Policy Implementation Gaps and Institutional Fault-Lines in the context of Healthcare Access for Vulnerable Segments of Society and its Impact on the Lowest Economic Class

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KJPP

Citation:
Shah, S. A. R., Nazeer, K., Ali, S., Qasim, F., & Khan, J. (2025). Policy implementation gaps and institutional fault-lines 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), PP. 116-146*

Article Info:
Received: 15/05/2025
Revised: 20/05/2025
Accepted: 25/05/2025
Published:31/05/2025

Abstract:

This paper explores economic and institutional barriers to healthcare access among vulnerable populations in Pakistan, with a specific focus on Khyber Pakhtunkhwa (KP). Despite constitutional mandates and global health commitments, Pakistan's healthcare system remains fragmented and underfunded, with public health expenditure below 1% of GDP. Vulnerable groups—daily wage earners, women-headed households, persons with disabilities, and rural communities—face intersecting challenges such as high out-of-pocket expenses, long distances to facilities, discrimination, and limited infrastructure. Applying economic theories including Human Capital, Welfare Economics, Market Failure, and Opportunity Cost, the study analyzes structural inequities. Using KP as a case study, it advocates for targeted policy interventions including expanded Sehat Sahulat coverage, mobile clinics, and rural health workforce incentives. A phased strategy is proposed to enhance access, equity, and sustainability in healthcare delivery.

Key words:

Healthcare Access, Vulnerability, Economic Barriers, Khyber Pakhtunkhwa, Universal Health Coverage

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Introduction

Globally, healthcare is recognized as a public good and a fundamental component of human development. Health and well-being of a population not only represent a moral and constitutional obligation but also serve as key enabler of economic growth, poverty reduction, and social cohesion. A healthy population positively impacts labor productivity, educational achievement, and decreases public expenditure on curative health. In recent decades, global frameworks such as the Sustainable Development Goals (SDGs) and the Universal Health Coverage (UHC) have placed health at the forefront of the development policy. The World Health Organization (WHO) affirms that health must be treated as both a human right and a global public good, calling universal healthcare an "utmost development priority" (WHO, Close to one billion people globally are served by health-care facilities with no electricity access or with unreliable electricity, 2023)

Pakistan has also embedded the commitment to healthcare within its constitutional and strategic frameworks. Article 38(d) of the Constitution of Pakistan obligates the state to provide basic necessities including "medical relief, for all such citizens, irrespective of sex, caste, creed or race, as are permanently or temporarily unable to earn their livelihoods on account of infirmity, sickness or unemployment". This domestic mandate is reinforced by international commitments under SDG 3. National strategies, including Vision 2025, pledged to increase public health expenditure to 3% of GDP (GoP, 2016). However, actual spending remains around 1% of GDP (Finance, 2024) which is significantly below both targets and global norms.

In 2010, the 18th constitutional amendment devolved healthcare responsibilities to the provinces. While this reform allowed local authorities to tailor interventions to regional contexts as per their specific needs, it also exposed capacity gaps, fragmented responsibilities, and uneven levels of institutional maturity. At the federal level, the Ministry of National Health Services, Regulations and Coordination (M/o NHSR&C) deals with the subject of health, national and international coordination in the fields of public health, enforcement of drug laws and regulations and vertical programs such as polio eradication (NHSR&C, Mission & Vision, 2025). Provincial governments are responsible for health infrastructure and service delivery, including Basic Health Units (BHUs), Rural Health Centers (RHCs), Tehsil Headquarters Hospitals (THQs), District Headquarters Hospitals (DHQs) and Medical Teaching Hospitals (MTIs). The implementation of health polices is typically delegated to district-level health offices, although the erosion of elected local governments has weakened their operational effectiveness.

This fragmented and resource-constrained health system poses particular risks for vulnerable groups. WHO defines vulnerable groups as "groups that experience a higher risk of poor health outcomes due to barriers in accessing healthcare services, discrimination, socio-economic disadvantage, or underlying health conditions".

As per the National Social Protection Policy (2016), these include women-headed households, persons with disabilities, the elderly, transgender persons, minorities, and geographically isolated communities. Besides these vulnerable communities, the lowest economic class, approximately 39% of the population (Pakistan Bureau of Statistics, 2023) comprising of daily wage earners, informal workers, and slum residents, also face the greatest structural and financial barriers to quality healthcare. In Khyber Pakhtunkhwa (KP), approximately 48.50% of the total population lives below poverty line.

Summary for KP based on PBS Census 2023			
Area	**MPI Incidence %**	**Population (million)**	**Estimated Number of Poor People (million)**
Overall	48.50%	40.85	19.81
Urban	19.60%	10.63	2.08
Rural	54.10%	30.22	16.35

Source: Directorate of Health Services-KP

Vulnerable populations in Pakistan encounter multiple and overlapping barriers in accessing healthcare. The far-flung rural communities lack nearby health facilities or functioning referral systems, even when services exist, financial costs such as transport, user fees, and informal payments deter utilization. Moreover, these people reportedly often experience discrimination or neglect at public hospitals, reducing trust in formal care (Aman, 2020). Cultural and linguistic barriers further complicate outreach to ethnic minorities or indigenous populations. In urban slums, overcrowding and poor sanitation increase health risks, which further results into massive pressure on public hospitals.

Conceptual Framework

Vulnerable groups in Pakistan face considerable problems in accessing proper healthcare for their families. For instance, a father who needs to take his ill child to remote hospital usually does not have transport or assistance. While government healthcare is theoretically free, drugs and transport can be expensive, and distance itself is a barrier. These challenges can be understood by studying them in conjunction with core theories.

- **Human Capital Theory:** Human Capital Theory postulates that health and education are investments that enhance the productivity of an individual. A sick child left untreated may suffer long-term health and educational deficits, reducing future productivity and human capital. Similarly, ill parent (or one who needs to take care of an ill child on a regular basis) cannot work regularly, eroding human capital of the household.

- **Opportunity Cost:** Opportunity cost is the value of the best alternative forgone. For a daily wage worker, a day of going to a hospital is a day of lost pay. Rural informal workers, particularly men, prefer to delay or skip treatment since it is extremely costly to take time off. As the journey itself costs time and money that could have been spent earning. This high opportunity cost traps families into a vicious cycle of debts, poor health, since untreated illness can get worse and eventually cost more.
- **Market Failure:** Market failures occur when free markets fail to distribute resources efficiently or equitably. Rural healthcare is under-provided by the market. Private providers are unable to make profits in low-density, low-income areas. Rural hospitals or clinics, that are crucial to communities, cannot exist if profit is the sole criterion—there are insufficient paying patients to cover costs. Externalities like disease transmission and the social benefit of a healthy workforce are not accounted for by the market. This justifies government intervention to correct the failure.
- **Welfare Economics:** Welfare economics aims at maximizing social welfare and equity. When 56–60% of Pakistan's health expenditure is out-of-pocket, poor households experience catastrophic expenditure. Increased OPE drive many poor into deeper poverty. This discriminatory outcome is a welfare loss. From a welfare economic perspective, interventions (e.g. insurance, subsidies) are needed in order to ensure access of the poor to proper healthcare. Initiatives to offer the poor free care, such as the Sehat Sahulat program, serve the purpose of equity.
- **Demand and Supply Theory:** Basic economics of supply (health care that is available) and demand (ability/necessity to pay for health care). Demand is high in rural areas because of disease burden in absence of preventive care, but effective demand is pushed down by in-adequate ability to pay and poor health literacy. Supply is unevenly distributed, i.e. specialist doctors and clinics are in cities, leaving villages underserved. Long distances and absence of public transportation further lower the quantity consumed. The outcome is unmet need: families forgo care because of high costs.

The above theories emphasize the need for targeted interventions. A State has to ensure that children's health requirements are met immediately, if it wants to invest in human capital. There is a need to reduce the opportunity costs by bringing the healthcare closer – for example, through mobile clinics or adequately staffed BHUs/RHCs – meaning daily wage earners don't have to lose a day's wage to access healthcare. In order to correct market failures, for the poor, the government may extend programs such as Sehat Sahulat to include outpatient care and make rural hospitals financially sustainable. Improving welfare and equity demands universal health coverage, so that no one is driven poor by a child's sickness. Lastly, matching supply with demand means training and incentivizing healthcare providers to cover rural areas and increasing outreach services.

The combination of these interventions would constitute a strong policy response, enabling poor rural households to receive care for their children without excessive economic sacrifice.

