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# Operational and Financial Factors Affecting The Implementation of The Sehat Card Scheme

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**Abstract**
*This study intended to identify and analyse the multiple factors affecting the implementation of the Sehat Card Scheme in the empanelled hospitals in the Islamabad Capital Territory (ICT). Focusing on operational and financial aspects of the panelled hospitals in the Sehat Card scheme, this study was aimed to identify challenges and barriers in the implementation of health insurance packages. Specifically, this study attempted to understand the issues associated with the hospital registration procedures, monitoring mechanism, patient documentation requirements, costing for health services, claims submission and liaison with the insurance companies & govt. bodies. This study used the interview-based data from the hospital administrators in the sampled hospitals in the ICT region. Our objective was to highlight the operational and financial issues from the prospective of the health service providers in order to understand the service delivery challenges in the empanelled hospitals.*

**Introduction:**
The Federal Government of Pakistan launched its social health protection initiative, named Sehat Sahulat Program (formerly known as Prime Minister's National Health Program), in 2015, which envisioned improving access to healthcare for the lower income segments. The program initiated a social health insurance scheme named as the Sehat Card that aimed to provide free of cost healthcare services to the poorest population in targeted 34 districts (Two districts of each Azad Jammu & Kashmir & Gilgit Baltistan, six districts of ex-FATA, Islamabad District, five districts of Sindh, five districts of Baluchistan, thirteen districts of Punjab and four districts of KPK) in Pakistan. Initially, the maximum financial coverage limit per family per year was PKR 300,000 (Rs. 250,000 for priority care treatment and Rs. 50,000 for secondary care treatment) with a coverage of same amount as excess of loss coverage financed by Pakistan Bait Ul Mal.
The operating mechanism of the Sehat card scheme was to pay a fixed premium to a health insurance company and selection of the hospitals for treatment of the beneficiaries. The government paid a premium of Rs.1,299.98/- per year per family to the State Life Insurance Corporation of Pakistan which reimbursed the treatment expenditures to the hospitals. During its 1st phase (pilot-testing) around 500 public and private hospitals across the Pakistan were empanelled to provide the healthcare services to the poorest population of the country. The data of beneficiary families were provided by the BISP from its National Social Economic Registry database 2009-10 (NSER). The NADRA also played a vital role in composition and real-time verification of the household data of BISP into families database.

The second phase of the Sehat Card was started in 2018 in which entire population of ex-FATA and AJK were included in the beneficiaries list through 700 plus hospitals across country thereby moving towards the Universal Health Coverage (UHC). In this stage, KPK and Punjab were handed over the financial and administrative operations of their respective districts. In the third phase of the Sehat Card scheme beginning in 2022, the entire population of AJK, GB, ex-FATA and Tharparkar District of Sindh were covered in the Sehat Card scheme with treatment from 100 plus hospitals across Pakistan. The Govts. of Punjab and KPK are managing the financial and administrative aspects of the Sehat Card scheme from their own resources. At present, the federal government is providing the technical and administrative support to these provincial governments on need basis. The financial contribution of federal government on account of health insurance premium till 2022-23 is about Rs. 14 billion (Rs. 3 billion related to below poverty population and Rs. 11 billion related to Universal Health Coverage).

Pakistan, being a developing country, has implemented the Sehat Card scheme within the ambit of the social health insurance. However, compared to the regional peers, Pakistan has made a late entry in the social health insurance model. The social health insurance coverage was started in Thailand in 2012, in Indonesia in 2014, in 1983 in Singapore, in 1984 in Malaysia. Pakistan, with its, 250 million population is the fifth largest country of the world and has historically relied on the crowded and poorly funded govt. run hospitals for providing health services to the population.

Pakistan, being a developing country, had historically spent less than 1% of its GDP on health. The Govt. of Pakistan has mostly relied on govt. run hospitals for managing the health-related issues. These hospitals were often located in urban and semi-urban areas with fewer facilities and crowded patient wards. The high-income groups have relied on private hospitals for health treatment across the country. As the construction of new govt. run hospitals were a time-taking and a costly option, the govt. considered the option of social health insurance models. The Sehat Card scheme, being a mixture of the Bismark & Beveridge model, was designed to provide social health insurance to the wider segments of the society through private sector hospitals located in various cities.

