ORIGINAL ARTICLE

The experience of implementing a social health insurance programme at health facilities in Khyber-Pakhtunkhwa, Pakistan

Shifa Salman Habib[1], Anum Shaikh[2], Kiran Sohail Azeemi[3], Waqas Hameed[4], Junaid Ur Rehman Siddiqui[5], Ali Hussaini[6], Asma Altaf Hussain Merchant[7], Adil Haider[8], Sameen Siddiqi[9]

Abstract

Objective: To explore the experiences of key stakeholders, including hospital managers, clinicians, and hospital-based State Life Insurance Corporation (SLIC) representatives, SCP's implementation challenges and successes.

Methods: A qualitative descriptive exploratory design was employed across 38 empanelled public and private facilities in KP. Key informant interviews (n=103) were conducted until data saturation was reached, exploring barriers and facilitators within the SCP's operational framework. Data were analyzed using NVivo software, applying a mix of deductive and inductive approaches.

Results: Strengths and enablers included a comprehensive benefits package design, a robust third-party administrative system, and the digitization of health management information systems for efficiency. Implementation barriers included low reimbursement rates affecting service quality at health facilities, documentation issues hindering patient access, uneven availability of services causing patient frustration, resource-intensive claim preparation with a slow reimbursement process, and a lack of quality assurance mechanisms.

Conclusion: This study provides a nuanced understanding of the SCP implementation, highlighting the need for revisiting reimbursement rates, addressing documentation challenges, ensuring service availability, streamlining reimbursement processes, and strengthening quality assurance mechanisms. The SCP's comprehensive benefits package, effective purchaser-provider relationships, and digitization efforts emerge as key strengths that contribute to its success.

Keywords: Sehat Card Program (SCP), Social Health Insurance, Implementation Challenges. Stakeholder Perspectives, Reimbursement Processes, Khyber Pakhtunkhwa (JPMA 74: S-51 [Suppl. 11]; 2024)

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Introduction

Ensuring equitable access to quality healthcare services is a challenge globally, especially in Low- and Middle-income countries (LMICs).[1] The World Health Organization (WHO) consistently emphasizes the importance of Universal Health Coverage (UHC), as a key component of the Sustainable Development Goals (SDGs), to ensure that all the individuals receive healthcare services they need, without any financial burden.[2] Regionally, South Asia faces a unique set of challenges, with high out-of-pocket (OOP) payments acting as a significant barrier to accessing healthcare.[3]

In Pakistan, an LMIC with the fifth largest population globally, the healthcare financing reflects these global and regional challenges, with OOP spending in Pakistan contributing to 52.9% of the total healthcare costs.[4] To progress UHC, health financing systems must respond with optimal quality, efficiency, equity, and responsiveness in health service provision, including arrangements with insurance providers.[5]

[1-6,9]Department of Community Health Sciences, Aga Khan University, Karachi, Pakistan; [7]The Clinical and Translational Research Centre, Medical College, Aga Khan University, Karachi, Pakistan; [8]Medical College, Aga Khan University, Karachi, Pakistan.

Correspondence: Sameen Siddiqi. e-mail: sameen.siddiqi@aku.edu
ORICID: 0000-0001-8289-0964

Social health insurance (SHI) is increasingly recognized as a valuable approach to extending UHC, especially in LMICs. SHI has the potential to increase healthcare utilization eventually leading to improved health outcomes and offers benefits in terms of fairness, efficiency, service quality, and prevention of catastrophic health expenditure.[6,7]

The Sehat Card Programme (SCP), a flagship social health insurance initiated by the Khyber Pakhtunkhwa (KP) government in Pakistan, seeks to address these issues by increasing access to care and providing financial risk protection to the citizens of the province. This initiative aligns with the broader objectives of UHC as emphasized in the SDF-3, developing region-specific strategies to address challenges of healthcare access. The Government of KP, through a competitive bidding process, selected State Life Insurance Corporation (SLIC) as the insurance provider. While the overarching goals of the SCP are clear, a deeper understanding of the implementation challenges and successes from the perspectives of those directly involved is crucial.[8,9]