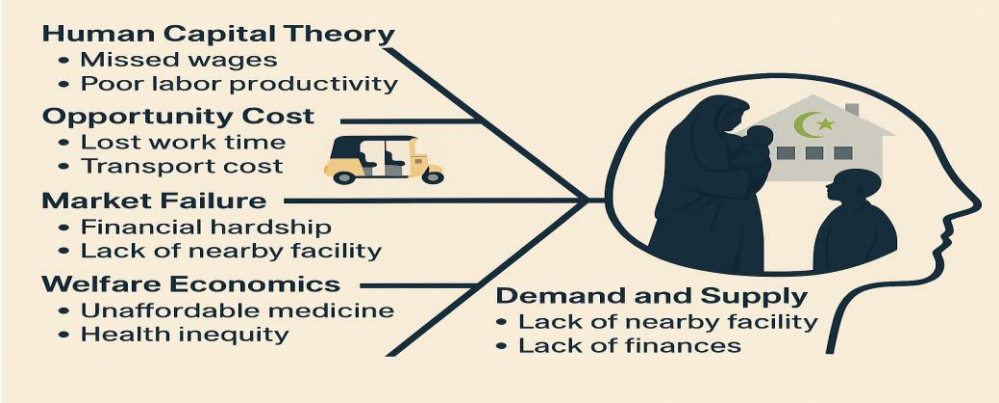


Figure: Fishbone diagram illustrating how various economic factors contribute to access barriers to healthcare among rural daily wage earners. Each "bone" is one economic theory category of cause, with sub-causes such as lost income, transport, cost of medicines, and facility distance.

Statement of Problem

The Constitution of Pakistan and international commitments such as the Sustainable Development Goals (SDGs) recognize access to healthcare as a fundamental right. However, the vulnerable segments of the society in Pakistan including the lowest economic class seemingly face significant barriers in accessing healthcare services. Therefore, there is a need to identify policy implementation gaps and institutional fault lines that hinder equitable access to healthcare for vulnerable groups.

Scope of Study

The research is grounded in the identification and examination of salient gaps in policy implementation of healthcare policies as well as the fault lines in the institutional mechanisms in Pakistan and particularly how these gaps affect healthcare access to the poorest economic strata. This study investigates institutional, financial, and operational aspects of access and delivery of healthcare, particularly to the vulnerable groups like the informal sector workers, female-headed households, disabled individuals, transgender individuals, and peri-urban or rural populations.

The analysis is provincial in scope, with primary focus on Khyber Pakhtunkhwa (KP), but uses national, provincial and district-level data to highlight differences and implementation divergence by context. Public sector schemes, including the Sehat Sahulat Programme in KP, are compared with multilateral, donor-sponsored, public-private schemes like People's Primary Healthcare Initiative (PPHI) and civil society-supported schemes to give a broad overview of the health scene. The analysis also uses Pakistan's constitutional guarantees, National Health Vision 2016–2025, SDGs, and WHO standards to review systemic alignment and identify institutional fault lines.

The aim is to provide evidence-based recommendations to the policy makers on healthcare governance reforms and improving access for the vulnerable communities. The paper focuses on structural, administrative, and policy issues influencing healthcare accessibility to the lowest economic class.

Research Methodology

This policy paper applies a qualitative, descriptive research design to evaluate the institutional and economic barriers to access to healthcare among vulnerable groups in Pakistan with specific focus on KP. The research integrates a multi-level institutional analysis at the federal, provincial, district, and tehsil levels. Semi-structured primary data was collected through interviews of senior government official of the Directorate of Health Services (KP), the DHO (Peshawar), and the official of the M/o NHSR&C. The interviews provided firsthand data on governance problems, coordination gaps, and frontline implementation loopholes.

Secondary data were gathered from policy reports, performance audits, World Bank and World Health Organization reports, and research papers on public health financing and the health system of Pakistan. Analysis tools, including situational analysis, SWOT & EETH, GAP analysis, to identify the policy implementation gaps and institutional fault-lines. The research design allows contextual and evidence-based comprehension of the issues and informs practical policy recommendations.

Situational Analysis

Pakistan's healthcare sector is not uniformly developed, and there are extensive access and outcome gaps, particularly among the poor and rural segments. Maternal mortality ratio (MMR) fell from 276 to 189 per 100,000 live births (NIPS, 2019) and life expectancy is 66 years (Economic Survey of Pakistan, 2023). Yet, nearly 50% of the population has no access to primary healthcare, and 42% are also not covered under health insurance and are at risk of high out-of-pocket health costs (Ijaz, 2024).

Despite targets for SDG-3 and the National Health Vision 2016–2025, maternal and child health indicators are poor. Infant mortality is 53 per 1,000 live births, and under-five mortality is 63 (Statista, 2021), making it the worst in Asia. Stunting is found in 38% of children under five, and the incidence of tuberculosis is 264 per 100,000 (Economic Survey of Pakistan, 2023). Public health expenditure is a mere 1% of GDP, far from the WHO's 3% threshold. Pakistan's health workforce, 1.1 doctors and 0.5 nurses/midwives per 1,000 persons (Country Nutrition Profiles, 2019), is also far short of the needed level. Primary healthcare facilities are plagued by absenteeism, shortages of medicines, and infrastructure, especially in rural regions of KP.

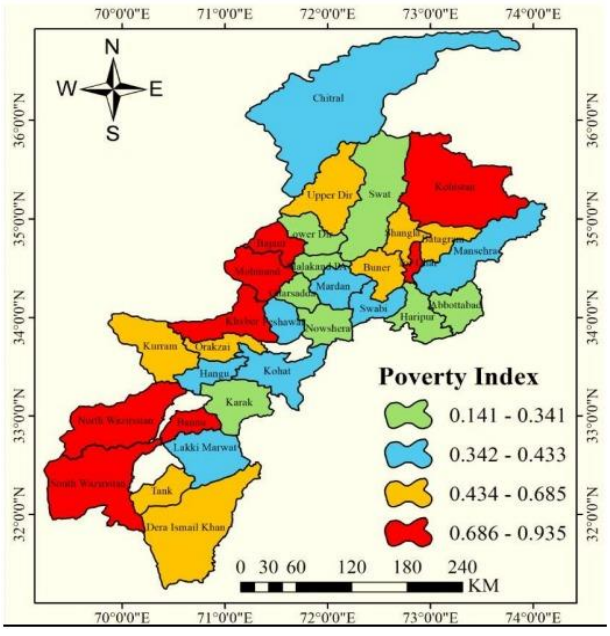
18th constitutional amendment shifted health responsibilities to the provinces, allowing KP to develop region-specific interventions. Decentralization promoted programs such as Sehat Card Plus but exposed capacity and coordination gaps.

Resultantly, KP find it difficult to harmonize with federal programs in polio eradication, nutrition, and disease surveillance. The COVID-19 pandemic revealed the vulnerability of KP's health system, derailing routine immunizations, maternal care, and chronic disease management. Rural areas experienced medicine shortages and redeployment of staff to emergencies. KP established 1166 health helpline, and establishing district emergency coordination cells. These efforts demonstrated innovation, but infrastructure and data constraints limited scalability.

KP's rural districts, like Lower Kohistan, Tor Ghar have serious healthcare access challenges. Though efforts such as the Sehat Card Plus and mobile health exist, they are poorly distributed and lack adequate resources. In Chitral district, the KP government employed telemedicine services and furthermore have contracted out 4 health facilities to Agha Khan Development Network (AKDN). Moreover, while some of the primary and secondary healthcare facilities do have the necessary medical equipment, but there are no medical technicians to operate this equipment. Similarly, massive gap in female health workers deters women from receiving maternal care. UNICEF states that skilled birth attendance in KP is significantly lower than in Punjab and less than 50% in rural settings (UNICEF)

Geographic barriers, conflict legacies, and cultural attitudes towards gender increase inaccessibility to maternal health. Rural settings usually lack functional emergency, obstetric care and referral services. While there are better services in urban cities like Peshawar, they are overcrowded and receive patients from the surrounding districts, which adds to overcrowding and decreased quality.

Figure 1: Poverty heat-map of Khyber Pakhtunkhwa



As per studies, the urban areas of KP are less poor as compared to the rural areas. Some of the major hubs of poverty in the province include Bajaur, Mohmand, South & North Waziristan, Kohistan and Khyber district, with poverty rate in these districts exceeding 70% (Fig-I) (Nafees Ahmad, 2024). Due to prevalent security situation in these districts and absence of adequate healthcare facilities in these areas, the vulnerable groups face extreme difficulties in accessing appropriate healthcare.

Moreover, many of the transgender community members also faced problem in accessing healthcare due to non-issuance of CNICs by NADRA. However, this issue has reportedly been resolved.

