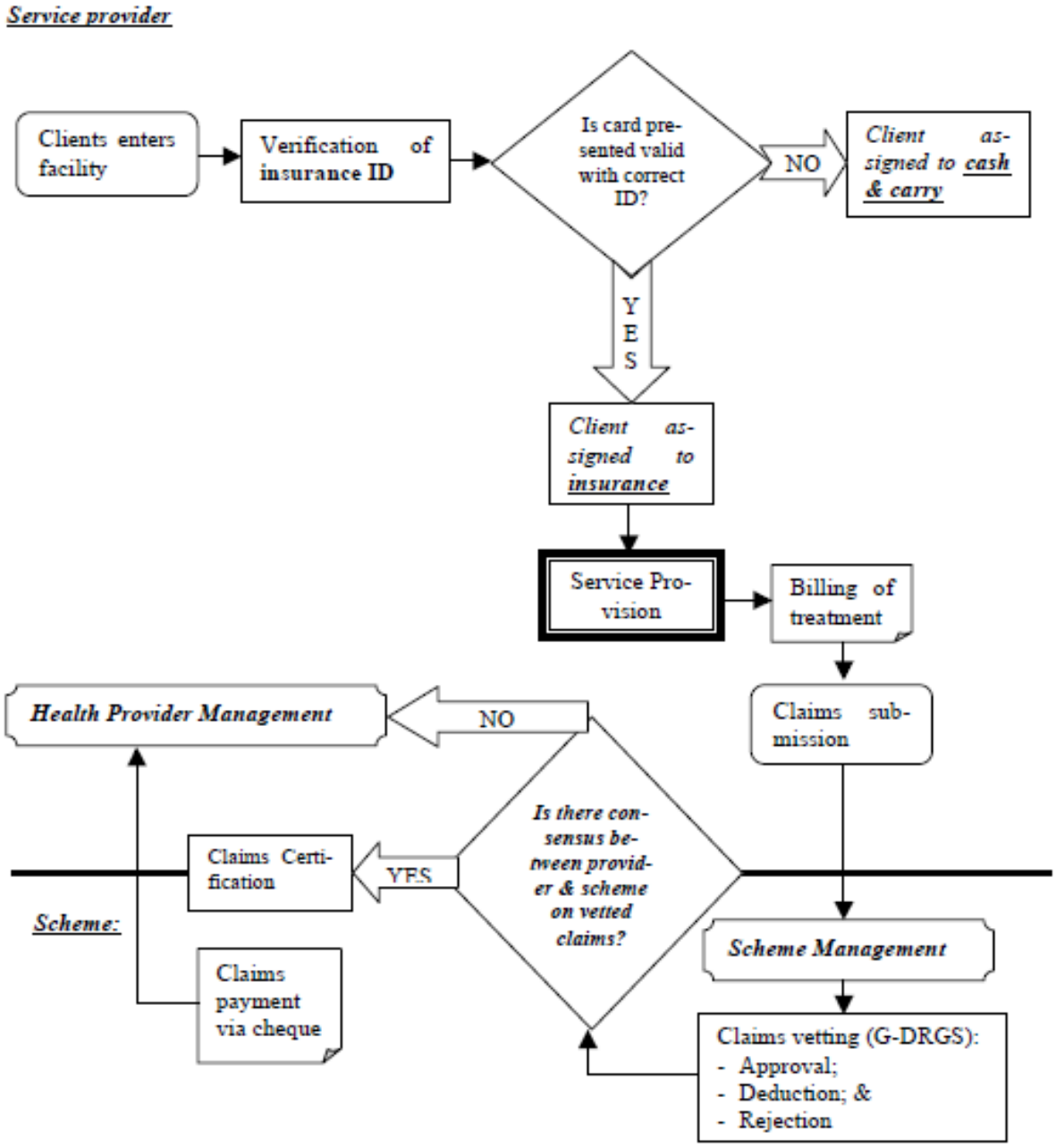
The issue of primary health care and its financing matters strikes mostly at the poor themselves. Material wealth, health and the ability to bear the adverse health events are intimately related (Ranson, 2002). The World Bank defines poverty as ''encompassing not only material deprivation but also low achievements in education and health vulnerability and exposure to risk'' A person with a low income may be unable to afford preventive care—or curative care in the event of illness—and this may worsen their health. In the incident of serious illness, the poor are mainly vulnerable to the financial burden of lost income and out-of-pocket medical expenses, as they have low levels of the assets(Ranson, 2002)

The claims processing system may be a manual system, semi-automated or fully automated, which is implemented by a payer (e.g., health insurance company) for processing medical bills (health insurance claims) received from various healthcare entities. For example, the claims processing system may consist of an application or tool which functions on one or more general purpose or specialized computers and which provides an appropriate user interface and automated methods for processing and reviewing medical claims from healthcare providers (Rao, 2005). For purposes of claim settlement, the claims processing system may include methods that enable data validation, medical management validation, benefit validation, pricing validation, eligibility validation, affliction validation,, and fraud/abuse detection, and otherwise eventually determine whether or not claims should be accepted, reduced or rejected (Rao, 2005)

Talking about the developing countries, we see that insurance is less prevalent; we do realize that insurance can play a pivotal role since their governments are not able to cater to all the necessary fields, including health and education (Usman Hanif, 2019). According to an insurance company's official, Pakistan's current 0.3% of insurance penetration can be easily taken up by ten times, increasing to 3%.

6.1 Conceptual Framework





Frame adopted from *GHANA MEDICAL JOURNAL* , Volume 46, Number 4.

The schemes have an established claims process that vet the claims against provider eligibility incompliance with the Ghana Diagnostic Related Groupings (GDRGs) (S. SODZI-TETTEY, December 2012)

Chapter4

ANALYSIS

During the initial stages of this research, the researcher conducted interviews of the CEO of this health project along with its Deputy Director. During the initial phase of this research, lots of different avenues of this project were discussed, which made the researcher able to pinpoint and narrow down the relevant areas of this project which needed the utmost attention. It was during these moments of general discussion that the question of Sargodha came up, and the question of its insurance claim rejections was brought out as a strong element in management of the project generally. Its role as the key determinant of patient satisfaction was also highlighted. An effort was made to develop a pilot study on this aspect of the programme and for this purpose the details were worked out together with a plan of action to be followed for this study. It was during these interview sessions that the units of data collection were determined and research methodology was finalized to be able to carry out research that led to clear findings that could be used to design follow up measures likely to create the required remedial impact.

