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[Sehat Sahulat Program of KP and its Impact on Medical Practitioners' Professional Life]

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ABSTRACT

This study looks into the impact of the Sehat Sahulat Program on the job satisfaction of medical practitioners who are part of this program. The study also investigates the mediating role of workload, ease of process and transparency of process between Sehat Sahulat Program and their job satisfaction. For detailed analysis, a sample of 275 medical practitioners were interviewed from the three largest tertiary care hospitals, Lady Reading Hospital (LRH), Khyber Teaching Hospital (KTH), and Hayatabad Medical Complex (HMC). The results of the structural equation model technique revealed that the Sehat Sahulat Program has a significant influence on the medical practitioner's job satisfaction (professional life) (β=0.699, t=17.3, p<.05). The results also demonstrate that all three mediating variables partially mediate the relationship between the Sehat Sahulat Program and the job satisfaction of medical practitioners. The study has both research and practical implications. On the research side, this study has looked into the behavioral aspect of health service facilities, which are basically aimed at providing free health facilities to people at large. On the practical side, the study is likely to help practitioners and policymakers capitalize on the strengths of this program and address its weaknesses. By addressing these aspects, the program is expected to achieve its set goals of better health service delivery.

Keywords: Sehat Sahulat Program, Sehat card plus, medical practitioners, professional life, job satisfaction, workload, ease of the process, transparency of the process.

Introduction

By and large, the provision of health facilities to everybody is considered one of the primary responsibilities of the state. That is why most governments around the globe invest heavily in this sector. However, there is no universal standard set as to how much government should spend. Countries are only categorized between those who invest much and those who invest less here. Generally, investment in healthcare facilities in developing countries is quite low. Pakistan, a developing country, needs to catch up in providing health facilities to its citizens across the country. This national status negatively affects different aspects of human life in the country. According to the 2016 statistics of the World Health Organization [WHO] report, the life expectancy of birth for males and females is 66 and 67 years, respectively, and the probability of dying under five years (per 1000 live births) is 75 (WHO, 2016, 2017). The major reason behind such lower average life expectancy is less government spending on health infrastructure (Ali & Audi, 2016). Estimates exhibit that Pakistan is spending less than 0.8% of its GDP as compared to 1.4 percent and 1.2 percent of Sri Lanka and Bangladesh,

respectively (Khalili et al., 2021). This meager financial allocation is further heavily consumed by secondary and tertiary care, leaving merely 15 percent for preventive and primary healthcare services (Hasan et al., 2022).

Within the country, the availability of healthcare facilities varies. People of urban areas can easily access health care centers as compared to those living in rural areas and the whole of the erstwhile FATA (Akbari, Rankaduwa, & Kiani, 2009). Keeping the overall economic conditions of the people and the availability of health-related services vis-à-vis the demand and variation in healthcare expenditures, there are several types of healthcare providers in Pakistan. The Pakistani government, in response to the appalling conditions in medical facilities, has been implementing a number of health coverage initiatives, including the Waseela-e-Sehat program, the Prime Minister National Health Care Program, the Cancer Treatment Program, the Prime Minister Program for Prevention and Control of Hepatitis, the Drug Abuse Control Program, and the Dengue Prevention Cure. In actuality, the COVID-19 pandemic has had a detrimental and significant impact on the effectiveness of health systems everywhere, including in developed and technologically advanced nations as well as in poor nations.

An Overview of the Sehat Sahulat Program (SSP)

The SSP offers access to universal indoor health services to all residents across the country, making it a pioneering international initiative. Therefore, it is thought that the program should have a strong GR (good receipt) system to ensure excellent administration, optimal use, and citizen trust, thereby improving Value for Money (VFM). There are instances where past public funding on related efforts was compromised. For instance, the Waseela-e-Sehat (WeS) health initiative was launched by the Benazir Income Support Program (BISP) in the Punjab district of Faisalabad in 2012. In the eight affiliated hospitals, inside health insurance services were made available to almost 75,000 BISP families (Rahman, Ahmad, & Norsiah, 2023). The program included coverage for all medical patient services up to Rs. 25,000 per household year. However, just 0.8% of families utilized this facility in a year, and the reason behind underutilization was a lack of awareness, limited package, and unavailability of proper monitoring and evaluation of the project.

