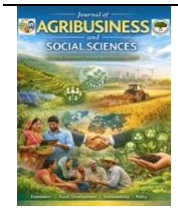

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Devolution and Rural Healthcare Delivery in Pakistan: An Institutional Analysis of Tehsil Headquarters Hospitals in Faisalabad

Fatmeen Shahid [a], Abdullah Khoso [a, *]

[a] *Center for Public Policy and Governance, Forman Christian College University, Lahore, Pakistan*

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A B S T R A C T

The 18th Constitutional Amendment in Pakistan, enacted in 2010, devolved legislative, financial, and administrative powers to the provinces for many subjects, including health, previously managed by the central government. Fourteen years after the devolution of power to the provinces, the study examines the impact of this constitutional change on healthcare delivery in two tehsils of Faisalabad district in Punjab. This paper is based on purposively selected 44 respondents for qualitative (in-depth) interviews with community members and medical staff at the Tehsil Headquarters (THQ) hospitals of Tandlianwala and Samundri in Faisalabad, alongside quantitative data from these hospitals and tehsils. The research finds that devolution has led to infrastructure development, increased funding for health care, and an increase in specialized units and medical personnel. Nevertheless, challenges remain in service quality, including lengthy waiting times, heavy workloads, and limited access to emergency medicines. It shows that improving rural health delivery is more than a matter of technological improvement and financial investment. It requires strengthening institutional responsiveness (capacity and staffing) and reshaping the rules-in-use to ensure that resources are effectively translated into high-quality care in tehsil-level health institutions. This study highlights persistent issues in grassroots healthcare provision despite decentralization and emphasizes the need for targeted interventions to improve healthcare quality in rural Pakistan. The research contributes to the ongoing discussion on post-devolution public healthcare service delivery, with a particular focus on two rural tehsils in Pakistan, providing targeted, detailed evidence of the 18th Amendment's tangible outcomes.

Introduction

The 18th Amendment to the Constitution of Pakistan in 2010 devolved significant legislative powers to the provincial governments of Balochistan, Khyber Pakhtunkhwa, Punjab, and Sindh, and to their legislative assemblies, enabling them not only to amend laws on various subjects but also to take practical measures (Musarrat, Ali & Azhar, 2012). Among other responsibilities, public health responsibilities were also decentralized to the provinces, including the regulation of health practitioners, mitigation of health threats, drug safety, pest-related illnesses, and mental health facilities (Nishtar et al., 2013). Before the 18th Amendment, the health sector, especially healthcare delivery, faced numerous challenges across Pakistan, including in Punjab. These included a lack of medicines, inadequate funding, scarce basic health technologies, and poor governance in various districts, including Faisalabad (Khan et al., 2023). After the amendment, the assessment of health service delivery at the micro (rural-tehsil) level has not received attention in research and policy circles. This is the region where real changes must take place to ensure high-quality health service delivery at the grassroots level (Khan, 2006). Existing research offers fragmented, generic, and macro perspectives, rarely addressing the micro or local-level context of public health service delivery in Pakistan (Premani & Mithani, 2016).

In Pakistan, the available literature indicates that HR issues have not been fully addressed since the 18th Constitutional Amendment. According to Zaidi (2019), whereas decentralization enhanced budgetary allocations and overall sector planning, provincial leadership and political interference impeded HR reforms. Khan et al. (2014) found that the post-devolution technical training, recruitment, and staff retention systems were not in place. Later, Ahmed (2024) noted that HR functions, such as hiring, transfers, and promotions, became highly political in the hands of provincial governments, contributing to inefficiencies in service provision. These results indicate that decentralization has increased administrative authority, but not necessarily enhanced HR capacity in a way that can improve patient outcomes. Decentralization reforms have been widely studied in the context of health sector governance, with human resource (HR) management emerging as one of the most persistent challenges. International experiences illustrate both the potential and the pitfalls of devolved HR systems. In Kenya, for example, decentralization improved county-level autonomy in procurement and staffing but created confusion over healthcare workers' roles and responsibilities, requiring new local-level capacity to manage staff effectively (WHO, 2018). Syntheses of global evidence further support these concerns. Sapkota et al. (2023) concluded that decentralization can frequently lead to infrastructure growth but seldom addresses reported chronic health worker shortages or a lack of accountability. Brennan & Abimbola (2023) found that, in weak Indo-Pacific nation-states, as facilities expanded due to decentralization, disparities in service provision also increased.

