Policy

Utilisation Challenges of Public Health Insurance Initiatives: Evidences from Sehat Sahulat Programme (SSP) in Pakistan

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EXECUTIVE SUMMARY

Healthcare utilisation largely depends on both demand and supply-side factors. On the supply side, health infrastructure could be better to serve the population's needs, whereas, on the demand side, affordability is the main challenge, especially for poor households. Health insurance provides an opportunity to avail of decent health facilities. The government of Pakistan launched the Sehat Sahulat Programme (SSP) to provide equitable and affordable indoor health services through public-driven health insurance.

The current study has analysed the SSP by focusing on the factors that may reduce the in-door utilisation of health services. Besides secondary analysis, we have managed the qualitative and quantitative field survey by conducting in-depth interviews with all the supply and demand side stakeholders. A household survey is also carried out with the beneficiaries.

Our analysis found that the programme has been facing the issues of lower utilisation due to various factors, including lack of awareness and a limited number of empanel hospitals. In some districts, there is only one hospital to cater to the needs of 73,000 families. The programme also requires focus to ensure 100 percent enrolment of all the eligible families, as in study districts, the pending cases range from 22 percent to 74 percent, with an average of 39 percent. Around 7 percent of the inpatients are deprived of seeking indoor treatment, either due to lack of hospital or lack of facility in the hospital or denial of services by the empanel hospital.

The programme requires improving the environment of the empanel hospital by ensuring the availability of communication material, the 24/7 presence of a front desk person (HFO), and the availability of the operational manual. On the demand side, we found that most beneficiaries need more proper knowledge about various programme features, including where they should go for treatment, package amount, type of treatment covered in the package, and whom to contact for information.

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Despite the low utilisation rate, a heartening element is the high satisfaction level of the beneficiaries who had received treatment. As a way forward, we recommend the following:

First, the programme may ensure every citizen receives in-door health treatment by improving accessibility and availability of health services and easing the documentation requirement.

Second, there must be a sufficient number of empanel hospitals, and offered packages against a treatment must be attractive to avoid the 'pick and choose' option by the hospitals. The entire government health infrastructure must be on the pool of SSP. It should be mandatory that all private hospitals be a part of the SSP.

Third, the authorities must ensure that HFOs should be available in hospitals 24/7. The hospital list should be publicly available through various sources, including the website and dedicated SMS service. Moreover, the programme should introduce some Android applications to find the nearest hospital to a patient.

Fourth, there is a need for a grassroots-level communication strategy, especially in districts where the programme is universal. The key messages must be disseminated at the doorsteps of beneficiaries. For this, the programme may involve local notables, education and health departments, and other social safety net departments having a ground-level presence (i.e., BISP, Zakat, Pakistan Bait-ul-Mal, and various provincial social protection/security authorities). Overall, the communication strategy must be heterogeneous, considering the population's needs.

1. INTRODUCTION

1.1. Introduction

Healthcare utilisation largely depends on both demand and supply-side factors. In developed countries, it is mostly determined by the demand-side factors as these countries have well-structured supply-side facilities and financing elements, including health insurance systems (Kale, et al. 2013, Kressin & Groeneveld, 2015). However, in low-income countries, access to health facilities and quality of health services are the major concerns, as poor individuals cannot utilise the health facilities due to the availability and affordability challenges (Lyu, et al. 2017).

Most low-income countries, including Pakistan, face supply and demand-side constraints on effective health financing tools. On the supply side, they lack high-quality health infrastructure—uniformly available to all the population segments. On the demand side, the informal markets, and health insurance mechanisms are inadequate and accessible only to a limited population segment. The social protection programmes also cannot ensure health financing for vulnerable and low-income families. As a result, most of the population has to finance their expenses from their pockets (Vujicic, Buchmueller, & Klein, 2016). The heavy health expenditures raise their present vulnerability, i.e., compromise on low or forgo treatment, and push them into chronic and intergenerational poverty. As a coping strategy, they mostly borrow, cut down on consumption, sell assets, and curtail other investments, including that on child education (Bredenkamp, Mendola, & Granolati, 2010).

Health insurance provides an opportunity to avail adequate health facilities Finklstein, et al. 2012). Different health insurance models are operatable around the globe, including single-payer, multiple insurers, government-sponsored and employer-sponsored insurance, etc. Ellis, Chen, & Luscombe, 2014). However, such models could be more mature and operational in developing countries by targeting most of the population due to various socio-economic imperfections, including informal economy, lack of affordability, absence of competitive health insurance companies, and cultural, religious, and other beliefs. For example, various religious segments in Pakistan consider health insurance as '*haram*'.

Health insurance helps the public, especially the poor, to afford equitable health facilities; therefore, insurance schemes can enhance the health utilisation rate across various socio-economic groups, including inpatient, outpatient, and emergency services [6]. Multiple governments in developing countries have devised health insurance schemes for the poor segments to facilitate them through in-door/out-door services, i.e., Rashtriya Swasthya Bima Yojana (RSBY) and PMJAY in India (Thakur, 2016), National Health Insurance (NHI) in South Africa (Setswe, et al. 2015), and National Hospital Insurance Fund (NHIF) in Kenya Kazungu & Barasa, 2017). Some programmes are non-contributory, where the government fully pays the health premium, whereas some are contributory.

There are various challenges in the supply-driven health insurance programmes for the poor segments. For example, the need for more awareness about health insurance schemes plays a vital role in influencing the coverage and acceptability of the schemes amongst the beneficiaries, leading to lesser effective utilisation of health care services and, consequently, poorer health outcomes. Although the public sector programmes offer free health insurance to the poor and vulnerable segments, they mostly face coverage issues and lower utilisation. The programme may also need better awareness among beneficiaries, lack robust planning, delays and irregularities, etc. (Thakur, 2016). Several determinants of poor understanding include political factors, social/cultural norms, and economic factors (Thakur, 2016, Capuno, et al. 2016). Supply-side factors include hospital access, lack of requisite facilities, denial of services by empanelled hospitals, and lower health insurance limits (Setswe, et al. 2015, Wagstaff, et al. 2016). Sometimes, the poor beneficiaries have to purchase medicine out-of-pocket due to the non-availability of ensured treatment in empanelled hospitals or because the scheme does not cover prescribed drugs (Rathi, Mukherji, & Sen, 2012, Devadasan, et al. 2013). Regular awareness campaigns, automated health insurance systems, and efficient complaint management systems significantly improve health insurance utilisation care (Kotoh, Aryeetey, & Van Der Geest, 2018).

1.2. Health Utilisation Issues in Pakistan

According to the constitution, the state is responsible for providing the necessities of life to all citizens irrespective of sex, caste, creed, or race (Article 38 of Pakistan). Still, health is treated as a commodity in Pakistan, and most population finances health services from their own pockets Malik & Syed, 2012). The state lacks sufficient resources to provide equitable health facilities to all population members. The country has been facing a doubled disease burden where, on the one hand, health budgetary allocation is insufficient (only 0.6 percent of GDP), and, on the other hand, around two-thirds of the population finances their health expenses themselves (Figure 1). The employed population working in the formal sector may avail of health insurance as provided by the government part of their perks. Still, the poor and informal workers mostly lack such facilities.

Fig. 1. Sources of Health Financing in Pakistan (%)
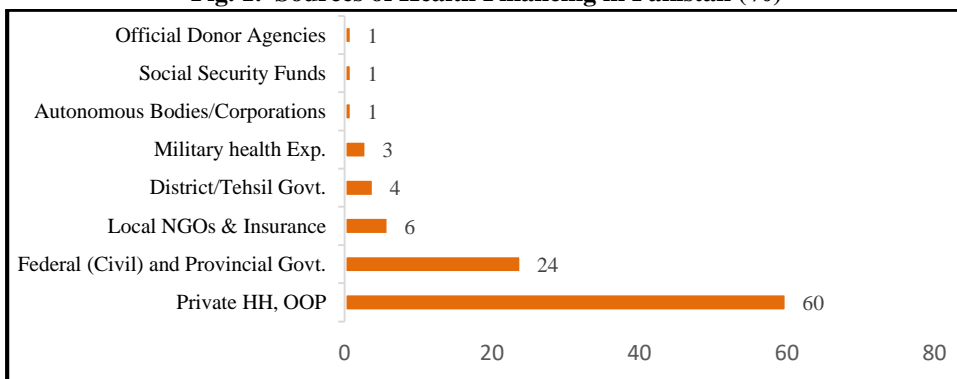
Source: GoP, National Health Accounts, 2013.

The public health system of Pakistan can only serve part of the population due to resource constraints and the lack of a well-structured health infrastructure. For example, the 2008 Mouza Statistics show that 65 percent of the rural population of Balochistan in Pakistan has to travel a lot (more than 10KM) to access health centres (Figure 2).

Fig. 2. Average Distance to Health Centres for Rural Masses (in Kilometer)
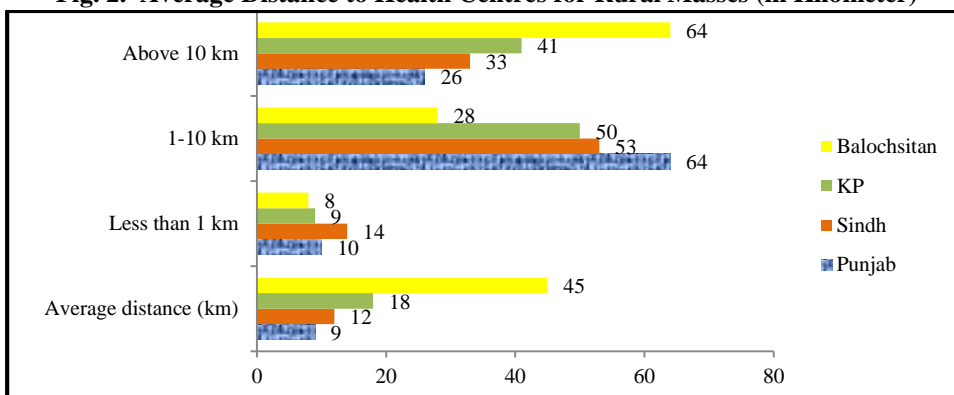
Source: Mouza Statistics, Pakistan Bureau of Statistics (PBS), GoP (2008).

Due to poor public sector infrastructure, private hospitals bridge the gap. The statistics of the 2017/18 National Health Accounts (NHA) reveal that 83 percent of the population in Pakistan has experienced using private health facilities, whereas only 17 percent used government health facilities. In such a scenario, the poor and marginalised households in Pakistan are more disadvantageous as they face the double burden of diseases—on the one hand, they face more chances of sickness, and on the other, they lack resources to purchase the desired health services in private hospitals (Shaikh & Hatcher, 2005).

Before the emergence of SSP, most low-income groups financed their health services from their own pockets. Affordability was one of the significant barriers to their utilisation of health facilities, and they had only the option to visit government health centers. The emergence of SSP has eased the lives of people with low incomes by providing reasonable and affordable insurance coverage for in-door treatment for the entire family.

Private hospitals are empanelled with the SSP to ensure the supply-side facilities, as there could be overcrowding and attitude issues in government hospitals.

The SSP programme uses the Benazir Income Support Programme (BISP) poverty score data for targeting. The SSP has a clear eligibility threshold of a score of 32.5. Our estimates suggest that the programme covers more than one-third of the population; therefore, most of the bottom two quintiles are covered in the SSP. The critical challenge of the SSP is the low utilisation rate of the provided health insurance. Global evidence suggests that it should be around 4-7 percent but below 1 percent per annum for the SSP. Potential reasons could be manifolds at both the demand and supply sides. There could be certain constraints related to policy, implementation, and database. An eligible person must enrol in the programme or avail of the services. The reasons may include:

- Non-traceability of beneficiaries due to incomplete addresses and migration and incomplete database (lack of CNIC and non-registration of all family members).
- Card delivery challenges due to migration of the recipients and weak communication and awareness strategy.
- Lack of a sufficient number of hospitals to provide indoor treatments.
- Poor and marginalised segments mostly lack proper information on how to be enroled in the programme and utilise health services.

Our previous analysis of BISP's Waseela-e-Sehat Programme (WeS) found alarming findings: the utilisation rate was below 1 percent. A lack of awareness was the critical reason for not utilising health insurance services. Many beneficiaries considered that they would get cash instead of using the health card. There was no reliable information center to guide the beneficiaries despite BISP's Tehsil offices in the area; however, they were not properly trained to guide the beneficiaries. Another constraint was the lack of OPD facility in the health insurance card. OPD is quite essential in reducing catastrophic health expenses. The 2017-18 NHA report suggests that around 78 percent of the population used health facilities for outpatient, 8 percent used in-patient facilities, 5 percent used delivery, and 11 percent used self-medication.

1.3. Objectives of the Study

The proposed research aims to evaluate the barriers that can hinder the potential beneficiaries from enroling in the Sehat Sahulat Programme (SSP) and utilising the health services. The study revolves around the following objectives:

(i) To review the existing communication and awareness policies and guidelines on enrolment and service delivery as well as the implementation of these guidelines;

(ii) To analyse the operational challenges in enrolment and card delivery to the beneficiaries;

(iii) To identify the potential collaboration with the public sector social protection initiatives;

(iv) To evaluate the in-door utilisation of the programme, whether there is some non-utilisation of health facilities due to lack of information; and

(v) To draw policy implications for enhancing enrolment, coverage and awareness among the beneficiaries.

1.4. Organisation of the Study

The current study is organised into seven sections. A literature review is detailed in Section 2, followed by data and methodology in Section 3. A secondary analysis is carried out in Section 4 using the SSP dataset. Section 5 details the analysis of data validation and communication arrangements on enrolment and service delivery. Section 6 explains the demand and supply side analysis of health utilisation. The last section concludes the study along with recommendations.