Currently, there is no existing exploratory work in the area of social health insurance to understand implementation challenges and successes in Pakistan where the programme is still in infancy. In addition, very limited literature is available from LMICs on the subject. This study provides insights of key stakeholders involved at the facility-level, including hospital managers, clinicians, and SLIC representatives, as these are directly involved in providing clinical services under the SCP. The study is nested within a larger third-party evaluation of the SCP, KP[10] and delivers a comprehensive view of the programme's implementation journey. The first-hand experiences of these stakeholders offer a valuable understanding of the programme's real-world challenges and achievements.[11,12]

Methods

This study was conducted using a qualitative descriptive exploratory design, which is consistent with methods employed in similar healthcare research within Pakistan,[13] aimed at capturing comprehensive insights from stakeholders. The study was initiated in August 2022 and completed in August 2023. It was conducted across 38 empanelled secondary and tertiary hospitals, across public and private sectors in KP, the northwestern province of Pakistan. The sample districts for the study included Peshawar, Kohat, Swabi, Upper Dir, DI Khan, Malakand, Chitral, Bannu, Abbottabad, and Swat.

Conceptual Framework and Approach

The conceptual framework for the study, as illustrated in Fig 1, based on the implementation model for SCP guided the design of interview guides, data collection process and subsequent analysis technique. This framework, adapted from a study evaluating health insurance schemes,[14] helped in understanding the interaction between the primary stakeholders in service delivery within a health insurance scheme. The framework depicts the basic model of a publicly funded SHI scheme under which the government empanels various hospitals, which in return provide the services in terms of a benefit package to its beneficiaries. The insurance underwriter serves as the third-party administrator managing hospital empanelment, communication, billing, and reimbursements. The framework was further refined using the working model of the SCP, concepts from health policy and system literature on UHC, Publicly Funded Health Insurance, and health service delivery in mixed health systems.[15]

Sampling Strategy

The sampling strategy for the districts was informed by a previous study by GIZ on baseline communication strategy for SCP and has been described elsewhere in this supplement.[10] Stratified; proportionate sampling was done to select 40 facilities from the list for evaluation. Two facilities refused to participate, while 38 facilities took part in the survey and formed the final sample. Stakeholders

