Pakistan

The Commonwealth Fund

International Health Care System Profiles
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Overview

Pakistan's health care system is a public-private hybrid, with services delivered through government facilities, private providers, and nongovernmental organizations.[1] The system is mainly financed by out-of-pocket payments, which account for more than 50 percent of total health expenditure — significantly higher than the average for lower-middle-income countries (36%).[2]

The Sehat Sahulat Program, a government-led social health insurance program, has expanded coverage and is envisioned as the central mechanism for achieving eventual nationwide coverage. Decisions on whether to take part in the program, however, lie with federal governments, leading to uneven access to and the lack of unified care.

Pakistan also faces challenges of limited access to quality care in rural areas, fragmented service delivery, workforce shortages, weak regulatory oversight, and insufficient infrastructure.[3]

HEALTH SYSTEM
BY THE NUMBERS

2.52%
Health care spending as a percent of GDP

67.6 years
Life expectancy at birth

127
Number of GPs per 100,000 people

Coverage and Access

Background and History

Following independence in 1947, Pakistan had a shortage of health care infrastructure, particularly in rural areas. The creation of rural health centers in the 1960s and basic health units in the 1980s expanded access. Since 2000, nongovernmental organizations (NGOs) and public–private partnerships have further improved the health care system.[4]

In 2012, Pakistan established the Ministry of National Health Services, Regulations and Coordination (NHSRC) and the Drug Regulatory Authority of Pakistan.[5] A move toward universal health coverage began in 2015, when the provincial government of Khyber Pakhtunkhwa launched the Sehat Sahulat Program (SSP). In 2019, the federal government, in collaboration with provincial authorities, expanded the program to other provinces; by 2022, it covered about 44.6 million households and was operational in 36 districts of Punjab; 35 districts of Khyber Pakhtunkhwa; 10 districts of Azad Jammu and Kashmir, Gilgit-Baltistan, and the Islamabad Capital Territory; and one district of Sindh.[6]

As of July 2025, the Punjab government suspended the SSP in public hospitals, ending free treatment at all public hospitals across the province.[7] According to the Punjab government, this decision was taken following the Chief Minister's recent health care reforms (commonly known as the CM's health initiatives), which, operating in parallel with the SSP, duplicated financial benefits for patient and public hospitals. The CM's health initiatives include coverage for high-cost treatments, such as pediatric heart surgeries, dialysis, and organ transplants (*see The Role of Public Health Insurance*).[8]

Pakistan is a geographically diverse federal parliamentary republic comprising four provinces (Punjab, Sindh, Khyber Pakhtunkhwa, and Balochistan), the Islamabad Capital Territory, and two self-governing regions — Azad Jammu and Kashmir and Gilgit-Baltistan.[9]

The Role of Public Health Insurance

Historically, the country has relied heavily on out-of-pocket health expenditure, resulting in more than half the population lacking affordable access to basic health care services.[10] The SSP initially targeted families earning less than USD 2 per day.[11] This represents a significant portion of the population: the latest data show that about one in four people (24.4%) are considered poor when looking at both income and basic needs, such as education and health care. By income alone, poverty affects:

- 1.8 percent of people living on less than USD 2 per day, based on the international poverty line
- 21.9 percent of people living below the national poverty line (about PKR 3,741–3,769 per month per adult, or USD 13.1–13.2).[12]

The SSP, launched in 2015, is administered by the State Life Insurance Corporation of Pakistan and is fully subsidized through provincial tax revenues. Beneficiaries access covered services using the Sehat Sahulat card, which functions as proof of enrollment in the program.[13] The SSP typically provides PKR 460,000 (USD 1,620) for each family, primarily to cover inpatient hospital care.[14] However, in 2021, the government launched a pilot initiative in the Islamabad Capital Territory to extend coverage to outpatient and primary care services (*see Primary Care*).[15]

While the SSP remains operational in several regions, Punjab retracted the program in 2025, prioritizing the CM's health initiatives (*see Background and History*). Since July 2025, Punjab-based Sehat Sahulat cardholders have been unable to access free treatment in public hospitals in Punjab, the federal territories, and regions such as Islamabad, Azad Jammu and Kashmir, Sindh, Khyber Pakhtunkhwa, Balochistan, and Gilgit-Baltistan.[16] The CM's health initiatives in Punjab focus on expanding access by covering the cost of high-cost treatments. These include the CM Punjab Children's Heart Surgery Program, the CM Punjab Transplant Program, and the CM Punjab Dialysis Program Card.[17]

