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ADAPTIVE RESILIENCE IN PAKISTAN'S HEALTH SYSTEMS AND RESOURCES CHALLENGES: EVIDENCE FROM FEDERAL PUBLIC HOSPITALS IN ISLAMABAD

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Abstract

Pakistan's under-investment in public health, in the long run, has resulted in a weak system that is struggling to provide needed health services, medicines and emergency readiness. This study examines the impact of fiscal constraints on the ability of Pakistan to develop a resilient health system to prevent and promptly respond to health emergencies. It tackles the central issue of whether the health security gap in Pakistan is due to the scarcity of resources or the malfunctioning political economy. Researcher used a mixed methodology, combining three data types: longitudinal archival data analysis of health expenditure data (2009–2024); cross sectional survey of 232 patients at the Pakistan Institute of Medical Sciences (PIMS) and Federal Government Polyclinic Hospital in Islamabad; and 12 in-depth interviews with stakeholder groups consisting of federal and provincial government officials, facility managers, clinicians, front line workers and representatives of international health organizations. PIMS and Polyclinic provide a nationally representative view of system performance as multiple ethnicities, socioeconomic and cultural groups are served by their hospitals, and cross reference provincial hospitals are not representative. Key findings show that public health expenditure at 0.9–1.4% of GDP is much lower than the 5% WHO threshold and is also lower than the spending on public health in other countries in the region. The findings are normatively and analytically framed via Social Security Theory, the health system resilience framework of Kruk et al. and the Securitization Theory. The health security deficit is a failure in the political economy and requires a reallocation of funds, redesign of budgets, institutional reforms, and an institutional framework for coordination.

Keywords: *COVID-19, Fiscal Constraints, Health Security, Health System Resilience, National Finance Commission, Out-Of-Pocket Costs, Pakistan, Public Health Expenditure.*

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1. Introduction

Public health system in Pakistan faces a crisis which is well documented and is yet to be resolved. Throughout the entire 2009-2024 period, the government health expenditure as a share of the gross domestic product (GDP) remained within the range of 0.9 percent to 1.4 percent, well below the minimum government health expenditure of five percent as recommended by the World Health Organization (WHO) as a prerequisite for universal health coverage (World Health Organization, 2007). This is no mere figure. It is expressed with inevitable human concreteness, in the day-to-day reality of millions of Pakistanis who access health facilities without medicines, hospitals without qualified staff, surveillance systems that are unable to track disease outbreaks in real-time and an emergency preparedness infrastructure that has regularly failed to respond to crises (World Bank, 2025; Government of Pakistan & WHO, 2016). It is a scholarly as well as a policy challenge of the first order to understand exactly how fiscal constraints cause these effects to occur, and why, despite the documented effects, fiscal constraints continue to exist in a political economy.

The concept of health system resilience offers an analytically useful lens to assess these consequences. Kruk et al. (2018) defined health system resilience as the ability of a health system to anticipate, absorb, adapt and recover from adverse events and continue to perform its essential functions that include disease prevention, service delivery, and population protection. A truly resilient health system needs the financial resources to have a large enough "surge capacity" when facing a crisis, information systems that deliver information in real time to support adaptive action, and institutional investment in creating the learning and reform needed to prevent future vulnerability. When viewed through these lenses, the health system in Pakistan shows structural weaknesses in all three areas and these weaknesses can be traced through causal chains of events to the entrenched fiscal underinvestment in the health system that has been the result of decades of budget decisions.

There are some important contributions in the existing literature that seek to address various aspects of health financing in Pakistan, but there are still gaps in the analysis of the data. Nishtar et al. (2013) conducted an extensive review of the health system reform requirements in Pakistan, naming budget imbalance as one of the main issues facing the health system. A World Bank (2025) report recorded expenditure trends and structural issues of the budget. Cheema and Sayeed (2014) analyzed fiscal federalism and the delivery of health services after devolution. Political economy explanations for the persistence of health underinvestment when it has harmful impacts were provided by Khan and Shawar (2021) and Ali and Tariq (2017). The contributions have all depended, however, on the use of archival and administrative data in the main. Few studies have brought the direct patient evidence of effects of fiscal constraints into the quality,

availability and financial effects of health on the most reliant citizens in the public health system. This study fills that void by reporting primary data from 232 patients at the two leading federal public hospitals—with their first-hand experiences forming a distributed and original audit of the performance of health systems across all four provinces—and institutional testimony from twelve health sector professionals.

