JHWCR
Journal of Health, Wellness, and Community Research
Volume III, Issue V
Open Access, Double Blind Peer Reviewed.
Web: https://jhwcr.com, **ISSN**: 3007-0570
https://doi.org/10.61919/j6evtz02

Article

Comparative Analysis of the Health Care Systems of Pakistan and Nepal

Sehrish Ashraf[1], Zunaira Ashraf[2], Mehvish Yaqoob[3]

1 University of Lahore, Lahore, Pakistan

Correspondence
muhammadtouseef1988@gmail.com

Cite this Article

Received	2025-04-21
Revised	2025-05-11
Accepted	2025-05-17
Published	2025-05-21
Conflict of Interest	None declared
Ethical Approval	N/A
Informed Consent	N/A
Data/supplements	Available on request.
Funding	None
Authors' Contributions	Concept, design, data collection, analysis, and manuscript drafting were contributed by SA, ZA, and MY.

ABSTRACT

Background: Health care systems are foundational to public well-being and vary significantly across nations, especially in low- and middle-income countries. Pakistan and Nepal, while geographically proximate, differ in system structures, resource allocation, and policy priorities. **Objective**: To compare and analyze the health care systems of Pakistan and Nepal using the World Health Organization (WHO) Health System Framework, focusing on governance, financing, workforce, service delivery, technology, information systems, and health indicators. **Methods**: This qualitative document analysis used secondary data from official health ministry reports, international health organization documents, and peer-reviewed literature published between 2015 and 2022. The data were categorized and analyzed thematically using the WHO framework to identify structural differences, strengths, and system gaps. **Results**: Pakistan operates a decentralized health system with substantial private sector involvement, limited government spending (<1% GDP), and workforce and infrastructure challenges. Nepal, under a centralized federal system, allocates a higher share of GDP (6.3%) to health but faces geographical and access barriers. Both countries show underdeveloped health information systems, limited research output, and struggle with equitable service delivery. **Conclusion**: Despite structural differences, both Pakistan and Nepal face common challenges in financing, human resources, and quality care. Reforms must emphasize equity, system integration, and investment in primary care and information infrastructure.

Keywords: Health Care Systems, Health Policy, Comparative Study, Nepal, Pakistan, Health Workforce, Health Financing.

INTRODUCTION

Health care systems (HCS) are structured frameworks designed to provide health services to individuals, families, communities, or populations. These systems are comprised of organizations, personnel, resources, facilities, and technologies that collectively respond to the health needs of a population (1). At their core, health systems aim to value human life by promoting health, preventing illness, treating disease, and supporting rehabilitation (2). The effectiveness of an HCS is influenced by the availability and quality of its technologies, resources, facilities, and budget, all of which play essential roles in improving national health indicators (3).

A well-functioning HCS ensures the delivery of appropriate care in an organized manner that aligns with the expectations and needs of the population it serves. The rationale for comparing Pakistan and Nepal lies in their geographical proximity in South Asia, similar economic classifications as developing nations, shared challenges in public health governance, and mutual potential for learning and policy exchange. Both countries have pluralistic health systems involving public, private, and non-profit sectors, yet they differ in structural governance, health financing strategies, and the extent of decentralization in service delivery. These similarities and differences make a comparative analysis both relevant and valuable, especially when contextualized within regional health goals and global frameworks. This paper discusses the healthcare delivery systems of Pakistan and Nepal using the World Health Organization (WHO) Health System Framework as an evaluative lens. The analysis focuses on core components such as health indicators, governance, financing, workforce, service delivery, technology, and information systems.

The purpose of this study is to identify comparative strengths and weaknesses in the health systems of both countries and to explore actionable strategies that could inform policy improvements in similar low- and middle-income country contexts. The central research question guiding this analysis is: How do the health care delivery systems of Pakistan and Nepal compare in terms of governance, resource allocation, service quality, and system efficiency within the WHO framework?

MATERIALS AND METHODS:

This study employed qualitative research design using document analysis as the primary method of data collection and interpretation. Document analysis is a recognized method in qualitative research that involves systematic evaluation of printed and electronic materials to gain understanding and generate insights (1). The approach followed the framework analysis method, as it allows comparison across predefined categories aligned with the World Health Organization Health System Framework.

Data were collected between January 2021 and December 2022 from publicly available secondary sources, including official reports from the Ministries of Health in Pakistan and Nepal, policy documents, national health surveys, international organization publications (such as WHO, UNICEF, and the World Bank), and relevant academic literature. The search strategy involved reviewing government health portals, international databases, and institutional libraries. Documents were included based on their relevance to health care delivery, governance, financing, human resources, service provision, and health indicators within both countries. Only documents published in English and accessible in full text were considered.

