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ORIGINAL ARTICLE

Sehat Sahulat Program: Assessing the awareness and utilization effectiveness of Sehat Insaf Card among the general population of District Rawalpindi.

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ABSTRACT… Objective: To determine the awareness of using Sehat Insaf Card and to determine the utilization effectiveness of Sehat Sahulat Program. **Study Design:** Cross Sectional study. **Setting:** Sehat Insaf Card Authorized Hospitals. **Period:** July 2020 to December 2020. **Material & Methods:** Data was collected via self-administered questionnaire. The sample size was 316. Non-probability purposive sampling was done. The questionnaire consisted of three parts; Part A: Demographics, Part B**:** Awareness, Part C: Utilization Effectiveness. IBM, SPSS statistics version 25 was used for data entry. Descriptive statistics like frequency, percentage and proportion were measured. **Results:** Most of the participants belong to the rural area and fall into the category of 10 – 20 thousand monthly income. The awareness about program came from 2 main sources; Word of mouth and campaign by a local party representative. Majority of the services availed were curative services i.e. 72.8%. Before the launch of SSP, 3/4 of the participants self-paid their medical bills and with this program, its 100% free. 72.8% of the total participants were satisfied with the transportation charges covered in SSP. 92% of the total participants felt no discrimination in hospital in any regard, either from the doctor or the paramedical staff. 99.4% of the total participants were of the opinion that Govt of Pakistan should launch similar new programs. **Conclusion:** Sehat Insaaf Card distribution among the under-privileged citizens was almost similar in the urban and rural population of Rawalpindi. More involvement of females is need of the hour.

Key words: Citizen, Program, Sehat.

INTRODUCTION

Urdu word "Sehat" means "Health", "Insaf" means "Justice" and "Sahulat" means "Convenience". Basically, "Sehat Sahulat Program" is a program launched by federal government in collaboration with provincial governments and its an important health insurance initiative to cover the health expenditures of especially poor people. Its main purpose is to reduce or overcome the out-of-pocket expenses of poor people in an attempt to reduce poverty.[1] It covers a variety of emergency treatment and in-patient services requiring secondary and tertiary care other than OPD services which is not included yet. Range of total treatment coverage in terms of finances vary from 720,000 to 10,00,000 Rs in federal and provincial level and also included maternal (for transportation in case of childbirth), transportation (if referred to tertiary care from secondary care) and funeral allowance (if family member dies during hospital admission).[2] Another reason for this health initiative is that "out of pocket (OOP)" health expenditure in Pakistan is greater than 70% which was quite alarming in regard to providing health facilities to lower middle class and poor people.[3]

One of the main principles of primary healthcare is accessibility and in order to improve access to health services in middle and low income countries for deserving population, micro health insurance (MHI) schemes have been launched.[4] These health initiatives are extremely important in achieving country's aim towards universal

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health coverage. The main difference between micro health insurance and national health insurance schemes is that MHI works at local level while NHI works at government level for its rules, regulations, enrolments etc. In Pakistan, at least five MIH schemes launched since 2005 i.e. Adamjee Health Micro Insurance, 2005; First Micro Insurance Agency (FMiA), 2007; Naya Jeevan Health micro insurance, 2011; Social health protection initiative (SHPI), 2011 and Waseela-e-Sehat, 2012.[5] However, population experience about these schemes and their details have not been well shared. Recently, a national health insurance initiative called the Prime Ministers National Health Insurance Scheme later renamed Sehat Sahulat Program (SSP) was launched in 2015. Information is lacking from existing MHI projects in Pakistan about their usage and factors affecting it and among different factors, client opinion matters the most.

In developing countries like Pakistan, vulnerable and low income population form the major chunk of country's population and health sector has not made any good progress before sehat sahulat program in providing accessibility to quality healthcare services to such people. This is very critical because this single step of inaccessibility contribute to 68% and 92% of global annual deaths from non-communicable and communicable diseases in population of such countries.[6] This data is showing how difficult the situation is in developing countries like Pakistan in the absence of adequate health insurance system because more than 3/4th of population pay health expenses by themselves increasing the burden on themselves and more often leading to careless attitude towards health.[7] To develop an appreciating healthcare insurance schemes and to record the feedback of clients who utilized these schemes is of utmost importance for upscaling the healthcare services.