The selection of Pakistan Institute of Medical Sciences (PIMS) and Federal Government Polyclinic Hospital in Islamabad as the survey sites has been methodologically and analytically suitable. From the four provinces of Pakistan, both institutions cater to patients from across the country with ethnic, cultural and socioeconomic diversity. The overwhelming majority of patients who were referred to these hospitals were referred from the local public health facilities because they were unable to treat them: 59.3 percent were referred from public health facilities in their provincial or district that they were unable to attend, 26.3 percent reported that there was no public health facility in their home district that they could go, and 14.4 percent had sought specialist care which was not available anywhere in their home province. The patients thus had first-hand experience of the failures at lower levels in all four provinces, as well as their present hospital experiences. Their testimony was both evidence of their experience and a distributed patient-level audit of the public health system of Pakistan, in primary and secondary care settings.

The theoretical framework introduced a dialogue with Social Security Theory, specifically Marshall's (1950) Social Rights of Citizenship and Esping-Andersen's (1990) approach to decommodification, linking this with Kruk et al.'s (2016) resilience framework. Marshall's understanding of social citizenship placed emphasis on health protection as a fundamental right that is not merely the choice of the budgetary process, but a necessary element of being a full member of a political community: the illegality of denying a right because the state does not provide for it is a fundamental failure of the social contract. The concept of decommodification by Esping-Andersen furthered this argument by arguing that access to health should not be determined by market capacity, meaning health outcomes of a citizen should be determined by the quality of the public health service, not by his or her capacity to pay. In Pakistan, where 60–70 percent of total expenditure on health was spent on out-of-pocket payments, such theoretical frameworks transformed the empirical findings of this study from a developmental perspective of poor investment into a normative perspective of the systematic denial of social rights to citizens. This normative foundation provided the policy recommendations that grew from the study with their ethical urgency; not a technical problem with governance to be optimized.

2. Methodology

The analysis of the national level patterns and interprovincial differences in health outcomes and distribution of health resources of Pakistan as a bounded case was feasible

within a case study framework (Yin, 2018) as the study spanned twenty years (2009-2024) and the year 2009 was the year of Eighteenth Constitutional Amendment in Pakistan that devolved the governance of health sector to the provincial governments, and the year 2024 provided a 15 year of view of the period of study.

The analysis was done in two ways: the quantitative trend analysis and comparative benchmarking with regional and international counterparts, and the qualitative content analysis of policy documents and official evaluation. The sources were categorized into eight groups: World Bank World Development Indicators 2024, Pakistan Economic Survey annual editions 2009–10 to 2022–23, provincial health budget documents for FY 2022–23 from Punjab, Sindh, Khyber Pakhtunkhwa and Balochistan, the Pakistan Demographic and Health Survey 2017–18 (National Institute of Population Studies & ICF, 2019), the Pakistan Joint External Evaluation of IHR core capacities (Government of Pakistan & World Health Organization, 2016), the Global Health Security Index 2021, WHO World Health Statistics 2023, and peer-reviewed academic literature on health financing, political economy and health security in Pakistan between 2010 and 2024.