The Sehat Card Scheme promised universal health coverage for the lower income people in Pakistan. This study aimed to highlight the challenges in the implementation of the Sehat Card scheme with a view to identifying the challenges and barriers in the effective delivery of the services. In addition to this, this study intended to highlight the point of view of private health service providers (hospitals) empaneled by the government. The study also aims to identify the operational (hospitals registration, patient documentation requirement, monitoring mechanism etc.) and financial (costing for health services, claims submission, funds release, liaison with insurance company etc.) challenges in the implementation of the health card scheme in order to devise strategies for improving service delivery.

**Literature Review:**

Many researchers have studied the Sehat Card scheme in multiple perspectives. Some experts have worked on assessing the doctors' responses, patients feedback and other end users' perspectives while others have evaluated the impact of Sehat Card scheme on meeting patients' needs. For example, McIntyre et.al. (2003) examined the design features of the social health insurance schemes in the South Africa and reported that mere launching of social health insurance schemes is not enough if their design and administration is not carefully made. Apart from financing mechanism, the administrative and service delivery concerns of the social health insurance schemes need to be examined to promote equity and sustainability.

World Health Organization (2004) in its discussion paper on social health insurance has called for developing a comprehensive social health insurance scheme to achieve the universal coverage. The paper called for designing social health insurance schemes by examining the local conditions; health

infrastructure, financing patterns, capacity of insurance companies, stakeholders' dialogues, and political factors for ensuring sustainability and fairness. Similarly, Hsiao & Shaw (2007) worked on designing and implementation of social health insurance programs in developing nations and called for observing the fiscal space, health infrastructure, income level, quality of insurance firms and selection criteria for the beneficiaries. They also called for checking political willingness among different political parties and other stakeholders' participation levels for effective management of health insurance schemes.

Tien et. al. (2011) checked the health financing patterns of Vietnam focusing on social health insurance and identified the issues in institutional design and organizational practice of health financing. They surveyed the existing health financing mechanism and identified the potential issues in the system. The suggested to develop a contributory system of health financing for Universal Health Coverage by pooling funds and devising suitable social health insurance schemes. Knaul et. al. (2012) examined the universal health coverage in Mexico and reported that transition towards universal health coverage through social health insurance has been a challenging task. With the passage of time, health coverage, financial mechanism, service delivery concerns and satisfaction of patients have increased. Atun et. al. (2015) examined the health reform and universal health coverage in Latin America and reported that since 1990s governments across the continent are struggling to manage both supply side and demand side factors for enhancing the health coverage to the vast segments of population. Within this context, social health insurance models can play a significant role if their design and structure is thoughtfully planned and executed. In the African context, Ogundeji et. al. (2019) developed a checklist for designing health insurance programmes for Nigerian states and identified six key areas to be considered for designing a social health insurance scheme. These areas include sources of finance, benefit package, provider payment mechanism, contributing population and level of contribution, pooling of funds and administration and management.

Within the context of the Sehat Card scheme in Pakistan, different researchers have worked on the financial and non-financial aspects of the scheme. For example, Hasan et. al. (2022) discussed the Sehat Sahulat Program of Pakistan found that it's a good program for provision of health services. However, with its expansion across Pakistan, there is a risk of delays in claims settlement and funds deficiency that requires dynamic risk management tools. This requires a consensus among the key stakeholders to arrange funds for the provision of healthcare facilities to every segment of population in an affordable manner. Similarly, Forman et. al. (2022) examined the Sehat Sahulat Program and appreciated the efforts of the Govt. for launching a health insurance model on a larger scale. The authors highlighted the role of health insurance as a tool to enhance the access of health facilities across the country. However, they asked for conducting an in-depth study on the actual recipients and the overall program structure to address the short-comings and enhance the health support mechanism specially for lower income groups.

