HEALTH SYSTEMS

A Comparative Analysis of Pakistan and Vietnam

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1. INTRODUCTION TO HEALTH SYSTEMS

A health system consists of all organizations, institutions, resources, and people whose primary purpose is to improve health. According to the World Health Organization (WHO), a well-functioning health system requires six building blocks: service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership/governance. This assignment presents a comprehensive comparative analysis of the health systems of Pakistan and Vietnam—two developing Asian nations with different approaches to healthcare delivery, financing, and universal health coverage (UHC).

Both countries face similar challenges including limited resources, rural-urban disparities, and the double burden of communicable and non-communicable diseases. However, Vietnam has made remarkable progress toward UHC through its Social Health Insurance (SHI) system, while Pakistan continues to grapple with fragmented service delivery and low public health spending. Understanding these systems provides valuable insights for public health professionals and policymakers.

2. HEALTH SYSTEM OF PAKISTAN

2.1 Overview and Historical Background

Pakistan's health system is a complex mixed system comprising federal government infrastructure, provincial governments, parastatal organizations, private sector, civil society, and philanthropic contributors. Following the 18th Constitutional Amendment in 2010, health became primarily a provincial responsibility, except in federally administered areas.

The system has evolved from a centrally managed structure to a decentralized provincial system. Healthcare delivery has traditionally been jointly administered by federal and provincial governments, with districts mainly responsible for implementation. The National Health Vision 2016-2025 provides the strategic framework for health sector development in Pakistan.

2.2 Organizational Structure

The health system in Pakistan operates through multiple parallel systems:

- Federal Government: Ministry of National Health Services, Regulations & Coordination (NHSR&C) oversees national health policy, regulation, and coordination. It also manages health services in federal territories (ICT, GB, AJK).
- Provincial Governments: Four provinces (Punjab, Sindh, KPK, Balochistan) have their own Departments of Health responsible for service delivery, regulation of private providers, and implementation of health programs.
- Parastatal Organizations: Armed Forces, WAPDA, Railways, Sui Gas, Fauji Foundation, and Employees Social Security Institutions provide health services to employees and dependents, covering approximately 10% of the population.
- Private Sector: Includes qualified practitioners (doctors, nurses, pharmacists) as well as traditional healers (hakims, homeopaths), drug vendors, and unqualified practitioners. About 67.4% of households consult private providers for health problems.
- NGOs and Philanthropic Sector: Includes organizations like Edhi, Shaukat Khanum, and various international NGOs providing complementary health services especially in underserved areas.

2.3 Three-Tier Healthcare Delivery System

Pakistan's public healthcare delivery follows a three-tiered structure:

TIER	FACILITIES	POPULATION SERVED
PRIMARY	Basic Health Units (BHUs) Rural Health Centers (RHCs) Maternal & Child Health Centers (MCHCs) Dispensaries	10,000 – 25,000

SECONDARY	Tehsil Headquarters Hospitals (THQs) District Headquarters Hospitals (DHQs) Private clinics/hospitals	50,000 – 1 Million
TERTIARY	Teaching Hospitals Specialized Hospitals Large Urban Private Hospitals	1 – 2 Million+

Primary care services are supported by a network of approximately 5,000 Basic Health Units, 600 Rural Health Clinics, and 7,500 other first-level care facilities. Secondary care includes 989 hospitals at district and tehsil levels. Preventive and promotive services are delivered through national programs and community health workers, particularly the 100,000 Lady Health Workers (LHWs) who provide outreach services at the community level.

2.4 Health Financing and Expenditure

Pakistan's health financing is characterized by low public spending and high out-of-pocket (OOP) payments:

- Total Health Expenditure: Only 1.4% of GDP is spent on health (2021), which is among the lowest in the South Asian region.
- Per Capita Health Spending: Approximately $28-30 USD per capita annually.
- Public vs Private: Government spending constitutes about 27% of total health expenditure, while 73% comes from private sources, primarily out-of-pocket payments by households.
- Coverage: Only 27% of the population enjoys full healthcare coverage; the majority depends on OOP payments.
- Social Protection: Limited social health protection mechanisms exist. The Sehat Sahulat Program (now Sehat Card) provides cashless treatment for vulnerable families in some provinces, but coverage remains limited.

