ALLOCATION AND EFFICIENCY OF SEHAT SAHULAT PROGRAM

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Submitted by:

HAMZA FEROZ

Registration No: 02091913043

Supervised By:

Dr. Anwar Shah Associate Professor

School of Economics

Quaid-i-Azam University, Islamabad

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CONTENTS

LIST OF TABLE CONTENTS

LIST FIGURE CONTENTS

ACRONYMS AND ABBREVIATIONS

- **SSP** : SEHAT SAHULAT PROGRAM
- **SLIC** : STATE LIFE INSURANCE CORPORATION
- **BISP** : BINAZER INCOME SUPORT PROGRAM
- **FGD** : FOCOUS GROUP DISSICUSION
- **GIZ** :DEUTSCHE GESELLSCHAFT FÜR INTERNATIONALE ZUSAMMENARBEIT
- **NSER:** NATIONAL SOCIO-ECONOMIC REGISTRY
- **PKR:** PAKISTANI RUPEE
- **WHO:** WORLD HEALTH ORGANIZATION
- **GOP :** GOVERNMENT OF PAKISTAN

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ABSTRACT

Pakistan has made great step in health coverage, offering valuable in patient (IP) cover to some of the most vulnerable members of society through the Sehat Sahulat Program. The program was first initiated in 2015 by provincial government of Khyber Pakhtunkhwa. Now the government of Pakistan intends to extend the Sehat Sahulat Program to the whole country. Though the said program is a great initiative but there arises a question that whether it will work efficiently or not. This study aims to explore the efficiency and sufficiency in allocation of Sehat Sahulat health cards and its amount. The study explores the objectives with the help of case study design, taking district Mardan of KP as a case. The questions are examined with the help of primary data collected through questionnaires and focus group discussions. The study concluded that around 49% of total sample were cardholders and 51% were condition holders. There were 76% cardholders which hold the Sehat Sahulat Program conditions the rest were not. Consequently, efficient allocation of cards and distribution of income has been made by the government. However, the Sehat card amount utilization is not efficient. The factors contributing to this are lack of awareness, fraud by the public and hospital administration. The program will achieve the desired objective more efficiently if the line departments paid the timely attention to these problems.

Keywords: Sehat Sahulat Program, Cardholder, Condition holder, Sehat Card, Efficiency.

ALLOCATION AND EFFICIENCY OF SEHAT SAHULAT PROGRAM

CHAPTER 1: INTRODUCTION

1.1: Background of the Study

The driving force behind the abilities of individuals in running economic, political, and social systems is health. The proper functioning of all these systems forms an organized and welfare society. In which people of every class and sect are treated equally while getting basic needs. State ensures the provision of these basic rights to its citizens. In other words, to ensure the efficiency and productivity of the labor force state provide improved health facilities. However, the modern capitalist world usurped the health sector too and this usurpation resulted in the victimization of the marginalized class. In contemporary world there is not a single health section which has no private sector involvement. From hospitals to pharmaceutical companies and service delivery many are owned by the capitalist class. This has greatly increased the health spending around the world.

The World Health Organization report indicates that, from 2000 to 2017 world health expenditures are increased by 3.9% a year. In which the 2017 health expenditures are recorded as $ 7.8 trillion. This growth has occurred faster than the overall economy which has seen 3.0% increases per year, (WHO, 2019 Report). Although greater share in these expenditures came from develop countries but developing countries also increased health expenditures. In Pakistan, Budgetary allocations to health care have shown an increasing trend for Khyber Pakhtunkhwa with a slight dip in 2015-16. The percentage allocated as % of GDP was 0.8% in 2010, but has steadily increased by 1-2% every year, resulting in an increase from 0.8% in 2010-2011 to 1.7% in 2016-17 With the increase in GDP of KP from 283 billion to 505 billion rupees, the amount allocated to the health sector has more than doubled with an increase from approximately 17 billion PKR (0.2 billion USD) in 2010 to 57 billion PKR (0.56 million USD) in 2016-17. At 1.7%, KP has the second highest spending on health as a proportion of GDP, and had the highest per capita allocation of approximately PKR 2200 (21 USD) per person. (Government of Pakistan; Finance Division, 2017) At one end these expenditures came with beneficial outcomes for health sector as new equipment, medicines, trained health professionals, and quality health services came in existence. But at the same time these health facilities are not available to common man in both rich and poor countries. This preferential treatment results in poor health of the working class (categorized as common man).

The health services delivery also became abundant where people are now getting treatment with more ease and comfort. It also has reduced the burden of health provision from government. State which at times unable to reach the large part of the population; nowadays private sector has access to that far away people. State tries to meet the needs of every individual but still problems occur in these endeavors. The aim of the state is to provide health services at a low price which

cost them huge. Its manifestation occurs when government hospitals cannot avail the modern health equipment due to lack of funds. Together with all these problems and the provision of good health to people induce state to initiate social support programs for the needy people. As (Ihram & Jahangir 2007) put this accomplish better, more talented, proficient, and useful human resources assets, governments finance the medical services offices for its kin.

The most common used method for wellbeing financing in numerous low and middle income nations is basically out-of-pocket (OOP) payments. Out of Pocket payments are one of the most essential kinds of wellbeing financing. They go about as an obstruction to get to, contribute towards family destitution, produce little income (normally under 5% of absolute medical care spending plan), and promote perverse incentives, bureaucracy, and corruption. About 1.3 billion people worldwide don't move toward adequate clinical benefits or they are compelled to rely upon inadequate consideration as a result of frail medical services financing framework (Bonu S, Bhushan I 2007). At the point when individuals should pay expense for medical services, and the out of pocket payments are so high corresponding to their pay that it brings about "financial catastrophe" for the individual or the family. Such high use for medical services can imply that individuals should eliminate necessities like food and clothing, or can't pay or pull out their kids from schools or placing them in to government schools and so forth Besides, Moreover, the impact of these out-of-pocket payments for health care goes beyond catastrophic spending alone. Many individuals might choose not to use wellbeing administrations, since they can't bear the cost of either the immediate expenses for example, for conferences, meds and lab tests, or the circuitous expenses, for example, for transport and uncommon food. Thusly, the poor either don't arrive at the wellbeing framework or get inadequate consideration. Indeed, even little payments for medical care can drive poor into obligation or develop their neediness (Krishnaswamy K, Ruchismita R 2011). When the cost of health care for the lower class of the society increases, this causes exclusion termed as market exclusion. This further exacerbated by the financial stress, unemployment, and the state of public health services. To help these excluded people, the government initiates different health services schemes or other social support programs. The size and distribution of which varies from country to country. The developed countries have started these support programs long before. But almost all middle-income countries have started a widespread program too. This gives support to the excluded people of the community. However, the size, range and the methodology of these programs is dependent on the economic development, the social and political setting of the country.

Like many developing countries Pakistan too is faced with many problems in health sector. These problems range from the policy making to budget allocation and the availability of health services to common man. All these problems aggravated the burden of diseases, which shows the weakness of health sector. Compared to regional countries malnutrition, mortality, and tuberculosis rates are high in Pakistan. Diarrhea, cholera, and other respiratory diseases are still fatal among children. The burden of Hepatitis B and C is 7.6% to the total disease burden in

Pakistan. Similarly, non-communicable diseases along with injuries and mental health contributing more than 11% to total burden of diseases (WHO, 2017).

The treatment of all such diseases requires a stable financial status but it is a luxury for our people who cannot afford. That‟s why different governments in the past also initiated support programs for the most vulnerable segment of the society. Regardless, of what there aims were they do provide the short-term relief from the burden to these people. Keeping in view such challenges faced by the people, the government of Pakistan has initiated "Sehat Sahulat Program". This program is a step towards providing healthcare facilities to the registered families. Sehat Sahulat Program (SSP) program provides financial health protection to families who are living below poverty line. Sehat Sahulat Program leaves them in better position to manage their socio-economic condition. The amount once they spent on health now, they can allocate that to other needs.

1.2: Problem Statement

In Pakistan there is a history of social support programs initiated by governments in its times. All of those aimed at providing social support to the poor and needy section of the society. For this purpose, billions and trillions of rupees worth plans were devised, and the amount was distributed either in cash or other form. But most of these programs are failed to translate into uplifting the status of the target population. Many reasons are enlisted to state the failure of these programs. To broadly categorize them all these have the problem of allocation and efficiency. One such initiative is Sehat Sahulat Program which has received considerable attention from the public health authorities, development partners and policymakers. This was launched by government of Khyber Pakhtunkhwa and is now extended to the whole Pakistan. The aim is to provide financial assistance to the poor and vulnerable who cannot manage expenses of the treatment of listed diseases.

As stated above the problem with earlier social support programs was allocation and efficiency. It becomes inevitable to check the allocation and efficiency of this program also as it will now cover the whole Pakistan. So, as it was first initiated in Khyber Pakhtunkhwa the assessment will be start from here. For this purpose, Tensile Takht-Bhai of District Mardan is selected as the locale. The aim is to find out the allocation and efficiency of Sehat Sahulat program.

1.3: Significance of the study

Every citizen has the right to have food on his plate and roof over his head. Furthermore, he has his birth right to be provided basic education and decent job opportunities. These basic facilities serve as the backbone of the infrastructure of a welfare society. However, basic health care system along with other necessities is as crucial as it can get to develop a stable society. It's proven a healthy society consequently generates a healthy nation. In any society, the measurements done to provide women healthcare facilities basically give the parameters to analyze how healthy and developed this very society is, for a healthy mother will be able to give

birth to a healthy generation. In the past, the rapid increase in population and environmental pollution has given birth to several fatal diseases, consequently rising the number of effects to an alarming number. About 1.3 billion individuals worldwide do not approach sufficient medical services (Bonu S, Bhushan I 2007). Keeping in view the challenges faced by the people at the grassroots level, the government of Pakistan has initiated "Sehat Sahulat Program". This program is a step towards providing healthcare facilities to the registered families.

The question arises here, that how we find out the exclude people of the marketplace? For that policymaker collect information of that people and design a benefit package to cover the excluded segment of society. The Health Insurance system is being followed in many created and non-industrial nations with empowering results (Amina and Fazli 2019). For virtually all nations, one of the primary targets of these changes is to work on the productivity and adequacy of projects. It is started that this finding of the review would likewise frame a base for exploration and promotion for related reason. By illuminating both the interest and supply side of the SSP. The review will likewise be helpful in proposing strategy suggestion to resolve the basic issues. This will assist with working on the plan and conveyance of the program and accomplish its goals prior to extending it to different areas of the country.

1.4: Objectives:

- To investigate the allocation of Sehat card to potential benefices is efficiently.
- To investigate whether the Card amount provided by SSP to benefices is sufficient.

CHAPTER 2: LITERATURE REVIEW

Sisko et.al (2014) examined the public wellbeing Expenditure projections, quicker development expected with extended inclusion and further developing economy from the period of 2013 to 2023. Survey outcomes show that government expenditures were very less from the last few years so that expenditure should be higher in future for the better health care.