Interviews / Focus Group Discussions

All the necessary details regarding the representatives of State Life and the managers of the Health Programme were shared, so that the research interviews could be facilitated in different cities of the country.

Interview with Dr. Noor ul Haq – Provincial Management Officer (PMO)

The interview started off by giving the researcher a brief but important introduction of the programme. It was clearly brought out that this project is a cashless scheme and the only interaction is when treatment of the patients takes place during hospitalization.

When preliminary inquiries were made about insurance claim rejections, it was clarified that in most cases the claims that are rejected relate to those patients who are not entitled to be admitted under the scheme. It is the duty of the Health Facilitation officer to engage actively with the patient in helpful counseling, exercise due

diligence and check the entitlement of the patient as well as the available balance in the card before admitting the patient.

During review of the claim rejections (if any), about 15 days are given to the hospital to justify the rejection and, in case they cannot, to indicate their reason for the mistake made in not abiding by the rules laid down by the insurance company. Mostly, the rejected cases are sent back for correction or reconsideration. If the matter is far beyond the limits of what is allowed by the project, the claims rejected.

During the first two to three months of this project, there were lots of claim rejections, since it took time to train the staff and inform the hospitals and patients about this facility and about its limitations.

Once during serious litigation in a matter, an issue of some complexity emerged in one of the empanelled hospitals. It was found to be of such significance that serious corrective steps had to be taken by the insurance company. As a result, a couple of hospitals of that particular city were removed from the panel of this project.

During one interview, the researcher came to know that the patient is not in the loop with regard to the processing of the insurance claims. The patients are generally not involved in this aspect of the project, and made to appear as if they are not concerned about it either. They are not fully briefed about the essential requirements that have important bearing upon them and upon the programme.

Mostly, the rules prescribed by the insurance company are quite clear. Hence, if rules are followed and the position clarified to the hospital and to the patient, it should be quite rare for such issues to emerge regarding insurance claim. But at times there are some basic errors – simple but important - which lead to rejection of insurance claims: these include billing errors and billing delays.

Initially, when the patient first comes to the hospital, he is completely unaware of this process. Members of the extended family also came along who are not entitled to this facility but want to receive the service. Gradually, with more awareness among families and their neighborhoods, this process has become better understood.

This insurance facility is designed to cater to the poorest families of areas that are covered. However, the researcher heard that this is certainly not the case in some

areas of this project. Patients have been seen coming in their own vehicles, and have been given the *Sehat Sahulat card*, making them entitled to the facility of this project. Of course upon investigation, those patients were warned and the sensitivity explained to them. It was emphasized that this programme was available for the poorest only, and not for them as they were clearly not poor, even though they claimed to be eligible on account of being in possession of the health cards that should not have been issued to them. Apparently no corrective action was taken, perhaps not even contemplated.

The insurance company has significantly reduced the package rates of charges for the government, and has made the minimum rates available to serve the most deserving segments of the population. However, despite lower rates, the company is earning a decent profit.

It was also noted during this interview that the announcement of increasing the amount in the health card to Rs700,000was more of a political figure, and the actual figures of Rs. 300,000 for Priority Disease Treatment and Rs. 60,000 for Secondary Care Treatment persisted on ground.

Meeting with the (Project Coordinator – Assistant Director) Pakistan Institute of Medical Sciences (PIMS), Islamabad.

Generally, there is lack of clarity of the Health Card which prevails significantly.

This gentleman, who has had experience in numerous hospitals, said that there are payment issues prevalent in the system of the health card. Although most patients are treated free, payment issues still confront the patients; with the hospital left unpaid, patients are encouraged or pursued to pay accordingly.

At one point, with gradual increase in usage of the health card and its popularity brought in hostile attitudes and its usage began to be discouraged by the doctors.

Most of the patients are being operated under the normal routine procedure of the hospital. However the staff manages to manipulate the patients with regard to the health card, and argues with them that their illness is not treated in that particular hospital, trying to convince them to go out and find their way to any other empanelled hospital.

Before travelling to the actual locale, the researcher also conducted interviews in his hometown to gain more knowledge and develop a strong footing in comprehending the area of research.

Meeting with Mr. SohailAmeen– (accounts officer) Pakistan Institute of Medical Sciences:

At times non-surgical cases come in which are not covered under the Health Card in the first place, and cannot be made part of treatment. When hospitals accept such patients, the charges incurred are not admissible under the scheme. Further, such patients tend to overstay, without any documented reasons.

The previous procedure was that the claims used to go to Karachi for processing which was of course time consuming because of distance. Now they are settled in the same city.

M. Asif Ali – Key Punch Operator at PIMS

The patients insist that the card should also cover food expenses. However, nothing of this sort has been considered by the government and is not part of the health card package.

Chemo cases and Radiation are not included.

The staff here claims that the patient goes away after getting the treatment, and there is no direct effect on patients with this.

In NORI hospital, there is no surgery case.

There were eight cases so far addressed through the health card.

At times, the patient is required to pay for the first visit; however, the follow up cases are free. As the patients and the hospital staff are not informed clearly about the rules, a great deal of confusion is bound to prevail.

In the Nuclear Medicine, Oncology, Radiology Institute, Islamabad (Nori), the OPD cases were also covered, but deductions were made from the card.

Major issue which the patients face here is that they come from far away, and the dates of follow-up appointments are given to them at times after 15 days.

One patient had come all the way from Vehari and had no place to stay until the follow up meetings. Coming again is costly, and obviously the health card is unable to cover the commuting and lodging expenses.

Interview of Key Punching Officer at NORI:

Two chemo cases, which also includes a CT Scan and Biopsy.

Referral in itself has issues: for example if there are two Chemo cases, they cannot be deferred without any reason.

