DOI: https://doi.org/10.54393/pjhs.v4i06.884

PAKISTAN JOURNAL OF HEALTH SCIENCES

https://thejas.com.pk/index.php/pjhs

Volume 4, Issue 6 (June 2023)

Original Article

Sehat Sahulat Program; A perspective from beneficiaries of Faisalabad, Pakistan

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ARTICLE INFO

Key Words:

Sehat Sahulat Program, Sehat Insaf Card, Responsiveness, Patient Satisfaction,

How to Cite:

Tehreem, R. ., Mahmood, H. ., Khan, J. ., Habib, M. F., Zulfiqar, R. ., Hassan, U. ., Nadeem, Z. ., Bano, B. R. ., Shaheen, D. E. Y. ., & Diba, F. . (2023). Sehat Sahulat Program; A perspective from beneficiaries of Faisalabad, Pakistan: Sehat Sahulat Program. Pakistan Journal of Health Sciences, 4(06). https://doi.org/10.54393/pjhs.v4i06.884

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Received Date: 4th June, 2023
Acceptance Date: 26th June, 2023
Published Date: 30th June, 2023

ABSTRACT

Central Bureau of Health Intelligence denotes to offer financial protection through paying illness cost, and quality services of Healthcare. The Sehat Sahulat program is one of the best program that has been started by the Pakistan government, launched in 2015 to work on health for all. **Objective:** To assess the responsiveness of Sehat Sahulat Program. **Methods:** A descriptive cross-sectional study conducted in Faisalabad's hospitals from Feb to Sep 2022. A validated structured questionnaire was administered to assess responsiveness of participants. A total of 307 participants aged 12 to 90 years fulfilling the inclusion criteria were recruited. **Results:** 307 participants were included in the study in which 139 (45.3%) were males and 168 (54.7%) were female. 140 (45.6%) of the total participants were rural, while 167 (54.4%) were urban. Of these, 26.6% expressed satisfaction with the services, and 48.7% thought they were good. **Conclusions:** It concluded that the greater part of individuals was satisfy with the services of Sehat Insaf card. It was found that age, residence, education, occupation and monthly income has shown statistically significant association with responsiveness. From eight domains of responsiveness quality of basic amenities was most important for beneficiaries then prompt attention and communication. In spite of satisfaction of beneficiaries, there is still a need for enhanced performance and fulfil their needs.

INTRODUCTION

Human is a fundamental need of people. A sound individual is a resource of country [1]. In 2018, health expenditures globally reached US$ 8.3 trillion (10% of global GDP) The out-of-pocket spending from total health expenditure remained more than 40% in low and lower-middle-income countries [2]. Social protection is referred to program and schemes that provide to the public a variety of social and economic benefits to the poor and those at risk of reducing their vulnerability and risk to life [3, 4]. Community-Based Healthcare Insurance (CBHI) denotes to offer financial protection through paying illness cost, improving the accessibility and quality services of Healthcare [5]. The occurrence of CHE status is characterized as from out of pocket (OOP) family costs more than 10% of absolute family costs [6]. Globally 68% of deaths due to non-communicable diseases and 92% due to communicable diseases in developing countries annually, indicates the severity of Healthcare issues in developing countries specially Pakistan where 78% population pays expenses of healthcare by themselves [7]. The Sehat Sahulat program is one of the best program for the Pakistan government. The program was launched in 2015. Sehat Sahulat program is

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the great drive of Pakistan's administration towards social assurance through fair funding to improve the local area and to accomplish SDG health for all. Checking its working is significant [8]. Another justification for this health programme is that Pakistan's "out of pocket (OOP)" health spending is higher than 70%, which is highly concerning when it comes to delivering health services to the lower middle class and the poor [9]. In developing nations like Pakistan, the vulnerable and low-income population make up a large portion of the population. Prior to the Sehat Sahulat programme, the health sector had made little progress in ensuring that these individuals had access to high-quality healthcare services. This is extremely important since, in the population of these nations, a single step of inaccessibility contributes to 68% and 92% of all annual global fatalities from communicable and non-communicable diseases, respectively [10]. Private hospitals sign up for the NADRA programme on a daily basis since it is so simple to access. To improve services throughout Punjab, an integrated health management system is aiming to standardize private and public healthcare facilities. The charitable programme and charter mentioned on the website are updated daily [11]. The data were collected, analyzed and entered in SPSS version-26.0 For quantitative data, mean ± standard deviation (SD) and for qualitative data frequency and percentage were calculated. Sensitivity was measured.