In addition to the SSP, there are province-specific public health insurance programs for formally employed individuals. The Punjab Employees Social Security Institution (PESSI) and the Khyber Pakhtunkhwa Employees Social Security Institution (KP ESSI) cover private-sector industrial and commercial workers in those provinces through employer contributions (6% of wages under the PESSI, and 7% of wages under the KP ESSI). These autonomous bodies operate independently of federal funding and offer protection to registered workers and their dependents.[18]

By offering both universal and employment-linked coverage options, the system is gradually reducing dependence on out-of-pocket spending.[19] Meanwhile, the essential package of health services, a government-defined list of basic health care services, helps standardize care at primary health facilities, particularly in underserved regions.[20]

However, several studies highlight crucial implementation challenges regarding the SSP, including logistical issues in card distribution, low awareness among target populations, and inadequate enrollment and service delivery mechanisms.[21] These studies also point to persistent gaps in health care infrastructure and capacity, particularly in remote regions (*see Addressing Health Inequities*), along with the need for a stronger and more transparent system for addressing grievances. These issues limit the program's accessibility and trustworthiness, even for people who have coverage.[22]

Services Covered by Public Health Insurance

Members of the PESSI and the KP ESSI have access to the following services through official Social Security Hospitals and affiliated facilities:[23]

- Inpatient care (including hospitalization and surgeries)
- Emergency services (such as ambulance transport)
- Specialized treatments, including for cardiac conditions (angiography, angioplasty, and bypass surgery), cancer therapies, and dialysis
- Maternity services
- Dental care (available under KP ESSI, particularly when related to employment injuries)
- Free medications (explicitly offered by KP ESSI if prescribed by affiliated doctors)
- Prosthetics (included in PESSI's list of medical benefits).

Where the SSP is still in effect, members are covered by two treatment packages, one for priority treatment and one for secondary care.[24]

Priority Treatment:

- Inpatient services (including surgical procedures)[25]
- Heart disease treatment (including angioplasty and bypass)
- Diabetes care
- Burns and road traffic accidents (life- and limb-saving treatment, implants, and prostheses)
- End-stage kidney disease treatment (including dialysis)
- Treatment of chronic infections (including hepatitis and HIV/AIDS)
- Treatment for organ failure
- Cancer treatment (including chemotherapy, radiotherapy, and surgery)
- Neurosurgical procedures.

Secondary Care:

- Inpatient services (including surgical procedures)[26]
- Emergency treatment requiring admission
- Maternity services
- Consultancy for family planning services, immunization, and nutrition
- Treatment for fractures and injuries
- Transport to tertiary care hospitals.

Under the SSP, most eligible families receive coverage of up to PKR 460,000 (USD 1,600), rising to PKR 1 million (USD 3,500) under certain circumstances. Premiums are fully covered by the government.[27]

Individuals who are not living below the poverty line can participate in the SSP but must pay an annual contribution of PKR 4,500 (USD 16).[28] While this fee is intended for those above the poverty threshold, it's important to note that the poverty line for lower-middle-income countries such as Pakistan is USD 4.2 per day.[29]

Safety Nets

The social protection system includes several programs that support health care access by reducing financial burdens. Under the SSP in Khyber Pakhtunkhwa, more than 7.5 million families have access to free inpatient health care services as of 2021–22.[30]

The Pakistan Treasury (Bait-ul-Mal) is a social welfare program funded by the government and charities that provides medical assistance to people earning less than the monthly minimum wage for unskilled workers, which is PKR 37,000 (USD 132) per month.[31] Its medical assistance component — individual financial assistance — prioritizes the poorest people, widows, orphans, people with disabilities, and those without family or financial support.[32]

Other foundations and NGOs that work to provide health care are funded by the government, international aid, and Zakat. Zakat, a legally mandatory 2.5 percent tax on annual savings paid by Muslims, is collected by the Ministry of Religious Affairs for each province and partially allocated to health care as one of six provincial welfare programs.[33]

The Role of Private Health Insurance

As of 2022, 1.3 percent of health spending in Pakistan is prepaid private spending, compared with nearly 50 percent that is out-of-pocket.[34] Private health care plays a dominant role: about 83 percent of out-of-pocket spending goes to private providers.[35] Private hospitals and clinics are mostly concentrated in urban centers.[36]

The lack of reliable, high-quality care in the public sector has led to the growth of the private sector as the default provider of health care, even for essential, life-saving services. According to Babar Shaikh, Dean of the School of Public Health at the Health Services Academy in Islamabad, "Pakistan's health system is a complex mix of public and private health care systems. The private sector has grown hugely in Pakistan in the last three or four decades because of the weaknesses in the public health care system."