2. UTILISATION ISSUES IN PUBLIC DRIVEN INSURANCE PROGRAMMES

The word health insurance is unknown to most poor living in developing countries. Health is still a significant shock and permanent threat to the livelihood and earnings of low-income people, where they have to bear both the direct (i.e., doctor fees, medicine, etc.) and the opportunity cost of missing their labour hours. Various developing countries have started social health insurance schemes to improve access to acceptable healthcare for the marginalised segments.

Alternative healthcare financing and cost recovery strategies like user fees are generally criticised. This makes the insurance option appear to be a sound alternative as it allows pooling the catastrophic risks and unforeseeable health care costs to fixed premiums. Various health insurance models are operatable around the globe, including non-profit, mutual, and community-based health insurance schemes etc. An ethic of mutual aid, solidarity, and the collective pooling of health risks characterises these schemes. In several countries, these schemes operate with health care providers, mainly hospitals in the area.

In South Asian countries, India has a good example where less than one-fifth of the population has a considerable health insurance plan. Approximately 70 percent are covered under various government schemes in India, i.e., Pradhan Mantri Jan Arogya Yojana (PMJAY), Employment State Insurance Scheme (ESIS), Aam Aadmi Bima Yojna (AABY) and the Janashree Bima Yojna (JBY).

A well-designed health insurance programme for the poor must hold the following characteristics:

- The programme must enrol a large proportion of the poor;
- The enroled population must increase their utilisation of health facilities;
- The programme must improve financial protection for the poor by reducing out of pocket payments that lead to increased poverty; and
- Over time, successful health insurance schemes should improve health outcomes for the poor.

Success in achieving the desired results from health insurance for poor segments depends on multiple factors, mainly outside the health insurance scheme, including good quality services (supply-side) and social and cultural norms on the demand side. While designing the programme, the policy-makers must consider these aspects (Watson, Yazbeck, & Hartel, 2021). The evidence suggests that programmes with universal

eligibility for insurance with a substantial premium subsidy can significantly improve enrolment rates. For example, in Thailand, citizens not covered in formal sector programmes are eligible for a non-contributory health insurance programme, and almost 100 percent are enroled, with an increase in utilisation over time (Suphanchaimat, et al. 2016, Wagstaff & Manachotphong, 2012). In Ghana, universally exempting all pregnant women from paying premiums significantly expanded coverage of people with low incomes Nguyen, Rajkotia, & Wang, 2011).

Even if people experiencing poverty are rightly identified/selected, a scheme can achieve pro-poor enrolment only if it has a well-administered plan to enrol the poor segments. The Indonesian programme Kesehatan Masyarakat programme is available for all the poor households in the bottom two quintiles. However, it requires a lot of documentation and official procedures for registration, resulting in limited registration (Brooks, et al. 2017). We have found in SSP that a significant number of eligible families still need to be enroled due to specific communication-related challenges.

Information and administrative features of schemes are the most critical aspects. The insurance increases health utilisation only if the beneficiaries understand the programme's features. Still, there is evidence that many do not, especially if they have been automatically rather than voluntarily enroled and have yet to be well informed about their entitlements. In Kerala, a lack of knowledge about the benefits package and empanelled hospitals was the main reason people who held a Comprehensive Health Insurance Scheme card did not use it (Philip, Kannan, & Sarma, 2016). On the other hand, the awareness campaigns led to significant knowledge and utilisation of services in the case of the Rajiv Aarogyasri Community Health Insurance Scheme in Andhra Pradesh and VAS in Karnataka (Sood & Wagner, 2018, Rao, et al. 2016).

The impact of health insurance on the utilisation of health care services in low and middle-income countries is demonstrated well in the literature. The utilisation depends both on demand and supply side factors and constraints. Gotsadze, et al. (2015) found that medical insurance for low-income families increased the use of formal health services by 12 percent in Georgia (Gotsadze, et al. 2015). Another study in Indonesia found that the Jaminan Kesehatan Nasional Programme increased inpatient admission for the premium voluntarily paid group by 8.2 percent and the subsidised group by 1.8 percent Erlangga, Ali, & Bloor, 2019). However, evidence on the effect of health insurance on out-of-pocket (OOP) reduction was found inconsistent by some studies (Aji, et al. 2013, Erlangga, et al. 2019). Some studies have reported that health insurance reduces OOP expenditures (Gotsadze, et al. 2015, Kanmiki, et al. 2019), while others found that health insurance increases OOP expenditures. For example, evidence from the Indian National Health Account 2017 shows that OOP health expenditures for inpatient care constitute around 32 percent of the total OOP health expenditures despite the coverage offered by various health insurance programmes.

Karan (2017) analysed the Rashtriya Bhima Yojana (RSBY) programme in India and found that RSBY has raised households' non-medical expenses by 5 percent without impacting OOP spending. The schemes could have been more effective in reducing the burden of OOP on low-income families. Some of the reasons cited by them were denial of services and lower coverage limits to provide care by empanelled hospitals and lower coverage limit. Nayab and Khan (2015) evaluated the Waseela-e-

Sehat Programme (WeS) in Pakistan and found poor health utilisation among insured families. The critical main reason for not utilising health insurance services was a need for more awareness. The other reason was that there needed to be a reliable information center to guide the beneficiaries properly. Another constraint was the need for an OPD facility in health insurance cards.

Better accessibility increases utilisation and decreases income-related differences. Thus, improving geographic accessibility, a structural approach, could improve utilisation and decrease income-related disparities (Fujita, et al. 2017). The study of Thakur (2015) evaluated the awareness, enrolment, and utilisation of Rashtriya Swasthya Bima Yojana (National Health Insurance Scheme) in Maharashtra, India, and found that only 29.7 percent were aware of the scheme and 21.6 percent enroled 2-4 years post the rollout of the scheme. A significant rural-urban differential was found in the level of awareness, with rural understanding greater than urban awareness by 13.2 percent. The study found that the political factors (voting in recent elections, participation in local politics, political contacts, contesting in the local election, and being a member of a political party) were more significantly related to awareness as compared to social/cultural and economic factors in both urban and rural areas Thakur, 2016). However, in comparatively developed countries (i.e., South Africa), the respondents' knowledge and awareness were high (Setswe, et al. 2015).

Panda, et al. (2015) found that various awareness tools (i.e., stories and folklore evoked in flipbooks, posters, and wall paintings based on the local understanding of insurance and risk-pooling mechanisms) improve beneficiaries' awareness. The findings suggest that the enrolment rates can be increased through frequent interactions and communication of concepts to the public (Panda, Chakraborty, & Dror, 2015). Philip, et al. (2016) found that the enrolment rate is high among families having pre-existing disease(s) or having a member who is chronically ill (Philip, Kannan, & Sarma, 2016). El-Sayed, et al. (2015) managed the analysis in 48 countries through a quasi-experimental design. They found a higher enrolment rate for the chronically ill compared to the general population in various health insurance schemes in many LMICs (El-Sayed, et al. 2016). Another study in Kenya showed that the sick chronically had, despite having a borderline significance, 22 percent greater odds of coverage compared to those without a chronic disease (Kazungu & Barasa, 2017).

Kotoh et al. (2018) employed a multi-level perspective to examine the reasons for enrolment and retention in the Ghana's National Health Insurance Scheme via canvassing household survey 20 months after educational and promotional activities to improve enrolment and retention rates. The results indicated factors influencing enrolment and retention in NHIS can be multi-dimensional across all stakeholders. People enroled and renewed their membership because of NHIS benefits and health provider's positive behaviour. Barriers to enrolment and retention included poverty, traditional risk-sharing arrangements influencing people to enrol or renew their membership only when they need healthcare, dissatisfaction with health providers' behaviour, and service delivery challenges (Kotoh, Aryeetey, & Van Der Geest, 2018). A Meta-analysis is given in Table 1.

Table 1

A Meta-Analysis of Health Insurance for Poor Segments

Study	Pro-poor Enrolment	Pro-poor Utilisation	Pro-poor Financial Protection	Pro-poor Health Outcomes
Georgia Medical Insurance (2007-2008).		No pro-poor effect.	Reduced OOP and CHE.	
Georgia Medical Insurance for the Poor (2006).		Increase utilisation of inpatient services by the poor.	-	
Ghana Two Rural Districts.	Enrolment rates much lower for the poor than for the rich.		Insurance had a strong protective effect against CHE for the poor.	
Ghana NHIS Coverage of Pregnant Women in BrongAhafo.	Enrolment was automatic for all pregnant women. Enrolment rates much lower for the poor than for the rich.	Narrowed the differential in facility deliveries between rich and poor.	Not explicitly examined, but pregnant women were exempt from the premium and all co-payments.	
Kenya Jamil Bora CBHI.	Poorest were most likely to be enroled.	Utilisation of inpatient services was highest among the poorest quintile.		
Ethiopia CBHI.	Participation in the productive Safety Net Programme increased the likelihood of enrolment in CBHI.			
Burkina Faso Nouna CBHI.	Use of community wealth ranking increased enrolment by the poor.			
Mexico (Seguro Popular).	Not reported, but the data came from a programme that also increased enrolment of the poor.		Reduced CHE for the poor (who were the people eligible to join).	
Colombia India VAS Karnataka.	Coverage was mandatory Enrolment is automatic.	Point estimates suggest a large increase, but the study was not powered to detect significant changes.	Substantially reduced OOP costs for hospital admissions. Reduce OOP.	Reduced mortality. Reduced mortality.
India RSBY Himachal Praceshy.				
India RSBY Gujrat.	Most BPL families in the sample were enrolled.		Most enrollees who were hospitalised still faced OOP payments.	

Continued—

Table 1—(*Continued*)

China NCMS TB	Enrolment rates are high.		Small positive effect.	
China NCMS Puding Country 2009 Reforms	Enrolment rates are high in NCMS.		Reform removed the pro-rich bias in reimbursement by NCMS.	
China NCMS Rural. China Urban Schemes Shaanxi.	Enrolment rates are high in NCMS.	One of the two schemes had a pro-poor effect on outpatient utilisation. Both had pro-rich effects on inpatient utilisation.		
China NCMS Six Countries.	Enrolment rates are high in NCMS.	Small pro-poor impact on inpatient utilisation; no significant impact on outpatient utilisation.		
Vietnam Health Care Fund for the Poor (HCFP)	Successfully enrolled the poor.	No significant impact	Significant pro-poor impact on financial protection.	
Vietnam HCFP for the Rural Elderly Poor.		Increase utilisation	No significant impact on financial protection.	
Vietnam under 6 Years Old. Vietnam HCFP.	Enrolment is automatic.	Increased utilisation Small impact on outpatient visits; larger impact on inpatient utilisation by the poor.	No impact found ion financial protection.	No impact found on number of sickness days or bed days.
Vietnam Health Insurance in Rural Areas in Philippines.		Pro-poor impact on utilisation of both outpatient and inpatient services. No pro-poor effect that could be attributed to insurance coverage.		
Indonesia Jamkesmas Celivery care.		Modest effect on facility-based delivery and skilled delivery among poor women.		
Indonesia obstetric care in three hospitals. Thailand migrants			Insurance significantly reduced CHE for poor women.	
Thailand	Some success in enrolment.	Utilisation remained low.		

Source: Watson, et al. (2021) [18].

3. CONCEPTUAL FRAMEWORK, DATA AND METHODOLOGY

To accomplish the objectives in Section 1, we have adopted a multi-approach strategy that includes desk analysis, secondary analysis, and primary data collection (qualitative and quantitative) from relevant stakeholders. The current section details the conceptual framework, methodology, and data collection process against each tasks according to the study's objectives.

3.1. Conceptual Framework

Health insurance schemes must be available, accessible, and acceptable to the targeted population if they are to be used. The decision-making process for individuals to use such schemes depends on their choices about when and where to seek care and the various socio-economic and cultural factors that influence their perceived needs and demands. Before their perceived needs result in demand for and utilisation of health services, they must interact with the reality of the health insurance system. This includes knowledge and facility of features and services covered, level of affordability (for expenditures not covered), and quality (actual or perceived) of treatment given under such schemes, in addition to the ease in identifying and registering.

To understand the potential reasons for lower utilisation rates, the level of awareness of the scheme, and various factors that can increase the scheme's uptake, we employ a modified Tanahashi framework (1978) to review the demand and supply side constraints. The framework is beneficial for ascertaining challenges to universal coverage – defined by WHO as access to critical promotive, preventive, curative, and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access.

The framework helps identify the barriers and enabling factors in accessing hospital care services under the Sehat Sahulat Programme (SSP). This model has supported the identification of bottlenecks through a stepwise approach by evaluating six determinants of the effectiveness of coverage of an intervention.

(i) *Availability coverage:* This considers the resources available for delivering an intervention and their sufficiency. That is the number or density of health facilities and personnel or the availability of technology (drugs, equipment). In other words, availability coverage measures a health system's capacity about the size of the target population or, ideally, the people in need.

(ii) *Accessibility coverage:* There are two main dimensions of accessibility: physical access and affordability. On the physical dimension, access may be hindered if the resources are available but located inconveniently. For example, the distance from a health service provider is a vital accessibility factor. Time is another factor closely related to distance and transport. The travel time to a health facility to access services and the waiting time to see a health professional seem well-associated with patients' perceptions of the accessibility of services. However, the value of time (opportunity cost) is different for different groups of people and, consequently, has varying impacts as an access barrier. The second main dimension is the financial barrier to access or financial accessibility (affordability). User fees and transport costs have been shown to negatively impact access to health services, rendering health services inaccessible to poor and vulnerable households. Out-of-pocket (OOP) health expenditure as a percentage of total health expenditure and the percentage of the population suffering from catastrophic health expenditures can be used as indicators to measure the financial barriers to accessibility.

(iii) *Acceptability coverage:* Tanahashi defines acceptability coverage as the capacity of health services to be appealing and sought by the people. Even if resources are available and accessible, they may not be used if the population does not accept them. Acceptability includes non-financial factors such as culture, beliefs, religion, gender, age-appropriate services, and confidentiality, as well as aspects of affordability that relate to people's perceptions of the value of health services. People's perceptions influence the acceptability of coverage and expectations of health services, such as expected costs, effectiveness and quality of care, religious views, and personal beliefs.

