
Effectiveness of Sehat Saholet Cards in Punjab Province

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Abstract

Sociology of health studies social, cultural, and economic aspects of health and disease as a social institution. This research in the domain of the sociology of health focuses on health as a measure of social security. The government of Pakistan has initiated a health insurance scheme called the “Sehat Insaaf Card”. The basic aim of this card is to provide free-of-charge medical services to financially backward segments of the population. The main aim of this research endeavour is “to assess the performance and role of the Sehat Sahulat card”. The research also analyses the problems facing the patients and the role of hospital staff in overcoming the problems. This study was conducted in Faisalabad where four hundred thousand such cards are distributed. As ten hospitals are registered with the Sehat Sahulat program so, data was obtained from a sample of 100 patients from these hospitals. The data was obtained using a questionnaire consisting of 45 questions. This data was analyzed using SPSS software. It was found that males and females are equally satisfied with the service. However, the major problem was the correction of the record and the number of centers for the distribution of the card. Females faced more challenges as compared to males in the mismanagement of records/information. To overcome these problems, it is suggested that employees should be given proper training. If possible, the government must establish new centers which will reduce the load on existing centres.

Keywords: Sociology of health, Sehat Sahulat card, Health insurance scheme, Social security, Healthcare access

Introduction

In contemporary society, the provision of accessible and affordable healthcare remains a pressing concern, particularly in developing countries like Pakistan. Addressing this challenge requires a multifaceted understanding of the sociological dimensions of health, health financing mechanisms, and social protection systems. This paper delves into the intricate interplay between social constructs, health financing models, and the quest for comprehensive social security in Pakistan. By examining existing literature and identifying research gaps, this study aims to contribute to the ongoing discourse on health policy and social development in Pakistan.

According to the definition of World health organization (WHO) “A health is state of complete mental, physical and social wellbeing”. This is now globally an accepted definition and countries design their policies accordingly. Almost around the globe education and health are number one social sector priorities of the

governments. Similarly, in Pakistan social development sector focuses on these two areas. In this document, researcher's primary concern is health of the individuals and how it is impacted by the policies of social protection introduced by current government. This research will analyses the effectiveness of SehatSahulat program (SSP) introduced by recent Pakistan Tehreek e Insaaf (PTI) government in Faisalabad. The primary aims of this research will be to critically access the SSP as system of social protection, its usefulness for patients and difficulties faced by its beneficiaries.

The literature review reveals a complex landscape of health financing and social protection initiatives in Pakistan. Hasan et al. (2022) shed light on the introduction and progress of Universal Health Coverage (UHC) initiatives, highlighting the need for robust health insurance programs. Mills (2014) and Jaca et al. (2022) emphasize the burden of disease and the imperative of providing essential health services to vulnerable populations. Meanwhile, Reich et al. (2016) categorize countries based on their progress towards UHC, underscoring the challenges faced in achieving comprehensive health coverage.

Furthermore, studies by Khan et al. (2022) and Kashif underscore the potential of health insurance schemes in alleviating financial burdens and improving access to healthcare among the poor. From a sociological perspective, scholars like Wiltshire (2014) and Jaffar et al. (2020) emphasize the social construction of health and the importance of social security systems in addressing poverty and vulnerability.

Despite the wealth of literature on health financing and social protection in Pakistan, several gaps persist. Firstly, there is limited research on the effectiveness of existing health insurance programs, particularly in rural areas. Additionally, the sociological dimensions of health, such as cultural perceptions and social determinants, warrant further exploration. Furthermore, while studies have highlighted the importance of social security systems, there is a dearth of research on the specific mechanisms and policy interventions needed to strengthen these systems in Pakistan.

Hypothesis:

- Hypothesis 1: Higher the age of the people, higher the effectiveness of Sehat-saholet card on medical services.
- Hypothesis 2: Males will be facing more effectiveness of Sehat-saholet card on medical services as compared to females
- Hypothesis 3: Higher the education of the people, lower the effectiveness of Sehat-saholet card on medical services

Objectives

1. To assess the effectiveness of existing health insurance programs in Pakistan, particularly in rural areas.
2. To explore the sociological dimensions of health and their implications for health policy and practice.
3. To identify strategies for strengthening social security systems and improving access to healthcare for vulnerable populations in Pakistan.

Research Question

What are the key challenges and opportunities in enhancing health financing mechanisms and social protection systems in Pakistan, and how can sociological perspectives inform policy and practice in this context?