* Corresponding author. *E-mail address:* abdullahkhoso@fccollege.edu.pk (Abdullah Khoso).

Globally, research on linkages between devolution and decentralization of power (within the domain of public health governance) at the grassroots level and their impact on health service delivery is increasing, covering economic, political, and cultural aspects (Ahmed & Rafique, 2024; Elliot & Seye, 2023; Sapkota et al., 2023; Khoso & Shah, 2025; Memon & Khoso, 2025). Devolution of power and resources in any sector, including health, is an intricate phenomenon that calls for a thorough examination of its processes, operations, influencing factors, and mechanisms within the broader social-political environment of a country (Zaidi et al., 2019). With growing public concerns, decentralization is not only widely accepted and practiced but also demands a thorough examination of structural or power changes and their impacts on service delivery (Malik, 2012).

However, the literature remains focused on provincial and national-level trends. Systematic data on the impact of decentralization on HR management and service delivery at the tehsil level, where frontline staff are in closest contact with patients, are very limited. This is a critical gap in Punjab, where rural tehsil headquarters hospitals are the primary access points for healthcare. This research paper would help fill this gap by providing micro-level evidence on the two THQs in Faisalabad, Tandlianwala and Samundri, thereby explaining how decentralization has transformed HR dynamics and healthcare delivery 14 years after the Amendment. In the Faisalabad district, Tandlianwala and Samundri are rural tehsils that offer an opportunity to comparatively assess improvements in health service delivery before and after the amendment. This micro-level comparative analysis aims to understand the complexities of healthcare service delivery and to examine its relationship with broader perspectives, such as the decentralization of healthcare governance (Khan et al., 2014). It uses the tehsil-level context to assess whether public health service delivery after the devolution of powers through the 18th Amendment has brought changes (accessibility) in the lives of local people at the grassroots level.

Theoretical framework

This paper draws on the political economy of decentralization theory (Rondinelli & Cheema, 1983) and Institutional Analysis and Development (IAD) (Ostrom, 2005) to examine the dynamics of health service delivery in the post-devolution context. This integrated framework offers a multi-angle lens for understanding how devolved governance, health structures, or institutions shape joint actions and health service delivery at the local level.

Rondinelli and Cheema (1983) assert that decentralization involves not only the transfer of legislative authority but also a conditional process in which other factors play a significant role, including:

- Administrative capacity refers to the ability to perform assigned tasks;
- Institutional adaptation refers to the process by which institutions adjust their roles, responsibilities, and structures; and
- Political interests refer to the power, motivations, and incentives of political actors, including local leaders, bureaucrats, and interest groups.

It is also important to note that constitutional developments, such as Pakistan's 18th Amendment, are significant milestones that empower provinces and regions to develop and implement health policies. However, the performance of health institutions (such as hospitals and dispensaries) in rural settings depends heavily on how effectively they assume new roles and responsibilities, respond to public needs, and coordinate with provincial authorities. This view underscores the importance of institutional linkages, governance structures, and mechanisms in shaping outcomes (Rondinelli & Cheema, 1983). The IAD framework provides a systematic way to evaluate institutional performance by examining how rules and actor interactions produce outcomes in service delivery. This framework focuses on four key premises: action arenas, rules in use, material conditions, and community attributes. In action arenas, actors (i.e., administrators, doctors, nurses, and other staff) operate under specific rules. Under the rules-in-use premise, both formal and informal norms guide financial investment, human resource allocation, recruitment, and accountability. Under material conditions, the availability of physical infrastructure, medicine supply networks, and the appointment and duties of staff at rural hospitals and dispensaries are vital. Community attributes concern communities' trust and expectations, as well as their engagement in the governance of health service delivery.