(iv) *Initial utilisation:* It means that people are initially enrolled or intend to use the services.

(v) *Continuous utilisation:* It is defined as the actual contact between the service provider and the beneficiaries in the last six months. The number of beneficiaries who have contacted a service measures output. It is similar to the 'use of services'. Contact coverage may be equivalent to adequate coverage for health interventions requiring a one-time action.

(vi) *Effective utilisation:* The contact between the service provider and the beneficiary only sometimes leads to successful intervention by health programmes or effective utilisation. Some services may not be available since they enrolled or may be far away, poor quality of in-door health services, unaffordable or unacceptable for specific groups may not be satisfied with the treatment, etc.

The first two factors focus mainly on supply-side constraints, while the others concentrate on demand-side barriers. The framework is useful for analysing the level of awareness to access the hospital care services under the Sehat Sahulat programme (SSP) as it helps identify the entitled beneficiaries who do not have any knowledge about the features and process of the scheme and helps identify the barriers/constraints encountered in reaching out to the potential beneficiaries. Information may not have reached /available to the beneficiaries, or the location of beneficiary enrolment centers (BEC) or hospitals for registration may be far away, unaffordable, or unacceptable for certain groups of beneficiaries who will never contact the health system to take advantage of the benefits of the scheme.

Significantly, the above six determinants will help to differentiate between nominal (potential) and practical (actual) coverage, as it highlights the gap between available supply (service capacity) and the three determinants of service output (initial utilisation, continuous utilisation, and effective utilisation). As long as these bottlenecks exist, programmatic interventions will fail to reach those in need, and an effectiveness utilisation "gap" will remain, with an endurance of inequitable health outcomes. Removing the bottlenecks is, therefore, a mandatory step towards achieving the equitable impact of SSP.

Fig. 3. Tanahashi Framework for SSP
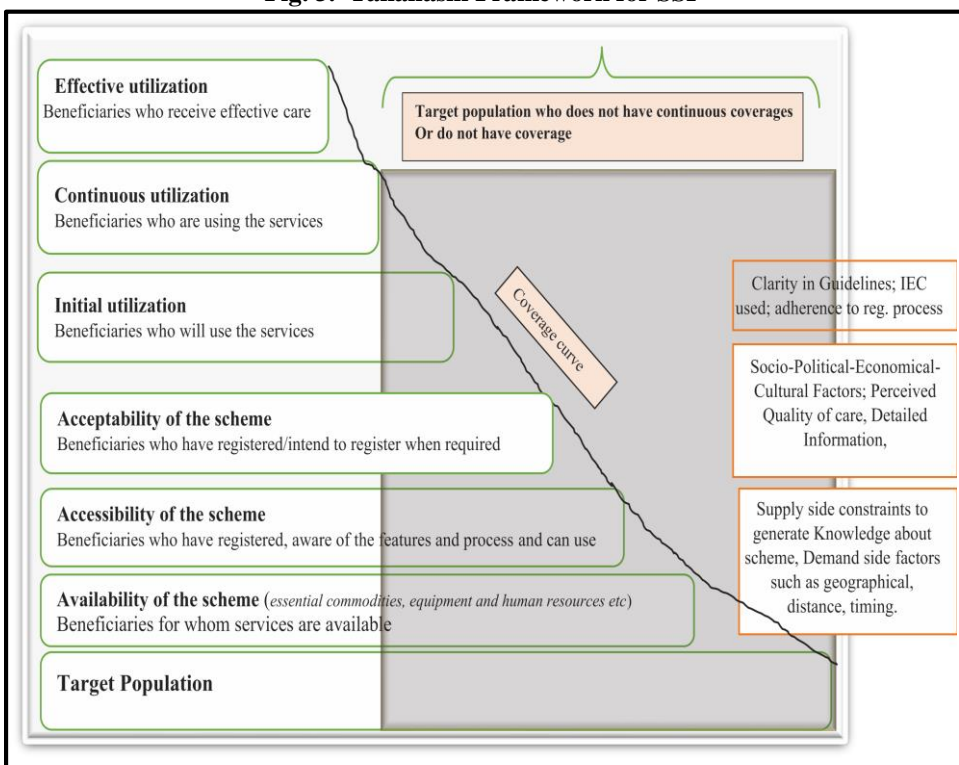
3.2. Data Description

Following the study's objectives, we have adopted a multi-approach strategy for data collection. The current section has explained the data collection details according to the study's objectives.

Following the first objective, we have reviewed the existing policy and guidelines to enroll the beneficiaries and service delivery. We also reviewed the material disseminated for enrolment and placed in hospitals for the guidance of beneficiaries. To review the implementation of communication material, we have visited more than 13 districts where we have interacted with the concerned stakeholders, including concerned NGO and local partners in each of the districts who have been tasked to enroll the beneficiaries, around 40 hospitals where the meeting was carried out with front desk officer, hospital manager and district medical officer (DMO). We also examined the communication material placed in empanel hospitals.

To accomplish the second objective, we have conducted in-depth interviews with the concerned stakeholders regarding enrolment-related arrangements, starting from data acquired from BISP, transforming into family level, and then enrolling beneficiaries at the BECs. The information has been acquired from the NADRA (responsible for preparing the data for enrolment) and the concerned NGO in each district (having the mandate to enroll the beneficiaries at designated centers by providing health cards). The analysis has covered the following aspects:

(a) How the BISP household level data is being converted from household to family level?[1]

(b) How data matching is carried out to fine-tune the family level information?

(c) How certain data is enhanced through family tree (i.e., CNIC numbers, age, marital status, address completion).

(d) Data triangulation with other datasets, i.e. NADRA dataset to add certain information of family members, addresses, CNICs, new family addition, mobile numbers etc.

(e) If a family is not added in the BISP data, how some data is updated (unmarried to married) and what systems are being placed for it?

(f) What services have been added in the HMIS to update the data? What are the key challenges of HMIS at the hospital level due to which data cannot be updated?

(g) How the programme is dealing with null data, lack of addresses and CNICs.

(h) Is there any policy to catch-up missing households in the BISP survey?

Due to the COVID-pandemic, the Beneficiary Enrolment Centers (BECs) were closed. Therefore, the analysis on registration at the BECs has yet to be carried out; however, we have managed meetings with the focal persons of concerned NGOs who managed BECs and enrolled beneficiaries. They have reported the critical challenges faced during the enrolment.

Since the core team itself has visited 13 districts, we have also reviewed the potential collaboration of SSP with other programmes for improving communication and awareness. Various social protection programmes, both at the federal and provincial levels, are operational in the country, being set at the district and Tehsil levels, i.e., BISP, PBM, Zakat, etc. We have explored how these institutes can be used in exploring the coordination for improving communication by conducting meetings with the operational teams of these programmes in 13 districts. We probed how much they knew about the programme's features and how effectively they could disseminate information about the SSP programme to its beneficiaries.

Following the study's fourth objective, the ongoing study's core task was to manage a household survey to review utilisation trends. To accomplish the task, we have conducted the desk-based secondary microdata analysis and primary household survey. The secondary analysis has covered the coverage and utilisation in selected districts by linking the analysis with various factors, including enrolment year, poverty, empanel hospitals, etc. Across regions and time, the study has identified areas with lower and higher coverage rates. The analysis has been linked with years of enrolment, deprivation, urbanisation, hospital availability, and load of beneficiaries in the district/Tehsil.

Regarding the household survey, we have taken a sample of 647 households from 13 districts (45 to 53 from each of the districts). We have followed a two-stage stratified sample design where the universe was the eligible families in the district. The list of 13 districts and the sample size is below.

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[1] The SSP programme used BISP household level data. The data was converted from household to family level by developing married couple in the household.

Table 2

Sample Size for Household's Survey

Province	District	Category A	Category B	Category C	Category D	Total
Gilgit Baltistan	Astore	14	37	0	0	51
	Hunza	4	38	4	5	51
	Gilgit	30	15	6	2	53
AJK	Bagh	10	22	0	18	50
	Neelum	2	39	0	9	50
	Bhimber	10	12	3	20	45
Punjab	Bahawalpur	14	4	2	30	50
	DG Khan	2	11	0	34	47
	Gujrat	5	14	2	32	53
	Sarghoda	3	6	5	36	50
Islamabad	Islamabad	6	11	6	24	47
Sindh	Tharparkar	0	11	2	37	50
KP	Khyber agency	7	21	14	8	50
Total		107	241	44	255	647

The village has served as the Primary Sampling Units (PSUs) and households as the Secondary Sampling Units (SSUs). We have taken 4-5 villages from each districts where 10-12 households have been interviewed. While conducting the sampling, we established the following four groups:

(i) *Category A* is the eligible group comprising those still not enrolled despite massive efforts. It would be worthwhile to analyse the group to understand the enrolment challenges.

(ii) *Category B* are the enrolled beneficiaries that have still not utilised the card. The group can effectively inform on specific challenges, including enrolment, communication, and awareness as well as utilisation related issues.

(iii) *Category C* are the enrolled beneficiaries who have punched the health card but have not utilised the health facility. The group can better explain the potential denial of services, and utilisation-related issues.

Category D are the beneficiaries who have utilised health facilities in the last six months. The group can respond to questions linked to challenges in using the health services, satisfaction, etc.

3.3. Survey Tools

Separate survey tools were developed for each of the stakeholders, keeping in view his/her
nature of involvement. For example:

The qualitative tool to interview the Front Desk Officers and District Medical Officer in hospitals has focused following aspects:

(i) What are the main data related issues that families usually face when they visit hospital for enrolment and/or treatment, i.e., lack of data, data up-dation, system functionality etc?

(ii) What data related issues you can resolve yourself and what issues you cannot resolve in CMIS.

(iii) Limitations of CMIS that needs to be build-in to update data and to register all sorts of complaints.

(iv) Have you received sufficient training? Whether operational manual is available?

(v) What are the core communication related challenges that usually the public and beneficiaries face when they approach to front desk officer?

(vi) What are the main challenges that may lead late admission or denial of services etc.

(vii) Please comment on the package amount and the sickness that still not covered.

(viii) Package comparability, number of sufficient hospitals, hospitals having good services and complaints resolution. What are the main data related issues that families usually face when they visit hospital?

The qualitative tool to interview the <u>Hospital Managers</u> in empanel hospitals has covered following questions:

(i) What are the main challenges of beneficiaries due to that they either face wait in admission or has to pay certain amount from own pocket or lack of services in hospital/denial of services.

(ii) What are the main challenges of beneficiaries related to the communication due to that they often don't know where to go for treatment.

(iii) What are the key challenges of CMIS due to that every complaint cannot be entertained?

(iv) Do your hospital has all the requisite facilities and there is no denial of services.

(v) Which sort of sickness have not been covered in the package and they must be covered.

(vi) Please comment on the comparability of packages and certain sickness that has not been covered.

(vii) What are the key challenges that hospital has been facing to admit beneficiaries and coordination with DMO.

(viii) Your suggestions that how in-door health utilisation can be enhanced.

The main tool of the Household survey was designed to capture various aspects of communication including knowledge about the programme and utilisation related issues to the beneficiaries. The tool comprised of the following key information:

(i) Roster having individual information including gender, age, disability, chronic sickness, status of member's registration in programme and status of CNIC/B-form.

(ii) Education and employment information

(iii) Out-of-pocket expenditures' information including sickness, type of treatment received by family, nature of treatment (out-door and in-door) and medical expenses.

(iv) Asset profiling including dwelling, durable and productive.

(v) Media habit strategy and knowledge about SSP programme.

  (vi) Knowledge of Beneficiaries about SSP Programme about packages, where to go for treatment.
 (vii) Practice on receiving treatment including maternity other sickness.
(viii) Knowledge and attitude about the complaint.

3.4. Training, Data Collection and Analysis

While visiting the concerned district, we managed two-days of training with an enumerator hired for each district. The training's key objective was to ensure that the enumerators had a sound understanding of instruments, correctly implemented the fieldwork protocols, and comfortably used the instrument in the field.

While conducting the field survey, we have not faced any major difficulty. However, one difficulty is worth explaining here. Our field team faced many problems tracing the 'category A' beneficiaries, that is, the beneficiaries who still need to be enrolled in the programme. We found multiple reasons against it, including decease, migration, name mismatch issues, and inability to find despite the massive effort.

Data were entered by the persons hired for the purpose at PIDE using the programme designed in CSPRO. The application allows not only establishing certain filters to avoid wrong data entry but also to ensure consistency. Once all the data were entered, it was imported in STATA version 15 for analysis. The technical team of the study did the analysis itself or a more thorough and robust understanding of the collected data.

3.5. Ethical Considerations

We have used multiple data sources, both secondary and primary. Keeping the ethical considerations in view, the following care was strictly followed in the field:

  (i) The SSP shared secondary dataset for the analysis. The PIDE team confidentially used the data and none of the information was shared with any of the 3rd parties. The same was communicated to the entire team, especially those in the field.
 (ii) During the household survey, participants were taken in confidence that their provided information will not be disclosed to any third party.
(iii) The survey ethics were fully explained to the enumerators during training.
 (iv) Keeping in view COVID-19, we have adopted all the precautionary measures during field activity.
  (v) We have followed a set of ethical principles in conducting all fieldwork that we have previously followed in the fieldwork. The survey have followed the international best practices including the OECD DAC International Quality Standards for Development Evaluation, the OECD DAC Principles Standards for Development Evaluation, UNEG's Ethical Guidelines for Evaluation. These includes:

   (a) Consent of respondents during field activity.
   (b) Ensure confidentiality of respondents is maintained, and personal information is protected.
   (c) Respect for culture.

4. INDOOR HEALTH UTILISATION: A SECONDARY ANALYSIS

Before the emergence of SSP, the majority of the population in Pakistan financed their health expenses from their pocket. This resulted in catastrophic health expense issues for poor households due to affordability issues. We may call it an 'unmet need' when the population needs medical care but cannot receive it due to various factors, including affordability, accessibility, and other cultural/belief factors. The percentage of unmet needs varies across countries, ranging from around 8 percent globally to much higher in low-income countries (Publishing, 2018).