Shifting from the government hospital to private hospital involves a delay of about 21 days.

Another major issue which some of the Key Punching Officers face (especially at NORI) is that there is a major delay in the email approvals given from the DMO's (District Management Officers). A chemo-sheet is sent to them via the WhatsApp application, and at times even emailed for their perusal and approval. Their delay in responding back to the email keeps the customer waiting. At times, even the network issues become a major hindrance here, with the customer hanging in the middle for their approvals being processed.

Chemo injections are quite costly. The Health Card indeed has made a major facility available, and has proved to be a source of great relief to the patients. However, in the case of chemo injections, the cost is Rs. 130,000 per injection. Buying three to four of such injections utilizes the finances completely, exhausting all the financial coverin the card, leaving the balance at zero.

The patient at this hospital complains that there are constant charges in the system. The costs of tests which are mandatory are being directed to the patients, which are non-refundable.

Majority of the patients require that OPD should be included in the system of the Health Card, which should cover at least the diagnosis of the ailment that pertains to them. Some patients insist through the documentation, that the money incurred on their tests should be refunded. Further, that medicines should be readily available for this process.

Interview with Dr. Mehwish – DMO (District Monitoring Officer)

There is a 24 hourly distant monitoring being carried out by the DMO's.

Within 24 hours, unnecessary claims are detected.

In this programme, there happen to be several guest riders who are not entitled to the facility, but try to avail benefits from here. Ineligible Patients aren't admitted, but still they manage to avail the facilities.

The hospitals do refuse them and bring the card criteria in discussion, explaining to them how they don't qualify for this facility.

Most hospitals try to cooperate, even when the patients don't qualify to be part of their facility, and facilitate them with their query and nature of illness.

Mostly there aren't any payment issues; as per the interviewee, the hospitals usually facilitate the patients with their treatments despite the payment delays/issues.

The Rawal Teaching Hospital had issues and was not honest with its performance. It admitted patients which weren't qualified to be there. There were non-surgical cases mostly which shouldn't have been treated on the card facility. Mostly, these were cases of anxiety and headaches, which under any circumstances, cannot be entitled to insurance benefit on the card.

Interview with the HFO of Munir Hospital – Dr. Babar

This is the 3rd year of the Sehat Insaf Card: it started in the PPP government.

Not much research took place during this programme.

A survey took place back in 2007-2008, according to which the data is managed.

Some hospitals are only for day care, with no facility for admissions of the patients. The cost for treating the patients exceeds at times what is permissible. There are issues of poor medication also. The State Life Insurance is not clear in this regard. Some patients are admitted in the general ward. The emergency is not strong enough in the hospital.

Some hospitals in Sargodha that are on the panel of this project are purely business oriented.

OPD is a major issue in the project, which is in great demand by the patients. There is lack of proper guidance for the patients.

At the time of distribution of this Sehat Sahulat Card, some random representatives were hired by the government on daily wages who were asked to distribute the card amongst the target population of this project. Those distributing the card, and those receiving it, were both unaware of details of this project, and the facilities provided by the health card. There was just a simple understanding being spread -that there is some money available in the card.

It is significant that there have been several cases where patients had this card in their pocket but were not aware of its usage. At times, numerous trips to the hospitals were made, and the card was not utilized, despite it being readily available.

There have been a large number of OPD files which were sent for claims that were delayed and rejected. Most patients who come to the hospital want to avail the OPD facility, but their claims are rejected by the insurance company, thus creating an issue for the hospitals.

The satisfaction rate of the in-house patients is fairly high.

At times the health facilitation officer is able to filter out those patients who do not qualify for the treatment before the claims are sent forward for approval by the insurance company.

During the initial stages of this project, there were periods when the claims were not received, and the patients who visited the hospitals during this time had to be turned away because of this. The insurance company also significantly revised the ICU

charges of admission, subsidizing them for the government to payless in this programme.

Moreover, some limitations of this project were also brought forth, which include eliminating the usage of this card after the death of the card-holder. Also, the couples who get divorced are affected so that the divorced wife cannot claim benefit from the usage of this card.

During an interview, some more experts of the hospital joined in and a point of relating to population control was also raised. This discussion focused on eliminating the free facility of delivery cases (maternity services) on the health card, to discourage childbearing amongst the population.

Strict SOP's should be further defined by the government and the hospital should be bound to follow them so that hospitals cannot misuse their authority over the patients, and they can't be turned away.

Chapter 5

FINDINGS

Initially, when the research was carried out, the idea of insurance claim rejections was denied by most of the officials managing the programme who were interviewed in Islamabad – an exercise which was part of the pilot study of this research. The representatives of State Life Insurance refused to accept the possibility of rejection, and insisted that the claims are delayed only when complications arise, but are not rejected.