Diseases are making unexpected economic shock to families as it prompts cash-based consumptions, undermines income generation and future financial welfare. In this situation, the public authority, as response to work proficiently and move towards universal health coverage. Therefore Community-based Health Insurance (CBHI) schemes are recommended for providing financial risk protection to low-income households in developing countries. Sarker et al. (2018) investigate the Experience and Satisfaction of Utilizing Healthcare Services in a Community Based Health Insurance Program in Bangladesh. The author conducted a cross-sectional household survey and uses spearman correlation analysis and Multivariate linear regression analysis to identify factors and overall satisfaction score. The study concluded that overall score of satisfaction level was 4.17 out of 5 which means that the clients were highly satisfied with the health services provided by the self-financed health scheme. Nair (2016) investigate the similar scheme in Kerala, South India in 2008 and conclude that needy individuals were benefited through the plan however, delay in settling finds. Genuine recipients were not perceived and remembered for the rundown. Along these lines, pay based worth is questionable. Further Ahmed et al. (2018) examined the problem of adverse selection in a CBHI scheme in this unique situation. EuroQuol-5 dimensions questionnaire was used and collect data from 1292 respondents where 646 insured and 646 uninsured. For empirical analysis the author used multiple logistic regressions to predict the association between CBHI scheme enrolment and health status. The CBHI scheme enrollment was regressed on Demographic and household characteristics. The result of this study shows that mobility ratio is high in insured respondent as compared to uninsured. The average EQ-5D score was significantly low among the insured (0.704) than to the uninsured (0.749). Further regression result showed that the individual who had an issue in mobility, self-care and pain and inconvenience were bound to join the scheme. Given that adverse selection was clear in the pilot CBHI scheme, there should be thought of this difficult when arranging scale-up of these sorts of schemes.

Wang, Zhu et al. (2019) examine the full coverage of essential medicines policy of the primary healthcare in the rural area of Qidong country of Jiangsu, China in 2015.The objective of the study to find out the long-term effects of Full coverage of essential medicines policy utilization for senior beneficiaries. The time series analysis 47month longitudinal data and ADF unit root along with Durbin Watson test was utilized. The outcome showed that FCEMs strategy has reduced the financial burden of the rural seniors and marginally improved the efficiency of essential wellbeing administration used. However, it had no positive outcome on day-by-day hospitalization costs. Therefore, in the overall system of FCEMs strategy, the Chinese wellbeing strategy producer should take important supporting measures to control climbing hospitalization

consumptions and advance the judicious medication use in essential medical services establishments.

Boyce & Brown (2019) argued that Health assumes the vital part in deciding the human resources. Further Lamiraud, Booysen and Adlung (2005) tracking down that better wellbeing works on the effectiveness and the efficiency of the workforce, eventually contributes the financial development and prompts human government assistance.

Uslu & Linh (2008) studied the impact of transformations in health sector to develop the proficiency and the production of general hospital in Vietnam. For this study data duration was from 1998 to 2006 from 101 public hospitals and DEA two stages method was used. Result revealed that in each year there is 1.4% improvement in the production of hospital in Vietnam. Moreover, the disparities in hospital proficiency can be recognized to both the controlling changes and specific characteristics of hospital. The measure of autonomy and fees user was found to improve technical proficiency. Regional hospital was shown to be more technically capable than their main counterparts while emergency clinic set in the Southeast, Northeast and Mekong River Delta regions works better compared to medical clinic from different regions.

Chen (2006) studied revealed that National Health Insurance implementation was significantly positively related to hospital productivity and quality, however adversely connected with proficiency because of the expanded usage of resources. Public hospitals were discovered to be less effective in the single-period in the single-period appraisal yet acquired proficiency and less assistance quality in the blended period researched.

The efficiency of health extension program in Tigray, Ethiopia. Sebastian & Lemma (2010) examined to estimate the technical efficiency of the health post in rural area of Tigray. Collect data from seven rural district in the period of July 2007 to July 2008 and utilizing DEA and Tobit model to quantify efficiency and to distinguish that factor that may be clarifying the productivity performance. The author was found that technically efficient constituting is the best practice frontier. In the regression analysis, none of the variables was significantly associated with the efficiency outcome. Conclusion of the studied that there is a need to audit the administration of the wellbeing data framework around there. The findings have also revealed that only a quarter of the health posts are working efficiently and pointed the need for improvement. A closer monitoring of the health extension programmed is needed to accomplish the most ideal presentation.

Chisholm & Evans (2010) studied WHO (Report 2010) in financing for widespread inclusion and contended that there is an alarmingly huge level of failure in the wellbeing area, independent of the pay level of various areas or nations. This is something of a rough approximation and totally shrouds the inescapable varieties that exist between nations yet serves to remind that everything nations could and can do significantly more to utilize assets gave to wellbeing. As far as

reasonable strides forward gives a schematic show of the different strategy apparatuses that could be considered to work on allocate productivity.

Tenkorang (2001) examined the efficiency and quality of care provided of health care system of low-income countries, mainly in Africa in the period of 1980 to 1990.This study has provided evidence from the literature that the poor household are being exposed to financial risk and decreasing access to health care because of the user fees. This paper finally suggests that the poor household, particularly in the informal sectors are to be provided with a different financing mechanism.

In this study Wang (2010) has found out that the provision of both the preventive and curative health care are equally important and complementary for improving health status. The result show health services are rather a luxury good than necessity goods and concluded that such services are demanded more by higher income economies than lower income. This study is applicable to the evaluation of the effectiveness of health care by other developed and developing countries.

2.1 : BRIEF REVIEW OF PAKISTAN HEALTH CARE SYSTEM

The 18th amendment in constitution of Pakistan, the responsibility of health care has been shifted to provincial government except in case of federally administered territories. However, the federal government is responsible for planning and formulating national health policies. Each provincial government has established a department of health with the mandate to protect the health of its citizens by providing preventive and curative services. The provincial health departments also regulate private health care providers. Akram and Khan (2007) argued that large variations are found in public sector spending on health care across provinces. Therefore, Pakistan has got to exploit the full potential approaches which are being used by other countries such as pre-paid premium base state insurance. Different studies were cover Pakistan Health care system such as PIDE (2014), Akram and Khan (2007), Toor and Butt (2005) finding of this studies that health care program has provide a significant benefit to his citizens.

Pide (2014) studies a health insurance scheme which was a pilot project by the name of waseela e Sehat launched in Faisalabad district, Punjab in 2012. This study evaluated the efficiency and efficacy of the project by targeting the beneficiary of the waseela e Sehat scheme. This study concluded that because of illiteracy of the majority, the project was not fully utilized but the overall result shows satisfaction and higher utilization of hospital resources by the beneficiaries.

Toor and Butt (2005) investigated the determinants of health care expenditure in Pakistan using time series data. They applied Conventional Log Linear Model and the Co integration method to investigate the short-run and long-run relationship between health expenditure and socio-economic factors in Pakistan. Per capita GDP, crude birth rate, literacy rate, urbanization, foreign aid were the explanatory variables and per capita health expenditure was the dependent variables.

It is inferred that the government should increase the contributions of their expenditure in the health sector for the betterment of health care services.

Abbas and Hiemenz (2011) probed the determinants of public health expenditures in Pakistan over the period of 1972 to 2006. There were some demographical, economic, political, and social variables. Co integration and error correction approaches were employed to detect some possible short-run and long-run relationship between health expenditures on both income and non-income terms. There were some variables which inversely affect public health expenditures. The result indicates that government should increase their expenditures in underdeveloped areas so that people take many advantages from that.

Akram and Khan (2007) examined the frequency of government expenditure on health sector in Pakistan at regional, both urban and rural level. For this investigation primary data of the Pakistan Social Standard Living Measure Survey (PSLM) used from 2004 to 2005 and apply the Three-step benefit incidence approach (BIA) techniques. The study analyses the domestic policies emphasizing health facilities as well as the tendency in gain access to and public division expenditure on health care services in Pakistan. The study reveals the imbalances in resource allocation and facilities providing compared to the government health spending. The rural areas of Pakistan are poorer to provide the health care services. The spending in health area is totally going back in rural area of Pakistan as well as at regional and provincial level. Mother and Child subhead is returning in Punjab and General Hospitals and Clinics are backsliding in all provinces. Only the Preventative Procedures and health services sub-sector is developing in Pakistan. Public health spending is pro-rich in Pakistan.

According to the Pakistan Social Living Measurement (2007-08), around 47% of patients do not use government hospital in Pakistan. The studies find that only one patient out of three was use government hospital here the query provokes for health policy makers in Pakistan. Should public assets not be coordinated towards financing the private area medical (health) care as opposed to public sector medical care which should focus on serving the most unfortunate of poor people? To address this inquiry Akbari, Rank Aduwa, and Kiani (2009) analyze to gauge (estimate) the demand model that disclose the outpatient visit to government medical clinic utilizing time series information from 1989 to 2006. The dependent variables were outpatient visit per capita while government clinic (hospital) per capita, specialist expense per visit at private center, pay level per capita, drugs costs and the amount of outpatient visits per capita in the previous year are controlling factors. In econometrics model utilizing co-integration and Phillips-Perron unit root test .The consequence of the contemplated show that all factors are huge determinants of the demand for medical services in at any rate one region yet their signs, sizes, and the degrees of importance change. Further result shows these fluctuations might be credited to social, cultural, and strict (religious) elements that shift across provinces. Variations in medical care quality offered at public emergency clinics may likewise be a factor. These variables and improved

openness of medical services offices ought to be the focal point of public policy pointed toward expanding the utilization of public medical services offices in Pakistan."

Ahmed (2018) directed a study to gather information and utilized Logical casing way to deal with investigation BISP. The targets of the review might be summed up as to make an intensive audit of various social wellbeing nets being run in various nations across the globe with uncommon reference to Pakistan; to examinations the advantages of the program and to perceive how these could be augmented; and to find the openings in the current government managed retirement net program (BISP) and to further develop it through provisioning of procedure measures and ideas.

2.2 : **Research Gap**

Health systems play an important role in the status and stability of national and regional economies. But the cost of health care increase day by day which causes exclusion. In order, to help excluded people government of Pakistan lunch‟s different programs. One such program is Sehat Sahulat program. The success of this program depends on allocation and efficiency of the Sehat card. We have studied it, but little is known about efficiency of this program. Hence, we fill this gap to find out that the Sehat card allocation and Sehat card amount utilization was efficiently. For this the rest of the thesis is organized.

We believe this analysis will be useful and timely resource for policy maker and practitioners engaged with health financing and services delivery reform. This analysis provides evidence that can be used to help guide these programs on the population and diseases burden target. Additionally, given the lack of costing studies available in Pakistan, the SSP allocation and efficiency may be useful point of reference for social protection program.

