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Analyzing the Impact of Government Expenditures on Health Sector in Pakistan: Challenges, Opportunities and Policy Reforms

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Abstract
Pakistan's healthcare system experiences issues due to lack of funding, poor facilities and shortage of staff. The government allocates only 1.2% of GDP towards the healthcare sector, but the WHO urges it to spend 5% instead. Due to limited money, the government is unable to handle issues involving healthcare infrastructure, hiring talented people or investing in necessary equipment. Rural areas often struggle to receive adequate healthcare as they do not have enough infrastructure and must travel a greater distance compared to people living in cities. There is a shortage of healthcare workers in the country and most of its skilled healthcare workers have the training of secondary education. Many people do not get the necessary health care they need because they have to pay more than half of the bill out of pocket. There are differences in people's health because health resources are not shared equally between the cities and rural areas in different provinces. People in Pakistan may benefit from development through the Sehat Sahulat scheme (SSP) and digital health, including telemedicine, online healthcare and smartphone health apps. International organizations such as the World Bank, have granted Pakistan loans to boost its development and healthcare. To achieve sustainable healthcare, policymakers should invest more in medical care, improve primary care, distribute resources properly, motivate healthcare staff to stay and improve technology used in health care.

Keywords: *Public Health Expenditure, Health Policy Reforms, Healthcare Financing, Pakistan Health Sector, Fiscal Policy and Health, Health System Challenges GDP, World Bank, IMF*

Background of the Study
Good health is a vital component of life, influencing education, income, and societal well-being. A healthy environment yields positive results, yet Pakistan's healthcare system faces significant challenges, including disparities in access, inadequate financing, poor management, and a lack of accountability (Zaidi et al., 2017). These issues are compounded by financial and non-financial barriers embedded in the nation's social fabric. Historically, policies designed by bureaucrats and technocrats have favored urban and feudal elites, leading to a neglect of the social sector. Although a constitutional amendment devolved health to the provinces, granting them autonomy over their health systems, systemic problems persist (Nishtar, 2013). Health spending in Pakistan is alarmingly low, with funding sourced primarily from general tax income and out-of-pocket costs. Consequently, Pakistan has one of the highest out-of-pocket health spending percentages of GDP in the region, far exceeding neighbors like Bangladesh and India (World Health Organization, 2024). The country's health profile is defined by rapid population growth and high rates of maternal and neonatal mortality, yet curative care is prioritized over preventive services (World Health Organization, n.d.). Despite a clear need, only a small fraction of Pakistan's budget is allocated to health facilities. One notable intervention is the Lady Health Worker Program (LHWP), established in 1994 to improve primary healthcare and reduce poverty (Hafeez et al., 2011).

Globally, healthcare spending patterns vary widely. In contrast to Pakistan's low investment, many high-income countries like France, Canada, and Japan spend over 10% of their GDP on healthcare, while the pre-pandemic OECD average was 8.8% (Indicators, 2019). The United States is an outlier, spending 16.8% of its GDP on healthcare yet suffering from a lower life expectancy than the OECD average, a discrepancy attributed to high administrative costs, and challenges with access and equity (Papanicolas et al., 2018). The COVID-19 pandemic dramatically altered global health financing, pushing total spending to a record high of over $9 trillion in 2020, or nearly 10% of global GDP (World Health Organization, 2022). This surge was driven by government spending to manage the pandemic, but rising debt and difficult macroeconomic conditions make this level of public expenditure difficult to sustain, especially for low-income nations. Achieving Universal Health Coverage (UHC), which aims to protect all people from health threats without financial hardship, requires a robust link between health financing and Public Financial Management (PFM). PFM deals with the creation, execution, and oversight of national budgets, while health financing focuses on mobilizing resources and purchasing health services efficiently (World Health Organization, 2017). The two are interdependent: PFM can create the fiscal space for health, and health financing strategies must align with the national budgeting process to be effective.

