

The challenge of ensuring elderly people can access their health insurance entitlements: a mixed methods study on the Republic of Srpska's Protector of Patients' Health Insurance Entitlements

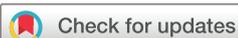
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ABSTRACT

Introduction Healthcare utilisation requires knowing one's entitlements and how to access them (navigation) and having access to grievance redressal when entitlements are denied. To ensure citizen access to and use of health insurance entitlements, the Health Insurance Fund established an initiative called the Protector of Patients' Health Insurance Entitlements (PPHIE). PPHIEs are supposed to provide patient navigation and grievance redressal services. This paper explores to what extent this initiative meets its objectives and is used by the elderly in rural areas.

Methods This study employed a mixed methods approach. We conducted in-depth interviews with elderly patients in rural areas, PPHIEs, health providers and health insurance managers (N=39), as well as focus groups (N=5) and a household survey (N=715) with elderly rural patients. Qualitative data were analysed using content analysis, and the household survey results were analysed using descriptive statistics.

Results The majority of elderly patients were not aware of the PPHIE initiative and instead received patient navigation support from their healthcare providers. The PPHIE programme was poorly publicised among the population. Although PPHIEs had a mandate to pursue grievance redressal they rarely did so, and their role in the system was more symbolic than functional.

Conclusion While healthcare providers have (by default) filled the navigation role left by inactive PPHIEs, the grievance redressal role remains unfilled. Information about health insurance entitlements and access to grievance redressal must be provided through visible, accessible and efficient mechanisms that should be continuously monitored and improved.

INTRODUCTION

The right to health is enshrined in the Universal Declaration of Human Rights.¹

WHAT IS ALREADY KNOWN ON THIS TOPIC

- ⇒ If health insurance entitlements are not easy to understand and use, the value of health coverage is eroded as people may delay or forgo care to which they are entitled.
- ⇒ The elderly and people with lower education and incomes are especially likely to have poor understanding of their health insurance benefits and to face barriers in accessing their entitlements.

WHAT THIS STUDY ADDS

- ⇒ Elderly people in the Republic of Srpska largely fail to benefit from patient navigation and grievance redressal support mechanisms provided by the Health Insurance Fund.
- ⇒ The Protector of Patients' Health Insurance Entitlements (PPHIE) programme has not been sufficiently publicised so most elderly people are not aware of its existence.
- ⇒ The initiative has been designed for the general population without consideration of the particular needs and constraints of the elderly, such as poor use of the internet.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

- ⇒ While primary care doctors and nurses can fill the patient navigation gap caused by the poor functioning of the PPHIE, these already-overburdened healthcare workers lack the time and training to fully perform this role.
- ⇒ Moreover, grievance redressal cannot be handled by clinicians alone and instead requires a dedicated, accessible and well publicised mechanism.
- ⇒ For health insurance to work for all members of society, patient navigation and grievance redressal programmes must be designed with the unique needs of vulnerable subgroups in mind.

It creates a legal obligation on states to ensure health-care that is accessible, acceptable and affordable for all.² Progress towards universal health coverage is hence an objective of many countries. Many governments have set up national health insurance schemes to enable people to use healthcare services when they need them, without financial hardship.

Accountability in health systems is critical to enable citizens to understand and participate in decisions about which health services are provided, how much they will cost and how to access them, which can ultimately contribute to improving service efficiency and quality.³ Health insurance benefits that are not easy to understand and use erode the value of health coverage, as evidenced in both high-income countries such as the USA,^{4,5} as well as low or middle-income countries such as Senegal and India.^{6,7} People with a poor understanding of health insurance benefits are more likely to delay or forgo healthcare.^{5,8} Low health insurance literacy is common across a wide range of countries,⁹ and has been found to be particularly concentrated among those with lower education and incomes,^{10,11} and among the elderly.⁷

While healthcare needs and health service utilisation increase with age, elderly people are particularly vulnerable to exclusion from healthcare globally. This is also due to the fact that the elderly have lower education and socioeconomic status than the working age population, and disproportionately experience social isolation, and lower mental or physical functionality, as evidenced in low-income, middle-income and high-income countries.¹²⁻¹⁶ Rural elderly populations are especially likely to have low levels of knowledge about health insurance because remote areas tend to have poorer media connectivity, a lower density of health and social service facilities that can provide this information, and the out-migration of working-age adults to urban centres for employment.

