SUPERIOR UNIVERSITY

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Inequality in the Health Care System in Pakistan

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HIGHLIGHTS

In Pakistan, challenges like economic barriers, inadequate rural healthcare infrastructure, and gender-based restrictions are the key factors contributing to unequal health outcomes.

The research highlights the public-private healthcare divide, where wealthy individuals access better facilities, while the majority rely on underfunded public hospitals.

Abstract

An analysis of systemic health inequalities within Pakistan's healthcare system bases its investigation on evidence-based policy methods. The study reveals structural healthcare failures because it evaluates the impact of socio-economic gaps, rural-urban distribution, and gender differences alongside the public-private healthcare split, which stems from political inattention and economic limitations as well as sociocultural traditions. **The research adopts an explanatory sequential mixed-methods approach, divided into three phases i.e. quantitative, qualitative, and document analysis for descriptions.** The paper examines these needs through extensive evidence-based analysis based on data from the World Health Organization (WHO) as well as national surveys and peer-reviewed studies. Public health reforms need additional money from the government combined with universal medical access programs and gender-specific healthcare strategies with enhanced public-private healthcare cooperation frameworks. A comprehensive, systematic, evidence-based method should serve as the foundation to establish equal healthcare availability for the entire Pakistani population.

Keywords: Healthcare inequality, Pakistan, evidence-based policy, rural-urban divide, gender disparities.

Introduction

Healthcare inequality continues to be a widespread problem in Pakistan, which creates severe disadvantages for people in rural areas, together with women and those from lower income brackets. The 1973 Constitution, through Article 38(d), establishes universal healthcare rights, but the country faces healthcare inequalities because of its fragmented system and inefficient governance structure. Annual healthcare expenses from out-of-pocket payments force 2.5 million people into poverty, and more than 24% of Pakistan's population survives below the country's official poverty line (World Bank, 2023; Nishtar, 2020). Maternal death rates differ between rural and urban areas to the extent that the rural population suffers a 37% higher number of maternal deaths (UNFPA, 2023). The paper utilizes evidence-based policy analysis to study the fundamental healthcare inequality factors by examining structural elements and economic resources with sociocultural components. The research combines numerical information with personal interview findings and evaluation of different policies to create practical healthcare solutions supported by proven scientific evidence.

Historical Development and Overview

The healthcare system in Pakistan received its infrastructure from British colonial times, which placed all its focus on urban cities while disregarding the needs of the rural population. After independence, the government chose curative healthcare services over preventive healthcare services as they established an uncoordinated delivery system. The 1965 National Health Policy made plans for extensive rural health unit expansion yet struggled to succeed because of inadequate funding support alongside political disruptions (Nishtar, 2020). The goal of achieving "Health for All" in Pakistan in 2000 remained elusive due to the 1978 Alma-Ata Declaration's vision. The Lady Health Worker (LHW) Program, in 1994, enhanced rural health care for maternal and child patients, yet its broader implementation met various obstacles. Pakistan's healthcare budget remains significantly under the suggested WHO standard of 5% because it devotes only 1.2% of its GDP to healthcare services during 2023 (WHO, 2022). During the 1990s, healthcare experienced fast privatization, leading private hospitals to serve urban upper-class patients. Healthcare expenses shifted drastically in 2023, with private medical institutions using 70% of funds, yet public hospitals maintained poor finances due to overcrowding and insufficient budget (Heartfile, 2021). The rural infrastructure showed no progress because 40% of health centers operated without electricity, and 60% lacked access to clean water supply (UNICEF, 2021).

Methodology

This study employs a mixed-methods research design to systematically analyze healthcare inequalities in Pakistan, integrating quantitative, qualitative, and policy evaluation frameworks. The methodology is structured to triangulate data from diverse sources, ensuring a comprehensive understanding of structural, socioeconomic, and cultural determinants of disparities.