Policy Review

Impact of the 18th Amendment (2010) on Healthcare Administration

The 18th constitutional amendment, enacted in 2010, was a landmark shift in Pakistan's healthcare governance by devolving major subjects like health to provinces. The amendment accorded provinces jurisdiction over policymaking on matters relating to health, infrastructure, personnel, and program implementation. The federal government, post-amendment, assumed a coordinating role—managing international commitments, setting national standards, and overseeing vertical health programs such as TB and HIV/AIDS. Devolution, besides ensuring tailor made interventions, also uncovered interprovincial heterogeneity, fragmented delivery of health services, and administrative redundancy. Punjab and KP provinces showed relative harmony in the implementation of health reforms, whereas Sindh and Balochistan lagged behind because of their weak institutional and fiscal capacity.

International Health Responsibilities

Pakistan is a signatory to various global health frameworks:

- SDG 3 demands universal health coverage (UHC), improved maternal and child health, and access to medicines. National integration of SDG indicators continues in effect in the face of subnational inequities (UNDP, 2022).
- Immunization Agenda 2030 (IA2030) promotes global vaccine accessibility to all ages. Vaccine hesitancy, logistics shortages, and insecurity in some parts are the issues that haunt Pakistan (WHO, 2024)
- International Health Regulations (IHR 2005) demand preparedness to respond to health emergencies. Pakistan has been better since the post-COVID-19 but is behind in disease surveillance and cross-sectoral coordination (WHO, 2023)

Organizational Structure for Provision of Healthcare

- **Federal Institutions**: M/o NHSR&C guides national health policy, coordinates vertical programs, manages donor coordination, and offers standard setting
- **Expanded Program on Immunization (EPI):** Initiated in 1978, EPI provides immunity against ten vaccine-preventable diseases and is run in collaboration with the provinces with the assistance of WHO, GAVI, and UNICEF (WHO, 2023)
- **Coordination with Development Partners**: WHO supports UHC and International Health Regulations (IHR), GAVI and Melinda & Gates Foundation provides financing for immunization, and UNICEF coordinates cold chain systems and maternal-child health programs (WHO, 2023).

- **Provincial Institutions (Post-Devolution):** Provincial Health Departments are responsible for planning, budgeting, human resources, and public health programming. Punjab and KP have been the forerunners of systematic reforms, while Sindh and Balochistan face systemic challenges related to finances.
- **Immunization Support Programs (ISPs):** Provinces are responsible for EPI delivery, training, and monitoring. Punjab and KP programs are enhanced due to GAVI-supported system strengthening.
- **District Health Authorities (DHAs):** Function as operational wings in charge of grassroots-level service delivery but are plagued by chronic underfunding and capacity deficits.

Regulatory Authorities:

- **PMDC (Pakistan Medical and Dental Council):** Governs licensing, ethical issues, and curriculum accreditation (PMDU, 2023)
- **DRAP (Drug Regulatory Authority of Pakistan):** Regulates drugs, ensuring drug quality and safety through enforcement of the DRAP Act 2012 (DRAP, 2012).
- **Provincial Health Commissions**: PHC (Punjab) and KPHCC (KP) oversee healthcare standards, accredit facilities, and conduct probes.

National and Provincial Health Policies

- **The National Health Vision (2016–2025)**: It is the federal health governance roadmap for the post-devolution era. UHC, primary care, immunization, maternal and child health, and emergency preparedness are given top priority (NHSR&C, 2016). The UHC Benefit Package (2020) lists 88 key services to be provided across the country as a standard package, focusing on the poorest 40%.
- **National Immunization Policy:** This policy anchors EPI operations, connecting services to maternal-child health platforms. Technologies like E-Vaccs (Punjab) and EPI-MIS (KP) facilitate real-time monitoring. Vaccine hesitancy, rural-urban disparities, and security issues still exist despite the progress.
- **Provincial Health Strategies**: Punjab's policy (2019–2028) is on rural governance change and health. KP's Health Policy (2018–2025) is on digital health, Sehat Card Plus, and services for tribal districts. Sindh (Health for all policy) and Balochistan (Health Sector Strategy 2018-2025) are confronted with siloed service delivery, donor dependency, and information gaps.
- **Vaccination and Immunization Services:** They deliver routine immunization through 6,000+ EPI sites throughout the nation. Fixed, outreach, and mobile modes of vaccine delivery includes TB, polio, hepatitis B, tetanus, measles, mumps, rubella, putisis and rotavirus. Cold chain equipment is WHO-compatible, and DHIS-2 and LogTag systems support digital surveillance. Birth registrations are getting interconnected increasingly with EPI databases. Punjab and KP are leading in digital tracking, while Sindh and Balochistan lag behind

due to logistical and security concerns. Federal level has allocated PKR 10 billion for immunization and PKR 20 billion per annum for SSP in 2022. GAVI has utilized about USD 70 million in 2023 on vaccines and infrastructure.

Stakeholder Mapping

Effective healthcare delivery to the vulnerable populations in KP involves a complex network of stakeholders across all administrative levels, from the grassroots (union councils) up to the KP Health Department. An overview of key stakeholders at each level and their roles, including public sector entities, development partners, civil society, marginalized groups, and the private sector, is as follows:

- **Union Council Level:** As per the law, Union Council officials and community leaders are responsible for making health initiatives. However, the local government elections have not been held in KP since 2018. Therefore, in the absence of local government bodies, District Health Officers (DHOs) are currently managing the primary health units, which basically consist of BHUs/RHCs and LHWs, who operate as the first point of care, providing preventive and basic curative services to the community. Marginalized groups (women, the poorest households, persons with disabilities) are primary stakeholders as service beneficiaries, and their engagement through community committees or health volunteers is crucial for participatory planning.
- **Tehsil (Sub-district) Level:** Tehsil administrations oversee a cluster of Union Councils, with Tehsil Headquarters Hospitals (THQs) delivering secondary care. Key stakeholders include the hospital management, medical superintendents, and tehsil health officers who ensure referral services. They coordinate with BHUs/RHCs in their area for referrals. Local private practitioners and clinics also operate at this level, often filling gaps in provision of healthcare services.
- **District Level:** DHOs are primarily responsible for implementing health policies and managing public health programs across the district at primary and secondary level. The District Headquarters Hospital (DHQ) provides tertiary care and supervises lower facilities. In the absence of elected district officials (e.g. District Council members, Mayors), DHO is responsible for health budgeting and oversight. Civil society organizations are prominent at this level, including local chapters of national NGOs and advocacy groups focusing on women's and children's health. For example, AKDN, Merlin International, Central Excellence of Rural Development (CERD) and other charities operate healthcare services or clinics for the poor in certain districts. Private sector stakeholders at district level include owners of private hospitals, laboratories, and pharmacies, which often cater to those who can pay, but also extend services to the broader community.

- **Provincial Level:** After the 18th constitutional amendment, health is a provincial subject. Thus, each province's Department of Health (e.g. KP Health Department, Sindh Health Department, Punjab Health Department) and the provincial Minister of Health are pivotal stakeholders. They formulate provincial health policies, allocate budgets, and manage type-A category public hospitals, like Medical Teaching Hospitals (MTIs) and province-wide programs. Provincial Ministries of Finance and Planning also influence health outcomes through budgetary support and development schemes. Chief Ministers and provincial cabinets can champion health initiatives or conversely, deprioritize health in favor of other sectors. Provincial public health programs, for instance, Sehat Card Plus in KP, immunization & LHW programs, involve coordination with development partners and NGOs. Additionally, provincial branches of professional associations (doctors, nurses, like YDA) and health worker unions are stakeholders that can affect service delivery (e.g. through strikes or advocacy for reforms).
  The private sector is significant at the provincial level as well: private medical colleges, pharmaceutical companies, and hospital networks (such as the Aga Khan Health Services or Indus Hospital network) partner with government on training, referrals, and sometimes public-private service delivery models, e.g. district Chitral. Development partners like WHO and UNICEF have provincial offices or focal persons liaising with provincial authorities to support programs (e.g. WHO supporting polio campaigns in high-risk districts of KP).
- **National Level:** Federal stakeholders provide overall vision, coordination, and resource mobilization. M/o NHSR&C is the apex body setting national health policy guidelines and liaising with provinces to ensure alignment with national targets (such as SDG 3 – Good Health and Wellbeing). Other relevant federal ministries include the Ministry of Finance (which allocates federal funds and conditional grants for health), Economic Affairs Division (which manages donor-funded health projects), and the Ministry of Planning, Development & Special Initiatives (which includes health projects in PSDP). The federal government, despite devolution, continues to fund health projects of provincial nature through PSDP allocations. International development partners are key national-level stakeholders: WHO, for instance, advises on policy and disease outbreaks; GIZ supports health system strengthening projects (such as improving health services in refugee-hosting communities); the World Bank and Asian Development Bank fund health reform and insurance programs; and UNICEF, UNFPA, USAID, DFID/FCDO.