The Sehat Sahulat Program (SSP) was initiated in the year 2015 with the purpose of delivering indoor, free-of-charge health services without any assistance from the general population. The program was designed in such a way as to address all the deficiencies of the previous health-related initiatives. The Benazir Income Support Program (BISP) data was used to identify the program's beneficiaries first, who were the poor and vulnerable groups. Health cards were then given to eligible households (Habib & Zaidi, 2021). The government decided in 2021 to make indoor healthcare services available to all individuals as part of the Universal

Health Insurance (UHI) program. The National Identity Card (NIC) now serves as the eligibility document instead of a separate health card. The agency that issues NICs, NADRA, keeps track of formal citizenship records and possesses data at the family level. It is important to note that the inside benefits are given to families, with families being defined as parents and their unmarried children.

Table 1 ***Roles and Responsibilities of SSP Operational Stakeholders Department***

Department	Role in SSP operation
Federal Sehat Sahulat Program	• Hire the services of an insurance company. • Formulate policies and regulations and engage stakeholders. • Custodian of program
Provincial Health Departments	• Supervise and monitor the operational activities. • Public awareness • Custodian of the program at the provincial level
NADRA	• Managing an outbound call center to acquire feedback from beneficiaries using in-door health services. • Provide updated family-level data by issuing B-form/CNIC. • Data verification, as demanded by SSP
State Life Insurance Corporation (SLIC)	• Resolve all grievances related to in-door enrollment, admission, and indoors. • Manage the Impanel hospital to ensure that beneficiaries admit the front desk in each Impanel hospital to ensure that beneficiaries are admitted and acquire in-door health services. • Hire impanels impanel hospitals as per agreed packages. • Sole insurance company to manage entire operational responsibility. • Managing an inbound call center (0800-09009) to address the queries of the general public and to register complaints.
Empanel Hospital	• Provide five days of medicine and transport charges after a patient's discharge. • Provide in-door health services to eligible beneficiaries by charging no money on admission, surgery, doctor fees, medicine fees, medicine, etc.
Partner NGOs	• Disseminate key messages. • Enroll beneficiaries by delivering cards at dedicated Beneficiary Enrolment Centres (BECs)

Health issues have been found to be one of the serious issues of developing countries. Pakistan is not an exception to this fact. This lack of health facilities negatively affects the county's different aspects of human life. Statistics exhibit year exhibit that the Pakistanis' life expectancy is very low (66 percent for males and 67 percent for females; the probability of dying under five years (per 1000 live births) is 75 percent (Hafeez et al., 2023). To address this issue, Governments have been trying to improve public health statistics by introducing different health-related programs. However, it is not only the introduction of new health-oriented programs; the real issue is the effectiveness or success of any such program. Most of the time, it has been observed that a program appears to be good in its initial phases but fails to achieve the set targets.

One prime example is the Institutional Private Practice (IPP) program of the government of Khyber Pakhtunkhwa in 2001, which was stopped due to resistance from Medical Practitioners (Khan, 2019). The most common reasons behind the failure are initiatives that such programs are either launched as a politically popular idea and weakly implemented or a bureaucratic initiative lacking in taking all the stakeholders in the decision-making process. In addition, no evaluation studies are being undertaken that could closely look into the effectiveness of these programs. Generally, evaluation studies have commonly been found scarce in Pakistan. Consequently, public monies are spent without benefitting the public as desired. This study is targeted at evaluating the Sehat Sahulat Program and to find if the program is successful in effectively providing the needed health facilities and its impact on the professional life of medical practitioners.

The key objectives of this study were:

i. To determine the impact of the Sehat Sahulat Program on the job satisfaction of medical practitioners who are part of this program.
ii. To investigate the mediating role of workload, ease of process, and transparency of process between Sehat Sahulat Program and their job satisfaction.

Theoretical Foundation

Herzberg's "two-factor theory" of 1966 is one of the most well-known theories for analyzing and comprehending job satisfaction. (Holmberg, Caro, & Sobis, 2018). This theory provides a collection of motivation and hygiene elements that influence both job satisfaction and dissatisfaction. Herzberg (1968) refers to the theory as the motivation-hygiene theory or the dual-factor theory. According to this theory, a number of "motivational variables" inherent in the profession—such as opportunities for personal development, recognition of performance, career advancement, and so on—are required for job satisfaction (Herzberg, 1968;

Purohit & Bandyopadhyay, 2014).