The reliance on private health care has significantly contributed to high out-of-pocket expenditure.[37] Initiatives such as the SSP have tried to help by covering services in both public and private hospitals; however, many private facilities don't participate in the SSP because of high operating costs and limited reimbursement.[38]

In the private sector, outpatient service providers account for the largest share of overall spending, 62.9 percent. Hospitals account for the second-largest share, at 31.2 percent.[39]

The Role of Government

The health care system operates under the oversight of various government agencies and regulatory bodies. The NHSRC is the primary authority responsible for formulating health policies, setting national health care standards, and overseeing the implementation of health programs.[40]

At the local level, provincial health departments manage health services, address region-specific challenges, and aim to make health care accessible. Regulatory bodies, such as the Pakistan Medical and Dental Council and the Drug Regulatory Authority of Pakistan, uphold medical standards. The Medical and Dental Council is responsible for licensing and regulating medical professionals, and the Drug Regulatory Authority of Pakistan checks that pharmaceutical drugs meet safety, efficacy, and quality standards before they reach the market.[41]

Several semi-governmental and government-affiliated organizations provide dedicated health care services to their employees, and the armed forces also deliver health care in some locations.[42] NGOs play a significant role in complementing government efforts, filling service gaps, and reaching marginalized communities.[43]

Before the decentralization of health care in 2009, the federal government had significant control over health, with the NHSRC overseeing planning, financing, and regulation. Provinces played a limited administrative role. Post-2009 reforms, however, shifted resources and responsibilities to the provinces, abolishing the Concurrent Legislative List and redistributing the NHSRC's functions across multiple federal bodies. This led to challenges in national coordination, especially in drug regulation and licensing.[44]

Integration and Care Coordination

To improve vertical and horizontal health care integration and coordination, the government launched 17 national programs aligned with its commitment to meet the United Nations' health benchmarks by 2030. These initiatives are designed to bridge gaps in service delivery across primary, secondary, and tertiary care by addressing specific health needs. Care delivery has been restructured with a strong focus on public-private partnerships to support initiatives such as the Tuberculosis Control Program, child and maternal health awareness, and the Expanded Program on Immunization.[45]

However, the health care system continues to lack a formal referral mechanism, resulting in patients often bypassing primary care and overwhelming tertiary hospitals with the treatment of minor ailments.[46] Some provinces have begun addressing this. Efforts, such as the Punjab Healthcare Commission's two-way referral model, are integrating general practitioners (GPs) into care pathways to streamline access and reduce pressure on hospitals.[47] In Islamabad, the capital, the transformation of basic health units into community health centers is providing a broader range of services, including nutrition, mental health, and family planning services, to cater to nearly 70 percent of health care needs at the community level.[48]

Operations and Resources

Overview of the Delivery System

The public health care system has three levels of care:[49]

- **Primary care** includes services provided at basic health units, rural health centers, and family welfare centers. Focus areas include preventive care, maternal and child health, immunizations, and treatment of common illnesses.
- **Secondary care** includes services at district and subdistrict (*tehsil*) hospitals and offers specialist consultations, inpatient care, surgical procedures, and referred cases from primary care.
- **Tertiary care** includes advanced medical services at major hospitals and specialized institutions, covering complex surgeries, critical care, and high-end diagnostics and treatments.

Public-sector health care facilities are primarily funded through line-item budgets, with allocations based on historical spending rather than population needs. Some tertiary hospitals receive global budgets, while contracting out, which is a practice in which private entities manage public hospitals on a fixed budget, has become common among primary and secondary care facilities.

In the private sector, providers are primarily paid through fee-for-service arrangements. Some private facilities also offer profit sharing to incentivize better performance. Since 2015, three social protection programs using case-based payments have been launched, all of which are administered by the same private contractor, allowing for some standardization. However, there's no overarching authority to align payment systems with health outcomes or the coordination of care.[50]

Primary Care

GPs provide about 71 percent of primary care services, with the majority practicing in the private sector.[51] About 24 percent of GPs are employed in the public sector.[52]

While primary health care is not covered by the SSP, in 2021, the government launched a pilot initiative in Islamabad Capital Territory to explore the inclusion of outpatient services. This project, supported by the World Health Organization (WHO), enables access to GP-provided care included in the essential package of health services, such as reproductive health, family planning services, and other outpatient services.[53]

ESSIs have their own primary clinics and small hospitals for workers registered with the program.[54]

Outpatient/Specialist Care

Secondary care, which includes specialist outpatient services, is typically delivered through district and *tehsil* hospitals, which are mostly located in urban areas. These facilities are better equipped to handle complex conditions and offer a range of services, including surgeries, specialized consultations, diagnostics, and inpatient care. They often act as referral centers for primary health units, but the lack of a formal gatekeeping mechanism limits the efficiency of this referral system (*see Integration and Care Coordination*).[55]

