

Evaluating the Grievance Redressal System in Public Driven Health Insurance Program: Lessons and Learning for Pakistan.

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Abstract

Introduction The supply-driven public sector health insurance programs often face a lower utilization of health services due to an incompetent grievance redressal (GR) system, flawed design and bureaucratic hurdles. Resultantly, the targeted population faces poor quality of services, especially when their grievances are not addressed appropriately.

Methods This paper evaluates the efficiency and effectiveness of the GR system in the Sehat Sahulat Program (SSP)—a universal health insurance (UHI) initiative in Pakistan. Our research comprises both qualitative and quantitative components, where we conducted in-depth interviews with the supply-side stakeholders, patients, complainants and citizens.

Results We found that the program lacks an integrated case management system (ICMS). The complaints, registered through the call center, are only monitored. However, the call center lacks an automated system and hospital integration. Most of the population needs more knowledge about the program's features and how to register complaints. Despite being a universal health insurance (UHI) initiative, the program requires a clearer policy on the GR system, and there is a limited technical capacity to analyze the complaints.

Conclusion Currently, the inpatient utilization rate of health services is below 3%. An efficient GR system along with improvement in program design can raise the inpatient utilization rate to 8-10%. The program requires a robust communication strategy, an integrated case management system (ICMS), a referral system, a hospital tracking android application, and regular monitoring, which will effectively use the taxpayer's money.

Summary Box

What is already Known

- The Sehat Sahulat Program (SSP) is a national universal health insurance initiative that provides inpatient health services to all citizens.

- There are designated empanel hospitals to provide inpatient services to all citizens, however, limited research exists on the challenges associated with grievances at the various stages, including enrolment and service delivery.
- None of the studies has evaluated the grievance redressal system of the program.

What this study adds

- The program lacks an integrated case management system (ICMS), and complaints registered through postal letters and emails are pending. The only complaint registration source is the call center, and there is a conflict of interest as the same vendor (State Life Insurance Corporation) operates the call center and investigates the complaints.
- Inpatient services are largely underutilized due to certain issues in enrolment, service delivery, and the lack of a robust grievance redressal system.
- Currently, the inpatient utilization rate of health services are below 3%. An efficient GR system, and robust communication, can improve the utilization rate to 8-10%.

What this study might affect research practice and policy

- The program requires a robust communication strategy, a flexible complaint management system that integrates with all the stakeholders, and regular monitoring and evaluation to improve governance and service delivery.
- The findings suggest further research, such as pilots on community participation, the value for money of public resources, and how to boost effective collaboration among stakeholders.

Background

Primarily, the low-income groups in the developing world utilize public health facilities where the services are often compromised due to a host of challenges, including the attitude of staff and poor quality of services.^{1, 2} Resultantly, public trust in health facilities is compromised mainly due to poor accountability, especially when the complaint mechanisms become the victim of bureaucratic hurdles.^{3, 4} An effective complaint management system helps in improving service delivery,⁵ where the regular feedback helps in improving staff's attitude,^{6, 7} strengthening monitoring and accountability,⁸ and assure compliance with standards.⁹ Ultimately, it contributes to promoting equitable health services and the trust of citizens in health services.^{10, 11}

Every complaint may not be a genuine grievance, however, an efficient grievance redressal (GR) system must respond to each complaint.^{12, 13} The foremost element for an effective GR system is its easy access to the public for registering a complaint in a user-friendly manner,¹⁴ along with a clear complaint coding taxonomy and an integrated case management system (ICMS).¹⁵ The ICMS should be supported by technology features, e.g., automation, a defined resolution loop for each complaint, escalation process, tracking facility, dashboard, regular customer feedback, etc.^{16, 17}

Demand-driven health insurance programs perform proficiently due to their 'customer-in-nature' approach, as both health insurance companies and clients know the terms and conditions of an insurance plan.¹⁸ In contrast, supply-driven health insurance programs, especially in low-income countries, often face a host of risks as government pays health premiums rather than the public.¹⁹ These programs are commonly run under social protection schemes and face demand and supply-side risks that may result in lower utilization of health services.^{20, 21} The demand-side risks may include poor public awareness due to poverty, illiteracy, remoteness, cultural norms, etc.²²⁻²⁴ The supply-side constraints could be faulty program design,¹⁹ limited number of empanel hospitals, lack of good quality services, the politicization of schemes, insufficient package amount, and lack of an efficient GR system.^{25, 26} As a result, often the targeted population face constraints in enrolment, accessing the hospital and utilization of health insurance effectively.²⁷ Sometimes, they face denial of services and are often forced to make certain payments from their pocket as a bribe to avail themselves of health facilities.²⁸