In light of the 18th Amendment, this integrated framework highlights many challenges in rural health service delivery. One of those is administrative capacity, which implies that provincial health departments gained power, authority, and resources; however, tehsil-level hospitals and dispensaries lack skilled, competent staff, managers, and data systems (Rondinelli & Cheema, 1983). The rules-in-use dynamics suggest that, despite the formal transfer of power and authority, informal rules and practices continue to shape outcomes (Ostrom, 2005), including bureaucratic inflexibility and a shortage of staff. Regarding resource allocation, tehsil hospitals' financial dependence on provincial transfers limits their independence, thereby affecting medicine supply chains and the upkeep of physical infrastructure. Most importantly, regarding Ostrom's (2005) community attributes, the rural population faces challenges and constraints in accessing services and is not given the chance to participate due to weak participatory mechanisms. By merging the two theories (i.e., Rondinelli and Cheema's political economy of decentralization and Ostrom's IAD framework), this paper employs a robust theoretical lens to analyze the institutional performance of rural hospitals and dispensaries following the 18th Constitutional Amendment. This framework underscores that optimal health service delivery requires not only legal devolution but also strong administrative capacity, robust institutional rules, and community engagement. This pinpoints the gap between constitutional guarantees and ground-level outcomes, providing a basis for assessing reforms in Pakistan's rural health governance.

Material and Method

This study used a qualitative case study design, supplemented by quantitative secondary data, to examine healthcare governance and service delivery at the tehsil level following Pakistan's 18th Constitutional Amendment. Two Tehsil Headquarters (THQ) hospitals, Tandlianwala and Samundri, were purposively selected in Faisalabad district, Punjab. These tehsils were chosen because they represent rural settings with differing baseline levels of infrastructure and resources within one of Punjab's largest and most industrialized districts, providing an opportunity for meaningful comparison. A total of forty-four participants were included in the study. Of these, twenty were community members (ten from each tehsil), and twenty-four were healthcare staff: six doctors, six nurses, six midwives, and six pharmacists. Participants were recruited through purposive and snowball sampling to ensure diversity across gender, age, and professional role.

Primary data were collected through semi-structured, in-depth interviews that allowed participants to describe their experiences and provided flexibility to probe emerging themes. Interviews were conducted face-to-face at THQ premises or in nearby community spaces, depending on participants' preferences. The first author, with assistance from trained research associates, conducted all interviews between January and March 2024. Interviews were held primarily in Urdu and Punjabi, lasted 40-60 minutes, and were audio-recorded with consent. In addition to interviews, quantitative data on infrastructure, budgets, staffing, and patient volumes for 2010 and 2024 were obtained from the office of the Chief Executive Officer, District Health Authority, Faisalabad. This enabled triangulation of qualitative findings with administrative records. The data support respondents' qualitative narratives and the researcher's field observations.

The interview material was systematically analyzed using descriptive and narrative approaches rather than formal coding procedures. It emphasized rich description, context, meaning, how lived experiences were shared, and interpretation, rather than abstracting qualitative data into themes through coding. It relied on a rich narrative of respondents' experiences (Sandelowski, 2000; Riessman, 2008). Each transcript and translated note were read carefully, and key points were summarized in line with the study objectives. Recurring issues such as staff shortages, medicine availability, infrastructure improvements, and patient satisfaction were noted and compared between the Tandlianwala and Samundri THQs. Direct quotations were selected to illustrate the perspectives of respondents from different groups, including doctors, nurses, pharmacists, midwives, and community members. The descriptive findings from interviews were then compared with secondary

quantitative data on hospital budgets, staffing levels, and infrastructure changes (2010 vs. 2024) obtained from the District Health Authority. This process enabled triangulation, ensuring that participants' qualitative accounts were supported and contextualized by official statistics. The results are presented narratively, highlighting both the common themes raised by respondents and the contrasts between the two tehsils. This approach allowed the study to capture participants' lived experiences while linking them to measurable changes in healthcare delivery.

Results and Analysis

Improvement in healthcare technology, but a lack of capacity

The medical staff, including nurses, doctors, and pharmacists, in both hospitals reported improvements in healthcare technology over the past few years, which were not available before or at the time of decentralization. Patients echoed this, as one older man reported that his son had suffered a heart attack and was immediately brought to THQ Samundri, where the hospital had a cardiac monitoring machine, unlike in 2005, when he had sought medical assistance for his father. Most community members appreciated that the public hospitals in both tehsils had better technology, enabling successful treatment, services, and surgeries. However, the medical staff regretted that this technology was not up to the mark. Moreover, some medical staff reported that many lacked the know-how or capacity to operate the available equipment properly. Despite the availability of advanced technology, there was a lack of awareness and education about its operation because they lacked adequate training to use it. A pharmacist, age 33, BPharm from Tandlianwala, informed: We have received basic and higher-quality tools for patient checks; however, most of us are unable to utilize them fully.