To check awareness of the Sehat Card scheme among local population, Din et. al. (2022) worked in District Rawalpindi. Using questionnaire, they found that on majority of card holders receive the information on Sheat Card through word of mouth and the local political party. Another key finding was that 72% recipients used the Sehat Card for curative purposes. A positive finding of the study was that almost 90% respondents felt no discrimination in accessing the health facility through Sehat Card. The authors recommended that there is a greater need to widely circulate the benefits of Sehat card so that maximum number of people can use this facility. Another useful brief study by Farooq & Kunwal (2022) with the title of potential role of Sehat Sahulat Program (SSP) in reducing catastrophic health expenditures suggested that the present mechanism of Sehat Card only covers the in-door treatment of the patients while the major share of out of pocket health spending is made on OPD treatment.

Therefore, they suggested that some limited funds may be allocated in the Sehat Card scheme for OPD treatment. Similarly, they argued for coverage for patients with chronic diseases which also require a lot of expenditures.

Shahbaz et. al. (2023) conducted a study on knowing the public perception and satisfaction with the Sehat Card in Punjab. Through a questionnaire, they collected data from 350 recipients and found that majority of persons were satisfied with the facilities provided under the Sehat Card scheme. They also observed that Sehat card has also divided the burden of patients among the govt. and private sector hospitals enhancing access for the poor and reducing load on Govt. run facilities. In a similar way, another study by Shahbaz et. al. (2023) on Sehat Card with a view to explore the health professional perceptions in Lahore. They collected data from 200 healthcare professionals in Lahore and found that the Sehat Card scheme has increased job-specific burden on the healthcare professionals with increased administrative and compliance hours. They also observed lower job satisfaction and slow procedure in reimbursement rates under the Sehat Card scheme. The authors suggested to effectively manage the workload of the healthcare professionals for better treatment quality.

As the above studies shows the Sehat Card scheme has been explored by different researchers in multiple ways, however, less attention is paid to the study of overall design and structure of the Sehat Card scheme within the perspective of understanding the operational and financial issues of the private hospitals which are empanelled to provide health care services to the patients. This study fills the gap of studying the major operational issues i.e. registration as empanelled hospital, patient documentation requirement, costing of health services, monitoring mechanism, liaison with the policy makers and insurance company etc. Along with that, this study also explores the financial side of the Sehat Card scheme and attempts to document the funds release procedure, claims submission, costing of health services, billing and documentation procedures etc.

This study seeks to answer the following questions;

i. What are the operational issues in the implementation of the Sehat Card scheme for the empanelled hospitals?
ii. What financial challenges do empanel private hospitals face under the Sehat Card scheme?

**Research Methodology:**

This study used field-based approach for collecting data from the administration of different hospitals working in the ICT region. At first stage, all private sector hospitals located in the ICT region and registered under the Sehat Card Scheme with the Ministry of National Health Services Regulations and Coordination was identified. At second stage, a suitable sample of hospital was selected based on purposive sampling technique. This technique allowed for developing flexible inclusion (geographic, size of hospitals etc.) and exclusion criteria (access to data) for sample selection. At third stage, the sampled hospitals were contacted to get necessary data through interviews on operational and financial issues. At fourth stage the collected data was coded, classified, arranged, and analysed to identify different patterns and themes for highlighting the key areas of interest.

Since this research employs qualitative research design, identifying research themes are suitable format for documenting the results of the field work. As this study was aimed to document the operational and financial issues of empanelled hospitals, following primary themes with sub-themes is given here;

**Primary Theme 1:** Operational Issues in Sehat Card Scheme

Sub-theme 1: Hospital registration procedure

Sub-theme 2: Case processing procedures

Sub-theme 3: Monitoring mechanism

Sub-theme 4: Liaison with the govt. bodies

**Primary Theme 2**: Financial Issues in Sehat Card Scheme
Sub-theme 1: Costing for health services
Sub-theme 2: Billing & Claims submission
Sub-theme 3: Funds release procedure
Sub-theme: Liaison with health insurance provider
Qualitative data based on interviews was gathered for the above-mentioned themes and analysed to examine the specific themes/sub themes.

