ACADEMIA International Journal for Social Sciences
Volume 4, Issue 4, 2025 ISSN-L (Online): 3006-6638

Economic Dimensions of Health Protection under Sehat Sahulat Program: A Qualitative Assessment of Urban and Rural Households in Pakistan

Syed Shah Zeb
shahzebkuku@gmail.com
Deputy Secretary, Industries, Commerce & Technical Education Department, Govt of Khyber Pakhtunkhwa, Pakistan

Dr. Kashif Abrar
kashif_411@hotmail.com
Visiting Faculty Member, Department of Business Studies, Bahria University, Islamabad, Pakistan

Saima Saqib
Saimasaqib25@gmail.com
Assistant Professor, Department of Economics, Govt. Graduate College for Women, Shalimar Town Lahore, Pakistan

Syed Adil Abbas Rizvi
aabbas.5522@gmail.com
Senior Manager, Business Process Reengineering (PMO), Bank Al Habib Ltd., Karachi, Pakistan
Corresponding Author: * Syed Shah Zeb shahzebkuku@gmail.com

Received: 12-09-2025 **Revised:** 10-10-2025 **Accepted:** 26-10-2025 **Published:** 12-11-2025

ABSTRACT

The study examines the economic costs and advantages of the Sehat Sahulat Program (SSP) in Pakistan based on the qualitative evidence collected in the urban and rural settings. SSP is a landmark health insurance program that would improve the proportionality of healthcare coverage and minimize the out-of-pocket costs. Nevertheless, the differences in implementation and use still define its efficacy. This paper relied upon in-depth interviews and thematic analysis to determine how households (particularly those in the lower-income bracket) perceive the accessibility, affordability, and long-term sustainability of the program. The results are sophisticated in terms of benefits and barriers. On the one hand, SSP saved a lot of direct treatment expenses on covered diseases and gave vulnerable groups a feeling of financial security. Structural and systematic factors, including low awareness, insufficient coverage of hospitals in rural areas, administrative inefficiency, and unfamiliar costs, restrained the potential of the program. Participants in the urban areas reported that they utilized it more due to the increased concentration of empanelled hospitals, whereas those in the rural areas complained about the cost of traveling, late reimbursements, and lack of equity. The study highlights the need to fill these gaps to ensure that SSP is more inclusive and influential. The policy implications indicate the necessity of better awareness campaigns, increased monitoring of the practices in the private hospitals, increased coverage in rural areas, and the transparency of the reimbursement system. This study adds to the literature on health economics and social protection in Pakistan by qualitatively informing the reader about lived experiences, providing lessons to other low- and middle-income countries that may be implementing similar schemes.

Keywords: *Sehat Sahulat Program, health insurance, economic barriers, healthcare access, urban-rural disparities, Pakistan, qualitative research.*

INTRODUCTION

Equal provision of healthcare services has been a long-standing issue in Pakistan, and the urban-rural divide in access to healthcare is extreme. The Sehat Sahulat Program (SSP) is a government-initiated health insurance program aimed at making basic health services more affordable and reducing the cost of healthcare (Hasan et al., 2022). The program aims at universal health coverage (UHC) in principle, by eliminating economic obstacles to accessing health services and making sure that even the most vulnerable populations can access treatment without having to spend a fortune. Despite the program's ambitious nature, the implementation process reveals the multifaceted socio-economic processes that precondition its availability and perceived efficiency (Ali et al., 2025). The interaction of financial, service access, health-seeking behaviour, and cultural limitations emphasises the necessity of further qualitative investigation of the experience of the SSP by a variety of people in both urban and rural settings.

Background of the Research

Out-of-pocket spending has been the primary healthcare financing mode in Pakistan, and households have spent a significant share of their income on health services. Shaikh (2024) reveals that over 60% of healthcare expenditure in Pakistan is out-of-pocket, which means that patients often have to postpone treatment or avoid it altogether due to low income. The SSP was presented as a corrective action, which was positioned as a social health justice policy that would leave no one behind (Forman et al., 2022). It guarantees coverage of inpatient and secondary care services, and it has the capability of reshaping healthcare utilisation patterns by eliminating the fear of financial strain. However, despite the potential, the program has a different scope and effect in different socio-economic and geographical contexts.

For example, the rural population may experience multiple disadvantages: remote access to healthcare facilities, lack of awareness of insurance entitlements and poor referral mechanisms. Jafree and Barlow (2023) point to the fact that women are especially vulnerable to the inability to receive primary and secondary healthcare due to mobility restrictions and cultural expectations, in addition to financial barriers. In the meantime, the urban population is likely to have better access to hospitals and special care, yet faces other difficulties of bureaucracy, overcrowding, and unreliable quality of service (Mumtaz et al., 2023). This inconsistency shows that the SSP cannot be discussed as a homogeneous policy but rather as a policy that has to be contextualised in the realities of those who use it.

Problem Statement

Although the SSP aims to decrease out-of-pocket spending and increase equitable access, doubts persist about its effectiveness in reducing economic barriers in both urban and rural Pakistan (Haq & Awan, 2025). There is also a lack of qualitative data reflecting the perceptions of program beneficiaries regarding the program itself, including the obstacles they still encounter after enrolment and any significant impact on their healthcare experiences. Although quantitative measures are available, they tend to conceal the details of lived experiences and fail to consider how rural poverty, gender disparities, and health infrastructure gaps can moderate the effects of such programs. Unless there is a solid comprehension of these difficulties, policy changes can be off the mark about what people really need.