The phrase "hygiene factors" refers to a set of circumstances that contribute to job dissatisfaction but are not inherent in the employment. Organizational policies, interpersonal interactions, personal life, income and employment stability, and other factors are among them. Although the two-factor theory was first proposed in 1966, numerous academics (Goetz et al., 2016; Hunt, 2014) argue that it is still applicable today and that they have utilized it to better understand and interpret healthcare workers' job satisfaction. This study used Herzberg's theory as the foundation for understanding the correlations between the variables.

Other related theories include Maslow's theory of hierarchy of needs. Maslow's hierarchy of needs (McLeod, 2007) Is a psychological, motivational theory that consists of a five-tier model of human needs, frequently shown as hierarchical tiers within a pyramid. The needs are listed in the following order: physiological (food and clothing), safety (work security), love and belonging (friendship), esteem, and self-actualization. Lower-level needs must be met before persons can attend to higher-level requirements.

The research challenge, assessment of related literature, and relevance of Herzberg's theory all contributed to developing this study's conceptual model. Based on the examination of the extant literature, the study is set to explore to what extent this program (Sehat Sahulat Program) effects to what extent this program (Sehat Sahulat Program) affects the satisfaction level of medical practitioners. End-user satisfaction is achieved through excellent management and implementation of the Sehat Sahulat Program. The proposed model below depicts the association between Sehat Sahulat Program utilization and medical practitioner satisfaction with the workload, simplicity of the process, and transparency of the process serving as mediators.

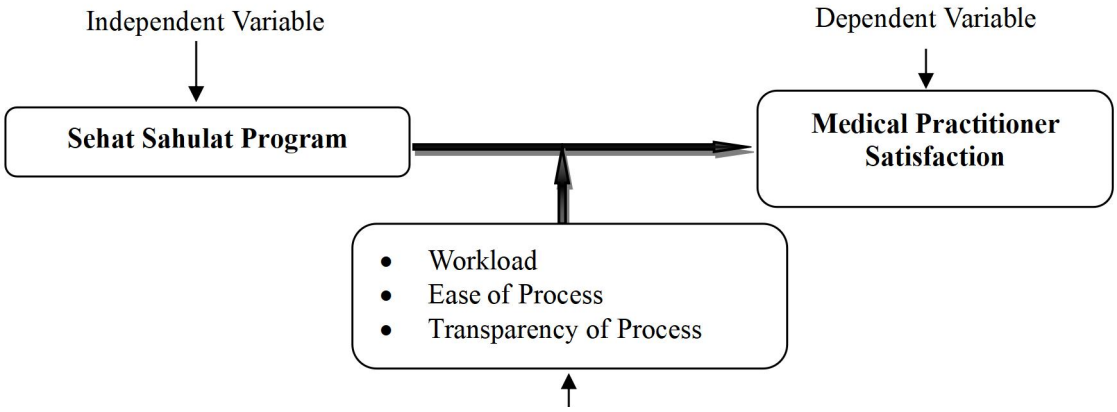

Figure 1: Conceptual Model of the Study

Research Population and Sampling

The study has been undertaken in the largest three tertiary care hospitals of Peshawar, i.e., Lady Reading Hospital (LRH), Khyber Teaching Hospital (KTH) i.e.,

Lady Reading Hospital (LRH), Khyber Teaching Hospital (KTH), and Hayatabad Medical Complex (HMC). The doctors' busy schedules made it difficult for them to find time for a formal interview. Therefore, the survey questionnaire served as the most effective means of gathering respondents' opinions on the matter at hand. Additionally, because most respondents were available at their particular wards, it was easy to implement the delivery and collection of surveys. The study's sample size is 275, using the sample size chart from Krejcie and Morgan (1970), taking into account the population of 957 medical practitioners in these three hospitals. However, a 20% non-response rate was taken into account when expanding the sample size to 330 in order to address the non-response rate pro-actively (Council, 2013).