3. Results and Discussion

3.1. Health Expenditure: Chronically and Consequentially Below International Benchmarks

Throughout the fifteen year study period, Pakistan's public health spending was always found to be very low when compared to the GDP. The World Bank (2024) recorded government health expenditure in the early years of the study at around 0.9 per cent of GDP, and in the later years between 1.3 to 1.4 per cent, but without any sustained upward trend. This short-term bump-up that is seen in fiscal year 2020–21 was related to emergency mobilization in response to COVID-19, but this upturn was not sustained after the emergency period of the pandemic. Pakistan's government health spending, USD 14–20 per capita over the study period, was less than one-third of India's and less than one-sixth of Sri Lanka's, despite generally similar per capita incomes compared to Bangladesh, which with lower per capita incomes over much of the post-independence period, did show measurably better results on key maternal and child health indicators through more sustained investment in primary health care and community health worker infrastructure (Organization for Economic Co-operation and Development [OECD] 2022; WHO 2023; Ahmed et al., 2021). This comparative perspective is analytically significant since it directly and obviously challenges the fiscal fatalism that sometimes is part of the official narrative of Pakistan's health underperformance. The reality is that what Pakistan citizens sees in their lives is not the natural result of Pakistan's income level, rather the correctable result of Pakistan's consistent political decisions on budget priorities, proved by international evidence.

The out-of-pocket nature of Pakistan's health financing was another dismal situation. Pakistan's access to quality health services was found, in very large measure, to depend on their capacity to pay, as OOP payments made up some 60 to 70 percent of the total health expenditure in the country over the study period — the opposite of a decommodified health system which Esping-Andersen (1990) has seen as a core function of the welfare state, and which Marshall's (1950) social rights framework requires as an essential component of democratic citizenship. To the patients at PIMS and Polyclinic, whose socioeconomic profile showed that 42.3 per cent of them earned less than PKR 25,000 per month, and 34.2 per cent had no formal education, this structural shift of the burden of health financing costs from the state to the household was less a nuisance and more a financial catastrophe. Table 1 recorded the specific out-of-pocket expenses faced by survey participants while they were attending these nominally free federal hospitals, and captured the extent of the financial risk the public health system's shortcomings created.

Table 1 Patient-Reported Out-of-Pocket Costs at PIMS and Federal Government Polyclinic

Cost Category	Patients Incurring (%)	Average Amount (PKR/visit)	Reported as Burden (%)
Transportation to hospital	78.9%	180–5,000+	61.4%
Medicines purchased privately	68.3%	600–2,400	74.7%
Private diagnostic tests	44.1%	800–3,500	66.2%
Informal payments to staff	19.6%	200–800	55.8%
Lost daily wages	61.2%	500–1,500	70.3%
Accommodation in Islamabad (out-of-province only)	34.7%	800–3,000/night	78.2%

Note. *Accommodation costs apply only to patients attending from outside Islamabad. PKR = Pakistani rupee.*

The largest cost burden was for the prescribed medicines that needed to be bought from a private pharmacy outside the hospital (68.3 percent of respondents reported this as a cost and 74.7 percent of those who had incurred the cost found it to be a burden). It is analytically significant because this did not represent a failure of the management of PIMS or Polyclinic, rather this was a consequence of the budget composition problem that was consistently observed in all provincial health budgets: non-salary recurrent budgets, from which medicines were procured, received only 15 to 20 percent of the total provincial health budgets, meaning that even the most resource-rich federal hospitals routinely couldn't afford to use the medicines their own doctors prescribed (World Bank, 2025). The amount of medicine paid averaged PKR 800 to 3,000 per night for the 34.7 percent of

respondents who came from outside of Islamabad, and which was one of the most common reasons for household poverty entry, according to a study by Pakistan Bureau of Statistics (2023). These results provide specific patient-level data on Marshall's (1950) notion of social rights: If transport, accommodation, private medicines, diagnostic tests, and lost wages were added up, the cost of an outpatient visit to a nominally free federal hospital for citizens earning under PKR 25,000 per month could exceed a month's worth of household income. It wasn't a problem of management of medicines in the state's own hospitals, but a clear violation of the social contract which Social Security Theory had defined as non-negotiable since those hospitals were required to provide sufficient medicines to the state's most vulnerable citizens, forcing them to purchase in private markets otherwise.