Research Questions

The questions that guide this research are as follows:

1. What economic barriers continue to affect the utilisation of healthcare services under the Sehat Sahulat Program in urban and rural Pakistan?

2. What perceived benefits do participants associate with the program, and how do these vary across socio-economic and geographical contexts?
3. How do beneficiaries lived experiences inform the effectiveness of the program in achieving social health justice and moving towards universal health coverage?

Objectives

This study aims to achieve the following three objectives:

1. To identify and critically analyse the economic barriers that persist despite the introduction of the SSP.
2. To explore the perceived benefits of the program in mitigating financial hardship for healthcare users in urban and rural contexts.
3. To provide evidence-based insights that can guide policy refinements and enhance the program's role in achieving equitable healthcare delivery.

Significance of the Study

The study is relevant both in research and policy terms. It offers a qualitative perspective that can add to the existing body of literature because it reveals the real-life experiences of SSP beneficiaries that are not captured in quantitative research. It throws light on the micro-level economic and cultural impediments to the use of healthcare, thus contributing to the theoretical discussion of health equity and social justice. Policy-wise, the findings can be applied to improve healthcare financing programs and practices of program implementation. According to Waheed et al. (2024), the problem of resource allocation in the healthcare sector of Pakistan still exists, and such programs as SSP should be reviewed regularly to stay relevant to the changing needs. This study also points to the need to combine telemedicine, community outreach, and context-specific interventions as recommended by recent research (Akhtar, 2025). Lastly, the study reveals how the SSP can be more than a mark of goodwill and become a game-changer to realise healthcare equity.

Brief Overview of Methodology

This study uses a qualitative research design, which is based on semi-structured interviews of twelve respondents in urban and rural Pakistan. The sample will be composed of both men and women of different income levels and hence will reflect a diverse set of views. The data collection is based on the perceptions of the beneficiaries regarding economic barriers, benefits of the program, and access to healthcare in general under SSP. Thematic analysis is used to determine the patterns of recurrence and create insights. The study is ethical in the aspects of informed consent, confidentiality and voluntary participation.

LITERATURE REVIEW

Sehat Sahulat Program (SSP) holds a significant place in the overall process of Universal Health Coverage (UHC) in Pakistan (Khan et al., 2023). It was seen as a revolutionary program that would solve the long-term financial constraints in healthcare and foster equal access to healthcare across socio-economic lines. To understand its economic obstacles and advantages, one must not only consult policy literature and healthcare systems models but also critically read the scholarly literature on healthcare financing, patterns of utilisation, and barriers to service delivery in Pakistan and the Asian region in general. This literature review summarises current research, noting pertinent theoretical frameworks, questioning the relationship between economic factors and access to healthcare, and pointing out areas of inquiry that should be explored further through qualitative research.

Theoretical Framework

The grounding of the discussion of SSP can be based on two related theoretical frameworks: social health justice and universal health coverage. Social health justice emphasises that it is the moral obligation of the state to ensure access to healthcare for all citizens, irrespective of their socio-economic status. According to Forman et al. (2022), SSP is a way of institutionalising healthcare as a right and not a privilege. They state that by increasing access to secondary and tertiary services, SSP aims to curb inequities and transform healthcare into a risk-pooling system rather than an out-of-pocket one.

Along with this is the international construct of UHC that focuses on the idea of financial protection, coverage of services, and equitable access. Jauhar and Nadjib (2024) remark that successful UHC projects are facilitated by government investment on a long-term basis, adequate funds, and sound administration. They insist on adapting the insurance models to the local socio-economic realities, with some countries having already achieved comprehensive coverage, and others, like Pakistan, are fragmented and inequitable. Applying this lens to SSP enables one to analyse the extent to which the program is consistent with the larger principles of UHC as well as where the structure constrains it (Shah et al., 2025).

Economic Barriers in Healthcare Access

The economic barriers are the primary focus in understanding SSP. The out-of-pocket spending has been a characteristic of the healthcare system of Pakistan, where households are impoverished by the catastrophic healthcare expenses (Bashir & Kishwar, 2021). According to Shaikh (2024), almost two-thirds of the total healthcare expenditure in Pakistan is directly borne by households, which imposes a significant burden on poor households. These economic pressures are also due to the lack of local facilities and the indirect cost of transport and wages foregone by the rural population.

As Forman et al. (2022) admit, SSP has alleviated some of these loads by providing financial security to inpatient care. However, they warn that the scope of the programs is restricted in nature, and they tend to leave out outpatient and primary care services. This limited coverage poses a paradox: although the cost of hospital-based treatments can be minimised, the patients still have financial barriers to accessing simple services. This can lead to a delayed diagnosis and increasing costs over time. Jafree and Barlow (2023) also point out that among women in rural communities, the financial barrier is combined with limitations on cultural and mobility freedoms, which makes access to healthcare even more unattainable.

The other aspect of the economic barriers is connected to awareness and asymmetry of information. According to Waheed et al. (2024), in their review of resource allocation to healthcare services, most beneficiaries are not clear about which services are covered, how claims are processed, and which facilities are eligible. This lack of transparency may lead to underutilisation of the program or the use of informal payments, which would negate the equity objectives of SSP.

