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[Allocation And Efficiency Of Sehat Sahulat Program]

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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.

Introduction

The driving force behind the abilities of individuals in running economic, political, and social systems is health. According to the Organization for Economic Cooperation and Development report indicates that health spending increased by around 6% on average in 2021. In which the 2022 health spending as a share of GDP as 9.06% (OECD 2021). This growth has occurred faster than the overall economy which has seen 4.6% increase per year, (WHO, 2021 Report). Although greater share in these expenditures came from develop countries but developing countries also increased health expenditures. 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 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 kind of wellbeing financing. 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.

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 (WHO, 2019). 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 the challenges faced by the people at the grassroots level, the government of Pakistan has initiated "Sehat Sahulat Program". Sehat Sahulat Program (SSP) program provides financial health protection to families who are living below poverty line. Sehat Sahulat Program leave them in better position to manage their socio-economic condition. 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. 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.

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. (Hasan, Mustafa et al. 2022) Many reasons are enlisted to state the failure of these programs. To broadly categorize them all these have the problem of 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, District Mardan is selected as the locale.

Literature Review

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.

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 are 1.4% improvement in the production of hospital in Vietnam. However, the Chen (2006) studied revealed that National Health Insurance implementation was significantly positively related to hospital productivity and quality.

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 those 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.

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 allocative 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.

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. Pakistan's overall SDGs Index score rose from 53.11 in 2015 to

63.5 in 2020, or 19.5% higher than the baseline in 2015. This score is a total. Sectoral accomplishments exist on several levels. Extreme poverty has significantly decreased, energy access has improved, industrial activity has expanded, maternal mortality has decreased, undernourishment, food insecurity, hygiene, and housing have all significantly improved, and climate change has finally been addressed. (SDGs Status Report for Pakistan, 2021).

According to 2022, Pakistan Bureau of Statistics, the number of public sector hospitals has risen to 1276, Basic Health Units (BHUs) to 5559, Rural Health Centers (RHCs) to 736, and dispensaries to 5832. Along with 282383 licensed doctors, 33156 registered dentists, and 127855 registered nurses, these hospitals carry the current ratio of one doctor to 963 patients, 9413 people to one dentist, and1608 people to one hospital bed (Finance Division, 2022). The human resource employed in the health sector plays a critical role in efficient service delivery. For this reason, capacity building of frontline and community health workers and health practitioners and improving medical staff to population ratio have been focus areas for the government. During year 2022, number of registered medical and paramedical staff increased as compared to previous year as can beseen from the following table:

Table 1: Registered Medical and Paramedical Personnel

(in Nos.)

Health Manpower	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
Doctors	195,896	208,007	220,829	233,261	245,987	266,430	282,383
Dentists	18,333	20,463	22,595	24,930	27,360	30,501	33,156
Nurses	99,228	103,777	108,474	112,123	116,659	121,245	127,855
Midwives	36,326	38,060	40,272	41,810	43,129	44,693	46,110
Lady Health workers	17,384	18,400	19,910	20,565	21,361	22,408	24,022

Note: Data is reported on Calendar

Year BasisSource: Pakistan Bureau of Statistics (PBS)

Moreover, sufficient healthcare financing and optimal allocation of financial resources is necessary for quality healthcare service delivery. During FY2022, the public health expenditure was 1.4 percent of GDP as compared to 1.0 percent during same period of last year. The consolidated position of both federal and provincial health expenditures was rise for last year 586,270million to 919,418million in 2022.A challenging opportunity was provided by the political devolution in the country for the health care system to address the problems related to planning health care delivery structures, systems, services, and programs. This is of greater importance because that the objectives of health-related MDGs were not entirely accomplished and to meet the much more ambitious objectives of the Sustainable Development Goals more determinations

are needed (Government of Pakistan, 2019). 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.

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 are deserving. 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 them constitutes for winning the second term. Hence, there exist a possibility of mis-allocation of the cards and it is possible that certain people who are not deserving 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 who 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.

