POLICY MAKING AND IMPLEMENTATION PROCESSES OF PUBLIC HEALTH INTERVENTIONS: A CASE STUDY OF SEHAT SAHULAT PROGRAM

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CERTIFICATE

This is to certify that this thesis entitled: **"Policy Making and Implementation Processes of Public Health Interventions: A Case Study of Sehat Sahulat Program"** submitted by **Asim Saeed** is accepted in its present form by the PIDE School of Social Sciences, Pakistan Institute of Development Economics (PIDE), Islamabad as satisfying the requirements for partial fulfillment of the degree in Master of Philosophy in Public Policy.

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Author's Declaration

I **Asim Saeed** hereby state that my MPhil thesis titled **Policy Making and Implementation Processes of Public Health Interventions: A Case Study of Sehat Sahulat Program** is my own 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: 1-3-2023

Signature of Student

Asim Saeed

Dedication

I dedicate this study to my parents. Without their prayers and encouragement, I would not have accomplished anything in my life.

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Abstract

This study explores the policymaking and implementation processes of the Sehat Sahulat Program (SSP). Using the qualitative research strategy and exploratory research design, this research attempts to understand the policymaking process and implementation through the Stage Heuristic Model of policymaking. The Stage heuristic model explains a policy event in a complete cycle starting from problem identification to policy revision of a specific policy. The data were analyzed using thematic analysis of semi-structured interviews with the stakeholders. A phone-based survey was conducted with the program's beneficiaries to understand their perception and satisfaction with the initiative.

Findings suggest that the purpose of initiating the Sehat Sahulat Program was to address the inadequacy of the existing public health infrastructure in Pakistan and provide financial risk protection to the vulnerable population segment. The federal ministry of health devised this policy with the technical assistance of GIZ, WHO, and SLIC. For implementation, the Program Management Unit (PMU) has been established, which implements the policy with the coordination of SLIC and the district health department. The program is executed in empaneled hospitals in the public and private sectors after a thorough investigation of their quality and standards. SSP has impacted the private healthcare sector the most. Firstly, it has enabled the private sector to improve its quality and outreach across the country and created a competitive environment within the private sector delivering healthcare. Secondly, it was found that the impact of the SSP intervention on the public health sector was not meaningful, and it has no role in improving the service delivery in the public healthcare sector. Thirdly, in achieving Universal Health Coverage milestones for Pakistan, the SSP has impacted the financial risk protection component the most. In contrast, the intervention has not impacted the other components of the UHC and SGD 3.8 targets. Overall, 95 percent of the beneficiaries were satisfied with the treatment they got from the empaneled facilities. Most of the beneficiaries considered the process of acquiring the program's benefits easy to access, and all of the beneficiaries considered the SSP intervention helpful in reducing their health expenditures. The research findings recommend a legislative, institutional, and financial framework for the sustainability and viability of the program.

Keywords: *Sehat Sahulat Program, Policymaking, Policy Implementation, Stage Heuristic Model, Social Health Protection, Universal Health Care, Insurance Based Healthcare*

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List of Abbreviation

ACF	Advocacy Coalition Framework
BHUs	Basic Health Units
BISP	Benazir Income Support Program
CDWP	Central Development Working Party
CEO	Chief Executive Officer
CMIS	Centralized Management Information System
CNIC	Computerized National Identification Card
CT Scan	Computed Tomography Scan
DHQs	District Headquarters
DMO	District Medical Officer
GIZ	The Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH
GoS	Government of Sindh
H&AI	Health & Artificial Intelligence
KP	Khyber Pakhtunkhwa
M&E	Monitoring and Evaluation
MIS	Management Information System
MoNHSRC	Ministry of National Health Services Regulation and Coordination
MS	Medical Superintendent
MoPDSI	Ministry of Planning, Development & Special Initiatives
MSF	Multiple Stream Framework
NADRA	National Database and Registration Authority
NEC	National Economic Council
NSER	National Socio-Economic Registry
OOP	Out of Pocket Expenditure
OPD	Outdoor Patient Department
PC	Planning Commission
PHFI	Public Health Foundation of India
PET	Punctuated Equilibrium Theory
PHIMC	Punjab Health Initiative Management Company
PIDE	Pakistan Institute of Development Economics
PMO	Provincial Management Officer
PMT	Proxy Mean Test
PMU	Program Management Unit
PSDP	Public Sector Development Program
PWDs	People With Disabilities
RHCs	Rural Health Clinics
RTA	Renal tubular acidosis
SCI	Service Coverage Index
SDGs	Sustainable Development Goals
SLIC	State Life Insurance Corporation
SP-SHIP	Support to Social Protection-Social Health Protection
SSP	Sehat Sahulat Program
THQ	Tehsil Headquarter
UDC	Unit of Data Collection
UHC	Universal Health Coverage
WHO	World Health Organization

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CHAPTER 1

INTRODUCTION

Public policy is any series of actions to solve societal problems. More precisely, policies are government statements of what it intends to do or not to do, including laws, regulations, decisions, or orders (Martinez, 2022). Hence, public policies can be conceived as the political systems' main output. The steps involved in policymaking around a range of subjects can be categorized using the Stage Heuristic Model for public policymaking. This consists of the following linear steps; (1) Agenda Setting, (2) Policy Formulation, (3) Policy Implementation, (4) Policy Monitoring and Evaluation, and (5) Policy Revision. However, contemporary policymaking is not linear, and the policy process may be rather complex. This complexity emerges due to the interaction of various stakeholders, actors seeking political influence, and globalization of localized public policy issues. Stakeholders with political or economic interests influence the policymaking processes to maximize their personal benefit from the policy being implemented. Political and economic actors primarily influence agenda-setting and policy formulation in the policymaking cycle. However, it can also impact the implementation and outcomes of a given policy (Yalmanov, 2022).

Using the theoretical approach of the Stage Heuristic Model, this research aims to study the role of policy actors in the different stages of the policymaking processes of the Sehat Sahulat Program (SSP). This research attempts to study the inception of one of the biggest social health initiative in Pakistan, the actors involved in the design and implementation stages of the program.

1.1. Sehat Sahulat Program

The Sehat Sahulat Program previously known as the Prime Minister Special National Health Initiative Program, is Pakistan's most significant social health initiative. SSP currently benefits 7.9 million[1] families across Pakistan. People living below the poverty, i.e. earning less than $2/day (as per 32.5 PMT [2]score of NSER[3]) in Punjab, KP, AJK, GB, and 100% population coverage for newly merged districts of KP and district Tharparkar (Sindh) are covered (Sehat Sahulat Program | Sehat Insaf Kay Sath!, 2021). This program was designed to provide health insurance for indoor health services at the tertiary level for people below the poverty line. This program was initiated by the federal government with the coordination of provincial governments and the technical support of WHO and GIZ, using the NSER data. Sehat Sahulat Programme provides services under two distinct benefits packages, i.e., priority/tertiary care package and secondary care package. Priority /tertiary care benefit package covers all significant high-cost critical treatments like cancer management, cardiology, accidents, ventilator support, burn, and renal dialysis (renal transplant in KP only). In contrast, the secondary care benefit package covers all the remaining medical and surgical treatments, including abdominal surgeries, medical conditions, and deliveries/C-sections. The covered population includes vulnerable and marginalized groups, including PWDs and transgender communities. Qaumi Sehat Card, Sehat Insaf Card, and Sehat Card Plus are the brand names for health cards being provided by Sehat Sahulat Programme to target families in Punjab, AJK, GB, Tharparkar Sindh, ICT and KP province. Data are secured from the NADRA based on each individual's permanent resident records as per the CNIC. Sehat Sahulat Programme has a

[1] https://www.pmhealthprogram.gov.pk/
[2] Proxy Mean Test (PMT) is a mean test of set criteria through which the income or consumption of people are measured if the precise measurement is not available or difficult to obtained. It is an informed guess based on the household characteristics.
[3] NSER is a data repository that contains information on the socioeconomic status of households. It was started in 2010. Data from 27 million household data were collected data for BISP. Currently, it is used by various social protection programs as a platform for targeting the population.

nationwide panel of hospitals, including private and public sector healthcare facilities. The healthcare services are provided through a cash-less arrangement with more than 450 empanelled hospitals, both public and private, across Pakistan (Maqbool, 2021). Currently, SSP is a PSDP-funded program with a budget of Rs. 55,553.644 million running till June 2025[4]. It intends to shift the program to the non-development head of the federal budget-making. SSP solely provides insurance for in-door health facilities at the tertiary level leaving the primary health out of this program. The program was initiated by the federal government and is currently being implemented in KP, Punjab, Tharparkar (Sindh), AJK, and GB when health remains a devolved subject to provinces after the 18th Amendment ("PIDE Webinar on "Sehat Sahulat Program," 2021).

1.2. Research Statement

Policymaking in the contemporary world entangles policy stakeholders and the political economy. The economics of health policies are based on ideological values and assumptions. Health policies are not detached from the politics of the policy actors. Current health policies revolve around one of three political assumptions. 1). Health interventions must be private market-oriented where the government has no or little control over health policy matters. 2). Public intervention oriented – a health system and policymaking purely in government control. 3). Modern pluralistic health interventions – a combination of public and private sectors. Modern pluralistic health intervention is now not limited to governments and the private sector. Instead, multi-national organizations have also jumped into the realm of national policymaking. Nevertheless, the base of policymaking for a modern pluralistic health system remains a puzzle. With more policy stakeholders, i.e., international organizations and modern states with differently ambitious federal, provincial, and local governments, policymaking further gets complicated (Rizvi, S. 2020). This research will

[4] As per the PC-1 document of the Sehat Sahulat Program

examine the policymaking processes of the SSP and how providing universal health insurance became a priority in Pakistan. Using the example of the Sehat Sahulat Program, this study will provide insight into the interaction of politics, bureaucracy, and international donor organizations that shapes policy decision-making at different stages of policymaking in Pakistan.

1.3. Research Problem

There is a consensus that public policymaking in the developing is not just influenced merely by concern for public welfare but by the interests of politicians, bureaucracy and international organizations (Wilder, A. 2009). These actors play a vital role in setting policy agendas and formulation. Using the Stage Heuristic Model's theoretical framework, this study attempts to study the policymaking process for health interventions such as the Sehat Sahulat Program. This study intends to study the role of diverse stakeholders at the different stages of the policymaking processes of the Sehat Sahulat Program.

1.4. Research Questions

1. What was the motivation for initiating the Sehat Sahulat Program when the country already has a public health infrastructure?
2. Who were the main stakeholders of the Sehat Sahulat Program policy, and what was their role in operationalizing it?
3. How is this policy being executed? What are monitoring and evaluation mechanisms adopted for compliance? What are the challenges different stakeholders face during the formulation and implementation of this policy?
4. How has this policy impacted the health sector of Pakistan? How sustainable and viable is this policy in the future?

1.5. Research Objectives

The study's objectives are to investigate the Sehat Sahulat Program from each step of the Stage Heuristic Model of policymaking as mentioned below:

1. To investigate the factors that led to the initiation of the Sehat Sahulat Program.
2. To analyze the role played by the stakeholders in the policy formulation of the Sehat Sahulat Program.
3. To understand the implementation process, monitoring and evaluation mechanisms, and how centralized decision-making works around those mechanisms.
4. To examine the efficacy of the program for health sector of Pakistan and to study the impacting factors that lead to the policy revision.

1.6. Explanation of the Key Terms/Concepts

The following are the key terms and concepts in this research:

1.6.1. Policy Actors

These are any individual or group directly or indirectly, formally or informally, affiliated with or affected by the policy process at any stage. A policy actor may directly define policy goals and evaluate possible means to achieve them (Sabatier, 1991).

1.6.2. Stage Heuristic Model

The most common theory explains a policy's endeavors in a complete cycle. This model explains the policymaking cycle from problem identification to policy revision of a specific policy.

However, in some of the literature, problem identification is not considered a separate step and is included in the policy initiation/agenda setting (Sabatier, 1991).

1.6.3. Agenda Setting

It identifies problems that require government attention, deciding which issue deserves the most attention and defining the nature of the problem (Sabatier, 1991).

1.6.4. Policy Initiation

The establishment of an original public law—results when the confluence of problems, possible solutions, and political circumstances leads to the initial development of legislation in the formulation phase (Sabatier, 1991).

1.6.5. Policy Formulation

It is the development of effective and acceptable courses of action for addressing what has been placed on the policy agenda (Sabatier, 1991).

1.6.7. Policy Implementation

It is when action is taken to address a public problem. At this stage, the design of a policy proposal is put into effect, and the policy is implemented by the respective government departments and agencies in conjunction with other organizations, as required (Sabatier, 1991).

1.6.8. Policy Monitoring and Evaluation

Policy monitoring and evaluation (M&E) is critical in effectively designing, implementing, and delivering public policies and services. It ensures that policymaking is informed by sound evidence essential to achieve vital long-term objectives (Sabatier, 1991).

1.6.9. Policy Revision

It refers to bringing changes in policies. This change could be brought either by the inclusion of new laws and regulations or either through the removal of outdated laws and regulations. The purpose of policy revision is either to cater to new needs or to scale up successful policies (Sabatier, 1991).

1.6.10. Universal Health Coverage

All people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care (Universal Health Coverage, 2022).

1.7. Significance of Research

This research study provides insight into the different stages of policymaking and implementation strategies in the provisioning of public health initiatives in Pakistan. Based on the findings and recommendations, it will be helpful for public policy practitioners to understand the role of various stakeholders in developing health policies specifically as well as other kinds of social policies. It will also bring clarity in policy formulation, targeting the right audience, devising effective implementation mechanisms, and developing efficient monitoring and evaluation framework while implementing a health intervention at a larger scale in the future.

