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Understanding Facilitation Practices Across the Patient Care Continuum in Pakistan's Social Health Insurance Scheme

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Abstract: *Social Health Insurance (SHI) is a key social protection instrument that helps to achieve equity in access to health services and to advance Universal Health Coverage (UHC). Financing arrangements are only part of the solution for effective implementation of SHI; facilitation practices are also important in ensuring that healthcare providers are able to provide timely and accessible services to beneficiaries. The present research focuses on the facilitation practices of public and private healthcare providers for the implementation of a big social health insurance in Lahore, Pakistan with special reference to its role in enhancing healthcare access and service delivery. The following qualitative research design was adopted and a total of 15 semi-structured interviews were conducted with administrators and relevant staff from nine public and private healthcare providers, insurance agency and health ministry Lahore. All interviews were transcribed word for word and analyzed using thematic analysis. The four themes were: (1) Entry-point facilitation – provider participation was influenced by social responsibility, patient demand, awareness initiatives and expectations of program expansion; (2) Service facilitation – differences in administrative processes between the public and private providers affected their capacity to deliver service timely; (3) Documentation and coordination facilitation – many stakeholders were involved in documenting and coordinating services, with some stakeholders more involved than others in the decision making process; and (4) Financial facilitation barriers – delayed reimbursements, inadequate service rates, and limited provider participation in the decision making process affected providers capacity to sustain equitable healthcare services. The results highlight the importance of facilitation practices as a key part of social protection and health service provision. From the social work and social policy point of view, formal coordination systems, more active involvement of providers, better communication and electronic claim management systems with clear rules can be introduced to ensure equitable access to health services, improve the quality of services and increase the effectiveness of the Pakistan's Social Health Insurance program.*

Introduction

A key policy approach to achieving universal health coverage (UHC) in countries has been the expansion of social health insurance (SHI), especially when the government's health spending has been limited and the household's out-of-pocket expenditures have been high (Suchman, 2018). In 2015, Pakistan implemented a big public-private social health protection scheme, specifically designed to protect low-income families from catastrophic health expenditure. This scheme relies on a network of empanelled public and private hospitals which agree to provide treatment to cardholders, and be reimbursed by the insuring agency for the expenses incurred.

The work of facilitation is not as readily visible between these moments; between a patient arriving at the hospital, and a provider being reimbursed. Facilitation services encompass verifying identity and eligibility at intake, preparing claim documentation, routing claims to various offices, and tracking down slow payments. It is conducted through a combination of actors: admissions staff, hospital administrators, a designated health facilitator from the insuring agency/district health officer, and scheme management staff. No one of these actors is a recognized profession of ‘facilitators' in a formal sense, and the seamless operation of the whole scheme hinges on the extent to which they coordinate.

The intent of this article is not to ask the traditional question of SHI research but rather to ask a more focused question that asks what really happens on the journey from patient intake to treatment to reimbursement and where do these processes fail? By doing so, it seeks to bring the invisible behind-the-scenes coordination of social health insurance into the spotlight for policy makers—and for the wider field of literature on health system intermediaries.

Literature Review

Relatively recently, universal health coverage (UHC) has been considered the main goal of any national health financing reform (Suchman, 2018; WHO, 2010) and SHI has become a preferred health financing mechanism for the pursuit of universal coverage in lower-middle-income countries (LMICs), especially following the discovery that user-fee financing models were deterring the poor from accessing care (Palmer et al., 2004; Dalinjong & Laar, 2012). The key to achieving UHC through SHI is to link a purchaser, usually a ministry of health or an insurance corporation, to a combination of public and private providers, as in many LMICs, a large proportion of providers are private (Mcintyre, n.d.; Prata et al., 2005; Dalinjong & Laar, 2012).

Many papers on the subject are about accreditation/payment design, namely how providers are chosen and certified (Smits et al., 2014; Mackintosh et al., 2016) and how the payment rates are negotiated and set (Robinson et al., 2005; Mathauer, 2011). Much less attention has been paid to the processes at the level of operations and facilitation that bring these designs to life in the experience of the patient on admission, treatment and payment for treatment. In some parts of the world where it has been analyzed, the results are inconclusive. Previous studies on similar schemes in Ghana revealed that delays in reimbursement of claims led some providers to adopt negative behaviours toward providers (Lamptey et al., 2017), and a study on the accreditation process in Kenya identified that insurance officials knew about the burden of accreditation on providers, but were unable to solve this problem (Suchman, 2018).