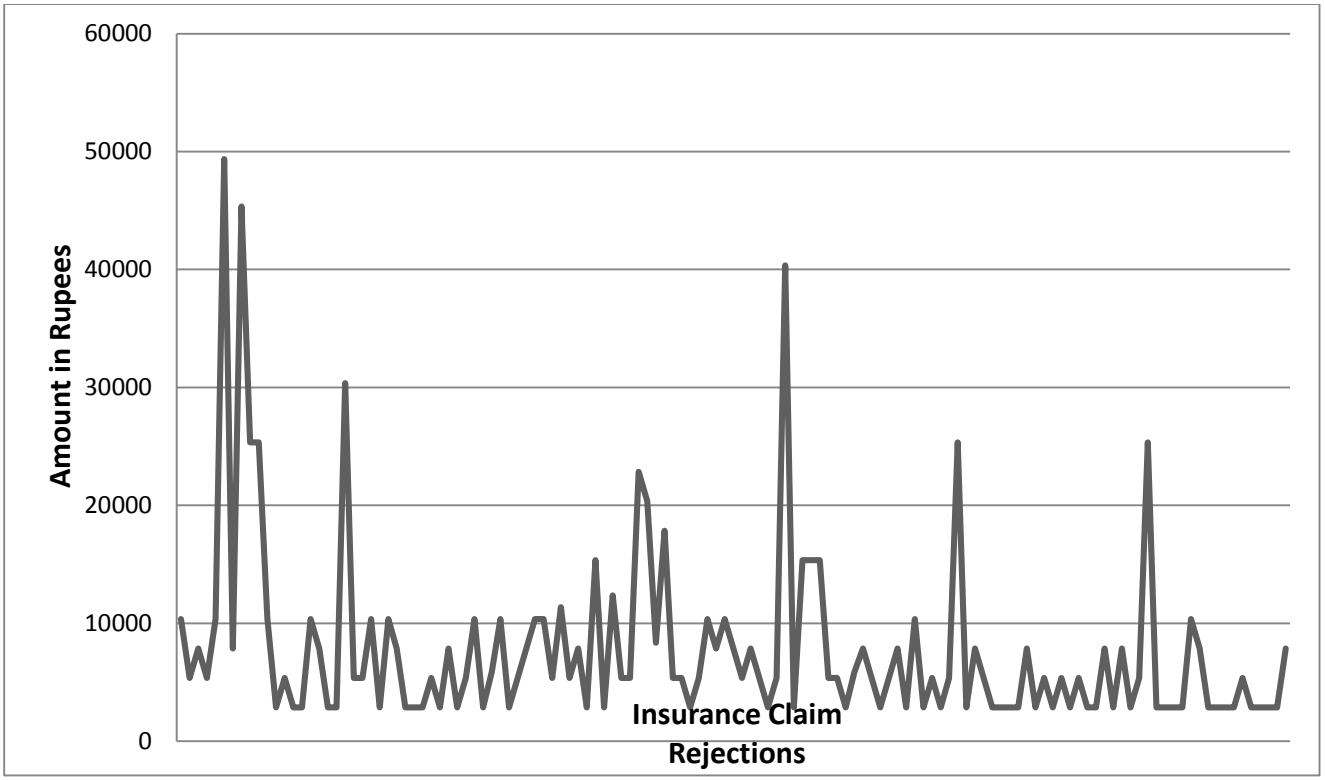
However, during interviews of the District Monitoring Officer and Health Facilitation Officer in Sargodha, it was found that significant amount of claims have been rejected.

INSURANCE CLAIM REJECTIONS

In Sadiq hospital, the data of about 128 cases of claim rejections was collected. In these claim rejections, nine cases were those which were incorrectly treated by the hospital management against the health card. Those diseases were not part of the health insurance project, and the patients were sent back during their follow up meetings with the doctor.

Apart from these nine cases, the remaining 119 cases were of OPD, which were also rejected by the insurance company because of their non-compliance with the Health Card project rules. The hospital management insists that there is an increased demand of patients for OPD cases, which they consider is valid and should be part of the insurance card for increased facilitation of the patients.

Such confusion and lack of clarity for the patients created an uncomfortable atmosphere for the doctors, which unfortunately encouraged the doctors to shift to other hospitals, at times even to those which are not on the panel of the Sehat Insaf Card programme.



The list of the insurance claim rejections is available, but it is not displayed here to maintain confidentiality of the names and details of the patients.

As portrayed in the graph above, the amount involved in the 128 rejected cases makes a total of Rs. 1,005,450. The average amount comes to about Rs. 7,855 per rejected case.

Some of the adverse consequences appear to be that:

The total Rs 1,005,450 could have been better utilized by treating another 128 eligible patients left unattended who could have been properly admitted after due scrutiny and given the treatment they needed.

Alternatively, it could have sufficed for the total entitlement of three entire families for the maximum medical cover (Rs 300,000 +60,000).

In addition the time spent in arguing with them (in case such as these of who were intruders and not entitled) would have been used to enhance hospital efficiency

Above all the climate of negative feelings created in that environment not only reduced the standing of the programme, making it that much difficult to advance to nest horizons, but also created bad feelings in the community.

Chapter 6

SIGNIFICANCE OF RESEARCH

The present political Government started the distribution of Sehat Sahulat Cards (Health Facilitation Card)to 3.7 million families (comprising 30 million people) in the Punjab, which covers the 20 districts (GOP, 2019-2028). Of these 0.816 million cards were distributed in four the districts (DG Khan, Muzaffargarh, Ranjanpur & Multan), and 44 thousand cards were distributed in 3 districts (Rawalpindi, Nankana & Attock). Thus a sum of Rs. 1,932 million was expensed for these 7 districts.

6.1. HEALTH CARD IN SARDOGHA

By the end of 2019, it is claimed that 6.9 million 'Sehat Sahulat Cards' would be provided to 32.5 million individuals in Punjab (GOP, 2019-2028).

*Picture of card from*https://www.pmhealthprogram.gov.pk/

The health Card has only recently become popular in Sargodha. At the time of its distribution during the initial stage of this project, about 90% of the population did not collect this card because of lack of awareness. During the distribution phase of this card, the government had hired random representatives on daily wages to give away these cards, which was a major reason for the lack of awareness of this facility amongst the population. Those distributing, and those receiving, both were not aware of the complete benefits of this card and of health insurance programme of the government.

Lack of awareness is a major issue, especially when there are cases where the health cards are readily available in the pockets of individuals, but are not put to the use for which these were intended. Insurance Claim Rejections in the hospital led to major misgivings being faced by the patients, which portrayed lack of clarity on the part of the patients, especially during times of their desperate illness when they should have been seeking treatment.

The Prime Minister's National Health Programme started in 2015. Despite the success it has achieved, and also despite the geographical and financial limitations it faced, very little research on the programme has taken place to date. Health Insurance is relatively a new concept for Pakistan which has shown positive signs of success and indicates vast potential as well. However, it needs a comprehensive examination of the various challenges that had to be overcome (while several remain) so that a way can be found to target potential users of the Sehat Sahulat Card in large groups with greater confidence who are completely unaware of its benefits and long-term positive outcomes.

The government is dedicated to the task of increasing the health coverage of vulnerable communities to meet the growing demand of the increasing population. Health outcomes have improved to some extent in the recent past, but some critical weaknesses that continue to affect the health system need to be addressed (Pakistan Economic Survey 2017-18). There is a dire need to address the shortfall in the health related facilities, making better use of technology.