However, misalignments between PFM and health financing can severely impede the delivery of healthcare services. Key issues include input-based budgeting, fragmented revenue streams, and complex procurement procedures. In Pakistan, evaluating progress toward UHC is challenging because the country's input-based budget system makes it difficult to link policy goals with resource allocation (Sarwar, 2021). Furthermore, fragmented funding from multiple sources can lead to duplication and inefficiencies. For Pakistan to make meaningful progress, it must synchronize its PFM systems and health financing strategies to ensure that financial resources are used effectively to meet the health needs of its population and advance toward the goal of universal health security.

Global Perspective on Health System

Life expectancy, the average number of years a person is expected to live, is fundamentally influenced by a nation's health conditions, including its crude birth and death rates. Investing in treatments, immunizations, and robust health infrastructure can significantly prolong and improve citizens' lives (Sachs, 2015). A critical analysis of healthcare spending reveals major disparities. Pakistan's public health expenditure remains critically low, consistently falling below 1.5% of its GDP. This is a fraction of the spending in developed nations and trails behind the WHO's recommended minimum for low-income countries (Abbas et al, 2022). While Pakistan's per capita health expenditure hovers around US $43, this figure is overshadowed by high out-of-pocket payments and remains one of the lowest in South Asia, far behind countries like Bhutan and Sri Lanka which invest significantly more per citizen (Khan et al., 2023).

Health System and Population in Pakistan

Pakistan's health statistics reveal a nation grappling with persistent challenges. The country experiences rapid population growth, unacceptably high infant and maternal mortality rates, and a high prevalence of low-birth-weight neonates. These indicators lag behind regional peers like Bangladesh and India. Reflecting these challenges, Pakistan's ranking on the UNDP's Human Development Index (HDI) remains low, assessing well-being through life expectancy, education, and standard of living (Conceicao, 2024). The country's health system is strained by a demographic profile characterized by a large youth population, high fertility rates, and the widespread prevalence of malnutrition among women and children. This situation creates a "double burden" of disease, where the nation must combat both infectious diseases like tuberculosis and malaria, while also facing a rising tide of non-communicable diseases (NCDs) such as diabetes, cancer, and heart disease (Atif et al., 2017). This

epidemiological shift places immense pressure on a system already suffering from inadequate resources and mismanagement.

Weaknesses and Inequities in the Pakistani Health Care System

The health system's core weaknesses lie in poor governance, insufficient resources, and critical shortages of qualified personnel, particularly female staff. Even when doctors are allocated to public facilities, especially in rural areas, a lack of incentives and oversight often leads them to prioritize private practice, resulting in widespread absenteeism (Shaikh & Hatcher, 2005). These systemic failures create profound inequities that manifest in several ways. Financial inequity is a primary barrier to healthcare. With public spending critically low, the burden falls heavily on individuals through out-of-pocket payments, which constitute the majority of health financing in the country. This system lacks safety nets for the poor and vulnerable. Furthermore, the limited public budget is poorly allocated, with a disproportionate amount spent on curative, tertiary-level care in urban centers, while preventive and primary healthcare services receive only a small fraction of the funds (Siddiqi et al., 2017). There is a severe geographical imbalance in the distribution of health facilities, creating a stark rural-urban divide. In remote and rural regions like those in Gilgit-Baltistan and Baluchistan, physical access to care is a major obstacle, with the nearest advanced facilities often hundreds of kilometers away. While a network of Basic Health Units (BHUs) and Rural Health Centers (RHCs) exists, their coverage is incomplete and they are often underutilized due to poor service quality and staffing issues, forcing many to bypass them (Jabeen, 2023).

Unfair Deployment of Human Resources

The shortage and maldistribution of qualified healthcare workers, particularly women, cripples the system's effectiveness. The gender imbalance is severe; rural health facilities consistently fail to fill posts for female doctors, leaving the 70% of the population in rural areas without adequate access to gender-sensitive care (Shaikh & Hatcher, 2005). This is a critical failure, as many women in conservative areas are not permitted to consult male doctors. Poor compensation, a lack of security, and inadequate living conditions contribute to absenteeism and the "ghost worker" phenomenon, further weakening the health workforce. Due to poor service quality, unprofessional staff behavior, and a lack of essential medicines at public primary care facilities, many Pakistanis either forgo care or turn to the often-unregulated private sector. On average, individuals have fewer than one consultation per year, far below the recommended minimum, indicating severe underutilization of available services (Atif et al., 2017). For women, access is further restricted by sociocultural norms that may require them to be accompanied by a male relative, effectively denying their basic right to healthcare.