Outpatient services have limited coverage, especially at the primary health unit level. The SSP has expanded inpatient insurance coverage for low-income populations, but outpatient services are largely uncovered, meaning patients must cover these costs out of pocket.[56]

Still, health care utilization among SSP beneficiaries has risen steadily. Hospital admissions have increased by 8 percent and outpatient visits by 10 percent annually, reflecting a significant year-on-year growth in program enrollment.[57]

Physician Education and the Workforce

Medical education includes five years of undergraduate medical training and a one-year supervised internship (called a house job).[58] After this, graduates have two main options for postgraduate clinical training. One is to pursue a basic specialization through the Membership of the College of Physicians and Surgeons, a two-year program that offers a more generalist foundation and quicker entry into clinical practice.[59] The other option is to follow a more advanced route to consultant-level specialization through the Fellowship of the College of Physicians and Surgeons, which involves four to five years of structured training, depending on the specialty. Upon completing that fellowship, doctors may choose to further sub-specialize through a second fellowship, typically lasting an additional two to three years.[60]

Most GPs lack postgraduate training in family medicine; just 7 percent have completed the training.[61] While 10 institutions offer family medicine programs, only six are formally recognized by the Fellow of the College of Physicians and Surgeons of Pakistan, and family medicine was only added in 2021 as a mandatory rotation for undergraduate medical students.[62]

Tuition fees in private colleges range from PKR 1 million (USD 3,596) to PKR 1.2 million (USD 4,487), with an annual cap of PKR 1.8 million (USD 6,415).[63]

The system faces major shortages and an uneven distribution of health care professionals. As of 2024, there were about 319,572 doctors and 138,391 nurses, which is one doctor for every 723 people.[64] This translates to about 127 doctors for every 100,000 people — higher than the average of 116 in the Eastern Mediterranean region in 2022.[65] Most providers are concentrated in urban areas, leaving rural communities dependent on untrained providers.[66]

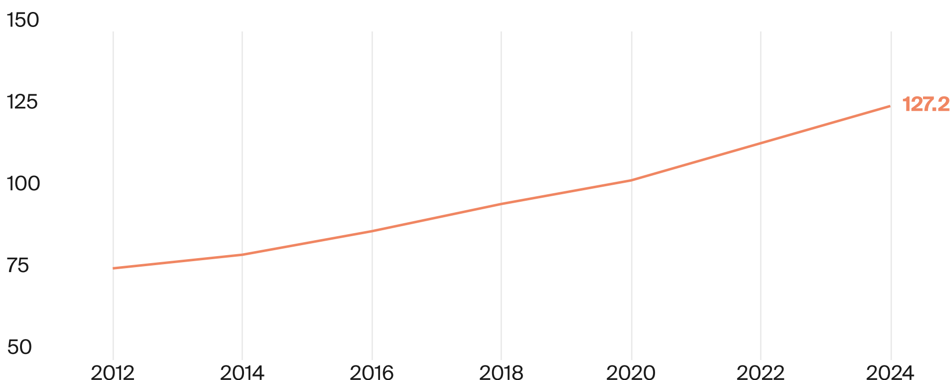
Health care professionals are also unevenly distributed across the different levels of the health system, according to Shaikh. "In terms of the distribution of human resource, it's the primary health care level which is suffering. You won't find many doctors in basic health units, which is the primary health care center and should be the first contact of any person seeking treatment for any common ailment. When patients go to a basic health unit and don't find a doctor or medicine, next time, they go directly to secondary or tertiary care hospitals."

Each year, Pakistan produces about 33,000 doctors, but this number is undermined by high rates of attrition.[67] The migration of trained professionals abroad exacerbates this shortage. As of 2019, more than 40,000 Pakistani doctors were working abroad, with about 2,400 doctors and 1,700 nurses leaving in 2022 alone.[68] About 40 percent of newly trained doctors migrate every year, citing low salaries, poor infrastructure, and limited growth.[69]

Hospitals

The health care system consists of public and private hospitals.[72] The public sector includes 1,276 hospitals, 5,558 basic health units, 736 rural health centers, 5,802 dispensaries, 780 maternal and child health centers, and 416 tuberculosis (TB) centers.[73] Hospitals typically operate under a global budget system, where they receive a fixed, preset amount to cover all services provided over a defined period.[74]

Number of Hospital Beds per 100,000 People, 2000–19



Source: Health and Nutrition (Pakistan Economic Survey, 2024–25); Calculated using population data from World Bank Open Data, Population, total – Pakistan, distributed by World Bank Group.