This situation highlights an important capacity gap in decentralization: technology, a formal resource, is transferred to tehsil hospitals; however, there is a lack of staff with the necessary skills and managerial competence (Cheema & Rondinelli, 1983), which means tehsil hospitals do not have the capacity to translate these inputs into better health service delivery. This shows that decentralization's benefits depend on institutional capacity; otherwise, the purpose of devolution remains insignificant, with resources plentiful but not effectively utilized. It also reveals that rules-in-use are not aligned with the new material conditions, leading to a mismatch between adequate infrastructure and poor institutional arrangements (Ostrom, 2005).

Lack of staff

While the researchers observed long queues of men and women, many of whom were in wheelchairs and some carrying minor children, it took each visitor at least 30 minutes to reach the service counter and another 30 minutes to reach the relevant doctor or nurse. Community members reported that both hospitals lacked adequate staffing. This opinion was endorsed by a senior doctor, age 52, at the THQ hospital in Tandlianwala, who reported as follows: There are very few doctors in our hospital, and the workload is too much. He added that there were only two nurses in the hospital, and seven doctors were managing hundreds of patients every day. Moreover, because it is a rural tehsil hospital with limited facilities, doctors often leave, and it takes many months to fill vacant posts.

Most doctors reported working around 9 to 10 hours a day, providing consultations and treatment to hundreds of visitors. They acknowledged that, due to the large number of patients, they were unable to provide adequate time and attention to each patient, which affected the quality of service and their satisfaction with it. A 33-year-old visitor at THQ hospital in Samundri reported on this as follows: I have been waiting for my turn for the last hour in this scorching heat. Due to overcrowding in these public-sector hospitals, patients must wait long in queues for their turn. First of all, hurried consultations are common; a doctor's time with each patient is severely constrained when they are expected to see hundreds of patients in a single day. In this regard, a 43-year-old MBBS doctor at Tandlianwala said: Doctors are unable to fully assess a patient's medical history or symptoms, potentially leading to incorrect diagnoses or inadequate treatment options.

With less time allocated to each patient, there is insufficient time for follow-up treatment and patient counseling. Doctors do not have enough time to thoroughly explain treatment plans, prescription guidelines, and preventive health practices, leaving patients uncertain or uninformed. The shortage of nurses and doctors often raises serious concerns for patients, especially during emergencies. A 31-year-old female nurse with a Diploma in Nursing in Samundri said: During emergencies, the visitors not only expect care but also shout for the attention of the doctors and nurses. Moreover, this happens when we are busy serving a large number of people in the emergency ward. It shows that without sufficient human resources, improved inputs cannot be materialized into effective decentralization outcomes.

Moreover, the researchers observed that only the midwife in the maternity ward at Samundri hospital was running from place to place. Exhausted, she was likely to make mistakes, leading to arguments with patients and the administration of incorrect medications. This case of a midwife in Samundri, along with the overall lack of staffing in both hospitals, clearly shows a staffing shortage that weakens institutional capacity to deliver health services, even when new machinery and technology are available. This aspect reveals that decentralization has failed because authority was devolved, but the administrative foundation was unable to absorb the responsibilities (Rondenelli & Cheema, 1983). This is also a problem of misalignment in the action arena, where material conditions in hospitals prevail, but the actors' attributes are inadequate due to poor staffing (Ostrom, 2005).

Lack of Medicine

In both hospitals, as part of the provincial government's policy, medicines were supposed to be provided free of charge. However, more than 60% of community members complained about the unavailability of life-saving medicines in these government hospitals. The pharmacists at both health institutions noted that the most common medicines, such as those for common infections and injuries, were readily available. However, those for major diseases, particularly cancer treatment, were not. A pharmacist in Tandlianwala reported a shortage of insulin. Diabetic patients have to wait for days for their insulin prescriptions to become available, and sometimes they need to order it from a nearby city. However, a senior male doctor, 54 years old, MBBS, at the same hospital, stated:

> The supply of medicine is good. Sometimes injections are unavailable, which can make it difficult and frustrate patients. A male doctor, age 43, MBBS from Tandlianwala, stated that a few months ago, a minor boy was registered in the emergency ward with a respiratory infection, but the hospital lacked nebulizers and inhalers. As a result, the boy's condition worsened further. A doctor in Samundri shared: Vaccines are often unavailable, including the snakebite vaccine.