2.5 Health Workforce

Pakistan faces significant challenges in health workforce distribution and capacity:

- Imbalance in skill mix and geographic distribution—insufficient managers, nurses, paramedics, and skilled birth attendants in peripheral areas.
- Urban-rural disparities with concentration of specialists in major cities (Karachi, Lahore, Islamabad).
- Approximately 100,000 Lady Health Workers (LHWs) and growing numbers of Community Midwives (CMWs) provide community-based care.
- Quality of medical and allied education in both public and private sectors needs improvement.

- Brain drain of qualified medical professionals to Gulf countries, Europe, and North America.

2.6 Major Health Programs

Key national health programs in Pakistan include:

- Expanded Program on Immunization (EPI)
- National Tuberculosis Control Program (NTP)
- HIV/AIDS Control Program
- Malaria Control Program
- Lady Health Worker Program (LHW)
- National Maternal, Neonatal and Child Health (MNCH) Program
- Sehat Sahulat Program (Health Insurance for poor families)
- Prime Minister's National Health Program

2.7 Challenges and Opportunities

Key Challenges:

- Low public health spending (1.4% of GDP)
- High out-of-pocket expenditure (73% of total health spending)
- Fragmented and vertical service delivery structures
- Urban-rural disparities in access and quality
- Unregulated private sector with quality and pricing issues
- Inadequate health workforce in rural areas
- Weak health information systems
- Double burden of disease (communicable + non-communicable)

Opportunities:

- Decentralization allowing provinces to tailor health programs
- Strong community health worker network (LHWs)
- Growing private sector potential for public-private partnerships
- Digital health initiatives and telemedicine expansion
- Youth bulge providing demographic dividend for health workforce

3. HEALTH SYSTEM OF VIETNAM

3.1 Overview and Historical Background

Vietnam has transformed from one of the world's poorest countries to a lower-middle-income economy, with corresponding improvements in health outcomes. The 1986 Doi Moi ("Renovation") reforms shifted Vietnam from a command economy to market economics, enabling rapid economic growth and health system development.

Vietnam's 1992 Constitution established the right to healthcare for all citizens. The country has made remarkable progress toward Universal Health Coverage (UHC), with over 93% of the population covered by Social Health Insurance (SHI) as of 2023. Life expectancy has risen from 69 years (1990) to 75 years (2020), and under-five mortality decreased from 30 to 21 per 1,000 live births.

3.2 Organizational Structure

Vietnam's health system is centrally coordinated with decentralized implementation:

- Ministry of Health (MOH): Central authority responsible for health policy, regulation, and oversight of national and specialist hospitals.
- Provincial Health Departments: Manage provincial hospitals and coordinate district-level services under Provincial People's Committees.
- District Health Centers: Manage district hospitals and oversee commune health stations.
- Commune Health Stations: Primary care facilities serving as the first point of contact, staffed by village health workers.
- Vietnam Social Security (VSS): Government agency implementing SHI, overseeing funds, collecting premiums, and contracting with providers.

3.3 Tiered Healthcare Delivery System

Vietnam's public healthcare system is divided into four levels:

LEVEL	FACILITIES & SERVICES	FUNCTION
COMMUNE (Primary)	Commune Health Stations Village Health Workers	First contact, general practice, vaccinations, maternity care, basic mental health, health education
DISTRICT (Secondary)	District Hospitals	Inpatient/outpatient care, diagnostics, less complex conditions, emergency care
PROVINCIAL (Secondary+)	Provincial Hospitals	Specialized treatments, advanced diagnostics, referral from district level
CENTRAL	National & Specialist	Complex surgeries, advanced

(Tertiary)	Hospitals (MOH managed)	diagnostics, rare/severe diseases, teaching & research

Note: Around 73% of total health spending occurs in hospitals, indicating a hospital-centric system. Patients often bypass primary care to seek treatment at central or provincial hospitals due to quality concerns, leading to overcrowding at higher levels.

