Key Informant Interview 4

Challenges:

Errors in the patient's ID number, spelling errors in the name. For example, with the registration number, every document should have the registration number on it. In the case of names, it's different in different places, whereas these should be the same. Then, we told them to send us all 8-9 papers with the file, but all those papers do not come together. In some cases, it was seen that one package got mixed up with another. As a result, one or two case packages were changed. This is an error. These are documentation problems. In some cases, there were treatment problems. According to the protocol we have set, in 1 or 2 cases, a little excess money is being spent. And the scheme operators who primarily prepare this, they initially did not have any doctors. Later, they appointed doctors. So, if there is a doctor, things become easier. This was a challenge in the initial stage, that the work would have been easier with a medical person. And here we have some challenges, like the review committee. We fix the review committee later. I mean, we also saw the first phase. But later it was seen that if this is done from the outside, it is better. For that reason, we are having it done by external experts. And in the case of claims, the biggest challenge is that it is not completely IT-based. If it were completely IT-based, then these mistakes would not happen. So, we have to focus on how to make this fully functional. Consultants are often not available at the time of meetings. For example, the time we want, he might be busy at that time; he is often not available. We also share some things with the consultant, for example, matching some IDs, matching names, matching serials, looking at the packages. We receive the claims every 2-3 months, not according to any fixed rule. They prepare and send them to us for 1-2 months at a time, and after receiving them, we hold a meeting at our convenience. We are not supposed to see all the files of the claim process. Our job here is to randomly check some work; the main work is supposed to be done locally. It is supposed to happen there. But initially, we saw that many mistakes were happening, so we are looking at almost every file. We are facing some problems in checking every single file. It is a problem for us to check the hard copies. The online version was supposed to have options to "hold" or "reject," but this has not been activated yet. It has not been done because it could not be activated. I mean, launching the online system itself is a challenge, I think. It is often seen that the development of the software that is supposed to be used is delayed. Then, after it is made, installing it here is time-consuming. I think if this could have been done by an institution from our own country, then the access would have been easier. Due to the delay in our enrollment, everything is falling behind. We are not experts in Claim Management. If we remain paper-based, the work will be a bit difficult. There were documentation problems due to not knowing about the pilot. A maximum of perhaps 5 patients come per day. If these 5 patients are discharged, if 5 patients are discharged in one day, it is not a very difficult task to prepare the papers for those 5 in one day. If we prepare the day's work on the same day, then it's fine. We check the 8-item checklist, see which of the 8 documents we received, and which one is missing. Most are there, maybe one or two are not. So, we just need to notify the responsible person about which one is missing. He might not have given the paper, or it might not have been prepared; in that case, we just have to urge him to bring it. Now, perhaps this is due to their lack of awareness, or they don't do it at that time. This was a big problem in the beginning. It was seen that for an investigation during treatment, the relevant order is given, but the supporting paper is not there. Anyone can ask for this. Medicine is written on the medicine slip, but the slip itself is not there. This is needed, since its bill has to be paid. This is perhaps a lack of awareness on their part. They had some shortage of human resources. They are not providing much cooperation or are considering it an extra burden, which is, of course, Overall Project Related. For example, when I went to a doctor, there was still some hesitation among them; one doctor was saying that the workload here is high. There is a perception about SSK that it is a separate, different project that has been imposed on them; it's not like that, the service is actually being provided in a different format. I mean, this is not something new, it's not something extra. The people of that area are taking the service, and they have taken service before. And in terms of responsibility, it cannot be called an overburden or over-duty. Because the duty is to provide service from 9 AM to 2:30 PM, and any patient who comes within this

time must be served. Awareness is a continuous process; training sessions are being held every few days, sirs from our side are going and talking. They are also asking if they have any problems. If we have any problems, they are addressing them. Their motivation, perhaps, the big thing is ownership of something; if they don't take complete ownership, then the problems arise. Many have the perception that if I go there, I cannot go to another place. I cannot be transferred. This is their perception. The problem is a bit with the OP; the OP's money has to be given within the government-specified time. We are always concerned about being able to give it within that time. Among the overall challenges, awareness is important. Another big thing is OPD. OPD is not in the package. We count how many received OPD service, but the benefit package has not been made. This is needed. This is actually a challenge. A big challenge.

Recommendation:

It would be better if the providers had a bit more ownership. Since this is a pilot project, everyone has an eye on it separately; for this reason, we need to be a little careful that vacancies do not remain for a long time. Even if someone leaves, it should be filled as quickly as possible. The problem will be easier for us if we can make it completely online. If we can check online, if we can settle it online. It would be better to settle the claim management system online. For Madhupur and Ghatail, it would be good to do everything online from the very beginning. Many do not fall within the 50 diseases. If they don't, but are very close, then it is considered. But still, 50 diseases are not sufficient; achieving this kind of pilot at a UHC is a big deal. Many countries might do it on a smaller scale for various reasons, we also do it, but still, it would have been better if it were a bit larger. Now it is very limited. For this reason, about 20 more have been added to the package. The way the professor is reviewing is actually a bit lengthy. If it were reviewed online, for example, if they came for an hour every 15 days, they could check it online. Because the documents are uploaded online. Looking at them online, they could make a decision right there to accept, hold, or reject. The ones on hold, we can send for review again. The rejected ones, they can reject by writing the cause. So if it's done online, I think it would be better. The first thing is that we should develop our own capacity. We are weak on this side, one might say. Maintaining it. Before that, manpower has to be developed in that way. In that case, until it is done from our side, we have to depend on them. In that case, we repeatedly urge them. For claims, increase manpower and simultaneously make it online. If they prepare the documents properly, the workload will decrease. The hard copy will remain, we might check it randomly, but the main thing has to be done online. It has to be done on a soft copy. Expanding the scope of the committee, it would be best if a separate unit is opened just to manage claims; this, plus the scope of the HEU committee should be made a bit larger.