Pakistan's Public Health Insurance Program

Pakistan, with a population of 230 million, lacks sufficient resources to provide equitable health facilities to its citizens. Before the emergence of the public health insurance program, the country was facing a twofold burden; on one hand, the health budget was only 0.6% of gross domestic product (GDP), and on the other hand, around two-thirds of the population financed their health expenses themselves.²⁹

Launched in 2015, the Sehat Sahulat Program (SSP), a public health insurance program in Pakistan, aims to provide inpatient free-of-cost health services without any financial contribution from the public as the government pays the annual premium to a single insurance company against each family.³⁰ A family is defined as the parents with unmarried children. A family can avail of inpatient services up to Pakistani rupees (PKR) 120,000 per year for basic sickness (i.e., maternity, fracture, etc.) and up to PKR 600,000 per year for severe sickness (i.e., diabetes, burn, cancer, kidney, heart and other chronic diseases). It is part of the insurance package that empanel hospitals must carry out medical tests during inpatient treatment and pay PKR 1,000 for transport and five days of medicine to the patients at discharge time.

Initially, the program targeted low-income families using the Benazir Income Support Program (BISP) data. Around 25% of the population was targeted by issuing health cards to the poorest families, who were workable only in empanel hospitals. In 2021, the government expanded the benefits of inpatient health services to all citizens, making it a universal health insurance (UHI) initiative. Now, no separate health card is required. Instead, the national identity card (NIC) serves as the eligibility document, subject to family members being registered in the national database.³⁰ National Database and Registration Authority (NADRA), which issues NICs, provides the family-level data to SSP for registration in the program.

The program is a federal-provincial joint venture; both are the regulatory custodians who run the program and engage other stakeholders. The federal government provides policy-level and technical assistance, whereas the provinces contribute financially.³¹ Currently, the program is operational in all the provinces and regions except in the province of Sindh, as the provincial government has yet to adopt it. So far, the program has enrolled 46.2 million families, covering 154 million of the country's population (75%). Above 16 million individuals have used inpatient health facilities in dedicated empanel hospitals (till May 2024).

So far, the federal and provincial governments have engaged three stakeholders to perform their operational activities (Table 1). The State Life Insurance Company (SLIC) services are hired through a competitive process to provide inpatient patient services to citizens. The SLIC is responsible for all the operational activities, including onboard empanel hospitals, providing free-of-cost inpatient health services, and addressing all service-related grievances.

Table 1 Roles and Responsibilities of SSP Stakeholders

Department	Role in SSP operation
Federal SSP	<ul style="list-style-type: none">Overall custodian of the program through policy formulation and provision of technical assistance
Provincial Health Departments	<ul style="list-style-type: none">Provincial the custodian of program by supervising all operational activities
NADRA	<ul style="list-style-type: none">Provide updated family-level data, and manage an outbound call center to acquire feedback from discharged patients

State Insurance Corporation (SLIC)	Life	<ul style="list-style-type: none"> The sole insurance company will manage all operational responsibilities, including hiring empanel hospitals, managing front desks in hospitals, resolving all grievances related to enrollment and treatment, managing an inbound call center to address public queries, and registering complaints.
Empanel hospital		<ul style="list-style-type: none"> Provide inpatient health services on agreed-upon packages by charging no money for admission, lab tests, surgery, doctor fees, medicine, etc. Also, provide transport fare (PKR 1,000) at discharge and 05 days of medicine.

Besides the provision of family-level data, NADRA manages an outbound call center to acquire feedback once a patient receives inpatient services in an empanel hospital. The empanel hospital, hired by the SLIC, provides inpatient services to citizens. There are settled package rates against each sickness, which could vary depending on the rating of an empanel hospital. For example, a hospital that has a better infrastructure and is located in a major urban city would receive a better package rate.

The program is too ambitious to obligate all citizens to receive inpatient health services.³² Currently, the SSP is facing a lower utilization rate, and it requires a robust GR system to improve accessibility and quality of services, and respond to every complaint effectively. There are examples in the country where earlier public spending went compromised in similar initiatives. For instance, BISP started a public-driven health program in 2012, Waseela-e-Sehat (WeS), providing inpatient health insurance to 75,000 families. However, during one year, only 0.8% of the families availed of health insurance, primarily due to lack of awareness, lower package limit, lack of monitoring and evaluation, etc.