The SSP programme has facilitated the beneficiaries and population (in universal districts)[2] to minimise the unmet need issues by resolving affordability challenges for in-door treatment and improving accessibility through the involvement of private hospitals. However, the programme may need to add OPD treatment as medical and outpatient expenditures incur much higher costs than inpatient treatment alone.

The inpatient health utilisation rates vary across countries. The study of Roodenbeke (2004) found it at 3.6 percent (De Roodenbeke, 2004), and Saksena et al., estimated it at 4.6 percent (2010) (Saksena, et al. 2010). However, we found a lower indoor utilisation rate in SSP in the 15 selected districts. Table 3 shows that the average annual utilisation is around 3 percent, which is much lower than the global utilisation rates. The utilisation rates vary across districts, with the highest in Gilgit and Bagh and the weakest in Islamabad.

Several factors can explain the varying utilisation rates in Table 3. Some of the key points are listed below:

  (i) There is high variation across districts, ranging from 1 percent to 8 percent. Although the programme was started very late in Rawalpindi, it has the highest coverage, possibly due to better patient referrals/movement from other districts.
 (ii) The programme was simultaneously started in districts Bagh and Bhimber, and both are universal districts where the entire population can avail of indoor health facilities. The higher utilisation in district Bagh and lower in Bhimber is linked with the number of hospitals in the district and more efficient services in the district headquarters hospital Bagh than the Bhimber.
(iii) The lower utilisation of health services in district Astore is the lack of a single empanel hospital in the district. It is a hard and hilly district where beneficiaries in far-flung areas have to travel a lot to other districts for in-door treatment. The same goes for Hunza Nagar, where the programme was started one year ago, but still, there is only one hospital in the Hunza district and no one in the Nagar district.
(iv) The lower utilisation in district Tharparker is due to multiple factors, including poverty, deprivation and scattered rural population in the desert having poor road connectivity. Although there are eight empanel hospitals, they lack good quality services, including laboratory, doctors, and surgical instruments.

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[2] Earlier the health benefits were limited only for poor segments, however, now the programme has started the in-door health treatment benefits for all the population (universalisation) and currently the population in 7 districts of Punjab, district Tharparkar, all districts of ex-FATA and AJK are part of SSP programme. Similarly the government of Khyber Pakhtunkhwa has extended the benefits of health insurance for all the citizens residing in province.

(v) The higher utilisation in districts Rawalpindi and Islamabad is due to the presence of tertiary care health facilities. A significant percentage of the beneficiaries from other districts also visit the tertiary hospitals in these two districts for treatment.

(vi) In Gilgit Baltistan there is no tertiary hospital, but the presence of AKDN in Gilgit makes beneficiaries from other districts also visit it.

As shown in Figure 4, the number of hospitals varies across regions. For instance, Islamabad has one hospital for 8 thousand beneficiaries, whereas there is only one for 55,000 and 73,000 beneficiaries in district Khyber and Bhimber, respectively. Islamabad and Rawalpindi may provide better health services as the cities have primary and tertiary care services. On the other hand, cities like Tharparkar have a few private hospitals that only provide primary-level services, and Bhimber only has a government District Headquarter hospital.

Fig. 4. Number of Families per Hospital
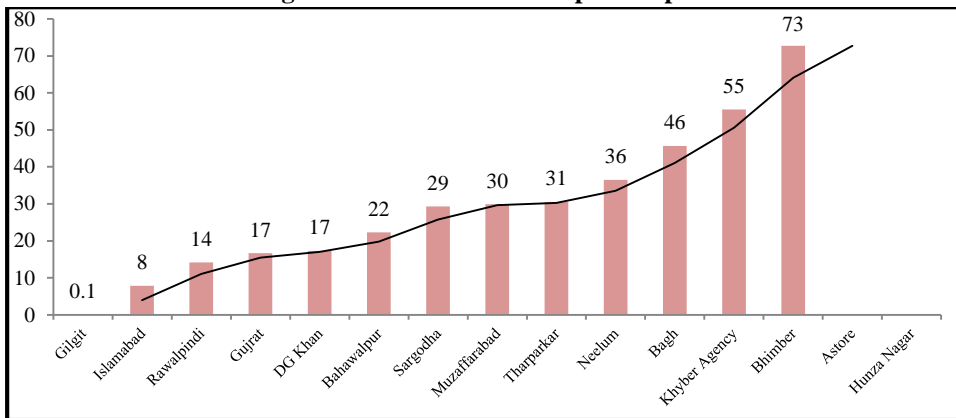
Source: Estimated from the Secondary data of SSP.

Table 3

Utilisation of Indoor Treatment among SSP Beneficiaries (in %)

Province	District	Registered Beneficiaries (in Numbers)	Who Utilised Services (in Numbers)	Total Months of Programme Start till August 01, 2021	Overall Utilisation Rate Since Inception (%)	Annual Utilisation Rate (%)	Number Hospitals
AJK	Bagh	91377	6122	20	6.7	4.0	2
	Bhimber	72739	1576	20	2.2	1.3	1
	Muzaffarabad	179659	32508	65	18.1	3.3	6
	Neelum	36495	1798	21	4.9	2.8	1
Islamabad	Islamabad	94477	22203	67	23.5	4.2	12
KP	Khyber Agency	221924	35806	53	16.1	3.7	4
Gilgit	Astore	4651	45	10	1.0	1.2	0
Baltistan	Gilgit	200	10	10	5.0	6.0	2
	Hunza Nagar	9486	133	14	1.4	1.2	0
Punjab	Bahawalpur	200680	17199	39	8.6	2.6	9
	Dera Ghazi Khan	190035	17259	29	9.1	3.8	11
	Gujrat	100052	3810	19	3.8	2.4	6
	Rawalpindi	170091	15566	14	9.2	7.8	12
	Sargodha	351331	52554	53	15.0	3.4	12
Tharparkar	Tharparkar	244259	9858	25	4.0	1.9	8
Total		1967456	216447	–	8.6	3.3	86

Source: Estimated from the Secondary data of SSP.

As a way forward, the programme needs to improve supply-side facilities that will ultimately improve health utilisation:

   (i) Every public or private hospital must serve as the empanel.
  (ii) A sufficient number of empanel hospitals in each district to create a competition among hospitals.
 (iii) Better communication and awareness among beneficiaries so they must know about the details of empanel hospitals and services available to them near their hospitals.
 (iv) Resolving the package-related constraints as some of the hospitals have been denying the services with the excuse that the benefit package is not enough to cover in-door expenses.

5. OPERATIONAL ARRANGEMENTS FOR ENROLMENT AND SERVICE DELIVERY

The current section broadly reviews challenges in targeting that may restrict some eligible beneficiaries from enrolling in the programme. Since the SSP programme has used BISP's poverty scorecard (PSC) data to identify the eligible families, we have analysed certain limitations of the PSC data that may prevent the eligible households from registering and, hence, receiving treatment. Targeting analysis is necessary to examine as programme authorities must review and design specific policies in the future to ensure complete enrolment and service delivery for every citizen. We have also reviewed the communication-related arrangements to enroll beneficiaries at the designated centers and the awareness material available in hospitals for beneficiaries' guidance.

5.1. Targeting of SSP Beneficiaries

The SSP programme has two sorts of beneficiaries:

   (i) Poor and vulnerable households where the programme has used BISP data to identify the beneficiaries. The SSP programme started its operations using the BISP's data throughout the country.
  (ii) All citizens are part of the programme in universal districts. The universalisation has been recently started. Currently, the population in 7 districts of south Punjab, district Tharparkar in Sindh, all districts of ex-FATA, and AJK are part of the SSP programme. Similarly, the government of Khyber Pakhtunkhwa has extended the benefits of health insurance for all the citizens residing in the province. Here, the programme is using NADRA data instead of the BISP data, and every married couple registered in the NADRA database is considered as a separate family.

It is worth mentioning that BISP conducted a nationwide poverty scorecard (PSC) survey by following the proxy mean test (PMT) formula technique in 2010-2011. PMT scores various household characteristics, including demography, education, durable, and productive assets. A lower score shows the high vulnerability of the household and vice versa.

     In 2010/11 PSC, a door-to-door census was carried out throughout the country. Collectively 27 million households were covered with coverage of 85 percent of the population. The following table provides an insight into the enumeration statistics of the 2010–2011 national roll-out, which shows that 15 percent of the households were not surveyed by the programme (Table 4). There is no issue if a well-off household is not covered; however, if a poor household is not surveyed, it is largely the exclusion error at the design level as these poor and vulnerable households have been deprived of the benefits mainly due to a lack of data. It is worth mentioning that BISP's PSC is a static registry, and there is no window that a non-surveyed household can be interviewed at the latter stage.

Table 4

Area-wise Coverage under Poverty Scorecard Survey

Province	No. of Districts	HHs Covered (in millions)	Estimated Population (in millions)	Population Covered (in millions)	Population Covered (in %)
Punjab	39	14.9	96.4	81.2	86.3
Sindh	27	6.6	38.9	34.3	88.1
KPK	24	3.6	26.9	21.3	79.1
Balochistan	30	1.1	7.6	6.1	79.4
AJ&K	10	0.6	3.9	3.5	88.5
GB	7	0.2	1.3	1.1	89.4
FATA	7	0.4	3.7	3.1	83.0
Total	144	27.4	177.9	150.6	84.6

Source: BISP's Poverty Score Card (2010/11).

     Following eligibility criteria was established for the selection of beneficiaries by the BISP:

   (i) PMT score equal or less than 16.17.
  (ii) Female beneficiaries either married, divorced or widowed.
 (iii) Beneficiary must have a valid CNIC.

     Every socio-economic registry faces specific targeting errors, i.e., inclusion and exclusion errors. Still, one can see a fair targeting of the BISP registry where the beneficiary proportion is reasonably aligned to the geographic poverty spread in the country. One can see the higher share of beneficiaries in remote and rugged areas (i.e., South Punjab, rural Sindh) and lower coverage in urban areas and north Punjab with lower poverty rates (Table 5). It reveals that although some poor households were not surveyed (as shown in Table 4), BISP's targeting is quite fair and aligns with the country's poverty spread.

     It is not easy to enroll the beneficiaries in the SSP programme as they are primarily the chronically poor who live in remote areas and need proper awareness. They often need more of the necessary documentation for enrolment. After completion of the poverty scorecard survey, BISP developed a dedicated Case Management System (CMS) to enroll the pending beneficiaries, but it took too much time to enroll them. The system was developed with the help of NADRA and was deployed in BISP's Tehsil and Divisional offices to enroll and verify the pending beneficiaries. Around 1.8 million beneficiaries were enrolled through CMS through a massive effort by BISP's Tehsil offices (Figure 5).

Table 5

Region-wise BISP's Beneficiary Concentration

Province/Region	Total HH Surveyed (In millions)	Benefiting Households (In millions)	Benefiting Households (In %)
AJK	0.57	0.08	14.71
GB	0.15	0.03	22.07
FATA	0.43	0.14	31.86
Balochistan	1.07	0.20	18.69
KP	3.63	0.95	26.17
Punjab-North	1.33	0.07	5.19
Punjab-Central	8.73	0.78	9.11
Punjab-South	4.61	1.01	21.81
Sindh-Rural	4.17	1.54	37.06
Sindh-Urban	2.43	0.23	9.47
Total	27.12	5.03	18.55

Source: Estimated from BISP National Socio Economic Registry (NSER) 2010 data.

Fig. 5. Enrolment of BISP beneficiaries, 2012-17 (in millions)
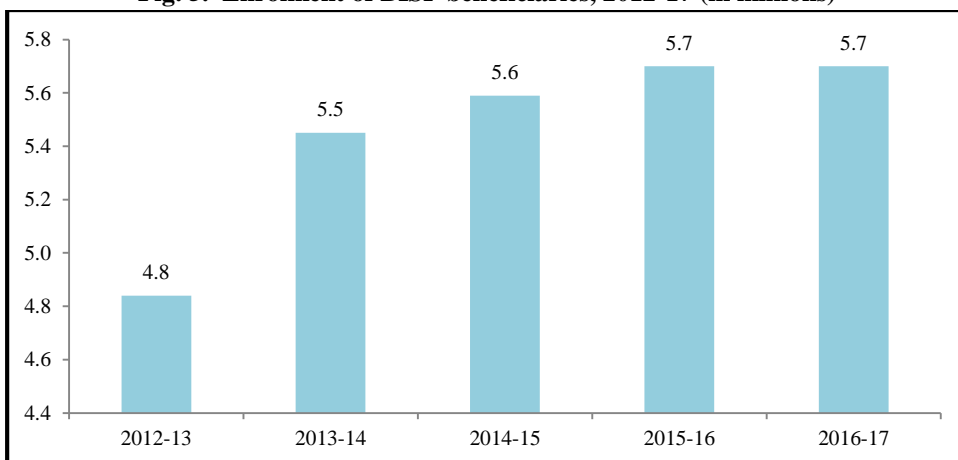
Source: BISP Annual Report 2019.

5.2. Data Validation for Enrolment

The SSP programme has used the BISP data for its targeting. It is worth mentioning that the BISP survey was conducted at the household level. In contrast, the SSP targeting is at the family level—a married couple with unmarried children is considered a family. After getting the data from BISP, the SSP hired the services of NADRA to convert the data from household to family level. NADRA is the custodian of citizen's data as it holds the data of birth, marital, and death registration, so it can efficiently convert the household data into family by adding the missing family members that do not exist in the BISP database but exist in the NADRA database.

NADRA enhanced the BISP data by adding CNIC numbers against the spouse and the number of family members who did not exist in the BISP database but exist in the

NADRA database. However, such conversion is not an easy task as the following limitations may be noted that NADRA faced during conversion:

(i) The BISP data is static in nature and has no provision for giving the appeal rights to the non-eligible and non-surveyed households to review/gather their data on poverty score card. The coverage of BISP registry was around 85 percent, and there was no mechanism to conduct the survey of the households that were skipped. The SSP has no mechanism to enroll such households.