Unfairness Due to Poor Access to Essential Medicines

Access to essential pharmaceuticals in lower-income countries is determined by health budgets, pricing, and availability. In Pakistan, the health system is dominated by the private sector, which finances over 70% of health expenditures, largely through out-of-pocket payments. This reliance on private care is partly because public facilities often lack essential medicines. While Pakistan has over 400 pharmaceutical companies, multinational firms control a majority of the market share. Local companies contribute to foreign exchange but are not systematically integrated into a framework of social responsibility to ensure equitable access to medicine for the nation's most vulnerable populations (Babar et al., 2011).

The healthcare system exhibits a strong urban bias, with most public and private facilities concentrated in metropolitan areas. Successive governments have often prioritized large, visible hospital projects in cities while neglecting primary healthcare in rural areas. Resource distribution has frequently been guided by political considerations rather than by population needs or disease burden, perpetuating a system driven by class demands instead of public health imperatives (Zaidi et al.,

2019). This bias is reinforced by a medical education system that often fails to instill a sense of moral duty in new doctors to serve in underserved rural communities. Furthermore, Pakistan's health policy and research priorities are heavily influenced by international donors and government bureaucracy, often sidelining input from local communities, NGOs, and academic scholars. This top-down approach has resulted in health policies that are misaligned with public needs, contributing to the failure to meet targets for the Sustainable Development Goals (SDGs). Critical issues that disproportionately affect women such as gender-based violence, mental illness, and complications from early marriage are frequently unaddressed in major policy documents, negatively impacting maternal and child health outcomes (Khattak, 2018).

Budgetary Challenges and Planning

Historically, Pakistan's health budget has been characterized by inconsistency and has struggled to keep pace with population growth and epidemiological challenges. Provincial budgets, while occasionally increasing for high-profile projects or specific initiatives like free medicine distribution, often lack the sustained and predictable funding needed for long-term system strengthening. This results in a fragmented approach where resources are not allocated efficiently or equitably across different levels of care (Malik et al., 2006). Ultimately, Pakistan's planning processes often fail to consider the critical interdependence of population, resources, the environment, and development, hindering the provision of sustainable welfare for the nation. To illustrate the context, the key health indicators for Pakistan in 2015 were a crude birth rate of 28.5 per 1,000 people, a crude death rate of 6.8 per 1,000 people, and a life expectancy of 66.4 years. By 2023, the most recent year with complete data, these figures had shifted to a crude birth rate of 25.5 per 1,000, a crude death rate of 7.0 per 1,000, and a life expectancy of 66.1 years, indicating persistent challenges in improving national health outcomes.

Table 1.1 Current Facts and Figures

Crude Birth Rate (per thousand)	**26.1**
Crude Death Rate (per thousand)	6.80
Life Expectancy (years)	66.5

Source Pakistan and Gulf economist (2015)

Pakistan faces significant challenges in its healthcare system. Life expectancy is 66.5 years, with a birth rate of 26.1 per 1000 and a death rate of 6.8 per 1000. The centralized health system, controlled by the federal government, excludes community and private stakeholders, causing communication breakdowns and resource duplication. This poor governance hinders policy implementation and fosters distrust (Table 1.1).

Lack of health equity is evident, with 30% of the population in extreme poverty. High out-of-pocket expenses (76% of health costs) and limited public facilities force the poor into expensive private care. Rural areas suffer from a scarcity of basic healthcare and professionals, increasing costs and limiting informed health choices. Healthcare infrastructure distribution is uneven by gender and location, impacting mortality and morbidity rates. Furthermore, education's impact on health is diminished by unfair compensation for new doctors, leading to protests.