The Republic of Srpska, one of the two entities of Bosnia and Herzegovina, has created the Health Insurance Fund (HIF) that provides compulsory health insurance coverage¹⁷ for the whole population of 1.15 million people.¹⁸ The HIF's benefit package covers a wide range of services, which are provided through contracts with 14 public and 7 private hospitals, 56 public primary health-care centres (PHCs), 55 private facilities and 5 health institutes.¹⁹ PHCs and private facilities are staffed by 714 family medical teams, which each consist of 1 or 2 nurses and a doctor. Out of 63 municipalities in the Republic of Srpska, 56 have 1 public PHC staffed by 1 or more family medicine teams (FMTs), depending on the size of the municipality and number of citizens.¹⁹ The family medical teams serve patients at the PHC and also travel to small health posts (called ambulanta) in the villages on a rotating basis.

People must co-pay for a defined set of diagnostic services, drugs, medical devices and hospitalisation; however, the elderly (over 65 years) are exempted from co-payments for all medical check-ups, all hospitalisation, almost all drugs and some medical devices.²⁰ Since its

launch in 1992, the scope of health entitlements within the HIF has changed frequently, with updates released two to three times per year. These updates include changes to the list of private health institutions contracted by the HIF, and the services, drugs and medical devices that are covered. While these changes tend to reflect an expansion of benefits, patients often lack timely information on their expanded entitlements, resulting in under-usage.

To help people understand and use their HIF coverage and the health services available to them, the Steering Board of the HIF created the Protectors of Patients' Health Insurance Entitlements (PPHIE) in 2011. PPHIEs are employees of the HIF who are mandated to inform insured people about their covered health insurance benefits and how to access these, and to help patients file grievances. As of 2022, there were 55 PPHIEs employed in the health system.¹⁹

The Republic of Srpska's health system grievance redressal process allows citizens to lodge complaints to the management of health facilities, to the HIF service in charge, and through the court system. When complaints are made to the HIF service in charge, they are to be resolved by HIF staff and commissions formed by HIF management, usually consisting of HIF staff and medical doctors. Complaints can be about healthcare providers, such as perceived disrespectful behaviour or patient disagreement with their clinical assessments, or about the HIF and its implementation of guidelines and policies, such as patients being denied reimbursement for a service that they believe is covered.²¹

This study examines the PPHIE's effectiveness as an accountability instrument that seeks to empower citizens with information provision and patient navigation support and improve the health system's responsiveness through grievance redressal. It also examines how some of these accountability functions have been filled by alternative arrangements. We have chosen to focus specifically on PPHIE's engagement with rural elderly people, since this population is especially likely to lack understanding of and access to health insurance entitlements. To do so, we assess this population's knowledge of their entitlements, their sources of patient navigation support and their use of grievance redressal mechanisms.

METHODS

Conceptual framework

To analyse the PPHIE accountability initiative, this study uses Molyneux *et al's* accountability assessment framework,²² which suggests exploring the 'context', 'content' and 'process' of accountability initiatives to understand their functioning and their effectiveness. Applying this framework to the context of health insurance and the setting of the Republic of Srpska, we analysed: (1) content, meaning how the PPHIE accountability initiative is supposed to function based on policy documents and legal provisions; (2) process, understood in terms of how this initiative actually functions in practice; and (3)

