Journal of Social Sciences Research & Policy (JSSRP)

GISSR Global Institute of Social Sciences Research

Evaluating the Sehat Sahulat Card Program: A Study on Social Protection and Health Equity in Khyber Pakhtunkhwa, Pakistan

Qamar Saeed Askari[1], Dr. Shakeel Ahmed[2]

1. M.Phil. Scholar, Department of Social Work, University of Peshawar.
2. Associate Professor, Department of Social Work, University of Peshawar.

How to Cite This Article: Askari, Q, S. & Ahmed, S. (2025). Evaluating the Sehat Sahulat Card Program: A Study on Social Protection and Health Equity in Khyber Pakhtunkhwa, Pakistan. *Journal of Social Sciences Research & Policy. 3 (03), 193-198.*
DOI: https://doi.org/10.71327/jssrp.33.193.198

ISSN: 3006-6557 (Online)
ISSN: 3006-6549 (Print)

Vol. 3, **No.** 3 (2025)
Pages: 193-198

Key Words:
Sehat Sahulat Card, Universal Health Coverage, Low-Income Families, Lady Reading Hospital MTI, Healthcare Access

Corresponding Author:
Qamar Saeed Askari
Email: Askariktk@gmail.com

Abstract: *The study assesses the social protection program of Sehat Sahulat Card (Health Facilitation Card) for low incoming families in Khyber Pakhtunkhwa province of Pakistan. The Sehat Sahulat Card (SSC thereafter) is an initiative created for low-income families and gives free access to healthcare services, especially in Khyber Pakhtunkhwa (KP). By concentrating on the program's accessibility, service quality, and obstacles experienced by recipients, Using T.H. Marshall's Theory of Social Rights & Andersen Behavioral Model of Health Service Framework, this study investigates the efficiency of the SSC program at Lady Reading Hospital (LRH) in Peshawar. In-depth interviews with 30 respondents including patients, patients' attendants, and healthcare professionals were conducted as part of a qualitative study design. The results show that even though the SSC has greatly reduced the financial burden for many low-income families, several issues such as low awareness campaigns, ineffective administrative procedures, a lack of transparency, and insufficient coverage of emergencies and outpatient services hinder their overall success. Based on the publication, the program should be expanded to cover outpatient treatments, transparency and accountability should be improved, awareness campaigns should be strengthened, and strong monitoring and evaluation systems should be established. By overcoming these problems, the SSC may more closely adhere to the principles of Universal Health Coverage (UHC) and provide equitable healthcare access to all marginalized communities.*

Introduction

About half of the world's population suffers from the problem of healthcare expense; over 930 million spent 10% of their earnings on medical treatment, which puts 100 million people into severe financial hardship every year. This problem is not unique to Pakistan. Everyone in Khyber Pakhtunkhwa is entitled to the same advantages and rights under the Sehat card, which is a fundamental human right. The Sehat Sahulat program was introduced in 2015 and offered universal health care to all residents (Shahbaz, Afzal et al., 2023). It offers in door-patient emergency care coverage up to Rs. 10,000,000 with financial

coverage and cost expenses, aiming to lower out-of-pocket costs and makes it easier for families with low incomes in Khyber Pakhtunkhwa to receive high-quality healthcare (Mashhadi, Din, & others, 2022). Research describes the Sehat Card initiative, which provides comprehensive medical care in Khyber Pakhtunkhwa, Pakistan, and emphasizes the need for Universal Health Coverage (UHC) as a solution. It also draws attention to the difficulties in developing plans and allocating resources in order to achieve universal health coverage (Ali et al. 2022). One of the Sustainable Development Goals (SDGs) is Universal Health Coverage (UHC), which aims to guarantee that no one is excluded from necessary health care because they cannot afford it. As a signatory to international human rights commitments and Sustainable Development Goals, Pakistan places a high priority on Universal Health Care (UHC) in its public health system through programs like Sehat Card, which is a major step towards recognizing health as a fundamental right (Khan, Asif et al. 2023).