Institutional Weaknesses, Fault Lines and Governance Gaps

Pakistan's healthcare system faces institutional weaknesses and governance gaps that stifle access on the part of the vulnerable subgroup despite the health programs. Within the lens of the eight facets of good government by the UNDP, such gaps include:

- **Participation:** Health sector decision-making is not normally done with the involvement of the community. The poor and minorities have no role in health planning. Although health committees are on paper, in absence of local government representatives, they are usually ineffective or dominated by local elites, ignoring the interests of the vulnerable population. This is reflected in low health literacy and trust, and poor communities feel excluded from a system that does not hear their opinions. Programs can therefore fail to address grassroots needs, and there is low participation, such as refusal of immunization. Empowering participation is essential to ensuring the "voices of the most vulnerable in society are heard in decision-making." Institutionalized citizen participation in health governance, other than occasional NGO consultations, does not exist.
- **Rule of Law:** Pakistan's enforcement of health regulations is patchy and reveals a governance gap. Healthcare policies are poorly enforced, leading to unqualified rural and low-income urban practice. Slum or village patients with vulnerabilities seek the services of “unregulated healthcare providers" as the formal sector is not reliable. The gap in rule of law extends to non-enforcement of patients' rights and medical negligence legislation, with the poor never suing for substandard quality care. Rural clinic absenteeism is another problem that goes unchecked due to patronage, compromising accountability. Therefore, while there are laws, such as a statutory body like healthcare commissions, effective enforcement is absent, leaving vulnerable groups at risk.
- **Transparency:** Health sector transparency remains poor, perpetuating inefficiency and corruption. Allocations and expenditure of the health budget are not publicly disclosed; for instance, communities and civil society struggle to trace how much of the allocated health budget actually ends up in a district hospital or BHU. Procurement of medicines and equipment, especially at provincial and district levels, are often opaque, sometimes resulting in shortages or substandard supplies in public facilities for the poor. Mismanagement of funds and essential medicines supply has been alleged; lack of publicly accessible information makes it easy for communities not to hold officials to account. Transparency of data is also lacking: health information systems are fragmented, and while there are national surveys and dashboards, real-time facility-level data (on service availability, staff attendance, drug stocks) does not exist.

This lack of transparency disproportionately harms the poor, as they cannot afford alternatives when public services do not function – for instance, if a government clinic has no doctor or medicine, a rich patient can seek private care, but a poor patient has no recourse and no information on where else to seek care. The government principle of transparency, making information freely available and in an understandable, is not yet a reality in much of Pakistan's health system.

- **Responsiveness:** A responsive health system "serves all stakeholders within a reasonable timeframe" (UNESCAP), but Pakistan's system frequently fails, particularly for the poorest economic group. Responsiveness gaps result in long waiting lists, non-treatment of patients, disrespectful patients' treatment, and delayed policy responses. Patients' complaints in government hospitals frequently go unanswered. Emergency services such as ambulances in rural areas are inappropriate, with no urgent needs. Health policies sometimes overlook cultural barriers; e.g., family planning and mental health services do not sufficiently respond to stigma in conservative societies. Overall, bureaucratic inertia prevents the system from responding to the poorest communities' needs.
- **Consensus Orientation:** Consensus-building among stakeholders and policy consistency is weak, indicating fault lines in developing health strategies. Post-devolution, provinces at times pursue divergent health policies, and federal visions and provincial priorities at times clash. For example, while National Health Vision 2016–2025 did provide a collective framework with focus on universal access for all including vulnerable groups, the degree to which provinces have adopted and implemented it is variable. Moreover, consensus orientation implies bringing non-governmental stakeholders into synchronization but often health policies are built with little consultation with civil society, private sector, and end-users. For example, marginalized groups and NGOs working among them are hardly consulted in policy-making, leading to policies that sound good on paper but don't account for on-ground realities. Fragmentation and silo-working remain issues; for example, nutrition, population welfare, and health programs may operate in parallel and not through an integrated consensus-driven approach, leading to gaps and overlaps confusing the community. Consensus orientation must be strengthened so that all provinces, ministries, and partners are in consensus on common goals and strategies so that there is continuity beyond political terms.
- **Equity and Inclusiveness:** Perhaps the most glaring governance shortfall is in ensuring equity and inclusiveness. Policy aims to reach the poor and vulnerable, but access to healthcare and health outcomes in Pakistan are highly inequitable. The poorest economic group still faces financial, geographic, and social barriers to care.

Inequity is reflected in health indicators: for instance, under-five mortality in the poorest quintile is 41 per 1,000 higher than in the richest quintile (DB, 2013) and rich women are much more likely to have skilled birth attendance than poor women (DB, 2013). Although the constitution and national vision require equal rights to health, in practice the system discriminates in favor of those with resources or power. Rural and remote areas (many of which overlap with poverty) have fewer doctors and health facilities; for instance, while over 5,500 BHUs, many are under-staffed or remote from small villages, and so are unused by those without transport. Lack of an effective safety net means out-of-pocket costs discourage the poorest from accessing care. An inequitable financing system makes this worse: out-of-pocket expenditure accounts for around 65-70% of total health expenditure, so the burden is extremely heavily on the poor. Gaps in inclusiveness also impact some groups – for instance, persons with disabilities have few accommodations in health facilities, and transgender individuals are often stigmatized in healthcare facilities. Although programs such as the SSP (health insurance for poor families) and primary care programs aim to enhance equity, governance shortfalls (such as poor budgeting and patchy implementation) restrict their impact. The goal of "leaving no one behind" is still unrealized, with disparities continuing to exist between provinces (Balochistan's health statistics trail behind Punjab's, for instance) and socioeconomic segments.

- **Effectiveness and Efficiency**: Institutional problems impede the effectiveness (achievement of health outcomes) and efficiency (utilization of resources) of the health system. Effectiveness is undermined when policies fail to deliver; e.g., despite a national TB control program, there remains a high burden of TB in Pakistan, indicating gaps in care for poor patients. Programs (maternal health vouchers, nutrition programs) have improved somewhat in some cases, owing to operational problems. Efficiency is undermined by wastage of resources owing to inefficient management. Government expenditure is in the direction of curative care for urban residents compared to cost-saving preventive care for rural poor communities, leading to low health expenditure (1.0% of GDP in FY2022-23) that fails to maximize health benefit for the vulnerable. Overlapping functions and roles and ambiguous responsibilities between institutions provide additional inefficiencies; post-devolution, federal and provincial governments sometimes replicate work (e.g., vaccine procurement) or gap in coordination (e.g., trans-provincial disease surveillance prior to the establishment of the health ministry in 2013). Human resource deployment also impacts efficiency: doctor concentration in urban areas results in over-deployment of doctors in towns and under-deployment in rural areas. Some of these are acknowledged by the government as seen in attempts to build an EPHS aimed at prioritizing cost-saving interventions. Until system reform is initiated, health campaigns are ineffective and useless, with continued poor health for the poor.

- **Accountability:** Pakistan's health governance accountability mechanisms are weak. There is no robust monitoring and accountability from top to bottom – from policymakers to front-line providers. Performance management is rarely linked to consequences; e.g., if a province does not increase immunization coverage or if funds for primary care are unused to the end of a budget period, officials are hardly held accountable. At the facility level, staff absenteeism or unofficial charges being levied to patients are frequent complaints, but punishment is rare. Complaint redressal mechanisms are poorly communicated or not trusted by the public. In regard to financial accountability, audits are done, but findings (e.g. irregularities in expenditures) don't always result in prosecutions or reforms, creating a culture of impunity. Politicization of health appointments (e.g. health directors, hospital medical superintendents, district health officers) further obscures accountability, as loyalty may be prized more than performance.

In summary, there are wide areas of governance that are inter-related, exacerbating each other, in Pakistan's health sector, a low accountability providing space for inequities and a lack of participation leading to unresponsive services. Institutional malaises, such as the implementation-policy gap, fragmentation post-devolution, and the urban-rural divide, further exacerbate these governance ills. Sustained efforts in reforms and capacity-building would be required in order to translate good governance at all levels of the health system to ensure benefits from health programs and policies accruing to marginalized citizens.