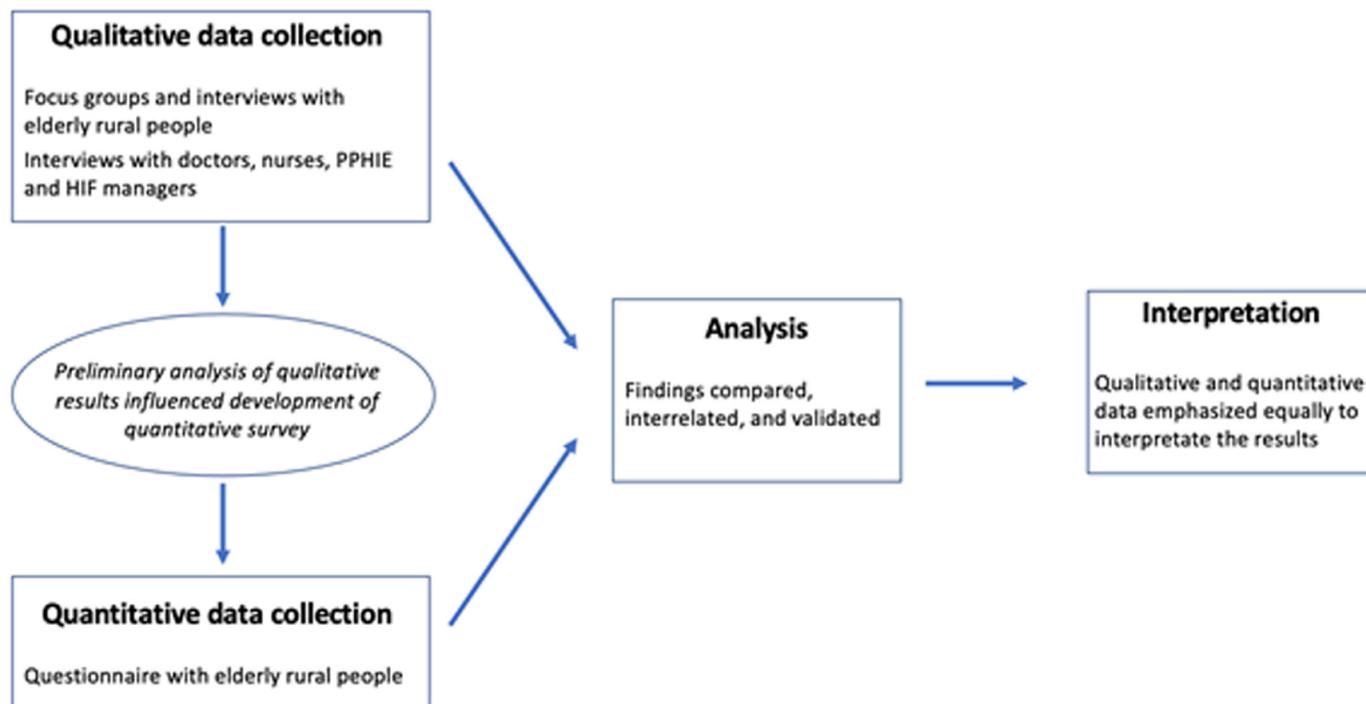


Figure 1 Overview of the study process with triangulation design. HIF, Health Insurance Fund; PPHIE, Protector of Patients' Health Insurance Entitlements.

context, referring to the broader social and economic factors that shape how well the initiative functions. These three aspects explain the impact of this accountability initiative on the HIF's responsiveness to community needs and concerns, and the reasons for the initiative's level of performance. In the context of our research on health insurance, responsiveness is the ability of the HIF to meet citizen needs through 'receptivity to the views, complaints and suggestions of service users by changing structure, culture and service delivery to make it more appropriate for users'.²³ Empowerment in the context of health insurance is the citizens' ability to exercise their entitlements.

Research design

We drew from both exploratory sequence and convergent mixed methods approaches²⁴ to collect, analyse and interpret data from in-depth interviews (IDIs) with elderly rural people, PPHIEs, doctors, nurses and HIF managers, focus group discussions (FGDs) with elderly rural people and a household survey administered to elderly rural people (figure 1). The exploratory sequence enabled us to use our preliminary analysis of qualitative data to fine-tune the quantitative questionnaire. For example, after qualitative findings that showed low awareness of the PPHIE initiative, we added open-ended questions to the survey to ensure we would fully capture the experiences of the rare respondents who had heard of and engaged with PPHIE. We then used a convergent approach for final analysis wherein qualitative and quantitative data were triangulated, interrelated and integrated, in order to enrich and validate our interpretation of the data.

The qualitative data informed all three domains of the Molyneux *et al's* framework (content, process and context), while the survey results contributed to our understanding of the process and context domains.

To identify participants for IDIs and FGDs, we first randomly selected one rural PHC from each of the Republic of Srpska's six areas (Banjaluka, Doboj, Zvornik, Foca, East Sarajevo and Trebinje). From each PHC, we then obtained a list of people registered with them and established a sublist of those who (1) are 65 or older in age; (2) live in rural areas; (3) had at least one disease diagnosed; and (4) had used healthcare services within the last 6 months. From this list, we randomly selected individuals to participate in the study. This purposive sampling ensured that our elderly rural respondents would have recent experience with the phenomena of interest: engaging with and navigation of healthcare and the HIF. The first contact with the selected elderly persons was realised by a PHC head nurse who explained the study purpose and objectives and invited potential respondents to participate either in an individual IDI or in an FGD, according to their preference. From each selected PHC, one doctor and one nurse were invited for individual interviews, as were the one or two PPHIEs and HIF management representatives for the municipality where the PHC was located. The first four interviews were conducted in March 2020 but, due to the COVID-19 pandemic, the remaining individual interviews and focus groups were postponed and finalised in June 2020.