**Results & Findings:**

**Table 1: Operational Steps Involved in Sehat Card Scheme in the ICT Region**

| Step No. | Stage | Detailed Process | Key Stakeholders | Typical Timeline |
|---|---|---|---|---|
| 1 | Eligibility Check | Permanent ICT residents send CNIC via SMS or check via Sehat Sahulat App/portal. Automatic NADRA verification for family coverage up to Rs 1 million/year (resets annually). | Beneficiary + NADRA + Federal SSP | Instant (SMS/app reply) |
| 2 | Hospital Arrival & Verification | Patient presents CNIC at Sehat Card Counter in empanelled ICT hospital (public/private). System verifies eligibility, remaining balance, and family linkage. | Patient + Hospital HFO + SLIC | 5–15 minutes |
| 3 | Pre-Authorization & Diagnosis | For major procedures, hospital issues referral; consultant diagnoses. Pre-authorization sent to SLIC/DMO (immediate for emergencies). | Hospital + Consultant + SLIC/DMO | 30 minutes max (emergency: immediate) |
| 4 | Admission & Cashless Treatment | Cashless admission in general ward. Full inpatient treatment (surgery, ICU, medicines, tests) provided free at empanelled ICT hospitals. Data uploaded to Central MIS. | Hospital staff + Patient + SLIC | Same day |
| 5 | In-Hospital Monitoring | SLIC/DMO conducts identity checks and feedback within 24 hours. Real-time updates in federal HMIS. | Hospital + SLIC/DMO | Within 24 hours of admission |
| 6 | Discharge | Discharge summary generated digitally. Patient provides feedback; CNIC returned. | Hospital HFO + Patient | At discharge |
| 7 | Claim Submission by Hospital | Hospital uploads claim (ICD codes, itemized bill per federal tariff, documents) electronically to SLIC within 7–15 days post-discharge. | Hospital Finance/Claims Team + SLIC | 7–15 days post-discharge |

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| 8 | Claim Verification & Approval | SLIC auditors review claim (may include physical audit). Approve full/partial or reject based on federal guidelines. | SLIC Auditors | 15–45 days |
| 9 | Funds Release / Reimbursement | SLIC transfers approved amount directly to hospital account. Federal budget (via development allocation) replenishes funds. | SLIC + Ministry of NHSR&C / Finance Dept. | 30–60 days from submission |
| 10 | Feedback, Grievance & Renewal | File complaints via helpline/app. Balance renews automatically. Federal monitoring ensures continuity in ICT. | Patient + SLIC + Federal SSP | Ongoing / Annual reset |

The above table 1 indicates the steps involved in the Sehat Card Scheme in the ICT region. These steps are well-defined and key stakeholders such as beneficiaries, hospitals, State Life Insurance Company, NADRA etc. are informed of their respective role. A maximum effort is made to digitalize the processes however, there is a further need to develop end-to end digital portal for facilitation of patients and hospitals. Along with this, there is a need to include big hospitals located in the urban areas where many experienced doctors are available.

**Table 2: Operational Challenges in Sehat Card Scheme in the ICT Region**

| Primary Theme | Sub-Theme | Key Findings | Illustrative Quote |
|---|---|---|---|
| **Operational Challenges** | Hospital Empanelment and Accreditation | Private hospitals reported that empanelment requires extensive documentation, infrastructure compliance, and periodic renewal processes which can delay entry into the program. | "The empanelment requirements are strict and sometimes take months to complete due to multiple verification stages." (Hospital Administrator) |
| | Patient Eligibility Verification | Hospitals face operational delays when verifying patient eligibility through national identity databases and program portals. | "Sometimes verification through the system takes time, especially when the portal is slow or patient data is incomplete." (Insurance Desk Staff) |
| | Pre-Authorization and Case Approval | Certain procedures require prior authorization from the insurance desk or insurer, which may delay treatment decisions in time-sensitive cases. | "For high-cost procedures we must wait for approval from the insurer before proceeding." (Medical Superintendent) |
| | Claim Documentation | Hospitals must follow standardized clinical coding and documentation protocols. | "Even minor documentation errors can lead to claim |