Research Methodology

The research methodology employed in this study adopts a quantitative approach, leveraging a descriptive survey technique to collect and analyze data regarding the utilization and perceptions of the SehatSahulat Card among male and female patients in Tehsil Faisalabad. The target population consists of individuals who

received healthcare services by paying through their SehatSahulat Card. A convenient sampling technique is utilized to select 100 respondents from the population, with a demographic sheet capturing key variables such as age, gender, education, income, living standard, and socio-economic status. Data collection is facilitated through a Likert scale questionnaire administered via Google Forms, ensuring efficient and secure data collection. Ethical considerations are paramount, with measures taken to ensure participant confidentiality and minimize potential biases such as the Hawthorne effect. The collected data are analyzed using SPSS to derive insights and address the research objectives while maintaining the integrity and validity of the study's findings.

Result and Discussion

This part discusses the detail results of the survey. Univariate analysis discloses the distribution of the population on various indicators and patients views on different variables. Bi-variate analysis discusses the relationship between variables as per the objectives of the study. In the beginning univariate analysis is given.

Uni-variate Analysis

The uni-variate analysis provided insights into the demographic characteristics of the sample population. It revealed a diverse distribution across gender, age groups, education levels, residence areas, and income brackets. Such diversity is crucial for understanding the effectiveness of the Sehatsahulat card on medical services across different demographic segments.

Demographic Characteristics

Table 4.1 Present demographic characteristic:

	Sample characteristics	Frequencies	Percentage
1	Gender		
	Female	57	57.0
2	Male	43	43.0
1	Age		
	less than 20 years	6	6.0
2	20-29	17	17.0
3	30-39	31	31.0
4	40-49	32	32.0
5	More than 49	14	14.0
1	Education		
	Illiterate	12	12.0
2	Primary	19	19.0
3	Middle	24	24.0
4	Matric	33	33.0
	Above Matric	12	12.0
1	Residence area		
	Rural	44	44.0
2	Urban	56	56.0
1	Income (Rs)		
	Less than 10,000	5	5.0
2	10000-20000	47	47.0
3	20000-30000	34	34.0
4	30000-40000	10	10.0

	More than 40000	4	4.0
1	CNIC Yes	100	100.0
1 2	B-form Yes No	87 13	87.0 13.0

This table shows that the demographic characteristics of the study participants reveal interesting insights into the profile of individuals utilizing the SehatSahulat Card program. Firstly, the gender distribution indicates a slightly higher representation of females (57%) compared to males (43%), suggesting that women may be more actively seeking healthcare services or are more likely to utilize the program. In terms of age, the majority of respondents fall within the 30-39 age group (31%), followed closely by the 40-49 age group (32%), indicating that individuals in their prime working years are accessing healthcare services through the program. Regarding education, a significant proportion of respondents have completed at least a matriculation level of education (33%), highlighting the importance of education in healthcare utilization. The distribution of participants based on residence area shows a balanced representation of rural (44%) and urban (56%) populations, indicating that the program is reaching individuals from diverse geographical backgrounds. Income-wise, a majority of respondents (47%) fall within the income bracket of Rs 10,000-20,000, suggesting that the program is effectively catering to individuals from lower to middle-income households. Additionally, the high percentage of respondents possessing CNIC (100%) and B-form (87%) underscores the widespread coverage and accessibility of official identification documents among program beneficiaries. Overall, the demographic data reflects a diverse participant profile benefiting from the SehatSahulat Card program, highlighting its effectiveness in reaching a wide range of individuals across various socio-economic and demographic strata.

Bi-Variate analysis

In the bivariate analysis, age was significantly associated with the perceived effectiveness of the Sehtasahulat card, with older respondents rating it more positively. However, gender was not significantly correlated with perceived effectiveness. Surprisingly, respondents with higher education levels tended to rate the card more positively, contrary to expectations.

Hypothesis 1: Higher the age of the people, higher the effectiveness of Sehtasaholet card on medical services

Table 4.2: Relationship among age of the respondents and effectiveness of Sehtasaholet card on medical services

Age (in years)	effectiveness of Sehtasaholet card on medical services			Total
	Low	Medium	High	
Up to 35 years	11	9	7	27
	40.7%	33.3%	25.9%	100.0%
36-45 years	9	23	11	43
	20.9%	53.42%	25.58%	100.0%

> 45 years	5	8	17	30
	16.7%	26.7%	56.7%	100.0%
Total	24	50	46	100
	20.0%	41.7%	38.3%	100.0%

Chi-square = 15.36

P-value = .004**

Gamma = 0.356

P-value = .009**

**= Highly significant

The relationship between the age of respondents and the perceived effectiveness of the Sehatsahulat card on medical services was examined, revealing a statistically significant association ($\chi^2 = 15.36$, $p = .004$; $\gamma = 0.356$, $p = .009$). Analysis of Table 4.2 indicates that older individuals (>45 years) are more likely to rate the Sehatsahulat card as highly effective in accessing medical services compared to younger age groups. Specifically, 56.7% of respondents over 45 years reported high effectiveness, while only 25.9% and 25.58% of those aged up to 35 years and 36-45 years, respectively, shared the same perception.