Table 1 Overview of in-depth interview respondents' characteristics

In-depth interview respondents	Gender		Education (years)				Total
	Male	Female	None	1–5	6–10	11+	
Elderly rural residents	6	6	3	1	5	3	12
Doctors	0	6	0	0	0	6	6
Nurses	1	4	0	0	5	0	5
Protector of Patients' Health Insurance Entitlements	0	10	0	0	4	6	10
Health Insurance Fund management	4	2	0	0	0	6	6
Total	11	28	3	1	14	21	39

We held a total of 39 individual IDIs with elderly people (aged 65 years and older) living in rural areas, doctors and nurses from family medical teams in rural PHCs, PPHIEs and HIF managers (table 1). The IDIs covered the following domains: (1) practice and experience of healthcare seeking (for patients) and healthcare provision (for practitioners), (2) knowledge of health insurance entitlements, grievance redressal mechanisms and cost sharing and (3) opinions about health insurance entitlements, health access, grievance redressal mechanism and cost-sharing. While the same domains were covered for all respondent types, the specific questions through which we elicited responses were adapted according to whether the respondent was an elderly rural resident, a healthcare provider, a PPHIE or an HIF manager. The interviews lasted an average of 60 min.

The five FGDs included 6–10 participants each, resulting in a total of 45 participants. They included participants ranging from 65 to 88 years in age and had a near equal balance of men and women. The focus groups included participants across the spectrum of educational attainment, from primary school to university. The focus groups lasted an average of 120 min and covered the same domains as the interviews. Both the IDI and FGD guides were developed a priori based on our research interests in understanding the content of the PPHIE policy.

The quantitative findings were derived from a face-to-face survey with elderly rural residents (N=715), which took place from September to November 2020. The sample for the household survey was developed in cooperation with the Statistical Office of the Republic of Srpska. The sampling frame was a subset of the master sample of census areas and households of the Republic of Srpska. The stratified two-stage random sampling first extracted all rural areas, and then randomly selected six PHCs within these rural areas, by listing all PHCs in these areas and then selecting six through the use of a random number generator. All elderly people registered with an FMT at these 6 PHCs who had a disease and used healthcare services in the last 6 months were identified, resulting in a list of 715 potential respondents. These potential respondents were approached, and all agreed to complete the survey. The survey took approximately

1 hour to complete and consisted of 55 questions covering 5 topics: (1) socio/demographic data, (2) health insurance status, (3) healthcare access and use, (4) the use of FMTs as navigators to access and (5) access to information on health insurance entitlements.

Quantitative survey respondents ranged in age from 65 to 98, with an average age of 74 years. Women composed 58% of the sample and men 42%. Almost a quarter (24%) did not finish primary school, while 34% and 33% completed primary and secondary school, respectively, and 8% completed higher education.

Patient and public involvement statement

There were no patients involved in this research. The elderly participants were recruited not as patients, but as stakeholders in health system, as service users and as citizens. Hence, the development of research question and outcome measures were not informed by the patients' priorities, experiences and preferences. Patients were not involved in the design of the research. Further, this is not clinical research or randomised clinical trial.

Data analysis

All recorded interviews were transcribed verbatim, and hand-written detailed notes were typed-up. Analysis involved five steps: (1) reading and rereading transcripts and interview notes to generate an initial coding scheme, (2) adjustment of the initially created coding scheme based on the content from transcripts, (3) applying codes to the transcripts; (4) grouping together related codes and generating categories and themes and (5) interpretation of categories and themes. In order to ensure the reliability, credibility and validity of qualitative research findings and their unbiased interpretation, coding of the primary data was done by two research team members, who independently applied codes to the data, and later compared the level of agreement, discussing and adjusting where needed. Codes were grouped into four domains of analysis: (1) use of the internet to learn about health insurance entitlements and grievance redressal, (2) FMT as navigators to access health services, (3) PPHIEs as navigators to access services and (4) awareness

of and engagement with grievance redressal mechanisms. Intercoder agreement was achieved for all codes and categories, and data interpretation of all researchers were convergent.

Survey answers were entered into MS Excel for preliminary analysis. To ensure data quality, a random check of 10% of the entered data was performed. SPSS V.22 (IBM 2013) was then used to generate descriptive statistics.

RESULTS

We present our findings according to Molyneux's content-process-context framework on the PPHIE's role in ensuring elderly rural people know about and access their health insurance entitlements and have recourse to action when they feel their entitlements are denied.