This study is a preliminary step, catering to the comprehension of issues which become stumbling blocks for the spread of this concept among the masses of the underprivileged echelon of the society. Patients' satisfaction level is of primary importance for hospitals and the government, which is examined here as a major part of research.

6.2 Policy Recommendations

1. A series of Seminars to resolve the issues of Insurance Claim Rejections to improve programme implementation. Users of the cards, hospital staff and State Life personnel be brought together to set out the nature of difficulties arising from claim rejection and suggest steps to eliminate them.

2. Providing basic awareness on health needs and role of *Sehat Sahulat* in opening the door to quality services for deprived communities in high schools for girls and boys. That would enhance the value of *Sehat Sahulat* and facilitate utilization of health insurance for needy patients.
3. A team of *Sehat Sahulat* specialists be assigned to empanelled hospitals for building their capacity to understand the fundamentals of health insurance and support its efficient management
4. Including health insurance management as a subject in universities of Health, Health Services Academy and similar institutions. That would ensure that health professionals have adequate understanding of the system when they occupy senior positions in empanelled hospitals and can make necessary improvements in handling clients from low income backgrounds to avoid delays, misunderstanding and conflicts
5. Specialized training courses for State Life staff to overcome difficulties encountered in processing claims from hospitals
6. Continuous and easy to understand public information for maximizing the satisfaction level for consumers of Social Health Insurance Programme.
7. Major campaign for creating awareness about *Sehat Sahulat* Card so that the community realizes its importance, develops respect for the system and builds wide understanding for its key features. This should promote attitudes of social disapproval for those who misuse the card.
8. Procedural improvements for Full utilization of money in the health card.
9. Grievance cell be located in each empanelled hospital. It should deal only with issues of the project and register complaints from both the patients and the hospital management staff.
10. The corrective action taken by Ehsaas to exclude from its benefits persons who own cars, travel by air or are employed by government should be replicated by *Sehat Sahulat* as well
11. The entitlement exercise should be reviewed stringently to ensure that those who are not in need (car owners, for example, those traveling abroad and categories of those recently excluded from BISP benefits) are not given this card.

12. Awareness of two aspects of the Health Card must be built up to a point where there is no risk of ambiguity: which facilities are included in the card and which facilities are not included in the card.
13. Rules should be clearly made known to enrolled families regarding benefits of the Health Card after the death of the card-holder: the entitled family members who are alive should not feel excluded.
14. The rules should be clearly made known to enrolled families regarding eligibility for Health Card usage in the case of divorce.
15. Expiry of the card should be made clear – so that patients do not come to hospitals when their entitlement has been fully utilized and no balance is available.
16. Professionals should be hired, instead of raw, uninformed people hired on daily wages who are neither trained nor have background in such matters. The hasty and unplanned approach to distribute the health cards amongst the poor, particularly those that are uneducated, has proved to be wasteful and disruptive.

CHAPTER 7

CONCLUSION

This project is a great pioneering initiative by the Government of Pakistan, and is continuously being expanded through various channels. However, during the further expansion phase of this project, great care should be taken at the time of distribution of these health cards. Trained persons should be engaged to distribute these cards amongst the eligible users, who should also be fully briefed about the relevant details of this card. The government should also consider including essential services vital to providing full range of treatment to chemotherapy patients including tests that are burdensome. Further the time lag between patients' visit and doctors' consultation (which keeps patients waiting for long durations) be eliminated and, where such delays persist, the waiting period should be covered by suitable financial payment.

As portrayed in the conceptual framework, insurance claim rejections have an adverse impact on Patients' Satisfaction level, which in turn lead to poorer performance of hospitals and management of resources.

The Out Patient Department (OPD), being in great demand by the patients and having quite a large traffic, should be introduced in a phased manner in experimental stages in this facility.

Some health programmes have been progressive and are doing significantly well, but many of them are without impact assessment by the third party (Khattak, 2019). This calls for effective monitoring and evaluation (preferably Third Party) in the Health Sector.

Prime Minister's desire of wanting "to cover everyone and provide health insurance to all" (Ikram Junaid, 2019) is on the road to achievement through this programme.

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Appendix 1

Interview Questionnaires and Interview Guides

Questionnaire for the patients

1. Are you aware about health insurance?
2. Distance of the hospital for the patient?
3. Does the hospital address the specific disease?
4. How was the behavior of the staff throughout your stay?
5. How long was your stay in the hospital?
6. How much did you wait to get your treatment and relevant feedback from the doctor?
7. Were you properly diagnosed?
8. Were the medicines prescribed easily available?
9. On admission, were there any extra charges? Out of pocket expenditures.
10. Has any claim been rejected?

Appendix 2

Interview guide for the representative of State Life Insurance (Health Facilitation Officers and District Monitoring Officers)

1. Why are the insurance claims rejected?
2. Why are the patients not fully aware about the health insurance project?
3. Why do the patients seek help for ailments which are not covered in the health card?
4. How can the rejection of insurance claims be reduced and an efficient approach be adopted for the patients?
5. Reasons for rejections:
    a. Payments not justified
    b. Employees do not write the reason clearly
    c. Over pricing
    d. Payments differ with the package rates made available
6. Are there any incorrect claims?

Interview guide for Front Desk Officers in Hospitals

1. Why are there delays in addressing insurance claims
2. Why is the insurance staff not prompt in addressing the insurance claims of the hospitals
3. Is there a gap between the hospital management and insurance company's management?

A strong Central Management Information System (CMIS) monitors the program activities that enable quick decision and effective implementation. Its reports indicate client satisfaction of more than 94%. On that basis the *Sehat Sahulat* Program has won acclaim internationally and in particular from World Health Organization and Asian Development Bank.