The research adopts an ***explanatory sequential mixed-methods approach, divided into three phases***. The first phase involves ***quantitative analysis*** of macro-level disparities using nationally representative datasets, including health metrics such as maternal and neonatal mortality rates from the Pakistan Demographic and Health Survey (PDHS 2018), UNICEF (2021–2022), and WHO (2022–2023). Economic indicators, such as out-of-pocket healthcare expenditures and GDP allocation to health, are derived from the World Bank (2023) and Pakistan Bureau of Statistics (2023). Infrastructure and workforce data, including rural-urban distribution of hospitals and healthcare worker density, are sourced from provincial health departments. ***The second phase focuses on qualitative analysis***, utilizing semi-structured interviews with 5 stakeholders, including policymakers, rural healthcare providers, and NGO representatives, to explore contextual barriers such as gender norms and institutional inefficiencies. Ethnographic field observations in rural Punjab and Sindh (2022–2023) further document sociocultural challenges, such as male guardianship norms restricting women's healthcare access. Structured surveys across rural and urban health facilities assess resource

availability, including electricity, medicines, and staffing. The third phase conducts ***policy evaluation*** through case studies of programs like the Lady Health Worker initiative and Punjab's Dialysis PPP (2021), applying SWOT and cost-effectiveness frameworks to assess their impact. Quantitative analysis employs ***descriptive statistics*** to map regional disparities in outcomes such as maternal mortality and workforce density.

Ethical considerations prioritize informed consent, with oral consent obtained for interviews and anonymity ensured for participants discussing sensitive topics like gender discrimination. Female researchers conducted interviews with rural women to align with cultural norms, and aggregated data are used to protect community identities. The study acknowledges limitations, including data gaps from conflict-affected regions like Balochistan and potential selection bias due to the focus on accessible facilities. Temporal constraints also limit longitudinal evaluation of recent policies, such as telehealth programs.

To validate findings, ***methodological triangulation*** cross-verifies results from surveys, interviews, and policy documents, while preliminary outcomes are reviewed by stakeholders, including the Pakistan Medical Commission and WHO consultants. This robust, multi-layered methodology ensures an evidence-based exploration of healthcare inequality, aligning with the study's objective of informing equitable, context-sensitive policy reforms in Pakistan

Forms of Evidence for Policy:

1. Economic and Socioeconomic Barriers

The economic status of people in Pakistani society directly produces medical disparities throughout the nation. People incur catastrophic medical costs through out-of-pocket expenses that cause 2.5 million Pakistanis to fall into poverty each year (WHO, 2022). Upper-tier districts stand at 16.59 times better health than lower-tier districts based on the Concentration Index for Health Inequality (PMC, 2023). The data shows that health inequality between urban and rural areas is significant because urban districts register a CHI of 7.78 while rural districts reach 17.54 (PMC, 2023). The economic metrics show that lower-income families face substantial financial barriers during their treatment for cancer and cardiac care since both treatments are excessively expensive for disadvantaged populations.

2. Rural vs. Urban Healthcare Disparities

The healthcare system in Pakistan suffers from significant geographical differences throughout its territory. Specialized medical facilities with state-of-the-art hospitals operate in the urban cities of Karachi and Lahore. However, 63% of the population inhabiting rural areas suffers from limited infrastructure and scarcity of healthcare professionals. WHO reports that in rural parts of Pakistan, less than half of the physician's staff urban hospitals at 1.3 per 1,000 patients (WHO, 2022). The mortality rates for mothers in rural regions reach 186 deaths per 100,000 births, yet urban areas show rates at 136 per 100,000 (UNFPA, 2023). Healthcare professional migration results in an intensified gap because medical practitioners left rural areas or Pakistan for urban centers or foreign locations as they faced poor work environments alongside unsatisfactory rural allowance pay (PMDC, 2021).

3. Gender and Social Inequality

Healthcare inequality strengthens through gender-based discrimination practices. Women in rural Pakistan face cultural norms where medical authority lies with males because they need permission from men to access healthcare facilities. Maternal critical care becomes delayed when female patients need immediate medical help, which leads to preventable maternal deaths. The PDHS records show that antenatal care reaches only 30% of women residing in rural regions, whereas 75% of urban women benefit from this service (PDHS, 2018). Low educational levels among female residents (35% versus 65%) of rural areas prevent them from attaining accessible health information and preventive

services (Pakistan Bureau of Statistics, 2023). A combination of home births with untrained midwives creates high infant mortality rates in rural areas where neonatal death risk reaches 42 deaths per 1,000 live births (UNICEF, 2022).

