EXPLORING PUBLIC AND PRIVATE PROVIDERS EXPERIENCE WITH SEHAT SAHULAT PROGRAM IN PAKISTAN

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CERTIFICATE

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I Sumaira Yasmin hereby state that my M. PHIL thesis titled '' exploring public and private provider's experience with Sehat Sahulat Program in Pakistan'' is my work and has not been submitted previously by me for taking any degree from Pakistan Institute of Development Economics or anywhere else in the country/world. At any time if my statement is found to be incorrect even after my graduation the university has the right to withdraw my MPhil degree.

Date: June 28,2022

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ABSTRACT

The incorporation of public and private healthcare providers is considered significant to achieving the goal of universal health coverage, by bringing in the new health financing mechanism based on the social health insurance model. In this regard, the provider payment mechanism plays an important role in efficient and standardized distribution of healthcare, owing to the nature of incentives it generates. Therefore, in this research, I set out to explore the public and private sectors' experience in their decision to participate in the Sehat Sahulat scheme and the role of incentives, and payment mechanisms in shaping providers' experience. Additionally, this research also explored the decision to remain with this social health insurance scheme.

To achieve my research objectives, I conducted fifteen semi-structured in-depth interviews with the administration and concerned person from nine public and private providers in Rawalpindi and Islamabad districts of Pakistan. The interviews were transcribed, and thematic analysis was performed. Findings demonstrate that providers realize the significance of this scheme and shows interest in enrollment. the biggest motivational factor for public and private sector for join this scheme were their customer demand and social welfare agenda.

However, the major constraints due to which both public and private sectors hospital decided to not participate in this scheme were their negative anticipation about the sustainability of the program and state life capacity to fund this program. apart from this, the ascertainment of rates to maintain and provide the quality health-services also discourage them regarding their inclusion decision.

Similarly, multiple other factors that put hindrance in public sector empanelment status were seen the presence of different hierarchy for approval, long waiting time for approval,

determination of health benefit package cost, absence of proper budgeting and exclusion of input feedback in the rates settlement.

Meanwhile, other challenges faced by providers included the inadequacy of the payments rate, the absence of negotiation in the settlement of the rate for the benefits packages and provision of incentives for consultants and other staff members engaged with SSP. These mention challenges hence bring about the discouragement to providers in the decision of continuation with this sehat sahulat program. Their perspective was the in the presence of lowest rates it's difficult for us to maintain the quality provision of services. Similarly, others challenge providers encountered were regarding the delayed in claims reimbursement with the passage of time and its possible impact on providers operation to run the institution and provision of services in an efficient manner.

However, providers also show their concerned on the matter of complaints lodged by patients. They consider such complaints invalid and demands proper investigation system to ensure the validity of complaints before any action by state life. on the other hand, the autonomy to not utilize funds generated under SSP program service provision caused the dissatisfaction among some public providers and impact their working with the scheme.

Keywords: Sehat Sahulat program, universal health coverage, public providers, private providers, provider payment mechanism

Table of content

List of Figures and Tables

Chapter 1

1.1. Introduction

Recently, because of healthcare reforms, social health insurance (SHI) has been initiated in Pakistan with the brand name Sehat Sahulat Program (SSP) for the provision of universal health coverage (UHC) (Abdula Khaliq, 2021). The program's basic objective was the provision of f-cost-free healthcare intervention to the impoverished economic class, that falls below the poverty line every year due to catastrophic healthcare expenditure (Abdula Khaliq, 2021). The exorbitant health expenses force them to sell their assets and saving. The expensive healthcare costs are an additional burden to such families, sliding them further into poverty trap and rendering them bankrupt.

According to the economic statistics of 2017-2018, the Government of Pakistan only spends $14 per citizen annually. However, the recommended threshold settled by the international task force as a per capita expense was $86. On the other hand the citizens themselves spend $28 healthcare in private sector institutions (Zafar Mirza, 2022). As a result of such low government spending, high out-of-pocket expenditure (OOP) is seen to lie at around 60 percent (Amjad, 2018).However, out of these total health expenses, around 73 percent incurred on outpatient, while 20 percent was spent on inpatient, in which private sector proportion is 80 percent (Amjad, 2018).

Therefore, stark realization of this alarming situation led the political governments to initiate this program as a major public-private partnership model (Zafar Mirza, 2022).In this model, the responsibility for the provision of health benefits packages is assigned to the state life insurance corporation (SLIC). This has been achieved through an auction that further empaneled public and private hospitals to make quality health services accessible for a deprived class (State Life, 2022).

If we look around, the global trends depict effective private sector involvement in the SHI is necessary to achieve universal health coverage (UHC) (Sieverding et al., 2018). The reason is private providers consist of a significant proportion of healthcare services. However, considerable literature from lower-middle-income countries on SHI schemes does not discriminate between public and private providers and includes the public provision of healthcare as well through SHI. (Sieverding et al., 2018)

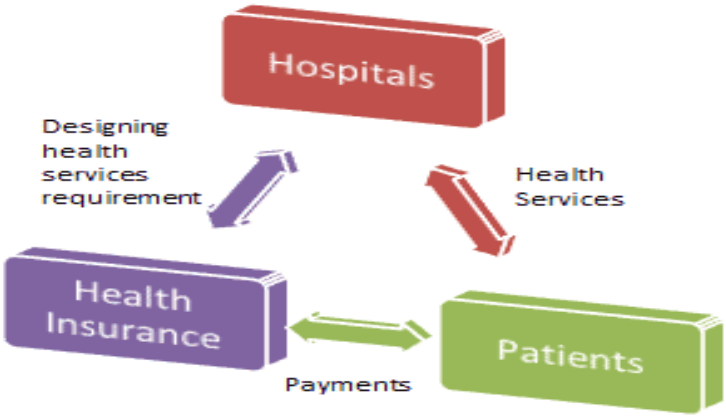

Figure 1: The Design of Social Health Insurance

Source: Pakistan institute of development economics blog by Anum Fatima Rizvi on public spending money to achieve universal health coverage.

The successful expansion and implementation of social health insurance (SHI) through public and private providers depends upon, the prudent design of their health financing, function of resource collection, pooling, and purchasing (Carrin & James, 2004). The transfer of prepaid accumulated funds to providers, for the provision of a predetermined set of health services, is known as purchasing (The World Bank, 2014). This purchasing includes several decisions like identification of health services to be purchased, selection of health services providers, and determining how these services will be purchased (Obadha et al., 2019).

Hence, accreditation of healthcare providers persuaded by higher authority is the outcome of the purchasing decision (Mcintyre, n.d.). This authority comes into contract with the purchaser on the agreed payment method, rates, reimbursement process, incentives, and timing scheduled. Strategic purchasing is the main aspect of this provider payment method (PPM), which can create incentives that further lead to improvement in quality, efficiency, and health service utilization (Obadha et al., 2019).

However, it has been observed many issues emerge in such type of social health insurance schemes. Like in the study of Ghana, the critical issue that emerged was the delay in the timing of reimbursement to private providers, leading to a negative impact on their business model to run the hospital. Other studies also suggest that the problem of delayed reimbursement causes change in the behavior of providers' practices. For instance, charging informal fees and providing low-quality healthcare services.

Similarly, in the Indian study of Gujrat, it was revealed by the women association, that 10 to 14 percent of claims of providers were rejected while the same observation has been noted in the American health plan (claims challenges references) as well. That is a worrisome factor for both private and public providers' inclusion. Apart from this, some private providers at the international level show reluctance to be part of the social health insurance system, due to administrative challenges posed by unclear lines of communication with SHI offices.

Therefore, considering the importance of the private sector in health system accessibility and removal of OOP spending, its inclusion in the social health insurance is a necessary step in achieving the UHC target.

For that reason, Sehat Sahulat Program also represents a major public-private partnership by empaneling more than 800 public and private hospitals in AJK, Khyber Pakhtunkhwa, GB, Baluchistan, Islamabad, and all over Punjab

including Karachi and Tharparkar districts of Sindh (State Health, 2021).

These hospitals opted for empanelment out of 1979 hospitals from all over Pakistan. But if we closely observe, out of these 1979 hospitals, only 800 public and private institutions have received empanelment status so far (International trade administration, 2022). This can be challenging for bed capacity, which is already constrained...

1.2 Problem statement

SHI program is extended to the whole population of Pakistan without any socioeconomic differences through public and private health services providers. On this pathway to provide UHC, productive involvement of private providers with SHI is a critical step. The challenges faced by providers at the international level, should also be kept in mind to ascertain the possible negative impacts on their involvement with a social health insurance scheme. Furthermore, public providers' inclusion was also considered mandatory recognizing their significance in the provision of health services. Secondly, we have noticed that inclination of these providers towards sehat sahulat program is low, which could create hindrance in the accessibility and escalate the workload on private providers. Therefore, it was imperative to understand the perspective of providers in both sectors, regarding the difficulties in their inclusion in this program with respect to accreditation process, requirements, incentives payment method, and payment rate. Considering this, my research aims were to reveal the challenges, benefits, and disincentives faced by providers in interaction with this Sehat Sahulat Program to policymakers. It would help policymakers to understand and timely resolve issues while increasing the trust and motivation of private providers in the system.

1.3 Objective of research

The objective of my research was to explore the public and private providers' perspectives regarding their experience of being part of the social health insurance scheme. I examine the grounds on which the private providers made decisions about whether to get accreditation with the social health insurance scheme. I also explore the experiences of private providers with the accreditation process and SHI scheme, alongside challenges regarding provider payment mechanisms.

1.4 Rational of research

Based on the statement of the problem in the preceding text, the following research questions would be examined

1.4.1 Research Questions

- Why did some public and private providers seek the empanelment process and not others?
- What are the experiences of public and private providers in working with State Life Insurance under this social health insurance program?