Appendix 3

NADRA FEEDBACK QUESTION

AUGUST 2018

السلام علیکم! میں وزیراعظم صحت پروگرام سے ---------بات کر رہا ہوں۔کیا آپ ----------صاحب بات کر رہے ہیں۔محترم آپ نے 8-8-2018 کو _____ ہسپتال سے اپنا یا اپنے گھر والوں میں سے کسی کا علاج کروایا تھا؟اس سلسلے میں آپ سے کچھ معلومات درکار ہیں۔برائے مہربانی تعاون کیجئے گا۔

سوال نمبر ۱۔ کیا آپ علاج سے مطمئن ہیں؟

سوال نمبر ۲۔ کیا آپ ہسپتال میں دی جانے والی سہولیات سے مطمئن ہیں؟

سوال نمبر ۳۔ کیا مریض کے ساتھ ہسپتال کے عملے کا رویہ ٹھیک تھا؟

سوال نمبر ۴۔ کیا ہسپتال میں موجود صحت کارڈ کے نمائندے کا رویہ ٹھیک تھا؟

سوال نمبر ۵۔ کیا آپ سے دوران علاج کسی قسم کی رقم وصول کی گئی تھی؟

سوال نمبر ۶۔ کیا آپ کو واپسی کے وقت -/350 روپے دیئے گئے تھے؟

محترم آپ کے تعاون کا شکریہ۔

--------حافظ

Appendix 4

1,005,800

12

Sr. #	Indoor #	D.O.A	D.O.D	Visit ID	Patient's Name	Procedure	Claim Amount	DATE CLAIM SENT	DATE CLAIM RECEIVED	REMARKS
1	0026-17	28-02-17	03-03-17			CONSERVATIVE	10,350	10-03-17	11-04-17	CLAIM REJECTED
2	0029-17	01-03-17	02-03-17			CONSERVATIVE	5,350	31-03-17	11-07-19	OPD CASE
3	0030-17	02-03-17	04-03-17			CONSERVATIVE	7,850	31-03-17	11-07-19	OPD CASE
4	0099-17	20-03-17	21-03-17			CONSERVATIVE	5,350	03-04-17	11-07-19	OPD CASE
5	0100-17	21-03-17	24-03-17			CONSERVATIVE	10,350	06-05-17	11-04-17	CLAIM REJECTED
6	0176-17	12-04-17	14-04-17			OPEN REDUCTION INTERNAL FIXATION	49,350	06-05-17	25-07-17	CLAIM REJECTED
7	0178-17	12-04-17	14-04-17			CONSERVATIVE	7,850	12-06-17	16-06-17	CLAIM REJECTED
8	0308-17	23-05-17	26-05-17			ANGIOGRAPHY + ICU	45,350	29-06-17	07-08-17	CLAIM REJECTED
9	0322-17	25-05-17	26-05-17			ANGIOGRAPHY	25,350	29-06-17	07-08-17	CLAIM REJECTED
10	0385-17	10-06-17	11-06-17			ANGIOGRAPHY	25,350	29-06-17	07-08-17	CLAIM REJECTED
11	0477-17	04-07-17	08-07-17			CONSERVATIVE	10,350	18-10-17	22-11-17	OPD CASE
12	0495-17	06-07-17	07-07-17			CONSERVATIVE	2,850	18-10-17	22-11-17	OPD CASE
13	0753-17	27-08-17	29-08-17			CONSERVATIVE	5,350	18-10-17	22-11-17	OPD CASE
14	0779-17	30-08-17	31-08-17			CONSERVATIVE	2,850	18-10-17	22-11-17	OPD CASE
15	0797-17	06-09-17	09-09-17			CONSERVATIVE	2,850	21-10-17	22-11-17	OPD CASE
16	0822-17	09-09-17	13-09-17			CONSERVATIVE	10,350	11-10-17	22-11-17	OPD CASE
17	1148-17	30-10-17	02-11-17			CONSERVATIVE	7,850	08-11-17	21-11-17	OPD CASE
18	1149-17	31-10-17	01-11-17			CONSERVATIVE	2,850	08-11-17	21-11-17	OPD CASE
19	1185-17	08-11-17	09-11-17			NON SURGICAL	2,850	04-08-18	03-10-18	OPD CASE
20	0051-18	10-01-18	22-01-18			NON SURGICAL	30,350	19-07-18	31-08-18	OPD CASE
21	0128-18	22-01-18	24-01-18			NON SURGICAL	5,350	19-03-18	03-10-18	OPD CASE
22	0142-18	23-01-18	25-01-18			NON SURGICAL	5,350	19-02-18	11-07-19	OPD CASE
23	0158-18	25-01-18	29-01-18			NON SURGICAL	10,350	19-03-18	03-10-18	OPD CASE
24	0168-18	26-01-18	27-01-18			NON SURGICAL	2,850	03-03-18	19-03-18	OPD CASE
25	0191-18	31-01-18	04-02-18			NON SURGICAL	10,350	13-03-18	11-05-18	OPD CASE
26	0211-18	03-02-18	06-02-18			NON SURGICAL	7,850	19-03-18	03-10-18	OPD CASE
27	0226-18	06-02-18	06-02-18			NON SURGICAL	2,850	19-03-18	11-05-18	OPD CASE
28	0243-18	08-02-18	09-02-18			NON SURGICAL	2,850	19-03-18	11-05-18	OPD CASE
29	0245-18	08-02-18	09-02-18			NON SURGICAL	2,850	03-03-18	11-05-18	OPD CASE
30	0335-18	22-02-18	24-02-18			NON SURGICAL	5,350	13-03-18	11-05-18	OPD CASE
31	0367-18	27-02-18	28-02-18			NON SURGICAL	2,850	13-03-18	11-05-18	OPD CASE
32	0396-18	04-03-18	07-03-18			NON SURGICAL	7,850	13-03-18	03-10-18	OPD CASE
33	0460-18	17-03-18	17-03-18			NON SURGICAL	2,850	04-04-18	11-05-18	OPD CASE
34	0502-18	22-03-18	24-03-18			NON SURGICAL	5,350	11-04-18	25-04-18	OPD CASE
35	0507-18	24-03-18	28-03-18			NON SURGICAL	10,350	21-04-18	11-05-18	OPD CASE
36	0510-18	24-03-18	26-03-18			NON SURGICAL	2,850	28-05-18	31-08-18	OPD CASE
37	0518-18	26-03-18	27-03-18			NON SURGICAL + GI ENDOSCOPY	5,850	21-04-18	11-05-18	OPD CASE
38	0525-18	26-03-18	27-03-18			CONSERVATIVE / ICU	10,350	22-05-18	09-08-18	OPD CASE
39	0530-18	27-03-18	28-03-18			NON SURGICAL	2,850	22-05-18	31-08-18	OPD CASE
40	0556-18	02-04-18	04-04-18			NON SURGICAL	5,350	21-04-18	11-05-18	OPD CASE
41	0559-18	02-04-18	05-04-18			NON SURGICAL	7,850	21-04-18	11-05-18	OPD CASE
42	0580-18	07-04-18	11-04-18			NON SURGICAL	10,350	21-04-18	11-05-18	OPD CASE
43	0609-18	14-04-18	18-04-18			NON SURGICAL	10,350	22-05-18	09-08-18	OPD CASE
44	0614-18	16-04-18	17-04-18			NON SURGICAL	5,350	22-05-18	09-08-18	OPD CASE
45	0633-18	18-04-18	21-04-18			WOUND DEBRIDEMENT	11,350	08-05-18	11-05-18	OPD CASE
46	0637-18	18-04-18	20-04-18			NON SURGICAL	5,350	22-05-18	09-08-18	OPD CASE
47	0639-18	18-04-18	21-04-18			NON SURGICAL	7,850	22-05-18	09-08-18	OPD CASE
48	0644-18	19-04-18	20-04-18			NON SURGICAL	2,850	22-05-18	09-08-18	OPD CASE
49	0657-18	21-04-18	23-04-18			CONSERVATIVE / ICU	15,350	28-05-18	03-10-18	OPD CASE
50	0670-18	23-04-18	24-04-18			NON SURGICAL	2,850	22-05-18	09-08-18	OPD CASE
51	0678-18	24-04-18	27-04-18			NON SURGICAL + CT SCAN	12,350	22-05-18	09-08-18	OPD CASE
52	0723-18	03-05-18	05-05-18			NON SURGICAL	5,350	28-05-18	31-08-18	OPD CASE