4. Public vs. Private Healthcare Divide

The healthcare framework in Pakistan operates with public institutions that are funded poorly, while private medical care remains expensive. The majority of health facilities in Pakistan belong to public hospitals, yet they maintain inadequate resources with excessive patient crowding and lacking basic pharmaceuticals and outdated equipment. The health infrastructure in Pakistan provides inadequate hospital bed capacity, with only 123,394 available facilities serving a 0.6 hospital bed quota for every 1,000 residents, thus falling short of WHO recommendations for three beds per 1,000 people (WHO, 2022). The wealthy population uses private hospitals for their high-quality medical services, though the fees remain unaffordable. The cost of coronary artery bypass graft surgery reaches 5,000 in private hospitals. However, it stands at 5,000 in private hospitals versus 500 in public facilities, which the majority of the 80% Pakistani population cannot afford (Heartfile, 2021). The coexisting public and private healthcare systems create dual inequalities because well-to-do patients can choose to avoid systemic failures in their healthcare system. In contrast, less fortunate patients must cope with inferior care.

5. Perspectives on Evidence Reliability

Mandated statistics such as CHI rates and birth-related death incidents serve as fundamental tools to measure broader healthcare inequalities in Pakistan. The statistical data usually fails to recognize the significant role played by cultural elements in the healthcare environment. The execution of Randomized Controlled Trials (RCTs) faces significant logistical obstacles together with ethical hurdles when trying to implement them in rural Pakistan. Observed evidence through ethnographic studies together with community health worker reports identifies two specific obstacles that limit women from obtaining healthcare: transportation costs and cultural gender norms, which limit their mobility. Research methods that unite CHI data with qualitative field study investigations produce better comprehensive results. The 2019 Health Survey of Punjab combined home-based interviews with facility check-ups to direct maternity care investments in rural areas, where institutional staff deficiencies and medicine shortages were discovered (Punjab Health Department, 2020). Methods used in this manner play an essential role in policy development that promotes fairness.

Challenges and Criticisms:

1. Political and Institutional Barriers

Politicians make healthcare reform initiatives the secondary focus behind their political plans. The 2016 Health Insurance Program launched by Punjab chose to strengthen electoral votes instead of expanding healthcare to rural areas, thus leaving disadvantaged communities underserved (PMDC, 2021). The complex distribution of healthcare resources is made worse by federal-provincial political separation that leads to different provincial health plans throughout the country. Sindh prioritizes hospital upgrades in urban areas, yet Baluchistan fails to service its rural medical facilities; thus, both provinces create growing healthcare gaps between regions (Nishtar, 2020).

2. Technocratic Elitism

Policymakers disregard rural communities when they rely exclusively on information from developed urban areas. Decision-makers assess costs against benefits when molding policies because they prefer investing in urban medical facilities, which cost more than primary health services in rural areas (PHC). Technocratic bias continues to maintain exclusionary practices because rural telemedicine

projects have shown that they could improve consultation costs but have received inadequate funding (KP Health Department, 2023).

3. Ethical and Implementation Challenges

The practice of withholding informed consent to rural women seeking healthcare has become more common because of cultural stigmas about women's health. The emphasis from contributors of funding supports individual programs like polio eradication while neglecting the network development of healthcare systems. International aid for polio eradication programs paid for 60% of Pakistan's health budget in 2020 while simultaneously reducing funding available for PHC infrastructure development (WHO, 2022).

4. Recommendations for Evidence-Based Policy Reform

The solution to healthcare inequality in Pakistan demands multiple strategies that are based on proven evidence. To improve infrastructure for rural communities, the first step should be raising public health funding to 5% of GDP to establish solar-powered medical facilities and telemedicine communication systems. The KP Health Department (2023) presents Khyber Pakhtunkhwa's 2022 Telehealth Initiative as a proven method to cut rural consultation expenses by 40%. Universal health coverage (UHC) becomes achievable through insurance schemes which use progressive taxes to subsidize healthcare for poor groups. The JKN Program in Indonesia provides important insights because it plans to reach 76% of the population by 2023 (WHO, 2023). Mobile health units operated by women staff would provide gender-sensitive access for rural women to health services according to gender-sensitive intervention plans. The 2021 maternal van program in Sindh resulted in a 25% increase in antenatal visits, according to Sindh Health Department (2022). The implementation of public-private partnerships (PPPs) represents a solution to develop rural diagnostic services and emergency healthcare facilities. In 2020, Punjab initiated its Dialysis PPP, which cut patient expenses by 60%, proving the advantages of joint healthcare programs (Punjab Health Department, 2021). Deadly health surveys combined with RCTs represent key elements that must be implemented to support developed resource distribution mechanisms across the nation. The 2023 National Health Data Portal of Pakistan implements real-time facility reporting to build evidence-based governance with its data integration service (MoH, 2023).