1.5 Salient features of sehat sahulat program scheme.

1.5.1 Enrollment process

The inception of the Pakistan social health insurance program started in December 2015 with the assistantship of the federal and provincial governments of Pakistan (actuarial report, 2019). It's a first step in the government's national vision to ensure universal indoor health coverage (UHC) (Charter of services, 2021). At the start, the eligibility criteria were limited to the indigent group whose status of poverty was determined through the Benazir socio-economic registry under NADRA (Mirza,2021). However, later, it's been decided to expand its coverage to the whole of Pakistan, without considering the socio-economic strata of the population (Charter of services, 2021).

Until now, the program had launched in Islamabad capital territory (ICT), Azad Jammu and Kashmir, (AJK), Gilgit –Baltistan, Khyber Pakhtunkhwa (KPK), Tharparkar-Sindh, and Punjab (charter of services,2021). As of today, this program has provided services to 20 million families and entertained 6 million indoor patients, providing cost-free health services under its Sehat Qaumi Insaf card (state life insurance,2021).

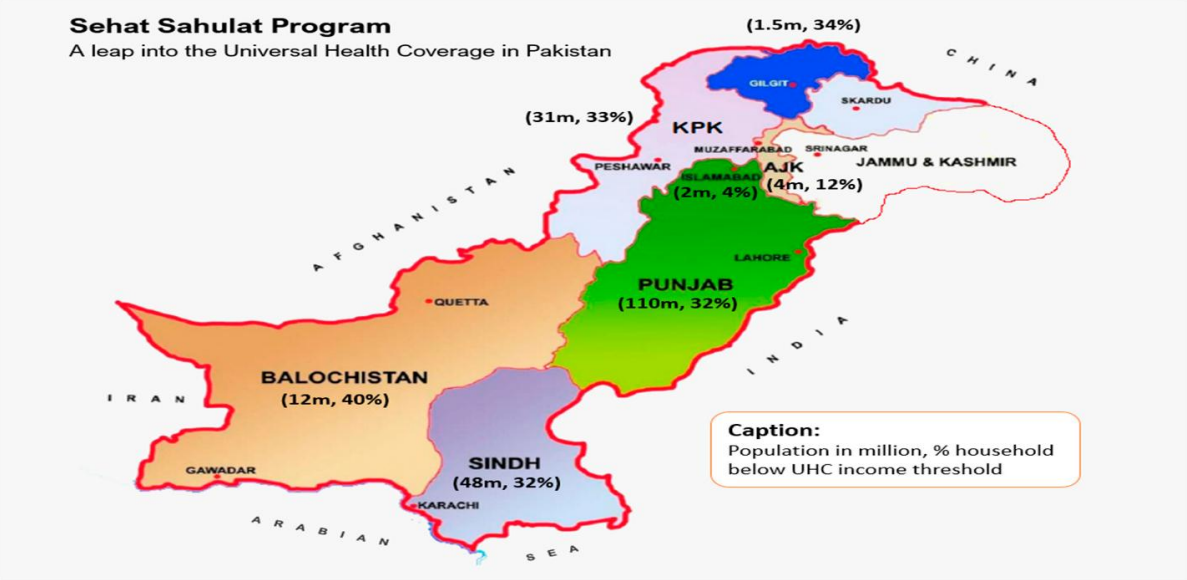

Figure 2: The percentage of population below the UHC income threshold

1.5.2 Benefits of Sehat Sahulat Program.

Under the sehat sahulat program the beneficiaries are entitled to hospitalization for both primary and secondary disease packages (Pm health program,2021). The benefits packages under primary disease treatment packages includes heart diseases, diabetes, end-stage kidney dialysis, chronic infection, all medical and surgical procedures, and cancer chemotherapy with initial coverage of 30,0000 per family. However, for secondary packages, emergency cases required admission, and all maternity- services including C-section and normal delivery under the limit of 60,000 per family were approved on a per annum basis (Charter of services,2021). This scheme covered the upper limit for cardholders of up to 720,000 annually, which can be

topped up in case the patient is suffering from any major disease. The ongoing treatment also couldn't be discontinued based on the insurance exhaustion limit but the government will provide a further 360,000 in such cases (Healthcare, 2022).

In addition to these medical facilities, this program also covered transportation allowances that include PKR 1000 per family per visit maximum of three visits permitted for a family on yearly basis(Healthcare, 2022). This scheme also applies to pre-existing disease conditions without considering any age limit boundaries of patients and incorporates five days' post-hospitalization medicines expenses too (Naya Pakistan,2022).

Figure 3: Qaumi sehat card issued by the government

This Qaumi Sehat Insaf cardholder can also get burial expenses up to the limit of 10,000 in case the patient dies under the proceeding treatment.

1.6 Significance of research

The expansion of the SHI scheme requires maximum engagement of private providers. This research will help the policymakers in improving private sector involvement in the SHI scheme, especially after getting information on the providers' concerns related to the scheme.

It will also help in improving the design of social health insurance in the future, by identifying factors they should consider regarding private providers' incentives, and motivation for the inclusion in sehat sahulat program**.**

1.7 Literature gap

Sehat sahulat program was recently launched in Pakistan to reduce out-of-pocket expenses and increased the disposable income capacity of Pakistani households. Until now, research has been conducted to check the impact of this program on the removal of out of -pocket expenditure and patient experience regarding this program. Furthermore, willingness to pay for such social health insurance schemes has also been also explored by researchers but there is a lack of literature on regarding the experience of providers with this scheme.

Therefore, in this respect my research basically took the providers' feedback on the challenges they are facing with the program by conducting in-depth interviews. This data will help us to comprehend the, on grounds realities providers are facing in getting empanelment. Their views will help identify indicators based on which, they are making decion on whether to apply for accreditation or not. These findings will help the policy makers to understand the business operation model, incentives and motivation of public and private providers as well as how to engage them in view of such indexes.

CHAPTER-2

2. LITERATURE REVIEW

2.1 Importance of universal health coverage

The basic goal of social health insurance (SHI) in any country remains the provision of universal health coverage (UHC) (Suchman, 2018). According to the world health organization report 2010, this universal health coverage indirectly means the provision of health services to anyone with financial protection from the cost of using health care. The emphasis on this universal health coverage (UHC) was also on the agenda of sustainable development goal (SDG) 3 by way of a target of 3.8 (UN ESCAP, 2014). Furthermore, it was also perceived that at a global level approximately 3.65 billion people lack access to health services, out of which 800 million people face catastrophic health care expenses while 100 million people are pushed into such a difficult situation the universal health coverage concept is flourishing in developing nations too.

2.2 Emergence of social health insurance to achieve UHC

To achieve the objective of this universal health coverage (UHC), countries started debates on their health care financing strategy since their health system was chronically under-funded (James et al., 2006). In the initial phase, the countries adopted the user fee policy to generate revenue for the functioning of their health system (Evans 2006). However, later, it brought about the issue of preventing behavior among poor and vulnerable group of people (Palmer et al., 2004). Consequently, social health insurance emerged as a promising financing mechanism in international community for the provision of health coverage against high health costs (Dalinjong & Laar, 2012).

2.3 Purchasing as a health financing strategy

However, these health financing strategies remain the main concern of lower-middle-income countries when they decided to reorient their health system toward universal health coverage (UHC). The focus of these reforms was revenue collection, that applies to elevate funds, while pooling connects with the accumulation of these prepaid funds with the main aim of transferring them to the providers. The eventual transfer of these pooled funds to health care providers to deliver services is known as purchasing (Mcintyre, n.d.).

This purchasing decision mainly involves the identification of health services to be purchased, selection of health care providers, and determination of how these services will be purchased including contractual arrangements and provider payment mechanisms. (Obadha 89). A purchaser can include a country's ministry of health, social health insurance scheme, private health insurer, or a different body. These entities are responsible for purchasing health services from a public and private hospitals that can be either passive or active.

2.4 Importance of purchasing from public and private providers

It was noted that a significant portion of the healthcare landscape in lower-middle-income countries (LMIC) consist of private healthcare (Prata N et al., 2005). Therefore, the inclusion of this sector along with the public sector is considered crucial; to achieving universal health coverage (UHC) (Dalinjong & Laar, 2012). The providers that fall outside the public provider's category fall in the private provider's list which works for both purposes for-profit and not-for-profit. The usage of this sector is most popular in the lowest socio-economic group quintile, whose ratio remains around 30 to 40 % therefore, emphasis was given to the effective inclusion of this sector in the SHI program.

However, for this purpose, the accreditation of public and private providers was considered important (Mackintosh et al., 2016). About 100 years ago, the American college of surgeons developed the abstraction of accreditation that further extended to lower-middle- countries

(Smits et al., 2014) in its adoption. This accreditation decision is bound to pre-determined criteria that particularly allows a public insurer to, purchase for quality. Therefore, in this regard, finance for the provision of services provided to the health facility that reached the standard. (Smits et al., 2014).

Though, it was also noted down accreditation consists of four essential components: developing an accreditation organization, structuring appropriate accreditation standards, and the relevant incentives and disincentives (Smits et al., 2014). In lower-middle-income countries (LMIC) it is also considered an important phenomenon to accredit healthcare providers (Suchman, 2018).

2.5 Elements considered before accreditation of providers

According to the suggestion of (slack and savedoff ,2001) health economist, the autonomy of private providers, should not be interrupted while monitoring their quality by purchasing agency. Indeed, research carried out in Ghana also showed that providers get accreditation scores on their level of quality between 2009 and 2012 that were barely passing. Hence, overall accredition ofprivate providers can make accessible financial services easy, especially, under the umbrella of the social health insurance scheme SHI. (Slack & Savedoff, 2001).

2.6 The challenges emerged in the accreditation of providers

However, the study conducted in Kenya, by (Lauren Suchman,2014) discussed the issues of accrediting private providers. It found health insurance officials have a strong desire to accredit private providers but at the same time, they are fully aware of the challenges providers face in gaining accreditation. These challenges are validated by the providers in their interview, regarding difficulties in their reimbursement payment, insufficient payment, and under capitation. On the other hand, the complaint of being charged with out-of-pocket (OOP) was

also observed, leading to pressure on the level of participation rate of the poor class (Suchman, 2018).