(ii) Among those surveyed households in the BISP database, a significant percentage (of adults) lacked a computerised national identity card (CNIC). Suppose both the husband and wife lack CNIC in the BISP database within the family. In that case, the NADRA has no option to establish a family tree for such families for enrolment as the availability of a valid CNIC is the primary data to develop a family tree.

(iii) The benefits are that BISP made a strong effort to update the data with a PMT score of 16.17 (its eligibility threshold); however the SSP has used 32.5—a higher PMT cut-off than the BISP. The data till a score of 16.17 was much cleaned and updated by the BISP; however, above 16.17, it is mainly the raw and un-cleaned data. As a result, the non-matching issues were much higher among households with a PMT score above 16.17.

(iv) Although NADRA has tried to enhance the data where family details of children are available in their database, Pakistan still faces challenges in achieving universal birth registration and CNIC for every citizen. Many women and children in remote areas do not have B-form/CNIC (Table 6). Without information in the NADRA database, people cannot avail of health services. Even for the SSP programme, a B-form is required, not the birth registration. It is worth mentioning that both birth registration and B-form are two different documents, the former being registered in the Union Council (UC) office. In contrast, the latter document is issued by the NADRA only if the birth is registered at UC. NADRA avoids issuing B-from without birth registration in UC.

Table 6

Proportion of Children and Adult having Birth Registration/CNIC (%)

| Province | District | % of Children Having Birth Registration in NADRA | % of Population (Aged 18 and above) Having CNIC | | |
			Female	Male	Both
Gilgit	Astore	12.0	–	–	–
Baltistan	Hunza	81.0	–	–	–
	Gilgit	16.0	–	–	–
Punjab	Bahawalpur	49.6	74.4	88.6	81.5
	DG Khan	30.3	70.1	87.1	78.4
	Gujrat	96.6	81.8	93.4	87.2
	Sarghoda	87.6	80.2	92.8	86.5
Islamabad	Islamabad	–	90.4	96.4	93.6
Sindh	Tharparkar	30.7	70.0	84.5	77.3
KP	Khyber Agency	–	77.1	94.0	85.5

Source: Population Census 2017/18, Multiple Indicator Cluster Survey (MICS), Punjab 2017-18, Multiple Indicator Cluster Survey (MICS), Punjab 2018-19, Multiple Indicator Cluster Survey (MICS), Gilgit 2016-17.

Note: Data of AJK is not reported due to non-availability.

    (i)   The SSP programme's database is not continuously updated using the NADRA database. For example, if a girl gets married, she may have to wait six months after updating the NADRA's database. Ideally, the SSP must have a live integration with the NADRA database and any update in the NADRA database should automatically be available in the SSP database.

    (ii) We observed that many recently married women are facing issues in health utilisation due to a lack of updated data. Although they are enrolled with their parents (with unmarried status), they cannot get maternal health care services as the programme does not allow them to update their marital status. Despite having updated CNIC, they cannot register themselves as a separate family in the programme. The issue prevails all around the country, even in universal districts.

We found from our household survey that 84 percent of the respondents reported that their family members have CNIC or B-form or birth registration; the rest either does not have or lack information. Unless the family members have CNIC/B-form, they cannot receive treatment. Figure 6 shows variation across districts where we may link the availability of CNIC/B-form with remoteness and accessibility challenges. For example, district Tharparkar is relatively poor and desert, where most of the population resides in rural areas and has a poor literacy rate. Similarly, Astore is again one of the hard districts in Gilgit Baltistan (GB), where road infrastructure and accessibility are challenging. On the other hand, districts like Gujrat and Islamabad are much better in all aspects and are close to 100 percent.

Fig. 6. Proportion of Family Members Having CNIC/B-form (in %)
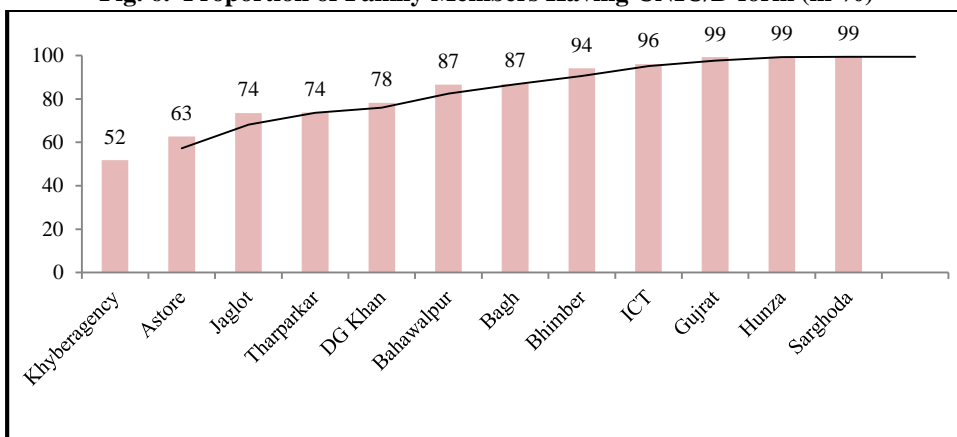
Source: SSP Beneficiary Survey 2021.

5.3. Communication Arrangements for Enrolment

After data preparation by the NADRA, the programme established specified protocols for disseminating the SSP cards to the eligible beneficiaries; the third parties were hired to establish beneficiary enrolment centers (BECs) in each area to guide the eligible households for card collection. The BEC's establishment had two objectives: first, to deliver the card, and second, to enhance beneficiaries' awareness. The SSP card holds communication material in its envelope where the flyers had vital messages, including helpline details, answers to critical questions, and package details.
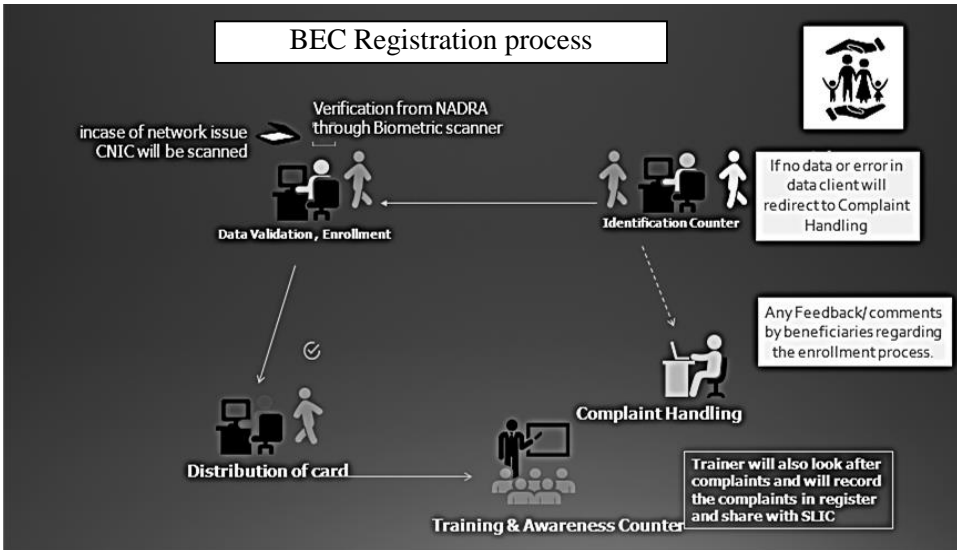
The protocols of concerned stakeholders were well defined in managing the BECs, where it was assumed that beneficiaries would receive the card after verification, and their cards would also be activated after biometric verification. Similarly, the beneficiaries who faced specific grievances will also be managed at the counter.

Despite the protocols, it was not easy to disseminate cards to everyone within a stipulated time. As noted earlier in Figure 5, it took five years for BISP to enroll the pending beneficiaries. BISP established dedicated permanent offices in each Tehsil and a CMS to address the grievances of its potential beneficiaries.

Although a third party made a massive effort to enroll the beneficiaries using various communication methods, including door-to-door campaigns and follow-up of migrant persons, a significant proportion of eligible households was not given the SSP card (Figure 7). The card delivery can also be linked with the period of a programme launched in a particular district. For example, the higher non-response rate in Gilgit can be reconciled with the programme's late start (just ten months ago); however, it is complex to explain the high non-enrolment rate in district Bahawalpur where the programme has been operational for more than three years.

Fig. 7. Proportion of Beneficiaries who were not Enrolled in Programme (in %)
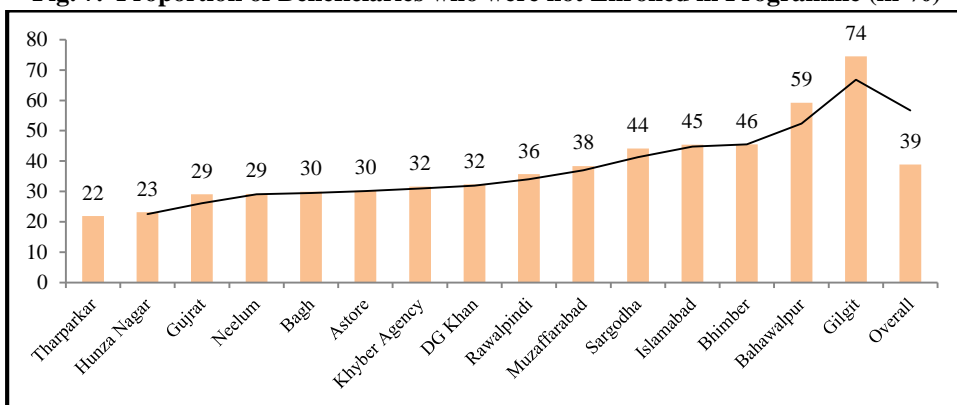
Source: Estimated from the Secondary data of SSP.

Few challenges may be noted in the communication campaign that we found while interacting with the concerned stakeholders:

   (i) Various beneficiates were found dead at card disbursement (around 5 percent). There is no exact number of it as it was reported by the focal persons of third parties involved in communication campaigns and card delivery. In such cases, sometimes the health card cannot given to the children of the deceased card holder until they provide sufficient documentation.

  (ii) Although the programme attempted to ensure biometric verification for card delivery, it was optional, considering the vast rush and internet connectivity issues at the BECs. Many cards were given to beneficiaries without biometric verification, and some faced activation challenges.

 (iii) As reported by the third-party focal personnel in Nagar, some beneficiaries have been facing the name mismatch issue where the name is wrongly printed on the SSP cards. Still, there was no way for such a correction.

 (iv) In GB, the SSP card was exploited by the political parties as the SSP card was disbursed right before the election, so different parties claimed and attempted to get its ownership. Similarly, different package limits were announced by different political parties where the ruling party tried to exaggerate the package amount, and the opponents gossiped that it was 'fake'. In Tharparkar, we found that the provincial government (as the opposition in the federal government) doesn't want beneficiaries to use cards, so there is a rumor that an 'SSP card is not workable'.

(v) In many parts of GB, despite the inception of the programme, no hospital was taken on empanel for more than one year except in Gilgit city, so people started to consider that it is a fake card as cards were in the hands of beneficiaries, but there was no hospital for treatment.

(vi) The COVID-19 severely affected the performance of BECs. As a result, the management closed them and adopted an alternate strategy to deliver cards to doorsteps.

(vii) Three main challenges with the communication strategy are listed below:

(a) A third party was hired for communication and card disbursement.[3] However, they mainly focused on card delivery rather than awareness. Overall, there were temporary awareness arrangements as it cannot be done in a just few minutes and in a rush at BECs. It requires consistent interaction with the beneficiaries. The eligible families received the card but they lack sufficient information on usage.

(b) The third-party established temporary offices/set-up for communication and card delivery. After completing of their contract with the SSP, they have now closed their offices. Currently, there is no center where beneficiaries or non-card recipients go to acquire information or receiving their undelivered cards.

(c) The SSP lacks its offices at the Tehsil/district level. Except for hospitals, there is no in-person office where beneficiaries can interact with someone for certain information and queries and register their complaints.

5.3. Communication Arrangements for Service Delivery

Our team has visited more than 25 districts, where more than 40 hospitals were visited to review the available communication arrangements to the beneficiaries. We have interacted with front desk (HFO), hospital management, and district medical officer (DMO) to acquire available communication measures for the public and beneficiaries. All the hospitals have a dedicated counter for SSP beneficiaries where the focal person of SSP is available to guide both the public and beneficiaries. The same focal person is responsible for coordinating with the hospital and DMO to facilitate the patient's treatment, including admission, treatment, and claim management.

Currently, it is the HFO that is the primary source of in-person interaction with the public and beneficiaries, not only to make them aware but also to address certain grievances, especially data up-dation.[4] We have found that HFO exists in every hospital. They have been doing an excellent job. Except in a few hospitals, communication material is also found to guide the beneficiaries.

Few limitations can be noted on communication related arrangements in hospitals:

(i) Some HFO were found quite trained and motivated; however, a vast majority were quite demoralised due to their contractual jobs and lower salary as they were not even hired by the SLIC.[5] We made few questions to them for observing

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[3] Mostly some NGOs were given contract for card delivery. Overall 6 NGOs were hired for card disbursement in the whole country.

[4] HFO is hired by the SLIC where one HFO manages one or multiple hospitals. S/he is the primary interaction source in each hospital and after his/her verification and consent, hospital examines the patient.

[5] SLIC recruited HFOs through another firm and have no contractual obligation with them.

their knowledge about the programme and found that some of them were not fully trained. Even some of them do not know the package amount.

(ii) Internet issue was found in some parts of GB where HFO cannot guide beneficiaries or update their data due to poor connectivity (i.e., Hunza, Gakooch).