Methodology

The objectives of the study were achieved by applying mix method approach that combined different yet interconnected components. The research design was qualitative. A micro level survey was conducted in the households of district Mardan 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). By applying the Yamane's (1967) formula 200 sample collected. Since the union councils are different in size,

a random sample selection is used, where some respondents are Sehat Cardholders, and some are not.

DATA ANALYSIS AND INTERPRETATION

In this section of the study, the focus will be on descriptive and empirical analysis. 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 2:

Age of Cardholder HH Head	**Frequency**	**Percentage**
≥ 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%
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%
Cardholders' family members	Frequency	Percentage
≥ 4	13	14%
5 to 6	47	49%
7 to 8	25	26%
≤ 9	11	11%
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 overall statistic data shows in table 2, that above 40 years aged families head are condition holder and most of them were hold the Sehat card and 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. 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 level 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.

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 2 show 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 3: Cardholders Family Income and Earnings ratio

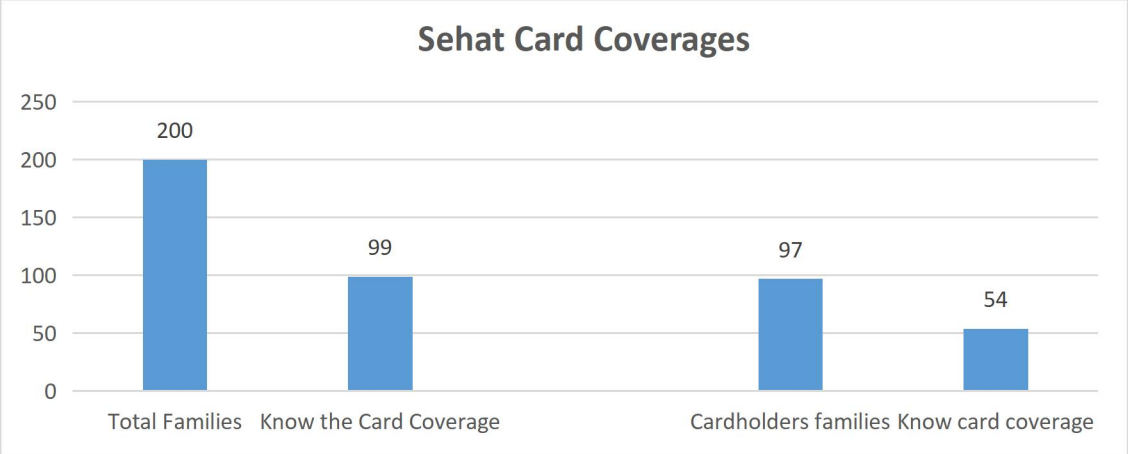
Income in Thousand	Frequency	Percentage	One Member One Earner in family (Frequency)	Two Member Two Earner in family (Frequency)	Three Three Earner in family (Frequency)	Four Four Earner in family (Frequency)
≥ 10	24	26%	18	4	1	1
11 to 20	48	49%	10	32	6	0
21 to 30	11	11%	1	3	6	1
31 to 40	7	7%	0	2	2	3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

Table 3 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 these 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 is not only an indicator of a family economic condition but also define the way they can access health facilities and related information. 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 show that the allocation of the card was efficiently.

Figure 1: 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.

Estimation of Sehat Sahulat Program Efficiency

To identify the allocation efficiency of SSP, we use logistic model where dependent model is dummy.

Equation 1.1: Here the dependent variables is 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

Cardholder (Yes/No) =α+β_1INC+β_2DIS+β_3CASPENT+β_4CON +μ _____Eq 4.1

Where,

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 disable (Yes/No).

Income (INC): Respondent monthly total income

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

Table 4: 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 5 : 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

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

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

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; 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 5, 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 TakhtBhai, Mardan. Further log likelihood value is -54.65 and R-square value is 0.59 which mean model is strongly fitted.

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 treat 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 district Mardan. 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 families 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. 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.

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 that 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.

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