A cover letter was sent to the randomly chosen respondents, who were asked to fill it out entirely and return it within two weeks. Ten days later, a reminder message was sent to all responders. It was distributed in various formats to those who could not return the questionnaire. Over the course of around two months, 275 fully completed questionnaires were returned by the participants.

A qualitative-cum-quantitative, perception-based methodology was employed in this study. It was qualitative in that the respondent's quality of perception was evaluated using a Likert scale. It was also quantitative in that a sizable number of respondents' responses were obtained, and quantitative tools were used to analyze the data. Data from the randomly selected respondents was collected via a personally administered questionnaire distributed in person. All research ethics were followed during the data collection process. Given the nature and dispersion of the population, simple random sampling is a suitable technique for the current investigation and has been applied in this study. Software like SPSS and Excel were also utilized where required for data analysis. The reliability of the scales and the internal consistency of the variables were first evaluated using the Cronbach's Alpha test. The correlation and regression processes were then used to look at the nature and strength of the associations between each of the study's variables. This was done by feeding data into the SPSS software, E-view, and AMOS as per the need of the respective data. The significance of the variables was checked by performing various tests, such as the t-test and ANOVA for continuous variables and the Chi-Squire test for categorical variables.

Results

Demographics

Table 2 presents the information about the age group of the sample respondents. The majority of the respondents (58.9%) are in the group up, and the majority of the respondents (58.9%) are in the group up to 30 years. The second largest age group is 31-40 years (34.5%). At the same time, the remaining all are in the age groups 41-50 and above 50 years. This information demonstrates that the sample

was representative of both the young and adult respondents, demonstrating its diversity.

Table 2: ***Age-Based-Estimation***

Ages	Frequency	Percentile
Up to 30 years	162	58.9
31-40 years	95	34.5
41-50 years	12	4.4
Above 50 years	6	2.2
Total	**275**	**100.0**

Gender

Table 3 presents the data regarding gender. Male participants were the dominant (65.8%) age group. The high percentage of male respondents may be due to the fact that there are more male medical practitioners than female counterparts.

Table 3: ***Gender-Based-Estimation***

Gender	Frequency	Percentile
Male	181	65.8
Female	94	34.2
Total	**275**	**100.0**

Marital Status

The marital status of the respondents is shown in Table 4. The data illustrates that the majority (68.7%) of the participants were married; unmarried participants were the second majority (30.5%) among participants. However, the ratio (0.7%) of Widowed / Divorced / Separated participants was very low. The high number of married respondents illustrates the social phenomena of marriage at a young age among the community of Pashtuns, who are dominant in Peshawar, Pakistan.

Table 4: ***Marital-Status-Based-Estimation***

Marital Status	Frequency	Percentile
Married	189	68.7
Unmarried	84	30.5
Widowed/ Divorced/ Separated	2	0.7
Total	**275**	**100.0**

Education

Table 5 displays the frequencies and percentages of responders based on their qualifying criteria. The data clearly shows that the majority of respondents fall into the specialization group (n = 116) and the basic medical degree holder's category (n = 114), with valid percentages of 42.2 and 41.5, respectively. In this group, the responders with M.Phil./PG Diplomas (n=36) came in second with a valid percentage of 13.1. In the other category, there were (n=9) employees with a valid percentage of 3.3. The dominant number of participants with specialty and

MBBS/BDS degrees shows that these are the basic degrees for medical practitioners (doctors) to perform their clinical practice.

Table 5: ***Education-Based-Estimation***

Education	Frequency	Percentile
FRCS/ FRCP/ MRCS/ FCPS/ Ph.D.	116	42.2
MBBS/BDS	114	41.5
M.Phil. / PG Diploma	36	13.1
Other	9	3.3
Total	**275**	**100.0**

Experience

Table 6 displays the frequencies and percentages of responders based on experience categories. The data amply illustrates that the majority of respondents (n=59) had experience spanning from zero to one year, with a valid percentage of 21.5. The valid percentages for the respondents with one to five years and six to ten years of experience (n = 89) were 32.4% each. The valid proportion for responses with over 10 years of experience was 13.8%. It clearly shows that the selected hospitals had a mix of experienced and fresh medical practitioners.

