Case Study

Mismatch Between Health-Management Training and Public-Sector Employment in Punjab, Pakistan: A Case Study

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Abstract

Effective health systems require not only clinical expertise but also competent management. In Pakistan, physicians who complete graduate training in public health, maternal and child health, hospital administration, or related fields often report difficulty finding public-sector roles that match their qualifications. This paper examines that mismatch in Punjab through a descriptive qualitative case study with embedded policy review. The analysis combines official policy and service-rule documents, peer-reviewed literature on health systems and workforce management, and three de-identified physician career narratives from Punjab. The evidence indicates that Pakistan has expanded its health infrastructure, but the organization of management careers remains weak. In Punjab, policy discourse has acknowledged the importance of management posts, yet the publicly visible service architecture still does not function as a clearly institutionalized management stream comparable to the province's clinical tracks. The three narratives show recurring barriers: lack of designated posts, uncertain career progression, frequent transfers, and stronger perceived incentives in clinical specialties.

Keywords: *health management; public health workforce; Punjab; Pakistan; qualitative case study; management cadre*

Date Submitted: 2025-09-22 **last Modified:** 2025-12-18 **First Published:**2026-01-22

Introduction

Health-system strengthening requires not only clinical expertise but also capable management of people, budgets, supplies, information and institutions. Pakistan's National Health Vision 2016-2025 places universal health coverage, provincial stewardship and improved coordination at the centre of reform, making health-management capacity a core systems issue rather than a peripheral administrative concern.[1]The public delivery system is large. According to the Pakistan Economic Survey 2023-24, the country had 1,284 hospitals, 5,520 basic health units (BHUs), 697 rural health centres (RHCs) and 151,661 hospital beds in 2023, alongside 299,113 registered doctors and 127,855 nurses.[2] Yet expansion in physical infrastructure has not fully translated into better performance. Recent analyses describe persistent weaknesses in governance, financing, medicines, monitoring and frontline workforce support within primary health care.[3,4] In Punjab, these weaknesses have important implications for doctors who obtain graduate training in public health, maternal and child health, hospital administration or related fields. Although such programmes are meant to produce managers for hospitals, districts and public-health programmes, many graduates perceive that the provincial public sector offers no stable, clearly signposted employment track

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through which they can use their training. This case study examines that mismatch by combining policy review with three de-identified physician career narratives from Punjab.

Policy and Institutional Context in Pakistan and Punjab

After the 18th Constitutional Amendment, provinces assumed greater responsibility for health planning, service delivery and workforce stewardship. Punjab responded with reform initiatives and sector strategies, but analyses of the post-devolution period have repeatedly noted the need to strengthen governance, service delivery and human-resource management.[5] The Punjab Health Sector Strategy 2019-2028 likewise frames governance, stewardship, accountability and workforce development as central reform priorities.[6]The difficulty is that policy ambition has not been matched by a clearly institutionalized management career stream. On the public service-rules portal, Punjab formally lists general medical, specialist, teaching and miscellaneous rules, but no stand-alone, separately tracked management-cadre rules are publicly displayed.[7] This is especially striking because the Punjab government announced in 2012, as part of a negotiated service-structure package, that a health-management cadre would be created for administrative posts in the health department.[8] The more visible formal rule-making that followed was the Primary and Secondary Healthcare Department (General Medical Cadre Posts) Service Rules, 2017, which clarified recruitment for general medical posts but did not establish a separately tracked provincial management cadre comparable to the province's clinical streams.[9] A useful comparison exists within Pakistan itself. Khyber Pakhtunkhwa created Health Management Service Rules in 2008 that explicitly identified management posts across BS-17 to BS-20, including programme managers, medical superintendents and director-level positions.[10] The province continues to maintain separate management-cadre seniority lists, indicating that management posts are institutionally recognized as a distinct stream.[11] Punjab's lack of comparable public documentation contributes to uncertainty over entry points, progression and sanctioned posts for doctors with management qualifications. Publicly available provincial data on the annual number of MPH/MHM graduates and on sanctioned management-cadre vacancies in Punjab remain fragmented. This information gap is itself a planning problem: when the supply of trained managers and the demand for management posts are not transparently mapped, workforce planning becomes reactive rather than strategic.[7,8,9,10,11]

Methodology

This paper uses a descriptive qualitative case-study design with an embedded policy review. Two forms of evidence were brought together: (1) official policy documents, service rules and peer-reviewed literature relevant to management cadres, workforce planning and public-health careers in Pakistan; and (2) three de-identified career narratives from physicians in Punjab who completed management-oriented training.