1.8. Locale of the Research

This research focused on the role of the federal government in the policymaking and implementation of the SSP policy. As the federal government is implementing the SSP program in ICT, therefore it was found suitable to select the research locale of ICT for a profound understanding of the role played by the federal government.

CHAPTER 2

LITERATURE REVIEW

This chapter comprises a review of the available literature. It discusses different theories of policymaking, various policy analysis frameworks, approaches to health policy analysis, and literature on social health protection policies as well as the stakeholders' role in devising or influencing those policies. This study focuses on the policy process that is often studied less as compared to the impact of a policy. Policy theories and frameworks become relevant to this study as it describes the research gaps and become an avenue of analytical approaches for studying the processes of policymaking. Following are some of the widely used policymaking theories and framework for studying the processes of policymaking.

2.1. Theories of Policymaking

2.1.1. Elite Theory

This theory posits that public policy is, by and large, the reflection of the interests of the ruling elites, and the belief that pluralism is an in-built mechanism for ensuring equity in the share of power and influence is an unrealistic claim. The elite theory has roots in the work of Gaetano Mosca in 1939 (Mosca, 1939). Vilfredo Pareto, and Robert Michels (Obi et al, 2008) were the proponent of this theory and wrote about the role of elites in shaping society and public policy in the early 20th century. The elite group is divided into governing and non-governing ones. People with unique qualities such as skills, material wealth, cunning, and intelligence have the right to govern, while most of the population is destined to be ruled. From the perspective of elite theory, public policy can reflect the values and preferences of a governing elite. The essential argument of elite theory is that public policy is not determined by the demands and actions of the people or

the masses but rather by the ruling elite, whose preferences are carried into effect by political officials and agencies (Anyebe, 2018).

2.1.2. Group Theory

Group theory in public policy refers to the study of how groups, such as interest groups, advocacy groups, and grassroots organizations, influence the development and implementation of public policies. This theory suggests that these groups play a significant role in shaping policy outcomes by providing information, resources, and political pressure to policymakers. Group theory also suggests that these groups can serve as a check on government power by representing the interests of marginalized or underrepresented groups in society. Group theory is a major area of study within the field of public administration and policy analysis. Robert A. Dahl (Dahl, 1974) is considered as the main the proponent of this theory who wrote the book "Who Governs? Democracy and Power in an American City" which examined the role of interest groups in shaping policy outcomes in a local government setting. (Anyebe, 2018).

2.1.3. Systems Theory

David Easton developed this theory in 1953 (Easton, 1965). Per this theory, policies and decisions are implemented in society due to a system of interactions for authoritative allocations. Public policy is the response of the political system arising from its environment. The political system comprises identifiable and interrelated institutions and activities in the society that make authoritative allocations of values (decisions) that are part of the society. This theory is applied in public policy analysis regarding the systems, sub-systems, and external components that impact the system (Anyebe, 2018).

2.1.4. Institutional Theory

According to this theory, institutions' formal and structural aspects can be employed for policy analysis. These institutions include the legislature, executives, and judiciary, and these institutions formulate and execute public policy. The institutional approach concentrates on different aspects of government institutions – the formal structure, legal power, procedural rules, and functions. It also focuses on the relationship between government institutions and other institutions that support, oppose and analyze public policies produced by these institutions. The institutional structure, arrangements, and procedures have essential consequences on policymaking. One of the main proponents of the institutional theory of public policy is John W. Meyer, (Jepperson & Meyer, 2021) who has written extensively on this topic and has argued that policy decisions result from the interaction of various elements within institutions. Meyer's work has had a significant influence on the development of the institutional theory of public policy, which emerged in the late 20th century, and has been influential in the study of organizational behavior and comparative politics (Anyebe, 2018).

2.1.5. Incremental Theory

As per this model, due to a combination of disagreement over objectives and an inadequate knowledge base, it is impossible for most of the issues to adopt rational decision-making. Therefore policies are made through the pluralistic process of mutual adjustments in a policy proposal by multiple participants only incrementally different from the status quo. The main proponent of this policy was Charles E. Lindblom (Lindblom, 1959). He argued that policy decisions are often made through an incremental change in response to specific problems. Policy

changes occur through a gradual accumulation of small changes, which Lindblom called seriality (Hayes, 2017).

2.1.6. Rational Choice Theory

The rational choice theory, also known as social choice theory was developed by economists. The theory has roots in the work of scholars such as Adam Smith (Smith, 1776) who wrote about the role of self-interest in shaping economic decisions in his book "The Wealth of Nations," published in 1776. According to this theory self-interest is a motivating force in politics and policymaking. Rationalists believe in gaining power; political parties act as rational decision-makers seeking to maximize their votes to attain their preferences. The rationalist model aims to improve the public policy-making process to get favorable outcomes. It is considered a helpful tool for policymakers and administrators for policy output analysis. (Anyebe, 2018).

2.2. Policy Analysis Frameworks

2.2.1. The Advocacy Coalition Framework (ACF)

The ACF was developed by Paul A. Sabatier and Hank C. Jenkins-Smith (Sabatier, 1988) in the 1980s and has been applied to various policy issues. It says people engage in politics to turn their beliefs into policy, forming advocacy coalitions with actors who share their beliefs to compete with other coalitions. The action takes place in a subsystem devoted to a specific policy issue and a wider policymaking environment that can influence the dynamics of the subsystem and provide opportunities and constraints for policy actors. The policy process contains multiple actors and levels of government which leads to intensely politicized disputes and policy learnings. Per the ACF, it is crucial to focus on how policy actors simplify and act individually to understand this

complex world by identifying and promoting their beliefs into actual policy, and so do their opponents (Cairney, 2013).

2.2.2. Multiple Streams Framework (MSF)

The MSF was developed by John W. Kingdon in 1985 (King, 1985). It is a tool to understand the policy process, particularly agenda setting, through three separate and parallel processes called streams. These are the problem stream, policies stream, and politics stream. Policy entrepreneurs are the most important actors who develop policy alternatives and couple them to problems. The policy entrepreneurs present a package of problems and solutions to policymakers. The problem is placed on the political agenda if the policy entrepreneur is successful. The policy entrepreneur provides the same package to a different policy problem (Knaggård, 2015).

2.2.3. Punctuated Equilibrium Theory (PET)

PET was developed by political scientists Frank R. Baumgartner and Bryan D. Jones in 1993 (Baumgartner & Jones, 1993) and has been applied to a variety of policy issues. It explains why public policies can be characterized by stability for long periods and punctuated by a short period of radical change. The centrality of this theory is the concepts of the policy image and policy venue. The policy image conceptualizes a given problem and set of solutions. One image may predominate over a long period but may be challenged at particular moments as new understandings of the problem and alternatives come to the scene. The policy venue is the set of actors or institutions that make decisions concerning a particular set of issues. These actors may hold monopoly power but eventually face competition as new actors with alternative policy images gain prominence. When new actors and images emerge, rapid bursts of change are possible. Thus,

the policy process is constituted by stability and change rather than one or the other alone (Walt et al., 2008).

2.2.4. Eugene Bardach's Eightfold Path

Bardach developed the Eightfold Path in 2012 (Eugene Bardach, 2012). It is a framework for analyzing and evaluating policy problems and solutions. It suggests that policy analysts should consider eight key factors when analyzing a policy problem: context, actors, alternatives, trade-offs, communication, implementation, evaluation, and feedback. The Eightfold Path is designed to help policy analysts take a comprehensive and systematic approach to policy analysis and decision-making (Cairney, 2019).

2.3. Health Policy Analysis

Walt and Gilson (1994) stated that while making health policies, proper frameworks and theories are needed to help the policymakers' reform or create better policies for the healthcare sectors to protect the actors per the policy reforms. The motive of the policymakers is to keep the actors alive on the edge so that the policies can be appropriately framed to protect them from any emergent situation or problems. Further, it will benefit the actors to use those policies per their interests. Policymakers must focus on policy analysis, research designs, and theories to make good policies. Policymakers must focus on societal issues and create policies to protect society from those problems. In the healthcare sector of lower income countries, it has been seen that the policies made for the sector are not very fruitful, as these policies are not making favorable results for the actors involved in the policy reforms. (Walt et al., 2008) state that the challenge of health policy analysis is conceptual and measuring levels of resources, values, beliefs, and power of diverse actors are difficult to validate. Also, there remains a tension between the long-term nature of

implementing health policies and the short-term nature of policymakers' demand for quick answers and remedies. The research uses the term ‘curse of the temporal challenge’ for this tension that affects the analysis of a health policy.

The below literature explains the role of policy actors or stakeholders in policymaking process, policy design and implementation processes and policy framework used for policymaking in the health sector and social health protection initiatives in Pakistan and the region.

Multiple studies in the research literature have shown that political actors have a dominant role in the policymaking processes in Pakistan. From agenda-setting/policy initiation to revision of the policy, political actors play a broader role in policymaking. However, the role of other stakeholders, such as bureaucracy, international donors, or interest groups, cannot be ignored. These actors also play a significant role in different phases of the policymaking process.

Haq et al. (2017) studied health policy and planning processes in Pakistan and concluded that political actors dominate decisions that impact all policy aspects, i.e., context, processes, and content. Research is mainly influenced by the priorities of donor agencies—the usual proponents and sponsors of the generation of evidence. The authors find that Pakistan's provinces continue to follow processes as were prevalent before the 2012 devolution of health, with little capacity to generate evidence and incorporate it into health policy. Party manifestos are an indicator of how political priorities and agendas shape policies. The ultimate decision-making lies with the ruling party or cabinet or head of the government at respective administrative levels, i.e., federal, provincial, or district. The usual motivations are how such decisions affect the leader's public image and chances of getting another term in the government. Their research further says that the technical administrative-political nexus of policy is based on ad-hocism and that policies are

finalized in a non-systematic way. There is neither a culture of needs assessments nor one of paying attention to the available evidence. Even the budgetary allocations may not convey the policy intent as the budgets are often revised.

Another study on the impact of political context on the health policy process in Pakistan was conducted by (Khan et al., 2007) concluded that due to frequent changes in government in Pakistan has had a negative influence on the health policy process in Pakistan. Every new government changes the health policy formulated by the previous governments. It means insufficient time is available for any health policy to implement effectively, resulting in wasting resources. The research further elaborated that the frequent changes in government have disturbed health resources and have resulted in a centralized health system either at the federal or provincial levels. This has hindered broader participation and disrupted health policymaking, planning, and implementation levels since the policy planning and formulation by the federal or the provincial governments, do not reflect the health needs of the population at the local level, thus leading to failure of policy implementation. Similarly, Nisa et al. (2021) analyzed the health policy formulation in Pakistan and concluded that planning and policymaking/formulation in the health sector in Pakistan is capable of preparation but not at the execution level. The study recommended formulating and implementing sound, assertive and credible policies.

The influence of external donors on the national health policy processes of Pakistan and Cambodia conducted by Khan et al. (2018) concluded that national structures for decision-making have improved in Cambodia and Pakistan. Nonetheless, frustration with international donors, their ability to influence the policy process through financial means, unequal distribution of expertise, and imbalances in technical and organizational resources for strategic planning persisted with the domestic policymakers. They suggested a truly 'new aid approach' should reconsider not only

macroeconomic aspects, such as financing and lending modalities, but also important issues in the daily practice of donor-recipient relations, including the extent to which local expertise is supported, valued, and involved at all stages in the policy process.

Tarin et al. (2009) researched the policy process for health sector reforms in the Punjab province of Pakistan and concluded that the health sector in Punjab, Pakistan faced many problems and indicated that there were deviations from the government guidelines and that the policy processes used were weak. The progress of other reforms was affected by various factors, such as the immaturity of the political process and civil society, which, together with innate conservatism and resistance to change on the part of the bureaucracy, resulted in weak strategic sectoral leadership and a lack of clear purpose underpinning the reforms. It also resulted in weaknesses in preparing the details of reforms leading to poor implementation. The study suggested a need for broadening the stakeholders' base, building the capacity of policymakers in policy analysis, and strengthening the institutional basis of policymaking bodies.

Policy design and implementation of a health policy is also important aspect of policy analysis. Using different health or social health protection policies literature explains how policy design and implementation of social health protection programs function in Pakistan and the neighboring countries. The Waseela-e-Sehat Scheme was one of the BISP initiatives that aimed to provide health insurance by improving access to health services for poor people. Launched in 2012, the Government of Pakistan and the World Bank were the main financiers of the scheme; GIZ provided technical assistance for designing the program, and the SLIC was tasked to provide health insurance to the beneficiaries. The design of the Sehat Sahulat Program and the Waseela-e-Sehat scheme are identical in manifolds. Khan and Nayab (2016) studied the beneficiaries' experience, satisfaction, and hospital utilization under BISP's Waseela-e-Sehat Scheme and concluded that the

essential socioeconomic characteristics of the poorest segment of Waseela-e-Sehat beneficiaries should be taken into consideration before designing policies and advocacy campaigns. The benefits under the WS scheme are low utilization because of a lack of awareness. Higher reporting of hospitalization of the beneficiaries was due to the financial cushion provided by the WS scheme. The card users were satisfied with the services provided by service providers, while the majority of the complaints were related to assessable distance. The study recommended increasing awareness of the services, enhancing OPD services, empanelling more hospitals, strengthening the BISP institutional structure, the inclusion of chronic/epidemic diseases, and the availability of BISP data. The Sehat Sahulat Program could improve the lacunas in the implementation processes by considering the specified recommendations.