METHODS

It is cross sectional study performed in Faisalabad's hospitals from February to Sep 2022. The study population was Sehat Insaf card users and sample size for the study was 307 by applying the following formula:

$$S=\frac{Z^2 x P x Q}{E^2}$$

A random sampling technique was used. A total of n=307 participants aged 12 to 90 years. Ethical approval was obtained from the Armed Forces Postgraduate Medical Institute, NUMS Rawalpindi. Inclusion criteria include patients who had undergone their treatment through Sehat Sahulat card. Exclusion criteria include, all patients coming to hospitals for esthetic purposes, who had run out their health coverage amount, and who didn't give informed consent. WHO Questionnaire was used, it was to be noted that this questionnaire has been utilized in several studies, where its reliability and validity has been approved. In which First part includes demographics and information about card, second section was about SIC user's perspective, about responsiveness of health system. Responsiveness was checked for eight domains defined by WHO using WHO standard questionnaire. Third section for participants to rate their satisfaction with the domains The final section was asked them how important each domain to them. The items were measured on a Likert scale 3-point scale ranging from 1(poor) to 3(good). The data were collected in the form of survey and the participants were asked to self-complete the survey to minimize methodological bias. The close ended questionnaire was filled after taking verbal and written consent from the participants. Ethical approval to conduct this study was obtained from AFPGMI, NUMS. Responsiveness was measured by adding the scores against all eight items. Maximum was 80 and minimum was 15. Responsiveness score less than 49 was labeled as poor responsiveness, score between 49 was labeled as satisfactory and more than 50 and above was marked as good responsiveness. Statistical analysis was carried out using SPSS version-22 and for descriptive statistics like frequencies and percentages were calculated while for chi square test of significance was applied to check associations among independent variables and self-care activities.

RESULTS

Among 307 participants included in the study, 139 (45.3%) were males and 168 (54.7%) were female. Out of which 167 (54.4%) were urban and 140 (45.6%) were rural. In this study 44 (14.3%) people were not employed while 25(8.1%) were self-employed whereas 87(28.3%) were private/ govt. employee and 151 (49.2%) were housewives. Marital status of participants was that 241 (78.5%) people were married, 33(10.7%) unmarried and 33 (10.7%) were Widow/Divorced/Separated. The sociodemographic characteristics of participants are shown in Table 1.

Table 1: Frequencies and Percentages of Demographic Variables (n=307)

Variables		Frequency (%)
Gender	Male	139(45.3)
	Female	168(54.7)
Residence	Urban	167(54.4)
	Rural	140(45.6)
Age	12-40 yrs.	89(29)
	40-60 yrs.	178(58)
	>60 yrs.	40(13)
Occupation	No Employment	44(14.3)
	Self Employed	25(8.1)
	Private/Govt. Employee	87(28.3)
	Housewife	151(49.2)
Marital status	Married	241(78.5)
	Unmarried	33(10.7)
	Widow/Divorced/Separated	33(10.7)
Family Size	1-5	147(47.9)
	6-10	148(48.2)
	>10	12(3.9)
Education	No Education	130(42.3)
	Primary	64(20.8)
	Secondary	62(20.2)

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	Higher secondary	28(9.1)
	Higher	23(7.5)
Income	< or equal to PKR 5,000	42(13.7)
	PKR 5,001 to 10,000	48(15.6)
	PKR 10,001 to 15,000	58(18.9)
	PKR 15,001 to 25,000	66(21.5)
	>PKR 25,000	93(30.3)

Distribution of responsiveness domains is presented in table 2.

Table 2: Domains of Responsiveness

Variables	Frequency (%)
Quality of Basic Amenities	108(35.2)
Prompt Attention	63(20.5)
Communication	50(16.3)
Dignity	28(9.1)
Autonomy	24(7.8)
Support	18
Confidentiality	14
Choice	2

It was found that Variables like age, residence, education, occupation and monthly income has shown statistically significant association ($p < 0.05$) with responsiveness. The association of socio-demographic variables with responsiveness are shown in table 3 after applying chi square test of significance