3.2. Budget Composition: Salary Dominance and the Mechanics of Operational Paralysis

Lots of structural biases in the allocation of the limited — and already inadequate — health expenditure within the health system directly exacerbated its human impacts and effects on the aggregate level. It was observed that salary costs accounted for about 68 to 75 percent of the provincial health budgets for FY2022-23, while only 8 to 12 percent of the total provincial health budgets were allotted to development expenditure for capital investment, and non-salary recurrent budgets which included medicines, medical supplies, facility maintenance, equipment repair, diagnostic consumables, and utilities received only 15 to 20 percent of the provincial health budgets for FY2022-23 (World Bank, 2025; Pakistan Economic Survey, 2023). This composition, in its own way, produced a paradox in the structure of the health system, fundamental to an understanding of the nature and meaning of fiscal constraint in practice: Pakistan's health system employed, paid, and maintained a large workforce, a physical infrastructure of hospitals and health units, and organizational capacity to pull them together and get them to perform — but was also regularly unable to do so because the resources required to effectively operate and staff the units were systematically and predictably absent.

The operational paralysis was most clearly and intensely felt during the in-depth interviews. Non-salary budgets were viewed by 11 of the 12 respondents (91.7 percent) as completely inadequate to ensure basic service quality throughout the fiscal year, more than any other theme in the interview data. This was very clearly expressed by one district hospital manager from Sindh, who said this, ‘Our medicine budget is exhausted by December or January. We then inform patients that there is nothing until the end of June. While the wages continue to roll in, what is a doctor's salary if there's no medicine to give? This testimony summed up the core of the salary-dominance problem: a system that was continuing to pay staff but couldn't provide their basic professional service due to the depletion of operational resources. Interview information verified that this was not a one-

off situation, but a common feature of health facility functioning in all four provinces at all levels of health facility services, from Basic Health Units through to major district hospitals.

The results are consistent with and build on Nishtar et al. (2013) comprehensive analysis of the health system in Pakistan which indicated that budget composition is one of the most harmful structural features of the health system and with Atun et al.'s (2010) finding that disease-specific health interventions could not achieve their intended results without support from a functioning health system infrastructure. The salary dominance pattern was one that Khan and Shawar (2021) were able to capture analytically: salary expenditure provided health workers with an organized political defence of their expenditures, which made them less susceptible to fiscal cuts, whereas non-salary recurrent and development expenditure were the most susceptible to fiscal pressure because they were not politically defended by health workers. It created a health system with much of the input, but with a capacity kept under constant threat by the systematic undermining of it — one that could, in theory, be able to deliver services, but in practice, often was not.

3.3. Health System Infrastructure Deficits: Evidence from the Patient Perspective

The patient survey at PIMS and Polyclinic produced evidence from the patient or citizen perspective of health system performance that would not be available from any administrative data source: a citizen level overview of the failures of primary and secondary care in his or her home province prior to coming to Islamabad. Their testimony recorded health system performance at the federal level and the impact of health system failure at the provincial level as they were patiently receiving patients from all four provinces (whose local health service had failed them). Table 2 shows patient satisfaction ratings with the services they received at the federal hospital where they were attending.

Table 2: Patient-Reported Perceptions of Service Quality at PIMS and Federal Government Polyclinic (n = 232)

Indicator	Always/Usually (%)	Sometimes (%)	Rarely/Never (%)
Medicines available at facility pharmacy	22.4%	31.5%	46.1%
Doctor/nurse present on arrival	48.5%	27.3%	24.3%
Diagnostic tests available	31.2%	28.6%	40.3%
Clean waiting area and exam room	39.7%	33.4%	26.9%
Full consultation (>5 minutes) with doctor	44.2%	29.8%	26.1%
Satisfied with overall quality of care	38.8%	26.3%	34.9%

Note. *Chi-square tests significant at $p < .05$ for all comparisons between rural and urban respondents on medicine availability and satisfaction indicators.*

