



Bridging Vision and Reality: A Critical, Comparative and Scenario-Based Evaluation of Pakistan's Health Policy

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ABSTRACT

This study uses a multifaceted framework that combines empirical evaluation scenario, forecasting and comparative analysis to critically assess Pakistan's Health and Population Policy. The study highlights mainly focuses on strategic gaps in digital health infrastructure, equity implementation, financing and governance by comparing it to Bangladesh, Rwanda and India. Three conceivable futures—optimistic, status quo and regressive—are projected by a scenario analysis based on institutional capacity and policy implementation. Significant differences in health infrastructure, workforce distribution, budget utilization and climate resilience are revealed by ground-level analysis. The policy's success depends on strategic execution, interprovincial coordination and adaptive learning that reflects global aspirations and SDG alignment.



Introduction

For many years there have been significant issues with Pakistan's healthcare system. Weak institutional coordination, a lack of funding and weak structures caused the nation to enter these issues. In an effort to reduce these issues and boost system efficiency a number of health policies were introduced. In accordance with international standards the National Health Policy of 2001 and the National Health Vision 2016–2025 offer guidance for the future. Aside from this the nation continues to struggle to provide its citizens with universal access to high-quality affordable healthcare. The shortcomings are most apparent in rural areas where medical services are frequently sporadic or non-existent and health outcomes are still poor.

A significant turning point in Pakistan's health governance occurred in 2010 with the passage of the 18th Amendment to the Constitution which transferred health-related duties to provincial governments (Rana, 2020). Although it promised customized interventions and localized decision-making it also revealed weaknesses in accountability capacity and coordination. Provinces found it difficult to formulate cohesive plans and the lack of a single national framework resulted in policy drift and effort duplication.

Pakistan's health priorities have been significantly re-evaluated with the introduction of the Health and Population Policy 2025–2034. This policy in contrast to its predecessors acknowledges the interdependence of demographic trends, reproductive health and healthcare delivery and unifies population planning and health into a single strategic vision (Chaudhry & Khan, 2020). It seeks to establish a health system that is inclusive resilient and technologically advanced so that it can address both long-standing and new issues.

The new policy's emphasis on digital health infrastructure is among its most innovative features. AI-powered diagnostics, telemedicine and electronic health records all work together to modernize service delivery and increase access particularly in underprivileged areas. This digital revolution is more than just a technical one it is a manifestation of a larger dedication to openness. data-driven decision-making and citizen empowerment.

The policy's emphasis on financial protection and equity is equally crucial. By giving priority to vulnerable groups including women, children and low-income households: the policy aims to eliminate structural obstacles to care. It aligns Pakistan's health objectives with the Sustainable Development Goals (SDGs) and the World Health Organizations (WHO) global health agenda by introducing mechanisms for universal health coverage such as targeted subsidies and insurance schemes.

The long-standing gap between health services and population planning is also addressed by the policy (Khan et al., 2024). Recognizing the demographic pressures on Pakistan's health system it promotes reproductive rights and incorporates family planning into primary healthcare (Islam et al., 2002). This all-encompassing approach represents a more sophisticated understanding of public health and departs from compartmentalized approaches.

Furthermore, the policy is based on multi-sectoral cooperation which unites international partner's federal ministries provincial governments and civil society (S. Zaidi et al., 2024). The goal of this inclusive governance model is to encourage accountability, creativity and ownership at every level of the healthcare system. Additionally, it makes room for publicprivate partnerships which can accelerate implementation by mobilizing resources and expertise.

The novel dynamics strategic priorities and implementation challenges of the Health and Population Policy 2025–2034 are the main topics of this papers evaluation. It aims to ascertain whether this ambitious framework can actually change Pakistan's health landscape or if it runs the risk of becoming just another well-meaning blueprint lost in bureaucratic inertia through comparative analysis and policy evaluation.

Literature Review

Pakistan's health policy has developed as a result of a complicated interaction between demographic political and economic factors. Prioritizing infrastructure development and disease control early initiatives like the National Health Policy of 1990 and 2001 lacked strong implementation mechanisms (Nishtar et al., 2013). Particularly in rural and underserved areas these policies were frequently criticized for being unduly centralized and detached from the