Table 6: ***Experience-Based-Estimation***

Experience	Frequency	Percentile
0-1 year	59	21.5
1-5 years	89	32.4
6-10 years	89	32.4
More than 10 years	38	13.8
Total	**275**	**100.0**

Job Title

The job titles of the respondents are illustrated in Table 7. The Medical Officer category was dominant (n=129), having a valid percentage of 46.9%. The Medical Officer category was dominant (n=129), having a valid percentage of 46.9% of participants. The second category on the list was Junior Registrar (n=36), with a valid percentage of 13.1% participation. The high number of medical officers is because these are the basic positions in each hospital. When a doctor is appointed in any hospital, is they are appointed against the post of medical officer.

Table 7: ***Current Job Title-Based-Estimation***

Current Job Title	Frequency	Percentile
Medical Officer	129	46.9
Junior Registrar	36	13.1
Senior Registrar/Specialty	11	4.0
Assist. Professor	18	6.5
Assoc. Professor	5	1.8
Professor	5	1.8

Other	71	25.8
Total	**275**	**100.0**

Level of Satisfaction

The mean taken mean value of each parameter (i.e., Sehat Sahulat Program, Job Satisfaction, Workload, Ease of Process, and Transparency of Process) was calculated by taking a mean of all the questions falling under that parameter. Out of 5, Sehat Sahulat Program had a mean satisfaction level of 3.41, Job Satisfaction had a mean satisfaction level of 3.34, Workload had a mean satisfaction level of 3.27, Ease of Process had a mean satisfaction level of 3.42, and Transparency of Process had a mean satisfaction level of 3.35. It shows that the participants were satisfied with the ease of the process more than the other categories. It also shows satisfaction over the policies of the government who, making the process easy for all the stakeholders.

Table 8: Level of Participant Satisfaction Regarding each Parameter

Level of Participant Satisfaction	Mean	Standard Deviation
Sehat Sahulat Program	3.41	0.664
Job Satisfaction	3.34	0.642
Workload	3.27	0.680
Ease of Process	3.42	0.684
Transparency of Process	3.35	0.752

Sehat Sahulat Program and Medical Practitioner Job Satisfaction

The subsequent table and figure depict the regression estimation of the Sehat Sahulat Program on Medical Practitioner Job Satisfaction.

Table 9: ***Regression Estimation Sehat Sahulat Program on Medical Practitioner Job Satisfaction***

Effect			Estimation	SE	CR	p
Sehat Sahulat Program	→	Medical Practitioner Job Satisfaction	0.699	0.040	17.312	0.001

The Sehat Sahulat Program was regressed on Medical Practitioner Job Satisfaction via linear regression. The outcome revealed that the Sehat Sahulat Program has significantly influenced Medical Practitioner Job Satisfaction, portraying the value (β=0.699, t=17.3, $p<0.05$).

Workload in Sehat Sahulat Program and Medical Practitioner Job Satisfaction

The subsequent table depicts the hierarchal regression estimation to measure the mediating influence of workload in an association between the Sehat Sahulat Program and Medical Practitioner Job Satisfaction.

Table 10: ***Regression Estimation of Mediating Influence of Workload in an Association between Sehat Sahulat Program and Medical Practitioner Job Satisfaction***

Direct Effect					**Estimation**	**SE**	**CR**	**P**
Sehat Sahulat Program	→	Medical Practitioner Job Satisfaction			0.458	0.043	10.55	0.001
Indirect Effect					**Estimation**	**SE**	**CR**	**p**
Sehat Sahulat Program	→	Workload	→	MPJS	**0.241**	0.043	***	0.001
Total Effect					**Estimation**	**SE**	**CR**	**P**
Sehat Sahulat Program	→	Medical Practitioner Job Satisfaction			0.699	0.040	17.31	0.001

The direct effect of the Sehat Sahulat Program was regressed on Medical Practitioner Job Satisfaction. The outcome revealed that the Sehat Sahulat Program has a significant influence on Medical Practitioner Job Satisfaction (β=.458, t=10.6, p<.05). Secondly, the indirect influence of the Sehat Sahulat Program was regressed and found that workload partially intermediates in an association between Sehat Sahulat Program and Medical Practitioner Job Satisfaction (β=.241, p<.05). The total influence of Sehat Sahulat Program was regressed on Medical Practitioner Job Satisfaction. The result depicted that the Sehat Sahulat Program has a significant influence on Medical Practitioner Job Satisfaction (β=0.699, t=17.3, p<0.05).