To enhance analytical rigor, the selected documents were reviewed and coded according to the six WHO building blocks for health systems: service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership/governance. Each document was read thoroughly, and key themes were extracted using a framework analysis approach to allow thematic comparison across both countries. Efforts were made to ensure reliability by cross-referencing data from multiple sources.

While every attempt was made to gather comprehensive and objective information, potential bias may arise due to the reliance on publicly available reports, which may reflect political or institutional priorities. Furthermore, discrepancies in the availability or currency of data between Pakistan and Nepal posed challenges to direct comparison. The study did not involve human participants, and all materials analyzed were in the public domain; therefore, formal ethical approval was not required. Nonetheless, ethical principles such as data integrity, proper citation, and responsible reporting of findings were strictly observed.

FINDINGS AND INTERPRETATION

Profile of Pakistan and Nepal:

The Islamic Republic of Pakistan is a developing country located in South Asia, sharing borders with India, Iran, Afghanistan, and China. According to the national census, the population stands at approximately 207,862,518, making it the fifth most populous country in the world (1). Pakistan possesses nuclear capabilities and maintains a mixed economy with significant regional disparities. Islam is the state religion, practiced by 95–97% of the population, while minorities include Hindus, Christians, and others making up the remaining 3–5% (2). Urdu is the official national language, though Punjabi is the most widely spoken language at 48%, followed by Sindhi at 12% (3). Politically, Pakistan operates under a parliamentary system, governed by both federal and provincial tiers. This dual structure influences health service delivery, especially following decentralization reforms such as the 18th constitutional amendment.

Nepal, officially known as the Federal Democratic Republic of Nepal, is a mountainous, landlocked country situated in the Himalayan region of South Asia. It borders China to the north and India to the south, east, and west. With a total area ranking 93rd globally, Nepal had an estimated population of 29,136,808 as per the 2019 census, positioning it as the 49th most populous country worldwide (4). Approximately 79% of the population resides in rural areas, which poses significant challenges for health service access and infrastructure development (5). Hinduism is the predominant religion, followed by 8% Buddhists, 4.4% Muslims, and other minority groups (6). The country's rich linguistic diversity includes Nepali and Maithili as the most spoken languages. Nepal also follows a parliamentary republic model with a multiparty system, and the adoption of federalism in recent years has restructured governance—including health system administration—across national, provincial, and local levels (7).

Health Care Delivery System of Pakistan and Nepal:

At the time of independence, Pakistan inherited its health care system (HCS) from British colonial governance. The structure, protocols, and policies were initially modeled on those of the British system (1). Over time, amendments were made to align health services with the population's evolving needs. Today, Pakistan operates a mixed health care system comprising public, private, philanthropic, donor-based, and military-run services (2). Traditional and religious healers also play a role in the informal health sector. The private and non-profit sectors serve a substantial portion of the population, often compensating for the limitations of the public system. Pakistan's health services are structured across three tiers—primary, secondary, and tertiary care—delivering services that include health promotion, disease prevention, treatment, and rehabilitation (3). Governance of the system is shared between federal and provincial governments, especially after the 18th constitutional amendment that decentralized health-related responsibilities to the provinces (4).

Similarly, Nepal has made notable strides over the past two decades in strengthening its health system. The country officially refers to its public health infrastructure as the Public Health System, which is managed centrally by the Ministry of Health (MoH). The MoH oversees policy formulation, health financing, strategic planning, and coordination, while actual service delivery is implemented through local governments and decentralized networks (5). Nepal's health care delivery is structured through regional, zonal, and district hospitals, with the federal government maintaining supervisory and regulatory authority. The public sector is complemented by private providers, donor agencies, and non-governmental organizations, all working collaboratively to enhance health outcomes (6). The focus of Nepal's HCS spans curative services, disease prevention, health promotion, and primary care, with primary health care centers serving as the backbone of service delivery (7).

While both countries maintain a pluralistic health system with multi-actor involvement, their structural governance models differ. Pakistan continues to grapple with coordination challenges between federal and provincial levels, while Nepal's federal system has recently restructured responsibilities to better align national policy with local implementation. Despite resource limitations, both countries strive to deliver essential health services, with varying degrees of success in access, quality, and system efficiency.