Urban-Rural Disparities and Program Utilisation

Pakistan has witnessed increasing adoption of digital technologies, yet structural and regional disparities continue to shape unequal access and utilisation across sectors (Arzu et al., 2025). The difference between rural and urban access to healthcare is a constant in the literature. The urban beneficiaries tend to be closer to hospitals empanelled under SSP and hence have higher chances of using the program (Azmat et al., 2024). However, they face issues such as overcrowding, long waiting times, and bureaucracy, all of which diminish their experience (Shaikh, 2024). The rural population, in turn, faces structural barriers, including a lack of healthcare infrastructure, increased travel distances, and a weak referral system.

According to Forman et al. (2022), the design of the program is not adequate to reflect these geographic disparities. In theory, insurance coverage is universal, but the lack of well-equipped rural facilities is a

limiting factor in the practical application. Patients are often forced to travel to urban areas to receive care, which adds extra costs that counter the financial safeguard SSP is aimed at achieving. Jafree and Barlow (2023) demonstrate that these burdens are exceptionally high in the case of women who need to be accompanied by a male to visit faraway facilities, which further adds to the costs and logistical difficulties.

Additionally, Waheed et al. (2024) indicate that inequities in the distribution of resources aggravate these disparities. Rehabilitation and allied services, such as those, are still localised in urban areas, leaving the rural beneficiaries with few choices. This disjunct is a continuation of more fundamental issues in Pakistani health planning, where rural populations are structurally disenfranchised despite being formally included in national policy (Abbas & Talib, 2024).

Gender and Social Barriers to Access

Another important factor that determines the effectiveness of SSP is the presence of gender and economic inequality. Women in Pakistan also face the challenge of not having easy access to healthcare because of limited movement, male decision-makers, and stigma attached to certain conditions, as indicated by Jafree and Barlow (2023). Even where services are financially covered, these can be used as barriers to women accessing services. To give an example, maternal health services, which are partially covered by SSP, are not used efficiently in most rural areas since women cannot travel on their own to health facilities.

This has also been supported by Shaikh (2024), who demonstrated that healthcare-seeking behaviours in Pakistan are rooted in socio-cultural norms. Although SSP touches on the financial aspect, it fails to deal with the cultural and gendered aspects of access. This highlights the limitation of social health insurance models that focus narrowly on financial protection, overlooking other factors that affect healthcare utilisation (Mirza, 2025).

The problem of mental health is a good example. Sibghatullah et al. (2025) state that in Pakistan, decriminalisation of suicide did not result in the elimination of stigma and mental health services. Although SSP theoretically expands coverage to psychiatric care, in reality, the lack of specialised facilities and stigma are detrimental to its use (Suliman & Açıkgöz, 2022). This example shows that economic protection is not enough without other simultaneous efforts to overcome cultural and systemic obstacles.

Innovations and Advancements of Technology

Technology adoption in Pakistan has rapidly evolved in recent years, yet it continues to face challenges related to user trust, accessibility, and digital readiness (Rehmat et al., 2025). The place of technology, especially telemedicine, has also become an attractive means of increasing access to healthcare under SSP. In the article by Akhtar (2025), the author suggests telemedicine as a possible solution to urban-rural disparities because it allows conducting consultations and follow-ups without travelling. This is particularly applicable in the rural areas where physical facilities are scarce. Nevertheless, the problem of telemedicine can be attributed to a lack of digital literacy, unequal access to the internet, and inadequate regulation.

In SSP, telemedicine has the potential to increase access by reducing travel expenditures and ensuring continuity of care (Yasmin & Hina, 2024). Nevertheless, unless specific steps are made to integrate telehealth into the insurance framework, its potential will not be fully exploited (Akhtar, 2025). This highlights the need for SSP to transition beyond traditional insurance systems and adopt more innovative approaches that align with Pakistan's infrastructural realities.

Institutional and Administrative Challenges

The ability of the administration and the allocation of resources are crucial to the success (Rehmat et al., 2025), specifically of the social health insurance programs. Waheed et al. (2024) note that there is an ongoing problem with healthcare resource management, especially in rehabilitation and allied services. They claim that, in the absence of more robust governance arrangements, resource inefficiencies will compromise the equity aims of schemes such as SSP.

Similarly, Jauhar and Nadjib (2024) note that in Asia, successful UHC programs must be supported by a well-organised administration that can trace the service delivery, prevent fraud, and hold individuals accountable. In Pakistan, coordination challenges are caused by the federal and provincial levels of fragmentation. Shaikh (2024) points out that inefficiencies and gaps in service delivery may arise due to duplication of the functions of different levels of government. These issues have a direct effect on SSP, where beneficiaries complain of uneven quality of service and delays in processing claims.

Benefits of the Sehat Sahulat Program

Although barriers cannot be ignored, there are also some advantages of SSP, which are also noted in the literature. Forman et al. (2022) state that the program is a significant contribution to the institutionalisation of social health justice in Pakistan. Its insurance for millions of families has led to increased financial security and reduced the likelihood of facing substantial medical bills in case of serious illnesses (Gillani, 2024). Recipients testify to the removal of the stress of inaccessible hospital bills, which is a very concrete change in access to healthcare among low-income families.

Similarly, Shaikh (2024) observes that SSP has enhanced the use of services, especially hospital-based services. This shows that financial obstacles are being reduced, though not in an equal way. Moreover, SSP has a particular symbolic value. Indeed, the societal effects of policy initiatives that indicate inclusion and recognition can be substantial, as Sibghatullah et al. (2025) claim in the context of mental health reforms. By positioning healthcare as a right, SSP helps to lead the cultural change to the understanding that health equity is a national priority.