3.4 Social Health Insurance (SHI) System

Vietnam's SHI is the cornerstone of its health financing strategy and UHC achievement:

- Coverage: 93.4% of population covered by SHI (2023), up from 58% in 2009.
- Enrollment Groups:
  • Compulsory SHI: Civil servants, employees (>3 months), pensioners, people with disabilities, veterans
  • Voluntary SHI: Self-employed, informal workers, students
  • Fully subsidized: Poor, ethnic minorities in disadvantaged areas, children under 6, elderly over 80, near-poor households
- Benefit Package: Covers preventive care, primary care, essential medicines, maternity care, rehabilitative care, inpatient and outpatient care. More than 17,000 services and 1,530 drugs are covered.
- Co-payment: Typically 80% coverage for most enrollees (20% co-pay). Pensioners and near-poor receive 95% coverage. Poor, children under 6, and merit people are exempt from co-payment.
- Referral System: Patients bypassing referral face reduced reimbursement (40-70% reduction depending on level).
- New Initiative (2026): Free annual health checks/screenings for all citizens starting January 2026, requiring approximately $227 million USD annually for priority groups.

3.5 Health Financing and Expenditure

Vietnam's health financing has evolved significantly:

- Health Spending: 4.6% of GDP (relatively high for a lower-middle-income country).
- Out-of-Pocket: Approximately 39.6% of total health expenditure (2020)—still high but declining. World average is 16.32%.
- Government Share: About 40% of total health spending comes from government sources.
- SHI Revenue: Funded by employer contributions (3% of payroll), employee contributions (1.5% of salary), and government subsidies for vulnerable groups.
- External Aid: Small proportion of total spending but major source for HIV/AIDS, TB, and malaria programs. The Global Fund pledged $130 million for 2024-2026.

- Hospital Autonomy: Public hospitals manage their own operating costs and revenues, including user fees and insurance payments.

3.6 Health Workforce

Vietnam's health workforce has expanded but faces distribution challenges:

- Strong primary care network with commune health stations in nearly all communes.
- Village health workers maintain strong community connections and trust.
- Concentration of high-quality medical staff in Hanoi and Ho Chi Minh City.
- Northern Midlands, Mountains, and Central Highlands face staffing shortages.
- Need for retraining primary care providers to handle NCDs and aging population (previously focused on infectious diseases).
- Hospital autonomy policy creates profit-driven competition with primary care centers.

3.7 Major Health Achievements

Vietnam has achieved significant public health milestones:

- Near-elimination of malaria (last barrier: remote areas and ethnic minorities)
- Impressive progress in HIV/AIDS control—one of Asia's fastest declining epidemics
- Significant reduction in tuberculosis incidence
- High immunization coverage rates
- Strong COVID-19 response attributed to health system capacity and community-based surveillance
- Life expectancy increased from 69 to 75 years (1990-2020)
- Maternal mortality reduced, though disparities persist among ethnic minorities

3.8 Challenges and Future Directions

Key Challenges:

- Hospital-centric system with 73% of spending in hospitals
- High out-of-pocket expenditure (39.6%) causing financial burden
- Overcrowding at central/provincial hospitals due to bypassing primary care
- Quality disparities between urban and rural facilities
- Rising non-communicable diseases (NCDs) and aging population
- Climate change vulnerability affecting health (6th most vulnerable country)
- SHI fund sustainability concerns due to rising medical costs
- Inequities for ethnic minorities and remote populations (maternal mortality up to 150/100,000 in some groups)

Future Directions (Resolution 72, 2026 onwards):

- Free annual health screenings for all citizens
- 100% insurance coverage for near-poor households and citizens aged 75+
- Piloting supplementary health packages
- Improving health worker allowances in difficult areas
- Expanding telemedicine and electronic health records
- Strengthening primary health care and referral systems
- Evidence-based benefit package revision

4. COMPARATIVE ANALYSIS: PAKISTAN VS VIETNAM

This section provides a side-by-side comparison of key health system indicators and features, useful for viva presentation and quick reference.