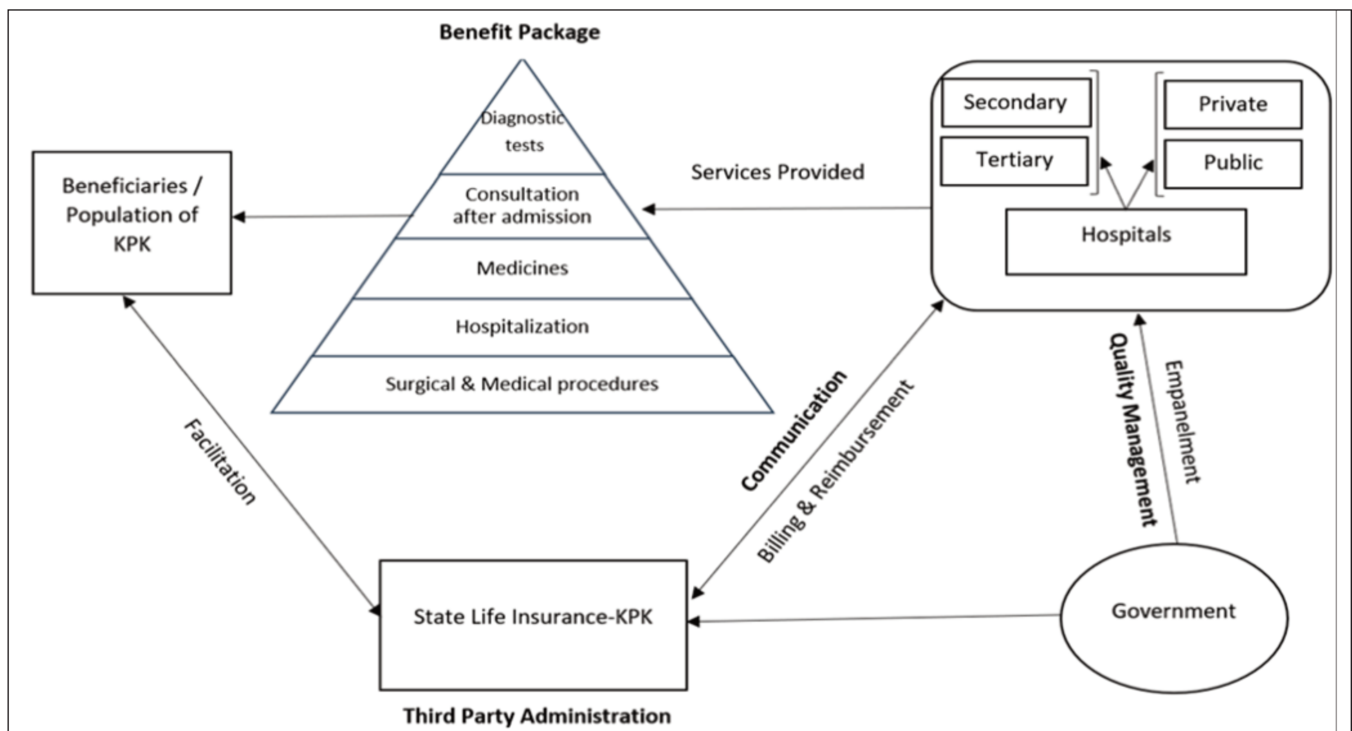

Figure: Conceptual Framework for evaluating the SCP-KPK through Providers' Perspectives adapted from a study.[14]

with official positions like clinicians, health facilitation officers, and health facility managers holding valid employment contracts at the sampled hospitals were included to participate in the study. The key informants were selected purposely, based on their direct involvement and experience with the SCP and interviews were continued until saturation was achieved. A total of 103 key-informant interviews were conducted with 42 hospital managers, 26 clinicians and 35 SLIC representatives.

Data Collection Tool

A semi-structured interview guide was developed to understand the implementation barriers and successes along each component of the study framework such as adequacy of the benefits package, role of third-party administrators and quality assurance knobs. Questions were also included to elucidate specific strengths, gaps, and potential areas of improvement in the SCP and specific probes were used for gaining insights in-depth.

Data Collection and Management

Interviews were conducted predominantly in Urdu and Pashto. The average duration of these interviews was 24 minutes and 44 seconds. The data collection period spanned from September 2022 to November 2022. Interviews at tertiary hospitals were conducted by Principal Investigator (PI) and Co-Principal Investigator (Co-PI) whereas interviews from secondary hospitals were conducted by a team of trained data collectors. The interviews continued until additional conversations no longer provided new or relevant information. Interviews were digitally recorded with explicit written consent obtained from the participants. Interviews were subsequently transcribed and translated in English language by two research associates who were trained in qualitative research techniques including data translation, transcription and analysis ensuring the accuracy and reliability in the process.

Researchers might have preconceived notions or hypotheses about the programme's implementation, influencing data interpretation. This was mitigated by involving peer review and validation of findings by external experts and a team of diverse backgrounds.

Table: Baseline characteristics of Key Informants (n=103).

Respondent Characteristics	n (%)	Respondent Characteristics	n (%)
Gender		**Years of Experience**	
Male	97 (94)	Up to 5 years	68 (66)
Female	6 (6)	>5 years	35 (34)
Age (years)		**Designation**	
Up to 45 years	72 (70)	Health Facility Manager	42 (41)
> 45 years	31 (30)	Clinical staff	26 (25)
		State Life Insurance Personnel	35 (35)

The trustworthiness of the study was upheld using Lincoln and Guba's Criteria.[16] Data was verified with participants to ensure credibility. Purposive sampling was used to include diverse perspectives for transferability. A consistent audit trail was kept to ensure dependability, and conclusions were based on these audits while acknowledging researcher biases to ensure confirmability. In order to ensure the study's reliability and applicability, detailed explanations and direct statements were provided to support the findings, thus maintaining rigor.