CHAPTER 3: METHODLOGY SECTION

The objectives of the study were achieved by applying mix method approach that combined different yet interconnected components. To achieve desired objectives, the study collected information from the four sectors of Sehat Sahulat program (SSP), which are citizens/beneficiary, State Life Insurance Corporation (SLIC) and Sehat Sahulat program officials.

- The citizens/Beneficiary data was collected through questionnaire and Focus Group Discussion (FDGs).
- The condition and criteria of Sehat Sahulat Program information is collected by Sehat Sahulat program official and State Life Insurance Corporation (SLIC).

3.1: Theoretical framework

The discipline of economics is concerned with the maximization of community well-being in the face of unlimited wants and limited resources. The primary focus of economics is the allocation of resources to enhance community well-being. In this study address Medical coverage program (Sehat Sahulat Program) depends on the idea of Micro Insurance. It is the method of giving insurance to the low-pay individuals or helpless gathering of the general public. For the individuals who are acquiring not exactly US$ 2 or less (the people who are lying beneath the destitution line) as per the danger implied against some ordinary premium installments. Poor doesn't approach adequate wellbeing hazard insurance; thusly, they have more prominent likelihood to fall in destitution trap and face calamitous scenes. The calculated structure utilized in this review shows that the wellbeing administrations are supportable given they are working under a coordinated framework, have long haul capacity to activate and designate adequate assets bring about the medical services exercises, and address the issues of individuals' wellbeing.

3.2: Conceptual Framework

When the cost of health increase this is causes of exclusion. To include the excluded people government, launch different programs for health .however, the issue with the government is that they must collect information from ground and then make decision about the allocation of Sehat cards. The collection of such information is costly in terms of time and money. Still the government must rely on the collected information for the allocation of Sehat cards. Still a question arises that to what extent the allocation of cards based on collected information reaches to those who deserve.

The reason of this question is that every government is run by political parties and each political party has the constraints to keep people happy in their constitutes for winning the second term. Hence, there exist a possibility of miss allocation of the cards and it is possible that certain people who do not deserve hold the card while deserving does not hold the Sehat card. To

provide answer to this question there is a need of case studies. This study aims to provide evidence of one such case study. We assume that all people have incentive to would information once they know that the collected information will be used for certain benefit. Hence, there could be some underestimation in the information provided to government people. But there is no incentive of misreporting to researches that are not going to provide them any benefit based on such information. Therefore, the collected information by independent researched can better allow us to examine the level of efficiently in the allocation of cards. We also collect information based on questionnaire and take the main input for the designing of our question from questionnaire used for this purpose. The main objective was to collect information about those variables which provide a base for the allocation and efficiency of Sehat card. We hypothesis that a person who holds card and fall below the given criterion is deserving. However, a card holder who fall above the given criterion is not deserving.

3.3 Area of the Sample

A micro level survey was conducted in the households of tensile Takht-Bhai which is part of district Mardan and in the provinces of Khyber Pakhtunkhwa (KPK). According to 2017 census the total population of Mardan District as 2.373061 million and number of households as 311,868. (Pakistan Bureau of statistics).District Mardan is further divided into three administrative units (Tehsils) namely Tehsil Katlang, tehsil TakhtBhai and tehsil Mardan. The detail description of the households of all three Tehsils of district Mardan is given in table.

Unit Area	No. of households 2017
Mardan Tehsil	178,434
Katlang Tehsil	41,930
Takht-Bhai Tehsil	91,504

Source: Pakistan Bureau of statistics

3.4: DATA COLLECTION

The main concern of our study is to find the Sehat Card allocation and Sehat card amount utilization based on SSP condition/criteria. The study aims to show whether the Sehat Sahulat Program is efficient allocate. As per SSP Report, Sehat card was distributed to poor people and utilize efficiently. Are the distribution and Sehat card utilization are efficient or not? To find out answers to such questions we conducted data in two methods, one is Quantitative and other is Qualitative data.

3.4.1: Quantitative Data

The primary data will be collected through a well-defined questionnaire which will cover the following dimension:

- Family socio-economic and demographic information
- Family health status: Illness and Health care cost.
- Awareness of Sehat Sahulat Program
- Patient experiences and perception regarding:
    - ♦ Hospital facilities
    - ♦ SLIC Helpdesk
    - ♦ Hospital charges
    - ♦ Care and treatment awareness
    - ♦ Overall experience of respondent
    - ♦ Suggestion about Sehat Sahulat Program

The sample size for the population is determined using Yamane‟s formula (1967) suggested simplified formula for calculation of sample size from a population. According to him, for

(Sample size) n = $\frac{N}{1+N(e)^2}$

Were,

N = Household size

e = level of Precision.

Let this formula be used for our population (households), in which N= 91,504 with $\pm$ 7% confidence level.

Assuming confidence level p=0.07, we get the sample size as,

n =$\frac{91{,}504}{1+91{,}504\ (0.07)^2}$ = 204

By applying the formula 204 families were selected. Since the union councils are different in size, a random sample selection is used, where some respondents are Sehat Cardholders, and some are not. The questionnaire obtained was thoroughly examined and four questionnaires were found incomplete and hence were not considering for analysis. Thus, the total questionnaires considered for analysis were 200 questionnaires.In month of February 2021 the random sample method was selected to collect 200 families‟ data in Tehsil Takht-Bhai. All four categories of respondents were included beneficiaries, non-beneficiaries, Sehat card user or Nonuser and control group. *(See full questionnaire in Appendix I)*

3.4.2: Qualitative Collect data

In addition of quantitative information, qualitative data was also collected through focus group discussions. In-depth interview method was used for beneficiaries and the services providers. The qualitative information provides rich contextual data and helped to understand the complexities of delivering the Sehat Sahulat Program and the factors affecting its functioning.

A total five Focus Group Discussions were conducted during the field work of which two Focus Group Discussions were conducted with the SSP beneficiary (i.e., past user and non-user of the scheme). The two were led with public clinic specialists while one Focus Group Discussions were directed with Sehat Sahulat Program specialist (i.e., Health Facilitate Provider, Technical staff) in region Mardan. Each Focus Group Discussions included five to seven member sharing normal attributes, like financial status and usage of medical care office.

3.5: SEHAT SAHULAT PROGRAM DESIGN

The Sehat Sahulat Program is the first of its sort and is completely financed by the public authority. It has been controlled by State Life Insurance Corporation (SLIC) since initiation toward the finish of 2015. The government currently pays a fixed premium per eligible family to State Life Insurance Corporation, which provides comprehensive cover to beneficiaries of free-of-cost hospitalization, emergency services, in-patient services (medical and surgical cases). All medical treatment worth Rs 720,000 per family in each year including all individuals from the family, who have CNIC or Form B. If a card holder or his relative gets any significant sickness which is costly, at that point, the treatment would not be stopped due to exhaustion of insurance amount. The government will provide further amount Rs 360,000 per annum till the treatment finish. The transportation cost of Rs 1,000 will be paid to the family per visit threefold in year. If a patient dies while admitted, burial support of Rs 10,000 will be paid to the deceased family. The card can be utilized in both public and private clinics. 90% of any unspent net premium is discounted to the public authority toward the finish of the three-year contract period with State Life Insurance Corporation. (SSP Report 2019).

The Program was commissioned by the Deutsche Gesellschaft fur International Zusammenarbeit (GIZ) on behalf of the Sehat Sahulat Program with funding from the Federal Ministry for Economic Cooperation and Development (BMZ) through the Pakistan-German bilateral project “Support to Social Protection incl. Social Health Protection”. The project aims to improve access to needs-based social protection services for people living in poverty and at risk of falling into poverty.

3.6: SSP Eligibility Criteria

As per official website for the programmed, it was introduced to provide indoor medical treatment to persons with disabilities, member of the transgender community and those living below the property line (earning less than USD 2 per day). To identify beneficiary, the household who living below poverty line, Sehat Sahulat program is using National socio-economical Registry (NSER) database of BISP/IHSAS program of the population living below PMT (Proxy Mean Test) 32.5 and their daily wage is not more than 2$.So it means a person whose monthly income is less than 10,000 PKR is eligible for Sehat Insaaf Card or hold the program condition. Further all family members (husband, wife, and unmarried children) registered with National Database Registration Authority (NADRA) are automatically enrolled in Sehat Sahulat Program , while in SSP there is a limit of 8 household members, respectively.

The Government of Khyber Pakhtunkhwa launched the Sehat Sahulat Program in 2015 in four districts with the financial support of the German government through KfW. State Life Insurance Corporation (SLIC) has runner of this project. Health Care Provider is hospital which has been empanelled according to SLIC standard. In empanelled hospitals must contain as:

- Provincial Medical officer (PMO)
- District Medical officer (DMO)
- Health Facility officer (HFO)
- Technical Staff

These staff of SLIC designing refinement and rollout of this insurance scheme for the ultra-poor.

The government currently pays a fixed premium per eligible family to SLIC, which thusly deal with individuals' IP medical services consumption. 90% of any unspent net premium is discounted to the government toward the finish of the three-year contract period with SLIC. The SLIC will get commission a yearly measure of PKR 2,849 for every family. The Sehat Card gave under Sehat Sahulat Programmed is substantial for one year. A recipient can utilize the card until as far as possible is accessible. The financial limit for each beneficiary will be refreshed on an annual basis. (Report Sehat Sahulat Program)

CHAPTER 4: DATA ANALYSIS AND INTERPRETATION

In this section of the study, the focus will be on descriptive and empirical analysis. Table 1 to table 7 will discuss descriptive analysis and table 8 to 10 will be discussing finding based on regression.

4.1: Descriptive Statistic

To evaluate data, total sample has been decomposed in cardholder and non-cardholder .we will provide the analysis based on age, family size, education, family earners and consumption to income ratio.

Table 1: Sample Age Structure

Age of Total Sample Household Head	**Frequency**	**Percentage**
≥ 40	70	35 %
41 to 60	94	47%
≤ 61	36	18%
Total	200	100%
Age of Cardholder HH Head		
≥ 30	11	11%
31 to 40	19	19.5%
41 to 50	21	22%
51 to 60	32	33%
≤ 61	14 (Max Aged 75)	14.5%
Total	97	100%
Age of condition holder HH head		
≥ 30	18	17.8%
31 to 40	15	14.8%
41 to 50	35	34.6%
51 to 60	13	12.8%
≤ 61	20	20%
Total	**101**	**100%**

The statistic of age wise sample data show that 47% respondent ages are between 41 to 60 years. And 18% respondent age is greater than 61 years. Further the age of cardholder household head show that 43% Sehat card receive to those family head which age between 31 to 50 years, 47% cardholders ages is above 50 years while less than 30 age family head respondents are low % to receive card. While 32.6% are those respondents who were condition holder their ages were less than 40 and 34.6% condition holder ages were between 41 to 50 years. While 32.8% condition holder ages were above 50 years. The overall table shows that above 40 years aged families head are condition holder and most of them were hold the Sehat card.