How are the PPHIE navigators supposed to work ('content')

PPHIEs are full-time employees of the HIF and, according to HIF policy guidelines,²¹ should be in direct contact with insured persons and health workers. They are mandated to spend at least half of their working hours in a PHC and the other half of their time within the HIF municipal office. PPHIEs are to serve as patient navigators through the health system and are obliged to undertake the following tasks: provide information to insured persons and health workers on health insurance entitlements; provide assistance to insured persons in accessing services; prevent denial of entitlements by healthcare institutions or the HIF; report potential violations of insured persons' entitlements to the HIF's management, analyse reasons for violation and suggest remedial measures to solve specific problems that individual patients face; and assess satisfaction of insured persons with health services provided.²¹

However, the policy on PPHIEs does not give PPHIEs the power to demand that the HIF provides case-specific information about individual insurance claims, nor does a PPHIE have the power to demand that the HIF respond to or change decisions as a result of citizen complaints on entitlements violation.²¹

When they [patients] get the decision on their complaints, we [PPHIE] can only read it to them and try to explain further action, but I cannot change any decision. (PPHIE 1)

PPHIEs are not envisioned as outreach workers beyond healthcare facilities, that is, they are not mandated or financed to visit the many outreach health posts (ambulanta) where elderly people often receive healthcare, nor are they mandated to develop informational material to teach the broader population about their health insurance entitlements or to perform surveys to assess patient satisfaction. Mass media communication about health insurance and quality assessment of services fall under the purview of other departments of the HIF. Instead, PPHIEs are envisioned to perform one-to-one patient support for those coming to the healthcare facilities or

HIF office, or for patients contacting them through their phone number. This support is to include explaining the HIF benefits and helping patients access these benefits (eg, helping patients request reimbursement for transportation costs to tertiary facilities) and lodge complaints to the HIF service-in-charge. Notably, there is no guideline or mandate in the policy documents setting out the number of PPHIEs that should be hired, their distribution, and the qualifications they should have.

How well does the PPHIE navigation mechanism work ('process')

The face-to-face survey revealed a low level of awareness of health insurance entitlements among the elderly in the Republic of Srpska. Only 2% of elderly respondents surveyed reported that they knew their health insurance entitlements well and 36% reported being partially aware of their health insurance entitlements. A significant majority (62%) reported that they did not have any information about their health insurance entitlements.

These figures demonstrate a clear need for information provision among insurance beneficiaries, a gap that PPHIEs are mandated to fill. However, there is a very low awareness of the existence of the PPHIE initiative, with only 4% of the elderly respondents surveyed aware of this initiative. Among elderly participants in interviews and focus groups, only one person had heard of the PPHIEs. This respondent, an elderly man, reported learning about the programme from a poster.

In our waiting room [in the healthcare facility] there is a phone number, which one can call if dissatisfied with the physician, nurse... I called once, just in curiosity to learn what is there. (FG5)

This lack of familiarity extends to those working within the health system. Out of six doctors and five nurses interviewed, a majority (seven) were also unfamiliar with the PPHIE initiative.

PPHIE respondents felt that efforts to publicise their existence were insufficient and that this was a key reason for the lack of public awareness. Basic information (name, work address and phone number) on the PPHIEs was mentioned on the HIF website and in posters, although key aspects of this information, such as the phone number to contact PPHIEs, were generally out of date. Even though posters were initially displayed in some HIF offices and health institutions to inform visitors about the PPHIE initiative, many were taken down over time. Posters were not uniformly displayed at all hospitals, PHCs, private facilities and outreach health posts. Moreover, these posters did not provide any information about the PPHIE's role and tasks, diminishing their impact.

Out of 10 PPHIEs interviewed, 9 reported that they worked exclusively from HIF offices, and spent no time in facilities interacting with patients. They further mentioned that they had no designated office space at PHCs. Several PPHIEs reported that they had been assigned administrative duties at the HIF office, which

took them away from health facilities, or were reassigned to quality control in healthcare institutions, which left them unavailable to work as patient navigators. Since they were not physically present in the waiting rooms of health facilities, and since posters or other forms of publicity about their existence were neither widespread nor particularly informative, their opportunities to educate and support patients in the tasks that they are mandated to carry out were severely compromised.

Among those surveyed who knew about PPHIEs 4%, 21% reported that they had sought to use PPHIE services. These respondents stated that they had needed administrative assistance (eg, for filling forms) or had used the PPHIEs as an avenue to complain about inadequate provision of health insurance entitlements. While none of the elderly respondents in the IDIs and FGDs had filed complaints, they identified many problems with healthcare provision and insurance coverage, including the persistence of out-of-pocket payments for health services or medication that should be fully covered, being refused rehabilitation care in specialised health institutions, unfriendly behaviour by health staff, long waiting lists for medical check-ups, and administratively complicated and time-consuming reimbursement of travel costs (that is covered by the HIF). Moreover, survey respondents assumed that grievance redressal processes would be cumbersome and likely futile, a key reason for them choosing not to try file a complaint, as indicated in the quotes below.