Institutional Fault Lines

- **M/o NHSR&C (Federal Level):** M/o NHSR&C retains oversight on health programs and international health commitments, but its coordination with provincial health departments, in this case KP, is weak. Delayed fund transfer, fragmented data sharing, and undefined roles in rolling out national programs (e.g., EPI, HIV/AIDS and TB) prevent harmonized delivery of services. Provincial alignment with national strategy is inconsistent, resulting in programmatic silos.
- **Khyber Pakhtunkhwa Health Department (Provincial Level):** The KP Health Department is at the center of policy making, resource allocation, and program management in the province. Despite the reforms like the MTI Act and Sehat Card Plus, the department suffers from deep-rooted issues: bureaucratic inertia, politicization of appointments, under-resourced planning units, and weak monitoring mechanisms. Its dual role of regulation of provincial programs and oversight of district services leads to over-centralization and blurred accountability. Health Information Systems like DHIS are not used for evidence-based policymaking.

- **Medical Teaching Institutions (MTIs):** MTIs, which are regulated by the MTI Act, are headed by Boards of Governors and therefore enjoy financial and HR autonomy. Implementation, however, has been inconsistent. Performance monitoring, service delivery targets, and frameworks for career progression remain vaguely defined. Resistance from within the medical community and weak alignment with non-MTI hospitals further weaken integrated service delivery.
- **KP Healthcare Commission (KP HCC):** KP HCC is mandated to license and regulate the entire healthcare facilities in KP. Currently, thousands of private health facilities, like clinics and hospitals are active across the province, however, in comparison the number of licenses issued by the HCC are quite less. These unregistered private facilities, especially private clinics, are not being monitored due to loopholes in legislation, inadequate human resources, and limited field presence. Moreover, lack of enforcement powers and incomplete integration with other regulators like the district administration, further reduces the effectiveness of HCC.
- **District Health Offices (DHOs):** DHOs are tasked with monitoring all the health institutions of a district, from BHUs, RHCs, THQs, and DHQs. However, they operate in an inflexible hierarchical chain of command with limited administrative and financial autonomy. Their dual reporting to the KP Health Department and local administrative governments (Deputy Commissioners) leads to jurisdictional conflict. Inadequacies in public health management, insufficient transport for field monitoring, and lack of authority to manage HR or budgets severely limit their effectiveness.
- **Tehsil & District Headquarters Hospitals (THQs & DHQs):** These secondary care institutions offer suffer from poor referral linkages with BHUs and RHCs. Many THQs lack specialists, emergency services, and diagnostic capabilities. Therefore, DHQs are overcrowded, absorbing both primary and secondary level cases due to poor gatekeeping. Most are managed under civil service rules, with little operational autonomy, and lack active, community-inclusive oversight mechanisms like Health Management Committees.
- **Rural Health Centres (RHCs) and Basic Health Units (BHUs):** Since they are the initial interface with rural populations, BHUs and RHCs are supposed to play a pivotal role towards preventive and primary healthcare. However, they are normally under-staffed, under-equipped, and lack functional infrastructure. Non-availability of physicians/medical staff, non-functional equipment, and limited drug availability compromise the quality of healthcare, thus resulting in low public confidence and movement of patients to secondary or tertiary hospitals.

- **Referral System:** KP healthcare system also lacks a structured referral system which can link BHUs, RHCs, THQs, and DHQs. Self-referral is common, exacerbating inefficiencies and overloading of high tier facilities. This disrupts the continuity of medical treatment across medical facilities.
- **Private Sector Hospitals and Clinics:** It is an unregulated industry and operates with minimal oversight. The majority of the clinics are unlicensed, have no standard procedure, and are not certified. There is overcharging, redundant testing (particularly under Sehat Card Plus), and unregulated laboratory facilities. The lack of active monitoring by the KP HCC or district governments allows these activities to be pursued uninterrupted.

Assessment of Implementation Bottlenecks

Policy implementation in the health sector in Pakistan is generally poor owing to a range of fiscal, procedural, administrative, and systemic barriers. These barriers deprive vulnerable people of the benefit of good health policies. The major barriers are:

- **Fiscal Bottlenecks**: Insufficient funding is a principal bottleneck. Pakistan's public health spending was a paltry 1% of GDP in FY2022-23 (a decline from 1.4% the year before), much lower than international benchmarks and inadequate for its population size. For example, primary healthcare scale-up and community health worker recruitment are typically slashed or deferred. Even the funds allocated can be unpredictable – fiscal crises inducing delays disrupt programs like vaccine purchases or BHU construction. Moreover, more than 52% of health spending is private, mainly OPE, placing financial burdens on individuals, particularly the poor. Moreover, most of the health budget is spent on tertiary hospitals and salaries, with little remaining for operations, maintenance, or outreach, thereby precluding new policies like essential health service packages without new funding. Conditional federal government grants sometimes conflict with provincial priorities post-devolution, resulting in double dipping.
- **Procedural Bottlenecks:** Cumbersome bureaucratic processes result in poor health policy implementation. Approving and initiating health projects involves several layers of paperwork (PC-1 forms, planning & finance department clearances, etc.), which can slow down initiatives considerably. For instance, if a provincial health department wishes to purchase ambulances for rural settings from development funds, the tender and approval process may take months or years, and needs go un-met. Procurement regulations, meant to bring in transparency, are sometimes implemented rigidly and cause delays (e.g. life-saving medications stuck in procurement loops).

Recruitment of health staff is another sphere with procedural bottlenecks: recruiting doctors or nurses to vacant positions can be time-consuming because of administrative clearances or public service commission formalities. By the time personnel are hired, communities have wasted years without essential health workers. In addition, inter-departmental coordination processes are weak. For instance, rolling out a nutrition program requires coordination between health, finance, and local government departments; lacking procedural guidelines, such multi-sector interventions collapse. There have been instances when donor-funded interventions were procedurally delayed in fund flow or government NOCs (No Objection Certificates), and Pakistan lost out on fully availing international aid. Inflexible processes and red tape thus become bottlenecks, and unless streamlined (through reforms like one-window approvals or delegation of powers), even quality-designed policies will have slow off-take.

- **Administrative Bottlenecks:** These are management and capacity limitations in health institutions that inhibit effective implementation. One of the significant administrative bottlenecks is untrained human resource. There is a deficiency of trained managers and administrators in the health sector; for instance, District Health Offices typically have very few management staff compared to the nature of their tasks. Many officials also don't receive training in new public health management practices, data analysis, and problem-solving, which impacts their capacity to implement programs effectively. Frequent transfer and rotation of key officials (partly because of political interference) disrupts continuity, a district health officer may not be able to complete a reform if they get rotated out within a year. Another administrative limitation is the poor health information system, i.e. weak data collection and monitoring & evaluation systems, which result in administrators not receiving timely, accurate data to guide decisions or to identify implementation problems. Logistics and supply chain management is also a recurring administrative issue: out-of-stock medicines and supplies are the norm in facilities serving the poor, undermining program implementation. Furthermore, poor supervision and mentoring of frontline health workers (because of few supervisory staff and large geographic coverage) is an administrative shortcoming that leads to variable service quality. Coordination problems between the government, such as between health authorities and their related agencies (education for school health, water for WASH), usually stem from hesitation or uncertain directions. Until administrative capacity and systems are built up, policy will not improve service delivery.
- **Systemic Bottlenecks**: One of the main bottleneck is urban-rural and inter-provincial health infrastructure disparity. Traditionally, more resources have flowed to urban tertiary institutions while rural primary healthcare has been ignored.

This systemic bias is such that policy intervention to improve rural health is a matter of reversing decades of neglect, new facilities to be built, staffed, and trusted by the community, a slow process. Absence of a composite health information architecture is another systemic bottleneck; parallel reporting systems (for immunization, for disease surveillance, etc.) rule out a composite picture and composite response. Cultural and social norms also constitute a systemic bottleneck: e.g., gender norms in some places limit women's mobility, so even if services are present, women from conservative poor families may not use them without a female provider or a community health worker's facilitation. Overcoming this bottleneck, require policies that recruit and deploy female staff (such as LHWs) and community mobilization. Another systemic barrier is the growing population and epidemiological transition – a dual burden of disease (communicable and non-communicable) that taxes an already resource-constrained system. Implementers have a tendency to find the reality of overcrowded health facilities and overburdened health workers. E.g., a single BHU serving a 15,000+ population cannot realistically implement all elements of an essential service package. Service fragmentation is structural; a patient may receive vaccinations from one group, antenatal care from a health center, and nutrition advice from an NGO, with little coordination. This reduces effectiveness and squanders effort. In other words, systemic bottlenecks slow implementation – unless solved through structural reforms (e.g. investment in primary care, role clarification, service integration, and social determinants), progress will be slow, sustaining gaps between policy and reality.