Davari et al. (2012) studied the Iranian health insurance systems and concluded that a wide range of issues had affected the healthcare system's services' efficiency, quality, and equity. The initial and most crucial step toward improving the health insurance system's efficiency, equity, and quality is to focus on evidence-based policymaking to generate feasible, reasonable, and comprehensive reforms. Another study by Banerjee et al. (2021) on the challenges of UHCs faced by the developing countries concluded that social insurance mandates are difficult to enforce in emerging economies. Temporary subsidies attracted lower-cost enrollees, partly by eliminating the practice observed in the no-subsidy group of strategically timing coverage for a few months during health emergencies. Michel, (2020) studied the policy and practice in rolling out UHC in South Africa. His findings revealed five groups of factors that brings policy-practice gaps; (i) Primary factors stemming from a direct lack of a critical component for policy implementation, tangible or intangible (resources, information, motivation, power), (ii) Secondary factors stemming from a lack of efficient processes or systems (budget processes, limited financial

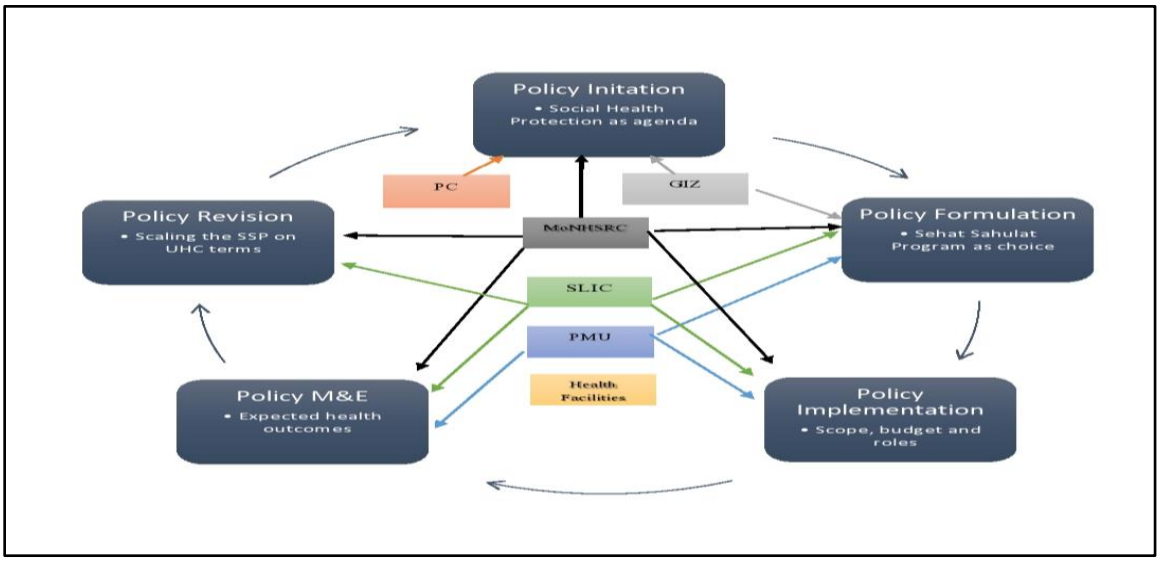
delegations, top-down directives, communication channels, supply chain processes, ineffective supervision, and performance management systems), (iii) Tertiary factors stemming from human factors (perception and cognition) and calculated human responses to a lack of primary, secondary and or extraneous factors, as coping mechanisms (ideal reporting and audit driven compliance with core standards), (iv) Extraneous factors stemming from beyond the health system (national vocational training leading to a national shortage of plumbers) and (v) An overall lack of systems thinking. Nandi (2019) studied the implication of equity, access, and utilization in the state-funded universal insurance scheme in the Chhattisgarh State of India. He argued that although Chhattisgarh has one of the country's highest health insurance enrolment percentages, enrolment was found to be equitable across gender, social groups' economical categories, and geographical areas. However, equitable enrolment did not translate into financial protection, availability of services, and equity in utilization or acceptability of the PFHI scheme. While empanelled public hospitals were spread relatively evenly across the state and catered to the more vulnerable areas and populations, private hospitals were concentrated in the less vulnerable and urban areas. Unequal availability of hospitals under the PFHI scheme led to unequal health service utilization and resource distribution, skewed against the vulnerable areas with the most health and social need. The private sector was many times more expensive than the public sector, and a higher proportion of those using private facilities was incurring more OOP expenditure than those going to the public sector.

Policymaking process is studied through theories and framework. Many of these theories and framework have been explained in Section 2.1 of this study. The Stage Heuristic Model or previously known as the Stage Model is the oldest and the most used framework for public policy analysis. It was introduced by Laswell in 1956 and initially consisted of seven stages. It is

considered the most significant and pioneering theory for public policy studies. This framework is considered significant because it makes the policy-making processes a progressive and well-defined cycle. Over the decades, the utilization of the stage model provided widespread success in social policies such as education, health, and social safety programs in developed and developing countries. Jones, Brewer, and Anderson in 1970, 1974 and 1979 reformulated this framework into five and six different stages/processes. The roles and effects of different policy actors, whether officials, unofficial or international, have brought the Stage Model back to the centrality of policymaking frameworks. Although many new policy analysis approaches have been developed, particularly the Multiple Stream Approach and Advocacy Coalition Framework yet, these approaches do not provide a complete synopsis and insights into the policymaking process. Details and profoundness of these approaches rest in a singularity of a phase, while Stage Model provides a complete, easily applicable, comprehensive, efficient policy analysis of public policymaking (Kulaç & Özgür, 2017).

2.4. Conceptual Framework

Figure 2.1. Diagram of Sehat Sahulat Program Using Stage Heuristic Model



This research employed the Stage Heuristic Model of Policymaking to study the role of different policy actors in policy initiation, policy formulation, policy implementation, policy monitoring, evaluation, and policy revisions of the Sehat Sahulat Program. The above pictograph provides a unidirectional relationship of different policy actors,' i.e., MoNHSRC, PC, SLIC, GIZ, and PMU, in a steps-wise policy framework followed in the Sehat Sahulat Program.

Policy Initiation/Agenda Setting - Political governments, sought to pursue UHC after 2015. Governments at the federal and provincial levels initiated an alternate health financing mode in the form of an SSP policy through the ministries of planning and health services. While this policy strengthens the tertiary health system, it will also secure votes for the party in the elections is how this policy became an agenda for a political government. This explains how a policy initiation/agenda setting relates to a political government's interests.

Policy Formulation - The federal and provincial ministries of health, with the technical assistance of international donor agencies, formulated the SSP policy. The reason for formulating the policy was that, once implemented, it would provide people with adequate health facilities at the tertiary levels. The success of this policy will lead to goodwill for both political governments at the provincial and federal levels, which can be further translated into an electoral means for winning the elections. For international donors, formulating the SSP policy is a means to expand their portfolios in health policies in third-world countries.

Policy Implementation - Successful implementation of SSP at the federal and provincial levels has high stakes for the PMU, SLIC, and health departments. Smooth execution of the SSP policy by the implementing agencies is in their interest to display their skills in implementing mega-budgeted development programs at the federal and provincial levels. Successful execution will entrust the federal and provincial planning bodies to allocate more resources at the disposal of the implementing agencies in the future. This explains the relationship of policy implementation with policy actors.

Monitoring and Evaluation of Policy - MoNHSRC, PMU, and SLIC, as the implementing partners, play an important part in devising monitoring and evaluation systems for measuring the health outcomes of the SSP policy. Better execution leads to better outcomes for the policy. This is possible if an efficient and effective M&E system were in place. It is in the best interest of the above stakeholders to devise an efficient and effective M&E system to achieve the maximum objectives of the policy. Achieving the outcomes will retain the stakeholders as vital institutions in future decision-making for UHC considerations. This explains the relationship between policy M&E and policy actors in the above pictorial format.

Policy Revision - Policy revision is an important aspect of the SSP policy. Stakeholders such as the federal and provincial governments aim to scale up the program across the country. Scaling up the program would yield countrywide access to healthcare security for people. This will show progress in the health sector by the political governments at the federal and provincial levels. Scaling up the program means achieving national and international health ambitions and considerations. This explains how policy revision is related to policy actors.

Using two studies, I explains how exploratory qualitative research design has been used previously for studying health policies particularly the social health protection programs in different part of the world. This shows the suitability of the exploratory qualitative research design I employed for my study.

Study 1: Adams et al. (2019) conducted an exploratory qualitative study in urban Bangladesh to comprehend the underlying motivation and strategies of the private for-profit health sector. Key informant interviews and in-depth interviews were carried out with government officials, private sector managers, and clinic owners in Dhaka, Sylhet, and Khulna cities of Bangladesh. The research argued that the capacity of the public healthcare sector does not meet the growing healthcare demands; therefore, engagement with private for-profit healthcare enterprises can achieve universal health coverage in Bangladesh. With a weak regulatory framework informal private healthcare sector, the engagement of the private sector in UHC must be a gradual process. Improving affordability, accountability and quality must be the cornerstone of private sector engagement for achieving the objectives of UHC in Bangladesh. The merit of using exploratory qualitative research for this study is it focused on both the vertical and the horizontal growth of private sector engagement for achieving the objectives of UHC. It discussed maintaining quality

and accountability along with accessibility while engaging the private sector to improve universal health coverage in urban Bangladesh.

Study 2: Abiiro et al. (2014) conducted qualitative exploratory study on the gaps in universal health coverage in the rural communities of Malawi, Africa. Thematic analysis carried out on the Focus Group Discussion and In-depth Interviews carried out with the rural population of Malawi argues that very little attention was being paid to the rural communities while designing the UHC. The reform adopted a technocratic, top-down approach. The UHC lacked consideration of the local needs. The uneven distribution of health facilities amongst different geographic communities led to the development of a sense of no entitlement for the UHC amongst the rural communities. This study's use of exploratory qualitative research is important because it studied the impression and sense of entitlement of the rural population towards UHC reform. It analyzed the reform developed for the needy is not considered beneficial by the very people.

CHAPTER 3

METHODOLOGY

This chapter discusses the research methodology used for this study. Research methodology is a study to assure valid and stable results that address the aims and objectives of the research. Methodology lays out how researchers articulate research problems and objectives and explore results from the data gathered during the study period (Bryman, 2012).

3.1. Research Strategy

For this research, I used a qualitative research strategy as its purpose is to collect primary data of qualitative nature. Qualitative research is a type of inductive approach that develops findings that were not determined in advance. The researcher collects evidence, and systemically analyzes data to produce new forms of knowledge. Qualitative research also explores research problems or topics from the perspective of the locals involved in the research process. It is especially effective in attaining culturally detailed information regarding values, behaviors, and social contexts of particular population groups (Bryman, 2012).

3.2. Research Design

Exploratory research is defined as research used to investigate a problem that is not clearly defined. It is conducted to understand the existing problem better but cannot be relied upon to determine cause and effect. For such research, a researcher starts with a general idea and uses this research as a medium to identify issues that can be the focus of future research. An important aspect here is that the researcher should be willing to change his/her direction subject to the revelation of new data or insight. Such research is usually carried out when the problem is preliminary (Bryman,

2012). I used exploratory research as a research design for this research. There is less available research on understanding the processes of policymaking in Pakistan. With the help of exploratory research design, it was suitable to understand the policymaking and implementation mechanism of the Sehat Sahulat Program.

3.3. Methods of Data Collection

Semi-structured interviews are the most widely used in qualitative research. Semi-structured interviews function between structured (properly planned) and unstructured (informal and free-flowing) interviews. It is a combination of structured and unstructured interviews. The questions are loosely structured and give interviewees more opportunities to express themselves fully (Bryman, 2012). The purpose of conducting semi-structured interviews in this research is to capture more insights with the UDCs.

I conducted semi-structured interviews to collect the data from the below 6 UDCs.

1. MoNHSRC
2. PC
3. GIZ
4. PMU - SSP
5. SLIC
6. Empanelled public and private hospitals enlisted in SSP

I conducted a telephonic survey for the 7th UDC, i.e., Beneficiaries.

The justification for conducting semi-structured interviews and surveys with the UDCs were;

UDC 1. MoNHSRC – To inquiry the role of this organization in policy formulation, planning, budget allocation, and expenditure of SSP.

UDC 2. PC - To analyze whether the program meets the strategic and broad health objectives and meets the UHC ambitions.

UDC 3. GIZ - For a better understanding of the role of this organization in policy formulation, technical assistance provided to the Sehat Sahulat Program

UDC 4. PMU - For an in-depth analysis of its role in the implementation of the program.

UDC 5. SLIC - For a better understanding of the role of this organization in actuarial matters, premium setting, and benefits.

UDC 6. Panel Hospitals - To deeply study the prospects and drawbacks of the program for hospitals in both public and private sectors.

UDC 7. Beneficiaries - To better analyze the easiness of application processes, beneficiaries' satisfaction, and utilization of the Sehat Sahulat Cards at public and private penal tertiary health units.

3.4. Procedure of Data Collection

The data collection process started after identifying the program's stakeholders. I contacted officials of these stakeholders. The interview date and times were finalized at the convenience of the interviewees. I conducted 30- 40 minute long semi-structured interviews with the interviewees. Interviews were conducted in both English and Urdu languages. Before starting the interview, I informed the interviewees that I would ask questions in English. As per their discretion, they could answer their preferred language. The verbatim of the Urdu interviews were translated into Roman English version of Urdu and later translated into the English language using back translation method (Ozolin et al., 2020). Before the interviews, I took verbal consent from the interviewees to mention their details such as name, designation, and organization in the thesis (Table 3.1) and use their statements in the form of quotes in the analysis part of the research. The interview was audio recorded, translated or transcribed. A total of 12503 words after the translation and transcription

of the interviews were formed. I manually developed codes for themes and sub-themes using the interview data. The data of 100 beneficiaries were randomly selected from the first quarter of 2021 from the CMIS at the SSP-PMU. Each beneficiary was contacted, and the questionnaire designed for the beneficiaries was filled out via phone call.