The lack of medicines at the tehsil level speaks volumes about the poor administrative and financial capacity within decentralized structures, where hospitals are unable to provide continuous free medicines. This indicates the failure of institutional improvement, actors' attributes, and resource management, weakening the potential of decentralization (Cheema & Rondinelli, 1983; Ostrom, 2005).

Low public health literacy and poor quality of care

In both hospitals, a common concern raised by government officials was low literacy and limited knowledge among the patients and their caregivers about diseases and infections. Consequently, it was difficult to explain their health complications to them. For instance, a nurse, Zahra, in Tandlianwala shared the following:

> I always tell these patients about the complications of the disease, but they never pay attention. Whereas a female patient, 38 years old, recalled her experience at Samundri Hospital as follows: My son experienced severe abdominal appendicitis. He was crying in pain. There were few staff at the

surgery, leading to delays that increased the risk of complications. Due to poor and unhygienic conditions at the hospital, many diseases spread quickly, making people ill. A patient's mother at THQ Hospital, Samundri, said, When I went to the toilet, there was no soap to wash my hands, and it appeared the washroom had not been cleaned for many days.

The poor condition of hospitals and the poor quality of care are evidence of poor institutional responsiveness under decentralization, where tehsil-level hospitals lacked the administrative capacity to translate decentralization policy into meaningful outcomes. It is a structural gap in which decentralization remains ineffective because these hospitals failed to involve communities, unable to redesign rules and ensure quality service standards (Rondinelli & Cheema, 1983; Ostrom, 2005).

Post-amendment tangible developments in two THQ hospitals

Quantitative data from the CEO indicate that the combined bed capacity of the two hospitals increased from 110 in 2010 to 368 in 2024, reflecting an approximate 234.55% increase. In 2010, the estimated population of Samundri Tehsil was 77,950; by 2023, it had reached 186,371, a 139 percent increase over the period. Compared with hospital beds (234.55%), population growth (139.06%) is significantly lower over the same period. This shows that the healthcare infrastructure, in terms of bed capacity, has improved despite population growth. It suggests that decentralization has enabled resource expansion and is a sign of positive material improvement. However, as indicated above, most staff reported that their hospitals are 'under-resourced'. From the IAD and political theory of decentralization perspectives, this means that such expansion may not serve its purpose if administrative capacity and institutional adaptation are not achieved and sustained (Cheema & Rondinelli, 1983; Ostrom, 2005).

Table 1: Health facilities and staff in THQ Hospitals in Tandlianwala and Samundri Tehsils of Faisalabad in 2010 and 2024

S. No.	Categories	2010 Tandlianwala THQ hospital	2010 Samundri THQ hospital	2024 Tandlianwala THQ hospital	2024 Samundri THQ hospital
1	All types of doctors	9	24	22	53
	Profession or practice-specific doctors				
	General practitioners	8	17	7	32
	Doctors with Primary Health Care training	-	0	5	10
	Surgeons	1	1	2	2
	Pediatricians	0	1	1	3
	Obstetricians / Gynecologists	0	0	3	3
	Ophthalmologists	0	2	1	1
	Pathologists	0	1	0	1
	Orthopedists	0	0	0	1
	Radiologists	0	1	0	0
	Dentists	0	1	3	1
	Dermatologist	0	0	0	0
	Pulmonologist	0	0	0	0
	Otolaryngologists (ENT specialists)	0	0	0	0
2	Nurses	10	27	17	33
3	Dispensers	5	8	7	7
4	Pharmacists	1	1	2	2
5	Midwives	1	3	1	2
6	Physiotherapists	0	0	0	1
7	Laboratory Technicians	2	2	1	2
8	Cleaners	4	2	8	2
9	Mali	3	2	3	1
10	Other staff	4	57	45	52

(data shared by Chief Executive Officer (CEO), District Health Authority, Faisalabad)

In 2010, Tandlianwala THQ hospital had a modest workforce of just 31 staff members, including doctors, nurses, pharmacists, cleaners, and others. By contrast, Samundri THQ hospital employed a considerably larger team of 150 staff members. This difference indicates that Samundri had a better-resourced health facility at that time, providing healthcare services to patients. In 2024, the same hospital added 128 staff members, bringing the total to 128, a more than fourfold increase. Samundri THQ hospital also saw staff numbers increase from 150 to 212, a 41 percent increase. This is larger than the number of staff members in Tandlianwala, yet it has a lower increase rate. However, this increase in staff numbers has not translated into improved service delivery, as most community respondents complained about poor hospital services. A poor woman shared; I often wait longer before the doctor sees me. Sometimes, my half-day is spent in the hospital. They [hospital administration] say they do not have enough doctors to see patients.