4.1 Structure Comparison

FEATURE	PAKISTAN	VIETNAM
Governance	Decentralized (provincial) with federal coordination	Centralized MOH with decentralized implementation
Levels of Care	3-tier (Primary, Secondary, Tertiary)	4-tier (Commune, District, Provincial, Central)
Primary Care	BHUs, RHCs, LHWs (outreach model)	Commune Health Stations + Village Health Workers
Private Sector	Dominant (67% utilization), largely unregulated	Growing but public sector remains dominant
Community Workers	100,000 Lady Health Workers	Village Health Workers in all communes

4.2 Financing Comparison

FEATURE	PAKISTAN	VIETNAM
Health Spending (% GDP)	1.4%	4.6%
Per Capita Spending	~$28-30 USD	Higher (lower-middle-income standard)
Public Share	~27%	~40%
Out-of-Pocket	~73%	~39.6%
Insurance Coverage	~27% (limited)	93.4% (SHI)
Main Financing	OOP + Limited Govt	Social Health Insurance + Govt + OOP

4.3 Coverage and Access Comparison

Pakistan:

- Only 27% have full healthcare coverage
- 73% depend on out-of-pocket payments
- Sehat Card provides limited protection for poor families
- Strong urban-rural disparity
- No comprehensive national health insurance (fragmented schemes)

Vietnam:

- 93.4% population covered by SHI (2023)

- Universal coverage target by 2030
- Generous benefit package (17,000+ services, 1,530 drugs)
- Pro-poor design with full subsidies for vulnerable groups
- Referral system to control costs and guide patient flow

4.4 Health Outcomes Comparison

INDICATOR	PAKISTAN	VIETNAM
Life Expectancy	~67-68 years	~75 years (2020)
U5 Mortality	Higher	21/1,000 live births
Maternal Mortality	Higher (140/100,000 est.)	Lower (but 150/100,000 in some ethnic groups)
Immunization	Moderate coverage	High coverage
NCD Burden	Rising rapidly	Major and rising concern

4.5 Key Lessons for Each Country

Lessons Pakistan can learn from Vietnam:

- Establish a comprehensive national health insurance scheme (like SHI) with mandatory enrollment for formal sector
- Increase public health spending from 1.4% to at least 3-4% of GDP
- Implement pro-poor financing with government subsidies for vulnerable populations
- Create a unified benefit package rather than fragmented vertical programs
- Strengthen regulatory framework for private sector quality and pricing
- Invest in primary health care as the foundation of UHC
- Develop electronic health records and telemedicine infrastructure

Lessons Vietnam can learn from Pakistan:

- Pakistan's Lady Health Worker program demonstrates effective community-based outreach model
- Decentralization allows provincial adaptation to local needs (though Vietnam's central coordination has merits too)
- Pakistan's experience with public-private partnerships in tertiary care (e.g., Shaukat Khanum)
- NGO sector engagement provides complementary services in underserved areas

5. CONCLUSION

Both Pakistan and Vietnam are developing Asian nations striving to achieve Universal Health Coverage, but they have taken markedly different paths. Pakistan's health system is characterized by low public spending, high out-of-pocket payments, fragmented service delivery, and a dominant but unregulated private sector. Despite these challenges, Pakistan has strengths in its community health worker program (Lady Health Workers) and a growing recognition of the need for health insurance expansion.

Vietnam, on the other hand, has made impressive strides through its Social Health Insurance system, achieving 93.4% coverage with a generous, equitable benefit package. Its pro-poor design, strong political commitment, and incremental expansion strategy offer valuable lessons for countries with limited resources. However, Vietnam still faces challenges including high out-of-pocket spending, hospital-centric care, and regional inequities.

For public health professionals like Dr. Irfan Khan, understanding these comparative health systems is crucial for identifying policy solutions that can be adapted across contexts. The key takeaway is that UHC is achievable even in resource-constrained settings through strong political will, adequate financing, pro-poor design, and investment in primary health care as the foundation of the health system.

Both countries must continue to address their unique challenges: Pakistan needs to increase public health spending, regulate its private sector, and expand insurance coverage; Vietnam needs to control out-of-pocket costs, strengthen primary care, and prepare its system for the rising burden of non-communicable diseases and population aging.

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