HOSPITALS BY THE NUMBERS

In 2024, there were **67 hospital beds per 100,000 people.**[70]

In 2024, there were **55 nurses per 100,000 people.**[71]

The Medical and Dental Council regulates all hospitals, and the Private Hospitals & Clinics Association represents the private sector. The government is increasingly focusing on public-private partnerships to improve access in underserved areas.[75]

Utilization data from the SSP further illustrate access constraints within the hospital system. A study of 400 households across Islamabad, Gilgit-Baltistan, and Azad Jammu and Kashmir found that only 11.8 percent of households had utilized the Sehat Sahulat card (*see The Role of Public Health Insurance*) in 2021–22. While many enrolled participants did not require hospitalization, others faced challenges in accessing care, ranging from difficulties in seeking and obtaining services to issues with receiving adequate treatment.[76] The program also faces barriers, including a lack of awareness and a shortage of empaneled hospitals. In some districts, a single hospital is expected to serve as many as 73,000 families, highlighting the significant gaps in accessibility and service capacity.[77]

Despite these constraints, patient and provider feedback from more established areas indicates high levels of satisfaction with hospital services. A 2022 evaluation of the SSP in the Lahore and Gujranwala districts found high overall satisfaction rates — 97 percent among patients and 85 percent among doctors.

For patients, core factors influencing satisfaction included the quality of assigned hospitals, curative services, out-of-pocket expenses, reduced financial burden, and overall service quality. For doctors, satisfaction was significantly linked to the availability of medicines and the efficiency of the payment process.[78]

Mental Health Care

The mental health care system faces significant challenges, including shortages of facilities, trained professionals, and funding. Stigma and weak policy enforcement also affect access to care.[80] Mental health isn't well integrated into universal health coverage plans. Although the essential package of health services includes basic screening at the primary care level, there's a lack of strategy regarding implementation, training, and funding.[81]

Public mental health services are managed by the NHSRC and include outpatient clinics, inpatient care, and community services. Their availability and quality vary, with most services concentrated in urban areas and tertiary care hospitals. In 2020, there were 11 psychiatric hospitals, 800 psychiatric units, and 578 community care facilities. Child and adolescent services are limited, with just 1 percent of outpatient facilities serving this group. Public services mainly offer basic psychiatric care, while private and nonprofit centers provide extra options, such as telecounseling and art therapy.[82]

Legislation, such as the Islamabad Capital Territory Rights of Persons with Disabilities Act, 2020 and the Allied Health Professionals Act, 2022, has been implemented slowly. No federal department coordinates mental health policy across provinces. Licensing is fragmented, with psychiatrists regulated by the Medical and Dental Council and psychologists and community mental health workers by the inactive Allied Health Professionals Council.[83]

MENTAL HEALTH CARE **BY THE NUMBERS**

There were **0.1 psychiatrists per 100,000 people** in 2020, significantly lower than the average of 0.4 for lower-middle-income countries.

There were **0.5 mental health professionals per 100,000 people** in 2020, compared with an average of 4 in lower-middle-income countries.[79]

The country faces a critical shortage of mental health professionals. As of 2023, there were 564 practicing psychiatrists and 100 psychologists. For a total population of over 200 million, this ratio has created a large treatment gap. A 2024 study found that 90 percent of people with mental illness had remained untreated.[84]

Several private sector initiatives have attempted to fill service gaps. The Integrating Mental Health Through Primary Care and Community Ties program, for instance, integrates mental health with primary care for HIV/AIDS, diabetes, and TB. Other initiatives include digital therapy platforms and GP training in psychosocial care.[85]

Long-Term Care and Social Support

The elderly population is expected to grow from 6.7 million in 2020 to 40.6 million by 2050, creating an urgent need for better geriatric care infrastructure.[86] The few dedicated elderly care organizations that exist often suffer from weak infrastructure, a lack of trained staff, and inadequate facilities. Chronic illnesses and disabilities are common among older adults, who face high out-of-pocket costs.[87]

Traditionally, the joint family structure, where families care for older relatives as they age, has served as the primary support system for the elderly. Socioeconomic changes, however, including the migration of younger generations for employment and the increasing participation of women in the workforce, have weakened these familial caregiving models.[88] Although home-based services, such as Health at Home, are emerging, old-age care homes are rare and stigmatized.[89] The Sindh Senior Citizens Welfare Act 2016 called for the establishment of at least one senior care facility per district; however, implementation has been limited.[90]

Only about 20 percent of people age 60 and over receive any form of pension, leaving many economically insecure and forced to work well past the retirement ages of 60 for men and 55 for women.[91]