Few studies have comprehensively evaluated the SSP program by reviewing its grievances, which could result in a lower utilization rate. The proposed research aims to systematically review the limitations of program design and its grievance redressal (GR) system. The design level issues include federal-provincial joint venture, insurance company hiring, public hospital engagement, data issues for enrolment, and the absence of a co-payment formula where citizens may contribute in premium. We have also evaluated the available complaint management systems and found several operational problems, i.e., the poor capacity of SLIC to provide adequate services, a limited number of empanel hospitals, awareness issues, a vague system to register complaints, and a lack of an integrated case management system (ICMS) for service delivery. The study proposes a framework to help resolve the grievances and improve inpatient health services. Improving these grievances would raise the inpatient services by 6-7% annually below 3%.

Methods

Analytical framework

Our evaluation approach broadly covers a review of all sorts of grievances that could result in lower utilization rates, including but not limited to flaws in program design, operational challenges to enroll citizens, hospital accessibility issues and denial of services, imperfections in service delivery, and caveats in the existing complaints management system. We developed an evaluation framework based on available literature on complaint management system,³³ automation,³⁴ receptive hospital governance,¹¹ and effective grievance redressal systems to improve service delivery.³⁵ ³⁶ The evaluation framework was carefully designed with the ethical aspects in view. The SSP management approved the design and provided various secondary datasets for analysis and primary surveys.

We have used multiple secondary and primary data sources from all the supply-side stakeholders (as detailed in [Table 1](#)). We have evaluated the call center and other complaint registration mechanisms

to gauge their efficacy. In-depth interviews were also conducted with the citizens, complainants, and patients to understand their issues, challenges, and knowledge about program features and service delivery. We have built an analytical framework for analyzing the GR system of the Sehat Sahulat Program (SSP), where all the possible grievances are analyzed, including:

- Enrolment: missing data in Health Management Information System (HMIS), data discrepancy, and lack of facility for data up-dation.
- Service delivery and denial of benefits: the hospital is too far, the staff is not available, partial/non-provision of benefits as detailed in the program.
- Quality of services: substandard care, poor attitude of hospital staff, complex admission process, and demand of bribes from patients.

Data collection

In-depth interviews were conducted with all the supply-side stakeholders at the federal, provincial, and district levels by using structured guidelines. At the federal and provincial levels, we managed interviews with the SSP management, provincial health departments, NADRA, and SLIC to understand the grievances related to the program design, contractual arrangements among stakeholders, data enrolment issues, and limitations in health management information system (HIMS) deployed in empanel hospitals for enrolment and service delivery. It is worth mentioning that the SSP management provided district-level numbers of enrolled families, empanel hospitals, service utilization, etc.

The SLIC and NADRA manage two call centers. NADRA manages an outbound call center, whereas SLIC manages an inbound one. The outbound call center acquires post-feedback on the quality of services from those citizens who receive inpatient treatment. While receiving the feedback from treated citizens, a complaint is automatically registered if a citizen reports some grievances, i.e., non-provision of good quality services, non-provision of medicine or transport charges, bribes, etc. The inbound call center is used to provide information and register complaint. The role of the SLIC call center is critical in registering complaints as it is almost the sole source of complaints registered by the public and citizens.

We visited the SLIC call center to evaluate how the complaints are being registered and handled, the automation level of the call center and its integration with the HMIS that operates at the district level, the functionality of dashboards, etc. Further, the SSP management provided data on more than 51,000 registered complaints from the year 2016 to 2021 to evaluate the nature of the complaints, resolution status, etc. In further verifying the registered complaints through the SLIC call center, a random sample of 618 complainants who registered a complaint in the year preceding the survey was drawn. An effort is made to ensure representation at the potential category-wise of complaints and province/region. These 750 complainants were interviewed through a computerized assisted telephonic interview (CATI) survey to acquire their feedback on complaint registration difficulties, resolution processes, satisfaction, and confirmation of whether their complaints were resolved.

To acquire feedback from citizens and the operational team at the district level, we devised a strategy in consultation with the SSP management by selecting 25 districts (out of 87) that fairly represent the heterogeneity, cultural variations, and remoteness. We designed a door-to-door quantitative household survey in 25 districts to gauge citizens' knowledge about the program features, enrolment issues, awareness about complaint registration mechanisms, and service utilization challenges in case they had approached the impanel hospitals. A total of 1,845 citizens were interviewed through a two-stage stratified random sampling technique where the SSP management assisted in devising the sample framework from the database of registered citizens. The households were briefed about the research objectives, and their consent was obtained before the interview.