realities on the ground. A major change was made when Pakistan's health priorities were brought into line with the Sustainable Development Goals (SDGs) through the National Health Vision 2016–2025. Maternal and child health universal health coverage and the development of the health system were highlighted. Scholars like (S. A. Zaidi et al., 2019) however, contend that the Vision did not address the fragmentation brought about by the 18th Amendment which gave provincial governments more authority over health matters without guaranteeing coordination or capacity building. In Pakistan population planning has long been considered a distinct field from health policy. One common theme in scholarly criticisms of Pakistan's policy framework is the absence of coordination between the population and health sectors. Integrated health and population policies have demonstrated potential for enhancing results on a global scale. For example Bangladesh's unified approach to family planning and health has been credited with lowering fertility rates and improving maternal health (Chowdhury, 2025). The new Health and Population Policy 2025–2034 of Pakistan seems to be based on these models with the goal of developing a unified framework that tackles both the delivery of health services and demographic pressures. One force that is revolutionizing global health systems is digital health. This has potential to increase access, improve quality and boost efficiency as highlighted in WHO's 2021 Global Strategy on Digital Health. Telemedicine and e-health pilot projects in Pakistan have shown promise especially during the COVID-19 pandemic (Rahim et al., 2025). The focus on digital infrastructure in the new policy reflects a growing understanding of how technology can help close service gaps. Two major topics in the discussion of health policy today are equity and financial protection. The Universal Health Coverage framework from the World Bank promotes inclusive financing models insurance plans and targeted subsidies. An initiative in this direction was Pakistan's Sehat Sahulat

Program which gave low-income families health insurance when it was introduced in 2015. Nonetheless assessments by (Värzaru, 2025) indicate that sustainability is unclear and coverage is still uneven. Building on this foundation with more extensive and equitable financing mechanisms is the goal of the 2025–2034 policy. In Pakistan health sector accountability and governance have consistently been problems. Research by (Shahid & Amina, 2025) draw attention to problems like a lack of transparency corruption and inadequate regulatory oversight. The new policy incorporates performance-based monitoring and multi-sectoral collaboration both of which are best practices for health system governance suggested by the OECD and WHO. Healthy human resources continue to be a major bottleneck. There is a shortage of qualified medical professionals in Pakistan particularly in rural areas. Works of (Das et al., 2024) highlights the necessity of funding health workforce development encompassing training retention and fair distribution. The new policy recognizes this disparity and suggests calculated measures to improve health-cares human capital. Concerns about climate resilience and environmental health are becoming more prevalent in the literature on health policy. Pakistan is susceptibility to climate change which manifests as heat waves, floods and water shortages directly affects public health. Planning for health should incorporate climate adaptation according to the Lancet Countdown on Health and Climate Change (2022). Environmental health is covered by the 2025–2034 policy which is a step in the right direction toward healthcare systems that are climate resilient. Changes in behaviour and community involvement are essential for the success of policies. In line with worldwide data on successful public health initiatives the new policy places a strong emphasis on culturally sensitive communication techniques health literacy and participatory governance. Pakistan's health environment has been significantly shaped by international cooperation. Immunization maternal health and disease control initiatives have been aided by collaborations with WHO UNICEF and bilateral donors. This trend is maintained in the 2025–2034 policy which has technical assistance from the UK and other partners.

Methodology

This study critically assesses Pakistan's Health and Population Policy 2025–2034 using a qualitative multi-method research design. The approach combines scenario forecasting, empirical evaluation and comparative policy analysis to evaluate the policy's global alignment, strategic coherence and viability in Pakistan's institutional and socioeconomic framework. The interpretive and analytical methodology enables thematic investigation of policy content, implementation dynamics and reform paths. Four fundamental methodological pillars form the framework of the study: (1) document-based policy analysis (2) comparative benchmarking against specific international health systems (3) scenario construction to project future outcomes and (4) critical evaluation using data from Pakistan's actual health system. Together these pillars offer a comprehensive understanding of the policy's advantages, disadvantages and transformative potential. Primary data sources include comparable health policies from

Bangladesh, Rwanda and India as well as official policy documents from Pakistan Ministry of National Health Services Regulations and Coordination. These nations were chosen because they are economically comparable, have a track record of successful health system reform and are pertinent to Pakistan's regional context. Reports from the World Bank, UNDP, WHO and SECP (Pakistan) are examples of secondary sources as are peer-reviewed scholarly works on digital health, health governance and SDG implementation. In order to identify strategic themes, implementation strategies and institutional arrangements policy texts are systematically coded as part of the document analysis process. The three global models that serve as its compass are (a) the WHO's Health System Building Blocks (b) the UN Sustainable Development Goals (SDGs) especially Goals 3, 5, 9 and 17 and (c) the OECD Principles of Good Governance in Health. These frameworks offer organized perspectives for assessing the health workforce digital infrastructure financing equity accountability and service delivery. Each nation's health policy is evaluated using a comparative matrix that takes into account five factors: governance structures, financing models, equity and inclusion, digital health readiness and SDG integration (Saheb & Saheb, 2024). This matrix highlights best practices gaps and contextual adaptations by allowing for both vertical analysis (within each policy) and horizontal comparison (across countries). The descriptive and evaluative comparative analysis concentrates on the design of policies their ability to be implemented and the results of reforms. Three likely futures for Pakistan's health system under various implementation conditions are projected using scenario analysis: (1) optimistic—full policy execution and reform success (2) status quo—partial implementation with uneven progress and (3) regressive—policy stagnation or reversal due to systemic constraints. Using strategic foresight techniques these scenarios are created by taking into account global health trends institutional capacity and current policy commitments. Every scenarios effects on equity resilience health outcomes and SDG advancement are examined. Actual health system data from Pakistan is used for a critical evaluation in order to ground the analysis in empirical reality. This covers things like workforce distribution insurance coverage digital penetration infrastructure statistics budgetary allotments and climate-health vulnerability. WHO's National Health Vision, the SECP healthcare ecosystem report, Pakistan's federal budget for 2025–2026 and publications from the provincial health departments are the sources of the data. Systemic limitations and implementation gaps that could impede the success of the policy are identified in this evaluation. Expert interviews are purposefully left out of the study in order to preserve document-based rigor and prevent subjective bias. Rather to guarantee analytical depth and transparency it triangulates institutional reports policy texts and international benchmarks. Some drawbacks include the dependence on publicly accessible sources, possible discrepancies in cross-country comparability and the lack of real-time implementation data. Careful interpretation, source validation and contextual framing