As a result, providers highlighted the issue of financial sustainability that emerged in their provision of facilities. They stated that in the last 13 years, their financial capacity had not increased, although membership had grown tenfold during the same period. In addition to this, some providers complain that due to restrictions put on the smaller facilities, they received too low a rate, which puts them in a disadvantageous condition. Despite these challenges, it has been seen some providers opt the social health insurance (SHI), in Kenyan and Ghana states, due to huge market pressure while others just want to serve their community.

2.7 Importance of provider's payment mechanism in the provision of incentives

Similarly, the successful implementation of social health insurance also depends upon the prudent design of purchasing decisions, that ultimately depend upon the provider's payment mechanism and remuneration rates which then create incentives for providers (Mathauer, 2011).

One of the characteristics of such payment mechanisms and the rate is that it should be acceptable, sustainable, and economical at the same time and set the right incentives to providers in terms of efficiency and equity (Robinson et al., 2005). Setting such a payment rate is a debatable process that requires negotiation between the purchaser, providers, and other stakeholders of health financing (Robinson et al., 2005). It's also been observed to set such payment rate, there is a strong need to consider costing information, according to particular providers.

In correspondence to that (Water and Hussy,2004) also explained that the determination of provider payment methods depends upon the price rate that the purchaser paid to them, according to cost, volumes, and costing information of equipment. The pricing of such

decisions also relies upon political, ideological, economic, and professional rationalization (Mathauer, 2011). However, the negotiation trend in the settlement of payment rates has been observed around the world instead of detailed costing information like at Denmark, Hungary, Korea, and Netherland (Mathauer, 2011). The main challenge that emerged behind this action was the absence of unit cost data in the developing countries (Valdmanis et al., 2003).

It's also been noted around the world, that the appropriateness of such a payment mechanism depends upon its acceptance and agreement by the providers, keeping in minds others related factors like purchaser and providers structure, the level of competition, and the administrative capacity of purchasing agency. The accreditation of providers under the social health insurance tag depends upon the adequacy of such payment rates, to maintain the quality and provision of health services timely without charging out-of-pocket expenses.

2.8 Significance of negotiation between provider and purchasing agency

However, in Kenya, it's also been observed to get accreditation and contract with the national health insurance the negotiation takes place between providers and national health insurance on the payment rate. Such negotiation considers the hotel cost plus, the care cost per inpatient day for the setting of remuneration rates. The accreditation score considers staff and bed numbers, available equipment, and other criteria related to structure and process quality (NHIF, 2005b). This hospital-specific rebate per inpatient bed-day is also supposed to cover the pharmaceuticals listed in the benefits package. As a reaction to the accreditation process, hospitals increased the number of beds, as this translated into higher remuneration rates. (Mathauer, 2011).

Furthermore, it's also been noted fixed rebate per inpatient day also creates incentives in terms of low-quality service provision and an extended average length of stay (ALOS). Considering this aspect, the national health insurance in several countries tried to control ALOS for specific

diseases by inspecting them. While keeping in mind these rebates some hospital increased the number of bed ratio in their hospital too as this brings about a higher payment rate (Mathauer, 2011).

At the international level, especially in Ghana, it has been observed that facility levels are reimbursed for the service utilization, and medicine, according to the level and quality of providers through predetermined contract-based criteria. In their health system, smaller facilities receive lower reimbursement rates while larger hospitals receive a great amount due to their more ratio in expenses like operational costs and maintenance costs of infrastructure (Lamptey et al., 2017).

Sehat Sahulat Program has been launched keeping in mind the same working model operated in lower-middle-income countries (LMIC) like Ghana and Kenya. This program is operating on the reimbursement model where providers are paid on a fee-for-service basis and reimbursement is done by SLIC on the claims rendered by providers. However, in other, countries where the social health insurance model is working, growing bodies observed significant delays in reimbursement of these claims that cause difficulties for providers that solely depend on these funds.

According to research the biggest constraint that emerged in Ghana, the NHI scheme was the delayed reimbursement made by higher authorities which further caused challenges with the purchasing of medicine. In a qualitative study, the staff members of health facilities pointed out that the delayed reimbursement affects the provider's behavior toward patients, patient satisfaction rate, and their ultimate enrollment with the scheme. However, he also mentions that it's a wide domain to further explore in what way these widespread delayed reimbursements put an impact on the private sector widely considered a profit-making organization.

It’s also been stated that the objective of social health insurance remains prepayment of health expenditure to avoid the over-the-counter bills known as an out-of-pocket expenditure. These out-of-pocket expenses remain significant barriers to access to quality health services. While it also has seen providers demand informal fees from patients too due to the delays in reimbursement payment that further put a negative impact on the SHI program.

According to the study findings conducted in Karnataka, India, the implementation of the social health insurance scheme is a bit difficult in the absence of coordinated incentives between consultants and providers. They have also revealed the importance of education and awareness for the effective implementation of the scheme.

2.9 Hindrance factors in the provider’s participation in SHI.

The main barrier that put a hindrance in the private provider’s participation level in the social health insurance scheme was the administrative burden, and lack of communication by higher management authorities on the concerned complaints related to the accreditation process, fees, and incentives. In the research of Al Hassan, it was also mentioned that unheard complaints, lack of voice of providers, and low level of satisfaction on the provided information related to empanelment impact providers’ attitude towards scheme in a negative way.

However, Sieverding's 2017 research study reveals that it's necessary to sustain private providers’ inclusion and considers their incentives too. their findings it’s also indicated that market pressure like client demand for accredited health facilities reinforces the government to consider the aspect that focused to incentivize them, especially in a scenario when they faced operational difficulties.

CHAPTER-3

3.1 Research Methodology

This chapter explains the methodology and data for the current study. Firstly, it defines the research method selected for conducting this research, which consists of the research setting, research design, data collection, and data analysis process. Then it further describes the conceptual framework along with the significance and limitation of this research.

3.2 Conceptual framework

To explore the experience of providers with this sehat sahulat program on provider payment mechanism; I adapted the Resilient and Responsive Health Systems (RESIST) consortium's framework, which considers multiple questions on the working of payment mechanism like is it is adequate, is it covers health benefits package cost and were the providers satisfied with these rates.

3.3. Research setting

Pakistan is the country that launched this sehat sahulat program (SSP) in 2015 (Morgan, 2019).it is the world's fifth-most populous country consisting of approximately 220 million population while a gross domestic product of 263 .2 USD billion (2020) (google). However, out of these 220 million populations by the end of October 2018, this program was providing services to 3.1 million but has been planning to extend its coverage to around 11 million people (Morgan, 2019). Though according to the estimates, the total health expenditure also remains scant for the fiscal year 2017-2018 which was 1206 billion only two percent of GDP.

According to the statistics, overall, in Pakistan, the total number of registered health care providers is approximately 1979 out of which the public hospital ratio is 1279 while private 800. (International trade administration, 2022).out of this, the number of accredited health care providers is only limited to 800 across the country.in the meantime, our focus of the research was just limited to two districts Rawalpindi and Islamabad which have barely 30 empaneled

hospitals out of a total of 70 hospitals in both public and private sectors. This shows that quite many hospitals, still have been out of the sehat Sehulat program which is a worrisome factor.

3.4 Research design

The research method applied in this research was qualitative to explore both public and private providers' experiences. Before this provider's experience with social health insurance (SHI) was also probed in Ghana and Kenya (Sieverding et al., 2018). The intention behind qualitative research remains to describe the way of studying the perception, experiences, and behaviors of people through their actions, verbal interviews, and writings (Butler-Kisber, 2019). However, according to Corbin, it's the procedure to discover the participant' inner experience 'and then figure out how meanings are derived from it (Corbin, 1923).

Hence, the main motivation behind this research was to investigate the factors why some public and private providers were getting empanelment while others were not. The second objective was to inspect the accredited provider, and their experience with this program in terms of empanelment process, provider payment mechanism challenges, and incentives provided by the higher authority.

At first, the intention was just to retrieve data from private providers about their decision on the inclusion of the social health insurance program (SHI). The approach behind this strategy was the challenges they faced due to operational cost, salaries, and their role in the determination of out-of-pocket expenses. But later, public providers have also included in the research keeping in mind the lowest enrollment trend of these providers against the private providers.

To get insightful data on the perspective of providers semi-structured interviews were conducted with management staff and the administrator who was directly engaged with the sehat sahulat program matters in that hospital. These interviews were also collected from the

representative of the state life insurance corporation (SLIC), the sehat sahulat program manager (SSP), and the ministry of health (MOH).

3.5 Sample selection

3.5.1. Selection of providers

The initial sampling strategy adopted for the selection of public and private hospitals was categorized into two groups: (1) the providers that joined the sehat sahulat program (SSP) empanelment through the state life insurance corporation (SLIC) and (2) the providers which are still out of this SHI program. The data on the status of providers' accreditation was retrieved from the state life insurance corporation (SLIC) website where all the empaneled hospital particulars were available district-wise. (State life insurance corporation, 2022)

I used the purposive sampling technique for the selection of the accredited providers considering the list available on the state life insurance website. so, to figure out the factors regarding provider decision on the participation with the SHI scheme, In the first stage of criterion sampling, we have narrowed down our sample research to two districts Rawalpindi and Islamabad, these selected districts have a huge number of private providers with different quality measures. We selected these districts considering the feasibility perspective and shortage of time duration factors too.

Next, we randomly selected a total of fifteen health care providers that at first comprised two categories public and private. Among these 10 healthcare providers were empaneled, that had been selected with an equal ratio of 5 from the public sector while 5 from the private sector. On the other hand, 5 providers that approached were not empaneled.