Our core team also conducted in-depth interviews in 45 empanel hospitals in 25 districts selected by the operational team, including district medical officers (DMOs), front desk officers (FDOs), and hospital management. The analysis mainly focuses on the critical supply-side challenges in enrolment and grievances in service delivery. It is worth mentioning that each empanel hospital has a front desk where a representative of SLIC (named FDO) is available for data up-dation, information provision, admission, and overall coordination with the hospital. Similarly, another medical doctor at the district level is named district medical officer (DMO) to monitor overall operational activities. While visiting the empanel hospitals, 215 admitted citizens in 45 hospitals were also interviewed for their feedback on service delivery.

The quantitative data, both secondary and primary, was analyzed by using STATA software.

Patient and public involvement

The study was designed and implemented with the SSP management, the Pakistan Health Service Academy, and the World Health Organization (WHO). The stakeholders approved the study design. The current study has not conducted any clinical or experimental research. The consent form was obtained before interviewing the citizens, patients, and complainants, and they were briefed on the study's objectives. The ethical approval was taken from the institute's ethical committee. The study findings were presented to the stakeholders in a seminar held in September 2022 in Islamabad.

Results

The program offers citizens three options for complaint registration. First, the SSP has a web portal for registering complaints through email. Second, SLIC manages an inbound call center that operates 24/7 to address general public queries and to register a complaint. Another outbound call center is managed by the NADRA to acquire follow-up feedback only from those citizens who utilize inpatient health services. The feedback is acquired on five questions, and if a citizen responds to poor feedback (i.e., purchase of medicine, bribe taken by empanel hospital, etc.), it is forwarded to SSP management for action. Third, citizens can mail complaints through postal letters.

Mechanized Systems for Enrolment

There are two mechanized systems to facilitate citizens for information and enrolment.

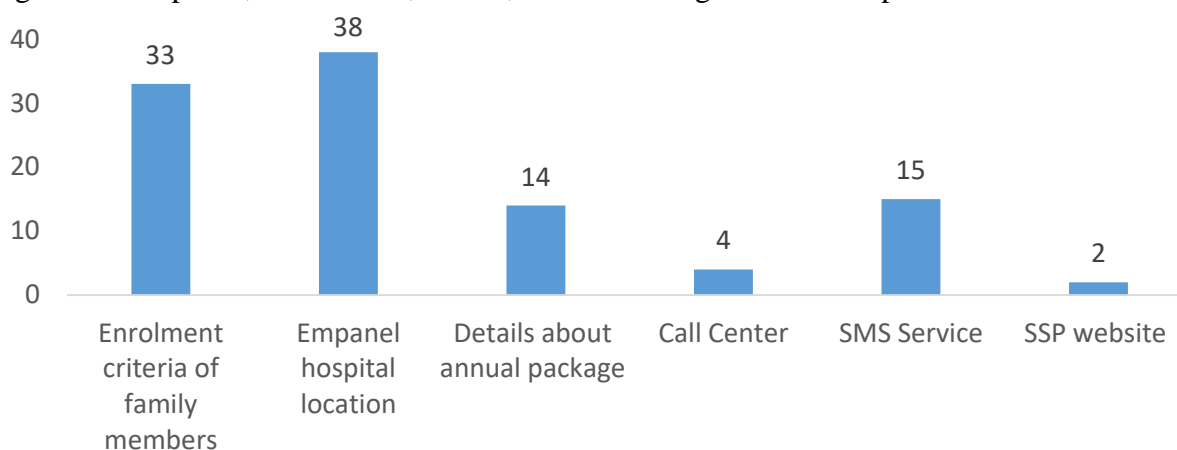
- An SMS service (by sending the NIC number at 8500) to check family eligibility status and details of unmarried children registered with their parents. It helps a family to know the unregistered children in the program.
- The Health Management Information System (HMIS) is operative in all empanel hospitals to enroll unregistered family members. It also manages the a family's entire inpatient service utilization record, utilized insurance amount, and remaining balance. The HFO operates the HMIS in an empanel hospital.

The below sub-sections have detailed the critical findings from secondary data analysis and household survey;

Public knowledge and utilization rate

The citizens must know the program's eligibility criteria and various program features, i.e., package amount, treatment location, where to go for complaint, etc. However, the program lacks a ground-level presence to interact with the citizens. As a result, a significant proportion of the population needs to learn the right information about the program. For example, only 33% of the population knows the enrolment criteria of family members, and 38% have knowledge about the empanel

hospital. A limited percentage know the Call Center to register complaints or acquire information, or SMS service (Figure 1). Only 0.6% of the citizens have registered a complaint, 1% have attempted to register a complaint, and the rest, 98.4%, have never registered a complaint.