The more recent Pakistani research on the Sehat Sahulat scheme in Khyber Pakhtunkhwa has found shortcomings in the scheme's accessibility, which were found to be enduring and connected with poor awareness, poor administrative processes, and the existence of an informal complaint-handling process (Askari & Ahmed, 2025; Khan, Cresswell, & Sheikh, 2023a). Similar findings of "friction in the delivery of services" and financial benefits of the scheme were also reported in a parallel qualitative study of

beneficiaries in Lahore (Ali et al., 2026). In isolation, a study of grievance handling in the same scheme found that there was a significant manual paper-based redressal process (Pakistan Institute of Development Economics, 2022).

A second, largely parallel literature reviews the professionals that are likely to be involved in this connective, facilitative role within hospitals: medical/hospital social workers. Despite the skills required for this role being similar to those needed in a scheme like this, reviews of the profession in Pakistan describe this as remaining largely underdeveloped, with hospital administrators not formally incorporating social workers into the process of services, and not seeking their input on psychosocial issues (Ahmad & Hassan, 2022, as cited in subsequent reviews). This implies that the facilitation aspect this scheme relies on is presently being executed in a disjointed manner with whoever is in the right place at the right time in the process, and not by a role that is specifically designed and trained for this role.

The study draws from these two literatures on health financing, purchasing and payments, and health-workforce literature on facilitation and social work roles, and focuses on the interconnected pathway of facilitation, as opposed to payment and accreditation issues.

Methodology

This study was a qualitative one to capture the lived experience of the providers of the facilitation processes under the scheme, not the frequency or cost. Given that facilitation, as it was practiced, is a product of informal routines, relationships among offices, and workarounds unlikely to be captured in administrative data, a qualitative inquiry was deemed appropriate.

The administrators and other relevant staff from 9 public and private healthcare facilities in Lahore were selected for the 15 semi-structured interviews, representative in terms of both empaneled and non-empaneled facilities. Further interviews were conducted with the representative of the insuring agency and with the staff of the scheme, to gain an understanding of facilitation on the part of the purchaser as well as the provider. The interviews were conducted in person, audio-recorded with permission, and then transcribed for analysis. The transcripts were analyzed by using codes that were identified in each transcript and subsequently clustered together into themes that represented different phases and failures in the facilitation process. Respondents were anonymized by role and sector (and not by name or institution) throughout to ensure confidentiality.

Findings and Thematic Analysis

Theme 1: Entry-Point Facilitation

Providers explained a number of different ways in which they entered the scheme and how they subsequently took it seriously when they became providers. Others described their involvement as a duty of caring for their community, because parts of the local community did not have the means to provide it. Most of our population would not have been able to afford health services, even people in America, so that's why there was a need of the community to be included in SHI for the community benefit, that is why we decided to be involved in it." Others were recruited on a reactive basis, at the front desk when patients of the scheme appeared.

This is what happened when one of our patients came in to the hospital and asked the consultant if this card could be used in our hospital, he was seeking dialysis treatment, and then our doctor took a picture of that card and told the director. A smaller proportion of private providers indicated that they participated partially because of the indirect advertising they received, and that they believed that their participation would lead to referrals from fee-paying private patients too, and some public providers explained that their participation was driven by government notification rather than an explicit

facilitation intent. Providers who approached participation reactively or defensively generally reported weaker internal facilitation arrangements later in the pathway, while those who had more of a sense of a community commitment to participation reported the opposite.

Theme 2 :addresses Procedural Facilitation and the Public–Private Divide

The empanelment process was found to be very different for public versus private providers. Private providers typically reported that the process was fairly simple, the approvals were on schedule and there were no restrictions. Public providers, however, explained that the process was far more complicated: approvals would take time to process, the conditions for participation might evolve, and an inspection of facilities would take place prior to empanelment that would impose additional steps. The empanelment process was the first step in the facilitation process to come after this, and as such, the public providers had a more complex pathway into the facilitation process than their private counterparts.

Theme 3: Documentation Facilitations from Intake to Claim Approval

The best picture of facilitation-as-practiced came out of providers' description of the claims pathway, which starts at the patient's admission. Patient's identity card is first verified for eligibility, and a claim sheet is then prepared by the provider and then passed through various actors for verification: designated health facilitator from the insuring agency, district health office, management office of the scheme and finally the patient's treatment costs are reimbursed after the claim is approved.

This chain, although working, was said to be manual and document-heavy rather than digitally coordinated – and providers directly connected to this delay.