Table 2: Sample Family Size

Total sample Family Members	Frequency	Percentage
≥ 4	19	9.5%
5 to 6	96	48%
7 to 8	45	22.5%
≤ 9	40	20%
Total	200	100%
Cardholders‟ family members		
≥ 4	13	14%
5 to 6	47	49%
7 to 8	25	26%
≤ 9	11	11%
Total	97	100%
Condition Holder Family members		
≥ 4	47	46.5%
5 to 6	29	29%
7 to 8	15	15%
≤ 9	9	9.5%
Total	101	100%

The Table 2 statistics shows that the average family size is 5. The maximum size of family is 11 while the minimum size is 3. Further shows that 49% cardholder family size is between 5 to 6 and 26% family size is between 7 to 8 while 14% cardholder family size is less than 4 and the 11% cardholder‟s family size is more than 9 members. The average family size of cardholders is 4 members, and the maximum size of family is 8 members. The 47% condition holders‟ family size are less than 4 while 46.5% condition holder family size as 5 to 6 and 24.5% condition holder family size are above 6 members. The overall data shows that less than 4 members size of family who was condition holder but not receive Sehat card was 32% which show inefficiency in family member‟s ratio while a family size greater than 9 members were allocate Sehat card efficiently. For the present study it means that single Sehat card must cater to the health needs of eight people per family making it 720,000 PKR per Sehat card per Anum.

Table 3: Education level of the Household head

Education level of the household head	Frequency	Percentage
No education	84	42%
Middle	27	13.5%
Metric	14	7%
Bachelor	31	16.5%
Master	10	5%
Total	200	100%

Source: Field survey

The education level was poor in study sample with about 42% respondents having never been to school as can be seen from table 3. These low education levels of cardholder have implication for the SSP especially about the usage of Sehat card and awareness of Sehat card receiving. For this different awareness creating strategies are needed to be designed for educated and uneducated population respectively.

Table 4: Occupation of the family

Occupation	Frequency	Percentage
Landowners	38	19%
Farmer	32	16%
Livestock	21	10.5%
Business	12	6%
Labor	48	24%
Gov. Employees	23	11.5%
Overseas	10	5%
Other	16	8%
Total	200	100%

Source: Field survey

A population occupational composition is good reflector of its economic standing. The table show that majority of peoples of this study belong to working sector which are 24% while the landowners and farmers are 35%.

Table 5: Income of the sample family

Income in Thousand	Frequency	Percentage
Less than 20	96	48
21 to 30	36	18
31 to 45	35	17.5
46 to 60	21	10.5
Greater than 61	12	6
Total	200	100%

Source: Field survey

The family budget is main source of financing, but enough proportion of the health cost is paid for by household saving, loan and even selling of assets. For health using saving or assets can

throw a household further deep into poverty and as many studies in Pakistan show health cost is major source of keeping household caught into poverty trap. This study table 4 shows that 48% family‟s income is less than 20 thousand and 6 percent family income is more than 60 thousand. In overall sample of the family‟s average monthly expenditure of per family as 27500 PKR while health cost per family as 2600 PKR in their total expenditure. Given the ever increase cost of health care including consolations, diagnostics and medicines ,there is hardly a scope for getting good quality medical help with such low-level income family.

Table 6: Non-Cardholders Family Income

Income in Thousand	Frequency	Percentage
≥ 20	27	26%
21 to 35	23	22%
36 to 50	18	18%
51 to 65	10	10%
Greater than 65	25	24%
Total	103	100

Table show that 34% family income is more than 51 thousand per month while 40% family income is 21 to 50 thousand. Further statistic shows that the average income each non card holder families 49000 PKR and the average earning members in each family is two.

Table 7: Cardholders Family Income and Earnings ratio

Income in Thousand	Frequency	Percentage	One Member One Earner in family (Frequency)	Two Member Two Earner in family (Frequency)	Three Three Earner in family (Frequency)	Four Four Earner in family (Frequency)
≥ 10	24	26%	18	4	1	1
11 to 20	48	49%	10	32	6	0
21 to 30	11	11%	1	3	6	1
31 to 40	7	7%	0	2	2	3
≤ 41	7	7%	0	2	4	1
Total	97	100%	29	41	19	6

Table 7 show that less than 10 thousand monthly income families are 26% where each family 75% earner member is one. The 49% card-holders‟ families‟ monthly income between 11 to 20 thousand PKR where 66% of this family‟s earner is two- and 21%-member earner is one. While 11% family‟s income is 21 to 30 range where 6 families earner member is three out of 11 families and 7% cardholders‟ family‟s monthly income is more than 40 thousand where 57% each family earner members is four. Data conclude that 49% low level families received Sehat card. It mean that Sehat card allocation be the right direction.

Assets Possession

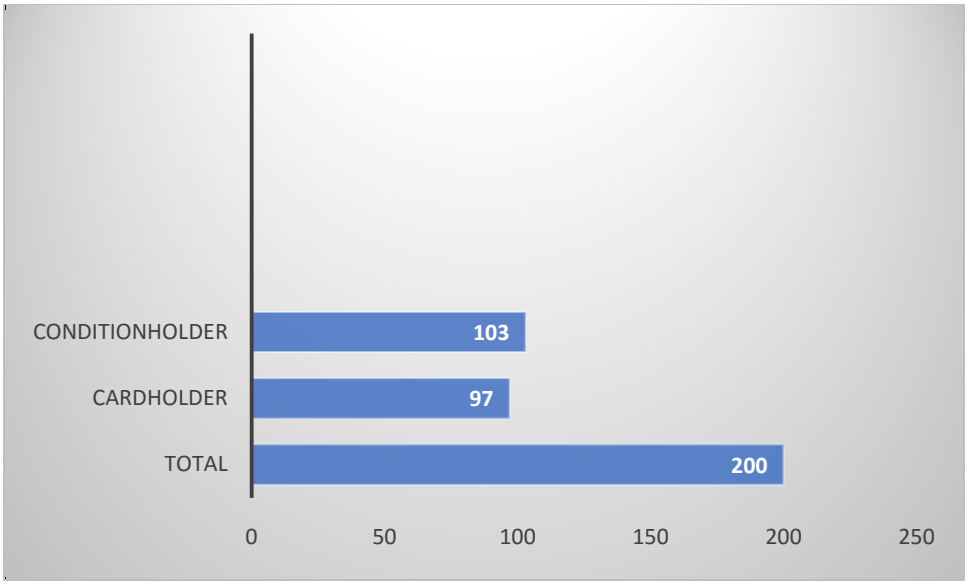
Possession different assets are not only an indicator of a family economic condition but also define the way they can access health facilities and related information. According to the data 93 families which have no livestock, and 69 families have one livestock the livestock are mostly present in cow nature. In total 200 families survey data there are 101 families which have no vehicles in home while 66 families who are afford motorcycle in home the rest of other afford car or other vehicles. The data further show that there are 55 families who have bank accounts while in 18 families where one disable person present. Further cardholder assets possession show (Appendix 2) that about 44% cardholders has own home, 10% are rent home and 46% are live in other home. The Data also show that 24% families which is cardholders have own house but no livestock while 32% cardholders‟ families have lived in rent/other houses and have livestock.

The overall descriptive statistic shows that there were most respondents belong to Labor sector which were mostly illiterate .further the families who individual has earn less than 10,000 PKR per month were hold Sehat card while non-card holder was mostly those whose income is more than 10,000PKR per month. Thus, this shows that the allocation of the card was efficiently. The next objective will be cover in next section.

4.2: Key Statistics of Sehat Sahulat Program in Sample Study

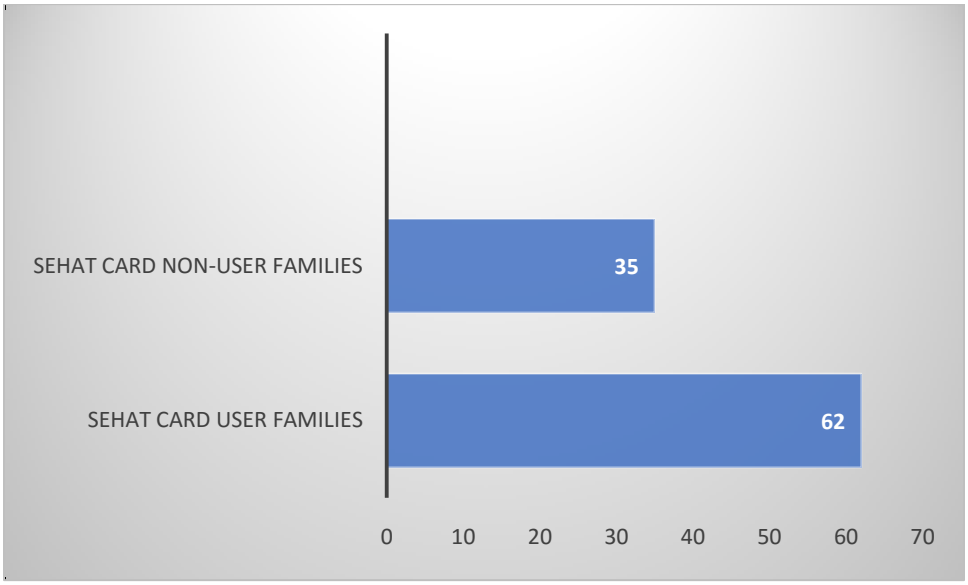
First, we will see how many of them was cardholders and condition holder, then we will examine the Sehat card user and non-user efficiency .After that we will see the different factor comparison and then through focus group discussion (FDGs) find out the hurdles which not proper utilize the Sehat card amount. We can see that 97 families were Sehat cardholder, and 103 families was condition holder of total sample population. Hence, 74 families out of 97 families hold Sehat Sahulat program condition and receive Sehat Card and rest of other was not condition holder but receive Sehat card.