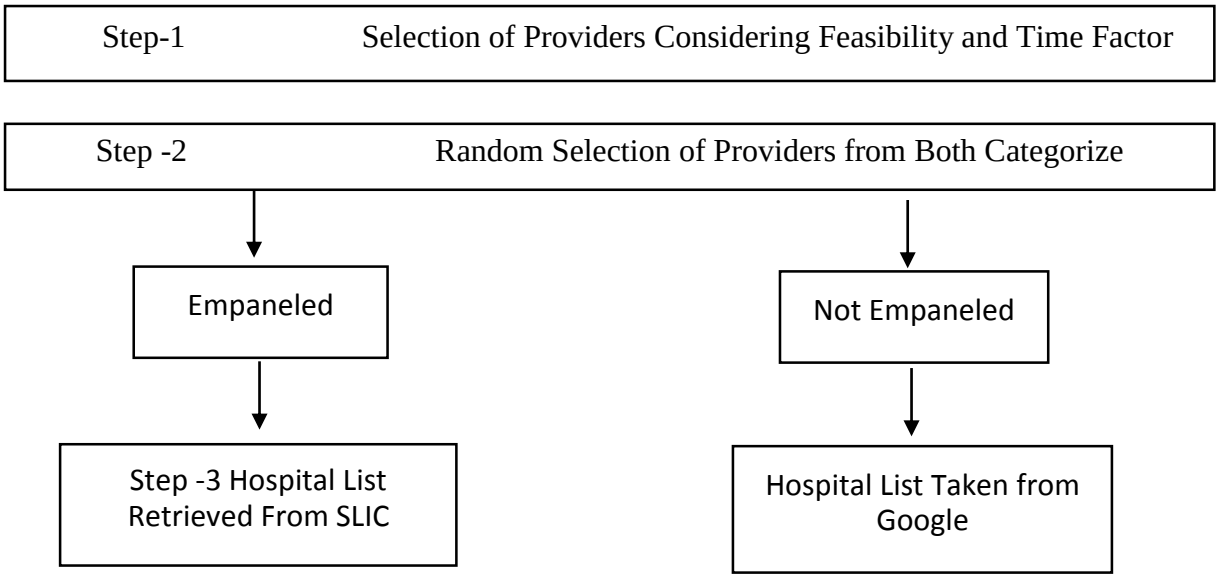

Figure 4: Process for the selection of public and private health-care providers

These selected healthcare providers at first were contacted through phone calls to their customer service agents who were asked the institution's head names and the information retrieved from their customers. Then a letter was requested from the university with PIDE's letterhead to ask for key informant interviews.

Table 1: Number of healthcare providers in districts Rawalpindi and Islamabad

Districts	Categorize	Public	Private	Total
Rawalpindi	Providers empaneled with SLIC	7	12	19
	Providers not empaneled with SLIC	5	30	35
Islamabad	Providers empaneled with SLIC	8	15	23
	Providers not empaneled with SLIC	7	35	42

Table 1: **Source:** Author's analysis of data available on state life insurance corporation (SLIC) and ministry of health (MOH) website plus Google.

Simultaneously, some public provider directors also referred me to their department who is directly engaged with SSP matters. However, others were those who asked me to take

permission from their research department and put my case in the ethical review committee though all this procedure took a whole month.

Meanwhile, three private providers were not ready to participate in this research and have shown reluctant behavior, one of them gave the reason that we get this empanelment three months ago, so we do not have enough experience regarding your research.

3.6 Data Collection

The data was collected based on semi-structured interviews that continue from April 2022 to May 2022. While the structure of these semi-structured interviews was built on the guide, which had been prepared before the conduction of the interview with the help of the supervisor in March 2022. The interview guide was consisting of three main topics relevant to the research objectives. (1) reason for participation in the Sehat Sahulat Program plus the incentives provided by SLIC for inclusion (2) and a section on the difficulties faced during the accreditation process and (3) providers' experience with the provider payment mechanism, on being the inclusion of this scheme.

This interview guide covered the main section on the decision of why the providers thought about participation consisting upon the question like when they have joined, where before this joining any customer of SSP visited the facility. Though the interview guide covered the sub-section of "provider payment mechanism "keeping in mind, the question on its understanding, sufficiency, time reimbursement, and further impact of this on the providers in terms of negative and positive experience. However, the guide covered the "experience regarding empanelment process "consisting of the dimension like terms and conditions to get accreditation, inspection, changes that occurred in the hospital after the inspection visit, etc.

To collect the data on a concerning topic, we conducted face-to-face interviews, with an overall 15 respondents at their place of work after obtaining written informed consent at their place of

work. These respondents were recommended by hospital dean to the medical director of concerned department. the officials of this department particularly dealing with the seat sahulat program legal matters. The existence of this sehat sahulat program department were dominant in public sector while it was absent in some private hospital especially with small set-up. Of these fifteen respondents, eight (8) were from a private hospital, while five from empaneled 3 from not empaneled yet, located in both districts Rawalpindi and Islamabad. Meanwhile, 6 interviews were taken from public providers, out of which three were enrolled public providers while two were not enrolled. All interviews were conducted in the Urdu language considering the convenience of both public and private providers in communication. These interviews were further audio-recorded and lasted between fifteen to forty minutes. the consent to record this interview was taken by the researcher before the interview started. Almost all public and private providers were permitted to record the interview except two private providers .so in such cases we additionally wrote field notes during and after the interviews. it was also ensured to achieve saturation point, but after the conduction of the interview, it was determined data saturation point had not been achieved especially on the question of what rates are determined to pay the providers.

To explore why some providers don't apply for this, participants would be asked regarding requirements, eligibility criteria, and information on how they could become part of this scheme and to collect reasons for not a participation in this. Experience with the accreditation process for those who had ever applied, the benefits and challenges of being in the scheme, and perceptions of the insurance scheme, including the prevalence of insurance coverage among people in the facility catchment area.

The essence of exploring this qualitative research lies behind to recognize the patterns among words in order to draw the meaningful picture .in this qualitative research the element of validity and reliability means the "appropriateness "of tools process and data. hence the essence

of reliability lies in the consistency. Silverman proposed five approaches in enhancing the reliability of process and results.

Table 2: characteristic of healthcare providers and interview respondents

District	Healthcare provider type	Interview respondent	NO
Islamabad	Public empaneled provider	Administrative officer	1
		Claim officer	1
	Public not empaneled	Public finance officer	1
Rawalpindi	Public empaneled provider	Assistant management staff	1
		Assistant medical director	1
		Assistant medical director	1
	Public not empaneled	Account officer	1
Islamabad	Private empaneled provider	Executive officer	1
		Assistant to chairmen	1
	Private not empaneled	Communication officer	1
		Administrative officer	1
Rawalpindi	Private empaneled provider	Claim management officer	1
		Communication officer	1
		Medical director	1
	Private not empaneled	Hospital chairmen	1
Total			15

As this research data extraction was mainly from the original source and primary in nature Therefore, the reliability and accuracy of the research achieved through the constant comparison by the researcher alone and through triangulation techniques.

3.7. Data analysis

These interviews were digitally recorded and transcribed by the researcher herself, while the language used for asking these interviews was English and Urdu both considering the comfort zone of the respondent. The translation of theses interviews from Urdu to English were done by researcher itself. the respondent didn't used any difficult phrases and terms that needs translation from the linguistic experts. the validity of such transcription confirmed after relistening the audio recording multiple times so to avoid error of the self-interpretation and biasedness.

An initial coding scheme was developed through the existing available literature from other countries based on which an interview guide was formulated on the reasons, providers' payment mechanism challenges, and incentives of this program. Then further after the conduction of every interview, open coding thematic approach was adopted which solely depends on the nature of the data derived, and then in the end common codes were identified across the interviews and grouped into code families and sub-codes. To analyze the data, thematic and open code methods had been used before coding these interviews into micro soft MS word. Similarly, additional codes were also developed were required depending on the nature of the content obtained.

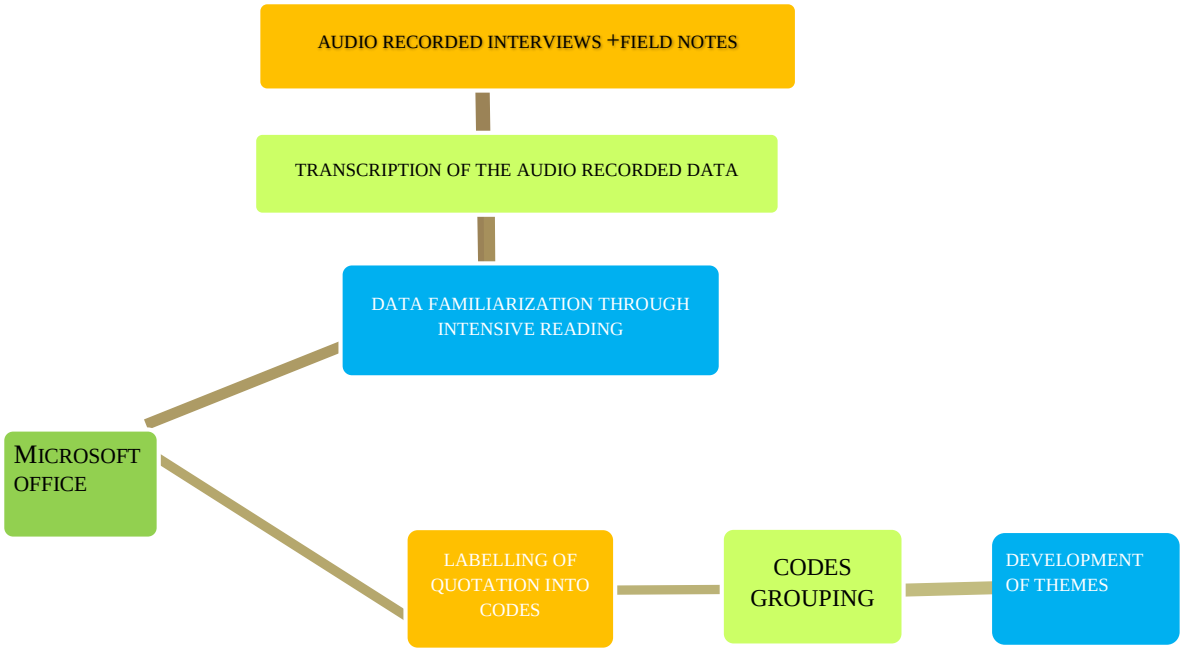

Figure 5: Data analysis process sketch

3.8. Ethical Considerations

The following research will consider all the basic ethics of the research. This research will be conducted after approval from the university committee. Being a researcher, my foremost priority will be the minimization of self-biases throughout the research project. Further, I will respect the intellectual property of others and I will avoid plagiarism. I will give proper acknowledgment to all of whom I have taken any kind of help. While before the conduction of the interview informed written and verbal consent will be obtained from the concerned provider's respondent.