(iii) They lack proper SOPs on operations. The documentation requirement as demanded by the HFO varies across hospitals. Some HFO demands multiple documents: original SSP card, cardholder CNIC and patient CNIC. If someone lack all three, there is denial of services. Similarly demand of document varies on hospital sides as well. For example in governmental hospitals (Bhimber, Bagh, Mirpur and Neelum), we found that hospitals lack automation system and due to manual system, they have been demanding various photocopies. Now if a person from Gilgit migrates to Karachi and s/he face some accident, s/he cannot acquire treatment unless s/he bring SSP card and CNIC of card holder. The same was reported by MS DHQ Neelum that people from far-flung areas usually come without card and as a result they face denial of services.

(iv) HFO lacks a proper operational manual having their clear roles and responsibilities. As a result they lack their clear SOPs.

(v) Mostly HFO works 8-10 hours with leave on Sunday. Even in some government DHQs (universal districts, they have no 24/7 presence. Their absence in the hospital, especially in government hospitals) can lead to denial of services when a person will visit on Saturday night or Sunday.

(vi) In various hospitals, their sitting place is not visible (i.e., Mirpur AJK a universal district). Ideally every patient in AJK region should be treated from SSP due to universalisation, but still the rate is just 35 percent in district Mirpur and around 10 percent in district Neelum. It is close to 100 in district Bhimber and Bagh.

(vii) The existing communication measures in hospitals are limited at the hospital level. Currently the programme lacks certain communication measures to interact with the public in their surroundings or at their door-steps.

(viii) The beneficiaries and the public living in remote areas do not have access to the various online communication modes. The programme lacks a 'word of mouth' communication strategy, which can work when technology is unavailable.

(ix) The SSP management has a poor presence in the field and is concentrated at the headquarter/provincial level.

Access to media is another concern where beneficiaries living in remote areas lack proper access to various communication sources through which they may acquire information. Although the programme has a dedicated helpline and SMS service; it may not serve those who are sitting in remote areas (Figure 9). We found different communication material available to beneficiaries in the empanel hospitals (Figure 8). The HFO in some hospitals demands health cards, CNIC of card holders, and CNIC of patients, although it is not in demand. Similarly, they sometimes also demand specific photocopies of CNIC. In some hospitals, there was no communication material, and the HFO desk was not visible place.

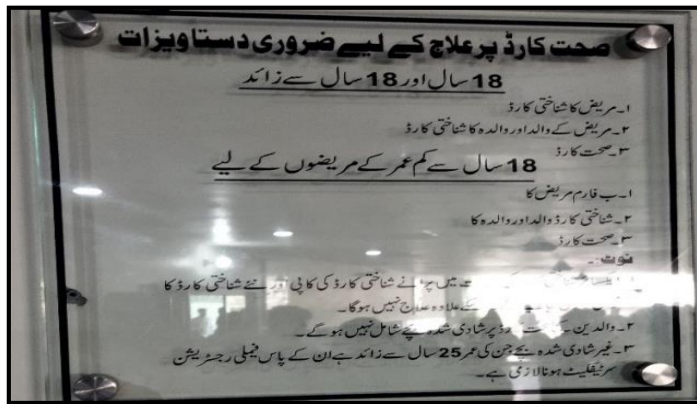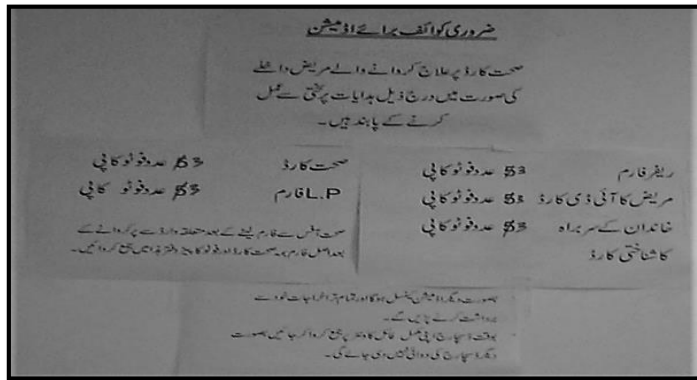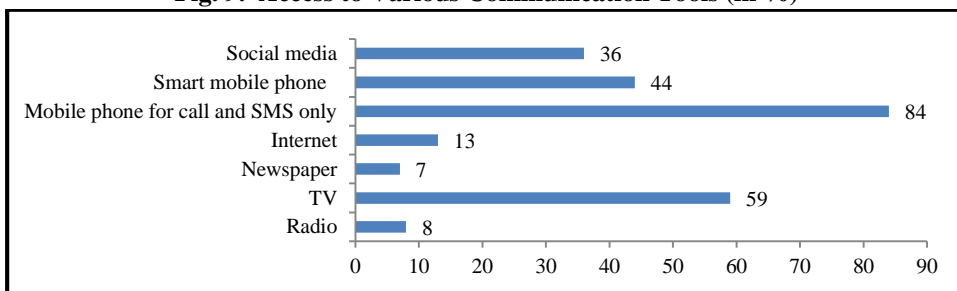**Fig. 8. Communication Material vary Across Hospitals**

Fig. 9. Access to Various Communication Tools (in %)

5.4. Collaboration with Local Stakeholders

As detailed earlier, SSP hired third-party services for card delivery and dissemination of key messages to both the public and beneficiaries. The third-party attempted its best to achieve the target (card disbursement) by involving various stakeholders, especially the notables, to trace out the eligible households and deliver the cards to them.

However, after completion of the contract with these firms/NGOs, there is no permanent set-up or arrangements to disseminate information to the public. HFOs in the hospital are limited to the secondary level and can cater to the need-based population, whereas the supply-driven communication campaign needs to be included. The public mostly believes in 'word of mouth,' and local norms and beliefs largely offbeat the right communication messages that must be known to the public. We interacted with the public and found that people in remote areas of Tharparkar have cards but think that 'it is not workable'. Similarly, as told by the focal personnel of an NGO in Nagar, the beneficiaries in two union councils of Nagar have refused to accept cards by stating that those who already have the card reported that the card is not workable.

To counter such illusions and misperceptions, the programme must collaborate with local partners, including academic institutes, governmental health departments, and other social safety net departments. For example, every BISP beneficiary is also part of the SSP, so BISP's gross-root level presence (having offices in each Tehsil) can be used to disseminate critical messages.

5.5. Recommendations

The findings in current section hold following recommendations:

(i) The programme must ensure a wider message through robust communication that there is no need of SSP card for in-door treatment and in parallel ensure the training of HFOs so they rightly communicate to the beneficiaries and general public.

(ii) In universal districts, the objective should be to provide in-door treatment to all the citizens by minimising the documentation requirements. Those beneficiaries who lack CNIC or B-form or health card can be treated on the basis of some other document including marriage certificate or on the basis of any other citizenship proof.

(iii) The programme must use the NADRA database and there should be live integration of SSP database with the NADRA database. When a citizen acquires B-form or CNIC from the NADRA, it should be automatically updated in SSP database.

(iv) The HMIS available to the HFO must be capable to update minor data related issues, i.e., name mismatch, card activation, address up-dation etc.

(v) The programme needs to closely work with provincial governments for utilising the provincial health infrastructure for communication and service delivery.

6. DEMAND AND SUPPLY-SIDE ANALYSIS IN HEALTH UTILISATION

The current section analyses health utilisation using the Tanahashi framework (1978) to review the demand and supply-side constraints. We explore the six dimensions, where four prevail on the demand side and two on the supply side. These six dimensions are discussed in the below sub-sections. It is worth mentioning that the analysis was carried out by using multiple data sources, both qualitative and quantitative, gathered through the field survey. The qualitative information has been gathered through in-depth interviews with hospitals, SLIC, SSP, front desk officers, and district medical officers. In contrast, the household survey has been carried out to capture demand-side limitations.

6.1. Accessibility and Availability of Hospitals

The programme has several empanelled private hospitals to ensure quality health services. The secondary data shows 86 hospitals for 1.75 million eligible families in 15 selected districts. Both the success and challenges prevail in the availability and quality of hospitals for the beneficiaries.

The salient features of successful instances are as follows:

(i) The addition of private hospitals has improved the competition and the quality of health services for poor citizens. In certain districts, private hospitals have more than 80 percent of their total caseload from SSP beneficiaries, i.e., Allied Hospital in Bagh, Kashmir Surgical Hospital in Muzafarabad, Maqsood Hospital in Peshawar, and many others.

(ii) Districts with a combination of government and private hospitals are highly effective as the workload is optimally divided among the two-tier, i.e., Bagh and Peshawar.

(iii) The programme has uplifted the capacity of various trust hospitals that are now part of panel by resolving their financial constraints, i.e., Kashmir Surgical Hospital in Muzafarabad, Al-Khidmat hospital in Mithi, Lovecare hospital in Chochro, etc.

(iv) The involvement of government DHQ hospitals in AJK has significantly lowered patient's indoor health expenses. Bhimber and Bagh DHQs are almost close to 100 percent in admitting the SSP beneficiaries in their total caseload, where an admitted patient has to make no payment during treatment.

(v) The involvement of tertiary hospitals in major urban centers has significantly provided equitable health services to the beneficiaries, i.e., Rawal hospital, Akbar Niazi hospital, and Heartcare hospital in Islamabad.

Following challenges, however, still prevail:

  (i) The number of empanel hospitals is still deficient, keeping in view the caseload. Some districts have fewer hospitals (only 1 in Ghizer) or no hospital (Astore and Nagar). The beneficiaries in districts without a hospital cannot purchase health services from their pocket.

 (ii) In Punjab, government hospitals are still not part of the empanelled that can provide secondary and tertiary care treatment. The same is in Tharparker, where few private hospitals are on the panel, but they are facing capacity challenges, and as a result, their caseload is nominal. Without the involvement of government hospitals, private hospitals alone cannot manage the caseload, and it may also create a monopoly of private hospitals.

(iii) In AJK, district government hospitals (DHQ) are part of SSP intervention. Few challenges prevail. *First*, they have been receiving a massive caseload after becoming part of the intervention; however, as a government hospital, they cannot uplift capacity from their own resources and require certain approvals from the ministry/department. *Second*, the resource sharing formula is still not finalised, so attitude and behaviour issues prevail with the doctors and paramedical staff as they have no incentive to deal with SSP beneficiaries. District Mirpur in AJK is a universal SSP district; however, DHQ Mirpur has hardly 30 percent caseload of SSP despite sufficient health capacity (teaching hospital).[6] On the other hand, DHQ Bhimber and Bagh are managing many times high caseloads. *Third*, THQs and RHCs are not part of SSP but have some capacity for inpatient services. The AJK Health Department should ensure certain amendments in the health regulatory framework by giving autonomy to hospitals.

(iv) Accessibility sometimes is also compromised with the 'pick and choose' option by the hospitals. Many hospitals (especially in Tharparker a universal district) have limited health facilities, resultantly with a limited caseload.[7] As a result, beneficiaries have no interest in visiting these hospitals due to the lack of services. We found that including private hospitals in Tharparker has kept the burden of public hospitals high. Denial of benefits also occurs in some hospitals. The DMO in Gujrat, Sargodha, and Faisalabad reported that some hospitals provide treatment only in that sickness where they have profit (i.e., surgery) by avoiding the medical treatment they don't have enough financial margin.[8] Similarly, we found that sometimes affordability is compromised due to a lack of medicines. The programme has ensured free medication. However, we found that in some governmental hospitals, the medical store is not open 24 hours, or the required medicines are not available in store (i.e., Bhimber and Mirpur). As a result, some beneficiaries have to purchase at their own expense. Similarly, the

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[6] Ideally every patient should be treated from SSP card; however, currently 70 percent of them are bearing expenses from their own pocket and only 30 percent are admitted under the SSP.

[7] In Tharparkar mostly the private hospitals have only one doctor, lack of full-time availability of doctor, the hospital can make treatment against only 1-2 sickness due to lack of capacity.

[8] The programme has defined a package against each of the sickness and the same is paid to the hospital after treatment.

Combined Military Hospital (CMH) Muzafarabad is violating the contract by providing medicine of only Rs. 1200 per day against the upper limit of around Rs. 3,000 per day.

(v) There are only a few empanelled hospitals in GB, and there is none of them have the tertiary level facilities. The area is hilly, and accessibility is a big challenge.

6.2. Awareness about Programme

The analysis in this section was carried out using the household survey data gathered from 647 beneficiary households. Conceptually, the beneficiaries must know whether their family is registered in the programme, as the benefits are linked with their enrolment. We asked the respondents to inform us whether the existing family members of their families are registered in the programme. As shown in Figure 10, 75 percent confirmed that the members in the roster are registered, 13 percent reported that the member is not registered, and 6 percent did not know the status of their family member's registration. The programme must have 100 percent registration of all the family members. Families must also know about such information and the availability of indoor health services whenever required.