The healthcare system in Pakistan was mainly under federal government control but after the 18th amendment the control and responsibility have been shifted to provincial governments. After initiating Sehat Sahulat program (SSP), the main aim is to improve the accessibility of target population to quality healthcare services which will automatically help in declining, if not eliminating, poverty by reducing out of payment expenditures.[8] The cost for insured families is completely free in accessing Universal Coverage to large range of preventive, curable and promotive healthcare services.[9]

As, in previous studies, little focus is done on determining client's satisfaction regarding different health schemes and few researches have been done regarding healthcare services in Pakistan, therefore, the main objective of this study is to provide a healthy contribution in the existing literature by assessing and analysing the awareness and utilization effectiveness of SSP in population.

MATERIAL & METHODS

This cross-sectional study was conducted in hospitals where Sehat Insaf card holders can get their treatments as per devised by government rules for 6 months (July 2020 to December 2020). Ethical approval was taken from ethical approval committee with reference number ERC/ID/45.

A sample size of 316 was calculated through Rao software. The inclusion criteria included holders of Sehat Insaf Card and who gave consent while those who didn't give the consent and who were not enrolled in this scheme were excluded.

Non-probability convenient sampling technique was used for collection of study participants. Data was collected from Sehat Insaf card holders reporting to hospitals for their illnesses or treatments. Pilot testing of questionnaire was done using 5% of the anticipated sample size. Time required to complete the questionnaire was 15 min. The questionnaire was translated before distribution and it consisted of three sections; demographic data, awareness regarding Sehat Insaf card and to check its utilization. The data was analysed using IBM SPSS Statistics Version 25. Frequencies and percentages were calculated. Chi-square test of significance was applied. P-value less than .05 was considered as statistically significant.

RESULTS

Table-I shows the different demographic properties about participants.

Sr. No.	Characteristic	Frequency (%)
1	**Age group**	
	21 – 30	116 (36.7%)
	31 – 40	102 (32.3%)
	41 – 50	68 (21.5%)
	51 and above	30 (9.5%)
2	**Residence**	
	Rural	192 (60.8%)
	Urban	124 (39.2%)
3	**Gender**	
	Male	264 (83.5%)
	Female	52 (16.5%)
4	**Income**	
	Less than 10k	6 (1.9%)
	11-20k	180 (57.0%)
	21-30k	104 (32.9%)
	31 and above	26 (8.2%)
5	**Family members**	
	1-3	51 (16.1%)
	4-6	148 (46.8%)
	7-9	101 (32%)
	10 and above	16 (5.1%)
6	**Earning members**	
	One	161 (50.9%)
	Two	104 (32.9%)
	Three	47 (14.9%)
	Four and above	4 (1.3%)
7	**Education**	
	Primary	60 (19%)
	Middle	68 (21.5%)
	Matric	102 (32.3%)
	Higher secondary and above	86 (27.2%)

Table-I. Socio-demographic properties

Table-II shows the awareness of participants about sehat sahulat program.

Table-III Shows the utilization effectiveness of participants.

DISCUSSION

A health initiative which will cover millions of deserving population and providing treatment to extensive variety of diseases in a developing country will be requiring extensive governmental support and legal reforms.[10]

Sr. No.	Awareness	
1	**History of past admission to hospital using card**	
	Yes	170 (53.8%)
	No	146 (46.2%)
2	**Family members admitted using this card**	
	Yes	106 (32.5%)
	No	210 (66.5%)
3	**Success of program due to campaign**	
	Yes	184 (58.2%)
	No	132 (41.8%)
4	**Source of knowing SSP**	
	Electronic media	54 (17.1%)
	Print media	4 (1.3%)
	Public campaign	72 (22.8%)
	Through a known person	186 (58.9%)
5	**Cost – knew card and its services are free**	
	Yes	292 (92.4%)
	No	24 (7.6%)

Table-II. Participants awareness

Sr. No.	Utilization Effectiveness	
1	**Usage of SSP**	
	Once	198 (62.7%)
	Twice	68 (21.5%)
	More than twice	50 (15.8%)
2	**Purpose of using card**	
	Diagnostic	16 (5.1%)
	Treatment	278 (87.9%)
	Rehabilitative	22 (7%)
3	**Satisfied with sehat insaf card**	
	Yes	274 (86.7%)
	No	42 (13.3%)
4	**Any discrimination observed**	
	Yes	24 (7.6%)
	No	292 (92.4%)
5	**Use card for surgery**	
	Yes	44 (13.9%)
	No	272 (86.1%)
6	**Completely used card funds**	
	yes	16 (5.1%)
	No	300 (94.9%)
7	**Demand increase in insaf card amount**	
	Yes	222 (70.3%)
	No	94 (29.7%)
8	**Transportation charges covered under this card are enough**	
	Yes	230 (72.8%)
	No	86 (27.2%)
9	**Given medicine for how many days**	
	Upto 3 days	98 (31%)
	Upto 7 days	182 (57.6%)
	Upto 14 days	21 (6.6%)
	15 days and above	15 (4.7%)
10	**Follow up visit**	
	yes	202 (64%)
	no	114 (36%)
11	**Favour launch of similar new programs**	
	Yes	314 (99.4%)
	No	2 (6%)
12	**Recommend use of this scheme**	
	Yes	314 (99.4%)
	No	2 (6%)