The fact that the respondents of this study from the apex federal hospitals, which are the most well equipped with institutional resources, well trained staff, and have the highest level of direct federal funding, reported that medicines were rarely or never available in the hospital pharmacy is one of the most analytically significant finding of this study. Its value was not only as it showed the situation with PIMS and Polyclinic but also as it suggested systemic possibilities – that where the country's most resource-rich public hospitals could not get the medicines they prescribed, surely things were proportionately worse at the provincial district hospital, health centre and basic health unit levels. The reason the medicine was not available at the head of the system was not because of the failure of a particular hospital's management; it was because of the visible terminal symptom of a structural problem of the public health system, namely a lack of money to cover all costs other than salaries, and that this lack affected all hospitals equally and indiscriminately. This was confirmed directly in the in-depth interview testimony, as detailed above, which revealed that medicine budget exhaustion was a universal characteristic of the operations of all health facilities sampled across all levels of the study.

The health workforce information corroborated and complemented this structural picture. The national physician density in Pakistan was estimated at 7 per 10,000 which is lower than WHO's minimum requirement of 10 doctors per 10,000 population (WHO 2023); whereas in Balochistan it was around 3 doctors per 10,000 people. Twenty-four.3 per cent of respondents said their assigned doctor or nurse was rarely or never present during their visit, especially true for rural respondents. The causal mechanism for this workforce shortage was documented in detail through in-depth interviews since the respondents who had clinical backgrounds estimated that 40–60 percent of their medical school cohorts had emigrated within 5 years of graduating, mostly to the Gulf states where they found higher salaries available than in Pakistan's public sector. This ‘brain drain' phenomenon was described by Birn et al. (2017) as a systematic movement of human capital from resource poor health systems to resource rich health systems, driven not only by individual career choices, but also by structural issues stemming from fiscal choices that made the international job options far more appealing than jobs in the public sector in their home country. Bennett et al. (2012) found that a key challenge for health systems in low-income countries was spatial maldistribution of health workers, the remediation of which required not only incentives for posting workers but investment in the infrastructure of health facilities in rural areas, and in professional development opportunities that Pakistan's limited health financing had never been able to supply.

The disease surveillance system in Pakistan was similarly flawed and had similar analytic linkages. The level of coverage of the Health Management Information System

was incomplete, reporting delayed, data quality poor and analytical capacity for real-time outbreak detection and response was limited. Emanuel et al. (2012) noted the absence of an integrated reporting framework, with various diseases reported through various agencies, with varying data collection systems and reporting timeframes, thereby leaving gaps in disease surveillance that enabled outbreaks to occur and spread undetected by national health authorities. Eighty-three percent (10 of the 12 respondents to in-depth interviews) identified post-devolution surveillance fragmentation as a key governance challenge, a finding that was directly corroborated by the country office representative of WHO who stated, 'For disease surveillance to work at the national level, four provinces need to report to one system in real-time. There is no such system. It's with a flight of blind eyes that we are flying. The consequences of this lack of surveillance for health security were clear and devastating: a health system unable to effectively detect new outbreaks would be unable to respond quickly enough to help control them, with the result that preventable localised outbreaks would become health emergencies, at significant human and financial costs.

3.4. Emergency Preparedness and Crisis Response

In line with the resilience framework developed by Kruk et al. (2018) highlighting the three operational aspects of health system resilience (absorptive, adaptive, and transformative), the health system in Pakistan was found lacking in all three. It was severely constrained by sub-optimal surge resources: too few intensive care beds/ ventilators; limited pre-positioned emergency medicine stockpiles (nearly nonexistent); overwhelmed HWs with chronic shortages who would not be able to manage a dramatic surge of patients without institutional and financial support; and an inconsistent level of physical infrastructure that failed to ensure basic environmental standards. The adaptive capability it was subjected to was hampered by the above-described weak and fragmented information systems, which failed to provide situational awareness in real time to inform adaptation to unfolding crises. The dimension that needed the most sustained and robust fiscal effort to be transformative was compromised by the political economy dynamics which hindered systematic institutional learning and reform from becoming entrenched between crises.