Key Health Issues and Indicators

Health indicators serve as essential tools to evaluate the performance and effectiveness of a country's health care system. Over the past two decades, Pakistan has faced numerous challenges including political instability, economic crises, natural disasters, and limited fiscal space. Despite these constraints, the country has achieved modest improvements in several health indicators, such as a gradual reduction in mortality rates (1). However, the unequal distribution of health resources—particularly in rural and underserved areas—remains a pressing concern. Provinces like Balochistan and Sindh report disproportionately high infant mortality rates, primarily due to malnutrition, diarrheal diseases, and respiratory infections such as pneumonia (2). Additionally, inadequate healthcare infrastructure and workforce shortages continue to strain service delivery and exacerbate health disparities (3).

Nepal, though economically constrained and geographically challenged, has demonstrated commendable progress in health outcomes over the last decade. Health policy reforms and donor-supported initiatives have contributed to declining population growth and crude death rates compared to earlier benchmarks (4). The government has implemented targeted interventions in maternal and child health, communicable disease control, and primary health care delivery, leading to improved national statistics despite financial and logistical hurdles (5). Nevertheless, significant gaps remain in service accessibility, especially in rural and mountainous regions, where transportation and infrastructure pose substantial barriers (6).

A comparative evaluation of key health indicators between Pakistan and Nepal reveals both progress and persistent challenges. While Nepal outperforms Pakistan in areas such as life expectancy and infant mortality, Pakistan reports a lower maternal mortality rate. Immunization coverage remains inconsistent in both countries and lacks uniform documentation. Table I summarizes selected indicators for both nations, highlighting contrasts in demographic and health outcomes (7). These statistics underscore the need for continued investment in primary care, equitable resource allocation, and targeted interventions in both countries to address system inefficiencies and unmet health needs.

Table I. Comparison of Key Health Indicators of Pakistan and Nepal

S. No.	Indicator	Pakistan	Year	Nepal	Year
1	Annual Population Growth Rate	2.05%	2018	1.7%	2018
2	Crude Birth Rate (per 1,000)	28.6	2017	20.2	2017
3	Fertility Rate (births/woman)	3.48	2016	2.12	2016
4	Maternal Mortality Rate (per 100,000)	178	2018	239	2016
5	Infant Mortality Rate (per 1,000)	56	2019	32.2	2018
6	Crude Death Rate (per 1,000)	7.5	2019	6.4	2017
7	Life Expectancy (years)	67.8	2019	70.6	2018
8	Immunization Coverage (%)	65%	2017	—	—

Sources: Nishtar et al. (2019); Nepal Fact Sheet (2019); World Health Statistics (2018)

Goals and Expectations of Both Countries' Health Care Systems

Health goals represent the intended outcomes that health systems or institutions aim to achieve within a specific timeframe (1). Since its independence, Pakistan has outlined several national health objectives, including tuberculosis (TB) control programs, immunization campaigns, and the strengthening of primary health care (2). While some progress has been made over the years, many planned goals have not been fully realized. For example, Pakistan aimed to achieve the Millennium Development Goals (MDGs) by 2015, but it fell short of meeting these targets, as well as those outlined in the Alma-Ata "Health for All" declaration, largely due to weak strategic vision, underdeveloped policies, and resource limitations (3). At present, Pakistan is working toward achieving the Sustainable Development Goals (SDGs) by 2030, guided by the National Health Vision 2025, which emphasizes universal health coverage and system-wide reforms. Similarly, Nepal has established health goals aimed at improving the overall well-being of its population. However, political instability, limited financial resources, and fragmented policy implementation have impeded progress (4). Like Pakistan, Nepal was unable to achieve the MDGs or fully implement the Health for All declaration (5). Nevertheless, the country has succeeded in eradicating several communicable diseases such as poliomyelitis, marking important progress. Nepal's current health strategy primarily focuses on curative services, with relatively less emphasis on preventive and promotive health care (6). In response to the shift toward federalism, the government has recently introduced reforms centered around public-private partnerships and the enhancement of primary care service delivery at the local level (7).

Leadership and Governance

Leadership and governance are critical components of any health system, as they define policy direction, resource allocation, and institutional accountability (8). Historically, Pakistan's health sector was centrally governed by the federal government. However, following the 18th constitutional amendment, a significant shift occurred, leading to the

devolution of health-related responsibilities to provincial governments (3). Currently, provinces are responsible for the operational delivery of health services, while the federal Ministry of Health retains authority over strategic planning, policy development, regulation, and international coordination. A major governance challenge in Pakistan is the lack of alignment between international non-governmental organizations (NGOs) and federal policies, as many NGOs operate independently with limited coordination (9).