Figure 1: Sehat Card Distribution



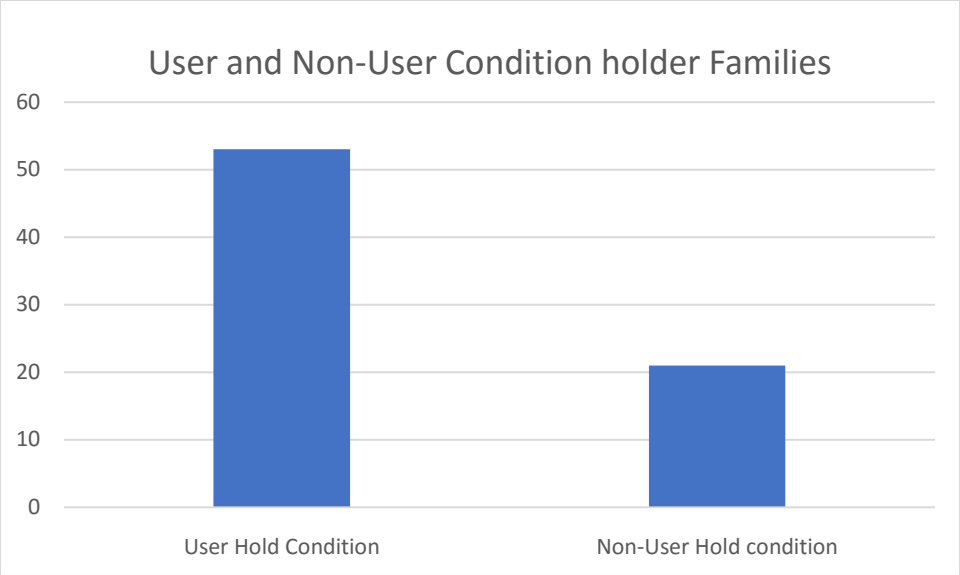
Source: Field Survey

Figure 2: Sehat Card User and Non-User Families



We are the view that about 70% the condition holder was receiving Sehat card. But still there were some families where Sehat card does not receive. This might be due to various reasons which we discuss in focus group discussion section.

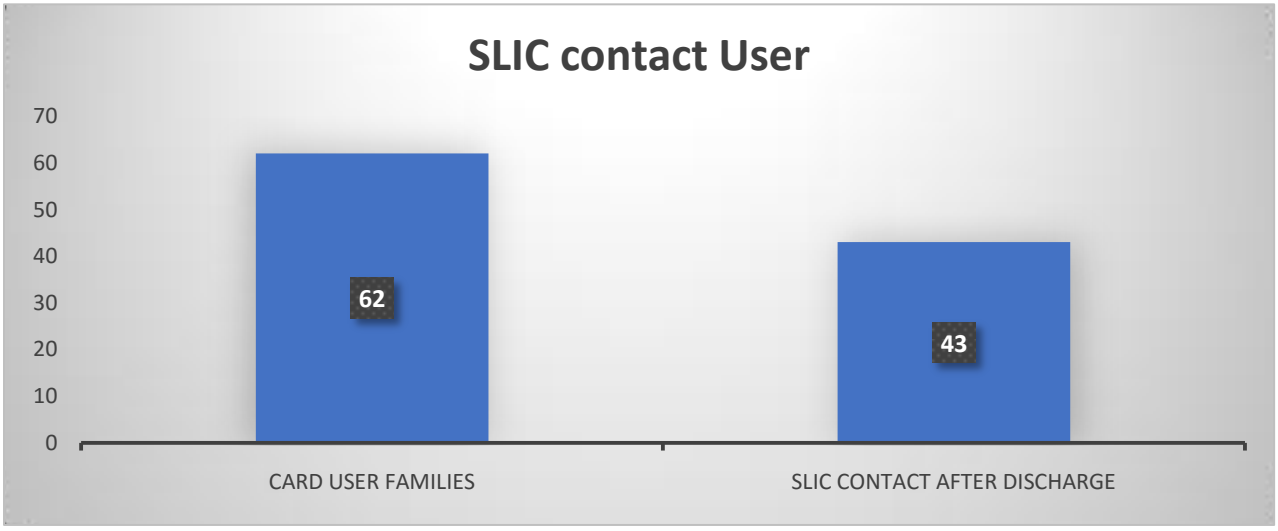
Figure 3: User and Non-User Condition Holder Families



Source: Field Survey

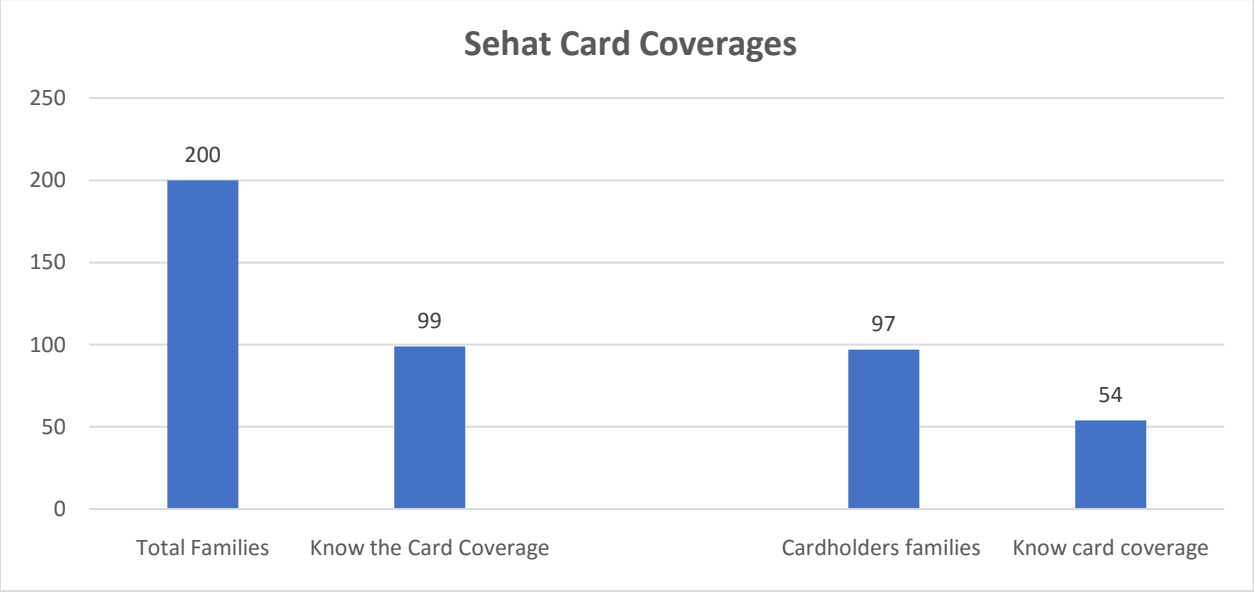
The Figure 2 explain that out of 97 cardholder families there were 62 families use Sehat card while 35 families are not used Sehat card. In figure 3 show that 53 user families are hold Sehat Sahulat condition while 21 non-user families were hold SSP condition. To address the second objective of this study, this finding shows that there were more than 50% families not user of Sehat card but there is lack of some factor such as beneficiary was unknown the card using and the other factors Sehat card allocation where the Sehat card does not reach to deserving person this show the inefficiency of allocation and card utilization.

Figure 4: SLIC contact User



According to the SSP official the card user patient after discharge the SLIC help desk contact to the patient for the confirmation of his treatment. In this study Figure 4 show that 43 families claimed that there is no contact SLIC help desk after treatment. While in appendix 4 show that there are 21 non-card user families do not know card benefits, they visit hospital for treatment (the treatment which will be include in SSP) but the lack of awareness they do not utilize card while 14 families was no need to visit hospital for operation treatment. While the card user 58 families use Sehat card for operation treatment. Thus, the finding show that the card utilization is average good there is show inefficiency on awareness which need before the program starting.

Figure 5: Sehat Card Coverage



Source: Field Survey

Beneficiary to know the coverage of the Sehat card is average best there are 54 families out of 97 families know the Sehat card coverage. But majority of families unaware to the procedure involved such as how to use the card and how to check the remaining amount in a Sehat Card .In Appendix 3, show that 29 families know that how much amount spend in card last year, only few families who are educated are knew that the Sehat card can only be used for free hospitalization and free medication coverage at selected empanelled hospitals. Further the data report show that education level is directly related to Sehat card information (Coverage) because the number of cardholders families which are illiterate 52 families; there are 33 families which do not know Sehat card use and its benefits. While the 13 families which education level is above metric, there is one family who are not know Sehat card benefits and procedure.

4.3: Comparsion of SSP Factors

The second objective of this study to find out the sehat card amount effieicent utilization.The SSP included services provided has utilize efficently or not for this following factors show whather the program was efficent utilize or not.

- Compare Hosptal visits with Sehat card and without sehat card:

The study show that the Card User avergae visit to hospital is about two times while eight times visits without card in last three year.The visits in hospital 90% visits for medicences purpose.

- Card Maximum Visit and Maximum Amount of card Spend:

In the sehat card govenmrnt insurance per card amount is 720,000 PKR for one year.In this study find out that the average spend amount of the card per family is 45,000 PKR in last three years and the maximum visits to hospital is 6 times further data show that the maximum amount spend of the card is 600,000 PKR.

- Total sample families and visit hospital without card:

The total 200 families , average visit to hosiptal is about 9 times in last year. There 8 times visit for medicencs purpose and one time visit for operation treatment.

- Comparsion of SSP Treatment Pakage rate and Public hospital Pakage rate:

According to the SSP official the SSP treatment cost is less than the other public hospitals .There is a proper process to empanelled hospitals. The SLIC give a fixed treatment rate to hospitals which are less than public hospitals.
According to services provider or public hospital doctors, there are not a treatment fixed rate in public hospitals while in SSP treatment rates are fixed (Examples Like a normal delivery rate in public hospitals is 800 PKR and C-Section rate is 12000PKR .In other side SSP rate are 10000PKR which are fixed for both delivery). The purpose of this statement that SSP treatment rates are in average and mostly less than public hospitals.

- Cardholder Monthly expenditure:

cardholder average monthly expenditure is 20500 PKR and their monthly average health expenditure is 2500 PKR of each family. The beneficiers told that the treteray treatment are some times in life while the headach of poor is regular mediciences because in pakistan mediciens prices are increase day by day which are not affordable by the poor people.So this finding show that sehat card was not utilize effiecently.

The overall above comaparsion factors result show that most of time people visit hospitalfor primaary treatment where data show that 90% people visit hospital for mediciecne purpose.the average vist hospital was 9 time per year where only one time visit for tretiotery

treatment.further the total amount of sehat card has 720,000 where the data show average cardholder amount spent of sehat card was 45,000 PKR.while the pakages rates of different treatment was mostly same or less than public hospitals.Thus conclude of the finding that the sehat card amount utilization was not effiecently the reason of this ineffiecency to not included OPD services or mediciences offers.

4.4: Finding of Focus Group Discussions

Qualitative data was used to triangulate the result achieved in quantities data part. A total five Focus Group Discussions were conducted during the field work which we explain in above 3.4.2 section. The finding from the FGDs with beneficiaries and non-beneficiaries showed that the overall awareness about SSP and its benefits was low. In above table 1 show the 30% Sehat card allocation inefficiency, the reason of that had low knowledge or was just unaware of the details regarding the SSP.

- The card distribution is average best, but beneficiaries receive Sehat card through union council Nazism which does not give proper guides about Card using procedure.
- Many thought that they can avail free medication and OPD services a well but some of respondent went to the empanelled hospitals but returned unsatisfied because they did not get OPD treatment so next time they not used card.
- Some of the respondents were really irate and thought tehsil office and Sehat Sahulat Program staff or clinics staff were bad.