Table 1.2 Number of Recognized Medical Colleges

Province	**Public**	**Private**	**Total**
Punjab	18	30	48
Sindh	9	14	23
KPK	8	9	17
Baluchistan	1	1	2
AJ&K	3	1	4
Total	39	55	94

Source Pakistan medical and dental council (2015)

Table 1.2 indicates Pakistan has 94 medical colleges with 42,000 total seats. Competition is high, with 3,405 medical and 216 dental seats at 17 public medical and three public dental colleges, alongside approximately 3,000 MBBS and 700 BDS seats in 28 private medical and 12 private dentistry colleges, suggesting a scarcity of doctors, institutions, and seats (Table 1.2). Lack of resources and physical accessibility plague healthcare facilities. Rural residents are often sent to tertiary care due to inadequate Basic Health Units (BHUs) and Rural Health Centers (RHCs), exacerbated by poor transportation, roads, and distance. The public sector is underutilized due to a lack of health education, transparency, language/cultural barriers, and scarce human resources, making BHU visits difficult for many. The COVID-19 pandemic highlighted inadequacies in Pakistan's healthcare system. Despite Dr. Tedros's advice to strengthen health systems, Pakistan faced a major catastrophe, with 255,769 cases and 5,386 deaths by July 15, 2020. The nation's unfavorable healthcare system and geographic location posed significant challenges. Initial efforts were hampered by a lack of medical labs, necessitating sample shipments to China. Later, testing facilities increased, with the WHO establishing COVID-19 testing centers at seven hospitals. The pandemic caused severe shortages of medical personnel, supplies, and infrastructure, disadvantaging the poor. Government policy failures led to congested ERs, dwindling staff, cramped ICUs, caregiver stress, strained lab facilities, and increased costs. Public concerns rose, and hospital maintenance was neglected, leading to threats and attacks on doctors by angry families. The healthcare system risked being overloaded as cases surged. While plasma antibodies showed promise, some exploited this for profit, leading to drug shortages like dexamethasone. Experts warned of a human tragedy if decisive action wasn't taken.

Despite operational errors, Pakistan's virus transmission rate was lower than expected. However, public disregard for Standard Operating Procedures (SOPs) and official orders, along with myths and conservative beliefs viewing the outbreak as a conspiracy, fueled a sharp rise in cases after lockdown easing. Mass prayer events and public activities, coupled with individuals evading screening and breaking quarantine, further spread the virus. Compared to developed nations, Pakistan's healthcare system is inadequate due to its dense population and unstable economy. As of July 15, 2020, the epidemic persisted, with inadequate testing, fear of revelation, and lockdown easing being primary causes of the surge; lifting the lockdown in late May led to 20,000 new cases and an increase in daily positive findings from 11.5% to 15.4%. The Pakistani government implemented additional measures like lockdowns, testing, quarantine, and information campaigns. Courageous physicians and overworked medical personnel continue to battle the virus, facing immense stress and personal risk.

Table 1.3 Detailed Record of Confirmed Cases as of 15 July 2020 (Government of Pakistan 2020a)

S/R no	State/province	Confirmed	Deaths	Recovered
1	Azad Kashmir	1688	46	1049
2	Gilgit-Baltistan	1708	38	1376
3	Punjab	88,045	2043	64,148
4	Baluchistan	11,239	127	7883
5	Sindh	107,773	1863	65,420
6	KPK	31,001	1114	21,607
7	Federal (ICT)	14,315	155	11,327

The COVID-19 pandemic began spreading in Pakistan in February 2020, with the first official incident announced in March. Lockdowns implemented in March were lifted in April, following suggestions from Muslim leaders. Malls and markets briefly reopened in May but were reclosed in June. A lack of personal protective equipment exposed some healthcare teams. While RT-PCR of the nasopharynx is the definitive test for infection, a low percentage of the population testing positive suggests wider community

transmission. Officials should advise symptomatic individuals to get tested. Pakistan partially adheres to WHO guidelines, quarantining tourists with viral symptoms while monitoring negative cases and following health guidelines for positive ones.