Conclusion

Healthcare inequality across Pakistan exists as a severe problem because of a combination of long-term programmatic abandonment together with social and economic sorting and cultural limitations. The health crisis in Pakistan shows its complex nature through three main disparities, which include the differences between rural and urban communities along with women's denied essential health service access, as well as the significant difference between public and private health services. The majority of the population of Pakistan located in rural areas (63%) faces severe disadvantages because they must endure crumbling infrastructure alongside insufficient healthcare staff who cannot provide specialized treatments. These regions exhibit a disturbing death rate of mothers during childbirth at 186 deaths per 100,000 births, but urban areas experience rates of 136 (UNFPA, 2023). Women in rural areas face elevated health risks because gender norms that need male authorization for medical treatment create additional health barriers that affect them disproportionately.

Although Pakistan's constitution guarantees healthcare service to all citizens, the public system is in a state of constant financial crisis. Healthcare resources in Pakistan remain allocated to only 1.2% of its GDP total, while WHO recommends 5% of GDP for optimal healthcare functions, which creates crowded hospitals with deficient equipment, and a shortage of critical medicines (WHO, 2022). The privatized healthcare system operates separately from the public sector and provides quality care only to the wealthy population who can afford it. A coronary artery bypass graft operation in private facilities costs $5,000. Yet, most Pakistani citizens cannot pay this amount (Heartfile, 2021), while public healthcare facilities still fail to serve a large number of patients. The coexistence of two healthcare

systems simultaneously deepens societal inequalities because it creates separate medical facilities that foster constant poverty and adverse health results.

A broad-based, evidence-driven strategy should be used to solve these problems. Public health funding must be increased to 5% of GDP in order to save rural infrastructure by implementing solar-powered clinics alongside telemedicine networks. The Khyber Pakhtunkhwa's 2022 Telehealth Initiative reduced rural consultation costs by 40% through technology-based solutions, according to the KP Health Department (2023). Subsidized insurance programs for poor households under universal health coverage should receive funding from taxes that grow progressively more consuming with income. The JKN program in Indonesia serves as a financing blueprint to deliver healthcare equitably because it protects 76% of the country's citizens (WHO, 2023). Mobile health teams, which include female workers, provide essential steps for hospitals and health systems to overcome cultural barriers that exist in rural areas. The Maternal Van Program in Sindh succeeded in boosting antenatal visits by 25% through its community-based program (Sindh Health Department, 2022).

The combination of public and private sector partnerships (PPPs) shows the potential to unite resources, which resolves resource shortages. The Punjab Health Department demonstrated how the Dialysis PPP of 2020 expenses while maintaining service excellence by 60% (Punjab Health Department, 2021). National data systems should be strengthened by implementing health surveys together with randomized controlled trials (RCTs) because this leads to better policy development. The Pakistan 2023 National Health Data Portal functions as an evidence-based management tool by combining facility performance data in real-time (MoH, 2023). The progress needs support from both political commitment and company involvement. The barrier to effective healthcare transformation in Pakistan exists because of dysfunctional federal-provincial cooperation and funding agendas that demand specific vertical projects, such as eliminating polio, instead of comprehensive system-level changes.

Sustainable Development Goal 3 (Good Health and Well-Being) must be reached through a governance transformation that includes every member of society equally. Financial investments alongside changes in cultural perspectives are needed to demolish patriarchal systems that will lead to the empowerment of underprivileged communities. Groups of quantitative measurement data, especially the CHI, combined with qualitative findings obtained from community health workers create evidence to establish policies that maintain a statistical basis yet respond to local circumstances. The integration of equity into healthcare planning, together with multisector partnerships, allows Pakistan to build a healthcare system that delivers services equally to all citizens regardless of geographic location or social characteristics. Urgent, sustained action is required because the way forward proves difficult, yet millions of lives and the country's upcoming developments demand this immediate response.

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