help to lessen these. This approach aims to generate a thorough globally informed and policy-relevant analysis of Pakistan's health reform program. The study provides practical insights for policymaker's, researchers and development partners looking to improve health governance and accomplish SDG-aligned results in Pakistan by fusing comparative benchmarking scenario forecasting and empirical evaluation.

Comparative Analysis

Through a methodical comparison with health policies from Bangladesh, Rwanda and India this chapter assesses Pakistan's Health and Population Policy 2025–2034. Each of these nations has distinct advantages in digital health, equity governance and SDG alignment and they all provide varied models of health system reform. OECD governance principles SDG health targets (particularly Goals 3, 5, 9 and 17) and WHO's Health System and Building Blocks are all incorporated into the comparative framework. Finding strategic gaps, contextual constraints and transferable innovations in Pakistan's policy architecture is the aim. Digital health infrastructure equity and inclusion financing models governance structures and SDG integration are the five dimensions that are the focus of this thematic analysis.

Pakistani policy emphasizes digital transformation through telemedicine, electronic health records (EHRs) and mobile health platforms (Akhtar et al., 2025). Implementation is still aspirational though because of a lack of digital literacy and rural connectivity. India's Ayushman Bharat Digital Mission has implemented a federated digital health architecture that includes distinct health IDs, interoperable systems and real-time dashboards (Aggarwal & Roy, 2023). Rwanda's Smart Health program uses mobile diagnostics and centralized data systems to efficiently reach remote population (Uwaliraye et al., 2019). Mobile health apps for monitoring immunizations and maternal care have been tested in Bangladesh (Tobe et al., 2018). In contrast to these models Pakistan digital health strategy lacks a clear budget, a phased rollout plan and integration with existing health services. Without foundational infrastructure and cross sectoral coordination digital health could end up being a fragmented add on rather than a game-changing pillar.

With pledges to gender-responsive budgeting rural outreach and services for marginalized groups equity is a major theme in Pakistani policy (Malick et al., 2024). Mechanisms for putting these objectives into practice, however, are still lacking. Bangladesh's health system is excellent at reaching out to the community, especially, with satellite clinics and female health workers. The poorest residents of Rwanda are covered by the country's universal insurance model which is backed by community involvement and targeted subsidies. India has improved maternal-health among low income women by implementing equity-focused programs like the Janani Suraksha Yojana (Thakur & Dalal, 2025). Although it is a positive step Pakistan's Sehat Sahulat Program has provincial inequalities and uneven coverage. Accountability is weakened by the absence of disaggregated data and monitoring instruments. Pakistan's equity strategy is weak structurally but strong conceptually, when compared to its peers. Important next steps include incorporating equity indicators into health information systems and fortifying community platforms.

A mixed financing model comprising public funding donor support and private sector involvement is outlined in Pakistan's policy (Ahmed & Rahman, 2019). It does not include a national health financing plan but it does suggest novel instruments such as health bonds and social impact investments. Through central programs and state-level co-finance, India pools resources to ensure scale and sustainability. Rwanda maintains universal coverage by utilizing donor partnerships and community-based insurance. Bangladesh depends on low cost service delivery models and focused on national and international donor support for stabling the health sector of the country. Pakistan's health spending continues to fall short of WHO recommended levels and resource allocation is

made more difficult by fiscal decentralization (Munir et al., 2022). Disparities between provinces continue and budgetary commitments are often unrealistic and ambiguous. Policy objectives run the risk of being underfunded in the absence of a clear financing roadmap. According to comparative analysis Pakistan needs to enhance fund utilization and institutionalize financing reforms. Results-based funding and transparent budgeting may increase trust and draw in investment.