No, no. I didn't intend to complain now. You complain to the one who rejected you and if the commission makes a negative decision, you should not complain. (elderly respondent, interview SL 2)

Oh, gosh, I don't know where to go. Wherever I came, I felt as if I was hitting a wall. I didn't ask for much, but what to say? (elderly respondents, FGD 3)

Some also expressed concern that complaining about their healthcare providers would cause tension and potentially result in poorer quality care in the future.

So what to do? Complain about the one who I have to see tomorrow? And yes, you are told you are too old to seek justice. (elderly respondent, interview SL 1)

While the PPHIEs and HIF management reported that PPHIEs were very helpful to patients, they did not have any information on the proportion of complaints and appeals filed by beneficiaries being resolved in favour of the complainants. They also had no information of the commission's decision or the extent of satisfaction of those who had complained with the help of a PPHIE.

In the absence of a functioning PPHIE mechanism, another mechanism is used by elderly rural patients to get information about their healthcare entitlements: doctors and nurses on FMTs. While these clinicians have taken on the information provision and navigation roles envisioned for PPHIEs, there has been no mechanism filling the grievance redressal gap. Family medical

team staff were reported to be the most frequent source of information on health insurance (43%) for elderly respondents living in rural areas, followed by TV (41%), and then family members, such as adult children (4%). When elderly people asked their doctors and nurses for information about health insurance entitlements, 95% reported that doctors and nurses provided all of the requested information or even more information than required. On the specific topic of drug coverage (in terms of which medicines were fully covered by HIF and which required a copayment) pharmacists also served as an important source of information for 48% elderly respondents, with 39% receiving this information from their doctor or nurse and 11% from their children.

Despite high patient satisfaction with receiving information from their FMTs, doctors and nurses expressed frustration that they were not mandated, trained or remunerated for this patient navigation role. They noted that the rules about entitlements were complex and difficult for elderly patients to understand. Thus, health workers had to engage in long conversations with their patients about health insurance related concerns, such as the circumstances under which transportation to a tertiary hospital was covered by the HIF or why a specific medicine is covered for some diagnoses but not others. They explained that it took time away from their clinical duties:

...To provide information takes a lot of time. It takes a quarter of working hours per day. [...] Especially in rural areas where [the patient] is not aware. (Health care provider from FMT 2)

While these conversations were time-consuming, doctors and nurses pointed out that some information provision about health insurance entitlements and how to access those entitlements is integral to healthcare provision and cannot be fully separated from the treatment of patients. The doctors and nurses not only wanted the PPHIE mechanism to be strengthened so that a portion of this patient navigation could be shifted to the PPHIE but also noted that, ideally, FMTs would also be given training and resources to support their inevitable role in patient navigation. All doctors and nurses were clear that the current arrangement—without active PPHIEs—was exhausting and time-consuming, and that it has caused them to reduce time spent on medical checkups and diagnostics.

I do not run away from information provision. We have to be aware of that, by definition, family medicine is the entry point. But it is not the same to work daily with 40 to 45 people: that's how many [patients] I have [each day]. And 30 patients is how many I should have. (Health care provider from FMT 3)

Doctors and nurses reported struggling to stay up to date on legal terminology used in the health insurance coverage rulebook due to its frequent modification. While changes in the HIF rulebook were often conveyed to doctors by HIF representatives and discussed at internal

medical professionals' meetings, doctors and nurses still found their information was sometimes out of date and often had to phone HIF staff to clarify questions from patients. Doctors and nurses also reported sometimes needing further clarification and consultations with their superiors, the Legal Department of the Health Center or the HIF employees, as indicated in the quote below:

There are things I can understand, and the ones I cannot understand. You know, I am not a lawyer (...) I think they are not adapted to health professionals. There are so many terms we simply do not understand (...) I did not graduate at the Faculty of Law. (healthcare worker from FMT 9)

If PPHIEs were active in their patient navigation role, the doctor or nurse could have these technical questions about coverage easily addressed by a PPHIE. Further, temporary placements for doctors at rural health facilities were common, with two-thirds of outreach health posts (ambulanta) reporting frequent doctor turnover. The elderly respondents in the IDIs and FGDs indicated that doctors in temporary posts were usually less proactive in informing elderly patients about their HIF entitlements. As a consequence, a large part of the rural population is disadvantaged in terms of benefiting from their guidance.