Source: SSP Household Survey

Figure 1 Citizen's Specific Knowledge about Program Features (in %)

The 2018/19 national out-of-pocket (OOP) health survey shows that 4.3% of the population used inpatient services; the utilization rate stood at 2.8% for the bottom and 5.7% for the fifth quintiles. However, there is an under-utilization of inpatient services in the SSP intervention; it stood at just 2.6% for 2023 (Table 2), leaving a utilization gap of 3.1% by assuming to catch up the utilization rate of the fifth quintile. The household survey further confirmed that 7% of the citizens were not able to avail of inpatient health services: 4% reported that they faced a situation where inpatient health facilities were required for a family member, but they had not visited a hospital, primarily because they lack necessary information, i.e., where to go, documents, hospital was too far, etc. Another 3% visited empanel hospital, but they could not utilize services due to a lack of family member names in the database, non-availability of treatment, denial of services, etc.

The lower utilization rate needs to be addressed by improving program design, service delivery, and disseminating right communication to the citizens. Besides awareness issues, access to empanel hospitals and quality of services are other reasons for lower utilization. Ideally, every hospital must provide inpatient health services to the public under the SSP initiative. However, only 11% of the private hospitals and 22% of the public hospitals are currently empaneled.

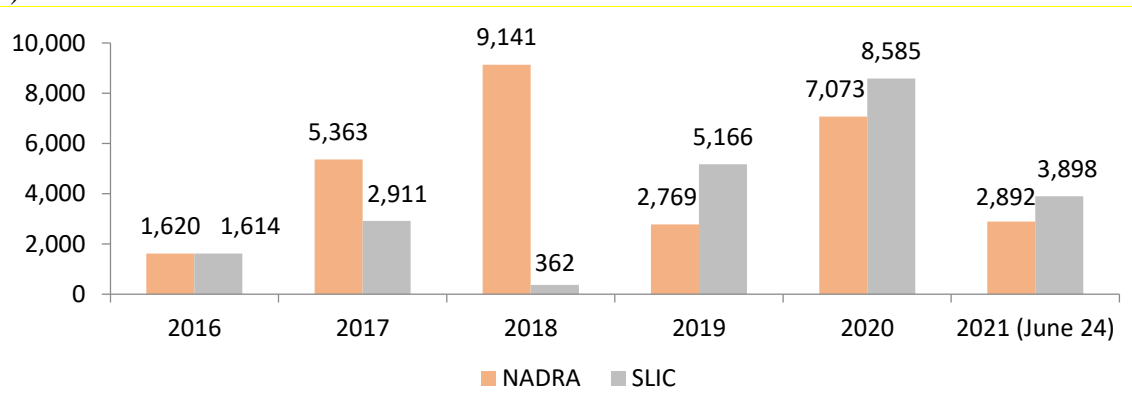
Table 2 Health Utilization Rate in the Sehat Sahulat Program for Year 2023

Province/Region	Families (in million)	Number of Beneficiaries (in million)	Inpatient Admission (in 000)	Annual Utilization Rate (in %)	Utilization Gap*
AJK	1.54	5.24	140.80	2.69	3.01
Gilgit Baltistan	0.37	1.28	44.78	3.50	2.20
ICT	0.28	0.92	25.69	2.79	2.91
Khyber Pakhtunkhwa	9.60	31.20	739.90	2.37	3.33
Punjab	32.00	107.32	2,984.54	2.78	2.92
Sindh***	0.38	0.95	10.38	1.09	4.61
Balochistan	2.00	6.71		**	

National	46.17	153.62	3,946.09	2.57	3.13
* The gap is calculated by assuming the inpatient utilization of top quintile (5.7%) and SSP utilization					
** The program was started in November 2023					
*** The program is operational only in one district Tharparker out of 30 districts					
Source: Information were provided by Sehat Sahulat Program					