Data Analysis

The transcribed data underwent analysis using NVivo software version 12. The analysis was primarily done through a deductive approach based on the conceptual framework, with the data being organized into categories, then further divided into themes and sub-themes. In addition, an inductive approach was also used to identify new emergent themes and sub-themes from the data that fall outside the framework, ensuring that valuable insights based on the data were not overlooked. The research associates coded the entire dataset, and any discrepancies were resolved by the Co-PI. The confidentiality and anonymity was ensured by de-identifying transcripts and field notes, assigning them unique codes. All data, including transcripts and recordings, were securely stored on encrypted and password protected computers. The coding framework was iteratively refined through collaborative discussions among researchers.

Results

The basic characteristics of the study respondents are given in Table.

The results section presents several themes that emerged from these interviews and identified as facilitators and barriers along with key statements, presented as direct quotes, made by different interviewees.

Implementation Challenges: The five themes that emerged as barriers to programme implementation include:

Theme 1: Low reimbursement rates potentially leading to poor quality of care.

In-depth interviews with key informants including hospital management and physicians revealed their dissatisfaction with the disease-wise reimbursement rates ascertained by SLIC. The reimbursement rates have also not been revised according to the rise in inflation and devaluation of the local currency. The process of setting reimbursement rates was not consultative and does not consider the quality of consumables and service delivery costs. Hospitals often need to settle for quality of medicines, consumables and prosthetics that is lower than what they would otherwise

recommend. A few important medicines were expensive, and were not covered in the predefined package, however they can be approved by SLIC as 'special approval' on reasonable request.

"It's difficult to entertain the patient in the given package of Sehat Card, the hospital bears more cost than we are reimbursed. We face difficulty in giving good standard medicines."

(Doctor, Private Secondary hospital, Peshawar)

"Some hospitals do not take medicines from certified distributors to manage their expenses. For example, Isoflurane, which is an imported anaesthesia drug from the US, costs PKR 2400. All the other hospitals take it in black, for Rs. 1200 to Rs. 1400. They mix chloroform and another volatile gas; this is severely nephrotoxic and hepatotoxic."

(CEO, Private, Tertiary care hospital, Swat)

"When we talk about knee replacement, its prosthesis comes in high quality as well, it comes in an acceptable quality and of low quality too. Forcibly, we have to go for low quality. Whoever has done the pricing of these packages, that is unrealistic."

(Director Quality, Public Tertiary hospital, Peshawar)

Theme 2: Incomplete documentation hindering access to care for patients

Based on the results of interviews with the key informants, it is known that among the population entitled to SCP benefits, there are members who are unable to access due to missing or incomplete identity documents. Most encountered issues include unchanged marital status (and husband's name) on CNIC for married women that hinders them from availing child delivery services. The names of children are also often not updated in the list of family members under the head of household. Also, B-forms for children are also not available in many cases that results in challenges in admitting paediatric patients, according to the SLIC policy. The key informants also reported that due to the requisite documentation required for SCP entitlement, they have witnessed an upward trend in KP locals registering their families, children and wives with the National Database and Registration Authority (NADRA). Delays at the end of NADRA may create further bottlenecks.

"In our province of KP, people do not make the Form B for newborn kids. So, when the kids are brought here without Form B, we can't facilitate them on Sehat Card. Or if their record or 'Shajra' is not correct, we ask them to go to NADRA and correct it."

(Health facilitation officer-SLIC, Public Secondary hospital, Upper Dir)

"The main problem is the CNIC and its synchronization with State Life. If a patient has made his CNIC to avail the facility, sometimes the patient's CNIC card is still not synchronized with State Life. So, we can't facilitate the patients."

(Health facilitation officer-SLIC, Public Secondary hospital, Upper Dir)

"NADRA updates the status after every 6 months like in June and January, therefore Gynae patients face many issues as their husband's name is not updated on their CNIC. Widows also face problems because of not updating their status in NADRA."

(Health facilitation officer-SLIC, Public Secondary hospital, Abbottabad)

Theme 3: Unavailability of required services at all empanelled facilities leading to patient frustration

The findings from the key informant interviews revealed that different hospitals are empanelled for provision of a varying set of services. The complete range of services covered in the benefits package are not available at every empanelled hospital. This often leads to confusion for the patients and can be frustrating if the required clinical service is not available at the hospital of their preference and convenience. This is especially true in the case of some specialist services such as cardiothoracic surgery, chemotherapy etc.