The Sehat Card initiative is an important step in this regard, since it reflects Pakistan's willingness to recognize healthcare as a fundamental right and its commitment to the SDGs. Furthermore, it is in line with the social justice and human rights ideals of the social work profession. The Pakistani Constitution's Articles 09 and 28 protect fundamental rights, whereas Articles 29 through 40 set forth the "principles of policy." There is no solid evidence to support the notion that Article 38 establishes the foundation for social health protection, as upheld by programs such as the Prime Minister National Health Program (PMNHP) and the Sehat Sahulat Program (SSP). As long as the necessary state institutions are able to implement it, Article 38 is within the scope of policy principles (Nishtar, 2011). The majority of countries have signed a number of agreements since the mid-1900s, demonstrating that access to health care is a basic human right (Chowdhury, Garrett, and others, 2009).

Universal Health Coverage (UHC) linkage with the Sehat Card program in Pakistan

Universal health coverage (UHC) is a global health policy goal that seeks to ensure that all individuals and communities have access to essential medical care without experiencing economic strain. The World Health Organization (WHO) claims that, UHC has three essential components: (1) Financial security against catastrophic out-of-pocket payments; (2) fair access to high-quality health care; and (3) comprehensive coverage of the entire range of health requirements, from prevention to treatment and rehabilitation. The United Nations Sustainable Progress Goals (SDG 3.8), which emphasize the right to health as a vital element of social and economic progress, are in line with UHC.

A major step towards attaining UHC is Pakistan's Sehat Card initiative, which provides low-income households' free medical treatment. The program mainly covers hospitalization costs for significant treatments, such as surgeries, maternal care, and chronic diseases, to satisfy the financial protection aspect of UHC. However, it restricts equal access for individuals in need of urgent or primary medical care by excluding emergency care and outpatient services (OPD). Furthermore, even though the SSC reduces out-of-pocket costs for inpatient care, structural obstacles including complicated eligibility requirements (CNIC linkage) and regional differences in healthcare infrastructure prevent equitable coverage, especially for underserved and rural communities. To completely adapt to UHC principles, the SSC program needs to broaden its mission by including primary and preventive healthcare, improve administrative procedures, and reinforce healthcare delivery networks in underprivileged regions. To guarantee that no citizen is refused medical care because of financial or practical limitations, Pakistan may move closer to attaining true universal health coverage by filling in these gaps.

The Role of State Life Insurance Corporation in the Sehat Sahulat Card Program

The skeleton of Sehat Card initiative is the State Life Insurance Corporation (SLIC), which is essential to the program's execution at all government hospitals. SLIC oversees the whole health insurance system

as the program's exclusive insurance company, processing everything from beneficiary enrolment to claims handling. To guarantee smooth transactions, it processes hospital reimbursements, confirms patient eligibility, and keeps up a digital payment system. Additionally, the company maintains uniform treatment guidelines among affiliated institutions and keeps an eye out for false claims. Through these roles, SLIC serves as a quality assurance organization that makes sure healthcare providers follow authorized medical practices and costs, as well as an insurance provider that monitors the government-funded risk pools.

SLIC's participation has greatly simplified healthcare finance in government institutions. Hospitals can now concentrate on providing services rather than collecting payments pursuant to the company's pre-authorization system for major surgeries and real-time claim processing, which have decreased bureaucratic delays. This collaboration has maintained accountability through third-party audits while significantly increasing insured patient volumes at institutions like Lady Reading Hospital in Peshawar. There are still issues, though, like disagreements over the scope of coverage for complicated treatments and delays in provincial payment transfers. As the program grows, SLIC's function keeps changing to balance its dual purpose of providing equal healthcare access for Pakistan's low-income communities while maintaining financial sustainability.

This concept of public-private partnership must be enhanced if the SSC program is to succeed. Even though SLIC has proven its ability to manage extensive health insurance, more reforms are required to close coverage gaps, especially for outpatient treatment, and enhance communication between the central provider and provincial health ministries. In Pakistan's limited resources public health system, this partnership provides a creative approach to achieve universal health care.

This study

So, in the light international commitments, constitutional obligation, the SHP of the Khyber Pakhtunkhwa government was studied with the key objective to assess the effectiveness, challenges, and policy improvements of Sehat Card initiative in ensuring equitable medical care facilities for low-income families. The study revolves around one encompassing question How can the Sehat Card be improved to ensure fair and effective healthcare access for low-income and marginalized communities in Peshawar? To answer the key question and achieve the set objective of the study, the theory of social rights of the T.H Marshall and the behavioural of Andersen (1968, 1995) was employed as framework for analysis the situation.