Fig. 10. Respondents Knowing that Members of Family are Registered (% Distribution)
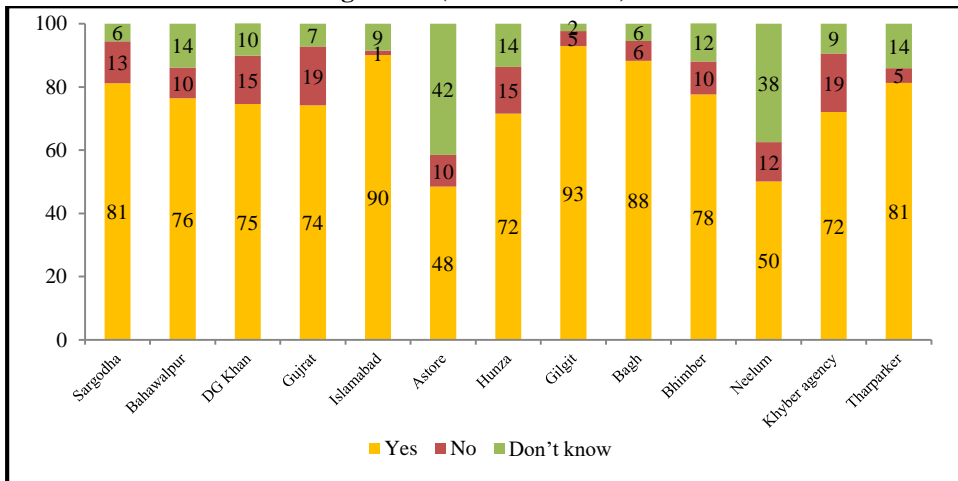
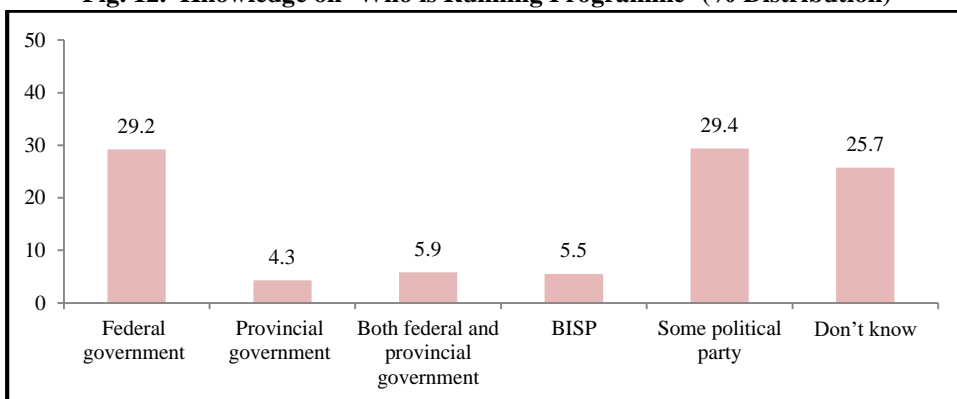*Source:* SSP Beneficiary Household Survey, 2021.

Among those who reported that some members of the family are not registered, the key reasons were: not knowing any reason as they have never visited hospital or used SMS service (47 percent); lack of birth registration/B-form or CNIC (25 percent); not knowing that treatment of SSP is linked with the CNIC/B-form and registration in database (21 percent); and change in marital status by 5 percent (Figure 11).

The programme needs to work on both fronts through its communication strategy: *first*, every citizen must know the status of whether s/he is enrolled in the programme or not; and, *second* to resolve specific bottlenecks that escape a minor percentage to be enrolled in the programme due to lack of documents.

Fig. 11. Reasons of not Registration in Programme (% Distribution)
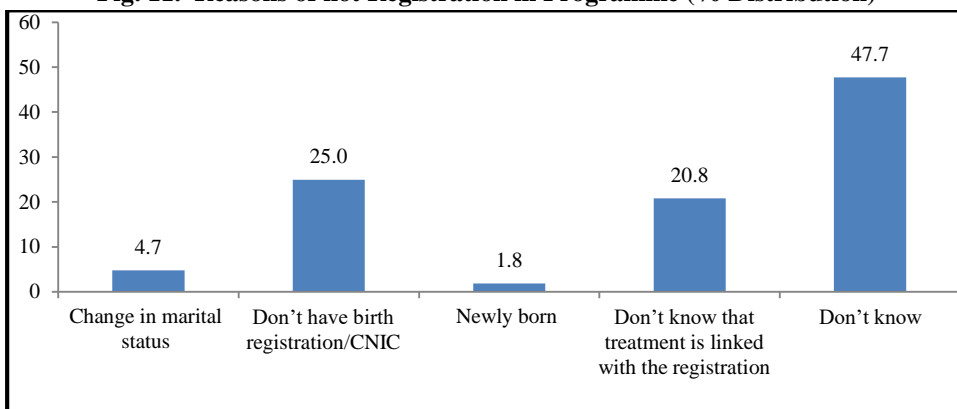
Source: SSP Beneficiary Household Survey 2021.

The political or ruling government parties mostly politicise the social protection programmes in low-income countries for their political interest. We have questioned the beneficiaries about who is running the programme. Around one-third of them rightly know that the federal and provincial government manages the programme; still, most of them either do not know or consider that the programme is run by some political party (Figure 12). The communication strategy must consider these aspects for rightly sharing the information with the public.

Fig. 12. Knowledge on 'Who is Running Programme' (% Distribution)

Source: SSP Beneficiary Household Survey 2021.

The beneficiaries must know the programme's eligibility criteria and various features, including packages, treatment location, documentation required for treatment, etc. A significant proportion of the population needs to learn the right information about the programme. For example, 16 percent of the respondents don't know who is eligible and should be part of the programme, 64 percent don't know that only indoor treatment is covered, 60 percent don't know that treatment can be taken only in empanel hospitals, 75 percent don't know that treatment is only for parents with unmarried children, and 68

percent do not know the upper financial limit of the card. Among those who reported the card limit, there was a lot of variation in reporting the amount, ranging from Rs. 50,000 per annum to one million.

Fig. 13. Beneficiaries' Lack of Clear Knowledge about Features of Programme (in %)
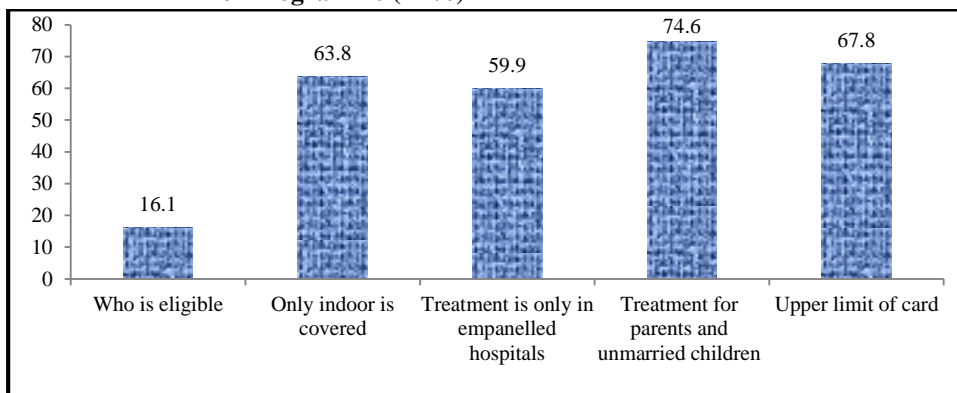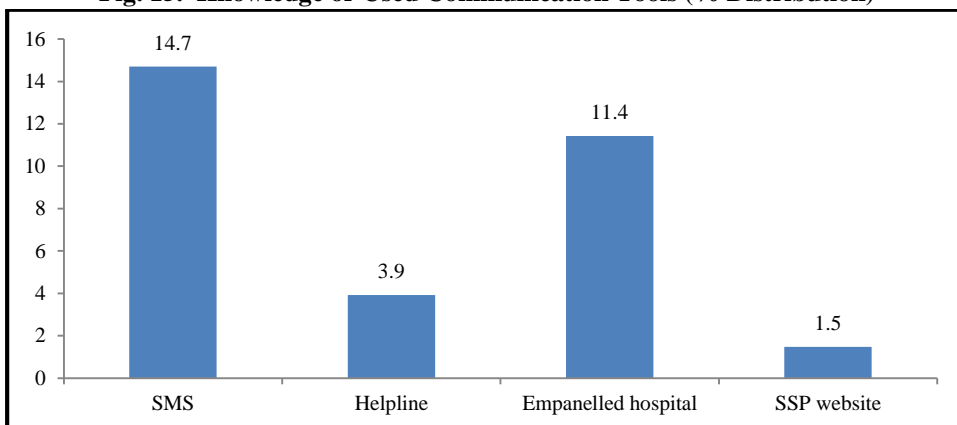

Source: SSP Beneficiary Household Survey 2021.

We also conducted in-depth beneficiary-specific questions and found that most beneficiaries need to learn about the programme's various features for service delivery, in-door treatment, and financial knowledge. For example, only one-third know how unregistered family members can be registered, and 48 percent know the eenrmpanel hospital near their home. Most must determine how many prenatal visits are covered in the package and when the card will expire (Figure 14).

**Fig. 14. Beneficiary Specific Knowledge about Programme (in %)**
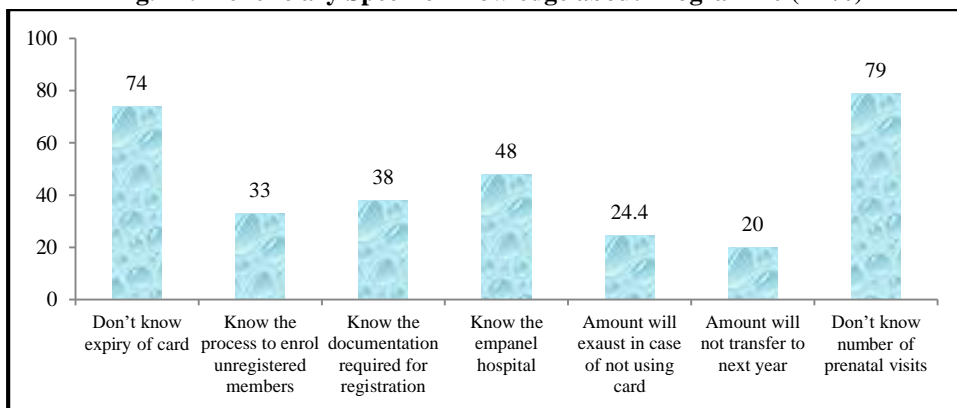
Source: SSP Beneficiary Household Survey 2021.

Only a minor proportion of the beneficiaries know or have used the various communication tools as provided by the SSP. For example 7 percent of them know the SMS service, and 4 percent have the knowledge of helpline, 11 percent have visited some empanel hospital for acquiring information and only 2 percent have visited the SSP website (Figure 15).

Fig. 15. Knowledge or Used Communication Tools (% Distribution)

Source: SSP Beneficiary Household Survey 2021.

We questioned beneficiaries about the source of communication they would prefer if they required some information about the programme. Most of them either needed to learn or preferred local notables for information. They need to learn more about the deployed communication facilities, i.e., SMS, helpline, empanel hospital, etc. There is a need to strengthen communication tools, especially in some centers/offices, where the beneficiary and public can interact with the focal persons of the programme. The beneficiary centers are commonly closed, and the lack of SSP offices at the grassroots level has generated a gap in acquiring information.

**Fig. 16. Source of Support Seeking if Beneficiary Need Information (% Distribution)**
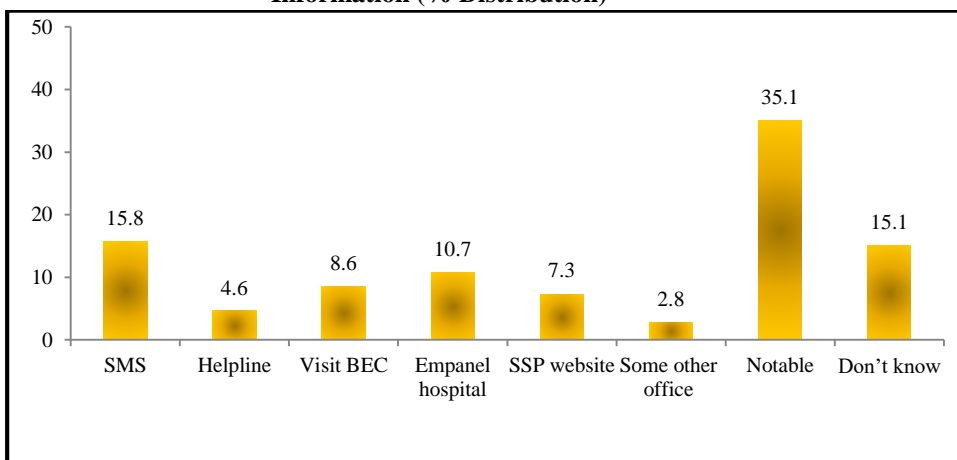
Source: SSP Beneficiary Household Survey 2021.

6.3. Card Utilisation Practice

Health utilisation largely depends not only on the knowledge but also the available health facilities. After getting the card, 4 percent of the beneficiaries reported that they

faced a situation where in-door health facilities were required, but they had not visited the empanelled hospital. Out of the 4 percent of such beneficiaries, the reasons are listed in Figure 17 that includes: do not know where to go, incomplete documentation, believe that some local quake/spiritual will make better treatment, hospital is too far away, etc.

Fig. 17. Reasons for not Visiting a Hospital (% Distribution)
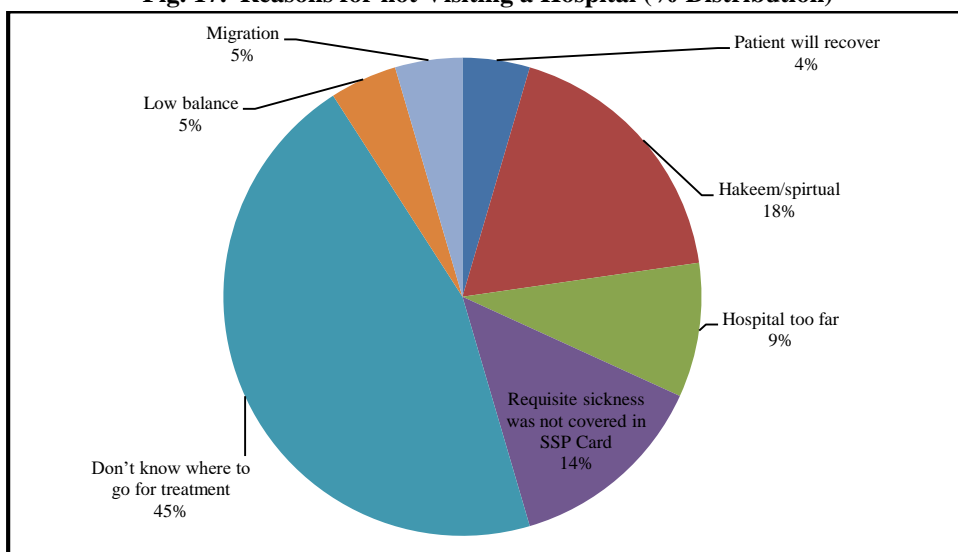
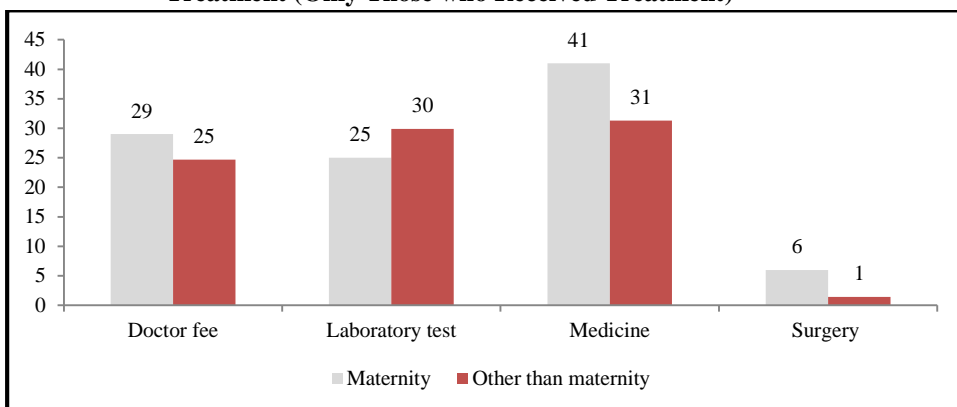*Source:* SSP Beneficiary Household Survey 2021.