The FGD further finds that people were mostly dependent on Local area self-helper (LASHs) and past users for information and gaudiness. The service provider told the Card utilization will be increase with depends on card holding tenure. So, the past user is an important source of information for other cardholders regarding utilization of the Sehat Sahulat Program facilities. A bad experience of past user could thus damage the reputation of an empanelled hospital, medical doctors as well as on the whole Sehat Sahulat Program.

The Focus Group Discussions showed that the main issue of non-users is the lack of awareness and misguides about Sehat card benefits. As just few Sehat card beneficiaries knew just the exact benefits of the program. Some are those people who avoid Sehat card treatment because they told ,for card treatment you will be wait for his treatment number in hospital for long days. This point claimed the service provider and told that the Type A or B hospitals are in limited, we provided the SSP services mostly in all those hospitals where the SSP included treatment are available, but unfortunately some cities where only one or two type A or B hospitals so here is large patient come for treatment that why patient are waiting for his treatment appointment, some beneficiary knew about card benefits have fully utilize the card and give a proper guidance to non-users.

4.4.1: Experience and satisfaction with service provider of Sehat Sahulat Program

Once the patient is going to hospital the attitude of the healthcare provider matters a lot for the satisfaction level and future utilization of the service. We would deal with the experience and satisfaction level of patient with both kind of services provider medical (Such as Doctors or Hospital staff) and non-medical (such as State Life Insurance Corporations recipient staff).

- State Life Insurance Corporations (SLIC): In FGDs asked to card user as SLIC recipient contact you after discharge, as can be seen from figure 4, the State Life Insurance Corporations recipient performance was not bad. The service provider told that State Life Insurance Corporations recipient could have played a better role but unfortunately the beneficiaries are mostly uneducated or unaware the card procedure, most of times they not pick the conformation call and not fill the feedback preformed. The educated and sensitizing cardholder attain a call a give a proper explanation about his treatment and give a good feedback.
- Satisfaction level about hospital treatment: The satisfaction level with the hospital treatment was generally very highly satisfy in this study because there is total 62 families which use card and all families are happy that there is no payment give for medicines, for lab tests, for operation and for admission of admitted.

In the FGDs further discussion show that in certain it was found out the hospitals staff refused that their diseases were not enlisted in the SSP. The hospitals staff told this claimed that they often face such frustrated patients due to lack of awareness. He further said individuals regularly requested free OPD with free medicine, which isn't covered under the SSP. When we refused to do so they think we are not entertaining them well and start cursing us. We try to entertain them as much as we can, but it is still very difficult to refuse anything which is not in their entitlement we know these frustrated would take a wrong impression and the cost us our reputation.

The overall FGD finally reached this result that Sehat card allocation was efficiently the SSP staff worked efficiently but here is rural area most people were uneducated that why not know about the use of Sehat card. Further discussion result show that the people were unsatisfied about Sehat card services it means card utilization were not efficient.

4.5: Estimation of Sehat Sahulat program efficiency

Economic analysis consists of estimation of model for efficiency through mix method approach by using Logistic and linear regression model. To identify the allocation efficiency of SSP, we use logistic model where dependent model is dummy while the other model used simple linear regression model where dependent variable is Card amount spent to find out the Card amount efficient utilization.

Equation 4.1: Here the dependent variables are a Cardholder, taking one if respondent hold a card, 0 otherwise. Cardholder variable regress on income, disability, card amount spent and conditions .To achieve the study objective we assume that if a person income is less than SSP condition and hold Sehat card and if income is more than SSP condition and not hold Sehat card than program is efficient otherwise inefficient. Further the cardholder and disability relation positive were for efficiency

Another equation 4.2: which shows the spent amount by a card holder? Here, we aim to see who has used the card and who are not using the card. Here, we assume that higher is the use of the card, higher is the benefit of the card holder, hence higher is efficiency. In equation 3.2 the independent variables are income, family size, card amount knows, card coverage, education and condition holding.

Cardholder (Yes/No) $=\alpha+\beta_1$INC$+\beta_2$DIS$+\beta_3$CASPENT$+\beta_4$CON $+\mu$ _____Eq 4.1

CASPENT$=\alpha+\beta_1$INC$+\beta_2$FSIZE$+\beta_3$CAK$+\beta_4$CCOV$+\beta_5$EDU$+\beta_6$CON$+\ \mu$ _____Eq 4.2

Were,

β_i Represent the estimated coefficients and μ is the random error term of the model.

There are some dummy variables which are.

Cardholder: Respondent receive Sehat Sahulat Program card (Yes/No).

Condition (CON): The respondent is holding the SSP condition (Yes/No).

Disability (DIS): The respondent family member is disabling (Yes/No).

Card coverage (CCOV): The respondent knows the total Card coverage (Yes/No).

Know Card Amount (KCA): Do respondents know that how much amount is in his card/account (Yes/No).

And other are continues variables.

Income (INC): Respondent monthly total income

Education (EDU): Family head education attain years

Family size (FSIZE): How many members in family

Card amount spent (CASPENT): Cardholder how much amount spent in card account.

4.6: Economic Theory or Estimated Sign

In Equation 4.1:

- Income: The expected sign is negative as a person who will have high income, is less likely to hold card. More income show, that a person is not poor. If such person holds a card, then it is an indication of in efficiency.
- Condition hold: theory suggests that there is positive relationship between cardholder and SSP condition holder. If person daily wages are less than 2$ he/she hold the SSP condition and hold Sehat card .so the criterion of program is full filing its mean program allocation is efficient.
- Disability: According to Sehat cardholder eligibility the disabled person is hold the Sehat card. So, the economic theory suggests a positive sign is estimated for coefficient.
- Card amount spent: Theory suggests if the Sehat card allocation was efficient than cardholders should be spent card Sehat card amount properly. But it also come inefficiency of the program if person does not know the usage. For usage there is need to card usage easily step.

In equation 4.2:

- Card Coverage: The expected relationship between card amount spent and card coverage is positive. Because the increase in card coverage will be also increase the card amount spending.
- Know Card Amount: The theory suggests that there is positive relationship between know card amount and card amount spent because if person know card amount than they will used the card amount on his diseases (which include in SSP).
- Education: The economic theory expects that there is positive relationship between education and card amount spent because if person is educated then they will know card coverage and also know card used process.
- Family size: Also has positive relation because a large family person more time used Sehat card.

4.7: Model Result

The empirical finding of the data by using regression analysis is following.

Table 8: Correlation Matrixes

Variables	CH	EDU	INC	EGS	BA	DIS	FSIZE	HS	HHME	CON	CAS
CH	1.0	-.25**	-.29**	.65**	-.33**	.276**	.00	.29**	-.29**	.44**	.34**
EDU	-.25**	1.0	.39**	-.41**	.55**	.07	-.22**	-.50**	.43**	-.62**	.13
I	-.29**	.39**	1.0	-.35**	.52**	-.12	.11	-.30**	.77**	-.42**	-.09
EGS	.65**	-.41**	-.35**	1.0	-.44**	.26**	.02	.30**	-.40**	.53**	.17*
BA	-.33**	.55**	.52**	-.44**	1.0	-.15**	.99**	-.41**	.99**	-.51**	-.15*
D	.27**	-.07	-.12	.26**	-.15*	1.0	.08	.06	-.04	.26**	.24**
FS	.00	-.22**	.11	-.02	.99**	.08	1.0	.19**	.99**	.19**	-.12
HS	.24**	-.50**	-.30**	.30**	-.41**	-.06	.19**	1.0	-.26**	.60**	.05
ME	-.29**	.43**	.77**	-.40**	.99**	-.04**	.99**	-.26**	1.0	-.44**	-.05
C	.44**	-.62**	-.42**	.53**	-.53**	.26**	.19**	.60**	-.44**	1.0	.16*
CAS	.34**	.13	-.09	.17*	-.15*	.24**	-.12	.05	-.05	.16*	1.0

** Show correlation is significant at the 0.01 level (1-tailed),

* Show correlation is significant at the 0.05 level (2-tailed).

Table 9: Logistic Regression Result

Cardholder	Description	LOGISTIC MODEL
INC	*Family income per Month*	{-0.000} (0.000) 0.004*
DIS	*If disable= 1 and zero otherwise*	{1.849} (1.101) 0.093**
CASPENT	*Each family per year how much Sehat card amount spent*	{0.000} (0.001) 0.003*
CON	*If condition* *holder=1 otherwise zero*	{1.124} (0.408) 0.006*
_cons		{-0.080} (0.492) 0.871**
Observation		200
Pseudo R2		0.59

*Note: The dependent variable Cardholder which is dummy variable. Value 1 if the respondent holder Sehat Card and zero otherwise. Coefficients in bracket, Standard errors in parentheses are robust while significance indicated by number of stars consigned to it as; ** $p < 0.1$, * $p < 0.05$.*

Source: STATA Software

Table 10: Linear Regression Result

CASPENT	Description	OLS Method
_cons		{-4.08} (2.58) 0.05*
INC	Family Income per month	{-0.045} (0.182) 0.800**
FSIZE	Respondent Family size	{-3.18} (3.05) 0.32**
CAK	If respondent Know card amount =1 ,otherwise zero	{7.83} (2.55) 0.00*
CCOV	If respondent know card coverage= 1 ,otherwise zero	{7.07} (2.23) 0.000
EDU	The family head education level	{5.02} (1.24) 0.00
CON	If condition holder =1 ,otherwise zero	{7.95} (2.16) 0.000

*Note: The dependent variable Card amount spent denoted by CASPENT. Coefficients in bracket, Standard errors in parentheses are robust while significance indicated by number of stars consigned to it as; ** p < 0.1, * p < 0.05. Source: EViews Software*

After assigning values to co-efficient of the variables of the logistic and linear regression, the above equation can be rewritten as under.

CARDHOLDER = -0.080 -0.000INC + 1.849DIS + 0.000CASPENT + 1.124CON + u

CASPENT = -0.4.08 - 0.045INC -3.18FSIZE + 7.83CAK + 7.07CCOV + 5.02EDU + 7.95CON + u

4.8 INTERPRETATION

First, we check estimated correlation Matrix; To find out that either the variables which we used in this study was interlinked in each other or not. Based on the results of the correlation matrix in table 4.7.1;it can be observed that the variable Cardholder(CH) has significant positive correlation with enrolled any government scheme(EGS),disability(DIS), Condition-holder (CON) and Card amount spend(CAS); and significant negative correlation with education (Edu) ,Income (INC) ,bank account(BA)and monthly expenditure(HHME). The variable income has strong positive correlation with education, bank account and monthly expenditure. Further condition-holder has significant correlation in income (.44**) and weak positive correlation with disability and card amount spend. While a strong negative correlation with condition-holder and education as (-0.66**).