Ease of Process and Doctors' Job Satisfaction

The subsequent table depicts the hierarchal regression estimation to measure the mediating influence of ease of process in an association between the Sehat Sahulat Program and Medical Practitioner Job Satisfaction.

Table 1: ***Regression Estimation of Mediating Influence of Ease of Process in an Association between Sehat Sahulat Program and Medical Practitioner Job Satisfaction***

Direct Effect				**Estimation**	**SE**	**CR**	**P**
Sehat Sahulat Program	→	Medical Practitioner Job Satisfaction		0.492	0.051	9.71	0.001

Indirect Effect				**Estimation**	**SE**	**CR**	**p**
Sehat Sahulat Program	→	Ease of Process	→ MPJS	**0.215**	0.047	***	0.001
Total Effect				**Estimation**	**SE**	**CR**	**P**
Sehat Sahulat Program	→	Medical Practitioner Job Satisfaction		0.699	0.040	17.31	0.001

The direct effect of the Sehat Sahulat Program was regressed on Medical Practitioner Job Satisfaction. The outcome revealed that the Sehat Sahulat Program has a significant influence on Medical Practitioner Job Satisfaction (β=0.492, t=9.7, $p<0.05$). Secondly, the indirect influence of the Sehat Sahulat Program was regressed, and it found Ease of Process partially intermediates in an association between the Sehat Sahulat Program and Medical Practitioner Job Satisfaction (β=0.215, $p<0.05$). The total influence of the Sehat Sahulat Program was regressed on Medical Practitioner Job Satisfaction, and the result depicted that the Sehat Sahulat Program has a significant influence on Medical Practitioner Job Satisfaction portraying (β=0.699, t=17.3, $p<0.05$).

Transparency of Process and Doctors' Job Satisfaction

The subsequent table depicts the hierarchal regression estimation to measure the mediating influence of Transparency of Process in an association between the Sehat Sahulat Program and Medical Practitioner Job Satisfaction.

Table 2: ***Regression Estimation of Mediating Influence of Transparency of Process in an Association between Sehat Sahulat Program and Medical Practitioner Job Satisfaction***

Direct Effect				**Estimation**	**SE**	**CR**	**P**
Sehat Sahulat Program	→	Medical Practitioner Job Satisfaction		0.476	0.052	9.15	0.001
Indirect Effect				**Estimation**	**SE**	**CR**	**p**
Sehat Sahulat Program	→	Transparency of Process	→ MPJS	**0.223**	0.042	***	0.001
Total Effect				**Estimation**	**SE**	**CR**	**P**
Sehat	→	Medical Practitioner Job		0.699	0.04	17.31	0.00

Sahulat Program	Satisfaction	0	1

Discussion

The current study uses a deductive approach and is explanatory in character. The study also sought to determine whether to accept or reject the hypotheses drawn from earlier investigations after examining any potential relationships between the variables. As such, it adheres to the paradigm of quantitative research. The primary sources of data are gathered by researchers. Through self-administered processes, questionnaires were floated, returned, and filled out, resulting in the data collection process. The current study was based on measuring the effect of the Sehat Sahulat Program on Medical Practitioners' Job Satisfaction. The study used a random sampling technique. The public teaching hospitals in Peshawar, Khyber Pakhtunkhwa province, where the provincial administration implemented the Sehat Sahulat Program, were selected as the case's borders, that is, the Hayatabad Medical Complex (HMC), Lady Reading Hospital (LRH), Khyber Teaching Hospital (KTH). These are the three biggest hospitals in Khyber Pakhtunkhwa, with heavy patients. Hence, the Sehat Sahulat Program is excessively used in these hospitals.

According to the theory put forth by (Ahmed, Jan, & Ozturk, 2018), the higher the sample size, the smaller the error; 275 questionnaires were tested to have the least bias and error. The Statistical Package for Social Sciences tool used several data analysis strategies. The reliability of the scales and the internal consistency of the variables were first evaluated using the Cronbach's Alpha test. The correlation and regression processes were then used to look at the nature and strength of the associations between each of the study's variables. The linear regression technique was used to analyze the impact of the Sehat Sahulat Program on Medical Practitioners' Job Satisfaction.