CHAPTER-4

Results And Discussion

Results

This section mainly comprises the results that were mainly collected through the semi-structured interview to fulfill the research objectives. This briefly presents the detailed answer of the respondent, research findings, and discussion on the research question.

4.1 Major themes and overview of results: -

The major themes that emerged as an outcome of the interviews are further presented here into two categories: public and private, keeping in mind their empanelment status. The sketch of these themes turns up because of the provider's narration on their intention for applying to Sehat Sahulat Program (SSP) accreditation process.

4.1.1 Common reason for inclusion in SHI by public and private providers

The major themes generated during interviews, further breakdown into public and private providers, as per their empanelment status. The sketch of these themes turns up because of the provider's narration on their intention for applying to the Sehat Sahulat Program (SSP) accreditation process.

4.1.1.1Community benefit

The most common themes turn out from providers of both types of public and private in Rawalpindi and Islamabad on their decision of inclusion community benefit. A respondent felt that some citizens couldn't get access to healthcare services. For community benefit, it's necessary to get accreditation status.

> *"If we consider the ground realities, most of our population couldn't afford health services, even people in America couldn't afford it, so that's why inclusion in (SHI) for the community benefit was the need of time, that's why we decided to be part of it."*

-Public healthcare provider, Pakistan, Rawalpindi

However, respondents at some of the private facilities mention that they took part considering their social welfare agenda. As their hospital already has the background to work as a charity foundation, this was as an opportunity to work for the social welfare of society.

", the scenario with us was that one of our managing directors also has a social welfare cause. She was running a school and has a hospital, where all the services are being provided free of cost. When we heard about this program, she stepped forward and offered that we would provide a free meal to sehat card patient. Hence, her motivation encouraged the institute to go for accreditation."

-Private Healthcare provider, Rawalpindi, Pakistan

4.1.1.2 Customer demand

Apart from that, they also mention that customer demand was one of the biggest factors that triggered them to go for empanelment.

"*It started, when one of our patients visited the hospital and asked the consultant if this sehat card is applicable in our hospital. He was looking for dialysis treatment. Then our doctor took a picture of that sehat card, then informed the director on this matter. That's how we made the decision to get empanelment. Even before this event, our marketing committee presented a proposal before the director, but at that time he had rejected it"*

Private Healthcare provider, Rawalpindi, Pakistan

However, some public providers also informed that, patients mostly visited them from the KP, Gilgit Baltistan, and Kashmir areas, as this program was launched there already. Hence, when the government sent them a notification, they responded to this on immediate basis.

4.1.2 Other reasons of public and private providers for the inclusion.

4.1.2.1 To attract private customer

Besides that, the respondent at some of the private empaneled facilities revealed, that they want to attract private customers, as mostly the population in their surrounding areas belong to the middle class, who cannot afford health care. Hence, their main concern was to capture such customers through the Sehat Card option.

"*Now, look if this sehat card is an option in front of people, they will prefer it, our patients were also decreasing due to this, so ultimately, we were bound to moves towards this to capture the private customer".*

-Private- providers. Pakistan Islamabad

4.1.2.2 Indirect advertisement

In some areas, private healthcare providers, especially in Islamabad, express that that it's an indirect way of advertising their hospital, due to this empanelment status, the number of the patients that approached our hospital, increased beyond this city, especially from Kashmir.

"As you know that this sehat card has been launched everywhere, one of our patients who visited from the upper areas of Kashmir mentioned that he visited our hospital on the recommendation of someone who got the treatment from our hospital last week. Therefore, it's a source of indirect advertisement for our health facility too".

-private-health care provider, Pakistan, Islamabad

4.1.2.3 Extension of a program in future towards UHC

Some of Respondent, also keep in mind the future approach, both in public and private level health set-up in twin cities. According to them, considering the government policy to extend this program at a universal level, we have decided on the inclusion in this sehat sahulat program, (SSP)

"As you know, soon this program is going to be universal, and the universalism indirectly means, that this card would be in everyone's pocket in the coming future, everyone would get this facility, then why shouldn't we get the empanelment status, what's wrong in it? "

-public-private providers both-Pakistan –Rawalpindi –Islamabad

Whereas the reason observed for the incorporation in this scheme, communicated by public providers was entirely different from the private providers. The biggest stimulus for the public sector in joining this program remains the government's push and their policy. According to them, it was the government policy, that all public providers should get empanelment with a state life insurance corporation. *How could we deny it?*

"We had received the notification from the government of Punjab, and they recommended we, get accreditation with this program as soon as possible, so in return we completed all our initial documentation, and got the empanelment status at its initial phase".

-Public -providers, Rawalpindi, Pakistan

"We *have been, informed by the government of Punjab, that they contacted the State Life Insurance Corporation (SLIC) directly, then the secretary of health updated us about our empanelment status and about a year ago, we got enrolled with this program".*

-public- providers, Rawalpindi, Pakistan

"It was also stated that it was the decision of the government, only the state can decide what should be the policy, and what steps will they take considering such aspects".

-Public providers, Islamabad, Pakistan

4.1.2.4 Privatization of the public sector

Meanwhile, respondents also anticipate that behind this government initiative, their basic intention is the privatization of the public sector, they want to shift the public sector into private mode. Therefore, it became mandatory for the public sector to accomplish enlistment with this

sehat sahulat program. Along with this they also supposed it's an attempt to change the entire health model. Their concern was authority would cut off their budget soon, so they were obliged to outreach.

> "*We knew that, very soon in the future, we will not receive any funds, it's actually government's deliberate attempt to shift the public sector into private mode".*
>
> -public-providers, Pakistan, Rawalpindi, Islamabad.

Reason for Public and private providers for the inclusion in the SSP program

Table 3: Provider's reason for inclusion in sehat sahulat program (SSP)

Why apply –SSP-Private providers	Why apply –SSP-public providers
• Community benefit	• Government push
• Customer demand	• Customer demand
• Capture private customer	• Privatization of the public sector
• Advertisement	• Social welfare agenda
• Universality of program	
• Join a trend	
Competition from other facilities	

4.2 The decision to not take participation in Sehat Sahulat Program.

4.2.1 Public providers' reason for non-empanelment

Just as, we come across the "government push" as the main rationale behind this public provider inclusion with the SSP program, it's been observed that, substantial list of public providers didn't get accreditation status yet. Data also suggests that only 300 public hospitals

out of 1200 were empaneled, which consists of only thirty percent of total public health providers. Further, in exploring this matter it was found that a number of public providers is on way to getting empanelment status, but are still struggling in their legal processing, and a lot of other challenges. Therefore, they had not gotten accreditation yet and not visible in the enlisted list of state life insurance corporation (SLIC).

4.2.1.1 Complex process

Though, in conversation with them, they disclosed multiple reasons for the question of why they didn't get accreditation yet.

"Actually, the problem was that this program instead of being a pilot project, or applied in phases, was directly implemented upon us, which created many challenges us, and we were not prepared for this".

-public providers, Islamabad, Pakistan, hospital-not empaneled

Whereas in another hospital, that was still not accredited, respondents pointed out, that they had faced a lot of issues, under government supervision, and the nature of their working environment, is different from the private sector. They cited out, that they had their specific issues, like procedures were quite complex, struggling with the ascertainment of prices, and lacking the costing techniques.

"Now the problem raised were that we had been operating under a different government, we had a different hierarchy, so we were liable to take approval from all this chain of command, to meet any condition for the empanelment".

In bringing up the above statement, the respondent quoted the below example.

"Look, the sehat sahulat program's main feature is to get empanelment for the public sector, where the condition of treasury non-nap-sable account, which means, the account would remain continuous and never end on any financial year. Meanwhile, earlier, the finance division had a rule, that no government hospital was allowed to open any non-nap sable account,

especially in a commercial bank. Hence, to meet this condition we sent an application to the finance division, and they further forward it to the federal cabinet, and only this process took one whole year".

-public-provider, Islamabad, Pakistan

4.2.1.2 Determination of cost

Though, a bunch of respondents also gave the reason that, since the announcement of the program, they had grappled with the challenge, in the ascertainment of the prices within the government-given package limit, in case this cost exceeded the defined limit.

"If I would have exposed the reality, the truth is, we have been fighting how to determine the cost of this package, for example, the surgical procedure price 20,000 while C-section is 15,000 how would we meet this rate, because normally our cost goes beyond this limit. So, we were working on the costing of this package".

-Public-provider, Islamabad, Pakistan, not empaneled

4.2.1.3 Absence of budgeting system

At the same time the manager of the public–providers also raised their reservations, about some technical issues in the budgeting system, in expressing their opinion they said that the state life insurance corporation had not defined the maximum limit upon the utilization rate of the package.

"One of our reservations, was that they did not have any proper budgeting, means a backup system, for example, if we would do 500 operations in the month, would they provide us its payment for the next one month, and if they held our payment for even the next six months, then how would we survive under this system. There is the absence of proper budgeting and limit on their behalf".

- Public - providers, Islamabad, Rawalpindi, not empaneled

4.1.2.4 Future concern about the sustainability of the program

Similarly, the respondent's reservation was also on the sustainability aspect of this package. They stated that our concern is how will we survive under this system in the future. They pointed out fingers at the state life insurance corporation (SLIC) payment reimbursement time duration, it is continually getting prolonged since the program started.