According to Marshall’s theory of social rights of healthcare, education, and social security which are necessary to guarantee social participation and equality. Marshall argues that social rights are essential to citizenship because they allow people to fully engage in society. While the Sehat Sahulat Card program aims to provide healthcare as a basic right (like Marshall's concept of social rights), its actual design meets market-driven rules, such as strict eligibility, private partnerships, and limited coverage. This clarifies how contemporary welfare programs often promise collaboration but eventually function like businesses, leaving many people excluded. The challenge is to make such programs truly accessible and community-oriented, rather than just another service controlled by bureaucracy and profit concerns. Through the SSC program, Marshall's theory offers a framework for assessing how well the program satisfies low-income families' social rights. The study evaluates if, as Marshall intended, the SSC program provides fair access to healthcare, reduces financial obstacles, and enhances social inclusion. While behavioural Model of Andersen (1968, 1995) offers a strong framework for examining healthcare access in three interrelated domains: predisposing features, need variables, and enabling factors. Predisposing factors refer to the demographics, social structure, and health beliefs that impact service-

seeking behaviour while enabling factors focus on the financial and logistical resources that facilitate access). Further, the need variables are perceived and clinically evaluated health statuses which are the factors that determine health service utilization, according to the model. In assessing the Sehat Sahulat Card (SSC) program, this framework is especially relevant since it methodically looks at the systemic obstacles (like service Coverage and administrative procedures) as well as the individual-level factors (like awareness and education) that influence healthcare use among low-income groups. When Anderson's approach is applied to Pakistan's SSC program, it highlights significant discrepancies between the creation and execution of policies. Important predisposing factors (like low health literacy in rural populations) and need variables (like the absence of outpatient care) are overlooked by the program, even while it tackles enabling factors by reducing financial barriers through insurance coverage. The study's conclusions that administrative complexity (such as CNIC-linked eligibility) and restricted service coverage limit the program's potential are consistent with the model's emphasis on contextual factors. By employing this paradigm, the research sheds light on how intersecting individual, community, and systemic determinants affect equitable healthcare utilization, going beyond financial access. This is a viewpoint that is not included in assessments that use more limited theoretical lenses.

Methodology

This study employed qualitative research approach by interviewing 30 participants including patients, patients' attendants, and medical professionals from ten major surgeries wards at LRH by using purposive sampling. Thematic analysis was used to examine the information gathered from in-depth interviews. Researchers can find various connections between emerging themes derived from the data by using a procedure called thematic analysis. Thematic analysis is made possible by these essential procedures: Step 1: Become acquainted with the data, Step 2: construct the initial code Step 3: Seek out recurring motifs. Step 4: Explore the primary themes in. Step 5: Determine the subjects Step 6: Write the article. (Maguire and Delahunt 2017). With an emphasis on the experiences of low-income families using the SSC, the study highlights both the program's strengths and shortcomings.

Study Findings and Discussion

Pakistan's Sehat Sahulat Card (SSC) program's implementation highlights significant discrepancies between its policy goals and the realities on the ground, highlighting structural issues that hinder the program's ability to provide fair access to healthcare. Our results show that although the program is a major step forward in social health protection, there are numerous obstacles that hinder its efficiency in five important areas: operational administration, security and accountability, service quality, accessibility, and awareness and utilization. In addition to limiting the program's immediate impact, these issues cast doubt on its compatibility with T.H. Marshall's conception of social rights, which views healthcare as a fundamental right of citizenship.

The empirical data emphasizes how urgently structural changes are required to turn the SSC from a well-meaning project into a fully inclusive system for universal health coverage. We shed light on the technical shortcomings in program implementation as well as the larger socio-political limitations that sustain healthcare disparities in Pakistan's marginalized communities by analyzing these findings via the dual the sights of Marshall's social rights framework and Anderson's behavioural. Model. The study revealed that many participants do not know how to utilize the program's benefits. Hospital employees' lack of enthusiasm and the absence of awareness programs are two factors that lead to inadequate utilization. The program's ability to realize Marshall's concept social rights is hampered by this ignorance, since many qualified people are unable to receive the medical care to which they are legally entitled. As far as the visibility the program is concerned, the program is invisible, and recipients

frequently don't know how their money is being spent or how much is left on their card. This lack of transparency further erodes the program's ability to uphold social rights by fostering mistrust and potential infractions.