"Key health issue is that cardiac surgery is not available anywhere in any medical centre of Swabi."

(Doctor, Private Secondary hospital, Swabi)

"The patient often complains about the unavailability of procedures. Sometimes the facilities are provided by the government, but it is not being provided at the hospital level, then the patients complain and even fight because they expected that it would be available."

(Focal person, Private Tertiary hospital, Peshawar)

"Main issue is that not all investigations are available here because of which the patient is unable to avail all Sehat Card facilities."

(Hospital In charge, Private Secondary hospital, D I Khan)

Theme 4: Arduous and slow claims reimbursement process

The standard time of two weeks is stated on the policy document for reimbursement, however minor errors and missing supporting documents result in delays in reimbursement. The delay becomes more challenging when payments have to be made to contractual employees and external vendors.

The process of filing the claims is tedious as no extra resource has been allocated for this function and hospitals

have to cater to the extra workload using their existing resource envelope. This also includes time and cost of hospital resource person/manager involved with filing and vetting claims, the expenses incurred on printing and photocopies of all supporting documents and the transportation/courier charges for the hard copies of the documents.

"When we send them the claim, we do not get a quick response on it. It sometimes takes several months. Now, if there is a signature or CNIC missing in a file, they send the file back for completion after 6 months, when only half an hour is required to complete it."

(Focal person, Private Tertiary hospital, Peshawar)

"We don't have an SSP pharmacy in the hospital. We have had meetings with the Pharmacy, but they complain that they had given medicines worth 50 Lakh Rupees in Sehat Card, but they get the payments so late. So, if the payments are received so late by SSP, the services are dropped."

(DMS, Public Secondary hospital, Upper Dir)

"Sometimes we do multiple procedures that are required, but we are getting paid for only one procedure. Time and logistics are being extra used but the system is not paying us for triple procedures, we are not getting even half the amount of it."

(CEO, Private Secondary hospital, Bannu)

"Their requirement is way too much, so much paperwork is required and verification, if something is misplaced then we have to print again, and resource usage is also an additional burden."

(Admin Officer, Private secondary hospital -Chitral)

Theme 5: Lack of quality assurance knobs and external monitoring systems

Quality assurance of service delivery is not carried out on a routine basis at most facilities. While the large tertiary care hospitals have quality assurance departments, monitoring of quality of care is not an area of focus at smaller secondary hospitals. SLIC carried out assessment of the hospitals at the time of empanelment, however routine monitoring is deficient. The role of the HealthCare Commission is still under development, as they are now conducting workshops with the hospitals on minimum service delivery standards.

"No, we have not made any department of quality assurance yet"

(Manager, Private Secondary Hospital-Peshawar)

"We had a workshop earlier with the HealthCare Commission on minimum service delivery standards. So, we are continuing to do our work on that, there are some standards and indicators. Some are completed and some are still in progress. So, we are following those."

(Manager, Public Secondary Hospital-Peshawar)

"Our hospital is certified by ISO and SGS group has also certified it, so it's one of the best hospitals at the secondary level and we are providing the best services."

(Admin Officer, Secondary Hospital- Chitral)

Programme Strengths and Enablers

Theme 1: Comprehensive benefits package design and cost

The SCP package takes a comprehensive approach to healthcare, ensuring that the beneficiaries have access to a wide array of curative inpatient services. The programme has empanelled both private and public hospitals, ensuring greater choice of health facility and healthcare provider for users and bringing care closer to them. With provisions like reserve funds and consultation allowances, it seeks to reduce their OOP expenditures significantly. In instances where the patient has already exhausted his benefit limit, a special request is made to SLIC for approval as a special case to be paid from 'reserve funds'.

"In our hospital, all procedures are done on Sehat card including urology procedures, general surgery procedures, gynaecology procedures, orthopaedic procedures etc."

(MD, Private Secondary hospital, Swabi)

"Suppose a cardiac patient has come into an emergency, so we would give him treatment, for example, angioplasty, the package is for Rs.1,60,000. If his balance is zero so we would take his documents, we prepare the file and send it to the DMO for special approval."