> *"We kept our eyes on this system, as you know that when this program started, its reimbursement time was 15 days, now it's reached 45 to 50 days' limit for the public sector. while if you look at the data, only 20 percent of the public hospital have empanelment yet. If this empanelment ratio reached 60 percent, then our assumption is that this payment return time will also double and extend to 180 days. How would we survive under this system".*

-public providers, Islamabad, Pakistan, not empaneled

4.2.2 Private provider's reason: -

The major, dominant aspects that had been observed by private providers on the participation, in this program in twin cities were their social welfare agenda narrative. Along with this, somewhat profit motive was also seen as a reason to apply for empanelment. Therefore, in this situation, upon asking from some private hospital why they didn't apply, varying themes were identified in comparison with the public providers.

4.2.2.1 Limited health services

Some private providers explained, that being a smaller hospital, they had limited facilities, a limited bed capacity, physicians, and packages that put them at a disadvantage. At the same time, others cited that they are new in the health system, and till now didn't have any huge

spectrum of inpatient services, apart from of C-section provision with only a three-bed capacity. This is the reason they are, still out of the system.

"We have not applied, as we had a limited number of facilities, and bed capacity to entertain the patients, that's why we have not shown any interest in it".

Private-providers, Rawalpindi, Pakistan

4.2.2.2 Lowest rates

On the other hand, other hospitals mention that they had put their effort to get empanelment, but they offered us low rates for the health benefits package, at such low rates we didn't have any advantage, it was difficult for us to agree on that rate.

"We have tried to get enrollment, but the offered rates were too low, how could we agree if we knew, it's not easy for us to run this system on such low rates?".

Private providers, Rawalpindi, Pakistan

While some of the providers also explained it's not easy to get empanelment for the smaller institution, even on the reasonable rates, especially for the facility like us, who have limited amount of services availability. They prefer those hospitals who had references and give them ideal rates.

"We have tried, but it's not easy for the smaller hospital to get empanelment, it's all the game of references, especially in the establishment of rates".

-Private providers, Rawalpindi, Pakistan

4.2.2.3 Quality issue

In contrast to the above reason, some of the respondents said, we had the customer that believed in us, because of the provision of quality health services so we couldn't compromise on our quality, nor did we want to lose our trustee customers.

"We have never thought about it because we have our set-up and customer who visited our hospital due to the standard of quality services".

- Private- providers, Islamabad, Pakistan

Contrary to this one respondent illustrated that they were already providing all services free of cost because they were working as a fund-based institution, therefore they felt there is no need to get empanelment.

"Why we would go for empanelment, as we were already providing cost-free in-patient services in our hospital".

Public and private providers' experience with social health insurance (SHI) scheme

Table 4: Provider's reason for denying inclusion in sehat sahulat program (SSP)

Why not apply-SSP-private providers	Why not apply –SSP –public providers
Limited health services	Determination of cost
Lowest rates	Absence of budgeting
Quality issue	Complex process
Corruption	Absence of feedback
Future concern	Future concern
State life capacity	Quality issue
	Sustainability of program

So, overall, we have seen; that nearly all the public and private providers that are avoiding the empanelment are due to the lowest rates and budgeting factor. Another point of convergence that has been observed was their future concern about the program sustainability and capacity

of state life in the provision of payment in the future. While some other smaller facility who want to get empanelment but didn't get it due to the low rates blame the corruption and reference factors existing in the market.

4.3 Experience regarding empanelment process challenges

Empanelment is the basic phenomenon that is used by the higher authorities for the assessment of healthcare providers in terms of quality health –services provisions (Abena pattern). To ensure the national health insurance objectives hospital accreditation consider the main legal requirement (Alhassan et al., 2016). This journey begins with the process of national health insurance accreditation and their provided accreditation score which is considered an imperative step. Before this, one research was executed in Ghana that looked at the private provider's perspective on this process while there is a lack of research on the public sector narrative. So, this research was mainly composed of both sector providers' narratives.

The providers that had already received the empanelment status from both public and private levels for a significant period shared their individual experience with regards to the procedure for acquiring the empanelment status, length of the gaining the accreditation, challenges regarding the condition to change, and others condition to secure the registration with this scheme.

4.3.1 Challenges regarding approval length of time

The Comparative analysis of both public and private sectors on the accreditation process proclaims enormous difference in terms of challenges faced during this process. Primarily most respondents in the private sector mark the process as straightforward. The respondent reported it was just an uncomplicated process we had just applied, completed all the documentation, and signed the contract. Although few respondents were those who instead of filling the Performa available on the website, directly visited the state life insurance corporation (SLIC)and

discussed their agenda. The outline of their visit was to what extent they could allocate their bed capacity for sehat card patients.

"It's a simple process, all the conditions mentioned in the contract, we just signed and agreed upon all the requirements indicated in this documentation, then state life further process on the process".

Private provider, Islamabad

However, the opposite trend is detected in the public sector, they had cited out this process was quite complex and ascribed to the involvement of different bureau-curacies, especially in the Islamabad district, they had a complaint about the delay in the approval of accreditation status happening on account of the existence of different hierarchy. Although the procedure observed in Rawalpindi was easier one for the hospitals that got approval in recent times revealed that Ministry of Punjab has done all the contracts with the state life insurance corporation on their own.

The respondent also explained, that for the empanelment they have gone through the documentation and legal contract separately from the ministry of health, (MOH), sehat sahulat program SSP, and the state life insurance corporation separately.

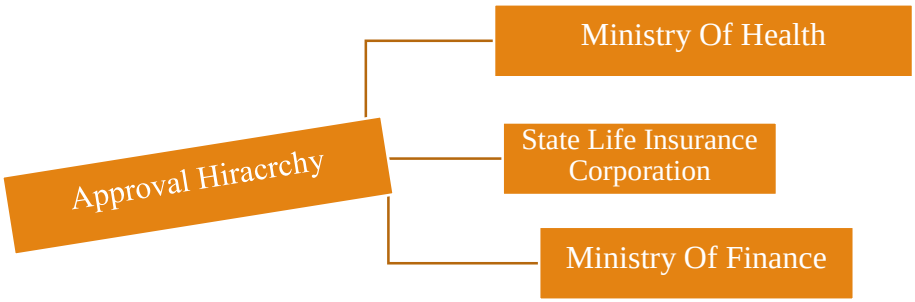

Figure 6: Approval Hierarchy Sketch

The common conditions met by both public and private providers in Rawalpindi and Islamabad were the opening of treasury accounts. However, for the public hospital, it was mandatory to open this in the national bank of Pakistan (NBP) while private had the freedom to open it in both commercial and national.

> *"We went through different contracts, every ministry had its terms and condition which is necessary to meet, like the condition to open the treasury account is the condition made by the sehat sahulat program (SSP) while the placement of claim staff of state-life was the condition made by state life insurance corporation".*
>
> Public-provider, Islamabad, Pakistan, Empaneled

4.3.2 Challenges related to conditions to change

However, an interesting factor was observed, that not a single private provider was required to make changes in the health facility of any type in terms of needing some equipment, water connection, additional staff demand, and the permits of the building as it was observed in Ghana accreditation process.

We have observed the providers who got empanelment on an initial basis went through changes in their health facility like the condition to build a model pharmacy, hiring of additional staff, to specify some room for sehat card administration particularly, put banners of sehat card at front of the gate and make their separate counters, etc. Some public and private health facilities respondents revealed that after filling the initial Performa, where all the conditions mention regarding accreditation, the official visited the health facility and check their presence but did not put any condition in case if anything were absent.

In contrast to this, there were some other mandatory list conditions, expressed by both providers, but the public sector had an extensive list for inspection and got accreditation. At

the same time some public providers stated considering the facilities aspect this program implements on us, on our existing infrastructure.

"We have not gone through any changes keeping in mind the facilities, nobody mentions us on inspection, you are failing in some particular departments, so; do changes; the fact was, the program implements on us, on our existing infrastructure".

Public –provider, Rawalpindi, Pakistan, empaneled

Public and private providers' experience with the empanelment process

Table 5: public and private provider's empanelment process themes

Public-providers empanelment process	Private-providers empanelment process
Complex process	Straightforward process
Approval time delayed	Approval time general
Condition to change	No condition to change
Non–nap sable account opening	Non–nap sable account
Inspection to check facilities	Inspection to check facilities

4.4 Provider payment mechanism challenges

Providers' payment mechanism is one aspect of strategic purchasing as it had the potential to create incentives for healthcare providers and then further create incentives that help to improve efficiency, quality, and utilization of health services. Providers report the persuaded payment mechanism in sehat sahulat program as "fee for services" excluding the consultation fee but after getting the admission. Moreover, the respondent delineates the payment structure encompasses all the services starting from the admission to discharge points such as per day

bed stay fee, laboratory test fee, medicine during the treatment, and the agreed payment to the health-service package.

Primarily both public and private providers disclosed the mechanism to decide the payment rate for their health facility corresponding to each other except the single institution. Almost all providers agreed that the rates given to them were based on the state life self-assessment approach. Certain private respondents clarify that the rate is decided by the sehat sahulat program representative according to the availability of facilities present in the hospital.

> *"After going through all the documentation and contract, their team visited, checked all the facilities, and then defined our class, based on primary, secondary, and tertiary. If we had 500 beds capacity in our hospital, then the given rates would be full, full means we could get a handsome package, such as we were having 40 bed-capacity and fall in the primary category. that was the reason we had five to ten thousand differences due to bed capacity issues".*

Private -providers, Islamabad, Pakistan, empaneled

One of the public providers' objections was that these rates were marked final based on tender, in this tender, the lowest bidder rates were implemented on us. However, on the flip side of it, some providers' narrative was that these are subsidized rates settled by state life itself, based on their self-assessment approach. Furthermore, upon asking what rate had been given to you by authority, not a single public and private providers deduce the information except a sole private provider. Other providers mentioned it was personal and confidential; therefore, we couldn't reveal that.