Table 2: Indoor-patients, out-patients, and budgetary allocations in THQ hospitals and two tehsils in 2010 and 2024

	2010	2024
	Indoor patients	**Indoor patients**
Tandlianwala Tehsil	2967	2753
Samundri Tehsil	2071	5800
Total	5038	8553
THQ hospital Tandlianwala	10000	22420
THQ hospital Samundri	29121	53261
Total	39121	75681
	Outdoor patients	**Outdoor patients**
Tandlianwala Tehsil	44673	36540
Samundri Tehsil	26726	185389
Total	71399	221929
THQ hospital Tandlianwala	77000	167285
THQ hospital Samundri	209372	331054
Total	286372	498339
	Budget	**Budget**
Tandlianwala Tehsil	5255000	42007000
Samundri Tehsil	9878867	47224762
Total	15133867	89231762
THQ hospital Tandlianwala	380000	38000000
THQ hospital Samundri	Data not found	69840143
Total	38 Lacs	107840143

Health infrastructure and human resources in two tehsils in 2010 and 2024

In addition to the staffing conditions of the two key hospitals, the data on the overall health infrastructure of the two tehsils, shared by the Chief Executive Office, District Health Authority, Faisalabad, with the researchers, show that both Tandlianwala and Samundri tehsils have experienced significant growth in healthcare

infrastructure from 2010 to 2024 (over 14 years) as well as a change in governance. Before the 18th Amendment, a single secretary oversaw the primary, secondary, and specialized departments. A male doctor, age 37, with an MBBS from Samundri, stated that in 2013, two secretaries were appointed: one for the primary and secondary sectors and the other for the specialized departments. At the provincial level, these secretaries are responsible for overseeing their sectors and performing a wide range of functions, including policy and regulation of the medical profession. He added: These secretaries gave adequate attention to their respective fields and brought improvements.

According to the shared data, in Samundri, the number of dispensaries has modestly increased from 5 to 9, while the number of BHUs has remained at 29. However, in Tandlianwala, dispensary numbers remained steady at 7, but BHUs decreased slightly from 23 to 22. A male doctor, age 42, MBBS, in Tandlianwala, informed that the government of Punjab launched the BHUs and RHCs, but these were the least effective. He added: These [BHUs and RHCs] are dysfunctional due to a lack of doctors and nurses. Thus, most people come to THQ hospitals, increasing the burden on the limited resources at the THQs. In 2024, Tandlianwala tehsil had 25 dispensaries serving 1,742,958 inhabitants, averaging about 10,628 individuals per dispensary. Likewise, Samundri tehsil had 19 dispensaries for 1,731,148 inhabitants, equating to roughly 10,556 individuals per dispensary. Each tehsil comprises 28 union councils, of which only three are classified as urban. This suggests that THQ hospitals, although located within urban union councils, primarily served the rural population.

According to data shared by the Chief Executive Officer of the District Health Authority, Faisalabad, from 2010 to 2024, Samundri received more specialized departments. She noted a significant rise in both indoor and outdoor patient numbers, while Tandlianwala saw moderate improvements. Furthermore, the overall healthcare budget for both tehsils increased from PKR 15.13 million in 2010 to PKR 89.23 million in 2024, reflecting substantial investments in the health sector. The quantitative data provided by the CEO also indicate a notable increase in the budgets of the two hospitals (see Table 2). However, in both tehsil hospitals, the medical staff offered a different perspective; for example, a doctor in Tandlianwala reported that the government hospital lacked sufficient financial resources to deliver quality treatment to the communities. A male doctor, age 33, MBBS at Samundri, also informed: We need the right number of equipment, staff, and medicines in the hospitals. It is not possible because of a lack of funds and resources. For more details related to indoor and outdoor patients and budgetary allocations in 2010 and 2024, see Table 2.