The health sector faces numerous problems. The WHO oversees global healthcare center supply, with developed countries assisting developing nations unable to provide basic medical care. Despite new immunizations for serious diseases, many governments, including Pakistan's, struggle to ensure basic necessities like housing, healthcare, education, clean water, and food. The Population Association of Pakistan notes that while urban areas have indoor and outdoor tap water, rural areas rely on motor pumps, wells, rivers, and canals, often supplying unsafe drinking water, leading to increased infectious diseases. In 2010, the World Bank listed Pakistan as ninth globally for infant mortality, with one-tenth of infants born between 2001 and 2007 not reaching five years of age, and one in 80 maternal deaths attributed to poor maternal health during pregnancy. Nearly one in five Pakistanis suffer from malnutrition, iron, or Vitamin A deficiency.

To improve health, the government allocated Rs9.9 billion for health issues and services, supporting 17 active programs and a new one. According to PSDP (2010), the National Institute of Health, Islamabad, and a program on immunization and diarrheal disease reduction will receive Rs2.8 billion. The Ministry of Finance (2010) highlights the health sector's significance, citing a fertility rate of 4.1%, 30% contraception usage, 1.8% population growth, 0.07% malaria cases, and 0.18% tuberculosis cases. Table 1.4 illustrates access to health facilities. Health is primarily a provincial responsibility in Pakistan, except for federally governed areas. The federal government develops national health policies for provincial implementation, including expanded immunization activities and vertical prevention strategies for malaria and AIDS. Both public and private entities facilitate Pakistan's health services, with nearly three-quarters of users accessing private healthcare, mostly through out-of-pocket payments. The government manages over 10,000 healthcare institutions, including Basic Health Units (BHUs) and Rural Health Centers (RHCs), which fall under Primary Healthcare (PHC). Most of Pakistan's 22 tertiary care facilities are educational institutions located in major cities. While over 70% of the population regularly uses PHC facilities, less than 30% use them less often due to staff scarcity, high absenteeism, mediocre services, and inconvenient layouts. The Pakistani army, railways, local agencies, and independent groups also offer healthcare to their employees.

Personal Heath Facilities

Basic Health Units	**5171**
Rural Health Care	531
Mother and child health centers	856
Medical Service Unit	131
Hospitals	876
Dispensaries	4635
Private Health Establishments	29,73,650

Source Population Association of Statistics, (2002)

The healthcare system in Pakistan is very important, but its growing population means there are fewer beds, doctors and nurses available. Because only 27% of the population can access quality health care, the healthcare system in the country is under threat (Settle, 2016). The purpose of health programs is to help people understand health care and how to prevent diseases. Despite health being crucial for the progress of the nation, Pakistan hasn't fully used the aid it has been given. There aren't enough hospitals, doctors, paramedics or medicines in rural Pakistan. This happens mainly because the government does not pay much attention to rural health. Many patients have to visit crowded cities for medical care since doctors tend to practice away from them. Consequently, people living in rural areas deal with poor healthcare and fewer medical facilities.

Health Sector Improvement Programs

In a few cases, the government can help its citizens by giving financial support during illness, having children and later in life. If a household has two or more disabled children, Pakistan Bait-ul-Maal offers them 25,000 rupees annually and this allows the charity to help underprivileged widows and orphans with medical care (Adeel, 2007). Pharmacy benefits management offers support to unprivileged groups with financial aid. The rising quality of drugs and vaccines has contributed to fewer untreated disease deaths. These campaigns work to make more people aware of diseases such as breast cancer and polio. They aim to protect young children from dangerous diseases and ensure a better life for everyone. Steps taken by the government make life better for Pakistan's people (Unicef, 2007). Since their inception, the National Maternal and Child Health Program, the Cancer Treatment Program and the HIV/AIDS Control Program have been developed by the government. Through HIV/AIDS and health nutrition programs, people are taught how to maintain a healthy lifestyle. The Benazir Income Support Program made it possible for poor people to have health insurance (World Bank, 2011). Many initiatives have been launched in Pakistan to fight against malaria, AIDS, TB and tobacco use. Seventy thousand people affected by TB were offered free diagnosis and treatment from the National TB program.