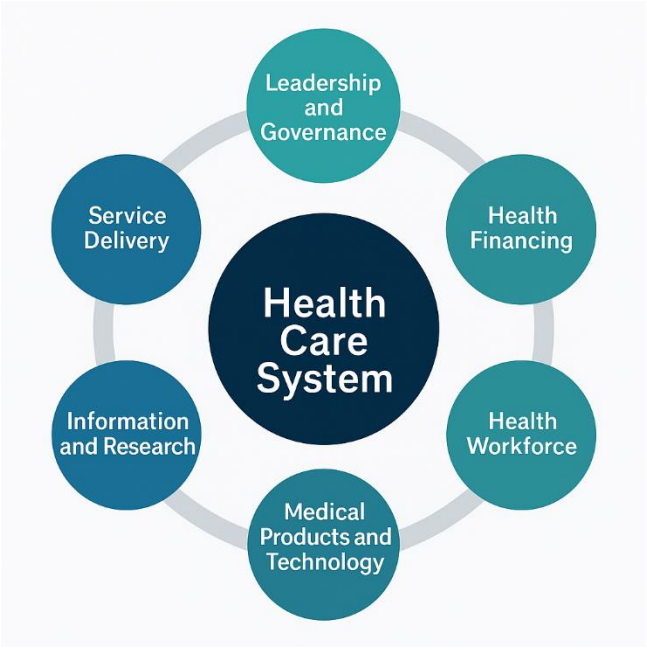

Figure 1 World Health Organization (WHO) Health System Framework

In contrast, Nepal's governance model underwent a transformation with the promulgation of its 2015 constitution, which introduced a federal system with more centralized authority over health policy and financing (10). Under this structure, the federal government holds the power to develop national health policies, enact regulations, allocate budgets, and oversee the development of public sector hospitals (11). Health resources are distributed to provincial and local governments, which are responsible for service implementation. The shift to federalism has introduced both opportunities and challenges, requiring stronger intergovernmental coordination and capacity-building to ensure equitable service delivery across all regions.

Leadership and Governance

The provision of health services and ensuring the well-being of the population is a fundamental responsibility of the state (1). Historically, Pakistan's health sector operated under the centralized authority of the federal government. However, this structure shifted following the 18th Constitutional Amendment, which decentralized health governance and delegated significant responsibilities to provincial governments (2). Currently, provincial governments are primarily responsible for the delivery of health services, while the federal Ministry of Health retains authority over strategic planning, policymaking, regulation, and coordination with international agencies. A critical challenge in this governance model is the limited coordination between the federal government and international NGOs, many of which operate independently, following their own protocols and priorities (3). This disconnect hampers uniformity in service delivery and undermines national health strategies.

In contrast, Nepal's leadership and governance framework is structured differently. With the adoption of the 2015 Constitution, Nepal introduced a federal system that restructured the health sector governance framework. The federal government now plays a central role in developing health policies, allocating financial resources, enacting laws, and overseeing the establishment of public sector health facilities (4). While health services are implemented through provincial and local governments, the federal Ministry of Health maintains supervisory authority, ensuring vertical coordination across the system (5). This centralized approach under federalism aims to streamline decision-making and improve the equitable distribution of resources across the country.

Health Financing

Health financing refers to the mechanisms through which resources are generated, distributed, and utilized within a health system. An effective health financing system ensures that necessary health services are accessible without imposing financial hardship on the population (6). In Pakistan, the lack of adequate financial investment in health care has remained a persistent issue. According to the National Health Accounts for 2019–2020, Pakistan allocated less than 1% of its gross domestic product (GDP) to health expenditure—far below international recommendations (7). The primary sources of health financing in the country are out-of-pocket payments and taxation. While taxation accounts for less than 20% of total health expenditure, out-of-pocket spending comprises approximately 78%, placing a heavy financial burden on individuals and families (8).

Despite government claims of enhancing health funding, progress has been limited. For example, joint health financing from provincial and federal governments increased to 203.74 million PKR, reflecting only a 3.29% rise from the previous year (9). Although national and international donor agencies contribute to various health programs—such as those targeting polio and HIV/AIDS—most of this funding is project-specific rather than system-wide. Key donors include the Asian Development Bank, World Bank, HANDS, Aga Khan Foundation, United Nations Development Assistance Framework (UNDAF), Shifa Foundation, and the World Health Organization (10). However, concerns remain about the efficiency and transparency of resource utilization, and whether these funds translate into sustainable improvements in health outcomes.