However, this overall positive increase in health budgets at the tehsil level, together with staff complaints at the hospital level, indicates that financial decentralization is not translated into adequate institutional improvement, creating a structural gap in which funds and authority exist at the tehsil level but resource provision at the hospital level fails. This gap also undermines the potential of devolution, as administrative capacity remains weak despite increased allocations (Rondinelli & Cheema, 1983). Inadequate drugs and supplies show a mismatch in the action arena. These increased budgets or infrastructural improvements cannot deliver high-quality treatment outcomes without rules-in-use and accountability mechanisms to ensure resources reach hospitals and serve the public.

Discussion

This study assessed healthcare changes over 14 years at two levels: 1) micro-level within hospitals and 2) macro-level for tehsils. It employs both qualitative narratives and quantitative data. The data reveal positive steps to address the growing healthcare needs of an expanding population. Considerable progress has been achieved in healthcare infrastructure, staffing (notably doctors, nurses, and midwives), and specialized services across both tehsils between 2010 and 2024. Notably, Samundri experienced greater growth in specialized departments and infrastructure, while Tandlianwala also made significant advances in healthcare access and services. This suggests that decentralization has strengthened the system, keeping pace with the increasing population, a positive development.

There is clear quantitative growth at both the hospital (micro) and tehsil (macro) levels, reflecting substantial investment and development in healthcare facilities and personnel. This indicates positive initiatives and a trajectory aimed at meeting local and rural healthcare needs. It highlights how decentralization of authority and resources has been crucial in expanding healthcare infrastructure, including human resources, through increased provincial government funding, to serve a growing population. Furthermore, 44 testimonies from healthcare officials and community members demonstrate notable improvements in the physical infrastructure of healthcare services at the two THQ hospitals over time. However, qualitative accounts from community members offer a contrasting perspective, particularly on staffing and service quality at the two tehsil hospitals. Medical officials cite shortages of personnel, funds, essential medicines, and suitable medical equipment as key issues. This underscores several areas of healthcare governance that require attention to ensure the full benefits of decentralization are realized (Brand 2007).

This persistent contrast between increased material resources, such as technology, and a lack of institutional capacity characterizes the delivery of rural health services under decentralization. On the one hand, decentralization has enabled the formal transfer of resources at the tehsil level, including apparent increases in health budgets, greater availability of technology, and expanded bed capacity. For instance, the budgets of the two rural tehsils have increased significantly from 2010 to 2024. However, staff continued to complain about shortages of medicine and equipment, and patients and their relatives also complained about poor services at the two hospitals. By incorporating firsthand accounts from community members and caregivers, this research deepens understanding of the social, cultural, and operational barriers to healthcare delivery. It demonstrates that quality issues persist, including unsatisfactory patient care, neglect, and potential flaws in healthcare processes. This perspective shifts the focus from solely data-driven improvements to a qualitative view of healthcare governance, emphasizing the need for comprehensive strategies that address both physical infrastructure and service quality standards (Brennan & Abimbola, 2023; Orton et al., 2011; Tsofa et al., 2017; Zaidi et al., 2019).

Furthermore, this research highlights the importance of community participation and responsiveness in healthcare reforms. Community engagement is vital to ensuring efficiency and accountability in healthcare reform and to advocating policies that foster capacity building, accountability mechanisms, and patient-centered approaches (Sam & Stewart, 2016). With these approaches, patients in rural areas will also not be left behind (Webster, 2024). In contrast to Pakistan, decentralization reforms in the health sector in Brazil and Portugal brought better outcomes but encountered ongoing challenges in implementing reforms to increase local decision-making power (Mahmood et al., 2024). Similar national-level assessments in Pakistan and international experiences in countries that adopted such reforms were consistent with these results (Wazed, 2025).

Combined, the results from Tandlianwala and Samundri suggest that decentralization has led to apparent improvements in infrastructure (technology and the number of hospital and tehsil beds) and in budgetary allocations. However, the day-to-day lives of patients and personnel remain constrained by ongoing shortages of professionals, gaps in the supply of medicines, and ineffective governance systems. From the perspective of the political economy of decentralization, there is a wide structural gap: financial allocations improved at the tehsil level and technology was available, but administrative capacity and mechanisms to ensure resource provision were absent or nominal. These improvements have not delivered services to the public or achieved better health outcomes. This implies that decentralization has remained symbolic and that administrative capacity is insufficient to absorb responsibilities or effectively operationalize new inputs (Rondinelli & Cheema, 1983).