Case Selection and Ethical Considerations

The three cases were selected purposively because they met three criteria: formal training in public health or health management; direct experience of administrative or programme work; and a subsequent career decision that illuminated the perceived mismatch between management training and public-sector employment. The cases were chosen to capture variation in seniority, training pathway and career outcome. To protect confidentiality, identifying personal and institutional details were minimized in the final narratives. No patient-level data were used.

Data Collection and Analysis

The narrative material was converted into short case summaries and analysed thematically alongside the document review.

Coding focused on five recurrent domains: (i) entry into administrative work, (ii) availability of suitable posts, (iii) remuneration and job security, (iv) promotion and transfers, and (v) implications for health-system performance. The purpose was not to estimate prevalence, but to identify recurring structural barriers visible across individual careers and policy documents.

Findings

Three interconnected themes emerged: (1) weak institutionalization of management careers in the public sector; (2) limited returns on management training relative to clinical tracks; and (3) the redirection of trained physicians into alternative specialties or roles.

Table 1. Summary of the three case narratives and their analytic relevance

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Case	Training	Administrative exposure	Key barrier identified	Career outcome
1	Specialist physician with management-oriented postgraduate qualifications	Programme management and hospital administration	No stable management stream; transfers and weaker predictability than clinical posts	Returned to clinical service
2	Master of Public Health (MPH)	Short placements in public-health and hospital-management settings	Few entry-level posts and no clear promotion ladder for management training	Shifted to anaesthesiology
3	Formal management training with junior administrative service	District-level administrative roles	Delayed progression, acting charges and perceived weak merit protection	Retrained in pathology

Mismatch Between Training and Deployment

Pakistan has long faced human-resource management problems. A national human-resources-for-health assessment reported that the public sector was inadequately staffed and that job satisfaction and work environment required substantial improvement.[12] Among public-health professionals working in the public sector, only 41% were satisfied overall in one Pakistani study; dissatisfaction was linked to low salaries, weak supervision, inadequate rewards and limited training opportunities.[13] More recently, a qualitative study of public-health graduates found a persistent gap between what is taught and what employers expect, including insufficient contextualization and uncertainty around the practical use of training.[14] Together, these studies suggest that management-oriented education in Pakistan is expanding within a labour market that still lacks clear absorption pathways.

The problem concerns not only the number of jobs, but also the design of management work. Pakistani health managers have described information systems and managerial structures affected by scarce resources, underuse of data, poor feedback, and the absence of clearly defined career structures.[15,16] A separate appraisal of Pakistan's human-resource information system similarly concluded that no reliable information portal captured the true state of health human resources and that policy and strategy for workforce information remained weak.[16] These system-level weaknesses are consistent with the uncertainty described by the three physicians in this study.

Summary of the Case Narratives

Case 1: Senior physician with hospital-management training. The first case involved a senior physician who moved from specialist clinical work into donor-supported and district-level programme roles in South Punjab. He later completed management-oriented qualifications and served in hospital administration. Despite this portfolio, he perceived permanent public-sector management positions as scarce, vulnerable to transfers and less predictable than clinical posts. He therefore returned to a frontline clinical appointment. Analytically, this case illustrates the weak conversion of management credentials into a protected public-sector career path.

Case 2: MPH graduate redirected to anaesthesiology. The second case involved an early-career physician who completed an MPH hoping to enter hospital administration or public-health programming. After limited placements and internships, she encountered few entry-level posts that explicitly valued management training and no clear promotion

ladder. She subsequently shifted to anaesthesiology, viewing it as a field with clearer training milestones and more stable employment prospects. This case highlights the opportunity cost of management education when alternative clinical tracks offer better-defined careers.

Case 3: Management trainee redirected to pathology. The third case involved a physician with formal management training who worked in junior administrative roles at district level. He described acting charges, delayed progression and appointments perceived as insufficiently merit-based. Over time he retrained in pathology, where the career structure appeared more legible and credential-driven. This case underscores how ambiguity in promotion and posting decisions can push trained managers away from administration.