Table-III. Utilization effectiveness

Constitution of Pakistan 1973 does not count healthcare accessibility as a basic human right; but in article 38, there is some similarity which includes social protection as a state responsibility. As mentioned by Jeffrey D Sachs, health is an individual basic right and there should not be any negative effect of poor health from people to whole community.[11] therefore, if investment is made in improving accessibility of poor people to health, it will benefit whole community as a whole.[12]

Redesign of health structure invites giving larger part to private fragment for plan of public administrations with back and stewardship from public sector.[13] The Stage II of sehat Sahulat program is totally financed by government, regardless of the way that Stage I was seriously subjected to promoter support, i.e., German Development Bank.

Examination of the usage data found that without a doubt, despite the way that the plot took into account the prosperity needs of the needy people and given them with money related risk security, its usage stayed low. Many factors account for it including lack of awareness of such programs. Most raised use was for treatment purposes rather than diagnostic or rehabilitations as compared to a study done by Wenjuan Wang et al where mainly, its used for maternity related issues.[14] A more significant dive into the abstract revelations featured a couple of impediments to use. The key blocks being I) absence of care and comprehension of the contrive inside the local area; II) the long travel needed to arrive at the clinics for a couple of districts; and III) access issues at office level hampering use.[15] Similar barriers to utilization were reported by the Jamkesmas cardholders in Indonesia who preferred to pay out-of-pocket rather than be stigmatized for being poor[16] and in Rwanda where lack of interpersonal skill of the staff was cited as the major reason for underutilization.[17]

The chance expense of making a trip to empanelled clinics that were a huge drive away for some regions came at the expense of their day's compensation, with the extra cost of employed vehicle. These hindrances in reaching to empanelled emergency clinics were important factors for the utilization of those health services. For these far off territories, it very well might be practical to go to a close by office and pay using cash on hand. Distance to the empanelled medical services office was observed to be important to usage in a few other worldwide investigations.[18] The terrible encounters would bring about a deficiency of confidence in the program and diminished usage. As an overflow impact of the negative encounters, other members of that area would likewise try not to utilize the card for dread or being dismissed.[19]

The disclosures of the contemplate have shown that underneath the community based prosperity assurances program of the health insurance, the patients have been satisfied with the facilities given at the health centre. It helps shows that the perspective and lead of the health providers are really fundamental for achieving the satisfaction of the patients just as for giving them with effective inclusion inside the recuperating focuses.[20] In our study, majority of the participants were satisfied with the scheme, with the transportation charges covered under such scheme and also demanded further launch of similar programs in other fields. Manzoor et al. (2019) also stated about the behaviour and attitude of the service providers for achieving patient fulfilment. It has besides been displayed inside the examination's revelations that patients who have been secured in using medical services organizations underneath the insurances program had a positive response towards satisfaction with the organizations at the reception just as with the explanations given by the service providers concerning drugs.[10] It is important for Pakistan to develop the operative design of healthcare system because it is regarded as one of the challenging tasks.

CONCLUSION

Sehat Insaaf Card distribution among the under-privileged citizens was proportional to the urban and rural population of Rawalpindi. This signifies that the campaign run by the Government is very successful and profound. Before the launch of SSP, 3/4th of the participant self-paid their medical

bills but now with the launch of SSP, medical service to the Identified Under-Privileged Citizens is 100% free. 9 out of 10 participants were satisfied with the service.

RECOMMENDATIONS

It is need of the hour to enlighten the public about the benefits of Sehat Sahulat program and to encourage the under privileged citizens to avail the Sehat Card. Government of Pakistan should launch programs like SSP in other developmental sectors such as Housing, Agriculture, Education and Food etc.

LIMITATIONS

Approach to female card holders was limited due to their non-compliance.

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AUTHORSHIP AND CONTRIBUTION DECLARATION

No.	Author(s) Full Name	Contribution to the paper	Author(s) Signature
1	Mohi Ud Din	Study design, Data analysis, Final drafting.	
2	Syed Fawad Mashhadi	Study design and concept, Questionnaire design.	
3	Shahzeb Arif Khan	Drafting and data analysis.	
4	Sadia Zubair	Introduction and data collection.	
5	Ayesha Khan	Data collection, Drafting.	
6	Sajjad Hussain	Introduction and data collection.	