Performance dashboards multi-tiered coordination platforms and citizen feedback mechanisms are examples of governance reforms in Pakistani policy. The OECD values of accountability, transparency and stakeholder participation are all in line with these. However, it is difficult to coordinate federal and provincial strategies due to Pakistan's decentralized governance model which was established after the 18th Amendment. The centralized health governance system in Rwanda facilitates expedited policy implementation and simplified decision making. With the help of digital monitoring and incentive based-initiatives India strikes a balance between state autonomy and central oversight. Bangladesh strengthens grassroots governance through partnerships with NGOs and local health committees. Despite their lack of institutional clarity and legal support, Pakistan's proposed reforms show promise. Policy coherence is weakened in the absence of interprovincial coordination mechanisms and enforcement protocols. Comparative models draw attention to the necessity of capacity building and governance laws. Accountability integrated into digital systems may increase responsiveness and transparency.

Although Pakistan's policy makes reference to the SDGs specifically Goals 3, 5, 9 and 17 it does not have a reliable tracking system. There are no quantifiable goals, baseline indicators or deadlines for SDG-related results. Annual progress reports are published by Rwanda and India which have integrated SDG metrics into their health information systems (Hategeka, 2024). Bangladesh uses donor supported dashboards to track its maternal and child health goals which are in line with SDG 3 (Ahmmed et al., 2024). Pakistan's inconsistent reporting and disjointed data systems make it difficult to evaluate progress. It is hard to assess impact or get resultsbased funding without clear tracking. SDG indicators must be incorporated by the policy into provincial planning instruments and national health dashboards. SDG alignment improves global engagement and policy legitimacy according to comparative insights. Pakistan must use quantifiable frameworks and open reporting to operationalize its commitment to the SDGs.

Integrating vertical programs like nutrition and immunization and bolstering primary healthcare are key components of Pakistan's policy. Nonetheless its service delivery strategy is still traditional and mainly depends on expanding its physical presence. Bangladesh effectively reaches underprivileged populations through community outreach and mobile clinics. Access is improved and the patient load at tertiary hospitals is decreased by Rwanda's digital triage systems and health posts. To decentralize care India has expanded its health and wellness facilities and teleconsultation platforms. Pakistan's capacity to assist vulnerable and isolated populations is hampered by its lack of scalable outreach models. To increase reach the policy must include community-based care digital triage and mobile health units. Comparative models show that service delivery innovation, increases equity and efficiency. Given its diverse population and geography Pakistan needs to modify these models.

The lack of qualified health workers is acknowledged in Pakistani policy which suggests funding for education retention and fair distribution. Nevertheless it is devoid of accreditation requirements specific workforce forecasts and incentives for rural service. For frontline employees India's National Health Mission offers digital learning platforms and structured training modules. Rwanda has put in place ongoing professional development initiatives and performance-based rewards. To

increase its workforce Bangladesh depends on training funded by NGOs and female health volunteers. The Lady Health Worker program in Pakistan has promise but it is underfunded and receives patchy assistance. Disparities in service availability and quality will continue to exist in the absence of a unified national workforce strategy. Digital training academic collaborations and incentive systems are crucial according to comparative analysis. To support the implementation of policies and the expansion of services Pakistan must give workforce planning top priority.

Strengthening health information systems to facilitate evidence-based decision-making is one of Pakistan's policy recommendations. Real-time analytics electronic records and digital dashboards are mentioned. Nonetheless the existing data infrastructure is dispersed among vertical programs and provinces. Centralized data collection and analysis is made possible by Rwanda's integrated health information system. Policy feedback and detailed reporting at the district level are supported by India's Health Management Information System (HMIS). Bangladesh tracks the health of mothers and children through donor-supported platforms. The efficacy of the system is restricted by Pakistan's lack of data governance privacy protocols and interoperability. Analytical models demonstrate how integrated data systems improve accountability planning and monitoring. In addition to investing in digital infrastructure Pakistan needs to create a national data governance framework. Adaptive learning and the success of policies are based on solid data.

Given Pakistan's susceptibility to floods heat waves and water shortages the country's policy incorporates measures for environmental health and climate resilience. Nevertheless there are few operational specifics and ambiguous implementation routes. Rwanda incorporates climate indicators into its disaster preparedness and health surveillance programs. Bangladesh trains medical personnel in emergency response and constructs clinics that can withstand flooding.

In states that are at risk India has started implementing climate-health adaptation initiatives. Pakistan's policy needs to shift from empty rhetoric to practical solutions in order to minimize the effects. This covers funding mechanisms inter-sectoral coordination and climate-sensitive infrastructure. The significance of incorporating climate resilience into health planning is highlighted by comparative insights. Localized adaptation models are necessary due to Pakistan's geographic diversity and climate risks.

Pakistan's policy places a strong emphasis on culturally sensitive communication health literacy and participatory governance. Campaigns for behavioural change and community health worker programs are suggested. Engagement strategies however are not well-developed and are not always used consistently. Strong local ownership is promoted by Rwanda's community health councils and Bangladesh's female outreach teams. India increases participation through village health committees and digital platforms. Although the Lady Health Worker program in Pakistan has promise it needs to be revitalized and integrated with digital tools. Empowered communities promote better health outcomes and maintain reforms according to comparative models. Establishing community platforms and making investments in capacity building are imperative for Pakistan. Continuous inclusive and locally sensitive engagement is required.