Finally, although doctors, nurses, pharmacists and other actors were to a large extent filling the patient navigation gap left by the absence of PPHIEs, the grievance redressal mechanism allocated to PPHIEs remained void. While any citizen can file a grievance with HIF service-in-charge, and take forward a legal challenge in the court system, actually engaging in these grievance mechanisms was far beyond the scope of most rural elderly people. PPHIEs would be vital to informing rural elderly people if indeed their complaint represented a potential violation of healthcare entitlements (as opposed to a misunderstanding). They could tell elderly people about their right to complain, help them complete and submit the grievance paperwork and follow-up on their case.

They come to us saying, 'I got this, I don't know why this is so. Nothing is clear to me in the explanation.' [...] These older people, they do not understand. When I look at the explanation, [sometimes] I write an appeal against the decision and they submit it to the protocol and then they have the right to appeal to the court. But mostly if there is an omission or if they are not understanding something, I am telling them, 'You are missing this and that, let's find it,' so we will find a solution within 15 days. (PPHIE 2)

What contextual factors influence how the PPHIE navigation mechanism works?

The PPHIEs limited effectiveness is grounded in resource limitations within the Republic of Srpska's health system, programme design flaws in relation to the rural health system, and social norms in rural areas whereby the elderly have low expectations and low willingness to complain. Resource shortages resulted in family medical teams taking on far more patients than they could handle,

making it extremely difficult for doctors and nurses to find the time to explain health entitlements to elderly patients.

I'm sure that colleagues all over the Republic will answer you the same; we have too many patients, they are a huge burden for us, so we absolutely need to change something to reduce the number of patients so that our service become better, without doctors and nurses burning out at work, and to do much more prevention and have less administrative work. (Health care provider from FMT 1)

Moreover, resource shortages caused HIF managers to shift PPHIEs from their mandated role as patient supports located in health facilities to administrative roles in HIF offices or quality control workers in hospitals. However, even if the 55 PPHIEs remained situated in waiting areas at PHCs and private clinics, the PPHIE programme's design still made it unlikely to meet the needs of rural elderly people. Rural healthcare is primarily provided away from the PHCs, at outreach clinics, thus most elderly people would never meet their PPHIE.

Further, this study found that rural elderly people were highly satisfied with the current situation, wherein they received information and help accessing their HIF entitlements from their FMT staff. The elderly respondents felt that their family medicine staff are proactive healthcare navigators, who help patients use healthcare services. The quantitative survey found that nearly all elderly people are registered in a family health team (99%) with 96% of them having confidence in the FMT that they had chosen. This high patient satisfaction initially appears somewhat at odds with doctor and nurse reports that they lacked the time, resources and training to adequately counsel their elderly patients about HIF entitlements. However, social norms among the rural elderly population suggest that patients had low expectations of the health system and high trust in their doctors and nurses. The elderly respondents expressed a sense that they had lived through a lot of upheaval and suffering and were now satisfied with basic healthcare and whatever information about their HIF entitlements that their doctors and nurses were able to provide. They seemed very disinterested in grievance redressal, expressing a sense of satisfaction with whatever care they received and fear that complaining would be futile and potentially mark them out as 'troublemakers' resulting in some unspecified reprisal.

DISCUSSION

This study examined the extent to which the Republic of Srpska's PPHIEs were performing a health insurance accountability role through patient navigation and grievance redressal for elderly rural people. There is no published research from the Republic of Srpska on elderly rural residents' knowledge of their health insurance entitlements, information seeking behaviour, nor the role of navigators or grievance redressal mechanisms. We found that the elderly rural population has a low

level of confidence in their knowledge about their health insurance entitlements and that very few (4%) were aware of the existence of PPHIEs, much less benefitting from their services. The gap in information provision and navigation support left by the low functionality of PPHIEs is currently being filled by doctors and nurses. The gap in grievance redressal remains unfilled. While patients are largely satisfied with receiving navigation support from their healthcare providers, their providers are not. Doctors and nurses reported that explaining health insurance coverage and how to access it to their elderly patients takes valuable time away from clinical duties and that they are not adequately trained for this role.

In several high-income countries, patient navigators have been found to serve as 'supportive allies' who increase marginalised people's use of healthcare services and access to insurance entitlements.^{25–27} However, the success of these navigation initiatives has hinged on extensive outreach engagement by a sufficient number of navigators to provide one-to-one support to their patients.²⁸ In the Republic of Srpska, where much of the elderly rural population receives their healthcare in remote outreach health posts (ambulanta), it would be prohibitively expensive to hire enough PPHIE's to each be physically present in each community and healthcare facility. Shifting PPHIEs back into the PHC to directly interact with patients there, as was originally intended in the policy, would still leave most elderly people (who access care in remote health posts) without navigation support.