In Nepal, health financing is derived from a combination of government taxation, international aid, non-governmental organizations, philanthropic donations, and out-of-pocket payments (11). Over the past several years, Nepal has significantly increased its health budget and currently allocates approximately 6.3% of its GDP to the sector (12). The health budget for 2019–2020 amounted to 56,118.80 billion Nepali rupees, with a major portion allocated to essential services such as education and curative public health programs (13). Major foreign aid contributors include International Financial

Institutions (IFIs), UNICEF, the Organization for Economic Co-operation and Development (OECD), USAID, and various global vertical funds (14). While many donors integrate their funds within the national system, others operate independently through direct programmatic support, which can create parallel structures and inefficiencies. Despite these financial inflows, Nepal still struggles to meet the health needs of its population. Limited resources and logistical challenges, especially in rural and mountainous areas, drive many individuals to seek care from private providers, increasing their out-of-pocket expenditures (15).

In summary, although Nepal allocates a larger percentage of its GDP to health than Pakistan, Pakistan has access to more diversified funding sources, including a wider network of national and international donors. However, both countries face significant challenges in ensuring efficient, equitable, and transparent utilization of these financial resources.

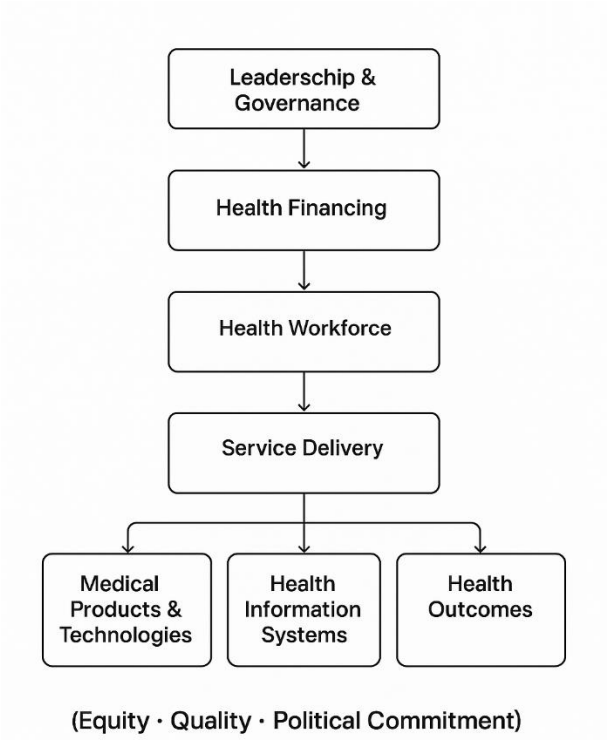

Figure 2 Thematic Overview

Health Workforce

The health workforce comprises a wide range of professionals including doctors, nurses, midwives, paramedical staff, traditional healers, and other personnel who contribute to health care service delivery. It is a foundational pillar of any health system and plays a critical role in ensuring timely and effective care (1). Despite being the fifth most populous country in the world, Pakistan faces a significant shortage of health professionals. Although various cadres of health providers are active across sectors, their numbers remain insufficient to meet the growing needs of the population (2). Current estimates suggest that one lady health worker is responsible for approximately 20,000 individuals, one doctor for every 1,300 people, and the nurse-to-patient ratio stands at 1:20 (3). These workforce limitations compromise the quality and accessibility of care, contributing to increased disease burden, lower patient satisfaction, and overall inefficiency in service provision (4).

Nepal experiences similar challenges in maintaining an adequate and equitably distributed health workforce. Although improvements have been made in recent years, such as better regional deployment, access to qualified health professionals continues to be a constraint that affects overall system performance (5). As of recent data, the doctor-to-patient ratio is approximately 1:1,724, and the nurse-to-patient ratio is 1:2,000 (6). Key concerns in Nepal include the disproportionate urban-rural distribution of staff, limited opportunities for professional training, low remuneration, and difficulty in attracting professionals to remote postings (7). Both Pakistan and Nepal need to prioritize strategic workforce planning and investment in training, recruitment, and retention to strengthen their health systems effectively.