Secondly, using Logistic regression in table 4.7.2, where the result shows that the coefficients which are in fact the corresponding values of the bi (beta) of all the independent variables that capture the change in the dependent variable whenever a change occurs in the explanatory variables .The value b1 is 0.002 which show that the respondents income is negatively affecting the cardholding for efficient allocation of the Sehat card. It is established that there is increase in respondent‟s income (PKR per month) will decrease the cardholding ratio. The result further reveals their positive and significantly relationship between beneficiary card amount spent (CASPENT) and cardholder .The condition holder of SSP (CON) has significantly positive relation to depend variable .result show that if the condition holder ratio increases by one percent, then the cardholding ratio for efficient allocation will increase by 1.12 percent. The result also shows that disability (DIS) has no effect on their card allocation in tehsil Takht-Bhai, Mardan. Further log likelihood value is -54.65 and R-square value is 0.59 which mean model is strongly fitted.

Thirdly run simple linear regression in EViews software in table 4.7.3, where income and family size have negative and insignificant relation to card amount spent for efficient utilization of Sehat card amount. The study results further reveal that card amount know (CAK), card coverage (CCOV), education (EDU) and condition hold (CON) has positive and highly significant relation to the card amount spent. Result show that if the card amount knows, card coverage and education year was increase by one percent then the card amount spent for efficient card utilization will increase by more than five percent in tehsil Takht-Bhai, Mardan.

CHAPTER 5: CONCLUSION AND RECOMMNEDATION

Health plays a key role in determining the human capital. Better health improves the efficiency and the productivity of the labor force, ultimately contributes to economic growth, and leads to human welfare, *(Akram & Jahangir 2007).* There are two schemes of treatments, one is preventive treatment, to prevent a disease before it happens to a person, and other is curative treatment where a person gets a disease and then treats him. For curative treatment we have hospitals, pharmacies. However, due to demand and supply in a treatment there is a gap, and this gap is filled by private sector but the issue with private sector is that poor people cannot bear its expenses. Hence, they suffer as better health facility is not available to them. Thus, to attain better, more skillful, efficient, and productive human capital resources, governments subsidies the health care facilities for its people.

One of these subsidize programs is Sehat Sahulat Program which Pakistan initiated. The question is whether the provision of cards will be or efficient or not. For this reason, this research studied the aspects of allocation of Sehat card and card amount utilization of Sehat Sahulat program in tehsil Takht Bhai of district Mardan. The data was collected through questionnaire and Focus group discussions and then collected data was analyzed through statistical techniques. The study found from the descriptive analysis that in total sample of study around 49% respondents were cardholders and 51% were condition holders. Further, there were 76% cardholder hold the Sehat Sahulat program conditions the rest of others not. This shows that there was no major difference in the trends between the Sehat card allocation and Sehat Sahulat program condition holding.

The study also revealed that 60% non-users were not aware of the Card use process and the card benefits. Because almost all the cardholders are illiterate or having low education. As there is no awareness campaign by the government so this causes problems for cardholders. Likewise, many being on daily wages finds it difficult to go too far for treatment as it will cost them the day‟s income. Furthermore, user family‟s card ratio is 63% but their maximum visit to hospital for operation treatment is 3 and the average visit is 2 where their average cost in treatment is 45000PKR and the Card amount is 720,000 PKR. From the economic analysis the Condition hold (CON) and card amount spent (CASPENT) has positively and significantly related to the cardholder while income has significantly and negative related and the disability(DIS) are insignificant and hence no impact of the cardholding. Another aspect of the study, card amount knows (CAK), card coverage (CCOV), education (EDU) and condition hold (CON) has positive and highly significant relation to the card amount spent. Similarly, income and family size have negative and insignificant relation to card amount spent for efficient utilization of Sehat card amount. Thus, any step towards the Sehat Sahulat program of these factors will positively affect the efficient allocation and card amount efficient utilization of the SSP in the study area. In the overall study show that Sehat card allocation was average best and the Sehat card amount utilization are inefficient.

Recommendation

Based on the findings from the interviews conducted with service providers, doctors and focus group discussion held with the Sehat Sahulat Program beneficiaries and non-beneficiaries, the study recommends the following suggestions.

- The people of the study area are unaware of the Sehat Sahulat program benefits. Hence government needs to educate the people through easy channels.
- Almost every beneficiary wanted to include free OPD services and medication in Sehat Sahulat program. The State Life Insurance Corporation official, however, opposed the free OPD idea and thought it will become a moral hazard.
- Every successful policy requires a highly motivated team with adequate resources and knowledge. Thus, for an efficient and effective implementation of SSP policy, the need is to strengthen the Sehat Sahulat Program institutional structure at the local level.
- During field visits the beneficiaries were complaining that there is no proper regulatory system on Beneficiary Enrollment Centers. Government should direct the concerned departments to frame the rules and regulations i.e., proper guidance to beneficiary at specific time should be available to increase the efficiency of the Sehat Sahulat program.
- It was observed during study that some beneficiaries are receive not for sale medicines in treatment time .It is strongly recommended that Gov. must interfere by the directing concerned department to check their input process and ban them who distributed not for sale medicine in SSP program.

Overview of current Social Health Protection Initiatives

In the 2013 elections, Pakistan‟s two mainstream political parties announced launching of national health insurance programs in their election manifestoes, and since then the federal and three provincial governments have launched social health protection programs in their constituencies. The Prime Minister‟s National Health Program (PMNHP), which is also now labeled Sehat Sahulat Program (SSP), and Sehat Sahulat Program (SSP) were launched by the federal and Khyber Pakhtunkhwa governments respectively in 2015. A year later, the provincial government of Gilgit-Baltistan (GB) also started its Social Health Protection Initiative (SHPI) in 2016.

In total, these programs have been expanded to 65 districts across the country and have enrolled about 5.7 million households (approx. 29 million individuals). Presently, all the three initiatives provide coverage for treatments that require hospital admission. The benefits package for each social protection program includes secondary care up to a limit which differs by each initiative. Federal and KP‟s SSPs have also defined the list of priority diseases and services to be covered under tertiary care, while SHPI does not currently cover tertiary care. All three programs also provide additional benefits, such as medication coverage and transportation expenses in varying

amounts, while SSP also provides a small wage replacement benefit. Funding for the social protection initiatives comes from a mix of federal, provincial and donor revenues, and none of the three initiatives includes any form of copayment from patients. Federal SSP is entirely funded by public funds; so far, premium for secondary care has been paid by the provincial governments, and federal government has been paying the premium for priority diseases. Lately, a decision has been made that all the premium amount will be paid by provincial governments.

Federal and KP‟s SSPs have contracted with State Life insurance company, while the SHPI has contracted with Aga Khan Development Network for patient enrolment and hospital empanelment. The beneficiaries of the three programs can access services from a mix of public and private sector facilities empanelled with the insurance companies. The insurance companies have negotiated treatment package rates with individual hospitals and reimburse checks to the hospitals once the services are availed by program beneficiaries. Other than these larger initiatives, poor populations also have access to Zakat and „Bait ul mal‟ funds to pay for health care. „Bait ul mal‟ is a publically funded social protection initiative created for the welfare of vulnerable populations such as the disabled, orphans and women. Zakat, on the other hand, is 2.5% tax paid by Muslims on their annual savings, which is collected (centrally) and allocated by the Ministry of Religious Affairs for each province. Health care is one of 6 programs administered under the Zakat fund. For both Zakat and „Bait ul mal‟, patients need to apply to receive payment for their treatment, which must be provided at a government hospital or selected hospitals for Zakat and NGOs for „Bait ul mal‟ assistance.

- **Achievements and Visions**

Pakistan has achieved significant progress in health financing in provinces through allocating and spending increasing amount of budget to the health sector and establishing subsidized programs such as federal and KP‟s SSPs and SHPI. The fully subsidized programs aim to mobilize/allocate government financial resources to purchase medical services from both public and private providers, targeting the poor and catastrophic conditions. It can be viewed as an insurance mechanism but the premium contribution is fully subsidized by the government, similar to, for example, the „UC scheme‟ in Thailand, and the „Ayushman Bharat scheme‟ in India. The poor have free access to health care – with a ceiling – mainly in the inpatient care, and can choose among public and private providers. Purchasing mechanism and competition among public and private providers are expected to improve health system performance.

- **Harmonization**

If a national entity plays a role of technical lead in the development and dissemination of guidelines, protocols, manuals for the health financing system, it can support provincial governments and improve the overall efficiency and equity of the health system. Design and implementation of different health financing arrangements across provinces is costly, and instead, sharing a core value and essential elements nationwide would be efficient and equitable

(considering the mobility of people across provinces). Each province can take into account or adjust the key elements of health financing system, which are provided by a national entity, in the design and implementation of its own strategy. They do not have to re-invent the wheel and can avoid a potential wasteful competition, while also incurring equity across various parts of the country.

- **Coordination with Primary Care**

It is logical for federal and KP‟s SSPs and SHPI to start the program with targeting catastrophic conditions and hospitalization, considering budget constraints of the government. However, inpatient based coverage has the potential to generate over-hospitalization/specialization at the expense of primary care. Enrolled beneficiaries can prefer hospital-based care because outpatient or primary care services are not covered. By-passing of primary care will result in inefficiency in service delivery and harm the financial sustainability of the health system.

There can be several policy options for the coordination between primary and hospital care. Federal and KP‟s SSPs and SHPI can extend the benefits coverage to outpatient and primary care (for both public and private providers), which requests more funding. For example, government can consider priority between extending the benefit coverage of the subsidized SHP schemes to outpatient care and extending the current population coverage to the vulnerable or near poor (or extending the current inpatient benefits to cover more conditions). Alternatively, government can give priority to the public primary care and require the beneficiaries to register in public health centers (e.g., Basic Health Units) and mandate a referral letter to be eligible for hospital benefits. In this scenario, the beneficiaries of the SHP programs can use private primary care providers by paying out-of-pocket – if they prefer to – but should get a referral letter from the registered public health center when they want to use the hospital care in the benefits package of the program. This option will strengthen the referral system and primary care in the public sector.

- **Empanelment and Assessment of Provider Performance**

Empanelment of providers and assessment of their performance is an essential role of strategic purchasing. Currently empanelment of hospitals is based on input measures (staffing, beds, equipment, etc.), which has had positive impacts on quality, but should further consider quality of care and patient outcomes. Selective empanelment of providers would be difficult to implement in rural areas where only a limited number of providers are available. Although an adjustment of empanelment criteria may be necessary in rural areas in the short run, how to improve quality of care and capacity of providers in those areas should be considered in the long run.

Governments need to consider whether to rely on contracting with insurance carrier in the long run, from the perspective of political as well as financial sustainability. In most other countries, SHP programs are managed by a public agency specializing in health financing, e.g., Philippine

Health Insurance Corporation, National Health Insurance Authority of Ghana, National Health Insurance Service of Korea, etc. There is a fundamental difference in goals between private insurance and public insurance. For public insurance, surplus is not the most important performance criterion. Rather, financial protection for the enrollees and improvement in service delivery are key performance measures of public insurance. Pakistan needs to balance the pros and cons of different governance arrangements for purchasing and insurance contracting and agree on the future policy direction for contract-out versus direct management of social health protection mechanisms.