Cross-Case Interpretation

Across all three narratives, the proximate reason for leaving management was not lack of interest in administration. The dominant issues were structural: unclear job descriptions, few visible entry points, uncertain promotion pathways, frequent transfers and weaker perceived returns than in clinical fields. The cases therefore point to a problem of workforce design rather than individual motivation. They also suggest that when management training is not linked to recognizable posts, the system effectively subsidizes a skills pipeline it does not retain. These patterns echo broader evidence from Pakistani public-health professionals who report low satisfaction, weak training-to-job alignment and inadequate institutional support.[13-16]

Discussion

The findings suggest that Punjab's challenge is not simply to produce more infrastructure or more training opportunities, but to align training, posts, incentives and governance. A province may expand hospitals, BHUs and programmes, yet still underperform if it cannot recruit, deploy and retain competent managers to oversee budgets, data systems, procurement, supervision and quality improvement.[2-4]

Punjab's policy context reveals a familiar reform gap. Official discourse acknowledges the importance of management capacity and earlier reform packages explicitly referenced a health-management cadre.[6-9] However, the publicly visible service architecture still does not function like a mature management stream of the kind documented in KP.[10,11] This gap matters because health-management qualifications only become meaningful career signals when governments define who is eligible, which posts belong to the stream, how promotions occur and what protections exist against arbitrary transfers or informal appointments.

The contrast with KP also shows that formal rules are necessary but not sufficient. Recent evidence from tertiary-care reforms in KP indicates that greater autonomy or administrative restructuring can still yield mixed results when staff communication, accountability, resource allocation and protection from political meddling remain weak.[17] Punjab therefore requires more than a nominal cadre: it needs a functioning service structure with transparent recruitment, competency-based development and predictable progression.

This study is illustrative rather than statistically representative. Because public reporting on annual management graduates and sanctioned management posts in Punjab remains incomplete, it cannot estimate the full scale of the mismatch. Its contribution lies in showing how policy gaps are experienced at career level and why trained physicians may rationally choose specialties or roles with clearer returns.[7-11,16]

Comparative Perspective

Experience from other countries suggests that management capacity can be institutionalized rather than left to ad hoc appointments. India's public health management cadre guidance explicitly proposes distinct public-health and health-management streams,

competency-based recruitment and protected career progression for management roles.[18] In Bangladesh, studies of mid-level and primary-care managers found that postgraduate public-health education and formal management training were associated with stronger managerial competency, while gaps remained in financial planning and information management.[19-20] These models are not directly transferable to Punjab, but they demonstrate that management posts can be defined, trained for and governed as a professional stream.

Conclusion

Punjab's health system depends on effective management as much as on clinical service delivery. This revised case study shows that doctors who invest in public-health and health-management education often face a poorly defined public-sector labour market in which posts are unclear, progression is uncertain and clinical tracks offer better perceived returns. Unless Punjab creates a transparent, merit-based management pathway and aligns it with training institutions, it will continue to lose managerial talent to other specialties and sectors. The resulting loss is not only personal; it weakens the governance capacity of hospitals, districts and public-health programmes.

Recommendations

1. Establish a Provincial Health Management Cadre. Punjab should create a distinct management cadre for eligible physicians and other appropriately qualified health professionals, with clearly notified posts, qualifications, promotion rules and protection from ad hoc transfers. Recruitment should occur through transparent, merit-based mechanisms.

2. Publish Workforce Planning Data. The department should publish sanctioned management posts, filled positions, vacancies and eligibility criteria, and should periodically map the number of graduates emerging from MPH, MHM and related programmes. This would directly address the current planning blind spot.

3. Create Entry-Level Pathways. Junior management fellowships, district-management residencies or competitively recruited assistant-management posts could provide early-career absorption for new graduates rather than forcing them to wait for senior posts.

4. Align Incentives with Responsibility. Management jobs should offer pay, allowances and progression commensurate with responsibility. Without credible financial and professional incentives, clinical tracks will continue to dominate career decisions.

5. Invest in Management Capability. In-service training should cover health information systems, budgeting, procurement, quality improvement, leadership and programme management, and should be linked to promotion criteria rather than treated as optional add-ons.

6. Strengthen Governance and Continuity. Transparent criteria for postings, transfers, acting charges and performance appraisal are essential. Managers should be evaluated on facility readiness, service-delivery indicators, data use and accountability rather than informal patronage.

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