SWOT and EETH Analysis of Relevant Institutions

For comprehension of health provision to the marginalized, examination of the most important public sector institutions through SWOT and EETH analyses is essential. They are Health Department and District Health Administration of KP. These are the key public institutions in KP to which the task of implementing health policy devolves. Private sector and civil society are significant, as well, but this focus is on public institutions serving the most disadvantaged.

SWOT Analysis

Strengths

There are several strengths in KP's health system. There is a wide coverage of BHUs/RHCs, and tehsil/district hospitals in rural areas. Sehat Sahulat program aims for universal health coverage through insurance coverage for poor families. The Lady Health Worker (LHW) program is an effective community outreach model. Digital initiatives such as the telemedicine clinics in remote areas like Chitral are a new direction in public service delivery.

Weaknesses

Though it has its strengths, the system is marred by serious institutional flaws. Public health expenditure is a mere 0.21% of GDP and 15% of KP's total budget (GoKP, 2024), far below international norms. Chronic absenteeism of personnel, shortage of trained staff and shortages of medicines are the common maladies of most BHUs and RHCs, particularly in rural areas. Quality assurance and patient safety practices are weak, and referral systems are non-functional. Inadequate monitoring and evaluation, and poor-quality health data constrain evidence-based policy-making. Moreover, Sehat Card Plus, which is providing coverage to 100% public is not cost-efficient as it creates undue burden on province's budget. Moreover, a double dipping dilemma is also created as the government not only has to run the public hospitals but also has to pay the private sector hospitals.

Source: FMIU, Finance Dept. Government of KP

Opportunities

There are various opportunities to bolster the healthcare system. Telemedicine and e-health can extend gaps in service in remote areas. Public-private partnerships can improve primary care delivery on the model of KP government-AKDN, which are most cost efficient. Post-devolution autonomy permits provinces to customize health reforms. Partnership with development agencies and NGOs can help increase the health service delivery in remote areas by contracting out facilities.

Threats

Systemic and external danger tests institutional resilience. Political intrusion into hospital management erodes professionalism. Medical professional emigration reduces capacity, particularly for specialties. Immunization resistance in conservative pockets jeopardizes public health. Climate change imposes additional health challenges (e.g., vector-borne disease, malnutrition), while security dangers in KP compromise access and demoralize health workers.

EETH Analysis

Elimination of Threats

There is a need to promote merit-based recruitment and professional independence in health leadership and to depoliticize the administration. The provincial government also needs to improve the safety of medical workers, working in conflict areas of KP through protective policies and incentives. There is a need to combatting vaccine hesitance through persistent community outreach in tribal and conservative areas.

Exploitation of Opportunities

KP's healthcare system is of huge unrealized potential for institutions. With a growing IT industry, government can scale telemedicine and digital health to cover remote populations in mountainous areas. Merging social protection and health (e.g., Ehsaas and Sehat Sahulat) can tackle poverty and enhance healthcare usage. Partnership with NGOs and local communities in disadvantaged communities can also be established to improve the healthcare.

Tolerance of Weaknesses

Structural adjustments are time-consuming, but certain institutional weaknesses can be addressed. Upskilling and deployment of rural health workers through phased models and task-shifting to trained mid-level health workers. Usage of mobile health units and LHW networks, rather than permanent facilities where there are no fixed facilities, can also be beneficial. Moreover, budgeting can be done for recurring operational shortfalls (transport, utilities) until system-wide planning and finance reforms are underway.

Harnessing of Strengths

Healthcare institutions must strengthen and expand their existing strengths to overcome implementation challenges. There is a need to standardize platforms such as DHIS to increase transparency and accountability across all provinces. Learn from good practices in the country and from around the world to rebuild the healthcare system.

Best Practices Integration

To uplift the healthcare sector, we must learn from the best practices and successful experiences in Pakistan and around the world that have demonstrated effective healthcare among marginalized communities. These instances provide lessons and models that can be employed for more effective policymaking.

National Best Practices:

- **Sehat Sahulat Programme (Health Care Insurance for the Poor)**: SSP, launched in 2015, is a government-funded health insurance scheme, providing free inpatient care to ultra-poor families based on Proxy Means Test (PMT).

Initially managed through financing of Kreditanstalt für Wiederaufbau (KfW) bank, the program was initiated in 4 districts of KP, including Malakand, Mardan, Kohat and Chitral. KP government launched the second phase in 2016 through provincial annual development program (ADP), under which 21% of the poorest population was included in the program. In 2016, the scheme was regularized and its budget was transferred to the current budget, which expanded the program to include 50% of the province's population based on PMT. SSP aligned with SDG 3.8 by offering financial protection and included transgender persons and individuals with disabilities. Evaluations show reduced out-of-pocket expenses and improved service utilization, though coverage was mainly limited to hospitalization, with outpatient care still unaffordable for many.

- **People's Primary Healthcare Initiative (PPHI)**: Initiated in the early 2000s in Sindh and extended to other provinces subsequently, PPHI outsourced management of government primary health units to non-governmental organizations, invariably headed by retired professionals. This was intended to circumvent bureaucratic lags and improve performance through managerial freedom and private-sector management. Assessments in Sindh revealed that PPHI facilities had more doctors, improved availability of medicines, and higher outpatient visits than non-PPHI facilities. By maintaining extended clinic timings and ensuring the presence of staff, PPHI-managed BHUs became more convenient for poor communities. This This model proved local replicability and community-oriented management within the public system. Variations were introduced in Balochistan and KP too. Success was achieved through clear accountability, sufficient funding, and fewer red tape, leading to more consistent services. The PPHI case provides a model of governance reforms that benefit marginalized rural communities that rely on BHUs for care.

Global Best Practices

- **Rwanda's Community-Based Health Insurance (Mutuelles de Santé):** Rwanda, a low-income country, has recorded significant health gains, on the threshold of having universal health insurance through a community-based scheme. In the early 2000s, barely 7% were insured; by 2010, under Mutuelles, this rose to more than 74%, and today more than 90% are insured, mostly through Mutuelles. The scheme promotes equity: premiums are based on income, with the poorest 25% fully subsidized by government and donors. This allows even the most vulnerable to access services without financial limits.

High insurance coverage has led to increased life expectancy, from 49.7 years in 2001 to 69.6 years in 2022, demonstrating that better access to healthcare leads to improved overall health. Rwanda also expanded services by building health posts in remote villages and training community health workers to provide outreach. For Pakistan, Rwanda is a model of effective community and government co-financing for health and of political will to support the poor. It demonstrates that high insurance coverage is feasible in resource-poor settings and is linked to stunning gains in health.

- **Iran's PHC Network:** Iran developed a strong PHC network after the revolution in 1979 to improve access to health in rural communities. They constructed "health houses" in major villages, staffed with trained community health workers (Behvarz), connected to rural health centers. This multi-tiered model strongly improved rural health outcomes, decreasing infant and maternal mortality and decreasing the rural-urban divide. High levels of immunization and universal prenatal care were obtained using this system. The key best practice is to build community-based primary care using local staff and an effective referral system. Pakistan's LHW program is similar, but Iran's had infrastructure for these staff and a well-defined career progression. Iran's experience shows that investment in care infrastructure at the community level is good for equity. For Pakistan, transitioning from a program-based approach (e.g., LHWs) to an integrated PHC model (with fixed health houses and strong supply chains) might achieve similar results.
- **Brazil's Family Health Strategy:** Brazil's Family Health Strategy (FHS) revolutionized primary care by deploying teams of physicians, nurses, and community agents for preventative care. A team makes rounds to each assigned number of houses on a regular basis, expanding access to favelas and the Northeast, and lowering infant mortality and hospitalization of sensitive cases. The outreach and extended care model brings patients to the healthcare providers rather than expecting the patients to come to the clinics, emphasizing prevention. Brazil's success in covering millions of poor citizens exemplifies the quality of decentralized team-based care with strong political commitment to invest in healthcare for the poor under its SUS system. Pakistan can bring the quality of care to the poor by similar family practice schemes and increasing the role of the health worker.

GAP Analysis

In spite of clear-cut policies and best practices, massive gaps still prevail between health policy plans and practice. This section identifies key misalignments and disconnects:

- **Policy Vision vs. Implementation Capacity**: Pakistan's National Health Vision 2016–2025 is for "universal access to quality essential health services…with a focus on vulnerable groups." Subnational implementation capacity is, however, weak.