During the course of the study, the most significant and best documented real world stress test of these dimensions of resilience was the COVID-19 pandemic. They reported on the swift depletion of ventilator availability during periods of high infection pressure; the significant shortage of personal protective equipment (PPE) which exposed thousands of health care workers to high risk of infection, and resulted in health worker attrition at the same time when their efforts were most needed; and the near complete lack of pre-positioned emergency stocks which could have made up for the time required to prepare a more managed response. Jafarey et al. (2021) reported on the swift depletion of ventilator

availability during periods of high infection pressure, the significant shortage of personal protective equipment (PPE) which exposed thousands of health care workers to high risk of infection, and the resulting health worker attrition at the same time when their efforts were most needed, and on the near total lack of pre-positioned emergency stocks that could have made up for the time required to prepare a more managed response. The structural weaknesses experienced by PIMS itself, were systemic and not necessarily the result of site-specific issues, in the context of Pakistan's COVID-19 response. COVID-19 was confirmed as having had a significant impact on the delivery of routine health services from the patient's perspective through the patient survey: 71.8 per cent (166 of 232) respondents experienced significant disruption to routine health services such as immunization services, antenatal care, and chronic disease management during COVID-19. Another 62.7 per cent reported that treatment for non-COVID conditions was challenging during the lockdown period. At the time of the survey, only 24.6 percent said the public health system would be able to respond to a future pandemic scale emergency, and only 18.3 percent said the government has adequate emergency medicine supplies at public facilities. Empirically, in the eyes of the population whose well-being the health system was supposed to serve, these indicators of perception of confidence and lack of preparedness of the structure confirmed that the structural preparedness gap reported in archival data was real, visible, and felt, and not just calculated.

The insights from the in-depth interviews data proved to be analytically most revealing of what was exposed by COVID-19 regarding the health system in Pakistan. Ten of the twelve (83.3 percent) said COVID-19 was not a crisis that caught an otherwise good system off-guard, but rather was a diagnostic tool that revealed structural issues that had long been ignored to people who could not. This is exactly how one medical superintendent of a large public teaching hospital put it: 'We got organised during COVID thanks to the military. Those were COVID problems, but the problems that I saw were lack of oxygen, lack of PPE, lack of ICU beds. They were 10-year crises come to light during COVID.' This characterization was analytically relevant since it directly refuted the official emergency-exceptionalism narrative, which sometimes formed the basis of official responses to health crises in Pakistan, where each disaster was seen as an unprecedented event that has rendered the system incapable of functioning normally. Overall, Bhutta et al. (2021) had a balanced assessment: Pakistan has had some decent achievements in areas which required political mobilization for success (effective public health communication, international vaccine procurement via COVAX and relatively speedy vaccine deployment) but was constrained in areas that required existing system capacity rather than exceptional political mobilization. The new National Command and Operation Centre had shown the potential of Pakistan to coordinate extraordinary emergency situations in the time of intense political pressure; however, according to nine out of the 12 respondents (75.0

percent) interviewed, it was a crisis tool, not a permanent health security architecture that the country needed for genuine preparedness.

The 2022 floods were a second significant and experiential stress test. The structural weaknesses which hampered the COVID-19 response were also found to be limiting the health system response at every stage, as reported by El-Khatib et al. (2023), with the health system almost entirely relying on humanitarian assistance for health services in the communities most severely affected by the pandemic in Balochistan and interior Sindh. This institutional testimony from the patient experience was confirmed by the accounts of disrupted care during and after the 2022 floods, and of journeys to Islamabad which were direct consequences of health system incapacity exacerbated by flood damage, in their provinces of Sindh and Balochistan respectively. Triangulation of the findings from the patient surveys, the in-depth interviews and archival documentation for COVID-19 and the 2022 floods revealed a consistent picture of failure of health systems, one that was strong across all data sets, consistent with Gostin and Friedman (2015) who found that the catastrophic consequences of the Ebola epidemic in West Africa was as a result of decades of under-investment in health systems rather than pandemic characteristics.