(HFO, Private Secondary Hospital, Peshawar)

"The amount exceeds in heart and kidney cases. Let's suppose, the kidney case amount exceeds 14 lacs, then a reserve fund is given after approval. Reserve fund facility is for heart cases, kidney cases and liver transplant patients."

(SSP Manager, Private Secondary Hospital, Bannu)

"Emergency cases do not require an approval, for example appendix or traumas. Hospital is bound to provide coverage first, then when a patient gets stable, we complete his documentation."

(HFO, Private Secondary hospital, Swabi)

Theme 2: Robust third-party administrative mechanisms

The SCP has incorporated a robust and comprehensive third-party administrative system that ensures transparency, efficiency, and patient-centeredness. The empanelment process is also undertaken by SLIC, with hospitals undergoing detailed assessments and on-site

inspections before being granted affiliation. This is followed by a grading system, ensuring that only facilities meeting specific standards are included. Communication is versatile, using online dashboards, emails and even WhatsApp, ensuring constant connectivity. The role of SLIC personnel is pivotal in bridging the gap between patients and the insurance provider. Additionally, the presence of a Health Facilitation Officer (HFO) at each facility ensures that beneficiaries receive guidance and assistance throughout their healthcare journey. The programme's emphasis on patient feedback further reinforces its dedication to continuous improvement and patient-centric care. The billing and reimbursement are transparent in most instances,

"A letter was first issued to the hospital regarding assessment. For this purpose, there was an assessment team which was composed of doctors. They visited the whole hospital which includes wards, pathology and pharmacy. Beds were checked in the ward and the hospital was assessed thoroughly. Then they met the doctors, the medical officers, and their PMDC registration was also checked. They sat with the consultants and checked their qualification and then they checked OT, equipment, labs, etc. The whole assessment was carried out. Afterwards, they did the grading."

(DMO, Private Tertiary Hospital, Peshawar)

"We report them through WhatsApp, and they have also given us their dashboard to directly communicate with them."

(Hospital Director, Public Secondary Hospital, Bannu)

"He (HFO) visits and revisits the ward to check if there is any new Sehat Card patient. He always asks if the patient has any problem with the staff or our department. I have seen in my shift that they have written their complaint number, and they tell the patients to feel free to call on this number in case of any problem."

(Nurse, Public Tertiary Hospital, Swat)

"After operation, we complete all documents and forward them to Peshawar Head Office where these documents are checked on 5-6 places. Once it's done, a cheque is issued to that hospital."

(SSP Manager, Private Secondary Hospital, Bannu)

Theme 3: Digitization of health management information systems

The SCP in collaboration with SLIC, is using digitization of health information systems to improve programme efficiency and to optimize healthcare delivery. It is noteworthy that many empanelled facilities are utilizing platforms like Oracle and AGLAM for their HMIS. These systems streamline patient data management and foster real-time communication with State Life Insurance, however the use of data for decision-making remains lacking. Additionally, SCP's shift towards e-claims signifies its commitment to modernization, however most hospitals have not been able to completely adopt the new system. As hospitals transition to this online system, the claim process will become swifter and more transparent. Together, HMIS and E-claims underscores SCP's dedication to leveraging technology for improved health outcomes.

"We have HIMS software which is controlled by the central web. In this system, everything is recorded from the patient's entry to exit. There's communication between ward, pharmacy, and State Life."

(Focal person, Public Secondary hospital, Bannu)

"We are going towards AGLAM, which is itself a great initiative. It is also time consuming, but it has its own benefits like all the record keeping is online, we and State life can check and get access to it whenever we want."

(Focal person, Private Tertiary hospital, Peshawar)

"They have taken a good initiative recently in this by introducing e-claim submission. You can now prepare the soft copy and upload it to their portal."

(Associate Professor, Private Secondary hospital, Peshawar)

"Previously our communication channel was in the form of hard copies via TCS. From this month, we have started the whole system online."

(CEO, Private Tertiary hospital, Swat)

Discussion

Drawing insights from key stakeholders, our study has revealed that the SCP has been, by and large, very well accepted by the implementers as well as the beneficiaries. While there were general improvements in ensuring equitable access to the beneficiaries, the quality of care remains underexplored. Notwithstanding, the facilities also enumerated significant challenges that must be addressed to streamline delivery of health services to the population of KP.