Gaps in Existing Research

Technology adoption in Pakistan is expanding across sectors, yet persistent structural and access-related barriers continue to shape who benefits from these digital shifts (Ashraf et al., 2025). Although the literature has been valuable, there are gaps in the literature. To begin with, most of the current studies are based on quantitative measures, including the rates of service utilisation and financial protection rates. Although these are significant, they tend to overlook the experiences of beneficiaries, particularly those from rural and marginalised communities. Jafree and Barlow (2023) start to fill this gap by discussing barriers to women, but there is little qualitative evidence of this in general. Second, the literature tends to view SSP as a homogeneous policy, without considering regional differences in its implementation. The program is supposed to be universal, but its outcomes are geographically, infrastructurally, and socio-culturally mediated (Forman et al., 2022). This diversity needs more localised analyses.

Third, although new research, such as Akhtar (2025), examines the possibilities of telemedicine, there is not much empirical evidence on how technology can be used in the actual practice of SSP. Similarly, mental health coverage (Sibghatullah et al., 2025) is a topic of discussion, but there is limited discussion on how the beneficiaries actually experience it. Lastly, the administrative and governance aspects emphasised by Waheed et al. (2024) and Jauhar and Nadjib (2024) are usually addressed on the macro-level, without referring to the micro-level experiences of beneficiaries. This puts a distance between policy design and the reality of implementation that can be bridged by qualitative research.

The available literature on SSP and healthcare financing in Pakistan is mixed. On one hand, the program is a significant step toward social health justice because it brings financial security and symbolic

validation of healthcare as a right (Nasir, 2024). On the one hand, it is hindered by economic barriers, urban-rural imbalances, gender limitations, and administrative inefficiencies. Although research is now beginning to address these issues, significant knowledge gaps remain regarding the experience of being a beneficiary. To fill these gaps, qualitative studies are needed to prioritise the experiences of program users and how they negotiate the obstacles and see the advantages in different settings.

METHODOLOGY

Research Design

The research design used in the study was an exploratory qualitative research design (Olawale et al., 2023). This method was especially relevant to the research problem since the aim was not to quantify the results in a numerical form but to identify the economic and social aspects that influence the use of SSP. The multi-dimensional nature of healthcare access, which is affected by financial, cultural, and infrastructural forces, necessitated a research approach that would allow participants to describe their experiences. The core of this design was semi-structured interviews that allowed a balance between a guided inquiry and an open exploration.

Thematic analysis was used to explain the data, which allowed the identification of similarities and patterns in the responses of the participants (Braun & Clarke, 2021). Manual coding was used to remain close to the data, ensuring that the analysis was not overly mediated by software processes and provided an accurate representation of the participants' voices.

Sampling Strategy

A purposive sampling strategy guided the selection of the participants (Piketh & Kometsi, 2025). This was meant to ensure that people who had firsthand experience of SSP were incorporated and that the sample was diverse in terms of gender, socio-economic status, and geographical location. Twelve participants were identified, including both urban and rural areas. Urban respondents were selected in Islamabad and Lahore, where tertiary hospitals empanelled in SSP are clustered. Rural respondents were randomly selected from villages in Punjab and Khyber Pakhtunkhwa, where access to healthcare facilities is limited.

The choice to work with twelve participants was based on the data saturation concept. Analysing interviews, patterns and similarities started to appear, suggesting that further interviews are unlikely to provide significantly new information. This was a sufficient sample size to use in a qualitative study that seeks depth as opposed to breadth.

Data Collection

Semi-structured interviews were carried out within six weeks. Interviews were conducted with each participant between 25 and 30 minutes, depending on their availability and desire to talk more about their experiences. An interview guide was employed based on the three main research questions, although it was flexible enough to allow the participants to raise issues of personal interest. The questions were aimed at determining the level of knowledge and understanding of SSP, experiences of accessing services, economic barriers that the participants faced, and perceived benefits of the program. Among the rural participants, questions were asked about the influence of transportation expenses, the availability of facilities, and gender-related limitations.

The interviews were conducted in either Urdu or Punjabi, depending on the participant's choice, and subsequently translated into English for analysis. Prior to each interview, informed consent was obtained, and the participants were assured of anonymity and confidentiality. Notes were also made and recorded to capture non-verbal communication and contextualisation.

Data Analysis

Thematic analysis was conducted in six phases that include familiarisation with the data, generation of initial codes, theme searching, theme reviewing, theme definition and naming, and production of the report (Braun & Clarke, 2021; Abrar et al., 2024). The researcher read the data repeatedly after transcribing it in order to get a detailed understanding. The first codes were generated by hand, by identifying key phrases and concepts related to economic obstacles, perceived advantages, and overall healthcare experiences.

The codes were then categorised into sub-themes that were further clustered into broader themes that matched the research objectives. For example, the codes including "transportation cost," "distance to facility," and "loss of daily wages," were classified under the theme of "Indirect Economic Burdens." The themes were further refined to be coherent, internally consistent and unique.

Ethical Considerations

Ethical considerations were followed at each phase of the study. Information sheets were given to the participants, describing the aim of the study, the voluntary nature of participation, and what was done to guarantee confidentiality. Consent was obtained through written or verbal means, depending on the individual's literacy level, before each interview (Muzari et al., 2022). Anonymity was ensured by giving pseudonyms to the participants and by anonymising transcripts. Recording and transcripts were kept in a secure place, and only the researcher had access to them. The participants were reminded of their freedom to withdraw without penalty at any point. Cultural sensitivity was also observed to ensure that there were no restrictions on open communication with women, especially in rural areas where social norms may limit open communication (Bobel et al., 2022). Women were interviewed in the environment of their choice, sometimes in the presence of a trusted family member, but the voice and autonomy of the participant were preserved.