Further, the study found that though the program pays for significant treatments, participants frequently must buy these things from outside the hospital due to a lack of basic resources like prescription drugs and diagnostic services. The program's capacity to deliver equitable healthcare access, as envisioned by Marshall, is hampered by this inconsistent service quality. However, most beneficiaries and people with low income faces significant challenges in accessible the program. The SSC's integration with CNIC verification puts people without the right paperwork at a disadvantage, especially those from rural areas. Many eligible people are unable to get healthcare services because of this administrative barrier, which also restricts the program's reach.

Moreover, budgetary restrictions, a lack of resources, and a lack of monitoring and evaluation systems are some of the program's problems that negatively impact patient outcomes and care quality. The necessity for structural changes to guarantee its effectiveness and durability is highlighted by these operational difficulties.

Hence, this study concludes that the Sehat Card program, reducing the cost of procedures and treatments and increased low-income households' access to healthcare in Peshawar. Its influence is limited by issues including administrative inefficiencies, a lack of transparency, and the exclusion of outpatient care, even if it is in alignment with Marshall's concept of social rights. Unresolved complaints, unethical provider practices, and eligibility verification are challenges for beneficiaries.

The efficiency of the program could be improved by better complaint resolution methods, streamlined processes, and awareness campaigns are required for strengthening the program. Equity would be improved by extending coverage to outpatient care and guaranteeing equitable provider reimbursements. To increase accountability, implementation should be supervised by impartial monitoring bodies. Improving hospital infrastructure and addressing resource constraints will also improve service delivery. The SSC can more effectively achieve its objective of universal health coverage, minimizing inequalities and fostering social inclusion, with these modifications. In the end, fixing these problems will make the program a more useful mechanism for providing Pakistan with equal healthcare.

References

Alhojailan, M. I. and M. Ibrahim (2012). "Thematic analysis: A critical review of its process and evaluation." *West east journal of social sciences 1(1)*: 39-47.

Ali, A., Ali, S., Hidayat, I., Ayub, M., Akbar, F., Ali, A., & Tamsil, M. (2022). Sehat Sahulat Program Effect on Patients Presenting to Secondary Level Hospital in Mardan. Medicine, 2224, 50.

Din, M. U., Mashhadi, S. F., Khan, S. A., Zubair, S., Khan, A., & Hussain, S. (2022). Sehat Sahulat Program: Assessing the awareness and utilization effectiveness of Sehat Insaf Card among the general population of District Rawalpindi. *The Professional Medical Journal, 29(07),* 1061-1066.

Garrett, L., Chowdhury, A. M. R., & Pablos-Méndez, A. (2009). All for universal health coverage. The Lancet, 374(9697), 1294-1299.

Hasan, S. S., Mustafa, Z. U., Kow, C. S., & Merchant, H. A. (2022). “Sehat Sahulat Program”: a leap into the universal health coverage in Pakistan. *International Journal of Environmental Research and Public Health, 19(12), 6998.*

Khan, S. J., Asif, M., Aslam, S., Khan, W. J., & Hamza, S. A. (2023). Pakistan’s healthcare system: a review of major challenges and the first comprehensive universal health coverage initiative. Cureus,

15(9).

Lederle, M., Tempes, J., & Bitzer, E. M. (2021). Application of Andersen's behavioural model of health services use: a scoping review with a focus on qualitative health services research. BMJ open, 11(5), e045018.

Maguire, M. and B. Delahunt (2017). "Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars." *All Ireland Journal of Higher Education 9(3).*

Maguire, M. and B. Delahunt (2017). "Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars." *All Ireland Journal of Higher Education 9(3).*

Moyn, S. (2020). TH Marshall, the Moral Economy, and Social Rights. *Humanity: An International Journal of Human Rights, Humanitarianism, and Development, 11(2), 235-240.*

Nishtar, S. (2011). Health and the 18th Amendment: Retaining national functions in devolution. Islamabad, Pakistan: Heartfile; 2011 [cited 2012 2 February].

Palinkas, L. A., et al. (2015). "Purposeful sampling for qualitative data collection and analysis in mixed method implementation research." Administration and policy in mental health and mental health services research 42: 533-544.

Shahbaz, F., et al. (2023). "Public perception and satisfaction with health insurance through Sehat Insaaf Card in Punjab: health insurance through Sehat Insaaf Card." *Pakistan Journal of Health Sciences: 181-184.*

Yasmin, S., & Hina, H. (2024). Understanding the Sehat Sahulat Program. Contextuality of Healthcare Choices in Pakistan, 119.