We sent 220 claims in the first week, 140 claims in the second week, in the month we sent 1,310 claims, but we have not even received a third of those claims till now and we are in May. We sent 220 claims in the first week, then 140 claims the next week, in the month we sent 1,310 claims and we have not received a third of that till now and we are in May.

Claims were supposed to be addressed within 15 days for private providers and 30 days for public providers, which were later raised to 30 and 45 days – this was itself a sign that the facilitation chain was not adhering to their original timeframes. Again, lacking one single accountable facilitator to address such gaps promptly, institutional providers reported that claims were delayed due to missing supporting documents, including diagnostic reports.

Theme 4: Financial Facilitation Barriers

In addition to the process of documentation, providers indicated that the monetary requirements of the process threaten facilitation. A widespread perception was that payment levels were too low to reflect the actual cost of some packages, especially packages with higher costs of the procedures, while public providers in more highly specialized areas like cardiac care felt payment levels were not commensurate with the risk and quality of the procedures. In addition, there was no incentive for the consultation of physicians, who were independent of providers and thus had little formal role in facilitating the scheme's facilitation objectives. Some public providers also said they had less autonomy over the use of scheme-generated revenue due to new rules that took effect which required a proportion of the scheme revenue to go through government accounts prior to return to the facility. One question every provider from every sector had was why the payment rates had been established without their input or feedback, and then why they were unable to raise concerns about the adequacy of the rates that were used to pay for their facilitation responsibilities.

Discussion

These four themes when read together suggest that in this scheme, facilitation is not a single designed

purpose, but rather an emergent process which integrates the actions of admissions staff, administrators, a designated health facilitator, district health offices and scheme management – none of whom is held accountable for the pathway as a whole. This aligns with the rest of the purchasing literature, which focuses on payment design (Mathauer, 2011; Robinson et al., 2005) but is attentive to an issue neglected by design accounts: the quality of the coordination of actors operating the payment mechanism.

The imbalance between public and private in the facilitation of procedures is similar to what has been observed in other LMIC contexts, where the insurance official reported experiencing the issue of accreditation burden, which was not solved (Suchman, 2018), and where manual, paper-based claims processing was found to be a structural constraint in the same scheme of the Pakistani government (Pakistan Institute of Development Economics, 2022). The delays reported here also align generally with the delays reported in Ghana's national health insurance scheme, which was correlated with the poor provider–patient relationship (Lamptey et al., 2017).

The lack of a clearly defined facilitation role is also consistent with the Pakistani health-workforce literature which consistently reports poor integration and recognition of the medical social worker role in hospitals, where the facilitation pathway outlined in this scheme is precisely what most case-coordinating, communication and advocacy work in the healthcare settings requires. The results indicate that facilitating is not something that is delegated to any available staff, but that it is a separate job and has its own staffing, training and lines of responsibility.

Conclusion

The aim of this study was to explore the facilitation practices in the process of patient entry into the health system, the treatment process and the process of reimbursement in a large social health insurance scheme in Lahore, Pakistan. The evidence suggests it has a process that works, but not the same process for all providers—it brings providers in through a range of entry points that are sometimes reactive, imposes substantially different procedural requirements on public and private providers, and leverages a multi-actor documentation chain that can often take longer to go through than its process. The evidence shows that it has a process that does work, but not the same process for all providers: it brings providers in through a range of sometimes reactive entry points, imposes substantially different procedural requirements on public and private providers, and relies on a multi-actor documentation chain that can often take longer to go through than its process. These problems are not any individual flaws in the financing of the scheme, but instead represent a facilitation function that is not recognized, staffed or held accountable for at the level of the scheme financing.

Recommendations

Identify and formally train a facilitator for the entire empaneled hospital in a facilitation role (e.g. case coordinator, patient liaison, and health facilitation officer) rather than just one phase of the process from intake to reimbursement.

1. Replace the current paper-based route of claims from provider to health facilitator, DHO to scheme management with a digitized chain to overcome the delays of the current manual process.
2. Reduce disconnect between provider experience of cost of services and rates received by engaging in a structured, recurring process for provider feedback on rates, instead of making payments unilaterally.
3. Align public and private provider timelines and enforcement and ensure this is not systematically slower for one provider sector than another, through enabling facilitation of the process (inspections, approvals, conditions for participation etc.).

4. Implement incentives to the institutional level as well as to front-line personnel, such as consulting physicians, whose co-operation is required for the facilitation pathway.

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