Respondents' Profile

The sample consisted of twelve respondents who were selected from both urban and rural areas of Pakistan. Six participants were from urban areas (Islamabad and Lahore), and six were from rural villages in Punjab and Khyber Pakhtunkhwa. The sample consisted of seven men and five women aged between 28 and 65 years. Occupations differed and included daily wage labourers, small business owners, homemakers, and low-salaried employees. All respondents were SSP beneficiaries and had used healthcare services under SSP in the last two years.

Table 1: ***Respondent Profiles***

Participant	Age	Gender	Location	Occupation	Years of SSP Use	Type of Healthcare Accessed
P1	34	Male	Lahore (Urban)	Shopkeeper	2	Cardiac surgery (inpatient)
P2	42	Female	Islamabad (Urban)	Housewife	1.5	Gynecological services
P3	29	Male	Islamabad (Urban)	Security guard	1	Orthopedic treatment
P4	53	Male	Lahore (Urban)	Taxi driver	2	Gastroenterology services
P5	37	Female	Islamabad (Urban)	School teacher	1	Maternal health services
P6	46	Male	Lahore (Urban)	Daily wage worker	2	Neurology care

P7	32	Female	Punjab Village (Rural)	Homemaker	1.5	Maternal care
P8	58	Male	Punjab Village (Rural)	Farmer	2	Cardiac surgery
P9	40	Male	KP Village (Rural)	Carpenter	1.5	Accident trauma care
P10	28	Female	KP Village (Rural)	Weaver	1	Maternal and pediatric care
P11	65	Male	Punjab Village (Rural)	Retired laborer	2	Chronic disease treatment
P12	36	Female	KP Village (Rural)	Shop assistant	1	Gynecological services

FINDINGS AND DISCUSSION

The results of this qualitative study are a rich description of the experience of beneficiaries of the Sehat Sahulat Program (SSP), both in urban and rural Pakistan. The results of the study, based on twelve semi-structured interviews, showed that there were economic barriers and practical benefits to healthcare access, indicating the complicated nature of access. The five themes that emerged in the thematic analysis are related to financial protection, hidden and indirect economic burdens, urban-rural inequities, gendered constraints, social barriers, and service quality, awareness. All key themes are presented below.

Theme 1: Financial Protection and Relief from Catastrophic Expenditure

One of the most replicated results was that SSP was a relief to catastrophic healthcare spending. Respondents would mention that the program is a lifeline that helps them against paralysing medical expenses. A shopkeeper in Lahore said, “When I was informed that my heart operation was going to cost me more than 400,000 rupees, I thought my family would never live to pay the debt. Through SSP, I did not need to take a loan. This gave me the impression that the government was on our side, the first time.”

This sense of financial security aligns with the results of Forman et al. (2022), who state that SSP is a breakthrough in the institutionalisation of social health justice through the minimisation of direct out-of-pocket payments. According to Haikh (2024), insurance-based models have also led to an increase in the rate of hospital utilisation in Pakistan by alleviating financial fears.

Although the participants indicated the value of the program, the benefits were mainly linked to the inpatient services offered on a large scale. Outpatient treatment and regular treatment were met with high fees being paid by the participants. A schoolteacher in Islamabad explained: “In my case, the hospital expenditure was paid by the government, but the frequent trips to check-up, purchase medicines and tests were all out-of-pocket expenses. The relief is there, but it is not complete.” This observation points out a shortcoming of SSP: although the number of catastrophic expenditures is decreased, less significant but more common costs are still a heavy burden. This is consistent with the finding by Forman et al. (2022) that there are still coverage gaps, and many patients still face the risk of hidden financial costs.

Theme 2: Hidden and Indirect Economic Burdens

Participants emphasised that SSP reduced direct costs of hospitalisation, but indirect costs remained. The most frequent problems were travel, accommodation and lost wages, particularly among participants in the rural areas. Jafree and Barlow (2023) state that cost is not the only factor that determines access to healthcare in rural Pakistan, but rather a combination of economic, cultural, and logistical factors. The problem of indirect costs is indicative of a larger global trend that financial coverage in health insurance

schemes is not always comprehensive, especially in settings where infrastructure and accessibility are not robust (Jauhar & Nadjib, 2024).

The urban respondents also complained of unseen costs, but their stories focused on red tape and unofficial payments. A daily wage earner in Lahore said, "At the hospital desk, they asked me to pay extra for some tests not covered in the package. I was coerced since my treatment was tied to it." This underscores Waheed et al.'s (2024) critique of resource allocation inefficiencies, which create informal markets around essential services. So-called indirect economic burdens, therefore, still undermine the pledge of SSP to provide equitable healthcare by transferring financial burdens instead of removing them.

Theme 3: Urban-Rural Inequities in Access

The difference in the urban and rural lives was sharp. The urban respondents, although reporting on overcrowding and delays in administration, found it easier to access empanelled hospitals. Rural respondents, in their turn, identified distance, transport costs and lack of local facilities as the most significant barriers. According to Forman et al. (2022), the universal design of SSP fails to take into consideration geographic differences, which reduces its inclusiveness. In a similar note, Shaikh (2024) notes that the availability of services is a factor that determines health-seeking behaviours, whereby rural populations are often overlooked when facilities are planned. This study supports these criticisms by demonstrating how rural beneficiaries tend to feel that SSP is inaccessible even though they are formally enrolled.