The IAD framework also views these failures as misalignments within the action arena, where material conditions, such as physical infrastructure and technology, fail to align with rules-in-use (formal and informal norms related to decentralization or the transfer of power and authority) and with actors' attributes. This framework underscores that technological improvements have not been realized due to insufficient medical staff capacity and staffing, and it reveals that active actors were unable to translate these resources (technological and financial) into effective service delivery. Moreover, problems of poor-quality care and limited public awareness reveal that rules-in-use (especially those dealing with accountability, procurement, and health workers' rewards and incentives) were misaligned with the material requirements of the health system (Ostrom, 2005).

Conclusions and Implications

grassroots level, including its efficacy and inefficiency, as well as the difficulties associated with operating healthcare services in these tehsils. In this case, the province of Punjab has a health strategy to improve infrastructure, enhance service quality, and make health service delivery available to the people. The Basic Health Units and Rural Health Units were expanded to ensure primary care for patients in rural areas. In 2014-2015, the Punjab Health Department initiated a project to improve the BHCs and RHCs available to the rural population of Punjab. This research concludes that to maximize the 18th Amendment's impact on healthcare outcomes, it is crucial to strengthen local government structures, ensure a more equitable distribution of resources, and provide additional provincial support, particularly for rural areas. Improving healthcare in Tandlianwala and Samundri requires collaboration between provincial and municipal authorities and substantial investments in healthcare infrastructure. Only through such coordinated action can these tehsils effectively enhance healthcare service delivery and meet their populations' needs. However, from the IAD and the political economy of decentralization perspectives, improving rural health delivery is more than a matter of technological upgrades and financial investment. It requires strengthening institutional responsiveness (capacity and staffing) and reshaping the rules-in-use to ensure that resources are effectively translated into high-quality care in tehsil-level health institutions.

Ethical Approval

Ethical approval for this study was obtained from the Institutional Review Board of Forman Christian College (The Chartered University), Lahore, Pakistan (Approval No. IRB-622/03-2024). Written informed consent was secured from all participants, and confidentiality was maintained throughout.

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Appendix

Table 1: Health facilities and staff in THQ Hospitals in Tandlianwala and Samundri Tehsils of Faisalabad in 2010 and 2024 (data shared by Chief Executive Officer (CEO), District Health Authority, Faisalabad)

S. No.	Categories	2010 Tandlianwala THQ hospital	2010 Samundri THQ hospital	2024 Tandlianwala THQ hospital	2024 Samundri THQ hospital
1	All types of doctors	9	24	22	53
	Profession or practice-specific doctors				
	General practitioners	8	17	7	32
	Doctors with Primary Health Care training	-	0	5	10
	Surgeons	1	1	2	2
	Pediatricians	0	1	1	3
	Obstetricians / Gynecologists	0	0	3	3
	Ophthalmologists	0	2	1	1
	Pathologists	0	1	0	1
	Orthopedists	0	0	0	1
	Radiologists	0	1	0	0
	Dentists	0	1	3	1
	Dermatologist	0	0	0	0
	Pulmonologist	0	0	0	0
	Otolaryngologists (ENT specialists)	0	0	0	0
2	Nurses	10	27	17	33
3	Dispensers	5	8	7	7
4	Pharmacists	1	1	2	2
5	Midwives	1	3	1	2
6	Physiotherapists	0	0	0	1
7	Laboratory Technicians	2	2	1	2
8	Cleaners	4	2	8	2
9	Mali	3	2	3	1
10	Other staff	4	57	45	52

Table 2: Indoor-patients, out-patients, and budgetary allocations in THQ hospitals and two tehsils in 2010 and 2024

	2010	2024
	Indoor patients	**Indoor patients**
Tandlianwala Tehsil	2967	2753
Samundri Tehsil	2071	5800
Total	5038	8553
THQ hospital Tandlianwala	10000	22420
THQ hospital Samundri	29121	53261
Total	39121	75681
	Outdoor patients	**Outdoor patients**
Tandlianwala Tehsil	44673	36540
Samundri Tehsil	26726	185389
Total	71399	221929
THQ hospital Tandlianwala	77000	167285
THQ hospital Samundri	209372	331054
Total	286372	498339
	Budget	**Budget**
Tandlianwala Tehsil	5255000	42007000
Samundri Tehsil	9878867	47224762
Total	15133867	89231762
THQ hospital Tandlianwala	380000	38000000
THQ hospital Samundri	Data not found	69840143
Total	38 Lacs	107840143