Medical Products and Technology

The proper functioning of a health care system depends significantly on the availability of modern medical products, equipment, medications, and vaccines. These elements are essential for ensuring standardized, safe, and effective treatment across preventive, curative, and rehabilitative services (8). In Pakistan, approximately one-third of the national health budget is spent on medications and medical equipment (9). However, despite this allocation, many healthcare facilities—especially in rural areas—lack adequate diagnostic tools, essential drugs, and functioning medical technologies (10). The pharmaceutical industry plays a vital role in supplying over 80% of the country's medicine needs, with the remaining less than 20% met through imports (11). Pakistan currently hosts around 530 pharmaceutical companies, including 38 multinational firms, all regulated by the Drug Regulatory Authority of Pakistan (12). Despite this infrastructure, many existing drug policies remain outdated, highlighting the urgent need for regulatory revisions and updates (13).

While Pakistan's urban centers benefit from some advancements in medical technology and specialized services, access remains limited in peripheral areas. High-end treatments such as advanced surgeries and organ transplants are mostly restricted to private institutions, making them inaccessible to lower-income populations (14).

In contrast, Nepal's medical product and pharmaceutical sectors are less developed. The country's first drug policy was introduced in 1995 and later revised in 2007 (15). The Medicine Regulatory Authority (MRA), operating under the Ministry of Health, is tasked with ensuring drug quality, safety, registration, and supply to health facilities (16). Most pharmaceutical companies are concentrated in Kathmandu, leading to distribution challenges in other regions (17). Nepal also faces critical shortages of medical supplies, essential drugs, and equipment, especially in remote areas. The country continues to struggle with ensuring equitable access to technology and modern diagnostics, due in part to its challenging terrain and limited financial resources (18).

Information and Research

Health Information and Management Systems (HIMS) are essential for collecting, managing, and analyzing health data, which supports policy-making, resource planning, and outcome evaluation. An effective HIMS can bridge fragmentation in health systems and improve service delivery quality (19). Pakistan introduced HIMS in 1991 with support from USAID. However, due to decentralization following the 18th Constitutional Amendment and limited institutional capacity, the system failed to achieve full implementation and sustainability (20). The public health system in Pakistan currently lacks a comprehensive HIMS framework, and there are no well-defined national policies for telemedicine or health-related research and innovation (21). Only a few private healthcare institutions offer HIMS and telemedicine facilities. Some efforts—such as pilot e-health initiatives in Gilgit-Baltistan—have been launched in collaboration with international partners, but progress remains slow and fragmented (22). Furthermore, Pakistan contributes minimally to global health research, with limited emphasis on evidence-based practice and clinical trials (4).

In comparison, Nepal implemented its HIMS in 1995–1996 to strengthen data collection, disease surveillance, and health planning. The system operates across both public and private healthcare sectors and facilitates the flow of information from community health units to central databases (23). HIMS has helped standardize monitoring and evaluation processes within the Nepalese health sector. However, comprehensive and timely data reporting remains a challenge (24). Research infrastructure in Nepal is also underdeveloped, with few opportunities for clinical or operational research. There is a clear need for greater investment in research capacity-building, training, and infrastructure to support data-driven policy decisions (25).

Health System Organizations and Service Delivery

Pakistan's health care system (HCS) is organized into multiple tiers, providing services through both horizontal and vertical delivery structures. The public sector includes a network of facilities ranging from primary to tertiary levels. Primary care is delivered through Government Dispensaries (GDs), Basic Health Units (BHUs), and Rural Health Centers (RHCs), primarily located in villages and small towns. Secondary care is managed by Taluka Headquarters (THQs), while tertiary care is offered at District Headquarters (DHQs) (1). These public hospitals deliver highly subsidized services; however, the quality of care remains inconsistent and often substandard due to resource constraints (2). Despite a structured framework, health delivery in Pakistan is far from meeting modern standards. Contributing factors include an underfunded health budget—less than 1% of GDP—increasing population pressures, and limited availability of essential resources (3). The private sector, while offering higher quality services, remains unaffordable for a large segment of the population. Notably, private hospitals provide care to nearly 70% of the population, underscoring their critical—but inequitable—role in the system.

In contrast, Nepal's health care infrastructure was historically underdeveloped due to its mountainous geography and limited investment. As a result, the population often relied on traditional healers for health services. However, over the past two decades, substantial progress has been made in expanding service delivery (4). The health system now includes a range of facilities such as Primary Health Care Centers (PHCCs), Sub-Health Posts, Health Posts, Regional Hospitals, and Zonal Hospitals (5). PHCCs serve as the backbone of Nepal's public health care delivery system. At present, both public and private facilities are functioning across the country, offering services from primary to tertiary care, including specialized maternal and child health services (6). Nonetheless, persistent issues such as inconsistent quality of care, limited infrastructure, and shortages of medical personnel continue to hinder progress. As in Pakistan, Nepal's public health services remain compromised, despite a growing institutional framework and increasing policy attention.