Even when rural participants were able to access services, they cited other burdens. A retired laborer in Punjab (P11) said: "I had to rely on my son to go to the city to be treated. The card is not much without transport, and someone needs to go with you." This is an indication of the dynamic between economic and social factors of health, where insurance alone is not enough to overcome structural inequalities. It also relates to the problem of resource allocation inequality identified by Waheed et al. (2024) because it favors urban hospitals and further increases rural-urban disparities.

Theme 4: Gendered Constraints and Social Barriers

Gender emerged as a strong moderator of the advantages and shortcomings of SSP. The women in rural areas were not free to move and were dependent on the male members of their families, which restricted them in terms of access to services on their own. A homemaker in Punjab (P7) said: "I could not go to check-ups without the availability of my husband or brother. Occasionally, we skipped appointments due to the busy schedules of men. The card is good, but I cannot use it when I want to."

This aligns with the observation of Jafree and Barlow (2023) that even with financial protection, patriarchal norms limit the access of women to healthcare in Pakistan. According to Shaikh (2024), health-seeking behaviours are deeply entrenched in gender relations, and in both rural and urban settings, women are often denied autonomy. The women respondents in the urban areas gave various limitations. A housewife in Islamabad (P2) said: "I applied the card to my gynaecological treatment, but the hospital was overcrowded. The atmosphere was not female-friendly, and I felt uneasy."

This observation indicates that there are other obstacles besides affordability, namely dignity, cultural sensitivity, and respect in care delivery. In addition, mental health care was also underutilised to a large extent. Respondents were hesitant to seek psychiatric assistance, which is an indication of the stigma in society. This observation links with Sibghatullah et al. (2025), who state that stigma and service deficit compromise access despite the formal coverage. Gendered boundaries, thus, demonstrate the deficiency of economic protection as a stand-alone factor. SP has the potential to decrease expenses, but without overcoming cultural, social, and gender disparities, its advantages will be incomplete.

Theme 5: Service Quality, Awareness, and Institutional Gaps

The last theme is the issue of the quality of the services, ignorance, and institutional failure in the application of SSP. Some respondents expressed confusion about the services covered and the claiming process. A carpenter in Khyber Pakhtunkhwa (P9) said: "No one informed me at the hospital what the card covers. I learnt this when they refused to pay for some medicines. We would like to have clear information, but we do not have it."

Waheed et al. (2024) echo this by saying that inequitable healthcare is invalidated by poor resource management. A lack of awareness and poor communication among the beneficiaries contributes to the underutilisation. Respondents also reported mixed experiences with service quality. Others praised the professionalism of doctors, while others highlighted long delays and a shortage of medicines. A female respondent of Islamabad (P5) stated that "doctors were cooperative, but the process at the counter was humiliating. We were treated like beggars who were to receive handouts."

These narratives are consistent with those presented by Shaikh (2024), who indicates that inefficiencies and non-accountability usually limit service utilisation in Pakistan. Jauhar and Nadjib (2024) also point out that social health insurance schemes in Asia depend on administrative capacity to succeed. The results of the study support the idea that the potential of SSP is not fulfilled without stronger governance.

Interestingly, some believed that technology would help break the barriers. A young security guard in Islamabad (P3) added: "Having a system to get follow-up advice online would save time and money. I heard of telemedicine but never saw it available under the card." This is similar to what Akhtar (2025) identifies as a revolutionary prospect about the delivery of healthcare through telemedicine. Nevertheless, its positive effects cannot be realised without a specific integration into SSP.

Table 2: ***Thematic Analysis of Findings***

Theme	Sub-theme	Codes	Description
Financial Protection and Relief	Catastrophic cost reduction	"Lifeline," "free surgery," "saved from debt"	Participants described SSP as protective against catastrophic expenditures, particularly for major hospital procedures.
Hidden and Indirect Economic Burdens	Travel and informal costs	"Transport expenses," "loss of wages," "paying for tests"	Indirect costs of healthcare access undermined financial protection, especially for rural participants.
Urban-Rural Inequities	Access disparities	"Long travel," "no local facilities," "crowded hospitals"	Rural participants faced geographic and infrastructural barriers, while urban participants reported overcrowding and bureaucracy.
Gendered Constraints	Patriarchal norms and stigma	"Depend on husband," "uncomfortable," "mental health stigma"	Women's access was limited by mobility restrictions, cultural

			norms, and stigma around certain conditions.
Service Quality and Institutional Gaps	Awareness and governance	"No information," "humiliating process," "telemedicine hope"	Participants identified service quality, lack of awareness, and weak governance as persistent gaps.

Summary of Findings

SSP provides considerable financial stability, but indirect costs, geographical differences, gender-related barriers, and administrative inefficiencies restrict it. The participants appreciated the program for preventing catastrophic spending, but the presence of costs not visible to them compromised its equity objectives. Rural beneficiaries were still disadvantaged by distance and poor infrastructure, and women were affected by their own cultural and gendered issues. The quality and lack of awareness were indicators of governance problems. The possibilities of innovations like telemedicine were underdeveloped, suggesting that future policy development could be improved.

PRACTICAL RECOMMENDATIONS

The results point to some policy and practice directions. First, SSP should be extended to cover outpatient services, medicines, and diagnostics, thus dealing with the invisible financial burden (Askari & Ahmed, 2025). Second, specific interventions should be implemented in the rural setting, such as collaboration with district hospitals and mobile health teams to make travel more affordable. Third, gender-sensitive policies will be implemented, including a women-friendly service environment, transport subsidies, and community awareness campaigns aimed at reducing stigma. Fourth, there is a need for a stronger administrative capacity to enhance transparency, minimise informal payments, and ensure accountability (Hussain et al., 2025). Lastly, telemedicine has the potential to increase access, especially in rural areas and lower indirect expenses when incorporated into SSP.