As reported by the respondents, another 3 percent visited empanel hospital but they were unable to utilise the SSP card. The main reasons, as told by the HFO/hospitals to the beneficiaries, were that concerned sickness is not for in-door patients (29.4 percent), the hospital reported that balance is not sufficient (23 percent), documents were incomplete (11.8 percent) and the required treatment was not available (11.8 percent).

Around 4.3 percent of the families got a birth delivery in their family after getting the SSP card. 5 percent of the birth took place at home, 64 percent in the empanelled hospitals and 32 percent in other hospitals.[9] Among those who have used the card, only 10 percent had received four parental care visits, 21 percent had received only one prenatal visit, 10.5 percent visited twice, while a vast majority did not know whether the prenatal or postnatal were covered in the package.

Among those who got treatment from SSP, 72 percent of the respondents reported that after discharge from the hospital, they received 5 days of medicine, 21 percent did not receive it, and the rest 6 percent did not have the knowledge. Similarly, 44 percent had received transport charges, 50 percent had not received it, and the remaining 6 percent did not know whether they had received transport charges or not. We also questioned the beneficiaries (only those who received treatment) whether they had made any payment during treatment or not. Some of them had paid fee to doctor, or made expenses on laboratory tests, medicine, etc (Figure 18).

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[9] The birth in other hospital could be due to 2 factors: either denial of services in empanel hospital or own ease of beneficiary that she is already engaged with some doctor and trust on it.

Fig. 18. Proportion of Beneficiaries who Payment OOP Payments During Treatment (Only Those who Received Treatment)

Source: SSP Beneficiary Household Survey 2021.

An encouraging element was that three-fourths of the beneficiaries were highly satisfied with the treatment (Table 7). Overall they were satisfied on quality of health services discharge procedure etc. yes the programme has to work on certain aspects where dissatisfaction is also shown on certain activities, i.e., information provision, admission procedure, doctor's availability and cleanliness.

Table 7

Beneficiary Satisfaction on Treatment (% Distribution)

Activity	Highly Satisfied	Moderately Satisfied	Not Satisfied	Total
Admission Procedures	82.3	11.8	5.9	100
Quality of Health Services	76.1	23.5	0.4	100
Doctor's Availability	76.4	17.7	5.9	100
Staff Availability	88.2	5.9	5.9	100
Cleanliness	82.4	11.8	5.8	100
Information Provision	76.5	5.9	17.6	100
Discharge Procedure	82.3	17.7	0.1	100
Overall	76.4	14.8	8.3	100

Source: SSP Beneficiary Household Survey 2021.

7. CONCLUSIONS AND WAY FORWARD

The current research has analysed SSP beneficiaries' demand and supply-side constraints in accessing indoor health services. A distinctive focus of the study was to evaluate the ongoing communication and awareness apparatus available to the public and beneficiaries. The findings reveal that most beneficiaries need more proper knowledge about various programme features, including where they should go for treatment, package amount, type of treatment covered in the package, and whom to contact for information.

Despite the low utilisation rate, a heartening element is the high satisfaction level of the beneficiaries who had received treatment. Multiple reasons were identified for the low

utilisation, including a limited number of empanelled hospitals, especially in remote areas, limited medical facilities in various private hospitals, and attitude issues in government hospitals.

Based on the findings, we have the following recommendations:

7.1. Targeting and Enrolment

The programme has been switching toward universalisation, where every citizen can receive indoor health treatment. The programme must ensure the enrolment of every citizen where collaboration is required with the NADRA and provincial and local governments to ensure universal birth registration as benefits are linked with the birth registration. In case of a lack of birth registration or national identity card, the programme must consider any other document as proof of citizenship and provide in-door treatment. Specific bottlenecks, i.e., name mismatch, marital status up-dation, etc., require resolution.

Data up-dation is crucial, and authorities must collaborate with the provincial and local governments to ensure birth registration, B-form, and CNIC. The programme may either use the live data or update the data with NADRA weekly. A policy must also be developed for newly married couples who were earlier registered with parents but could not receive treatment due to a change in marital status.

7.2. Sufficient Number of Hospitals

Currently, the number of empanel hospitals is fewer. It requires more empanel hospitals in each district to create competition among hospitals. There is a need for tertiary care empanel hospitals in each region, i.e., AJK, GB, along with the provision of referral services to link the remote areas beneficiaries with significant centers. The programme must also resolve the package-related constraints as some hospitals have been denying the services with the excuse that the benefit package is insufficient to cover in-door expenses. The entire government health infrastructure must be on the pool of SSP. It should be mandatory that all private hospitals be a part of the SSP. Otherwise, their registration should be canceled.

7.3. Improve Hospital's Environment

The hospitals face various challenges, including a lack of uniform communication material, limited presence of HFOs (i.e., morning to evening and leave on Sunday), and internet issues in remote areas. The authorities must ensure that HFOs should be available in hospitals 24/7. The list of hospitals should be made available to the public through various sources, including the website and dedicated SMS service. Moreover, the programme should introduce some Android applications to find the nearest hospital to a patient.

7.4. Robust Communication Strategy

There is a need for a grassroots-level communication strategy, especially in districts where the programme is universal. The key messages must be disseminated at the doorsteps of beneficiaries. For this, the programme may involve local notables, education and health departments, and other social safety net departments having a

ground-level presence (i.e., BISP, Zakat, Pakistan Bait-ul- Mal, and various provincial social protection/security authorities). The message should be simple, focusing on guiding beneficiaries on SMS service, call center, and in-person information source points (i.e., hospitals).

For urban centers and educated populations, communication must use social media, TV, and radio platforms. Recently, the government has made a massive campaign on breast cancer through IVR messages. A similar campaign must be launched to guide and raise awareness among the beneficiaries.

REFERENCES

Aji, B., et al. (2013). The impact of health insurance programmes on out-of-pocket expenditures in Indonesia: An increase or a decrease? *International Journal of Environmental Research and Public Health, 10*(7), 2995–3013.

Bredenkamp, C., M. Mendola, & M. Gragnolati (2010). Catastrophic and impoverishing effects of health expenditure: New evidence from the Western Balkans. *Health Policy and Planning*, 26(4), 349–356.

Brooks, M. I., et al. (2017). Health facility and skilled birth deliveries among poor women with Jamkesmas health insurance in Indonesia: A mixed-methods study. *BMC Health Services Research*, *17*(1), 1–12.

Capuno, J. J., et al. (2016). Effects of price, information, and transactions cost interventions to raise voluntary enrolment in a social health insurance scheme: A randomised experiment in the Philippines. *Health Economics*, *25*(6), 650–662.

De Roodenbeke, E. (2004). *Purchasing inpatient and outpatient care through hospitals*.

Devadasan, N., et al. (2013). Promoting universal financial protection: evidence from the Rashtriya Swasthya Bima Yojana (RSBY) in Gujarat, India. *Health Research Policy and Systems*, *11*(1), 1–8.

Ellis, R. P., T. Chen, & C. E. Luscombe (2014). Comparisons of health insurance systems in developed countries. *Encyclopedia of Health Economics*, *1*, 1–22.

El-Sayed, A. M., et al. (2015). Does health insurance mitigate inequities in non-communicable disease treatment? Evidence from 48 low-and middle-income countries. *Health Policy, 119*(9), 1164–1175.

Erlangga, D., et al. (2019). The impact of public health insurance on health care utilisation, financial protection and health status in low-and middle-income countries: A systematic review. *PloS One*, *14*(8), p. e0219731.

Erlangga, D., S. Ali, & K. Bloor (2019). The impact of public health insurance on healthcare utilisation in Indonesia: evidence from panel data. *International Journal of Public Health, 64*(4), 603–613.

Finkelstein, A., et al. (2012). The Oregon health insurance experiment: evidence from the first year. *The Quarterly Journal of Economics, 127*(3), 1057–1106.

Fujita, M., et al. (2017). Impact of geographic accessibility on utilisation of the annual health check-ups by income level in Japan: A multilevel analysis. *PloS One*, *12*(5), p. e0177091.

Gotsadze, G., et al. (2015). An impact evaluation of medical insurance for poor in Georgia: preliminary results and policy implications. *Health Policy and Planning, 30*(suppl_1), i2–i13.

Kale, M. S., et al. (2013). Trends in the overuse of ambulatory health care services in the United States. *JAMA Internal Medicine, 173*(2): 142–148.

Kanmiki, E. W., et al. (2019). Out-of-pocket payment for primary healthcare in the era of national health insurance: Evidence from northern Ghana. *PloS One, 14*(8), p. e0221146.

Kazungu, J. S. & E. W. Barasa (2017). Examining levels, distribution and correlates of health insurance coverage in Kenya. *Tropical Medicine & International Health, 22*(9), 1175–1185.

Kotoh, A. M., G. C. Aryeetey, & S. Van Der Geest (2018). Factors that influence enrolment and retention in Ghana'National Health Insurance Scheme. *International Journal of Health Policy and Management, 7*(5), p. 443.

Kressin, N. R. & P. W. Groeneveld (2015). Race/Ethnicity and overuse of care: a systematic review. *The Milbank Quarterly, 93*(1), 112–138.

Lyu, H., et al. (2017). Overtreatment in the united states. *PLoS One, 12*(9), p. e0181970.

Malik, A. M. & S. I. A. Syed (2012). Socio-economic determinants of household out-of-pocket payments on healthcare in Pakistan. *International Journal for Equity in Health*, *11*(1), p. 51.

Nguyen, H. T., Y. Rajkotia, & H. Wang (2011). The financial protection effect of Ghana National Health Insurance Scheme: evidence from a study in two rural districts. *International Journal for Equity in Health, 10*(1), 1–12.

Panda, P., A. Chakraborty, & D. M. Dror (2015). Building awareness to health insurance among the target population of community-based health insurance schemes in rural India. *Tropical Medicine & International Health, 20*(8), 1093–1107.

Philip, N. E., S. Kannan, & S. P. Sarma (2016). Utilisation of comprehensive health insurance scheme, Kerala: a comparative study of insured and uninsured below-poverty-line households. *Asia Pacific Journal of Public Health*, *28*(1_suppl), 77S–85S.

Publishing, O. (2018). *Health at a glance: Europe 2018: state of health in the EU cycle*. Organisation for Economic Co-operation and Development OECD.

Rao, M., et al. (2016). Has the Rajiv Aarogyasri Community Health Insurance Scheme of Andhra Pradesh Addressed the Educational Divide in Accessing Health Care? *Plos One, 11*(1), p. e0145707.

Rathi, P., A. Mukherji, & G. Sen (2012). Rashtriya Swasthya Bima Yojana: evaluating utilisation, roll-out and perceptions in Amaravati district, Maharashtra. *Economic and Political Weekly*. 57–64.

Saksena, P., et al. (2010). Health services utilisation and out-of-pocket expenditure at public and private facilities in low-income countries. *World Health Report*, *20*, p. 20.

Setswe, G., et al. (2015). Public awareness and knowledge of the National Health Insurance in South Africa. *Pan African Medical Journal*, *22*(1).

Shaikh, B. T. & J. Hatcher (2005). Health seeking behaviour and health service utilisation in Pakistan: challenging the policy makers. *Journal of Public Health*, *27*(1), 49–54.

Sood, N. & Z. Wagner (2018). Social health insurance for the poor: lessons from a health insurance programme in Karnataka, India. *BMJ Global Health*, *3*(1), p. e000582.

Suphanchaimat, R., et al. (2016). Impact of the health insurance scheme for stateless people on inpatient utilisation in Kraburi Hospital, Thailand. *Risk Management and Healthcare Policy, 9,* p. 261.

Thakur, H. (2016). Study of awareness, enrolment, and Utilisation of rashtriya swasthya Bima Yojana (national health insurance scheme) in Maharashtra, India. *Frontiers in Public Health, 3*, p. 282.

Vujicic, M., T. Buchmueller, & R. Klein (2016). Dental care presents the highest level of financial barriers, compared to other types of health care services. *Health Affairs, 35*(12), 2176–2182.

Wagstaff, A. & W. Manachotphong (2012). The health effects of universal health care: evidence from Thailand. (World Bank Policy Research Working Paper, 6119).

Wagstaff, A., et al. (2016). Encouraging health insurance for the informal sector: a cluster randomised experiment in Vietnam. *Health Economics, 25*(6), 663–674.

Watson, J., A. S. Yazbeck, & L. Hartel (2021). Making Health Insurance Pro-poor: Lessons from 20 Developing Countries. *Health Systems & Reform*, *7*(2), p. e1917092.