An important concern raised by informants from the empanelled facilities was their dissatisfaction with the reimbursement rates allocated by SLIC, which were deemed to be low. The perceived inadequacy of reimbursement rates is in line with what has been reported by stakeholders from National Health Insurance schemes in other countries such as Ghana,[17] India,[18] Nigeria,[19] Philippines[20] and Vietnam.[21,22] The literature also suggests that without regular adjustment for inflation and devaluation, these rates potentially compromise the quality of care, emphasizing the need for periodic reviews and consultative processes to ensure quality care delivery.[23] For

instance, in Ghana, a formal review of the reimbursement tariffs in July 2011, in response to provider agitations, lead to an overall 26% increase in the rates.[17] Similarly, in Vietnam, the absence of formal process and stakeholder engagement in developing an appropriate benefit package and settling reimbursements has lead to implementation gaps.[21]

Gaps in personal identification documents of the beneficiaries surfaced as another significant barrier limiting access, especially among beneficiaries eligible for SCP benefits. The SCP, in line with what is widely practiced in the NHIS in Thailand[24] has started using the existing computerized national identification card (CNIC) system for clients to gain access to the benefits of the programme, moving away from the programme specific “Insaf card”. However, complexities related to updating identity documents have hindered access to essential services particularly for women, for example, access to child delivery services. For efficiency reasons, it is worth exploring how to strengthen the use of existing identification platforms such as NADRA to facilitate the beneficiaries.

The resource-intensive claim process, coupled with slow reimbursement in certain instances, presents notable challenges. These are in line with global concerns where healthcare providers struggle with the administrative burden of reimbursement processes under health insurance schemes.[23] The claims and reimbursement experiences of health facility staff in Johannesburg, where there was excessive NHI-related workloads lead to staff demotivation.[25] To address these issues, a shift towards e-claims system and standardized disease coding mechanisms, as implemented in other LMICs, could help reduce the inefficiencies and workloads associated with paper-based documentation.[26] These initiatives have already been introduced by the SCP, however complete and mandatory implementation is required to improve programme efficiency. In addition, the use of data for decision-making needs strengthening.

The SCP's comprehensive benefits package design and the additional catastrophic insurance scheme are significant strengths, providing access to a wide array of curative inpatient services and reducing out-of-pocket expenditures. However, as non-communicable diseases (NCDs) contribute to 58% of all the deaths in Pakistan, the curative care is not addressing the rising trend of NCDs in Pakistan, which calls for a greater emphasis on health promotion and prevention,[27] including the provision of Primary Health Care.

Our analysis also highlighted the dominance of SLIC in ‘running the show’, without many external quality control mechanisms. Strengthening the capacity of the SCP secretariat or engaging the Healthcare Commission could ensure better oversight.[28] For SCP to realize its full potential, continuous feedback from ground-level stakeholders, as presented in this study, is invaluable. Balancing the programme’s challenges with its strengths and focusing on iterative improvements can pave the way for SCP to serve as a beacon for health financing solutions in Pakistan and other LMICs.

However, it is crucial to acknowledge that the insights drawn from this study are primarily applicable to the unique socio-economic and healthcare context of KP. The study's reliance on qualitative data from a specific set of stakeholders and its regional focus limit its generalizability to other settings. Another limitation of the study is the absence of patient and policymaker perspectives. This gap highlights an area for future research to gain a more comprehensive understanding of the programme's impact.

Conclusion

This study offers a detailed insight into the barriers and enablers of implementation of the SCP, emphasizing the necessity of reviewing reimbursement rates, tackling documentation issues, ensuring service accessibility, simplifying reimbursement procedures, and fortifying quality assurance measures. The SCP's success is underscored by its comprehensive benefits package, robust third-party administration, and initiatives in digitization.

Disclaimer: Limited findings from this study have previously been discussed in a report titled “Third Party Evaluation of Sehat Card Plus Khyber Pakhtunkhwa” which was conducted by the Department of Community Health Science at the Aga Khan University, Karachi, Pakistan.

Conflict of interest: None.

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