Although Pakistan's Health and Population Policy 2025–2034 is conceptually in line with international norms it is not yet ready for implementation. Its integration digital aspirations and equity pledges are its strongest points. Impact is nevertheless constrained by deficiencies in data systems governance funding and community involvement. Though it needs to speed up reform Pakistan exhibits promise in comparison to Bangladesh Rwanda and India. The comparative study identifies both context-specific difficulties and transferable practices. Success requires legal reform adaptive learning and strategic investment. If Pakistan adopts an innovative and accountable

approach its policy could become a regional model. Peer countries lessons provide a path toward resilience and change.

Scenario Analysis

Goal and Analytical Framework: Scenario analysis is a type of strategic foresight that is used to investigate conceivable futures under different policy implementation scenarios. Three different scenarios—Optimistic, Status Quo and Regressive—are constructed in this chapter in relation to Pakistan's Health and Population Policy 2025–2034 based on the level of execution institutional responsiveness and outside assistance. These scenarios are structured narratives not predictions that assist policymakers in identifying leverage points anticipating risks and modifying their approaches. The analysis incorporates knowledge of Pakistan's current health system realities along with comparative lessons learned from Bangladesh Rwanda and India. Every scenarios effects on equity resilience health outcomes and SDG advancement are assessed.

The optimistic scenario entails the successful implementation of the Health and Population Policy 2025-2034 in all provinces of Pakistan. The nation's digital health infrastructure is expanded and features real-time data dashboards, telemedicine access and interoperable systems. Because equity measures are institutionalized women, children and marginalized groups are guaranteed inclusive coverage. More budgetary allotments combined resources and creative funding methods are the results of financing reforms. Through platforms for citizen feedback performance monitoring and legal reforms governance structures are reinforced. With disaster-ready infrastructure and environmental monitoring climate resilience is ingrained in health planning. Progress is reported every year and SDG indicators are transparently tracked. Resurgent health worker programs and digital literacy initiatives foster community engagement. In terms of innovation and equity in the health system Pakistan becomes a regional leader.

Enablers of the Optimistic Scenario Political will institutional capacity and strategic investment must all come together to realize the optimistic scenario. Legal frameworks to institutionalize reforms donor alignment with national priorities and increased health budget allocations are important enablers. Adopting unified implementation plans with common accountability procedures and indicators is imperative for provincial governments. Cybersecurity measures, workforce training and infrastructure development are all necessary to support digital health. Collaborations with private companies and academic institutions can also increase innovation and growth. Localized adaptation plans and intersectoral coordination are necessary for the integration of climate and health. Robust data systems and public reporting are necessary for transparent SDG monitoring. Digital platforms must facilitate community engagement and integrate it into governance frameworks. Because they are interdependent these enablers need to be sought at the same time. The hopeful course stays aspirational in their absence.

Partial Implementation and Unequal Progress in the Status Quo Scenario: Pakistan applies the policy in different provinces in an uneven manner. Although pilot projects in equity and digital health have been started they are not large-scale or long-lasting. While rural areas continue to be underserved urban areas enjoy better services. Though they have been started financing reforms are still dispersed and innovative tools are not being widely adopted. Although governance reforms are implemented they are not consistently enforced. SDG tracking is irregular and climate resilience is recognized but not operationalized. Without national integration community involvement is restricted to projects funded by donors. The goal of the policy is still only partially realized with sporadic advancements and enduring structural flaws. Disparities increase despite a slight improvement in health outcomes. In this scenario political ambiguity and institutional bottlenecks limit reform reflecting inertia and incrementalism.

As a result of the status quo scenario the health system performs unevenly and makes little progress toward the SDGs. Digital health is still dispersed with incompatible systems and a low uptake rate in rural regions. Lack of disaggregated data and poor targeting compromise equity goals. Donor dependence endures and funding is still insufficient. Because of their inconsistent application and lack of transparency governance reforms are unable to foster public trust. Lack of proactive planning increases the risks to climate health particularly in provinces that are prone to natural disasters. The lack of depth in community engagement hinders service adoption and behavioural change. Concerns regarding impact and accountability are raised by international partners. Instead of being robust Pakistan's health system continues to be reactive. This situation could miss international standards and solidify already-existing inequalities. The policy loses its transformative potential if corrective action is not taken.

Policy Stagnation or Reversal in the Regressive Scenario Political instability budgetary restraints and institutional deterioration cause the Health and Population Policy 2025–2034 to stall. Service interruptions and data silos result from the abandonment or poor maintenance of digital health initiatives. In addition to vulnerable populations facing more obstacles to care equity measures are not given priority. Funding decreases as a result of donor withdrawals and budget cuts. Performance monitoring stops when bureaucratic inertia takes over governance structures. When climate resilience is disregarded health risks during environmental emergencies increase. Pakistan rejects SDG alignment and leaves international reporting sites. Trust in the health system declines along with community involvement. Inequalities increase and health outcomes deteriorate. A breakdown in the momentum for reform and a return to disjointed reactive policymaking are reflected in this scenario.