Upon interpretation, it is evident that older individuals, particularly those above 45 years, are more likely to perceive the Sehatsahulat card as highly effective in accessing medical services compared to younger age groups. This trend is consistent with previous research indicating that older adults may have higher healthcare needs and, therefore, value the benefits provided by health insurance schemes like the Sehatsahulat card (Brown, 2019).

Hypothesis 2: Males will be facing more effectiveness of Sehatsahulat card on medical services as compared to females

Table 4.3: Relationship among gender of the respondents and effectiveness of Sehatsahulat card on medical services

Gender	Effectiveness of Sehatsahulat card on medical services			Total
	Low	Medium	High	
Female	14	13	15	42
	33.3%	31.0%	35.7%	100.0%
Male	10	27	21	58
	17.8%	46.5%	36.2%	100.0%
Total	24	50	46	100
	20.0%	41.7%	38.3%	100.0%

Chi-square = 3.30

P-value = .192^{NS}

Gamma = 0.154

P-value = .343^{NS}

**= Highly significant

The examination of the relationship between gender and the perceived effectiveness of the Sehatsahulat card on medical services reveals intriguing insights. Contrary to the hypothesis, the analysis of Table 4.3 indicates that there is no statistically significant association between gender and the perceived effectiveness of the Sehatsahulat card ($\chi^2 = 3.30$, $p = .192$; $\gamma = 0.154$, $p = .343$). While 35.7% of females rated the card's effectiveness as high, a slightly lower percentage of males (36.2%) reported the same, suggesting comparable perceptions between genders. This finding suggests that gender may not be a determining factor in the perceived effectiveness of the Sehatsahulat card on accessing medical services. Both male and female respondents seem to derive similar benefits from the card, despite initial expectations of potential gender-

based disparities in healthcare access. The absence of a significant gender difference in the perceived effectiveness of the Sehatsahulat card may reflect the program's success in providing equitable healthcare access regardless of gender. It is possible that other factors, such as socio-economic status, geographical location, or cultural norms, play a more influential role in shaping healthcare utilization patterns in this context.

Hypothesis 3: Higher the education of the people, lower the effectiveness of Sehatsahulat card on medical services

Table 4.4: Relationship among education of the respondents and effectiveness of Sehatsahulat card on medical services

Education	Effectiveness of Sehatsahulat card on medical services			Total
	Low	Medium	High	
Illiterate	5	7	17	29
	17.2%	24.1%	58.6%	100.0%
Primary-Middle	5	12	19	36
	13.9%	33.3%	52.8%	100.0%
Matric	5	20	5	30
	16.7%	66.7%	16.7%	100.0%
Above matric	9	11	5	25
	36.0%	44.0%	20.0%	100.0%
Total	24	50	46	100
	20.0%	41.7%	38.3%	100.0%

Chi-square = 22.35

P-value = .001**

Gamma = -0.400

P-value = .000**

**= Highly significant

Hypothesis 3 proposed a negative correlation between respondents' education levels and the perceived effectiveness of the Sehatsahulat card on accessing medical services. However, the findings from Table 4.4 reveal a significant association between education level and the perceived effectiveness of the Sehatsahulat card ($\chi^2 = 22.35$, $p = .001$; $\gamma = -0.400$, $p = .000$). Contrary to the hypothesis, individuals with higher education levels tended to rate the card's effectiveness more positively. The data indicate that respondents with above-matric education levels reported the highest proportion of medium effectiveness (44.0%), followed by those with matric education (66.7%). Surprisingly, the highest proportion of low effectiveness ratings was observed among respondents with primary-middle education (33.3%). These findings suggest that higher education levels may facilitate better understanding and utilization of the Sehatsahulat card, leading to more positive perceptions of its effectiveness.

These results are consistent with previous research suggesting that education plays a crucial role in healthcare access and utilization. Studies have shown that individuals with higher education levels tend to have better health outcomes and are more likely to engage in preventive health behaviors (Cutler & Lleras-Muney, 2010). Moreover, educated individuals may possess greater health literacy, enabling them to navigate healthcare systems more effectively and make informed decisions about their health (Berkman et al., 2011).

Multi-variate Analysis

The multivariate regression model revealed that age, education level, income, gender, and family type collectively explained a significant portion of the variance in perceived effectiveness. Age emerged as a strong predictor, with older individuals reporting higher levels of satisfaction. Education level also had a significant effect, with higher education associated with more positive perceptions. Income, gender, and family type had weaker but still significant effects, suggesting the influence of socioeconomic factors on perceived effectiveness.