Table 3.1 Respondents Details

S.No	Name of Interviewee	Designation	Organization
1	Dr. Muhammad Asif	Chief Health	PC – MoPDSI
2	Dr. Murtaza Haider	Assistant Chief Health	PC – MoPDSI
3	Muhammad Ali Kamal	Chief SDGs	PC – MoPDSI
4	Mr. Muhammad Arshad Qaimkhani	Chief Executive Officer (CEO)	PMU - SSP
5	Mr. Zohair Ihsan	Deputy Director (MIS)	PMU - SSP
6	Mr. Muhammad Ashar	Regional Chief (H&AI)	SLIC
7	Dr. Taimur Khan	District Medical Officer	SLIC
8	Mr. Inam ul Haq	DG Development	MoNHSRC
9	Dr. Malik Safi	DG Health + UHC Advisor	MoNHSRC
10	Mr. Muhammad Uzair Afzal	Technical Advisor SP-SHP	GIZ Pakistan
11	Dr. Iftikhar Burney	Deputy MS	Riphah International Hospital, Islamabad
12	Mr. Inayatullah Khan	Manager Administration and Finance	Al-Khidmat Raazi Hospital, Islamabad
13	Dr. Erum Naveed	Director Indoors	PIMS

3.5. Sampling

Purposive sampling (also known as judgment, selective or subjective sampling) is a technique in which the researcher relies on his or her judgment when choosing members of a population to participate in the study. Purposive sampling is a non-probability sampling method, and it occurs when elements selected for the sample are chosen by the researcher's judgment (Bryman, 2012).

I used Purposive (Non-probabilistic) sampling for below 6 out of 7 UDCs i.e, MoNHSRC, PC, GIZ, PMU - SSP, SLIC, and empaneled hospitals enlisted in SSP. For UDC 7, i.e., Beneficiaries, I employed simple random sampling to study the context of beneficiaries.

3.6. Analysis

Thematic analysis is used in qualitative research and focuses on examining themes or patterns of meaning within data. The thematic analysis explores explicit and implicit meanings within the data making it a suitable approach to qualitative data analysis for understanding opinions, themes, and views using interviews, focus groups, surveys, and field research. Framework analysis is a suitable tool for understanding applied policy research and will be used as a tool for this analysis in this research. Framework analysis provides a more step-by-step approach (Bryman, 2012).

I employed thematic analysis as a qualitative data analysis approach and framework approach as a data analysis tool for six out of seven UDCs. The expert opinions, themes, and views were inferred and analyzed using the thematic and framework approach.

I conducted descriptive analysis for the 7^{th} UDC of this research, i.e., Beneficiaries. Descriptive statistical analysis was applied to collect information on the easiness of application processes, utilization, and satisfaction of the Sehat Sahulat Cards and health facilities the program's beneficiaries underwent for treatment.

CHAPTER 4

FINDINGS AND DISCUSSION

This chapter discusses the findings of this research study. A total of seven themes and eleven sub-themes emerged from the thematic analysis of the data. The research questions stated earlier are addressed within these themes and sub-themes that emerged from interviews with stakeholders involved in the policymaking and implementation of the Sehat Sahulat Program. This chapter also discusses the survey findings conducted with beneficiaries of the program.

Table 4.1 Themes and Sub Themes

Themes	**Sub Themes**
Theme 1: Inadequacy of Existing Public Health Sector	1. No Legal Cover for the SSP Policy 2. Social Development a Priority of Policymakers 3. The Debate of Privatizing Public Health
Theme 2: Non- Conflicting Policy with Devolution	1.Sindh Stance on the SSP Policy
Theme 3: Strategic and Operational Planning for SSP Policy	1.Donar-Assisted Policy 2.Developing Capacity of Stakeholders to Implement SSP Policy
Theme 4: Integrated Operation of the SSP Policy	1.SLIC's Hold on the Insurance of SSP Policy 2.Operational Challenges of SSP Policy
Theme 5: Multi-Monitoring &Evaluation of SSP Policy	NA
Theme 6: Unstainable Program Model	NA
Theme 7: From Supply Side to Demand-Driven Policy	1.Incentivizing the Private Sector 2.Insignificant Impact on the Public Health Sector 3.Inconsiderable Impact of SSP in achieving UHC Milestones

The first research question intents to understand the motivation for initiating the Sehat Sahulat Program with an existing public health infrastructure in the country. Following themes and sub-themes emerged out as a result of it.

4.1. Theme 1: Inadequacy of Existing Public Health Sector

Various approaches to health care provision have been undertaken within the public health sector in Pakistan. Before the 70s, primary dispensaries and hospitals were the government's focus. In 1978, after the Alma Ata Declaration, the government of Pakistan initiated health systems like BHUs, RHCs, THQs, DHQs, and vertical programs. In the 90s, the government launched the LHV Program to address the issues of family planning and child health. From 2000 onwards, the public health sector brought public-private partnership models into the country's public health domain to reinforce the public health sector.

The first theme that emerged in response to the question of the motivation for initiating the Sehat Sahulat Program was the inadequacy of the existing public health sector in the country. It was reported that the current health system is broken and does not yield results in dealing with the exacerbated health issues in Pakistan. Successive governments initiated different approaches to public health. Nevertheless, most people in the country prefer private health facilities over public health facilities. To deal with these issues, the federal government, in 2015, attempted to help the country's vulnerable population through an alternative financing mechanism. The Sehat Sahulat Program was initiated to help the vulnerable population i.e. earning below $2.00 a day or with a PMT score of 32.5 as per BISP data with the modality that the government would pay premiums to the insurance companies on behalf of the beneficiaries according to the set eligibility criteria. Dr. Muhammad Asif, the Chief Health at the PC, made the following comments when asked about the need for Sehat Sahulat Program policy:

"The traditional system over the years was not yielding the results hoped for due to weaknesses and gaps; therefore, it was considered to take up the issue of out-of-pocket expenditures of vulnerable people."

MoNHSRC officials also indicate that the state focused on the curative side and neglected primary healthcare. As a result, 70 to 80 percent of the total budget is spent on the curative side, and less is spent on primary health care. Respondents from PMU, PC and MoNHSRC consider the Sehat Sahulat Program another effort by the federal and provincial governments to provide tertiary healthcare to the vulnerable segment of the country through health insurance mode. Dr. Malik Safi, who remained the Director General of Health and is also a UHC expert at MoNHSRC, believes:

"The government in 2015 took up this program, and it was initiated in most parts of the country; the political stakeholders supported it as it was beneficial for their political slogans and because the people living below the poverty line got easy access to hospitals."

Officials at the PC also explains that the existence of public health infrastructure in the country does not necessarily mean that the government cannot take other initiatives to reduce catastrophic expenses. They believe most people do not have confidence in the public health infrastructure; they prefer to visit private hospitals instead of public sector health facilities. The priority of an ordinary man is to avail of the services of the private health sector. However, the cost may exceed the buying power, resulting in an increasingly catastrophic expenditure. The Sehat Sahulat Program has enabled the lower segment of the population to access the services of the private health sector without accruing catastrophic expenditure. Data gathered from the interviews with PC, MoNHSRC officials claim that the public sector covers around 25 to 30 percent of the health needs, and the remaining are covered by the private sector, increasing out-of-pocket expenditure. The main reason for bringing this policy is to even out the difference between the public and private sectors. Commenting on the question regarding the initiation of the Sehat Sahulat Program, Mr. Muhammad Arshad, the CEO of the Sehat Sahulat Program, said:

"This Program has, in a way, enabled this segment of the population to access the services of the private health sector without having catastrophic expenditure. This Program has also encouraged the private sector to expand their services and paved the way for a public-private partnership."

Interviews with SSP stakeholders concluded that this Program was initiated to deal with the inadequacy issues of the public health sector - improving access to healthcare facilities, improving the quality of services, and providing financial protection to the lower strata of the population. However, significant policy gaps exist in initiating the Sehat Sahulat Program. Respondents from PC pointed out that there needs to be a distinct institutional policy and a legislative framework that must define the criteria of affordability and payment of premiums. They cited that universal access to the Sehat Sahulat Program for beneficiaries makes it undesirable and costly. They also pointed out that the employees of federal and provincial governments and the armed forces are already entitled to different social health security schemes also enjoy the benefits of the Sehat Sahulat Programs. This leads to problems such as fragmentation of social health security services and duplication of expenses the government accrues on social health safety programs across the country.

4.1.1 No Legal Cover for the SSP Policy

Aligned with the initiation of the Sehat Sahulat Program, I asked about the legal cover for the Sehat Sahulat Program policy. It was reported that unlike the BISP, no legislation had passed for this program. Respondents from PC and MoNHSRC gave the reason that political governments did not resist starting the program because it has political advantages for political governments. So going into the complication of legislative procedures or regulatory compliance would have delayed the implementation. Therefore, the government started the Sehat Sahulat Program in a

project mode under the PSDP for five years. Respondents from the PC also believed that a legally binding program was not necessary since this program was approved by the highest approval authority, i.e., NEC, which is chaired by the Prime Minister. Also, for the PSDP-run projects, legal bindings are not necessarily required. However, they suggested that the SSP policy must be legally bound for sustainability and futuristic aspirations. Mr. Inam ul Haq, the DG of Development at the MoNHSRC, commented on this program's legal cover:

"In the future, some sort of legislation will be needed to make it an autonomous body or if the program's modus operandi is changed."

4.1.2. Social Development a Priority of Policymakers

A sub-theme that came out from the question of motivation for initiating the Sehat Sahulat Program was about the perception that the policymakers in Pakistan are generally resistant towards social development programs and more inclined towards infrastructural development projects. Government officials at PC, MoNHSRC and PMU disagreed with the perception that social policy issues are not worthy of national priority. Further, they said this perception is vaguely used by public intellectuals but in reality every sector is important from the government's view. They reported that social policy matters are devolved subjects after the 18th Amendment and as a result the federal government's sphere in the social policy domain was majorly curtailed after the devolution of ministries and departments to the provinces after the said amendment. While the implementation of social development projects falls under the ambit of the provincial government, the federal government plays its due role in regulating and coordinating such projects and programs across provinces. It was reported that priorities in the government are set on a need basis, primarily through public demands across sectors. Every sector has a proportion of defined resources for social development. However, the interview data suggest that suitable approaches

for social development projects should be used, such as projects that must be aligned with our national development discourse with a vibrant policy framework considering the benefits and costs. Chief Health at the Planning Commission commented on this question:

> *"There is no resistance. I would not call it resistance but rather an absence of a policy framework. Unfortunately, we go into ventures without a vibrant policy framework.*"

4.1.3. The Debate of Privatizing Public Health

Another sub-theme that emerges from the motivation of this program is privatizing public health. I inferred from the interview with SSP stakeholders that the respondents were divided into points of view on this debate. While most of the respondents agreed that the insurance-based model of the Sehat Sahulat Program is an appropriate way of dealing with public health issues in the country because the existing public infrastructure is overburdened and unsustainable for the future generation. The proponent of the insurance-based model argued that bringing the private sector into the public health domain is imperative to enhance competition, bring efficiency, and improve outreach. Incentivizing the private sector would further swing the private sector into the public health domain. The proponents of the Sehat Sahulat Program argued that the insurance-based model had improved health facilities' outreach issues. Access to quality health in rural areas, semi-urban areas, and for people of lower strata of the population has enhanced after the initiation of the Sehat Sahulat Program. On the contrary, opponents of the Sehat Sahulat Program policy argued that big cities do not have access to health issues. The major problem in big cities is the overburdening of public health facilities. The state has developed health infrastructure across the country, and the issue lies in the quality of health services and overall management. Opponents also believe that the existing model of the Sehat Sahulat focuses entirely on tertiary and curative

care, leaving the component of primary health care. Dr. Iftikhar Burney the Deputy MS at the Riphah International Hospital, Islamabad, commented in this regard:

"*I am not in favor of such programs. Instead of handing it over to an insurance company, the government should invest in public hospitals and provide quality service so that people visit public hospitals rather than private hospitals. The private hospitals have already seen an increase in patients visiting their facility."*

Officials that expressed reservations against SSP further claimed that health is a fundamental right of every citizen, and it is the primary responsibility of the government to provide better health facilities. Opponents believed public hospitals should be upgraded and improved and more hospitals should be built throughout the country. The government needs to increase the health budget and ensure that the resources are utilized properly and transparently. The opponents of the Sehat Sahulat Program called for using a trickle-up approach to improve the public health - starting from BHU to tertiary care.

4.2. Theme 2: Non-Conflicting Policy with Devolution

The 18th constitutional amendment has allowed provincial governments to design social policies according to local needs and choices. However, the federal and provincial governments sometimes disagree on the approach to adopting those policies. I intended to know whether the Sehat Sahulat Program affected the essence of the devolution of health policymaking.

It was reported that the constitution does not bar the federal government from initiating a program in any part of the country. Although it is the responsibility of the provincial government to design and implement health policies for their provinces, the provinces can make policies with aligned national priorities and set guidelines from the federal government. All interview respondents

favored the devolution of power. It has enhanced development and increases the capacity for effective policymaking after the 18th amendment empowered the provincial governments. However, respondents believes it should have been done so that the process and impact of devolution must reach down to the district and union levels where the actual need is. Interview data with SSP stakeholders suggested that the SSP policy is aligned with the aspirations of the 18th amendment. The modus operandi of the Program is that the federal government only supports a specific tertiary care component. The provinces will support primary and secondary care; tertiary care will be devolved later. The federal government now only supports the federal areas, i.e., ICT, AJK, and GB, while the provincial governments fully finance secondary and tertiary care.