Instead, PPHIE should provide information about health insurance entitlements and the right to grievance redressal and support grievance redressal through media appearances and via telephone. Regular television and radio appearances wherein PPHIEs publicise and explain changes in HIF coverage would potentially reach a far wider audience, and especially rural elderly people, compared with face-to-face engagement at a limited number of health facilities. Even with a strengthened outreach role for PPHIE, doctors and nurses will likely continue to play a role in patient navigation because of the interlinked nature of healthcare provision and health system navigation. Healthcare providers will need additional support to handle this aspect of their role.

Strengthening the PPHIE's grievance redressal role is complex, given that elderly rural people are often unaware of their entitlements, have low expectations and require extensive support to file a complaint to the HIF service in charge. While the literature is sparse on this subject, the absence of a functional grievance mechanism in the Republic of Srpska is mirrored in other countries.^{29–32} Research from India, Nepal and the UK have found that people are deterred from availing grievance redressal services by a lack of practical and emotional support to pursue complaints, high costs of using complaint grievance redressal, fear of reprisal from healthcare workers and belief that complaining is futile.^{29–32} Bolstering PPHIE capacity to support grievance redressal may

require a policy change to allow PPHIEs to directly file complaints on behalf of patients and to mandate the HIF to provide a response with explanations on the actions taken. PPHIEs could support grievance redressal via telephone by allowing elderly people to phone in about issues and then allow the PPHIE to file a complaint.

Policy-makers in the Republic of Srpska and other countries may derive two implementation lessons from the PPHIE experience. First, patient navigation models must fit the health system's resource availability and the accessibility needs of the target population. When face-to-face engagement with each marginalised patient is not feasible due to a low patient-to-navigator ratio and remote geographies, alternative mechanisms (such as media and telephone) may be necessary. Second, grievance redressal requires that patients know their entitlements, and have an accessible and supportive mechanism to demand redressal when entitlements are denied. While actors such as the PPHIE can be bolstered to take on a larger role in grievance redressal (such as through an expanded mandate allowing them to file complaints on a patient's behalf), it is essential that health system accountability be cultivated through multiple channels. Enforcing patient rights requires an enabling legal and regulatory environment at the constitutional, and administrative levels, as well as action from civil society and media actors.³³

Study limitations

The study was conducted in rural areas of six municipalities in the Republic of Srpska ensuring wide geographical coverage. However, the random sampling of study areas did not consider environmental and socioeconomic variations across the different areas and less developed areas may have been left out. It would be beneficial to replicate the study in rural areas belonging to less developed municipalities, to ensure a larger representation of the elderly population. Although the patient sample was randomly selected, only the elderly who had a diagnosed disease and who used FMT services in the year preceding the study were included. Those without any diagnosed disease and who are not registered at an FMT might have different health information seeking behaviour and health access. Finally, the study was conducted during the time of the COVID-19 pandemic. COVID-19 may have reduced elderly people's engagement with the health system due to fear of contagion, thereby reducing their need for information about how to navigate health services, and also reducing their access to information since they had fewer interactions with FMTs.

CONCLUSION

Health insurance accountability requires that citizens are empowered by information about their entitlements and how to use them, and that they have avenues to demand responsiveness to their needs through grievance redressal mechanisms. The Republic of Srpska sought to bolster the accountability of its HIF

through the PPHIE initiative. This policy has not been fully implemented as intended: PPHIEs are largely unknown to elderly citizens over 65 and are inactive as accountability mechanisms, instead serving in administrative roles for the HIF. In the absence of a viable and well-functioning PPHIE initiative, elderly patients rely on their healthcare providers to give them the information and support needed to navigate access to insurance entitlements. To truly achieve accountability, this stopgap navigation measure must be replaced with a strengthened PPHIE programme. Strengthening the patient navigation and grievance redressal role of PPHIEs requires increasing population awareness of and access to this resource, which could be achieved through media outreach and remote engagement, particularly by television, radio and telephone, which are popular among elderly rural people. Furthermore, success depends on a stronger role for PPHIEs to provide grievance redressal as well as navigation services. While strengthening the PPHIE programme, the Republic of Srpska could explore providing additional resources for doctors and nurses to continue also playing a role in patient navigation, particularly through training them on HIF entitlements and easing their high patient load to allow for this time-consuming service. Future research in the Republic of Srpska as well as across the globe could generate further evidence on how best to strengthen patient navigation as well as patient grievance mechanisms.

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