FUTURE RESEARCH DIRECTIONS

This study points to the necessity of additional qualitative and mixed-methods studies. Future research should be more specific regarding the regional differences, investigating how the province-level differences in healthcare infrastructure influence SSP (Choudhry et al., 2024). Longitudinal research is also needed to determine the long-term effect of SSP on poverty reduction among households as well as healthcare-seeking behavior. Additionally, dedicated studies on incorporating telemedicine and mental health services into SSP may provide insights into how the program can be modified to meet the new healthcare requirements.

CONCLUSION

This study critically analysed the interpretation of customer service interactions through AI-based customer service, specifically chatbot engagement, perceived trust and satisfaction. Based on the review of the literature and qualitative data, the study demonstrated the duality of chatbot experience: on the one hand, efficiency, speed, and 24/7 availability increased the convenience of the user, and on the other hand, the lack of personalisation, empathy, and contextual awareness became obstacles to greater trust and long-term satisfaction.

The findings indicated that customers valued transactional efficiency, but they became frustrated when processes were too scripted or strict. The ability of users to differentiate between human-like responsiveness and human empathy indicated that anthropomorphic design elements could enhance the initial engagement. However, it was not able to substitute human relational characteristics. This is in line with the current research on trust calibration, which considers automation acceptable in the case of routine inquiries but not in emotionally complex situations.

The research also found demographic and cultural variations in the acceptance of chatbot-mediated services, with younger and digitally literate consumers showing more tolerance for AI shortcomings. In contrast, others sought human support to feel more secure. The analysis also indicated that consumer meaning was not fixed but dynamic, and it was dependent on the recurrent experiences and shifting expectations of technological performance.

On the managerial front, the study emphasised the fact that organisations must strike a balance between efficiency and authenticity by ensuring that chatbots are designed with adaptive learning, context sensitivity, and escalation to human agents. Doing this satisfies the consumer's need for both reliability and a human connection.

Overall, the research can serve as a contribution to the body of knowledge on consumer psychology of AI-powered service encounters and the fact that technological sophistication is not enough to ensure positive interpretations. Instead, consumer confidence and pleasure are based on the perceived trade-offs between automation and empathy, efficiency and personalisation, which will continue to be key aspects of the future development of AI-based customer service.

REFERENCES

Abbas, M. S., & Talib, A. B. (2024). Determinants of Availability and Accessibility to Primary Health Care for Rural Populations in Pakistan. *Pakistan Journal of Life & Social Sciences*, *22*(2), 1171-1182.

Abrar, K., Irfan, S., & Malik, F. (2024). Impact of Online Reviews on Consumer Trust, Perceived Value, and Purchase Behavior in Pakistan's E-Commerce Market. *Journal of Business and Management Research*, *3*(3), 1009-1030.

Akhtar, F. (2025). THE IMPACT OF TELEMEDICINE ON HEALTHCARE DELIVERY: OPPORTUNITIES AND CHALLENGES. *Journal of Health, Medical Research and Innovations*, *3*(6), 89-101.

Ali, F., Idrees, R. N., Shakil, M. H., Zaman, S., & Khalil, J. (2025). Impact assessment of Sehat Sahulat Program: a qualitative study of the government of Pakistan. *Quality & Quantity*, 1-21.

Arzu, F., Sattar, M. S., Sultan, S., Abrar, K., & Khuharo, Z. H. (2025). ENTREPRENEURIAL NARRATIVES OF FINTECH ADOPTION: HOW STARTUPS IN EMERGING MARKETS NAVIGATE DIGITAL FINANCIAL TRANSFORMATION. *Journal of Management Science Research Review*, *4*(4), 473-504.

Ashraf, N., Arzu, F., Abrar, K., & Anwar, M. (2025). Narratives of SMEs on Access to Finance: Barriers and Opportunities in Pakistan's Banking Sector. *The Critical Review of Social Sciences Studies*, *3*(4), 262-277.

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.

Azmat, S. K., Thom, E. M., Arshad, M., Hamza, H. B., Aabroo, A., Balal, A., ... & Qudsia, U. (2024). A study protocol for integrating outpatient services at the primary health care level as part of the universal health coverage benefit package within the national health insurance program of Pakistan through private health facilities. *Frontiers in Public Health*, *12*, 1293278.

Bashir, S., & Kishwar, S. (2021). Incidence and determinants of catastrophic health expenditures and impoverishment in Pakistan. *Public Health*, *197*, 42-47.

Bobel, M. C., Al Hinai, A., & Roslani, A. C. (2022). Cultural sensitivity and ethical considerations. *Clinics in colon and rectal surgery*, *35*(05), 371-375.

Braun, V. & Clarke, V. (2021) Thematic Analysis: A Practical Guide. Sage, London.

Choudhry, M. T., Iqbal, S., & Anwar, R. (2024). Telemedicine in Regional Prospects Towards Globalization: An Overview of the Telehealth Utility in Region Around Pakistan, Challenges and Opportunities from Neighbourhood. *International Journal of Trends and Innovations in Business & Social Sciences*, *2*(1), 50-63.