For this purpose, the federal government constituted a steering committee that represented all provinces, and the federal government restricted its role coordination among the stakeholders, including the provinces. Resources and operation of the program rest with the provinces. Punjab and KP governments are implementing SSP policies utilizing their resources. The federal government implements the policy in AJK, GB, and ICT. Sindh opted out of the SSP policy, and Balochistan is preparing its health protection policy. Mr. Muhammad Arshad, the CEO of the Sehat Sahulat Program, considers health insurance a new concept and a 'grey area' between federal and provincial policymaking. He believes provincial governments have lesser technical skills and exposure than the federal government to the newly introduced concept of health insurance, so it became necessary for the federal government to participate in the policymaking process. He stated:

"After the 18th amendment, health is a provincial subject, but health insurance is a new subject not only for the federal government but also for the provincial governments where technical resources are scarce. On a more technical basis, insurance is a federal subject, and health is a provincial subject, so health insurance is a gray area. So it was necessary to involve the federal

government as well, and we convinced our provincial partners and the participating provincial governments to work with us."

4.2.1. Sindh's Stance on the SSP Policy

Regarding the second theme, I asked the interviewees their opinion about the Government of Sindh's decision of not implementing the Sehat Sahulat Program in the Sindh province and the reasons behind the GoS decision on the SSP policy. The data gathered from the interviews suggest that GoS had an existing health protection policy for tertiary healthcare. Unlike the SSP, this program is not an insurance-based social health safety but based on a public-private partnership model at the tertiary level of healthcare. GoS provides annual budgets to different health networks and charitable organizations operating at the tertiary level of care; these private hospitals provide free and specialized services to people of the province using the taxpayer's money. Respondents claimed that the public-private partnership model at the tertiary healthcare level by the GoS is another way of bringing efficiency to the public sector. Respondents suggested that both models must be studied from the perspective of cost, impact, and sustainability before adopting a model. Dr. Murtaza Haider, the Assistant Chief of Health at the PC, made the following comments on the decision of GoS regarding the Sehat Sahulat Program:

"Initially, the province of Sindh was also part of this program but then realized that they could formulate their program, the nature of that program will be the same, which is to provide people with health protection, but the formulation and implementation will be different."

The second research question discusses the stakeholders of the Sehat Sahulat Program policy and their role in the operationalization of this policy. To understand the role of different stakeholders that were directly involved in the policymaking and implementation of the SSP policy, I conducted

interviews with the officials of PC-MoPSI, MoNHSRC, PMU, GIZ, SLIC and empanelled hospitals. Following themes and sub-themes emerged out as a result of this:

4.3. Theme 3: Strategic and Operational Planning for SSP Policy

The third theme that emerged out of the interviews with the stakeholders was strategic and operational planning for policymaking. Interview data with stakeholders infer that policymaking and implementation are carried out at two levels in Pakistan's public sector organizations, i.e., strategic and operational planning. At the strategic level, a policy is overviewed from a broader perspective, such as inquiring whether the policy under consideration is aligned with the national goals, whether it will be able to meet the objectives of national ambitions and international obligation of development, and will this policy cause an impact on the overall situation in the country. Operational planning primarily deals with the operational side of the policy. It focuses on how a policy under consideration will be implemented and executed. It assigns roles and tasks to partners and collaborators. Operational planning also focuses on service delivery and monitoring results. From the interview data, I inferred that some stakeholders were part of the strategic planning while some were part of operational planning, and few were involved at both levels.

PC is the apex planning and development organization of Pakistan. It defines the national vision, undertakes national strategic planning, and forms a broad policy framework for every sector, whether it is the social sector, infrastructure sector, or inter-sectoral. The Planning Commission oversees the Sehat Sahulat Program's long-term vision, policy framework, and strategic planning. Dr. Muratza Haider, Assistant Chief Health at the Planning Commission, commented on the role of the Planning Commission in the Sehat Sahulat Program in the following way:

"For the Sehat Sahulat Program, we get a PC-1, scrutinize this PC-1, analyze it and identify any shortfall, and then send it back to the sponsors and ask them to modify it. After it has been

modified and appropriated by the sponsors, we send it to a forum called the CDWP. When they approve this project, it comes out as a policy document. So in this way, the ministry of planning, or as it is usually known, the planning commission has a direct and indirect role in the policy framework."

MoNHSRC is primarily involved in the strategic planning of health policies. It is the initiator of the Sehat Sahulat Program. This ministry provides the overall policy directions to the SSP. It develops a consensus between the federal and provincial governments, defines roles for departments, makes modalities for public and private health facilities, monitors the service provider's service delivery, liaison with donor agencies, and coordinates with the PMU. Mr. Inam ul Haq, the DG Development at MoNHSRC, made the following comment on the role of his ministry in the Sehat Sahulat Program:

"MoNHSRC is only involved at the policymaking level; we allocate funds, we monitor the Program, and for any directional change in the policy or anything related to the policy of this Program, MoNHSRC is involved. The implementation rests with the PMU of the Sehat Sahulat Program."

PMU is an independently functioning entity under the MoNHSRC. It is responsible for the operational planning and implementation of the Sehat Sahulat Program in the country. A CEO heads it, and the unit at the federal level oversees the SSP in ICT areas, while the regional PMU looks after the provincial SSP. It is responsible for executing the SSP policy in the empanelled hospitals, achieving the project outcomes, monitoring, and tracking targets, and liaising with the insurance company, NADRA, development partners, and line ministries. I inferred from the data that PMU has a more operational planning role than strategic level planning. Speaking on the part of PMU, Mr. Muhammad Arshad, CEO of the Sehat Sahulat Program, said:

"We are the key organization in the policy-making of Social Health Protection, and we decide matters regarding social health protection and social insurance protection in Pakistan."

GIZ is a German-based development organization. It is a major socioeconomic development partner of the Government of Pakistan. It has provided technical assistance to the health sector for the past 15 years. Hence, it has specific expertise in the health insurance sector. It only provides technical assistance to the Sehat Sahulat Program and has no financial involvement in the program. GIZ has been investing in the capacity building of medical and non-medical human resource of the Sehat Sahulat Program through its component called SP-SHP since the first phase started in 2015. Mr. Muhammad Uzair Afzal, who is a Technical Advisor for SP-SHP at GIZ, made the following comment when asked about GIZ's role in the Sehat Sahulat Program:

"We have constantly been working with our partners to enhance the capacity of the runners of this program, and we have taken different measures like training for the staff of this program."

SLIC is another important stakeholder of the Sehat Sahulat Program. All insurance-related operations are carried through SLIC. Data gathered from an interview with a SLIC official infers the major functions of SLIC in the Sehat Sahulat Program are actuarial in nature and monitoring the overall processes. SLIC devised strategies such as setting health benefits, setting insurance premiums for beneficiaries, setting standards and protocols for hospitals, empanelment of hospitals, and ensuring compliance of these health facilities. SLIC looks after the insurance claims from health facilities against health procedures conducted with beneficiaries. Mr. Muhammad Ashar, the Regional Chief of H&AI at SLIC, commented when asked about the role of SLIC in SSP:

"We currently provide actuarial and monitoring services for the Sehat Sahulat Program at the federal and provincial levels. When this program went universal, we were in phase 3 in Punjab. Within two and a half months, we met the target and made the necessary arrangements, which is a testimonial of our capacity."

4.3.1. Donor-Assisted Policy

One of the major criticisms by academicians and policy analysts about policymaking in Pakistan is that donor agencies influence the government in priority setting and policy formulation, which do not work in the context of Pakistan or are unsustainable in the long run. One of the sub-themes that emerged from asking about the role of stakeholders in the Sehat Sahulat Program was donor-assisted policy. The data gathered from the interview with SSP stakeholders tells us that donor agencies are involved in social policy issues such as health and education, but provide primarily technical assistance. Respondents of the interview agreed that there is donor involvement in policymaking, especially during the formulation stage. However, respondents also said it happens when the government puts forward a demand to donors when the government lacks sufficient funds or inadequate human resources for specific policymaking. Officials at PC, and MoNHSRC agreed that donor agencies provide assistance in financial or technical ways. In the case of the Sehat Sahulat Program, development partners such as GIZ and WHO played a key role in enhancing the capacity of human resources and the initial design of the program. Dr. Muhammad Asif, Chief of Health at the PC, made the following comment when asked about the role of donor agencies in the policymaking of SSP:

"At the moment, donor involvement is confined within KP province, where they support 4 districts; otherwise, this program is public sector funding. However, I have frequently seen that

when these donor agencies bring in investment in the form of a loan or grant, it is usually tied with some of their own aspirants, which does not reflect on the indigenous issues."

Data gathered from the interviews with SSP stakeholders tell us that the initial design of any project is primarily demand-driven. Constituents put their demands to the political representative of their constituencies. The political representative then puts these demands to the concerned ministry to take up that demand at the federal or provincial level. The ministry came up with an initial design called a project document. Later this document is shared with the line departments and ministries for input and opened for legislation if required. Regarding the initiation of the SSP policy, respondents said this program is unlike the conventional method of initiating projects or programs. Although better management and equipped public health facilities have always been a general demand, there was no such request for health insurance in the country. The initial design for initiating health-based insurance at scale was the idea of the ministry of health, and other technical partners such as GIZ, WHO, and SLIC played a key role in the initial design of this program. This proves under certain circumstances, non-governmental organization influences the priority setting and formulation of policies. Mr. Muhammad Arshad, CEO of the Sehat Sahulat Program, made the following comments when asked about the demand for SSP Policy:

"The idea that the catastrophic health care expenditure of the segment below the poverty line should be minimized was presented by the then prime minister, and at the provincial level by the chief minister of KPK, so we consulted with the stakeholders and different quarters of the government to introduce this policy, and it did not take us much to convince them to adopt this policy."

4.3.2. Developing Capacity of Stakeholders to Implement SSP Policy

Another sub-theme that emerged while asking about the role of stakeholders of the Sehat Sahulat Program and their roles in operationalizing this policy was the developing capacity of governments to implement the program. Most of the respondents agreed that the government at the federal and provincial levels has enhanced the ability to implement the program at scale. However, respondents believed that the capacities of provincial governments may vary. Respondents said KP, Punjab, and Sindh provinces had built their capacity to implement the programs over time. In the case of Balochistan and some of the federal areas, such as AJK and GB, are catching up. The agreed implementation strategy was that the federal and provincial governments would collectively support this program so that the provinces could also take ownership. Once the provinces develop their capacities, the federal government will withdraw its support. So far, the provinces of KP, Punjab, and Sindh have become self-sufficient, but the province of Balochistan cannot meet the required target. As a result, the federal government was helping Balochistan, but it remained unsustainable, so Balochistan had to opt out of the program. There has been a consultation between the federal government and Balochistan on how they can move forward with this program. The federal government is willing to support the marginalized areas of Balochistan. Still, there is a need to enhance the capacity building of the province so that it can self-sufficiently support this program. Responding to the capacity of the provinces, Dr. Murtaza Haider, Assistant Chief at the PC, said:

"After the 18th amendment was passed, provincial governments lacked the capacity to implement such programs, let alone a health insurance program of this caliber. Gradually the provinces have developed their capacity, but the federal government is still the main party in implementing such programs."

Regarding the resources dedicated to implementing the Sehat Sahulat Program, it was reported the federal government is utilizing its resources in the federal territories, i.e., AJK, GB, and ICT. While the provincial governments are fully funding their share of the business. The federal government is implementing the SSP for a 5 year-long project through its PSDP. The federal government supports this program through yearly ADP in AJK and GB. In the case of the province of KP, a donor agency is also providing assistance, but that is confined to 4 districts of the province, which will be winding up soon. The government of KP is keen to make this program universal. Initially, this program's main focus was people living below the poverty line. Now the province of KP aims to change the program status from social health protection program to a UHC component.

The federal and provincial governments have deployed different courses for implementing the Sehat Sahulat Program. The federal government has developed Program Management Units at the federal and regional levels. At the provincial level, the KP government has created a health insurance cell within the health department. The province of Punjab has developed an independent company called PHIMC to implement the program in the province.

The third research question deals with executing the Sehat Sahulat Program policy, monitoring, and evaluation mechanisms adopted for compliance. It also discusses some of the challenges stakeholders face while implementing this policy.

4.4. Theme 4: Integrated Operation of the SSP Policy

While conducting interviews with the different stakeholders, I learned that this policy's implementation is multifaceted and integrated. The primary stakeholders involved in the implementation of this policy are PMU, NADRA, SLIC, the district health department, and empanelled hospitals are working in collaboration. The fourth theme that emerged from the

interview data was an integrated operation of the Sehat Sahulat Program. The arrangement of the program is in such a way that the PMU looks after the day-to-day affairs of the program. NARDA looks after the data and verification processes of beneficiaries and their families. SLIC is responsible for empanelment hospitals, enrollment, benefits, claims, and dealing with customers' grievances. PMU, SLIC, and the district health department have constituted teams that work in coordination for this program.

The interview data explain the process of initiating the empanelment of hospitals. SLIC manages an online portal on which a hospital can apply for empanelment. The shortlisting criteria consist of 8 to 10 questions for the health facility's initial inquiry. Health facilities also provide pictorial evidence of the facility for the initial inquiry. Shortlisted health facilities are surveyed by a team of SLIC and health department officials for a detailed survey. SLIC has a standard empanelment criterion that consists of 400 questions that enquire about the emergency services, the wards, the faculty, the area covered, and the general management of the hospital. These 400 questions have 1000 points, and based on that, numbers are allotted to the hospital. Hospitals are into 5 categories. If a hospital scores high points, it is assigned to the A category, those low-scoring points are then assigned to B, C, or D categories, and the lowest rated are assigned to the E category. Based on these categories, the treatment rates are determined for the hospitals - A being the highest and E being the lowest. This mechanism is devised for private health facilities; the process is slightly changed for public health facilities.