An evaluation of call centers

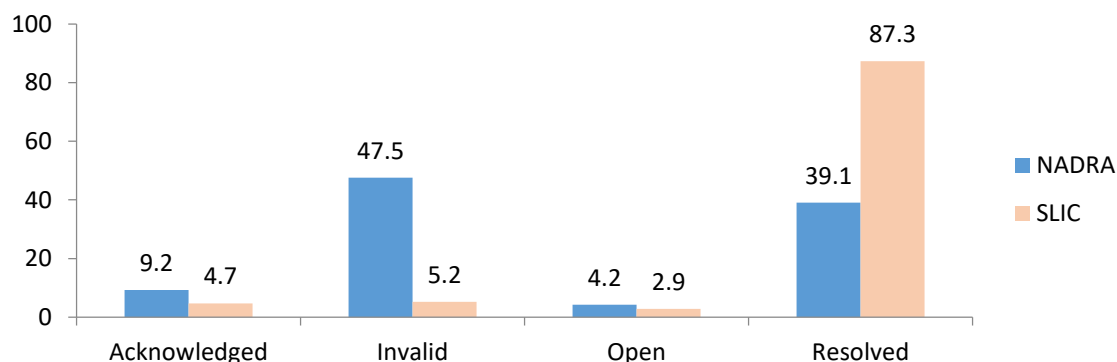
The analysis reveals that both call centers registered more than 51,000 complaints from January 2016 to June 2021. Ideally, the SLIC call center (inbound) should register more complaints as its helpline number is widely disseminated everywhere to address public queries and to register complaints; however, the NADRA call center received more complaints during a follow-up call from citizens who received inpatient treatment. This reflects the under-utilization of the SLIC call center (Figure 2).



Source: Complaint database provided by SSP till June 24, 2021

Figure 2 Complaint Registration Overtime (in numbers)

We found several limitations in the complaint database. First, the SLIC call center manages complaints manually (an excel sheet) without having a defined taxonomy and an automated complaint management system (CMS). Regrettably, there are no clear investigation procedures. Around 17% of the genuine complaints (i.e., bribes, non-payment of transportation charges, denial of services, etc.) were marked ‘acknowledged’ by the SLIC without any investigation. The investigation procedures of SLIC could be more robust and many complaints have been marked as ‘resolved’ and ‘invalid’ in the system without investigation (Figure 3). There is a matter of ‘conflict of interest’ as SLIC might intentionally declare a complaint ‘invalid’ as the same agency has been managing the operation and investigation.



Source: Complaint database provided by SSP till June 24, 2021

Figure 3 Complaint Resolution by Call Centers (% distribution)

Second, 78% of the complainants did not agree that their complaints were resolved; however, they were marked 'resolved' in the system, i.e., only 147 complainants consider that their complaints are resolved (fully or partially) out of 454 complaints marked as resolved in the database (Table 3). Third, we found various limitations in the technical capacity of the SLIC call center, i.e., lack of an automation system, no defined complaint loop, inability to generate a complaint number, no integration of both the call centers (managed by the NADRA and SLIC) as NADRA shares the complaints data with SSP through email. There is no caseload analysis of the SLIC call center and monitoring of call agents. The call agents need to gain proficiency in interacting with citizens in regional languages or call transfer facilities. The SSP management lacks its M&E capacity to conduct periodic analysis on registered complaints, especially those reported as 'resolved' by the SLIC.

Table 3 Complaint Resolution Matrix as mentioned in the Database and Confirmed by Complainants (in numbers)

Complaint Resolution matrix		Status in SLIC Call Center database (in numbers)			
		Invalid	Open	Resolved	Total
Confirmed by the complainant through follow-up survey (in numbers)	Fully Resolved	26	12	131	169
	Partially Resolved	7	1	16	24
	Not Resolved	57	48	250	355
	Don't Know	1	0	13	14
	Not applicable	6	6	44	56
	Total	97	67	454	618

Source: Telephonic survey from complainants, 2021

Discussion

Pakistan has a mixed health financing system comprising both public and private hospitals. The 2017/18 National Health Account (NHA) report showed that 83% of the patients visited private hospitals. Out-of-pocket is the primary source of health financing (52%), followed by federal and provincial governments (30%). The NGOs and private health insurance finance a minor share.³⁷ The program is facing certain challenges at the design and operational levels.

Design Relates Issues

Only those citizens can avail themselves of inpatient health services with their names in the HMIS. Still, around 18% of the adults lack NIC (10% male and 26% female), according to the 2017/18 national census. Similarly, a significant percentage of children lack birth registration. The SSP's HMIS is not directly linked with the NADRA's database, and it may take a few months to update the data on the B-form/NIC. Marital status up-dation is another issue. In case of a change in marital status, the program does not accept the newly married couple as a separate family. Since the program has declared it a universal health initiative, it must accept any citizenship document as proof of identity or devise some criteria where a citizen can acquire treatment based on someone's assurance. At the design level, the SSP needs to address a various limitations. First, there is a need to build a national consensus on the federal-provincial role. The province Sindh has yet to opt for the program, and two regions, AJK and Gilgit Baltistan governments, rely on the federal government for insurance premiums. Second, only one vendor (State Life Insurance Corporation) provides services, and there is no competition in service delivery. The SSP has no option except to continue with the SLIC even if the quality of services is poor, as it may take one year to hire another agency through the procurement process. There are few insurance companies in the country, and they can develop a cartel.