Table 3: Association of Socio-demographic variables with responsiveness

Variable value	Category	Good	Satisfactory	Poor	p-value
Age	12-40 yrs.	50	19	18	0.008
	40-60 yrs.	80	44	54	
	>60 yrs.	20	18	4	
Gender	Female	74	42	52	0.020
	Male	76	39	24	
Occupation	Housewife	48	39	48	0.023
	Private Employee/ Govt.	19	17	19	
	Self-Employee	4	8	4	
	Un-Employee	5	17	5	
Residence	Urban	75	55	37	0.017
	Rural	75	26	39	
Education	No Education	68	32	30	0.017
	Primary	32	18	14	
	Secondary	26	14	22	
	Higher Secondary	18	4	6	
	Higher	6	13	4	
Monthly Income	<=5000	20	15	7	0.003
	5001-10,000	28	13	7	
	10,001-15,000	23	24	11	
	15,001-25,000	35	7	24	
	>25000	44	22	27	

Chi square test is applied for testing significance
*p-value less than 0.05 is considered significant

DISCUSSION

In this study total number of members n=307 ages between 12 to 90 years. 54.4% are from urban areas and 45.6% from rural areas. 14.3% are jobless and generally pay between 10-25 thousand. Among them 75.3% were satisfied and 24.7% were think that services are not so good from the administrations. Concurring study the vast majority of the members have a place with the provincial region and fall into the classification of 10-20 thousand monthly earnings. The awareness about program came from 2 principal sources; Word of mouth and mission by a neighborhood local party delegate. Larger part of the administrations benefited were corrective administrations and people were satisfied i.e., 72.8%. Prior to the sendoff of SSP, 3/4 of the members self-covered their hospital expenses and with this program, its 100 percent free. 72.8% of the all-out members were happy with the transportation charges canvassed in SSP. 92% of the absolute members felt no segregation in clinic in any respect, either from the specialist or the paramedical staff. 99.4% of the all-out members were of the assessment that Govt of Pakistan ought to send off comparative new projects [12]. Pakistan has a long way to go before it can equal the healthcare delivery of primary, secondary, and tertiary healthcare sectors, if we compare it to south Asian and worldwide peers. The Sehat Insaaf card's usability and efficacy are notable accomplishments. And in Punjab's health care system, quality services are available to everyone. There were no socioeconomic gaps and a very high level of satisfaction with the project's implementation among the populace. This strategy implements a national healthcare system for Punjab and all of Pakistan [13, 14]. A similar study was done to evaluate the satisfaction of patients regarding Sehat Sahulat card, was not in favor of present study where 72.8% were satisfied this is because difference in demographic population as their mainly respondents were rural population [15]. Another study conducted by Shahbaz *et al.*, in Lahore reported that 98.765% were satisfied this study is not in accordance with present study because they collected data from only 1 private hospital [16]. As per Azhauri and Arshad 2020 from 386 members moved toward two primary clinics of Lahore where the protection program has been participated in offering administrations; these medical clinics included Sharif Medical City Hospital and Punjab Institute of Cardiology the vast majority of the respondents have concurred (51.6%) to the way that administrations at the gathering of the clinic have been critical while 48.2% have additionally concurred that the mentality of the specialist organizations has been acceptable towards the patients getting administrations under the protection program and they are satisfied. In this review Among 307 members 75.3% were fulfilled and 24.7% were feel that administrations are not very great from the all offices and administrations of Sehat Sahulat card [17]. In certain nations, including Turkey, Thailand, and Brazil, the

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programme universal health has very low levels of satisfaction. The project's sustainability is below average. While the UHC is successfully implemented throughout all of Pakistan's provinces [18]. The majority of participants in our study expressed satisfaction with the programme regarding the transportation costs that were paid by it. They also called for the continued introduction of similar programmes in other disciplines. In order to achieve patient satisfaction, Manzoor *et al.*, additionally made statements about the conduct and attitude of the service providers. Additionally, the results of the study showed that patients who had insurance coverage for using medical service providers expressed positive satisfaction with both the reception staff and the providers' explanations of medications [19]. Ikegami *et al.*, study conducted in Japan don't favors our study as their universal health coverage was not equal for all but in present study beneficiaries of the Sehat Sahulat card was equal for all and no discrimination on the basis of treatment was observed [20].

CONCLUSIONS

The study concluded that many of the communities do not have access to health facilities due to financial constraints, accessibility and unavailability to health services. The Sehat Sahulat program works mainly to improve the health of those who cannot afford their medical expenses and to make health services accessible. It concluded that the greater part of individuals was satisfy with the services of Sehat Insaf card.

Authors Contribution

Conceptualization: RT, HM
Methodology: JK, FD
Formal analysis: RT, MFH, RZ, BRB
Writing-review and editing: UH, ZN, DYS

All authors have read and agreed to the published version of the manuscript.

Conflicts of Interest

The authors declare no conflict of interest.

Source of Funding

The authors received no financial support for the research, authorship and/or publication of this article.

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