Policy ambitions and provincial health system capacities are not aligned. For instance, while policy encourages comprehensive primary healthcare, BHUs, especially in poor districts, are under-staffed and services fragmented. Integration of maternal care, child immunization, and nutrition counseling frequently collapses due to vertical silos. As a result, ambitious targets are deprived of management strengthening and training for effective implementation.

- **Resource Distribution vs. Equity Targets**: Distribution of resources and equity targets are out of alignment. Policies have the intention to address inequities, but nevertheless, funds disproportionately flow to urban areas and higher-order treatment. Although there is a consideration to give higher priority to primary care, the lion's share of public health expenditure goes to tertiary institutions in cities that are beyond the reach of poor individuals in the rural areas. Rural health units get a small proportion of health expenditure although they serve a large number of poor individuals. Pakistan Economic Survey shows that health expenditure rose (from 1.0% to 1.4% of GDP in 2021-22), and then dipped to 1%, showing the lack of uniform commitment. Second, disbursement is too often devoid of pro-poor orientation: prevention and community outreach schemes benefiting the poor are cut or reduced, but salaries and tertiary projects are spared. This is a reflection of a disconnect between equitable intention and fiscal action.
- **Intersectoral Action in Policy vs. Siloed Implementation**: Health policies acknowledge social determinants such as nutrition, sanitation, and maternal education, and encourage intersectoral action and its strategies focus on cooperation among departments (e.g., nutrition and agriculture, WASH and local government). In reality, however, cooperation is poor. Frequently, departments work in silos; health officials focus on curative services, ignoring preventive efforts which require coordination, such as improved village sanitation to prevent disease. As a result, the envisioned holistic approach fails at district and community levels, and preventable disease related to malnutrition and poor water continues among the poor, emphasizing the disconnect between strategies and delivery.
- **Availability of Services vs. Utilization by the Poor**: There is a gap between delivery of services and their use by the poor. For example, even if the government provides free maternal services or opens clinics, utilization is low because of indirect costs (transport, loss of wages), social barriers, or unawareness. The purpose of "free services" is negated by the fact that the poor pay hefty out-of-pocket charges (for transport, unavailability of drugs, etc.). Evidence indicates out-of-pocket expenditure varies between 56-70% of total health expenditure, indicating a gap between the intention of financial protection and the burden imposed. Having a facility or scheme is not a guarantee of benefits to the poorest, indicating problems of quality, outreach, and trust.

Conclusion

Pakistan's health system, while there has been some development, remains unequal and underperforming, particularly for the poor. National policies such as the Sustainable Development Goals and the National Health Vision 2016–2025 set universal health coverage as a goal, but systemic governance loopholes, inefficiencies, and regional disparities hinder effective implementation.

Khyber Pakhtunkhwa (KP) identifies issues in the delivery of health services under devolved government. In spite of political will through the Sehat Card Plus and telehealth technologies, most residents—particularly in rural, tribal, and conflict areas—continue to face geographic, cultural, and economic barriers. Inadequate infrastructure, female personnel, and emergency services further complicate access for women, children, disabled individuals, and minorities.

The results indicate that equity, institution capacity, and integrated health and social welfare must be the basis of a coordinated national and provincial response. Enhancing health governance through the eight pillars of UNDP is important in promoting universal healthcare access in Pakistan. Failure to implement initiatives improving healthcare quality and governance, particularly in such poor provinces as KP, will lead to continued health inequities and poverty in Pakistan. Provision of essential health services to all is a constitutional, ethical, and development imperative.

Recommendations

Closing gaps in Pakistan's health system requires a multi-faceted strategy. Below are evidence-based recommendations organized into short, medium, and long-term interventions to improve access to healthcare for poor communities.

Short-Term Solutions (1–2 years)

- **Increase Health Funding for Primary and Preventive Care**: Allocate a greater portion of existing health budgets towards primary healthcare facilities and outreach programs in underdeveloped areas. For instance, ring-fence funds for BHUs/RHCs so that they have operational budgets for local purchase of medicines and community outreach. Pakistan should target raising public health expenditure to at least 2% of GDP in the coming years, but immediately, federal and provincial governments can prioritize spending on immunizations, mother-child health, and community health workers which directly benefit the poor. This includes fully funding the Lady Health Workers program expansion (as per its 2022–2028 plan) and ensuring no stock-outs of essential medicines at primary level.
- **Increase Transparency and Citizens' Participation**: Implement transparency measures such as publicly displaying facility budgets, drug inventories, and attendance of staff in all government health facilities. This can be done through public notification, requiring each

DHQ hospital and rural health center to publish basic information (budget, key staff, services provided). Simultaneously, implement feedback mechanisms to record and address public grievances.

- **Close Human Resource Gaps in Underdeveloped Areas**: Use an incentive package to recruit and retain healthcare workers in rural and low-income urban settings. This would involve fiscal incentives, career progression for service completion in remote settings, and accommodation of staff. Evidence indicates that staff shortages are prevalent; incentives have been used successfully in other countries to boost rural availability of healthcare. A short-term intervention is to audit facilities in poor settings and recruit local female paramedics or nurses in the absence of doctors.
- **Enhance Community Engagement & Demand Generation for Vaccines**: Community engagement is critical to overcoming vaccine hesitancy and improving immunization uptake. Programs should focus on demand generation for vaccines through community-based initiatives, leveraging local influencers, religious leaders, and community health workers (LHWs). There is also a need to educate communities on the benefits of vaccination, particularly in underserved areas. Public awareness campaigns that highlight the importance of vaccines and counter misinformation can help foster a more positive attitude toward immunization.

Medium-Term Proposals (3–5 years):

- **Double Health Spending with Pro-Poor Targeting**: By years 3–5, Pakistan must increase public health spending to 2-3% of GDP. This must be targeted through conditional grants to provinces on the basis of need indices (poverty, disease burden) to focus the resources in poor areas. Federal transfers to provinces linked to performance in priority equity indicators (e.g., immunization or maternal health in poor districts) will promote a performance-based response.
- **Health Workforce Development and Training**: Roll out a complete Health Workforce Development Plan with emphasis on training and deploying mid-level providers and nurses from vulnerable communities. Upscale the production of nurses, midwives, and community mid-level providers (e.g., nurse practitioners or physician assistants) with compulsory rural rotations over 3-5 years. Reform medical and nursing curricula to incorporate community medicine and exposure to low-resource settings. Collaborate with medical universities to utilize a district hospital or community clinics as training sites (as in some international programs).
- **Revitalization of Primary Health Care – "Health for All" Districts**: Launch a "Model Districts for UHC" program by choosing pilot districts with weak indicators.

Launch a full PHC strengthening package, upgrading BHUs to 24/7 service, assigning Field Health Teams (FWW, LHWs, CMWs) for home visits, and unifying vertical programs under one administration. Pilot to develop a scalable model and scale up to additional districts in year 5.

- **Institutionalize Community Accountability Mechanisms**: Formalize community participation mechanisms. Establish Health Management Committees at the district and tehsil hospital levels, with participation from local government, civil society, and patients to ensure quality and equity of services. Introduce legal provisions for annual social audits of health programs, with each district submitting health outcomes and budgets to the public for feedback. Leverage technology by scaling up SMS or app reporting for patients to rate facilities anonymously and report drug stock status, which is fed into provincial health dashboards.
- **Targeted Health Education Campaigns**: Implement medium-term country-wide campaigns emphasizing citizens' health rights and poor people's services. For example, a local language campaign of "Healthcare in government facilities is your right – demand it!" to communicate free services (immunization, maternal care, insurance). Use local influencers (teachers, religious leaders) to encourage preventive behaviors and health service utilization in their communities.

Long-Term Recommendations (5+ years)

- **Raise Health Spending to 4-5% of GDP & Make It Equitable**: A minimum of 4% of GDP health spending in Pakistan by 2030 has to be the target, predominantly from the government, as suggested by WHO guidelines. This will necessitate a commitment, perhaps by special health taxes or out of GDP growth health allocations. Resource distribution needs to be done on the basis of equity using National Finance Commission or some other Health Equity Formula on the basis of population, poverty, and health need so that funds reach underdeveloped regions.
- **Multi-sector Action for Preventive Healthcare**: In the next ten years, enhance cooperation between health and other sectors to tackle root causes of poor health in poor communities. For example, ensure safe water and sanitation in every union council by working with municipal and public health engineering. Scale up initiatives like school health (in partnership with Education for nutrition, and health check-ups in poor schools) and conditional cash transfers for nutrition (with Social Protection). National and provincial inter-ministerial committees should plan and harmonize these interventions (some of which already exist, but need strengthening and continuation).