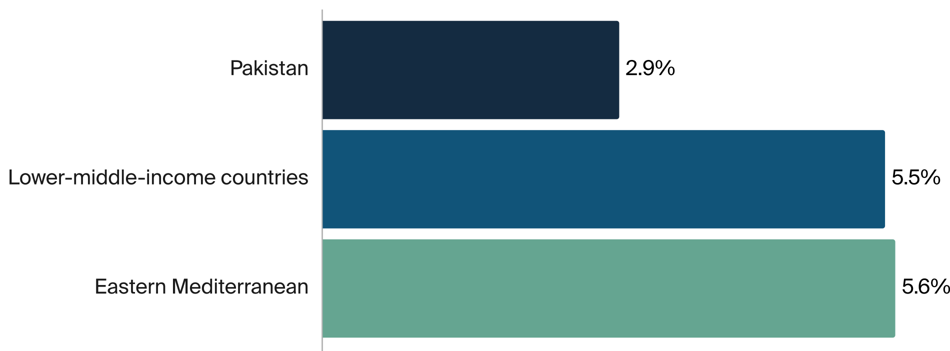
Cost and Affordability

Health Care Spending Overview

According to Shaikh, Dean of the School of Public Health at the Health Services Academy, "The public financing of health in Pakistan has been historically very, very meager. If you look at the official statistics, we have been getting 0.5, 0.6, 0.7% of the entire GDP of the country for health, which is nothing."

As of 2022, 2.9 percent of GDP was spent on health care, which was a slight increase from 2.2 percent in 2012. This figure remains significantly less than the average for lower-middle-income countries (5.5%) and the Eastern Mediterranean region (5.6%).[92]

Health Care Spending as a Percentage of GDP, 2022



Source: The Global Health Observatory, Current health expenditure (CHE) as percentage of gross domestic product (GDP), distributed by World Health Organization, accessed November 7, 2025.

In 2022, total health expenditure was about USD 10 billion, with government spending at USD 3.77 billion (38.2% of total spending). This translates to USD 41 per capita, out of which the government contributed USD 16 per person.[93]

Per capita health spending (USD 41) is less than half the USD 93 average for lower-middle-income countries.[94]

Pharmaceutical Spending

As of 2020, the pharmaceutical industry was valued at about PKR 423 billion (USD 3 billion). Per capita pharmaceutical spending was USD 12, lower than the regional average of USD 40.[95]

Drug spending reflects deep-rooted affordability issues that have been made worse by regulatory changes. From February 2024, the NHSRC allowed pharmaceutical companies to independently set prices for drugs not listed on the National Essential Medicines List (NEML).[96] Deregulation has led to consistent and steep price increases for a wide range of medications, particularly those for chronic conditions.[97]

The Drug Regulatory Authority of Pakistan plays an important role in overseeing prices, particularly for essential drugs included in the NEML.[98] Nevertheless, prices have continued to rise, especially since deregulation. While the Drug Regulatory Authority of Pakistan continues to monitor the NEML, it has expressed concerns over the lack of transparency from pharmaceutical companies about the pricing of nonessential drugs.[99] Significant price variations across originator brands, branded generics, and low-priced generics suggest there are regulatory gaps.[100]

Cost Sharing and Out-of-Pocket Spending

Health care financing relies heavily on out-of-pocket spending, with 47.4 percent of total health expenditure borne directly by individuals. This is significantly above the 35.5 percent average for other lower-middle-income countries.[101]

According to a 2021–22 report from the Pakistan Bureau of Statistics, Pakistanis spent more than PKR 983 billion (USD 4 billion) out of pocket on health care, which translates to a per capita annual expenditure of PKR 4,334 (USD 15). Urban centers absorbed 58.9 percent of all out-of-pocket health expenditures, suggesting that many rural residents travel to cities for medical treatment.[102]

The private sector dominates health care delivery. It consumes 82.8 percent of out-of-pocket spending, compared with just 17.2 percent in the public sector.[103] Within this, more than half of total out-of-pocket spending (50.6%) is allocated to medicines, followed by doctors' fees (12.9%), laboratory tests (8.2%), and transportation (7.7%).[104]

Percentage of Health Care Spending That Is Out of Pocket, 2022

Source: The Global Health Observatory, Out-of-pocket expenditure as percentage of current health expenditure (CHE) (%), distributed by World Health Organization, accessed November 7, 2025.

There are no universal caps on out-of-pocket expenditure for health care services.[105]

As of 2021, more than 10 million people were pushed into poverty each year because of out-of-pocket health expenses.[106]

How Are Costs Contained?