Regression scenario drivers may be influenced by a number of factors. Health reforms may become less important and policy continuity may be disrupted by political unpredictability and leadership changes. Infrastructure projects could be delayed and health allocations cut due to fiscal austerity and conflicting budgetary demands. Reforms to governance and digital integration may be hampered by institutional resistance to change. Reduced external support may result from donor fatigue and a lack of alignment with national priorities. Lack of incentives and a shortage of workers could impair morale and service delivery. Unprepared for climate-related disasters fragile systems may be overloaded. Unmet promises could cause public disenchantment and undermine community involvement. These motivators are linked to one another and have the ability to support one another. Proactive risk management and a persistent dedication to reform are necessary to avoid regression.

The optimistic scenario reflects best practices in digital health equity and governance and is consistent with global models of health system transformation. Many low- and middle-income nations exhibit patterns of institutional inertia and incremental reform which are mirrored in the status quo situation. The risks of systemic collapse and policy neglect are emphasized by the regressive scenario. Success depends on consistent investment legal reform and community involvement according to comparative analysis from Bangladesh Rwanda and India. Pakistan's future depends on its capacity to absorb lessons from these models and modify them for use in its federal setting. Scenario analysis emphasizes how crucial strategic vision and flexible planning are. It also makes clear the effects of inconsistent or postponed implementation.

By utilizing important strategic levers Pakistan can impact its health trajectory. Legislation pertaining to health governance increased funding and the formalization of SDG tracking are a few of these. Interoperability standards workforce training and infrastructure investment are necessary for the expansion of digital health. Through inclusive planning and targeted subsidies equity must

be ingrained in the provision of services. Integration of surveillance and health infrastructure is necessary for climate resilience. It is necessary to revive community involvement through digital outreach and organized platforms. These are context-sensitive and actionable levers. When activated they have the power to move Pakistan away from a regressive or status quo and toward a bright future.

Function of Global Partnerships and Education International cooperation can reduce risks and hasten Pakistan's health reforms. Funding policy advice and technical assistance can be obtained through partnerships with the UNDP WHO and bilateral donors. Rwanda's governance reforms, Bangladesh's community outreach and India's digital architecture can all be used to guide local adaptation. Additionally global engagement improves accountability and credibility. Positioning itself as a reform-focused partner dedicated to SDG advancement and health equity is imperative for Pakistan. Open reporting and strategic diplomacy are crucial.

International collaborations are success accelerators rather than alternatives to domestic reform.

Pakistan needs to set up a dynamic monitoring and evaluation (M and E) system in order to manage these scenarios. A scenario dashboard with metrics for equity outcomes financing trends governance performance digital coverage and SDG advancement is part of this. Mid course adjustments and adaptive tactics can be informed by real-time data and recurring reviews. M&E needs to be formally established at both the federal and provincial levels with distinct roles and duties. Stakeholder consultations and public reporting increase openness and confidence. Managing scenarios is an ongoing process rather than a onetime event. It makes responsiveness resilience and strategic learning possible. Evidence-based and proactive changes are needed in Pakistan's health system.

The implications and decisions that Pakistan's health system must make are made clear by the scenario analysis in Navigating Uncertainty with Vision. Though strategic execution is necessary for its realization the Health and Population Policy 2025–2034 offers a transformative vision. With dedication cooperation and creativity the hopeful scenario is attainable. While regression poses a threat to systemic collapse the status quo runs the risk of stagnation. The future must be shaped by policymakers taking decisive action based on evidence international learning and public participation. This chapter emphasizes that health policy is a dynamic strategy rather than merely a written document. The future of Pakistan's health will be determined by its ability to lead adapt and execute not just by its intentions.

Critical Evaluation: Policy vs Ground Realities

This chapter critically examines the Health and Population Policy 2025–2034 in light of Pakistan's current health system realities. While the policy presents a transformative vision, its success depends on the country's institutional readiness, financing capacity, infrastructure quality, and governance mechanisms. The evaluation draws on national health statistics, budget documents, SECP's 2025 healthcare ecosystem report, WHO's National Health Vision, and provincial health performance reviews. Each policy domain digital health, equity, financing, governance, climate resilience, and SDG alignment is assessed for feasibility and alignment with ground realities.

Health Infrastructure Deficits

The health system in Pakistan is still underfunded and unreliable. There are roughly 1282 public hospitals in the nation as of 2025 but access to essential services is poor in rural areas (Haq, 2021). Clean water electricity and necessary equipment are lacking in many Basic Health Units (BHUs). These fundamental flaws compromise the policy's objective of providing primary care to public. In

Balochistan and the rural of Sindh medical facilities are frequently understaffed or non-operational. The policy's goals of equity and access cannot be achieved without focused investment in infrastructure rehabilitation and minimum service delivery standards (MSDS).