- **Introduce Equity based Health Insurance System**: A federal government led initiative to introduce equity-based health insurance system can also be planned for the entire country. Under this program, the governments can privatize the public healthcare facilities and can introduce health insurance system. For the vulnerable and poorest strata, the provincial governments can offer 100% subsidized insurances, while for the lower income quantile, 75% subsidy can be offered. The middle and higher-income people can utilize private insurances. This system will not only ensure judicious use of public resources but would also prevent double-dipping (paying to the private sector in addition to developing public sector facilities).

Logical Framework

The logical framework presented below offers the key goals, indicators, responsible bodies, and time line for the actions proposed. The matrix is designed to enable the implementation, tracking, and accountability of the Health Minister's Task Force strategy to address policy implementation gaps and institutional fault lines. It encapsulates the strategic vision in formalized form:

Objectives	Key Performance Indicators (KPIs)	Responsibility
Short-Term (1–2 years)		
Increase Health Funding for Primary and Preventive Care	• Allocate a greater portion of health budgets to primary healthcare and immunization programs • Ensure full funding for the LHW program • Ensure provision of medicines	• M/o NHSR&C • Ministry of Finance • Provincial Finance Department • Provincial Health Departments
Increase Transparency and Citizens' Participation	• Publicly display of: o Facility budgets o Drug inventories o Staff attendance • Implement grievance redressal system	• Provincial Health Departments • Local Governments (when elected) • Auditor General of Pakistan
Close Human Resource Gaps in Underdeveloped Areas	• Use incentives to attract staff to rural areas • Ensure monitoring mechanism • Recruit local female health workers	• Provincial Health Departments • Public Service Commissions • Local Governments
Enhance Community Engagement & Demand Generation for Vaccines	• Conduct vaccine demand-generation through religious/community leaders and public awareness campaigns	• M/o NHSR&C • Religious Departments/Auqaf • Extended Program for Immunization (EPI)

Medium-Term (3–5 years):		
Double Health Spending with Pro-Poor Targeting	• Raise health spending to 2–3% of GDP • Use conditional grants linked to poverty and disease burden	• MoNHSR&C • Ministry of Finance/Finance Departments • M/o Planning /P&DD
Health Workforce Development and Training	• Train and deploy mid-level care providers • Reform curriculum • Expand community-based training	• PMDC/PNC • Health Services Academy • Provincial Health Departments • World Bank/WHO
Revitalization of Primary Health Care – "Health for All" Districts	• Launch Model Districts for UHC • Upgrade BHUs • Implement Field Health Teams and unify programs	• MoNHSR&C • Provincial Health Departments • WHO/UNICEF
Institutionalize Community Accountability Mechanisms	• Establish Health Management Committees • Implement social audits and citizen feedback apps	• Provincial Health Departments • Local Governments • Civil Society
Targeted Health Education Campaigns	• Run local language campaigns promoting health rights and free government services	• MoIB • MoNHSR&C • Provincial Information Departments • Health Departments
Long-Term (5+ years)		
Raise Health Spending to 4-5% of GDP & Make It Equitable	• Commit to higher spending via special taxes or GDP growth • Distribute resources using a Health Equity Formula	• Ministry of Finance • Federal Board of Revenue • MoNHSR&C • Provincial Governments
Multi-sector Action for Preventive Healthcare	• Collaborate across sectors for water, sanitation, school health, and nutrition programs.	• MoNHSR&C • PHE • Provincial Governments/SWDs
Introduce Equity based Health Insurance System	• Implement a national health insurance model with full subsidy for the poorest and sliding-scale for others	• MoNHSR&C • Provincial Health Departments • State Life Insurance Corporation/Insurance companies • NADRA

References

1. Aman, M. (2020). *"Go in disguise to receive medical treatment": Religious discrimination in Pakistan*. Institute of Development Studies.
2. DB, W. (2013). Vulnerable populations in healthcare. *Current Opinion in Anaesthesiology*. https://pubmed.ncbi.nlm.nih.gov/23385323/
3. Division, F. (2023). *Economic Survey of Pakistan*. https://www.finance.gov.pk/survey/chapters_23/11_Health.pdf
4. DRAP. (2012). *Drug Regulatory Authority of Pakistan Act, 2012*. https://www.dra.gov.pk/wp-content/uploads/2022/10/DRAP-2012-_As-Amended-till-Feb-2022.pdf
5. Finance Division. (2024). *Pakistan Economic Survey 2023–2024 (Chapter 11: Health and Nutrition)*. https://finance.gov.pk/survey/chapter_24/11_health.pdf
6. GoKP. (2024). *Citizens budget 2024–2025*. Government of Khyber Pakhtunkhwa.
7. GoP. (2016). *National Health Vision 2016–2025*. https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/pakistan/national_health_vision_2016-25_30-08-2016.pdf
8. Ijaz, S. (2024). *In sickness and in debt: The right to health*. Human Rights Watch. https://www.hrw.org/news/2024/04/22/sickness-and-debt-right-health#:~:text=In%20Sickness%20and%20in%20Debt%3A,The%20Right%20to%20Health
9. Nafees Ahmad, M. F. (2024). Multi-dimensional poverty in the newly merged tribal districts of Khyber Pakhtunkhwa: Identifying the key areas of priority. *Journal of Applied Development and Social Sciences*, *13*(3). https://doi.org/10.62345/jads.2024.13.3.126
10. NHSR&C, Ministry of. (2016). *National Health Vision 2016–2025*. https://phkh.nhsrc.pk/sites/default/files/2020-12/National%20Health%20Vision%20Pakistan%202016-2025.pdf
11. NHSR&C, Ministry of. (2025). *Mission & vision*. https://www.nhsrc.gov.pk/Detail/YjIxNDkyYWQtNzcxNi00NTNmLThiNzItYWI3YzY0ZGYxZmYx
12. NIPS, National Institute of Population Studies. (2019). *Pakistan–Maternal Mortality Survey*. https://dhsprogram.com/pubs/pdf/PR128/PR128.pdf#:~:text=Maternal%20mortality%20ratio%20,interval%201%20Punjab%20includes%20ICT
13. Pakistan Bureau of Statistics. (2023). *Health-related statistics and poverty analysis*. https://www.pbs.gov.pk
14. PMDU. (2023). *Pakistan Registration of Medical and Dental Practitioners Regulations, 2023*. https://pmdc.pk/Documents/law/Registration%20Regulations%202023.pdf
15. Report, G. N. (2019). *Country nutrition profiles: Pakistan*. Global Nutrition Report. https://globalnutritionreport.org/resources/nutrition-profiles/asia/southern-asia/pakistan/#:~:text=Population%20density%20of%20health%20workers,per%201%2C000%20people
16. Shahid Younas, A. (2025). Directorate of Health Services. (RG-4, Interviewer).

17. Statista. (2021). Under-five child mortality rate in the Asia-Pacific region in 2021, by country. https://www.statista.com/statistics/696072/asia-pacific-under-five-child-mortality-rate-by-country/
18. UNDP. (2022). *Annual report: UNDP Pakistan*. https://www.undp.org/pakistan/publications/undp-pakistan-annual-report-2022
19. UNESCAP. (n.d.). *What is good governance?* https://www.unescap.org/sites/default/files/good-governance.pdf
20. UNICEF. (n.d.). *Maternal and newborn health disparities: Pakistan*. https://data.unicef.org
21. WHO. (2023a). *Close to one billion people globally are served by health-care facilities with no electricity access or with unreliable electricity*. https://www.who.int/news/item/14-01-2023-close-to-one-billion-people-globally-are-served-by-health-care-facilities-with-no-electricity-access-or-with-unreliable-electricity
22. WHO. (2023b). *Joint external evaluation of the International Health Regulations (2005) core capacities of Pakistan*. https://iris.who.int/bitstream/handle/10665/380882/9789240106338-eng.pdf
23. WHO. (2023c). *Pakistan–Expanded Programme on Immunization*. https://www.emro.who.int/pak/programmes/expanded-programme-on-immunization.html
24. WHO. (2024). *Strategic framework for implementation of the Immunization Agenda 2030 in the Eastern Mediterranean Region*. https://applications.emro.who.int/docs/9789292745141-eng.pdf
25. WHO. (2025a). *Strategic framework for implementation of the Immunization Agenda 2030 in the Eastern* Mediterranean *Region*. https://applications.emro.who.int/docs/9789292745141-eng.pdf
26. WHO. (2025b). *Strategic framework for implementation of the Immunization Agenda 2030 in the Eastern Mediterranean Region*. https://applications.emro.who.int/docs/9789292745141-eng.pdf