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| | and Case Coding | Errors or missing information often leads to claim queries or rejections. | rejection, requiring us to resubmit the case." (Billing Officer) |
| | Monitoring and Audit Procedures | Periodic audits by program authorities and insurers create administrative workload and sometimes uncertainty about compliance standards. | "Audit teams occasionally interpret guidelines differently, which causes confusion for hospital management." (Hospital Manager) |
| | Coordination with Program Authorities | Hospitals reported communication gaps regarding updated treatment packages, operational guidelines, and policy changes. | "Sometimes hospitals receive updated instructions late, which affects service delivery." (Hospital Administrator) |
| | Digital System and Portal Functionality | Technical issues in the claim submission portal occasionally slow case approvals and claim processing. | "Portal downtime or system errors can delay claim submission and approval processes." (Insurance Desk Operator) |

Table 2 indicated operational challenges present in the Sehat Card Scheme in the ICT region. These include issues in hospital enplanement, eligibility confirmation issues of patients, claim documentation issues, monitoring and audit procedures, coordination with program authorities etc. These operational issues as reported by various stakeholders affect the functionality of the Sehat Card Scheme and slow down the overall processes. There is a need to consult all stakeholders and reform the existing procedures/steps, remove duplication, and digitalize the whole process to ensure fairness and promote transparency.

**Table 3: Financial Challenges in Sehat Card Scheme in the ICT Region**

| Primary Theme | Sub-Theme | Key Findings | Illustrative Quote |
|---|---|---|---|
| **Financial Challenges** | Package Rates and Cost Coverage | Hospitals reported that reimbursement package rates for certain procedures are lower than actual treatment costs, especially in tertiary care services. | "Some surgical packages do not fully cover the cost of medicines, equipment, and staff." (Finance Manager) |
| | Claim Processing and Reimbursement Delays | Delays in claim verification and payment cycles create cash flow issues for private hospitals participating in the scheme. | "Payments can take several months after claim submission, which affects our financial planning." (Hospital Finance Officer) |

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|---|---|---|---|
| | Claim Deductions and Rejections | Hospitals often face partial deductions or rejection of claims due to documentation discrepancies or interpretation of treatment protocols. | "Sometimes claims are partially approved even when the procedure was medically justified." (Billing Manager) |
| | Administrative Cost of Participation | Maintaining insurance desks, trained staff, and documentation systems increases administrative costs for hospitals. | "Managing the Sehat Card desk requires dedicated staff and adds operational cost to the hospital." (Hospital Director) |
| | Financial Sustainability of Participation | Some hospitals expressed concerns about long-term financial viability if reimbursement delays or low package rates persist. | "If payment delays continue, some private hospitals may reconsider their participation in the program." (Hospital Executive) |
| | Inflated Costs and Higher Overheads | Some hospitals have developed higher costs schedules for treatment under this scheme, and the issue of inflated bills is also reported. | "Hospitals significantly overcharge for treatment provided under this scheme even in cases where lower cost solutions are available" (Insurance company officer) |

Table 3 reported financial issues being faced by hospitals in the Sehat Card Scheme. These include package rates vs actual costs of treatment, reimbursement delays of claims, claim deductions and rejections, administrative costs for hospitals for participation in the scheme and financial sustainability for hospitals. The financial issues highlighted here require consultation at policy level and reforms are required by taking feedback from all stakeholders. Along with this, a cost audit of hospitals is also required to examine the issue of over billing and higher overhead costs.

**Conclusion:**

This study examined the operational and financial issues faced by hospitals in the Sehat Card Scheme in the ICT region Islamabad. The study highlighted the presence of significant operational issues such as coordination, monitoring, eligibility verification and empanelment requirements which are affecting the flow of services offered under the scheme. Similarly, this study also examined financial issues such as inflated bills, claims deductions, delays in reimbursement of claims and audit issues affecting the overall financial sustainability of the scheme. There is a need to reform the overall scheme with special focus on end-to-end digitalization, reducing paperwork, removing duplication, and minimizing steps for all stakeholders.

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