Budgetary Constraints and Utilization Gaps

PKR 14.3 billion is the federal health budget for 2025–2026 which includes funds for digital health initiatives, hospital renovations and vaccinations (Ministry of Finance). Even though there is more focus on health this is still less than the WHO-recommended threshold of 5% of GDP. Additionally the use of funds has historically been inefficient there are still disbursement delays a lack of transparency and inadequate monitoring. There are significant differences in the provincial health budgets Punjab and KP are given disproportionately larger sums than Balochistan and Gilgit Baltistan (Malik & Jamil, 2023). A well-thought-out national strategy and fiscal restraint are necessary to support the policy's funding goals which include health bonds and insurance expansion.

Workforce Shortages and Distributional Imbalances

There is a severe lack of qualified medical personnel in Pakistan especially in rural and periurban areas. Notwithstanding its effectiveness the Lady Health Worker (LHW) program is beset by inadequate funding inconsistent pay and inadequate training. Private insurance networks find it difficult to find qualified providers in remote areas per SECPs 2025 report. The policy suggests growing the workforce but it is devoid of specific forecasts certification requirements and retention incentives. Disparities in service availability and quality will continue to exist in the absence of a coordinated national workforce strategy and rural service bonuses.

Digital Health Readiness and Gaps

The policy places a progressive emphasis on digital health but Pakistan is not yet fully prepared. Frontline workers have low levels of digital literacy and less than 40% of rural areas have internet access. Although Punjab and KP have started pilot programs in telemedicine and e-health records infrastructure and interoperability problems limit scalability. According to SECPs report health insurance platforms have disjointed claims systems and inadequate cybersecurity measures. To achieve its goal of digital health the policy needs to fill in the fundamental gaps in data governance connectivity and digital training.

Insurance Coverage and Financial Protection

Low-income families are now covered by Pakistan's Sehat Sahulat Program although province-by-province adoption varies. Enrollment in Balochistan is still less than 30% and there are few services available. The 2025 analysis by SECP demonstrates that private insurance is still dispersed and has little traction in the unorganized sector. Although the policy suggests inclusive insurance models there are no integration mechanisms between public and private providers. Out-of-pocket costs are still high particularly for emergency services chronic care and diagnostics. The objectives of financial protection will remain aspirational in the absence of a unified insurance framework and regulatory reform.

Governance and Institutional Capacity

Although they face institutional limitations the policy's governance reforms like performance dashboards and citizen feedback systems show promise. Different levels of political commitment technical proficiency and autonomy are displayed by provincial health departments. Inconsistent regulatory oversight of private providers and inadequate contracting mechanisms are highlighted in

WHO's National Health Vision. The policy must use capacity building interprovincial coordination platforms and legal mandates to address these governance issues. Accountability reforms will not succeed in the absence of enforcement procedures and institutional clarity.

Health Information Systems and Data Fragmentation

The health data systems in Pakistan are dispersed throughout provinces and vertical programs. Integration is made more difficult by the distinct reporting formats maintained by nutrition maternal health and immunization programs. Interoperability issues and a lack of standardized data governance protocols are noted in the SECP report. Although the policy calls for electronic records and real-time dashboards it makes no mention of how provincial systems will be unified. Monitoring and assessment will continue to be inadequate in the absence of a national health information architecture and privacy protections. This compromises resource allocation adaptive planning and SDG tracking.

Climate and Environmental Health Vulnerabilities

Heat waves floods and vector-borne diseases are just a few of the climate-related health emergencies for which Pakistan's health system is ill-prepared. Although climate resilience is acknowledged there are no operational strategies in the policy. The emergency response protocols and medical facilities in the flood-prone districts of Punjab and Sindh are not disasterresilient. In the SECP's report climate adaptation is not mentioned in either insurance or infrastructure planning. Investments in resilient infrastructure regional climate-health models and the integration of environmental indicators into surveillance systems are all necessary for the policy. If these actions are not taken climate shocks will continue to interfere with the delivery of health services.

Community Engagement and Behavioural Change Deficit

Even though the policy places a strong emphasis on participatory governance community involvement is still lacking. There are infrequent health literacy initiatives and a lack of use of citizen feedback systems. Despite its potential the Lady Health Worker program lacks organized support and digital integration. Public health services are still viewed with suspicion in peri-urban slums and tribal districts. Service uptake and behavioural change will be restricted in the absence of empowered community platforms. Local health council's digital outreach and culturally aware communication techniques must all be used to institutionalize engagement in the policy. Community ownership is necessary for long-term change.

SDG Alignment and Reporting Gaps

Although there is no official tracking system Pakistan's health policy makes reference to the SDGs. Health indicators are disjointed and frequently contradictory according to WHO's National Health Vision. There are no SDG-linked metrics in the insurance or service delivery frameworks in SECP's 2025 report. Pakistan is unable to show progress and draw in resultsbased funding in the absence of baseline indicators quantifiable goals and public reporting.