Mr. Muhammad Arshad, CEO of the Sehat Sahulat Program, made the following comment when asked about the empanelment policy of the program:

"There are various factors that are taken into view before empaneling any hospital, such as the population of a specific area, the number of empaneled hospitals in a specific area, whether a

new hospital is needed to be empaneled or not in that specific area, given the population in that area."

For the admission of beneficiaries for treatment, the NADRA data is used. Every empanelled hospital has a designated desk, commonly called the Sehat Sahulat desk, to authenticate beneficiaries' data and provide relevant information to the citizens. Beneficiaries entitled to treatment are cleared from the SSP desk at the empanelled hospitals after verification of CNIC by the NADRA system.

The interview data also tells us the SSP desks situated at the empanelled hospital are used for complaints and redressal purposes. Besides this, SLIC has designated 2 toll-free numbers for the complaints mechanism. People can lodge their complaints on these toll-free numbers too. Once the complaint is lodged, an SMS alert is generated, which is received by both the beneficiary and the SLIC team, then referred to the concerned DMO, who is the designated personnel of SLIC and is responsible for resolving issues in a maximum of 3 days' time. Mr. Muhammad Ashar, the Regional Chief of H&AI at SLIC, claimed the majority of the issues are resolved within a day.

I also asked about the reports in media and social media about the abuse of funds and extra insurance claims by the hospital, especially by private hospitals. Mr. Zohair Ihsan, the Deputy Director of MIS at the PMU, rebutted these reports in the following way:

"Actually, when a hospital comes on our panel, they have an agreement with the insurance company that pre-defines the amount the hospital will charge for specific treatments. They are not allowed to exceed that. This package is also shared with all the concerned stakeholders. So there is a misconception regarding this."

4.4.1. SLIC's Hold on the Insurance of SSP Policy

SLIC is the major implementing partner of the Sehat Sahulat Program. One sub-theme that emerged from the interview data was SLIC's hold on the insurance of SSP. The data gathered from SSP stakeholder's interviews tell us that insurance companies must go through a bidding process to join the SSP. Competitors are analyzed based on their technical and financial capabilities. SLIC consecutively won thrice the bidding process in 2015 2019 and 2021 for Phase 1, 2 and 3 of the program.

Interview with SLIC official suggests a few reasons for the edge of SLIC. Firstly, competitors have come up with their insurance model, and SLIC's model was considered the best compared to other competitors. Muhammad Ashar, the Regional Chief of H&AI, claim SLIC has three levels of human resources for better management. 1- Trained health facilitators in every facility. 2- DMO for monitoring and compliance at the district level. 3- PMO who heads compliance at the provincial level. Secondly, the empanelment model of the competitors is reviewed during bidding. SLIC's empanelment mechanism of health facilities is extensive and at par with international standards. Thirdly, the financial capacity of the insurance has to be considered. The government ensures that the insurance company cannot face a liquidity crisis. Muhammad Ashar, the Regional Chief of H&AI at SLIC, commented when asked about the financial capacity of SLIC:

"With a market value of around 3 trillion, State Life has established itself as a trustworthy partner. Another advantage that State Life has is the experience that we have gained over the years through this program, and through that experience and lessons learned, we have solidified our position."

4.4.2. Operational Challenges of SSP Policy

Another sub-theme that emerged from the interview data is operational challenges while implementing the program. Most of the respondents were of the view that, currently, the program does not face any significant strategic challenges. Most of the challenges are operational and related to the day-to-day affairs of the program. It was found that the significant operational challenge was the empanelment of hospitals on the subsidized rates for treatment. The rates the program sets are subsidized and not market-based. Hospitals claim loss while treating patients at these rates. Another operational challenge is the treatment of patients within the program's primary and secondary insurance packages. Complex treatments exhaust the insurance coverage of the beneficiaries. Respondents also said that hospitals share false data and use dishonest means by filing medical tests for treatment to extract more money which is unnecessary and an abuse of funds. Respondents believed that by expanding the program, the program is witnessing significant issues of quality control and gatekeeping. Some health facilities side-step checks and balances. Another problem that was identified was the capacity issues at different levels of implementation. The capacity of health facilitators at the health facilities is not at par with the program's standards. When asked about the implementation challenges, Mr. Muhammad Arshad, CEO of the Sehat Sahulat Program, commented:

"We face no strategic challenges, but operational challenges are there, and we resolve them. In the beginning, of course, there were challenges, but with the passage of time and the continuous consultations and evaluation of the program, we were able to face those challenges."

Most respondents suggested that a health commission should be established consisting of different health bodies and regulatory bodies to enhance the quality of services. The hospitals involved in malpractice or abuse of funds should be checked and penalized. Data gathered from the

stakeholder's interview suggested further decentralization of the program. The administration should be devolved further to the tehsil level to bring efficiency and transparency to the program's implementation.

I also asked about the non-inclusion of OPD services in the SSP policy. Most respondents believed the reason for not including OPD services in the SSP would make the program more costly and resource constraints.

4.5. Theme 5: Multi-Monitoring & Evaluation of SSP Policy

M&E is a vital component of projects and programs. Monitoring reports about the day-to-day progress of the intervention followed processes and outputs these interventions produce. Evaluation, on the other side, provides a detailed inquiry into the long-term objectives and goals of the program. The fifth theme that emerged from the question related to implementation was the multi-monitoring & evaluation of the program. The purpose for calling it a multi-monitoring mechanism is because the program employs multiple approaches of monitoring, i.e., technology-based and physical intervention monitoring.

The Sehat Sahulat Program is technologically monitored through a central data repository called the CMIS with a centralized database to collect information on enrollment, complaint redressal, health-service usage patterns, claims data, customer grievances, and any related information regarding the delivery of benefits. CMIS provides real-time information on enrollment, claims, treatments, hospitalization, and other indicators for which the insurance company provides data through Web API. The CMIS also prepares citizen data of the beneficiaries and their families and shares it with the insurance company through Web API. It also provides biometric citizen verification service as Web API for biometric verification of Program beneficiaries. Stakeholders

such as MoNHSRC, PMU, SLIC, and NADRA digitally monitor the interventions taking place in the program across the country. The Sehat Sahulat desks are the primary monitoring units located at every empanelled hospital and are the main source of data collection and dissemination. The data received from Sehat Sahulat desks are cross-checked for data accuracy from two sources, i.e., NADRA and SLIC.

Mr. Zohair Ihsan, Deputy Director - MIS at the PMU, made a comment on the M&E mechanism in the following way:

"As everything is digitalized, we can measure all of these in real-time. The number of admissions in a particular area and how many patients have been discharged can be easily accessed. The project statistics we require to measure everything become quite easy."

Physical monitoring is another aspect of the M&E mechanism used for the program. It starts at the time of application for treatments after making a biometric impression of citizens. The health facilitators sitting at the empanelled hospitals' Sehat Sahulat desks make sure to admit the right person for admission. The DMOs at the district level conduct frequent visits to health facilities that fall under their ambit. PMOs also visit health facilities to ensure smooth and transparent program implementation. Federal government officials also visit these hospitals to see if the measures are aligned with the program policy. The helpline contacts patients to inquire about the quality of service. The documentation of every admission is prepared both manually and electronically. The manual record rests with the hospital and the Sehat Sahulat desks, while the electronic record is stored in the CMIS. The program has an obligation to participate in regular and special audits as per the law.

Mr. Zohair Ihsan made further comments on the audit of the program:

"Being part of the government of Pakistan, we are subjected to all the audit obligations as per the law, and any type of audit, special audits, and regular audits are done as per the law and schedule."

Data gathered from the interview with SSP stakeholders concludes that the monitoring and evaluation mechanisms placed for the program intervention are robust and timely. The program's dashboard is used for strategic and operational planning and decision-making. Respondents considered the program's M&E tool and real-time dashboards vital for the project's reporting, tracking, searching, financial management, and reconciliation system to effectively monitor, control, plan, and coordinate activities with the insurance company.

The fourth research question inquiries about the sustainability and viability of this policy and the impact of this policy on the health sector. Below themes emerged from the fourth research question.

4.6. Theme 6: Unsustainable Program Model

Based on the data gathered from the interview with SSP stakeholders, the sixth theme that emerged was an unsustainable program model. Analysis of the interview data with SSP stakeholders shows us that the respondents were divided into two point of view on the program's sustainability. Respondents from MoNHSRC, PC, and GIZ considered this program financially unsustainable. Respondents from the implementation partners, i.e., PMU and SLIC, considered the current model of the program sustainable.

Data gathered from the interview with SSP stakeholders tells those respondents who consider the Sehat Sahulat Program unsustainable argued that the SSP model of universality to access to tertiary healthcare is unviable. The policy does not segregate that population segment that can more easily

pay their premiums than those who cannot afford it. Secondly, some people are already entitled to health security, such as armed personnel, government employees, or people who have been taken care of by their employers. The inclusion of this segment exacerbates the financial burden on the government. Opponents further argued the Sehat Sahulat Program is unfeasible in the long run with the current financial model. Dr. Muhammad Asif, Chief of Health at PC, suggested the following when his opinion on the program's sustainability was asked:

"A well-defined policy and framework are required to establish the segment of the population it should include. This program is being run on public funds, and with the motive to make it universal, it overshadows other projects in the health sector due to a larger pool of funds. This can be resolved if this program is run in a company mode rather than funding it through a development budget"

To make the program sustainable for the long term, respondents recommended that an autonomous body run the program, which could generate revenue and meet its expenses. Opponents also argued that consecutively running the Sehat Sahulat Program on PSDP at the federal level will crowd out the development fund to be allocated to other sectors. Transferring the program to the recurring budget of the health ministry can sustain the program financially. However, respondents questioned the desirability of doing so. Replying on the viability of the program in PSDP mode, Mr. Inam ul Haq, DG Development at the MoNHSRC, said:

"I do not think the finance ministry has so many resources to permanently fund this program. Given our worsening economy, we must develop innovation to support this program."

Dr. Malik Safi, who remained the DG of Health and is a UHC Advisor at MoNHSRC, considers the political backing of the SSP as the primary reason for the continuation of this program. He

argued that the SSP was a flagship program of the previous government. If the program is curtailed, it will give a wrong signal to the public, and the political party which takes ownership of the program will charge sheet the incumbent government. Even with unsustainable model, the present political leadership of the country will restrain from shunning or modifying the program's modus operandi. The current political situation can impact the sustainability of the program. He said:

"It is challenging to financially sustain this program in the current mode that it is being run. This program is politically backed, which is why it is still running, but in the long run, it will not be viable to sustain."

On the contrary, PMU, the implementation agency, called this program viable and sustainable. The CEO of SSP believed that under the current allocation to health by the federal and provincial governments, the total health budgets exceed Rs. 800 billion. Suppose inpatient care service at the tertiary level is offered to every Pakistani national through a health card or insurance mechanism. In that case, Rs. 230 billion rupees will be required, which makes 27 percent of the total budget allocated to the health sector. The remaining budget, i.e., 73 percent, can be spent on outpatient services, community health care, and other primary and secondary components. He recommended that the primary and secondary health infrastructure be reformed and made efficient, simultaneously adopting an insurance-based model of tertiary healthcare. The cost of tertiary health care will decrease if the government focuses primarily on a preventive approach rather than the curative side. His justification for the initiation of an insurance-based model in health is to reduce catastrophic expenditure at the tertiary care level.

SLIC, another implementing agency of SSP, considers the program viable. Mr. Muhammad Ashar, Regional Chief for H&AI at SLIC, took a similar position to PMU on the program's sustainability. He argued that even if the program's current budget is projected for the future, the composition of

investment in the public and private sectors will remain the same, i.e., up to 40 percent of the total budget. The government levies a 10 percent tax on the private sector, which goes back to the government's exchequer. He further argued that 50 percent of the premium slashes. The remaining 50 percent of the budget is utilized in both sectors. Out of the 50 percent, 30 percent is utilized by the private sector, while 20 percent of the budget remains with the public sector. He rejected the perception that the insurance company spends 100 percent of the program budget. Out of 50 percent, he said 6 percent of the budget is used for administrative purposes, while 94 percent of the budget is returned to the government in one way or the other. In such a case, the government is making a profit from this project, making the project financially sustainable.

The data gathered from the interviews with the stakeholders concluded that the financial and actuarial arguments by PMU and SLIC sound convincing in making the Sehat Sahulat Program from a viability perspective. However, gauging the program from the strategic objectives, it has to achieve and the program's impact on healthcare with such massive resources pooled towards it weakens the justifications of PMU and SLIC. While keeping the prevailing political and economic uncertainty in mind, allocating funds in a PSDP project mode makes the program unsustainable overall.

The fourth research question also aims to analyze the impact of the Sahulat Program policy on Pakistan's health sector.

4.7. Theme 7: From Supply Side to Demand-Driven Policy

The seventh theme that emerged from the interviews with SSP stakeholders was supply side to demand-driven policy. As discussed, the Sehat Sahulat Program was initiated as a social health

protection program with an alternate mode of financing. However, for a period of time, the program is integrating UHC components in the future.