3.5. Political Economy of Persistent Underinvestment: Why the Cycle Continues

To understand this, it was essential to engage with Pakistan's political economy dynamics that influenced budget allocations and to understand why Pakistan's health system was underfunded despite a growing body of evidence linking its shortcomings to Pakistan's health outcomes. Rashid et al. (2019) showed that there was a structural crowding out effect in the defence budget, which consistently reduced the fiscal space available for other social sectors like health, and the effect was entrenched in Pakistan's institutional framework because of the political influence of the security establishment, geopolitical threat perceptions, and budget negotiation processes which systematically reduced the health ministry's submissions while treating the defence budget as a political commitment rather than a line item for negotiation. Another limiting factor was that Pakistan has been subject to repeated International Monetary Fund stabilization programmes, and fiscal deficit reduction measures in which social sector spending, health, was one of the most politically sensitive categories (International Monetary Fund, 2023). A chronic state of low tax-to-GDP ratio (c. 9–11 percent) provided very limited fiscal resources for all government functions, and paying interest on government debt that absorbed more than 50 percent of federal revenues meant little fiscal space for developmental expenditure (Zaidi, 2015).

In analytical terms, Ali and Tariq (2017) pinpointed the basic structural failure of health constituencies in the budget politics of Pakistan: unlike the defence sector, which had a politically powerful and institutionally entrenched constituency; or the infrastructure

sector, which could generate politically attributable, visible outputs that politicians could claim credit for in electoral contexts, health investment produced diffuse, long-term benefits that were difficult to see, difficult to attribute and difficult to mobilize political support around. The patients surveyed at PIMS and Polyclinic were the very people who have the least political voice and the least exit options; 42.3 per cent of them earning less than PKR 25,000 a month, and 34.2 per cent having no formal education, and mostly travelled hundreds of kilometres as a last resort after the local facilities could not provide their needs. They were the citizens who were most completely the citizens of the state health system, and least able to press for the improvements that their citizenship made so immediately necessary. Thus, the political economy of underinvestment in health was laid bare, if somewhat painfully, onto the socio-economic face of those who suffer the effects.

The health-performance dimension of governance was also a significant factor and was not analytically distinct from the fiscal dimension. Siddiqi et al. (2009) detected that three dimensions of governance systematically undermined health returns from public expenditure: accountability problems, transparency failures and problems in the enforcement of rule of law; thus, inadequate governance caused the health system to deliver less than the returns to the limited resources that were allocated. The patient survey was able to provide direct evidence of governance related efficiency losses; 19.6 percent of respondents at these federal public hospitals reported making an informal payment to staff for improved or rapid service. However, such payments were informal ones that did not add or improve care overall, but merely shifted the availability of care from those who were unable to pay to those who were able, in a nominally free care system which was nominally dedicated to equitable access. There was no justification for an additional informal payment since out-of-province patients had to incur travel and accommodation costs already, which were further increased by this informal cost. Khan and Shawar (2021) suggested that such a governance deficit could not be solved through institutional technical changes alone, and that it was important to shift the political incentives of those making decisions in the health sector, as fiscal constraint analysis could not create the needed shift alone, but without it, fiscal expansion would generate significantly less benefit than the investment would warrant.

4. Conclusion

The most significant findings of this study were that the health system resilience deficit in Pakistan is not an absolute shortage of resources, but a political economy issue. There was a general understanding of what was required and it was known and discussed by many in the policy community. The policy discourses that had been establishing the significance of health had been expressed — and in the case of National Security Policy 2022-6, the health issue was explicitly placed in Pakistan's national security framework. Their own paths had shown that neighbouring countries with comparable or less resource

bases can achieve better outcomes with greater political consensus surrounding health as a public good and a social right. All that was left was political determination to allocate the resources, organise the government and create the institutions to make the 232 patients at PIMS and Polyclinic — and the millions of Pakistanis they stood for — the beneficiaries of a health system that was truly a reflection of the social rights which their citizenship entailed and the fiscal commitments which the state's social contract obligations required.

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