S. #	Indoor #	D.O.A	D.O.D	Visit ID	Patient's Name	Procedure	Claim Amount	DATE CLAIM SENT	DATE CLAIM RECEIVED	REMARKS
53	0727-18	03-05-18	07-03-18			NON SURGICAL	5,350	19-07-18	31-08-18	OPD CASE
54	0728-18	03-05-18	12-05-18			NON SURGICAL	22,850	19-07-18	31-08-18	OPD CASE
55	0730-18	04-05-18	12-05-18			NON SURGICAL	20,350	28-05-18	09-08-18	OPD CASE
56	0739-18	07-05-18	08-05-18			EXAMINATION UNDER LOCAL ANESTHESIA	8,350	19-01-19	09-04-19	OPD CASE
57	0777-18	10-05-18	17-05-18			NON SURGICAL	17,850	05-06-18	09-08-18	OPD CASE
58	0783-18	11-05-18	13-05-18			NON SURGICAL	5,350	09-07-18	03-10-18	OPD CASE
59	0831-18	17-05-18	19-05-18			NON SURGICAL	5,350	05-06-18	09-08-18	OPD CASE
60	0847-18	21-05-18	22-05-18			NON SURGICAL	2,850	05-06-18	09-08-18	OPD CASE
61	0852-18	22-05-18	24-05-18			NON SURGICAL	5,350	05-06-18	09-08-18	OPD CASE
62	0870-18	26-05-18	30-05-18			NON SURGICAL	10,350	26-06-18	09-08-18	OPD CASE
63	0873-18	26-05-18	29-05-18			NON SURGICAL	7,850	05-06-18	09-08-18	OPD CASE
64	0874-18	26-05-18	30-05-18			NON SURGICAL	10,350	05-06-18	09-08-18	OPD CASE
65	0881-18	28-05-18	31-05-18			NON SURGICAL	7,850	26-06-18	09-08-18	OPD CASE
66	0883-18	28-05-18	30-05-18			NON SURGICAL	5,350	05-06-18	09-08-18	OPD CASE
67	0884-18	28-05-18	31-05-18			NON SURGICAL	7,850	05-06-18	09-08-18	OPD CASE
68	0891-18	29-05-18	31-05-18			NON SURGICAL	5,350	05-06-18	09-08-18	OPD CASE
69	0903-18	31-05-18	01-06-18			NON SURGICAL	2,850	26-06-18	09-08-18	OPD CASE
70	0916-18	02-06-18	04-06-18			NON SURGICAL	5,350	19-07-18	31-08-18	OPD CASE
71	0926-18	04-06-18	11-04-18			CONSERVATIVE / ICU	40,350	01-08-18	31-08-18	OPD CASE
72	0927-18	05-06-18	06-06-18			NON SURGICAL	2,850	26-06-18	09-08-18	OPD CASE
73	0943-18	07-06-18	13-06-18			NON SURGICAL	15,350	19-07-18	31-08-18	OPD CASE
74	0944-18	07-06-18	13-06-18			NON SURGICAL	15,350	19-07-18	31-08-18	OPD CASE
75	0946-18	09-06-18	15-06-18			NON SURGICAL	15,350	19-07-18	31-08-18	OPD CASE
76	0954-18	12-06-18	14-06-18			NON SURGICAL	5,350	01-08-18	31-08-18	OPD CASE
77	0959-18	12-06-18	14-06-18			NON SURGICAL	5,350	19-07-18	31-08-18	OPD CASE
78	0977-18	20-06-18	21-06-18			NON SURGICAL	2,850	01-08-18	31-08-18	OPD CASE
79	0979-18	20-06-18	21-06-18			NON SURGICAL + GI ENDOSCOPY	5,850	01-08-18	31-08-18	OPD CASE
80	1001-18	23-06-18	26-06-18			NON SURGICAL	7,850	19-07-18	31-08-18	OPD CASE
81	1034-18	28-06-18	30-06-18			NON SURGICAL	5,350	19-07-18	31-08-18	OPD CASE
82	1044-18	30-06-18	01-07-18			NON SURGICAL	2,850	19-07-18	31-08-18	OPD CASE
83	1060-18	03-07-18	03-07-18			NON SURGICAL	5,350	19-07-18	31-08-18	OPD CASE
84	1066-18	03-07-18	06-07-18			NON SURGICAL	7,850	04-08-18	03-10-18	OPD CASE
85	1067-18	03-07-18	04-07-18			NON SURGICAL	2,850	19-07-18	31-08-18	OPD CASE
86	1082-18	05-07-18	09-07-18			NON SURGICAL	10,350	19-07-18	31-08-18	OPD CASE
87	1118-18	10-07-18	10-07-18			NON SURGICAL	2,850	19-07-18	31-08-18	OPD CASE
88	1128-18	11-07-18	11-07-18			NEO NATAL CARE (BIRTH COMPLICATIONS	5,350	01-08-18	31-08-18	OPD CASE
89	1140-18	12-07-18	13-07-18			NON SURGICAL	2,850	19-07-18	31-08-18	OPD CASE
90	1149-18	12-07-18	13-07-18			NEO NATAL CARE (BIRTH COMPLICATIONS	5,350	18-07-18	31-08-18	OPD CASE
91	1182-18	28-08-18	29-08-18			NON SURGICAL	2,850	19-12-18	04-02-19	OPD CASE
92	1183-18	28-08-18	29-10-18			ANGIOGRAPHY	25,350	17-10-18	08-11-18	CLAIM REJECTED
93	1393-18	15-10-18	16-10-18			NON SURGICAL	2,850	01-12-18	04-02-19	OPD CASE
94	1502-18	07-11-18	10-11-18			CONSERVATIVE / ICU	7,850	03-01-19	09-04-19	OPD CASE
95	1606-18	29-11-18	01-12-18			NON SURGICAL	5,350	19-12-18	04-02-19	OPD CASE
96	1621-18	03-12-18	04-12-18			NON SURGICAL	2,850	03-01-19	09-04-19	OPD CASE
97	1634-18	05-12-18	06-12-18			NON SURGICAL	2,850	19-01-19	09-04-19	OPD CASE
98	1635-18	05-12-18	06-12-18			NON SURGICAL	2,850	19-01-19	09-04-19	OPD CASE
99	1655-18	08-12-18	13-12-18			NON SURGICAL	2,850	07-02-19	09-04-19	OPD CASE
100	1668-18	10-12-18	13-12-18			NON SURGICAL	7,850	19-01-19	09-04-19	OPD CASE
101	1669-18	10-12-18	11-12-18			NON SURGICAL	2,850	24-01-19	09-04-19	OPD CASE
102	1684-18	13-12-18	15-12-18			NON SURGICAL	5,350	19-01-19	09-04-19	OPD CASE
103	1744-18	26-12-18	27-12-18			NON SURGICAL	2,850	24-01-19	09-04-19	OPD CASE
104	1747-18	26-12-18	28-12-18			NON SURGICAL	5,350	19-01-19	09-04-19	OPD CASE
105	0026-19	04-01-19	05-01-19			NON SURGICAL	2,850	24-01-19	09-04-19	OPD CASE
106	0051-19	09-01-19	11-01-19			NON SURGICAL	5,350	24-01-19	09-04-19	OPD CASE