Managing the rising costs of health care has become a critical concern because of limited public health funding and the growing reliance on out-of-pocket spending. In response, the government has explored several ways to reduce the financial strain on public resources while improving service delivery. These include public-private partnerships, which have been used to extend health care services in underserved areas without the full financial burden falling on the government. For instance, the Sindh Essential Package of Health Services contracts private providers to manage rural health centers and hospitals while the government focuses on oversight and regulation.[107]

In addition, the SSP has significantly improved financial protection for enrolled families, resulting in a 40 percent reduction in the incidence of catastrophic health expenditures.[108] It has been particularly effective in easing financial distress among patients with chronic conditions. Notably, the program led to a substantial drop in mean monthly out-of-pocket spending, from PKR 72,139 (USD 254) to PKR 13,391 (USD 47).[109]

Quality and Outcomes

Addressing Health Inequities

Pakistan faces major health disparities, especially among the members of the transgender (*hijra*) community, young children, low-income households, and rural populations. In 2020, about 70 percent of *hijra* individuals reported poor treatment in public hospitals caused by stigma, lack of identity cards, and widespread discrimination.[118] Child undernutrition is widespread, with rural children being most severely affected.[119]

Women living in rural areas have significantly less access to hospital care, contributing to a higher maternal mortality rate — 23 percent compared with 14 percent for women in urban areas.[120] The 2020 Community Health Index revealed huge regional gaps, with top-tier districts more than 16 times healthier than the lowest-tier ones.[121] This finding is significant considering that 65 percent of the country's population lives in rural areas.[122]

The regions of Azad Jammu and Kashmir and Gilgit-Baltistan are particularly vulnerable. Azad Jammu and Kashmir has one doctor for every 4,900 residents. Six million residents live more than an hour away from suitable medical facilities, and one million people face over four hours of travel time to seek care.[123] Similarly, in Gilgit-Baltistan, there is one doctor for every 4,100 residents.[124] A 2024 study found that the region has poor primary care, with no district hospital providing care 24/7. There was also only one combined military hospital, which had one psychiatrist for the entire region.[125] Both Azad Jammu and Kashmir and Gilgit-Baltistan rely heavily on NGOs for support.[126] The Kashmir Welfare Foundation's facilities are often the only access people have to care.[127]

Health disparities in Pakistan are also deeply intertwined with social exclusion and disproportionately affect tribal populations and religious minorities. Acceptability of routine immunization remains low among poor and remote communities in Pakistan, particularly in rural and tribal areas.[128]

Meanwhile, religious minorities, including Christians, Ahmadis, and other non-Muslim communities, face systemic exclusion, economic marginalization, and limited access to health care.[129] Christian minorities in precarious jobs and those with lower education levels often experience poorer mental well-being.[130] In Balochistan, Hazara Shias (an ethnic and religious minority) report discrimination at both public and private hospitals, with some needing to conceal their identity to access medical care.[131]

Additionally, Pakistan ranks third globally in child mortality and under-vaccinated children.[132] Widespread vaccine hesitancy — driven by religious taboos, misinformation, and conspiracy theories — remains a critical barrier.[133] Some religious leaders publicly oppose vaccines, labeling them as part of a Western plot.[134] These beliefs have not only fueled resistance to childhood immunizations, such as polio, but have also led to deadly attacks on health workers.[135] During COVID-19, vaccine distrust worsened, with only 4 percent of the population expressing trust in Western vaccines.[136]

HEALTH OUTCOMES **BY THE NUMBERS**

Life expectancy at birth was **67.6 years** in 2023 (compared with 67.2 years in lower-middle-income countries in 2021).[110]

The top three causes of death in 2021 were:[111]

- Ischemic heart disease: **90 deaths per 100,000 people**
- COVID-19: **55 deaths per 100,000 people**
- Stroke: **48 deaths per 100,000 people.**

The maternal mortality rate was **155 deaths per 100,000 live births** in 2023 (compared with an average of 167 across the Eastern Mediterranean).[112]

The infant mortality rate was **50 deaths per 1,000 live births** in 2023 (compared with an average of 36 across the Eastern Mediterranean).[113]

In 2021, the share of the population with mental health disorders was **13 percent** (compared with an average of 14% in lower-middle-income countries).[114]

The suicide rate was **7 deaths per 100,000 people** in 2023 (compared with an average of 9.4 per 100,000 across lower-middle-income countries).[115]

The gun death rate was **1 death per 100,000 people** in 2023.[116]

23 percent of adults were affected by obesity in 2022 (compared with 12% on average in lower-middle-income countries).[117]

Such distrust is specifically rooted in suspicions surrounding Pakistan's polio eradication efforts, which were severely undermined after the Central Intelligence Agency (CIA) misused a vaccination campaign for intelligence purposes.[137] In 2011, the CIA ran a fake hepatitis B vaccination campaign in Abbottabad to locate Osama bin Laden, which severely undermined public trust in immunization programs.[138] This led to Taliban-imposed bans on polio campaigns, a sharp 12 to 20 percent drop in vaccination rates in areas with strong Islamist support, and a surge in violence, including the killing of over 70 health workers.[139]