In 2015, 70% of the budget for malaria went to prevention and treatment and the directorate aimed to reduce Pakistan's malaria cases by 50% by 2010. Over 96,000 people across different locations were supported by the family planning and primary care program. To avoid children catching TB, polio, diphtheria, pertussis, measles and tetanus, vaccination was initiated. The main objective of the national Maternal, Neonatal and Child health program was to improve and make health services readily available. As a result, 104 clinics were provided for free care and nearly 400,000 people were vaccinated. The CDC is coming up with strategies to protect babies from diseases such as pneumonia and meningitis. Punjab received over $100 million from the World Bank to change the health system, as it is the region with the largest population (Pasha, 2010). The human resources for healthcare have been monitored by the Federal Ministry of Health and provincial health ministry's ever since Pakistan was formed as a state. The United States has 3 nursing schools, 5 dental schools, 12 postgraduate medical schools and 18 medical schools. Recently, the private sector has built 8 undergraduate and 2 postgraduate schools in medicine. While training doctors, especially nurses, has made up most of the focus, the private sector has seen ever-increasing costs. In the majority of nations, the nurse-to-doctor ratio is 31, but in Pakistan, it is 13.4. Social Action Program was created by the Pakistani government in 1992–1993 to improve the country's low health and social numbers in important services. Efficiency was improved by the UK government introducing the Prime Minister's Program for Family Planning and Basic Health Care in 1994.

In an effort to improve health services for the public, the Pakistani government will create District Health Governments and ensure they are headed by a chief executive. DHGs are formed from non-governmental organizations, public officials, opinion leaders and health authorities, who have control over budgets and other systems. The government, through Health Foundations, provided the money needed to set up private hospitals in remote locations in 1997. These healthcare institutions are run by community people who get support from the government. It is primarily the role of DHGs to implement the prepaid, regulated health program that each Indian state has in place. In 1998, the prime minister designed a development strategy to increase both the government and human resources needed for enhancing the country's social progress. It is predicted that the health, education and information technology fields will all develop in the future.

Planning and Funding for Health Care

The health care planning process in Pakistan involves preparing a budget every year, an annual ADP and development plans covering five to fifteen years. The Ministry of Health and each Province's Health Department plan actions according to the policies set by the Planning Commission. Data on social and health conditions are needed to design suitable plans. Usually, Pakistani healthcare systems rely on population statistics to determine what is needed, but they fail to consider who can use these services and what their needs are. The planning process does not address equity. The government is responsible for financing public health; the most common sources of capital investments in the public sector come from development plans, province budgets and foreign aid. Even though only 3-4 percent of Pakistan's GNP goes to health in total and a further 2-3 percent to private, health spending per person has increased by a lot during the past 15 years.

Conclusion

In order to address inequality in health and achieve fair results, the article emphasizes how important it is to understand the interplay between public health, political institutions, and power dynamics. People working in healthcare should be involved in policy making at all stages and study the reasons behind high health costs to help decrease Pakistan's death rates among children. The government works to inform people, invest in health centers, use technology for better access to healthcare and introduce relevant laws and programs that encourage preventative efforts in Pakistan. Effective management of politics, public health and power requires transparency, accountability and decisions made through democracy. While Pakistan's health system has made progress in the past 50 years, the government needs to take strong actions to change its current situation.

Offering essential healthcare services to communities is emphasized in the World Bank and MOH's advice to the government. If the reforms intend to prevent interests' groups and avoid bureaucratic delays, they should begin showing results in Punjab and be enacted as soon as possible. The main reason for health inequality between Pakistan's rich and poor is that the system distributes health money more equally towards the privileged than to the poor. For this reason, provincial health bodies should develop government-run community pharmacies and dispensaries. Many problems relating to housing, literacy, food and health care have appeared for Pakistan because of the COVID-19 pandemic. Healthcare facilities are being improved and the government encourages people to be more aware of preventative actions. Problems in Pakistan's health system are mainly caused by political, social, economic and geographic factors. It might be important to alter the constitution so that the provinces have extra control over healthcare services. Provincial governments should deal with capacity issues in different aspects of healthcare, including finances, information handling, research, personnel issues, and main healthcare areas and registering medications. There is uncertainty within the Pakistani government about using herd immunity as a way to stop the COVID-19 spread. Following events like COVID-19, countries in the developing world must deal with low public spending and support more fiscal independence in healthcare. Health finance needs to be reshaped after the COVID-19 pandemic to help the health system support the public**.**

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