Challenges Faced by Pakistan and Nepal Health Care Systems

Both Pakistan and Nepal face numerous systemic challenges that obstruct the delivery of equitable, quality health care. In Pakistan, the extensive network of health institutions has not translated into a high-performing health system. Critical issues include an inadequate health workforce, insufficient financial resources, weak governance structures, and political interference (7).

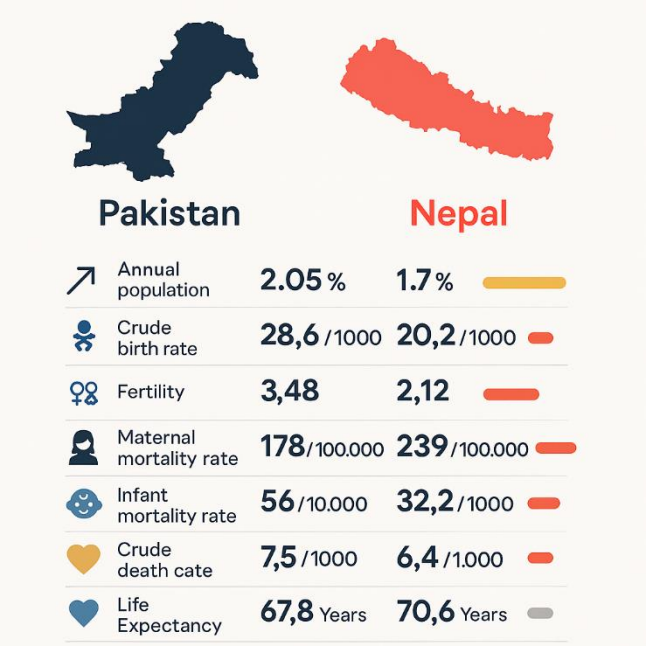

Figure 3 Comparative Presentation of the health care systems of Pakistan and Nepal

The allocation of less than 1% of GDP to health remains a significant barrier to sustainable improvement. The decentralization brought by the 18th Constitutional Amendment has also introduced coordination challenges between federal and provincial authorities. Additional problems such as corruption, brain drain of skilled professionals, and inefficient fund utilization further impede progress. Pakistan's failure to implement a nationwide Health Information and Management System (HIMS) has led to poor documentation, limited data for decision-making, and inadequate monitoring mechanisms. The absence of long-term, visionary health policies continues to delay meaningful reforms. Nepal, too, struggles with several challenges, the most prominent being a shortage of qualified health personnel and uneven distribution of existing resources. Despite improvements in health indicators, the health system

remains heavily curative in focus, neglecting preventive and promotive health strategies (4). This emphasis increases long-term financial strain on an already under-resourced system. Additional concerns include poor remuneration, lack of training opportunities, and limited career progression for health professionals, particularly those working in rural or hard-to-reach areas (8). A suboptimal work environment and major disparities in service accessibility contribute to dissatisfaction among healthcare workers and result in diminished care quality. Moreover, the country's research and data infrastructure is underdeveloped, limiting its capacity to evaluate performance and respond to emerging health needs.

RECOMMENDATIONS

- Based on the comparative evaluation of the Pakistani and Nepalese health systems, the following strategies are recommended to strengthen their respective frameworks:
- Increase health budget allocations to at least meet basic health system needs, and develop supplementary budgeting for emergencies, health insurance, and disaster preparedness.
- Ensure equitable distribution of resources and workforce by implementing merit-based and need-sensitive allocation strategies across both urban and rural regions.
- Revise and restructure health policies to reflect current health challenges, and ensure active collaboration between government bodies and stakeholders during policy development.
- Modernize health education and training programs, revising curricula to reflect emerging health technologies and disease patterns, while promoting continuing education and research opportunities.
- Implement robust and transparent HIMS and e-health platforms to address fragmentation, support real-time data collection, and strengthen monitoring and evaluation.
- Establish an independent Quality Assurance body responsible for auditing service standards in both public and private healthcare facilities.
- Geographic and socioeconomic contexts (1). Developed nations such as Sweden,

CONCLUSION

In conclusion, this comparative analysis highlights the structural, financial, and operational challenges faced by the health care systems of Pakistan and Nepal. While both countries have made commendable progress in certain areas, they continue to struggle with compromised service delivery, inadequate resource allocation, and limited system sustainability. Reforms introduced in recent years signal a growing political will to improve health outcomes, but implementation remains inconsistent. Moving forward, strategic planning, equitable resource distribution, increased investment, and intersectoral collaboration are essential to bridge existing gaps and build resilient, inclusive health care systems. Addressing these challenges holistically will be key to improving health equity and achieving long-term national and global health goals.