Tools for evaluating policies and health information systems must incorporate SDG alignment.

Third-party audits and transparent reporting can improve international engagement and credibility.

Even though the Health and Population Policy 2025–2034 offers a revolutionary vision its success depends on addressing local realities. There are significant implementation risks associated with budgetary restrictions workforce shortages governance issues and infrastructure deficiencies. Clear regulations and initial investments are required for insurance and digital health reforms. It is not

enough to simply acknowledge community involvement and climate resilience they must be operationalized. To bridge the gap between policy and reality Pakistan must institutionalize reforms build capacity and commit to transparent data-driven execution. At that point the policy can move from aspiration to effect.

Recommendations

- Pakistan needs to enact a national health governance law in order to formalize reforms and guarantee continuity throughout political cycles. This legislation should incorporate citizen feedback mechanisms mandate performance monitoring and specify the roles of federal and provincial authorities. Accountability will be improved and fragmentation will be lessened with legal clarity. India's digital grievance redressal systems and Rwanda's centralized governance model provide models for incorporating responsiveness and transparency into the law.
- Pakistan must develop a cohesive approach to health financing in order to overcome fragmented budgeting and reliance on donors. Pilot programs for health bonds results-based financing and pooled funding mechanisms should all be part of this. To reach WHO thresholds budgetary allotments must be raised and digital dashboards must be used to monitor fund utilization. Two examples of scalable approaches to fiscal sustainability are Rwanda's community-based insurance programs and India's cofinancing model.
- To accomplish the digital objectives of the policy fundamental investments in cybersecurity interoperability and connectivity are required. Initiatives for medical staff should be Pakistan's top priorities. A phased rollout strategy that starts with provinces that are already technologically advanced can guarantee scalability. Models that have been proven include India's Ayushman Bharat architecture and Rwanda's mobile first diagnostics.
- Annual progress reports and the integration of SDG indicators into Pakistan's health information systems are imperative. This entails establishing quantifiable goals establishing baselines and incorporating third-party audits. Adaptive planning will be made possible by transparent reporting which will also increase credibility and garner international support. Two real-world examples are Rwanda's integrated SDG surveillance systems and Bangladesh's donor-supported dashboards.
- Addressing shortages and distributional imbalances requires a national workforce strategy. Pakistan should digitize continuing education increase training programs and provide incentives for rural service. It is imperative to revitalize the Lady Health Worker program by integrating it into digital platforms and providing structured support. Rwanda's performance-based incentives and India's digital training modules have enhanced service quality and retention.
- Pakistan is susceptible to climate shocks so health infrastructure needs to be climate-sensitive and disaster-resilient. Flood-proofing buildings preparing emergency response teams and integrating environmental indicators into surveillance systems are all examples of this. Localized climate health adaptation is necessary with provincial plans based on regional hazards. There are practical examples in Rwanda's climate-health integration and Bangladesh's flood-resilient clinics.
- Pakistan needs to use digital outreach behavioural change initiatives and local health councils to formally establish community involvement. Expansion and digitalization of the Lady Health Worker program are necessary to promote service uptake and trust. Engagement needs to be ongoing culturally aware and inclusive. Rwanda's community

health governance structures and Bangladesh's female outreach teams serve as examples of the strength of grassroots ownership.

- Pakistan should set up a health innovation hub that supports start-up's fosters digital solutions and makes public-private partnerships easier in order to promote innovation. This hub can scale effective models assess impact and pilot technologies. Structured platforms can speed up reform and draw investment as demonstrated by Rwanda's innovation labs and India's health tech ecosystem.
- Through a common implementation framework Pakistan needs to coordinate its federal and provincial strategies. Coordinated budgeting standardized metrics and collaborative planning platforms are examples of this. Interprovincial agreements and federal assistance are necessary to address fragmentation. India's federated oversight and Rwanda's centralized execution provide opposing but useful models.
- Pakistan should institutionalize evidence-based revisions stakeholder consultations and mid-term policy reviews to guarantee adaptability. The Ministry of Health ought to incorporate this mechanism and connect it to the planning cycles of the provinces.
- Adjustments to the course can be informed by real-time data and scenario dashboards. Ongoing education will boost reform momentum and resilience.
- To include vulnerable groups rural residents and informal workers Pakistan must fortify and broaden the Sehat Sahulat Program. It is imperative that digital claims systems and private insurance providers be integrated. Transparency portability and equity must all be guaranteed by regulatory reform. Scalable pathways can be found in India's PMJAY model and Rwanda's universal insurance.
- Pakistan must ultimately transition from reactive service delivery to resilient proactive health system design. This entails making investments in cross-sectoral coordination emergency preparedness and surveillance. It is imperative to establish health as a cornerstone of national development interconnected with technology education and the environment. If supported by strategic execution and ongoing dedication the Health and Population Policy 2025–2034 can serve as a transformational roadmap.

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