The government has rolled out several initiatives to improve health care access for underserved populations. One of these is the Ehsaas Program, which features mobile health units and interest-free health care loans. The Kamyab Jawan Health and Life Insurance Program, meanwhile, was introduced to offer both free health care services and life insurance of up to PKR 500,000 (USD 1,781) to low-income families.[140]

The Lady Health Worker Program takes essential maternal, newborn, and child health services directly to households — especially in conservative and remote areas. Lady Health Workers have helped to reduce barriers to access for women living in locations that lack formal health facilities.[141] Pakistan has also participated in international efforts, such as the TB REACH Initiative, funded by the Stop TB Partnership, which pilots innovative ways to screen for and treat TB in marginalized communities.[142] These steps reflect growing efforts to reduce inequities by making health care more inclusive and accessible across socioeconomic and social divides.

Innovation and Reform

Health Care Innovation

To strengthen the quality of care across Pakistan's health care system, a range of policy reforms and service delivery innovations have been introduced. These encompass strategic planning, public-private partnerships, and mobile and emergency health care solutions.

Public-Private Partnerships for Federal Hospitals

To address fiscal constraints and enhance efficiency, the federal government is considering outsourcing major hospitals through extendable contracts or public-private partnerships. This is designed to reduce the annual budgetary burden of PKR 10 billion (USD 36 million), attract private investment, and potentially promote medical tourism.[143]

Field Hospitals and Clinics on Wheels

The Punjab government rolled out 32 mobile field hospitals, comprising 21 mobile health care units and 11 diagnostic units, alongside its Clinic on Wheels program in underserved rural areas across 36 districts. Equipped with pharmacies, labs, and ultrasound rooms, the program aims to serve 1.5 million people every year using a pay-for-performance model that links provider incentives to care quality and outcomes.[144]

Health Care Technology

The SSP functions as a digital-ID-based health care system through the Qaumi Sehat Card, integrated with a centralized health management information system. Enrollment is verified using Computerized National Identity Cards and biometric identification, supported by the National Database and Registration Authority (NADRA).[145] While this system is operational across the country, the Sehat Card is now limited to empaneled private hospitals in Punjab, following the province's withdrawal from the SSP in July 2025 (*see The Role of Public Health Insurance*).[146]

The One Patient One ID initiative also links medical records to citizens' national ID numbers, enabling a unified digital health system. Launched by NADRA and the NHSRC, the system supports telemedicine and aims to reduce patient overload at major hospitals. Initial implementation has started in Islamabad, and nationwide rollout is ongoing.[147] In June 2025, NADRA announced a series of reforms aimed at streamlining and securing Pakistan's digital identity infrastructure. Most notably, with regard to health care, birth registration became mandatory for acquiring a child registration certificate.[148] This recognizes the child in official records, enabling them to enter educational institutions, get a Computerized National Identity Card, and undergo other necessary processes.[149] NADRA also granted legal status to the Family Registration Certificate, which is a document that verifies a person's family members against NADRA records.[150] The result is that all families will now be registered to a certificate, making it a more reliable identification tool for all purposes, including medical, and families can also verify their records through a mobile application.[151]

Other projects have focused on immunizations, such as e-Vaccs, a comprehensive information system integrated with devices and real-time monitoring technology. This initiative, developed in collaboration with the WHO, was implemented in Punjab and Khyber Pakhtunkhwa, streamlining immunization workflows and significantly improving vaccine coverage in underserved areas.[152] On electronic health records (EHRs), meanwhile, Aga Khan University Hospital is digitizing records across its hospitals and outreach centers to enable seamless access to patient data and enhance research and medical training.[153]

There is also innovation in the private sector. Platforms such as Sehat Kahani use telemedicine, electronic medical records, and data analytics to reach remote populations.[154] For example, it can connect female doctors with patients via video calls in order to overcome cultural barriers.[155] Similarly, initiatives such as SehatYab, an online telemedicine clinic, and SUPARCO's satellite-based telemedicine network, are strengthening remote health care delivery.[156]

However, rural health care centers often lack the necessary information technology infrastructure and skilled personnel to implement EHR systems, and providers' limited training and digital literacy hinder progress.[157] A recent NADRA reform in April 2025 sought to improve local access to identity documentation by transferring registration services for Computerized National Identity Cards to union councils (local government administration).[158] The impact of this reform remains to be assessed at the time of writing.

This profile reflects data as of January 2026. New or updated information may have become available since its release.

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