Third, the government has to stop inpatient financing for public hospitals. Now, they should compete with the private hospitals and must be resource-wise independent. Public hospitals still have a sound health infrastructure, but there is no formula for utilizing funds if they treat patients under the SSP insurance scheme. Fourth, all the public and private hospitals are not part of empanel.

Operational-level Challenges

As per the design, the SLIC is required to develop a complaint management system by defining the complaint registration and investigation mechanisms. However, SLIC must develop an operational manual to address grievances, i.e., stipulated time to resolve a complaint, complaint taxonomy prevails, investigation procedures, etc. The integrated case management system (ICMS) needs to be included. Only the complaints registered through the call centers are analyzed, whereas those registered through web/portal emails and postal letters are pending. The SSP cannot monitor the complaints. There are few empanel hospitals, and many need better-quality services. Some districts even have either only one or no hospital, and utilization rates are below 1% in those districts. Some regions (i.e., AJK and GB) have no tertiary care empanel hospitals. The utilization of services is also compromised due to the limited availability of services and 'pick and choose' behavior by empanel hospitals. Citizens and hospital management also reported denial of services. Hence, they offer treatment only for that sickness where they have a profit (i.e., surgery) and avoid treating the medical patients. The SSP package allowed hospitals to provide medicine during inpatient treatment, but we found that medical stores were not open 24/7, making people buy medicines from their pockets. In some districts, there is only one impanel hospital, and despite complaints against it, the authority has no option to close its services. We also found that HFOs lack proper information about the program. They are usually available during the day, and there could be a denial of services if a patient visits the hospital at night or on the weekend when HFO is not present.

We propose a six-dimension framework for an efficient GR system and effective service delivery.

Program Design

There is a need to build national consensus across provinces to make the program apolitical. A national health financing framework would provide the guiding principles and roadmaps for the federal and provincial governments. The framework must address certain existing impediments, i.e., the future of insurance model, the autonomy of public hospitals to generate revenues from insurance program, removal of health entitlements to public sector employees, etc. A single health insurance company cannot provide an innovative solution. The government must involve multiple insurance service providers to create fair competition in the insurance market. Hence, insurance companies compete for services and allow citizens to choose the services from the best service providers.

Enrolment

The HMIS, operational in hospitals, requires several upgrades. First, it must have a live integration with the NADRA database to extract real-time up-dation once an individual submits or updates any information related to their identity, i.e., birth registration, marriage registration, name change, etc. The HMIS must be capable of declaring a newly married couple as a separate family after marriage registration in the NADRA database. Second, the HMIS allows citizens to add missing family members if a family provides a B-form or child registration certificate issued by the NADRA. Third, any other document or personal surety should be accepted if a patient lacks CNIC/B-form. It is worth mentioning that around one-third of the children need a birth registration, and 18% of the population (aged 18 years and above) don't have a National Identity Card (NIC) issued by the NADRA.

Service Quality

Currently, a limited number of hospitals are onboard for inpatient services, and many of them opt for a 'pick and choose behavior'. To incentivize, the treatment packages must be market-based, so every hospital feels an incentive to participate. Additionally, the provincial regulatory framework must

ensure that every private and public hospital with inpatient health facilities is part of scheme. The SSP model seems too unrealistic, as none of the world's countries has a universal health insurance scheme. Some co-payment formulas can optimize public resources. For example, the government should pay a premium for poor and vulnerable segments and allow citizens to augment the package by paying a top-up amount.