The statistical result revealed a significant relationship between the Sehat Sahulat Program and Medical Practitioners' Job Satisfaction. The result was similar to another study (Ahmad et al., 2019) Where workload or additional work has been shown to have a significant relationship with job satisfaction, the results from this study also showed that workload mediates between the Sehat Sahulat Program and Medical Practitioners' Job Satisfaction. In a similar study (Ahmad et al., 2019) stated that the impact of doctors' workload on their physical and emotional well-being has been brought up occasionally. It will, therefore, have an impact on how well they perform while doing their jobs. Overwork overload can lead to events because people frequently experience sleep problems, self-medicate, or overdo it, feel sad, worried, restless, and nervous, and react violently when they are furious or agitated. An unmanaged workload can harm one's general health, cause physical stress, and have an impact on one's thoughts and mood. For instance,

lack of sleep can have a number of negative repercussions, including the possibility of death (Johnson, 1982). A substantial alteration in mental state and cognitive performance can result from inadequate sleep (Killgore et al., 2007).

This study further revealed that Ease of Process mediates the Sehat Sahulat Program and Medical Practitioner Job Satisfaction. The result was matched with (Ullah, Ayub, Khan, & Shah, 2022), where the authors found that the process had direct and significant positive effects on their study participants. The participants of private hospitals were more satisfied than the participants of public sector hospitals due to the clear and easy process. The indirect influence of the Sehat Sahulat Program was regressed, and it was found that the transparency of the process partially intermediates in an association between the Sehat Sahulat Program and medical practitioner job satisfaction. These findings are matched with the other study (Hofmann & Strobel, 2020), in which the authors develop and empirically test a model that explains how transparency affects intentions to leave by affecting job satisfaction.

Conclusion

This study looked into the interplay between the relationship of working environment/requirements of the newly launched program of the Khyber Pakhtunkhwa govt. and the medical practitioner's job satisfaction. The study looked for direct relationships through important mediators like workload, ease of process at, and other important mediators like workload, ease of process, and process transparency. Data was collected from three main hospitals. The collected data was analyzed through hierarchal-linear regression. The result revealed that their results revealed a direct and positive relationship between SSP and medical practitioners' job satisfaction. However, all three mediators exhibited partial mediation between the Sehat Sahulat Program and Medical Practitioner Job Satisfaction.

The study concludes that the participants were generally satisfied with the Sehat Sahulat Program. It can also be concluded that mediators (like workload, ease of process, and process transparency) affect the job satisfaction of medical practitioners. However, one must realize that the SSP is a unique worldwide program as it provides universal indoor health services to all country citizens. Obviously, the facility for the general public comes with an additional workload that the medical practitioners have to face. Similarly, ease of process plays a vital role in executing the job well and on time. Generally, the medical practitioners were satisfied with the ease and the process, which influenced their Job Satisfaction.

Recommendations

a. An operating handbook must outline the roles, duties, and guidelines of all stakeholders in the Sehat Sahulat Program.

b. Frequent monitoring of operational procedures, recurring assessments of processes, follow-up surveys with sample size, and effect evaluations would encourage service providers to make improvements to improve their offerings.

c. c. A referral system, a contemporary technological requirement for the program, is necessary because tertiary-level hospitals are absent in certain rural places, such as AJK and GB.

d. To further enhance medical professionals' job happiness, hospital administrators and policymakers should strengthen internal management and develop and implement techniques to promote doctor-patient relationships and strike a balance between doctors' work and family conflicts.

e. Hospitals must be transparent about their organizational policies, resource allocation, and performance to keep the community and medical professionals satisfied.

Limitations

The study's scope has a few limitations. First, only a few factors (three) were considered to examine the tradeoff between the overall program and medical practitioners' jobs. Second, the study reports its conclusions based on a sample of 275 medical professionals. A third limitation is the satisfaction of the medical professionals who completed the questionnaire. Since no one's contentment may be treated as an absolute reality, their satisfaction may not be a flawless reflection of reality.

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