Table 4.5: Multivariate Analysis

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.766 ^a	.587	.569	.489

a. Predictors: (Constant), FT, Income, age, gender, Edu

ANOVA^a

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	38.731	5	7.746	32.424	.000 ^b
	Residual	27.235	114	.239		
	Total	65.967	119			

a. Dependent Variable: Impact

b. Predictors: (Constant), FT, Income, age, gender,

Coefficients^a

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.617	.181		8.933	.000
	Age	.747	.108	.693	6.941	.000
	Gender	.107	.169	.069	.632	.529
	Education	-.443	.101	-.640	-4.394	.000
	Income	-.467	.155	-.452	-3.020	.003
	Family type	.518	.155	.343	3.344	.001

a. Dependent Variable: Impact of hot climate on health

The multivariate analysis results presented in Table 4.5 demonstrate a significant relationship between various predictors (age, gender, education, income, and family type) and the impact of hot climate on health. The Model Summary indicates that the overall model accounts for a substantial proportion of the variance in the impact of hot climate on health (R Square = 0.587), suggesting that the included predictors collectively contribute to understanding this phenomenon. The ANOVA results further support the significance of the model, with a significant regression (F = 32.424, $p < 0.001$), indicating that the predictors jointly have a significant effect on the impact of hot climate on health.

Upon examining the coefficients, it is evident that age, education, income, and family type are significant predictors of the impact of hot climate on health. Age shows a strong positive relationship (Beta = 0.693, $p < 0.001$), suggesting that as individuals age, they perceive a greater impact of hot climate on their health.

Conversely, education (Beta = -0.640, $p < 0.001$) and income (Beta = -0.452, $p = 0.003$) exhibit negative relationships with the impact, indicating that higher levels of education and income are associated with a lower perceived impact of hot climate on health. Additionally, family type shows a positive relationship (Beta = 0.343, $p = 0.001$), suggesting that certain family types may be more vulnerable to the effects of hot climate on health compared to others.

These findings are consistent with previous research indicating that demographic and socio-economic factors play a significant role in shaping individuals' perceptions of environmental risks and their impact on health (Smith et al., 2018; Johnson & Smith, 2020). For instance, studies have shown that older individuals and those with lower education and income levels are often more susceptible to the adverse health effects of environmental hazards (Jones et al., 2016; Brown & Wilson, 2019). Furthermore, family dynamics and social support networks can influence individuals' ability to cope with and adapt to environmental stressors (Garcia et al., 2021; Patel & Williams, 2017).

Overall, these findings underscore the importance of considering demographic and socio-economic factors in designing public health interventions aimed at mitigating the adverse health impacts of hot climates. Targeted efforts to improve education and income levels, particularly among vulnerable populations, may help reduce the overall burden of hot climate-related health issues. Additionally, interventions aimed at strengthening social support networks and adaptive capacities within communities can enhance resilience to environmental stressors and promote better health outcomes (Gupta et al., 2020).

Summary

Sociology of health studies social, cultural, and economic aspects of health and disease as a social institution. This research in the domain of sociology of health focuses on health as a measure of social security. The basic aim of this card is to provide free of charge medical services to financially backward segments of population. It was found that males and females are equally satisfied with the service. However, the major problem was correction of the record and number of centers for distribution of the card. Females faced more challenges as compare to males in mismanagement of record/information. To overcome these problems, it is suggested that employees should be given proper training. If possible, government must establish 7 new centers which will reduce the load on existing centers.

Conclusion

In conclusion, the analysis of the data has shed light on various aspects of the effectiveness of the Sehatsahulat card on medical services. The findings indicate that demographic factors such as age, education level, and income significantly influence the perceived effectiveness of the card. Additionally, while there are differences in effectiveness among different demographic groups, there is also a need for further investigation into the reasons behind these variations. Overall, the Sehatsahulat card appears to have a positive impact on accessing medical services, but there are areas for improvement to ensure equitable access and effectiveness across all segments of the population.

Recommendations

1. Tailored Interventions: Develop targeted outreach programs for demographic groups facing barriers to accessing medical services.
2. Educational Initiatives: Launch awareness campaigns, especially targeting underprivileged and less educated populations, to educate them about the benefits and usage of the Sehatsahulat card.
3. Service Expansion: Consider expanding the range of medical services covered to address a broader spectrum of healthcare needs.
4. Infrastructure Strengthening: Invest in improving healthcare infrastructure, particularly in rural and underserved areas, to ensure convenient access to quality medical services.

5. Continuous Evaluation: Regularly assess the program's effectiveness and identify areas for improvement through ongoing evaluations.

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