However, we have drawn from the respondent's reply, that the following attributes of the provider's payment mechanism were important considering the resilient framework approach.

4.4.1 The payment rates were not sufficient

The providers had shown concern about the sufficiency of the payment rates provided to them. they consider them inadequate to cover the cost of what they spend on it. According to private providers, the cost is inadequate in some packages like in the case of female replacement implants.

> *"Some cases like female replacement implants were so expensive, and if institutions entertained such patients, then it means we didn't have any advantage, we hardly meet the cost of such packages and working on the no-profit, no-loss condition".*
>
> -Private -provider, Rawalpindi, Pakistan, empaneled

A Public provider also complained that the rates had remained too low, considering the quality aspect, "*it became difficult for us to maintain the standard quality services provision especially being a cardiac institution*."

> *"There were some procedures like cardiac-related disease, which were known as totally lifesaving procedures, in which one could die too, it's not like others general procedure like the appendix, Benin tumor surgery, polypectomy type procedures. so, we couldn't compromise on the quality level and the usage of standard products in procedure. So how could we compromise on such low rates if we do, we had to compromise on these quality procedures, which we cannot in any case".*
>
> -Public -provider, Rawalpindi, Pakistan, empaneled

4.4.2 Absence of incentives for the consultant.

Another main concern provider described with this sehat sahulat program payment mechanism was its lack of inclusion of any incentives for the consultant in the benefits package. This creates sometimes problems for the institution itself. Public and private both providers show

their distress that consultant is an independent body, why they would work with the institution in the absence of any type of incentives for them.

Few private providers' complaint about the barrier were raised because of any incentive present in their hospital. In their opinion state life insurance corporation accusation that consultants to take a bribe from a patient is wrong.

4.4.3 Absence of self-determination in public provider on funds utilization

There is of great significance for healthcare providers to utilize and access their funds in an autonomous way to fulfill their all needs and maintain the standard of quality. It has been observed that private providers received funds in their accounts and had absolute independence to use money in operating the institution. On the other hand, a few public providers complained, about restrictions imposed by the government of Punjab on them by announcing the new policy as a result they had completely lost autonomy in the utilization of funds. According to the new formula, the Punjab government would allocate funds to the hospital while the hospital had the liability to deposit the revenue first into the country fund.

According to the new allocation formula, eighty percent of the revenue generated through sehat sahulat program accreditation was returned to the government. However, out of this eighty percent sixty-five percent were kept by the government, and fifteen percent returned to the institution for their infrastructure, equipment, and quality improvement expenses initiative. Meanwhile, only twenty percent allowed the hospital to meet the expenditure regarding sehat sahulat patient treatment.

4.4.4 Absence of feedback from provider to settled payment rate

The adequacy of the provider payment mechanism (PPM) to cover the cost of services provided was also a concern to healthcare providers. The amount of sufficiency considers imperative by both sector providers to meet the standard quality provisions. But here the respondent review

shows there is an insufficient amount provided to them even though providers have shown their distress that rates were settled without their consultation.

> *"The problem with this program is that they didn't consider our concerns. we agreed that they were supposed to bring the stakeholders on board, but they took all the decisions by themselves. their narrative is that the market rates already are too high, and they want to break this chain".*

4.4.5 Delayed in claim reimbursement and cumbersome system.

According to the 'joseph kutzin,' framework purchasing services means the transfer of pooled resources from purchasing agency to the health care provider on behalf of the population (Reference). The government is the purchasing agency in this sehat sahulat prime minister program that outsourced the responsibility of purchasing this to SLIC from both public and private providers. Almost all respondents in both sectors describe the process of claim-reimbursement as hectic because of its manual nature and demand for the electronic system. Their opinion was, that the repayment of the claims system had a burdensome nature and required a lot of documentation and a long process for the claims approval.

4.4.5.1 Provider Claim management process

The figure given below represents the flow chart of the claim process that starts with the patient's arrival in a hospital. At first, the patient's identity is confirmed through their ID card submission. Then claim sheet is formed after the patient is admitted to the hospital. This claim sheet Is prepared by the providers themselves and further sent to the health facilitator officer representative of state life, district health officer, and sehat sahulat DMS for approval and verification.

Another foremost attribute of the provider payment mechanism was the claim reimbursement timing and certainty in it. Timely payment disbursement is considered crucial in front of health providers. However, respondents at both public and private providers mention their timing of

claim reimbursement in the contract was 15 days for private while 30 days for public providers was assigned at the initial stage of the program. Now this limit had been extended to 45 days for the public and 30 days for the private sector.

The respondent of public and private providers reported delays in receiving payment. Especially Public provider have shown their dissatisfaction in claims reimbursement while comparatively private providers were seen slightly contended with the payment reimbursement. It was also noticed at the time of data collection some public providers reported a delay of two to three months while for others it went beyond this period too. Furthermore, one public provider's complaints to fetch only one-third number of total claims even after a long-delayed.

> *"Like look, we are in May, fortunately, they have paid us up to January. Even though we sent them claims weekly, we sent the first claim on 15th January, several claims sent 220 cases, then on next week 140 cases, so totally we sent only 1310 claims in a month but till now didn't receive even one-third amount of it".*
>
> *Public –providers, Rawalpindi, empaneled*

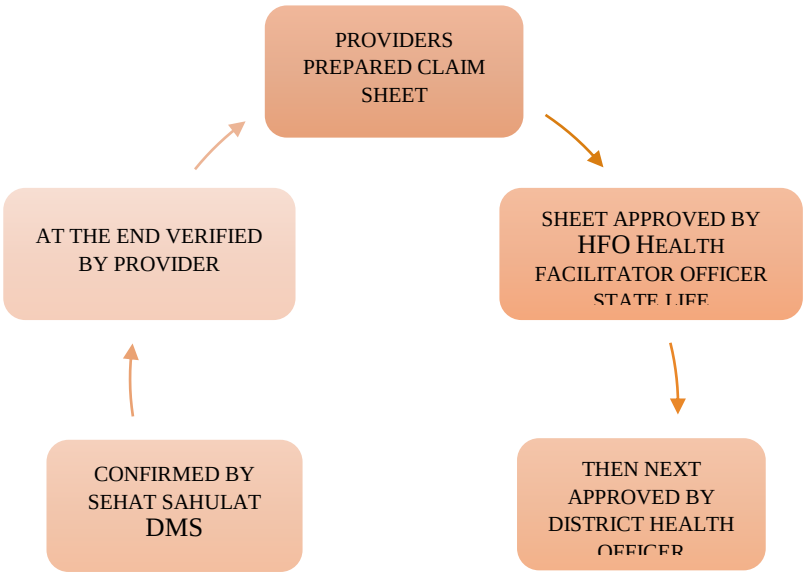

Figure 7: Claims Management Process

On the contrary side private providers, also complained about the delay in claim reimbursement. They bring up the reason for such delays were documentation problems like the absence of an ultrasound report in the gyne case file. They quoted because of this absence in evidenced paperwork authorities of state life put an objection in claims that result in a delay in payment. In such matters, we must proceed further and sort out their objections.

> *"We had observed in the past three years, that either rejection or objection in claims solely depends upon your institutional file work, now we learn through our past experiences if there would be any technical issue in claims, it gets rejection. Such as, if there is a neuro patient MRI would be a must for a spinal cord patient its stool test report would be mandatory, and for gyne and surgery client ultrasound reports are inescapable.so, these were genuine issues that caused delays in claims reimbursement in case of objection".*

Private providers, Islamabad

The actuarial report represented by GIS Lisa Morgan ,2019 also proclaims that the delays in claims recoup were more extensive in public hospitals than in private. This report also indicates a larger number of claims made by the private hospital as compared to the public.

Figure 8: claims usage by facility type.

The challenge of invalid complaints:

According to public and private providers the biggest challenge faced by them is the illogical complaint done on behalf of patient to state life insurance corporation (SLIC).their opinion was the nature of such complaints were illegal .mostly it's been observed patient do complaints regarding ,the hospital staff not entertaining them ,not giving them admission ,demands the fee upon check-up .the providers narratives was such issues emerged due to the patients lack of knowledge upon the working of this sehat sahulat card .

Their opinion was patients didn't have proper information like this sehat card not covered OPD and all expenses incur on test before admission. similarly, the absence of others technical knowledge like the limit of card and which disease are covered at what extent also creates issues for hospital. Therefore, in this regard state life insurance communication department lagging in terms of to understand the validity of complaint lodge by patients.

Discussion

The achievement of universal health coverage demands a reduction in out-of-pocket expenses for indigent persons through launching a new health financing system that is social health insurance (Kruk, 2013). The strategies to expand the social health insurance scheme demands effective involvement of both public and private sector (Prata N et al., 2005). As Pakistan has also initiated the sehat sahulat program based on the social health insurance model.

To accomplish the target of this program empanelment of both public and private providers tendered to the nominated department (Morgan, 2019). This department is further responsible for the effective engagement of public and private providers. In this regard, the results of my research examine numerous common factors that should be considered for the effective participation of providers.

At first, our findings demonstrate that both public and private providers realized the significance of public health value and were motivated to participate in the SHI scheme considering the community benefit and customer demand aspect. The critical aspect of customer demand was to be looking for accredited health facilities that accept sehat -card for treatment purpose. This aspect was critical to incentivizing for profit providers especially in a scenario when they were experiencing the operational difficulties .such type elements were also discovered in Ghana's social health insurance scheme(Sieverding et al., 2018).

The comparative analysis of both public and private providers shows the biggest factor for public providers regarding the decision of inclusion in the sehat sahulat program was the government policy that push them to participate in this scheme. however, the opposite trend was observed for the private hospital where the dominant factor behind their participation decision was their business motive. the private providers opinion was, their patient load was

decreasing due to the presence of sehat card option working in other hospitals. therefore, this ultimately compels them to consider about the inclusion in SHI model.