Sr. #	Indoor #	D.O.A	D.O.D	Visit ID	Patient's Name	Procedure	Claim Amount	DATE CLAIM SENT	DATE CLAIM RECEIVED	REMARKS
107	0052-19	09-01-19				NON SURGICAL	2,850	24-01-19	11-07-19	OPD CASE
108	0053-19	09-01-19				NON SURGICAL	2,850	24-01-19	09-04-19	OPD CASE
109	0058-19	09-01-19				NON SURGICAL	7,850	24-01-19	09-04-19	OPD CASE
110	0078-19	14-01-19				NON SURGICAL	2,850	24-01-19	09-04-19	OPD CASE
111	0090-19	15-01-19				NON SURGICAL	5,350	24-01-19	09-04-19	OPD CASE
112	0104-19	18-01-19				ANGIOGRAPHY	25,350	08-02-19	10-05-19	CLAIM REJECTED
113	0110-19	18-01-19				NON SURGICAL	2,850	08-02-19	09-04-19	OPD CASE
114	0131-19	24-01-19				NON SURGICAL	2,850	02-02-19	09-04-19	OPD CASE
115	0168-19	29-01-19				NON SURGICAL	2,850	20-02-19	09-04-19	OPD CASE
116	0187-19	04-02-19				NON SURGICAL	2,850	20-02-19	09-04-19	OPD CASE
117	0216-19	07-02-19				NON SURGICAL	10,350	19-02-19	09-04-19	OPD CASE
118	0223-19	08-02-19				NON SURGICAL	7,850	19-02-19	09-04-19	OPD CASE
119	0237-19	12-02-19				NON SURGICAL	2,850	28-02-19	09-04-19	OPD CASE
120	0281-19	18-02-19				NON SURGICAL	2,850	28-02-19	09-04-19	OPD CASE
121	0328-19	26-02-19				NON SURGICAL	2,850	18-04-19	10-05-19	OPD CASE
122	0336-19	28-02-19				NON SURGICAL	2,850	18-04-19	10-05-19	OPD CASE
123	0373-19	07-03-19				NON SURGICAL	5,350	18-04-19	10-05-19	OPD CASE
124	0376-19	07-03-19				NON SURGICAL	2,850	18-04-19	10-05-19	OPD CASE
125	0413-19	14-03-19				NON SURGICAL	2,850	18-04-19	10-05-19	OPD CASE
126	0442-19	17-03-19				NON SURGICAL	2,850	18-04-19	10-05-19	OPD CASE
127	0569-19	29-03-19				NON SURGICAL	2,850	07-05-19	16-07-19	OPD CASE
128	1007-19	12-06-19				NON SURGICAL-PYREXIA OF UNKNOWN ORIGION	7,850	25-06-19	16-07-19	OPD CASE