- **More Investment in Health**

Pakistan needs to invest more in the health sector to improve financial protection and the health of population. It is good news that health and education are of the highest government priority and SSP has been regarded as a politically important program. Policy priority needs to be realized by increased budget allocation to the health sector. Budget allocation needs to be stable and flexible, taking into account the priorities of the health sector. Increase in the tax on tobacco or other health-related commodities needs to be considered. Earmarking of that tax for the health sector can be an option. Unless finance ministry tries to reduce funding to the health sector, comparable to the increase in budget as a result of earmarking (i.e., no crowding-out effect), dedicated tax can increase the overall funding to the health sector. Even if the earmarked health tax does not substantially increase funding to the health sector, it will contribute to behavioral change and better health of the population.

APPENDIX

Appendix 1: QUESTIONNAIRE

Assalam-o-Alaikum Dear Respondent:

I am student of MPhil Economics at School of Economics, Quaid-i Azam University, and Islamabad. I am conducting a research study regarding "efficiency of Sehat Sahulat Program". In this regard, I am collecting data from people and you are urged to provide the required information and help me in completing my research. Please note that the collected data will be used for research and your confidentiality will not be disclosed. For further details, feel free to contact me or my supervisor via email or phone.

Wassalam,

Hamza Feroz (hamzaferoz095@gmail.com) 03149051244

A. Socio-Economic and Demographic Information of Family

A1. Sr. No.	A2. Relationship to the Family head?	A3. 1. Male 2.Female	A4. Age	A5. Education completed	A6. Type of school attended 1.Private 2.Public	A7. Marital status?	A8. Occupation	A9. Income	A10. Enrolled any Gov. scheme	A11. Bank Acc 1.Yes 2. No	A12. Disability 1.Yes 2.No

B. Assets Information of a Family

B1. Status of House: own/Rent/ other

B2. Total room/size in house: _____

B3. Structure of house: Kacha/Semi-Kacha/Pakha

B4. Number of Livestock: 0/1/2/ other

B5: Nature of livestock:

B6: Cycle/Motorcycle/car/etc:

B7. Monthly Expenditure in PKR:

1) Kitchen (Food related):_____
2) Health:_____
3) Education: _____
4) Utilities
5) Any monthly instalment in loan/committee etc: _____
6) Rent if any
7) Neighborhood (Mosque/Khami/khoshi)
8) Miscellaneous: _____

B8. Amount of loan to other if any:

B9. Amount of loan others have on you if any: _____

C) SEHAT SAHULAT PROGRAM

C1: Did you receive SSP card and when:

C2: In which through/process you receive Sehat card: _____

C3. In last one year, how many time have you used SSP card in following purpose:

i) For medicines: _____
ii) For doctor checkups: _____
iii) For operation: _____
iv) For admit_____
v) Any other

C4. If you are not SSP card holder, in last one year how many time did you visit hospital for following purpose:

i) For medicines: _____
ii) For doctor checkups: _____
iii) For operation: _____
iv) For admit_____

C5. If you are cardholder, did you pay money for below purposes to some one?

i) Payment for Medicines: _____
ii) Payment for lab test: _____
iii) Payment for operation: _____
iv) Payment for Admission in hospital:_____

C6. Do you know the total coverage in your card:
C7. How much of the covered amount did you spend in last one year?

C8. Have SLIC contacted you to take your feedback after treatment;

C9. Do you know that how much amount is in your card/account?

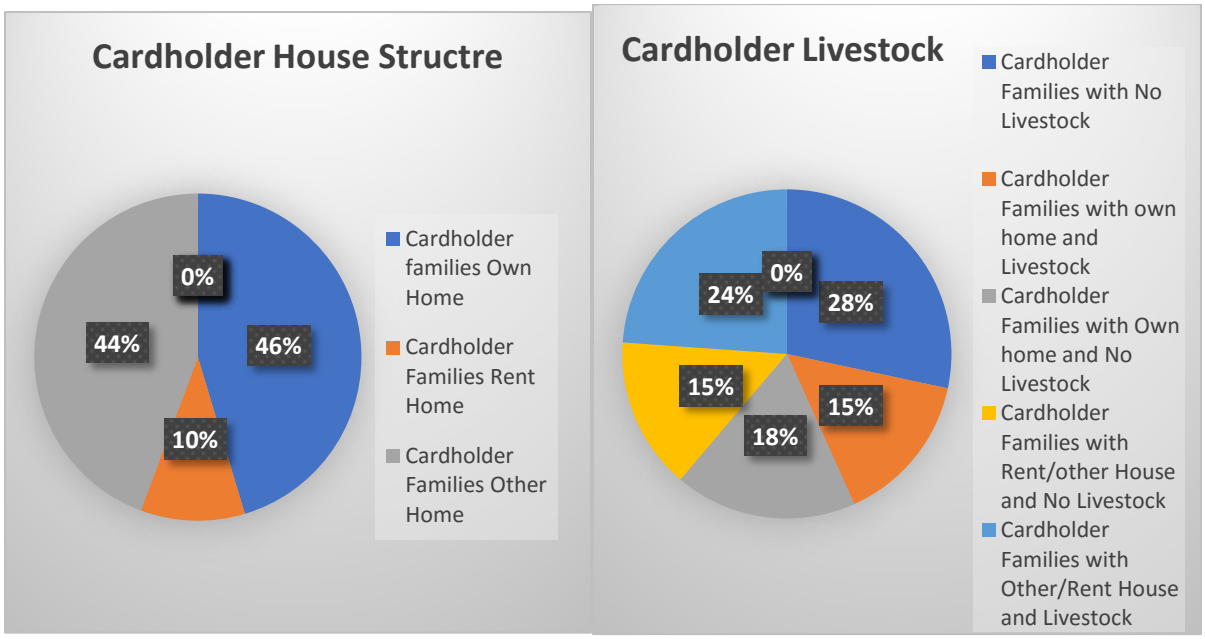
C10. Have you been given transportation charges?

C11. To what extend are you satisfied with the facilities provided through SSP?

i) Satisfied
ii) Dissatisfied
iii) Highly satisfied
iv) Highly dissatisfied

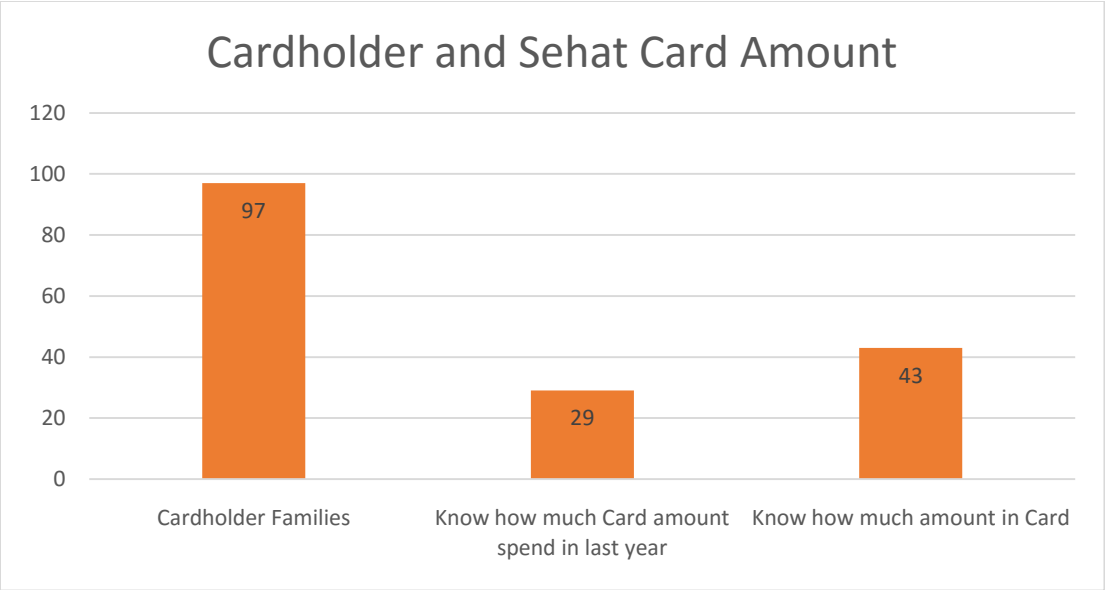
C12. Would you like to give any suggest with regards to SSP and its utilization from any aspect?

Appendix 2: Cardholder Assets Possession

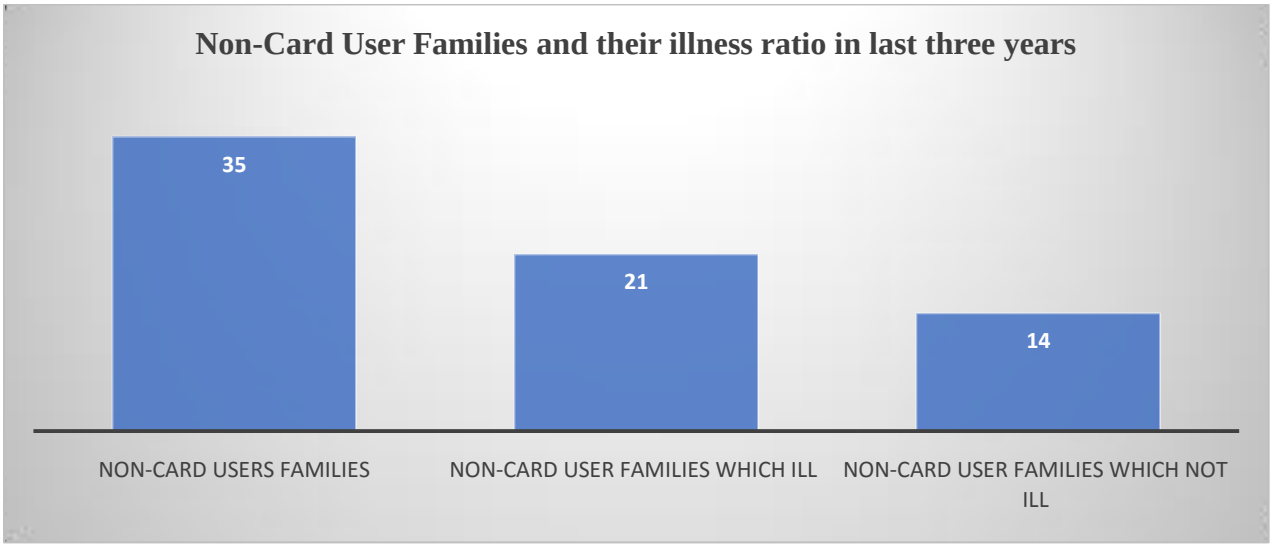


Source: Field survey

Appendix 3: Card Holder and Sehat Card Amount



Appendix 4: Non-Card User Families and their illness ratio in last three years



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