However, the biggest barrier observed in an expansion of this scheme for public provider were the presence of different hierarchy especially in the district Islamabad which resulted in long waiting time for approval .providers were also struggling with the other ingredients like determination of health benefits packages cost, assurance of quality by state life, state life capacity to fund this program in future considering the universal health coverage, absence of proper budgeting and exclusion of input feedback from public providers.

On the other hand, the accreditation process observed for private providers was straightforward in nature without any strict condition imposed to change the existing infrastructure. While opposite was observed in case of public-sector like to build their own model pharmacy, specification of room and staff that particularly deals with sehat sahulat technical problems. However, the presence of such constraint faced by public providers shows accreditation authority discriminating them comparing to private sector in inclusion process.

Similarly, the biggest factor to not participate in sehat sahulat program for private sector was the broad empanelment criteria given by state life where the hospital with limited number of bed capacity and staff couldn't get enrollment. This indicates that the program empanelment criteria should be narrowed down to make this program accessible to everyone without any socio-economic differences.

In addition to this, some challenges emerged regarding the provider payment mechanism. strategic purchasing is the main tool of health financing that is adopted by officials for purchasing health services. My basic motive was the exploration of the provider's experience in terms of the challenges they are facing with the prevailing payment mechanism and how it impacts their quality-of-service delivery and its availability. In the interview process, I have

picked out different distinctive attributes of providers' payment mechanisms that demand serious consideration from concerned officials.

The inadequacy of payment rates was another important aspect highlighted by providers. They complained that the rates offered by SLIC for multiple health benefits packages like female replacements implants, cardiac related surgeries, and C-sections were insufficient .their opinion as we are working on No-profit No-loss conditions .similar findings were also observed in other country's settings like Burkina Faso where they find out that capitation rates paid in CBHI scheme were inadequate to cover the basic service cost (Robyn et al., 2014). Although in another research capitation amount of reasonability pointed out for other chronic conditions like hypertension and diabetes(Obadha et al., 2019)

However, in this research one of the public providers linked these lowest rates with the provision of low-quality health services. they criticize the officials and state that it’s hard for them to sustain quality in such low packages. In the meantime, even one of the private providers also indicated the issue of informal payments received by consultants due to low cost. They assessed that no one doctor is willing to go for C-sections and other surgical procedures in a scenario where he could have earned a sizeable amount through their clinics

Their notion was that to keep them motivated the provision of incentives is mandatory particularly to attract experienced and professional consultants.

However, another prime aspect unfolded by both sectors' providers was predictability in the timing of claims disbursement. the outcome shows that public healthcare providers were more concerned about the delay in the timing of payment reimbursement even though they were receiving the operating cost and funds from the government. The reason behind their concern was their negative anticipation about the sehat sahulat program. they considered this program

is an attempt by the government to the privatization of the public sector. Therefore, they were more concerned about the timely reimbursement of payment rates.

Both public and private providers endured delays in payment from two to six months but this period for the reimbursement of payment is minimum as compared to other LMIC countries. They reported at such delayed periods difficulties emerged in the payment made to pharmaceutical companies. Though private providers quoted they tried to manage these expenses through their OPD.

This type of unpredictability in payment patterns is also observed in Nigeria's maternal and child health-care schemes that generate the stock out in medicine. this further resulted in the introduction of informal payments for the services that were otherwise free (Ogbuabor & Onwujekwe, 2018) similarly, in Indian NHIS (Rashtriya Swasthya Bima Yojana) scheme such delays discourage the providers to such an extent that they decided to move towards the DE empanelment. It has also been detected here in this scheme that one of the public providers due to prolong delayed in payments was thinking about turning away from the scheme.

Another challenge was the absence of incentives provided for both sectors provider's health workers, consultants, and other facilitators involved in this. Because of this informal payment challenges occurred in some private facilities that are reported by SLIC officials.

Furthermore, it's also noticed one of the private providers objected to the payment rates settlements procedure. They show their frustration and quote that state life does favoritism in payment rates settlement. they claimed that they are familiar with the rates received by other facilities and it's a market nothing could be hidden from anyone. therefore, they demand there should be a policy regarding visible accreditation score availability on the SLIC website that should be accessible to everyone.

Public –health care providers also show their dissatisfaction with the government of Punjab's new policy on returning funds to country revenue which hurts their autonomy badly. Their opinion was how they would entertain sehat patients and provide them quality services without funds in the presence of long government devolution arrangement of public finance. This was also observed in Kenya where public providers lost their autonomous nature with the beginning of devolution there. however, the literature review depicts Tanzania this autonomy given to public providers by announcing the policy of performance-based financing that gives them the liberty to receive the funds directly in their account instead of district managers. (Mayumana et al., 2017).

CHAPTER-5

Conclusion and Policy Recommendation

5.1 Conclusion

The proper engagement of public and private providers considers mandatory to accomplish the goal of universal health-coverage .to the best of my knowledge this research is the first step that examine both public and private providers' experience on their inclusion decision and the challenges with the provider payment mechanism on working with the sehat sahulat program. this research was also the first one that did a comparative analysis of public and private providers' that comes across with the social health insurance program.

This research discusses the providers who participated in the scheme on the ground of community benefit and customer demand aspect. however, some private providers deemed it as an indirect way of advertisement “this shows they had a business motive in their mind too. While public providers located in the Islamabad district believed the approval from different government hierarchies is the biggest challenge in their participation that should be overcome.

Although generic findings demonstrated that both public and private providers acknowledged the significance of SHI as a financing mechanism, and it is valued by society. however, several challenges bring about discouragement in them like the presence of disincentives, inadequate and lowest rates, absence of feedback from providers in settlement of rates, public provider’s autonomy to utilize their funds and invalid complaints etc.

All such factors caused distress in them and put constraints on program expansion. it is therefore important that before designing the structure of social health insurance such key indicators should be keep in mind. The purchasing agency must do analysis by their self on the define health-intervention real cost prevailing in markets. Then takes the providers on board before the settlement of such rates collectively to avoid their frustration regarding the

corruption and favoritism elements. At the same time, they should revise their empanelment criteria too to expand the bracket of UHC.

However, considering the themes emerged in this research in terms of providers difficulties in the involvement with social health insurance (SHI) number of aspects for further research could be consider .like the research can be done on the quantitative aspect of the claims reimbursement challenges and costing techniques of health benefit packages .As we have seen mostly providers were reluctant in the provision of data because of the restriction imposed by purchasing agency on them .Therefore , by taking purchasing agency on the board we can resolve these issues by conducting further research .meanwhile ,further research on the development of social health insurance structure can also be consider for its improvement .

5.2. Policy Recommendation

Allocation of incentives.

There is a need for allocation of incentives for the consultant, nurses, front health workers and other staff involved in dealing the sehat card patient in both public and private sectors.as it will motivate the consultant and increased their efficiency level to entertain the patient. Besides that, it will also reduce the problem of informal payments.

Monitoring the consultant

To increase the professionalism on behalf of the consultant and reduced the problem of informal payment proper monitoring of doctors ought to be by PMDC. provider's narrative was state life insurance corporation should take the action against any complaint received to them from providers by itself. They should give a warning and cancel the PMDC status of such consultants. This action ultimately will improve the satisfaction rate of patients with the scheme and boost their usability.

Reduced hierarchy

Similarly, bringing down the approval ladder for public providers can intensify the accreditation mechanism, and their inclusion in the system further results in increasing the accessibility ratio of sehat card hospitals to the masses.

Setting payment rates

To accredit more providers and to sustain the current provider's engagement with social health insurance it's imperative to consider their feedback in designing the payment mechanism. Considering their experience about what attributes are obligatory in the settlement of the rate of any intervention can build up their trust in the system. Secondly to re-design the payment mechanism of such intervention can create incentives for providers to deliver needed services efficiently. This will also help the providers to provide quality services without any compromise.

Explicit accrediting score policy

To overcome the frustration of providers on the matters of rates provision to providers was based on the favoritism element. The explicit policy regarding the determination of accrediting score formula on the website can be built on the provider's trust. it also ensures the credibility of purchasing agency.

Autonym in funds utilization

The recent policy announced by the Punjab government to submit the eighty percent generated revenue back to the government caused disappointment among them. It's difficult for them to operate and provide quality health services in this time lag period to submit and return money to providers. secondly, minimum share put them at a disadvantage. Therefore, to make sure their inclusion the provision of complete liberty on the funds' utilization is required.

Timely claims reimbursement

Timely reimbursement in claims disbursement ensures the monotony in payment patterns. This consistency in payment provision helps providers in their day-to-day functioning like to fulfill the operating cost, to pay timely, to pharmaceutical companies.

Widen the accreditation spectrum.

It’s have been seen that the number of providers is out of this social health insurance scheme due to narrowed criteria of accreditation given by state life for the empanelment.

Appendix

Interview guide

Q1 How did you first learn about sehat sahulat program?

Q2 Why did you decide to apply for accreditation?

Q3, can you describe the process to become accredited?

Q4 What are the requirement for the hospital to become accredited with social health insurance program?

Q5 What did they check about the hospital? *Probes:* look of the facility, size, records, license, others?

Q6 What has changed in the hospital since you had joined the hospital?

Q7 Are there any other changes to the clinic? *Probes:* Equipment, commodity supply, record keeping, branding?

Q8 what is the provider payment mechanism? Fee for services, cashed based payment, diagnostic related payment

Q9 What criteria they considered in setting payment rate?

: Q10, are they considered provider's experiences in design payment method?

Q11, are they developed any mechanism to resolve problem associated with this payment mechanism?

Q12 Are rates being equal to the services offered?

Q13 Is this being a good source of revenue for your hospital?

Q14 Is this cost being adequate and cover the cost of services provided by you?

Q15 Is the claim or payment reimbursement system being complex?

Q16 What type of incentive you have?

Q17 what type of others challenge you have?

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