Mr. Muhamad Arshad, CEO of the Sehat Sahulat Program, claimed the program is changing the landscape of the health sector in Pakistan. Previously, health policies in Pakistan were supply-side delivery oriented - The government would build a few hospitals, allocate them a budget, and give them the mandate to provide health care. This policy was not bearing fruits as the quality of health services and management of such facilities were below par. People who could afford private healthcare facilities have the access to quality of healthcare, while most people would suffer due to unaffordability, or the cost of catastrophic expenditure would further push them towards poverty. The Sehat Sahulat has changed it to demand-side delivery. The program functions in such a way that it creates demand for health services for the people, and people avail of those services, and the government pays the expenditure through an insurance mechanism. He said:

"SSP is a new concept in Pakistan where health services are provided first, and the government pays health expenditures to the hospitals, and this is a major shift in the approach towards public health."

I also asked if the Sehat Sahulat Program has reduced OOP[5] in the country. Most respondents claimed the SSP has remarkably reduced OOP in the country, but respondents had no evidence to validate this claim. While some of the respondents said, it is too early to comment on the impact of this program, especially the magnitude of OOP reduction in Pakistan. Respondents said this

[5] Household out-of-pocket expenditure on health comprise cost-sharing, self-medication and other expenditure paid directly by private households, irrespective of whether the contact with the health care system was established on referral or on the patient's own initiative.

program needs at least five years of time as people still lack awareness about the program's benefits, particularly in studying the impact of SSP on OOP.

4.7.1. Incentivizing the Private Sector

A sub-theme that emerged from gathered data was incentivizing the private sector. The interview data explains that this program benefited the private health sector the most. The private health sector has gained confidence as a result of this program. The private sector in the health sector is expanding and providing services in localities where private entities were hesitant to operate. Most respondents agreed that the Sehat Sahulat Program has led to easy access to tertiary healthcare for marginalized people. Access issues have been resolved. Complicated health procedures are now available in semi-urban and rural areas that have a significant impact. The network of private healthcare providers is expanding due to this program.

Most respondents viewed SSP as introducing healthy competition between private health facilities. It is due to the standards against which these facilities are inspected. In order to meet these standards, private hospitals must improve their quality of services. The profit motives of these private hospitals created a competitive environment. Respondents also considered purchasing power of people in terms of insurance benefits and choice of health facilities available for the people had also initiated a competitive environment for the private sector. Mr. Inam ul Haq, DG Development at MoNHSRC, commented when asked about the prospect of SSP for the private sector:

"Quite a lot, I would say. This program has introduced healthy competition between hospitals because there are multiple criteria against which they are looked, so to meet these criteria, they have improved their quality of services."

However, few of the respondents partially agreed with the impact of SSP and questioned the motive for prioritizing the private sector against the public health sector. They argued that the sole purpose of the private sector is to maximize profits and will shut down if the program is discontinued in the future, but public health facilities are permanent and will remain in depleted condition afterward. They recommended investing in public health facilities for better services and administration.

4.7.2. Insignificant Impact on the Public Healthcare Sector

Another sub-theme that emerged from the interview data is the insignificant impact on the public healthcare sector. The respondents were divided into two points of view when asked about the impact of SSP on the public health sector in Pakistan. Most respondents believed that the intervention has no significant impact on the service delivery mechanism in the public healthcare sector. Data inferred from this viewpoint is public healthcare units are already overburdened with an inflow of patients. The SSP intervention has little or no role in dealing with the occupancy of patients in the public sector. Respondents were of the view because of the SSP, the private health sector has significantly invested in developing its overall infrastructure, but in the case of the public health sector, infrastructure remains the same as before the implementation of the SSP. Respondents disagreed when asked if SSP has a role in resolving administrative and operational issues in public sector hospitals. Respondents also believed that because of the SSP intervention, there are no beneficial environment for public hospitals to compete with the private health sector. Respondents further said the implementation of the SSP in the public health sector is functioning well, but no value addition has been made in the public health sector due to this program.

Some respondents believed the SSP had brought changes in the public health sector. The government is devising a strategy for empaneled hospitals of SSP to generate their running

expenses through SSP. The government will eventually reduce the running and development budget for these empaneled public hospitals and will motivate these facilities to function like the private sector. More inflow of patients will generate more revenue for the public hospitals. However, these respondents agreed such changes are not obvious presently and will improve the efficacy of the public health sector. Dr. Erum Naveed, Director Indoors at PIMS, commented on the SSP's impact on the public health sector:

"Changes have been brought to the public health administrative infrastructure. They are trying to, and have to some extent, reached certain goals. For example, the KP government has introduced an act in which the public sector hospitals should be autonomous so that the revenue they generate can be used for infrastructure and resource development."

4.7.3. Inconsiderable Impact of SSP in achieving UHC Milestone

Pakistan's government envisions to achieve the UHC milestone by the year 2030. This research also tried to gauge the SSP's impact in achieving this milestone. A sub-theme that emerged from the interview data was the minor impact of SSP on achieving the UHC milestone. The common understanding was that health insurance is part of social health protection and is not directly part of the UHC framework. SSP intervention has a lesser impact on achieving the UHC objectives. It was reported that providing curative services at the tertiary level and addressing out-of-pocket expenditures will not help improve health indicators. And social protection that is equitable to both the poor and rich people is neither viable nor impactful for achieving the UHC objectives. Achieving universal health coverage will only be possible if the SCI[6] is improved, which is

[6] Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn, and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)

currently at 52%. The global target is 80%, and respondents considered achieving an SCI of 100% by 2030 to be a highly ambitious government plan. Respondents further said the provincial and federal governments had agreed on resolving health issues at every level by 2030. It will be a decent achievement if Pakistan can reach SCI of 65% by 2030. Dr. Malik Safi made the following comment when asked about the role of SSP in achieving SDG-3 target 3.8[7]:

"*SDG target 3.8 comprehensively talks about UHC like access, financial protection, quality, and affordability of healthcare. SSP does not cover every aspect of UHC. The government should invest in preventable equitable health care so that the hospital burden can be reduced."*

Respondents acknowledged the role of SSP in financial protection in health for people living below the poverty line. However, respondents consider the preventive side of health important since early screening can be beneficial in preventing diseases from getting serious. This sub-theme concludes that strengthening the primary and secondary healthcare services is pivotal for maximizing SCI by 65% in the future.

[7] Achieve universal health coverage, including financial risk protection and access to quality essential health-care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all.

4.8. Beneficiaries' Experience

Table 4.2 Beneficiaries Details

S.No	Hospital Name	Female	Male	Total
1.	AH & GR Pvt Limited (Bilal Hospital)	3	2	5
2.	Akber Niazi Teaching Hospital	2	5	7
3.	Al Shahbaz Medical Complex Hospital	1		1
4.	Al-Khidmat Razi Hospital	7		7
5.	Benazir Bhutto Hospital Rawalpindi	1		1
6.	Christian Hospital	1		1
7.	District Head Quarter Mirpur		1	1
8.	District Head Quarter Rawalpindi	1	1	2
9.	Farooq Hospital, Bahria Golf City		1	1
10.	Hazrat Bari Imam Sarkar Trust	9	4	13
11.	Hilal-e-Ahmar hospital	1		1
12.	Holy Family Hospital	2		2
13.	Islamabad International Hospital & Research Center		2	2
14.	Islamic International Medical College	2		2
15.	Isra Islamic Foundation	5		5
16.	Medikay Cardiac Center	1	1	2
17.	Nuclear Medicine Oncology & Radiotherapy Institute	3		3
18.	Pakistan Institute of Medical Sciences	19	4	27
19.	Rawal Foundation	3		3
20.	Rawalpindi Institute of Cardiology	3	2	5
21.	Riphah International Hospital	2	2	4
22.	Saidu Trauma Hospital	1		1
23.	Sardar Khan Memorial Hospital		1	1
24.	Zobia Hospital	1	2	3
Grand Total		**68**	**28**	**96**
Average age of beneficiaries		41.8 Years		

Another aspect of this research is understanding beneficiaries' experience of the Sehat Sahulat Program. For this, I conducted a phone-based survey of the SSP beneficiaries. 100 beneficiaries were randomly chosen from the 1st quarter data in the locality of ICT from the PMU-CMIS. Out of the 100 (31 males and 69 females) beneficiaries, I collected data from 96 individuals (28 males, 68 females) treated in the 24 hospitals mentioned in Table 4.2. 04 beneficiaries could not be reached due to inaccuracy of contact details. The survey was divided into two parts. First part

included questions related to the health facility where respondents availed medical treatment and the second part included questions related to the Sehat Sahulat Program. Based on the available data, below descriptive analysis was made for the health facility:

- *Pre SSP experience*: Before availing services of the SPP, 40% of the respondents preferred government hospitals, 38% preferred private hospitals, and 15% chose charity-based hospitals for treatment. 67% of the respondents said they visited the empaneled hospital for the first time.
- *Enrollment*: 24% of the respondents have enrolled for heart-related diseases in the empaneled hospitals, 15% were enrolled for kidney-related diseases, 15% for burn and RTA diseases, 12% were enrolled for organ failure, 11% for Diabetes Mellitus, 3% for cancer disease. While 20% of the respondents were enrolled for diseases categorized under *others,* mainly pregnancy-related cases.
- *Traveling*: 48% of the respondents said they travelled 10 or less kilometers from their home to the empaneled hospitals for treatment, 37% of the respondents traveled a distance of 11 to 20 kilometers, while 10% of the respondents traveled a distance of above 20 kilometers while 5% of the respondents visited the facilities from another towns/cities.
- *Waiting hours for treatment*: 41% of the respondents claimed they got the treatment right away, while 40% of the respondents waited for a little while for their turn. 10% said they waited for tolerable time, while it took a long time to get treatment for 9% of the respondents.
- *Satisfaction:* The overall satisfaction of the respondent was 95%. 93% of the respondents claimed that they would avail of services of the empanelled hospitals in the future as well.

The descriptive analysis of beneficiaries' experience with the Sehat Sahulat Program is as follows:

- *Additional cost:* 64% of the respondents claimed that all medical charges were accrued by the SSP. While 36% of the respondents claimed they bore additional costs for their treatment even after utilizing the benefits of the program. These additional costs were made for medication, especially for injections, expenditure on transportation, food for patients, discharge fee for infants, bed charges, and tests such as CT scans, X-Ray and Ultrasounds.
- *SSP desk*: The majority of the respondents i.e. 75% were satisfied with the information and assistance provided by the Sehat Sahulat desk located in the empanelled hospitals. 77% of the respondents also claimed that the deducted amount for treatment from the insurance card was properly communicated with them.
- *Ease of process:* When asked about the ease of the process of availing the services of the SSP, 85% of the respondents called the process easy to access while the rest of the respondents considered the process confusing.
- *Helpfulness*: All of the respondents were in view that the Sehat Sahulat Program has reduced the health expenditures of their families. 63% of the respondents found the program quite helpful and 23% of respondents said SSP was very helpful in reducing their household health expenditure.
- *Satisfaction*: The overall satisfaction with the program was 89%. While 23% of the respondents were very satisfied with the overall experience with the Sehat Sahulat Program.

CHAPTER 5

CONCLUSION AND RECOMMENDATION

In this chapter, I conclude the study and list policy recommendations for policymakers.

5.1. Conclusion

This research set out to meet four specific objectives, which have been analyzed in the form of themes and sub themes. The first objective was to understand the motivation for initiating the Sehat Sahulat Program when public health infrastructure was already present. The data analysis in this research indicates that existing public health infrastructure is not yielding results despite a huge budget and ample human resource at its disposal. In 2015, the then government sought to develop an insurance-based social health safety to deal with the catastrophic health expenditure of the vulnerable segment. The SSP was initiated for the people living below the poverty lines, i.e., earning 2 dollars a day and a PMT score of 32.5 as per the NSER data. While the SSP policy is considered an achievement for providing services at the tertiary healthcare level, it was also criticized for not focusing on the primary healthcare, which plays a pivotal role in resolving the overall health issue in the country.

The first objective of the research was also to understand the initiation of the SSP policy. This research concludes that the SSP policy is in line with the provincial devolutions. All stakeholders, including the provinces were on board to initiate this policy. Since health insurance is a newer and gray idea of legislation between the federal and provincial governments, it led the federal government to devise this policy and coordinate between stakeholders. Interviewees also called for providing a legal cover for the sustainability and futuristic aspirations of the Sehat Sahulat Program.

The second objective of the research was to understand the role of different stakeholders in the policymaking and implementation of the SSP policy. This study discusses how the operationalization of the Sehat Sahulat Program policy is mainly divided into two planning phases. At the strategic level, planning and health ministries' overview the SSP policy from a broader perspective, such as its alignment with the national goals, international obligation of development, and policy impact on health. Operational planning is carried out by the PMU-SSP, SLIC, and district health department and mainly focuses on implementing and executing this policy, roles, and service delivery and monitoring results. It was a surprising finding that majority of the interviewees disagreed with the notion that donor agencies completely influence policymaking in Pakistan. In their opinion, development partners such as GIZ and WHO played a key role in enhancing the capacity of human resources and the program's initial design because of their technical expertise in the said fields. In terms of government capacity for health policymaking, it was found that the provincial governments of KP, Punjab, and Sindh provinces have enhanced their capacity to implement the programs while Balochistan AJK and GB are catching up.

The third objective of this research was to understand the implementation processes and M&E mechanism placed for the program. Through the interview data, this research concludes that the implementation of the SSP is integrated. The implementation of this policy is multifaceted, and multi-stakeholders are involved in the M&E process. The program implementation process started with the empanelment of health facilities using standardized procedures and eligibility criteria devised and implemented by SLIC. NADRA's data is used for the verification of beneficiaries' data. The data enrollment of hospitals in the program, enrollment of beneficiaries in empaneled health facilities, insurance benefits, and insurance claims by health facilities is maintained through the CMIS. The CMIS is a central data repository used for monitoring and evaluation. The outcomes

of the SSP intervention are visualized through the CMIS. Program stakeholders use the CMIS dashboard for strategic and operational planning, and implementing partners use the CMIS for operational decision making and daily monitoring. It is also used for complaint and redressal mechanisms. The operationalization of the program through CMIS will help the program in evidence based decision making process, which will have a positive implication on the outcomes of the program.