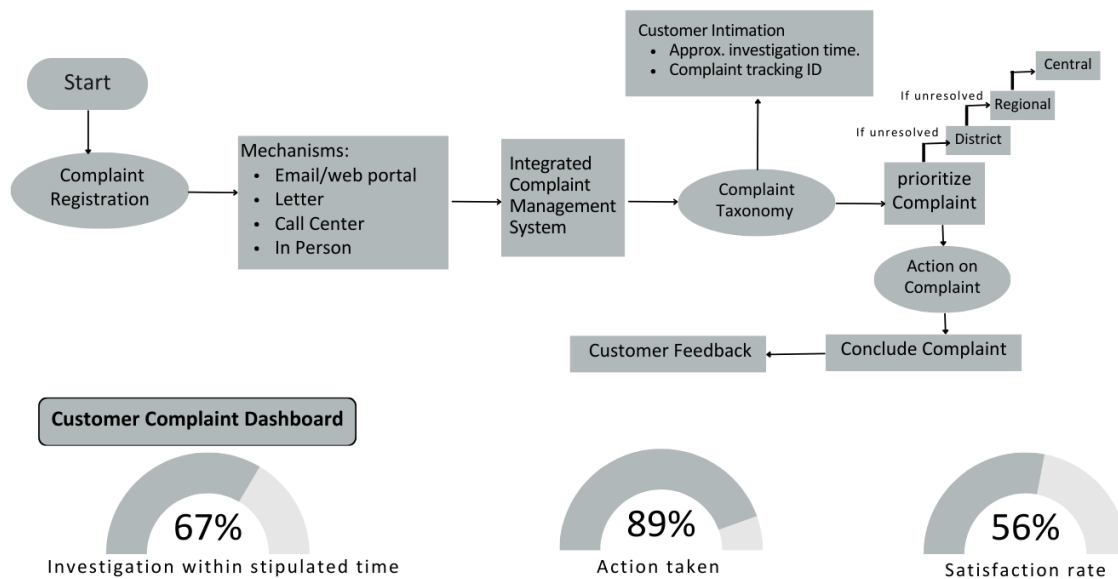
Citizens lack information about the nearest empanel hospitals and their treatment capacity. An Android application would be helpful by digitizing all hospital details so that a patient can easily find the nearest hospital, the services that s/he requires, and the hospital's rating. Certain features of a referral system should be added to the HMIS.

Robust Communication

There is a need for a grassroots-level communication strategy to disseminate key messages, especially in rural areas. For this, the program may involve local notables, 38 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 citizens 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.

Strengthening M&E

Currently, both the federal SSP management and provincial SSP teams need monitoring systems and field presence. Regular monitoring of operational activities, periodic process evaluations, sampled-based follow-up surveys, and impact evaluations would create deterrence service providers (e.g., SLIC and empanel hospitals) for improving their services. The SSP requires strengthening its in-house evaluation unit to analyze the complaints data and draw specific trends across districts.



Source: Author’s elaboration based on program review

Figure 1 Proposed Complaint Management System Integrated CASE Management System (ICMS)

The complaints registered through a web portal, email, and postal letter are pending due to limited manpower. As detailed in Figure 4, the program should allow citizens to register complaints in multiple manners. All the complaints must be pooled at one point, named ICMS, where the taxonomy

and loop of each complaint must be defined along with a stipulated time for complaint resolution. Currently, the complaints received at the SLIC's call center are managed in an Excel sheet, and then the HFO/DMO is informed through email/WhatsApp, which can lead to many errors and skipping. All this must be done through an integrated system that must be linked with HMIS/ICMS.

The SSP management should manage the call center to avoid a 'conflict of interest' as SLIC is responsible for providing health services, and the same company operates the call center and conducts complaint investigations. The call center must be integrated with the HMIS and NADRA call center without manual data entry. It should be serviceable in all languages. Specific dashboards help show a summary of progress and generate desired reports.

Conclusions

The Sehat Sahulat Program, with its aim to provide inpatient health services to all citizens, holds immense potential. Currently, there is underutilization of inpatient health service (below 3% per annum), but this can be significantly improved, potentially reaching 8-10 %, by enhancing awareness, service delivery, and establishing a dynamic GR system. The SSP program, while allowing complainants to register complaints only through the call center, is facing challenges with registered complaints through email and postal letters due to a lack of technical and manpower capacity. The call center, despite its limitations such as a lack of an automated system, poor investigation capacity, and no defined time to resolve a complaint, is a crucial part of the program. Several grievances related to enrollment and service delivery are due to a poorly designed HMIS, which can be addressed for better outcomes.

Effective communication is crucial for disseminating information about the program. The implementation of an integrated case management system (ICMS) is a significant step towards improving the complaint management system. The program can greatly benefit from the use of modern technology to enhance service delivery. For instance, a referral system, an android application for hospital tracking, and a hospital rating system can all contribute to a more efficient and effective program. Lastly, regular monitoring and evaluation are essential for continuous improvement in service delivery.

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