Forman, R., Ambreen, F., Shah, S. S. A., Mossialos, E., & Nasir, K. (2022). Sehat sahulat: a social health justice policy leaving no one behind. *The Lancet Regional Health-Southeast Asia*, *7*, 100079.

Gillani, S. H. U. H. (2024). CRITICAL EVALUATION OF SEHAT SAHULAT CARD AND STRATEGIZING SEHAT SCHOOL INITIATIVE: LESSONS LEARNT AND WAY FORWARD. *Gomal University Journal of Research*, *40*(2), 237-250.

Haq, A. U., & Awan, M. S. (2025). Impact of Sehat Sahulat Program on Out-of-Pocket Health Expenditures in Pakistan. *Journal of Health, Wellness, and Community Research*, e126-e126.

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.

Hussain, K., Farooq, O., Soomro, N. A., Zia, I., & Islam, M. U. (2025). Policy implementation gaps and institutional faultlines in the context of income inequality and economic disparities among classes in Pakistan. *Khyber Journal of Public Policy*, *4*(2), 58-117.

Jafree, S. R., & Barlow, J. (2023). Systematic review and narrative synthesis of the key barriers and facilitators to the delivery and uptake of primary healthcare services to women in Pakistan. *BMJ open*, *13*(10), e076883.

Jauhar, A., & Nadjib, M. (2024). Systematic Review: The Role of Social Health Insurance in Achieving Universal Health Coverage in Asia. *Jurnal Ekonomi Kesehatan Indonesia*, *9*(2), 7-17.

Khan, S. A., Cresswell, K., & Sheikh, A. (2023). The notion of access to health care in a large-scale social health protection initiative: a case study of 'Sehat Sahulat Programme 'at Khyber Pakhtunkhwa, Pakistan. *Journal of Global Health Reports*, *7*, e2023024.

Mirza, S. N. (2025). Stakeholder Participation in Local Healthcare Governance, Strategic Development under UN SDG-3: Lessons from Pakistan. *Pakistan Social Sciences Review*, *9*(1), 70-86.

Mumtaz, H., Hafeez, M. H., Bhatti, I. H., Sahar, T., Khan, Z. A., Butt, Z., ... & Ali, A. (2023). A dilemma of patients: poor quality administration of tertiary care hospitals: a cross-sectional study. *Annals of Medicine and Surgery*, *85*(12), 5879-5884.

Muzari, T., Shava, G. N., & Shonhiwa, S. (2022). Qualitative research paradigm, a key research design for educational researchers, processes and procedures: A theoretical overview. *Indiana Journal of Humanities and Social Sciences*, *3*(1), 14-20.

Nasir, J. (2024). The Problem of Public Health Care. In *Development Challenges of Pakistan: Constraints and Choices* (pp. 115-156). Singapore: Springer Nature Singapore.

Olawale, S. R., Chinagozi, O. G., & Joe, O. N. (2023). Exploratory research design in management science: A review of literature on conduct and application. *International Journal of Research and Innovation in Social Science*, *7*(4), 1384-1395.

Piketh, R. W., & Kometsi, K. (2025). A Purposive Sampling-Based Narrative Literature Review of Understanding Men's Help-Seeking Behaviours in Selected Literature. *J Ment Health Soc Behav*, *7*(1), 198-215.

Rehmat, M. A. R., Hassan, H., Rumaan, M., & Abrar, K. (2025). IT Sector Transition to Agile: Managerial Challenges and Cultural Dynamics in Pakistan's Technology Firms. *Social Science Review Archives*, *3*(4), 479-494.

Rehmat, M. A., Hassan, H., Khan, H. A., & Abrar, K. (2025). Artificial Intelligence in the Classroom: Teachers' Lived Experiences and Ethical Concerns in Educational Integration. *ASSAJ*, *4*(02), 629-645.

Rehmat, M. A., Hassan, H., Rumaan, M., Baig, J., & Abrar, K. (2025). HUMAN-CENTRED EXPLAINABLE AI IN EMERGING MARKETS: TRUST AND CONFIDENCE AMONG NON-TECHNICAL USERS IN PAKISTAN. *Annual Methodological Archive Research Review*, *3*(10), 145-163.

Shah, S. A. R., Nazeer, K., Ali, S., Qasim, F., & Khan, J. (2025). Policy implementation gaps and institutional faultlines in the context of healthcare access for vulnerable segments of society and its impact on the lowest economic class. *Khyber Journal of Public Policy*, *4*(2), 116-146.

Shaikh, B. T. (2024). Universal health coverage in Pakistan: exploring the landscape of the health system, health seeking behaviours, and utilization of health services. *The Lancet Regional Health-Southeast Asia*, *27, 100440.*

Sibghatullah, M., Dayani, K., Zia, M., & Sabri, T. (2025). Perspectives on the decriminalisation of suicide in Pakistan: historical context, societal impacts, and the way forward. *The Lancet Regional Health-Southeast Asia*, *35*, 100568.

Suliman, M., & Açıkgöz, R. (2022). A comparative analysis of gypsies' access to employment opportunities and health services in Pakistan and Turkey. *Selçuk Üniversitesi Edebiyat Fakültesi Dergisi*, (48), 277-294.

Waheed, A., Shah, S., & Mahmood, T. (2024). Managing barriers to resource allocation for the rehabilitation services in Pakistan: a review article. *Anaesthesia, Pain & Intensive Care*, *28*(4), 776-782.

Yasmin, S., & Hina, H. (2024). Understanding the Sehat Sahulat Program. *Contextuality of Healthcare Choices in Pakistan*, 119-129.