The fourth objective of this research was to examine the SSP policy's efficacy for Pakistan's health sector and lead it from social health protection to attaining an ambitious UHC in the country. The interview data from the stakeholders such as GIZ, MoNHSRC and PC indicates that the SSP's current model is unsustainable regarding the strategic objectives it has to achieve and the program's impact on healthcare with such massive resources pooled towards it. With the prevailing political and economic uncertainty in mind, allocating funds in a PSDP project mode makes the program unsustainable and undesirable. This research also concludes that SSP has been vital for incentivizing the private healthcare sector in Pakistan. This program led an exponential growth in private investment in the healthcare sector and enabled an environment for competition in the private sector. The research also concludes that the role of the SSP in improving service delivery in the public healthcare sector is currently negligible, and the government is devising a strategy to improve efficiency in the public healthcare sector. SSP has reduced the out-of-pocket expenditure related to tertiary healthcare. Regarding the SSP's role in achieving the UHC milestones, the research concludes that the SSP intervention has a minor role in achieving this milestone. Thus far, SSP has addressed the UHC's financial risk protection. However, SSP has no access to quality essential healthcare services and access to safe, effective, quality, and affordable essential medicines and vaccines for all as necessary components of UHC.

The overall conclusion of this research is that the policymakers in Pakistan have made an attempt in Pakistan to address the shortcomings of health policies and implementation strategies by introducing an innovative approach of health insurance.

5.2. Recommendation

Based on the research findings, I propose the following recommendations.

- The current non-legal status makes the SSP intervention unprotected. Future governments have the ability to scrape or shelve this program. It is recommended that the government should develop a legislative framework for the Sehat Sahulat Program. To attain legal sustainability, the program should be enforced through an act of Parliament with complete political backing for this program.
- Currently, the SSP is running on a PSDP mode of financing till the year 2025. In case of a financial crisis, the government can slash the funding for this program which makes the financial framework of the SSP unsustainable. It is recommended that either the program be shifted to the recurring budget of the health ministry or a new business model for SSP must be devised to generate revenue and meet the organization's operational expenses.
- The existing implementation strategy of the SSP appears to be unviable because of temporal institutional mechanism designed for the program. The government should develop an institutional framework by making the PMU an autonomous body. The PMU should have complete autonomy to set goals and objectives for itself, devise a budget, and make strategic and operational planning for health protection. The administration of the regional PMUs must be devolved further to the district level to bring efficacy and better coordination with health facilities.

- One of the research findings was that the universality of benefits, irrespective of the socioeconomic conditions of people, is undesirable. Currently, the program's benefits are accessed equally by the rich and poor segments of the population for free. It increases the cost of the program. It is recommended to develop slabs for beneficiaries according to their socioeconomic status. People below the poverty line should be benefited the most, and people with better socioeconomic status should be given less access to the benefits. For this, an updated data of NSER is required.
- One research finding is that the government is liable for providing all the premiums on behalf of every beneficiary. Because of this, the cost of the program has increased. The government may consider changing the premium mechanism into a contributory payment mode. The government and beneficiaries must make their contributions of premiums to utilize the program's benefits.
- Pakistan's system of social protection is fragmented. Various organizations, such as Pakistan Bait-ul-Mal, BISP or Ehsas provide social health protection to the marginalized segment of the society. This leads to duplication of work and resources. It is recommended that all social health protection initiatives must be clubbed together under SSP. All health insurance requirement for treatment for public and private employers must be met through the SSP mechanism.
- One of the research findings was that the SSP policy has a lesser impact on the public health infrastructure. The service delivery in the public sector hospitals have not changed due this intervention. However, this initiative has hugely incentivized the private healthcare sector as it has been vital for creating a healthy competition between the private hospitals and provided an opportunity for private hospitals to exist even in the peripheral areas. It is

recommended to devise strategies to improve service delivery, bring operational efficiency, and develop the human capacity of the public healthcare sector through the SSP policy.

- It is recommended that the federal government to establish a health advisory commission consisting of different health and regulatory bodies. This commission should advise the SSP to devise strategies to meet the strategic objectives of the program. The commission must advise the PMU or ministry to devise a strategy for incorporating all the components of UHC in the SSP policy to achieve the UHC milestones. As per the WHO standards, SSP policy should be required to incorporate access to quality essential healthcare services and access to safe, effective, quality, and affordable essential medicines and vaccines for all at the levels of primary, secondary and tertiary healthcare levels. The program already addresses the tertiary-level financial risk protection component but in order to provide a greater access to health the programs needs a detailed mechanism to address the primary and secondary health concerns.

5.2.1. Program Recommendation

Free enrollment for all: Should people beyond the lowest income group pay some premium?

- A balanced approach could be to make the enrollment free for those below a certain income threshold, while charging a small premium to those who fall above that threshold. This could help to ensure that the program remains sustainable and can continue to provide high-quality healthcare services to all individuals who need them. Additionally, if the premium is set at an affordable level, it may not pose a significant burden to those who are required to pay it.

Sustainability: How can the government ensure that the program doesn't run out of funds?

- To ensure the sustainability of a social health safety program, it is important to implement a diversified funding model that does not rely on a single source of funding. This can be achieved by exploring various funding sources, such as government budget allocation, private sector contributions, and individual donations. Additionally, implementing a cost-sharing mechanism, where beneficiaries contribute to the program in some way, can help to reduce the burden on the government and encourage beneficiaries to take more responsibility for their health. Outcome-based financing, which links payments to healthcare providers to the achievement of specific health outcomes, can incentivize providers to deliver high-quality care and ensure that funds are being used effectively. Finally, partnerships with private sector organizations can bring additional resources and expertise to the program, which can help to make it more sustainable and support its operations and expansion.

Complementary role of healthcare: Should public healthcare outside of the program only exist for primary care?

- Public healthcare should not only exist for primary care. A comprehensive healthcare system should provide a full range of services to meet the diverse healthcare needs of the population, including specialist care, surgeries, and hospitalization. Healthcare services should be accessible and equitable to everyone, not just those eligible for a particular program or benefit. While the Sehat Sahulat Program is an important initiative to provide health insurance coverage to those who cannot afford healthcare services, it should not be the only source of public healthcare services. The government should continue to invest in and strengthen the overall public healthcare system to ensure that all citizens have access to quality healthcare services, regardless of their financial status.

Overlap with other programs: Should other programs offering similar services be removed?

- The government should conduct an all-inclusive review to identify redundancies or inefficiencies of the social health safety programs. It should analyze all social health safety programs to ensure that there is no duplication of effort or resources, and that each program serves a unique purpose. There must be a coordination among different programs to ensure that they are working towards the same goals and objectives. This coordination can help to avoid overlap or duplication of services, and ensure that all segments of the population are receiving the healthcare coverage they need.

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Appendix A

Interview Questions with Stakeholders

Note: Sub-questions addressed by the interviewees in the main question were not asked separately.

Q1: What was the motivation for initiating the Sehat Sahulat Program when the country already has a public health infrastructure?

- Was there a genuine need for the initiation of social health protection?
- Was the initiation of the Sehat Sahulat Program a political decision?
- Was there pressure on the government by the international donor agencies to initiate such a program?
- Is there less resistance amongst policymakers to government projects that are meant for social welfare?

Q2: What role did your organization play in the policymaking or in the implementation process of the Sehat Sahulat Program?

Q: How did the federal government get involved in the formulation & operationalization of this program despite health being a provincial subject?

- What legal cover does this policy have? If not legally covered, what reasons could be there?
- Does this policy deny the spirit of devolution of health-related policymaking after the 18th Amendment?
- Do provincial governments have the capacity and resources to initiate and implement social health safety programs post 18th Amendment?
- How do you see the Sindh Government's disapproval of implementing the SSP policy in the Sindh Province?

Q3: What operational and administrative mechanisms have been placed for implementing the Sehat Sahulat Program?

- How does the SSP's insurance mechanism work, and at what stage does SLIC become part of the SSP Policy?
- What is the process of empanelment of hospitals in the SSP? Do public and private hospitals have different criteria for empanelment in the program?
- How does the premium mechanism of SSP beneficiaries work?
- What monitoring and evaluation mechanisms are placed to measure the program's outcomes? And how is this data shared with the different stakeholders?
- What mechanisms are placed for complaints and redressal?
- Being a life insurance corporation, how effective is SLIC providing health insurance?
- How competitive was the process for awarding the insurance scheme to SLIC? Why private insurance companies are not part of SSP insurance?
- Given the volume of the program, does SLIC has the capacity and resources to implement the insurance facility countrywide?
- Why is Outdoor Patient Department (OPD) service not included in the Sehat Sahulat Program?
- What are some of the most challenging aspects of implementing this policy, and what are your recommendations for mitigating it?

Q4: How financially sustainable is the Sehat Sahulat Program?

- Is it financially viable for the government to implement this program on PSDP/ADP mode?
- This program was initially designed for people below the poverty line (PMT Score of 32.5 or less, income below $2 a day). What rationale is for making this program universal?

Q5: Has the Sehat Sahulat Program brought a meaningful change in the health sector in Pakistan?

- To what extent has the Sehat Sahulat Program impacted reducing the Out of Pocket Expenditure (OOP) and catastrophic health expenditure in Pakistan?
- How has the SSP incentivized Pakistan's public and private health sectors?
- Does the SSP have a role in improving service delivery in public and private healthcare facilities?
- Has SSP a role in creating a conducive environment for public hospitals to compete with the private health sector?
- What is the impact of this policy on achieving Universal Health Care outcomes in Pakistan?
- Will implementing this policy achieve UHC Milestones, i.e., equity in access to healthcare, quality of health services, and protection against financial risks for all citizens by the 2030 target set by the GOP?

Q6: In what ways is this policy achievement for your organization, and what are your future expectations from this policy?

Appendix B

Beneficiaries Form

This questionnaire is being filled out for academic research on the Sehat Sahulat Program. The information you provide will be confidential and used only for research purposes.

Name of Beneficiary (optional):	
Gender:	Age:
Name of admitted hospital:	City:
Type of admitted hospital: • Government Hospital • Private Hospital • Semi-Government Hospital • Welfare/ Charity Hospital • Other: _____	

Questions

1- Have you used the Sehat Sahulat Card for the first time for your treatment?

- ☐ Yes
- ☐ No
- ☐ I don't remember

2- Previously, what type of hospital did you prefer for treatment?

- ☐ Government Hospital
- ☐ Private Hospital
- ☐ Charity-based Hospital (E.g., Shaukat Khanum Cancer Hospital, Edhi Foundation)
- ☐ Depends on the treatment's availability.
- ☐ Whichever was the nearest hospital from home

3- For which treatment are you admitted in this hospital?

- ☐ Heart diseases (Angioplasty/bypass)
- ☐ Diabetes Mellitus
- ☐ Burns and RTA (Life, Limb Saving Treatment, implants, Prosthesis)
- ☐ End-stage kidney diseases/ dialysis
- ☐ Chronic infections (Hepatitis/HIV)
- ☐ Organ Failure (Liver, Kidney, Heart, Lungs),
- ☐ Cancer (Chemo, Radio, Surgery)
- ☐ Other:_____

4- Have you previously availed treatments from this hospital?

- ☐ Yes
- ☐ No
- ☐ I don't remember

5- If yes, why do you want to avail treatment from this hospital on the Sehat Sahulat Card? (Multiple selections)

- ☐ I trust this hospital and its doctors/staff.
- ☐ This hospital is near to my home.
- ☐ I was satisfied with my last treatment here.
- ☐ This hospital was recommended to me
- ☐ No specific reason
- ☐ Another reason: _____

6- Will you still avail treatment from this hospital on the Sehat Sahulat Program in the future?

- ☐ Yes
- ☐ No
- ☐ I don't know

7- How far have you traveled from home to avail the Sehat Sahulat Card facilities in this hospital?

- ☐ Below 10 km
- ☐ 11 km – 20 km
- ☐ More than 20 km
- ☐ I belong to another city/town

8- How long have you waited to get the treatment done in this hospital?

- Too much time
- Adequate time
- Little time
- Got treatment right on time

9- How satisfied are you with this hospital's overall treatment and care?

- Very Satisfied
- Satisfied
- Neutral
- Dissatisfied
- Very Dissatisfied

10- Have you bore additional costs that Sehat Sahulat Card did not cover?

- Yes
- No
- I don't know

11- If yes, for what purpose did you bore those additional costs? _____

12- Have you approached the Sehat Sahulat Program counter in the hospital for assistance?

- Yes
- No
- I don't remember
- No Sehat Sahulat Program counter available at the facility

13- How satisfied are you with the help desk of the Sehat Sahulat Program at this health facility?

- Very Satisfied
- Satisfied
- Neutral
- Dissatisfied
- Very Dissatisfied

14- Were you informed about the deduction of the amount from your Sehat Cards after the treatment?

- Yes
- No
- I don't remember

15- How easy did you find the process of accessing the Sehat Sahulat Program?

- Very Easy
- Quite Easy
- Easy
- Difficult
- Very Difficult

16- How helpful was the Sehat Sahulat Program in reducing your health expenditure?

- Very Helpful
- Quite Helpful
- Helpful
- Unhelpful
- Very Unhelpful

17- Overall, how satisfied are you with your experience of the services of the Sehat Sahulat Program?

- Very Satisfied
- Satisfied
- Neutral
- Dissatisfied
- Very Dissatisfied

Thank you for your participation