REFERENCES

1. Garha M. Health Care in Nepal: An Observational Perspective. J Nurs Educ Pract. 2017;7(1):1â€“6.
2. Meghani ST, Sehar S, Punjani NS. Comparison and Analysis of Health Care Delivery System: Pakistan Versus China. Int J Endorsing Health Sci Res. 2014;2(1):46â€“50.
3. Medcalf AJ, Bhattacharya S, Momen H, Saavedra MA, Jones M. Health for All: The Journey to Universal Health Coverage. Hyderabad: Orient Blackswan; 2015.
4. Khan MU, Khan AN, Ahmed FR, Feroz Z, Rizvi SA, Shah S, et al. Patients' Opinion of Pharmacists and Their Roles in Health Care System in Pakistan. J Young Pharm. 2013;5(3):90â€“4.
5. Nizar H, Chagani P. Analysis of Health Care Delivery System in Pakistan and Singapore. Int J Nurs Educ. 2016;8(2):21â€“6.
6. Ather F, Sherin A. Health System Financing in Pakistan: Reviewing Resources and Opportunities. Khyber Med Univ J. 2014;6(2):53â€“5.
7. Magar A, Subba K. Strengthening District Health Care System Through Partnership With Academic Institutions: The Social Accountability of Medical Colleges in Nepal. J Nepal Med Assoc. 2012;52(187):1â€“6.
8. Naseem A, Rashid A, Kureshi NI. E-Health: Effect on Health System Efficiency of Pakistan. Ann Saudi Med. 2014;34(1):59â€“64.
9. Belay T, Tandon A. Assessing Fiscal Space for Health in Nepal. Washington, DC: World Bank; 2015.
10. Boulware LE, Cooper LA, Ratner LE, LaVeist TA, Powe NR. Race and Trust in the Health Care System. Public Health Rep. 2016;131(5):586â€“92.
11. Harris D, Wales J, Jones H, Rana T, Chitrakar R. Human Resources for Health in Nepal: The Politics of Access in Remote Areas. London: Overseas Development Institute; 2013.
12. Hafeez A, Khan Z, Bile KM, Jooma R, Sheikh M. Pakistan Human Resources for Health Assessment, 2009. East Mediterr Health J. 2010;16(Suppl):S145â€“51.
13. Kurji Z, Premani ZS, Mithani Y. Analysis of the Health Care System of Pakistan: Lessons Learnt and Way Forward. J Ayub Med Coll Abbottabad. 2016;28(3):601â€“6.
14. Ministry of Health, Nepal; New ERA; ICF. Nepal Demographic and Health Survey 2016: Key Indicators. Kathmandu, Nepal: Ministry of Health; 2017.
15. Mishra SR, Khanal P, Karki DK, Kallestrup P, Enemark U. National Health Insurance Policy in Nepal: Challenges for Implementation. Glob Health Action. 2015;8(1):28763.

16. Karkee R, Kadariya J. Choice of Health-Care Facility After Introduction of Free Essential Health Services in Nepal. WHO South-East Asia J Public Health. 2013;2(2):96â€“100.

17. Aslam L, Abdullah A, Ayub R. Analysis of Pakistan and Iran Health Care Delivery System. Int J Innov Res Dev. 2014;3(7):308â€“12.

18. Kumal AB, Mahato RK, Gupta RP, Ghimire J. Human Resource for Health Production Capacity in Nepal: A Glance. J Nepal Health Res Counc. 2019;17(1):126â€“8.

19. Mossialos E, Wenzl M, Osborn R, Sarnak D. 2015 International Profiles of Health Care Systems. Ottawa: Canadian Agency for Drugs and Technologies in Health; 2016.

20. Punjani NS, Shams S, Bhanji SM. Analysis of Health Care Delivery Systems: Pakistan Versus United States. Int J Endorsing Health Sci Res. 2014;2(1):38â€“41.

21. Qarani WM, Kanji SI. Health System Analysis: Pakistan and Afghanistan. Int J Endorsing Health Sci Res. 2015;3(3):6â€“11.