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Catalysing system reforms in Pakistan's Healthcare and Health Professions Education: National Stakeholder priorities for strengthening policy and system Governance

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Catalysing system reforms in Pakistan's Healthcare and Health Professions Education: National Stakeholder priorities for strengthening policy and system Governance

Running title: Multi-stakeholder perspectives on health professions education reform in Pakistan

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SK conceived, designed and is responsible for integrity of research.

KJ did analysis & editing of manuscript,

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Abstract

Objective: Pakistan has broadened its medical and dental education sphere, yet apprehensions last about undergraduates' competence, impact of regulation, international acknowledgment of qualifications and retention of the health workforce. This study explored multi stakeholder perspectives on training capacity, quality of education, governance, regulation and acknowledgment of health professions education in Pakistan, and identified prime reforms.

Methodology: A qualitative descriptive study was conducted using hybrid focus group discussion held on 4 August 2026 as part of national Health and Education Summit Pakistan (HESP) 2026. Fourteen purposively sampled stakeholders participated in discussion guided by 16 semi structured questions. Data were analysed using Framework Method, and Health Policy Triangle was applied as an interpretive lens.

Results: Nine themes were identified across three domains. *Educational quality and competence:* undefined and unenforced competency standards; deficits in clinical training infrastructure; faculty development and continuous quality improvement; and cautious, purpose-specific integration of artificial intelligence. *Governance, regulation and recognition*: fragmented, input-oriented governance; private-sector representation and public–private imbalance; and international recognition and global alignment. *Workforce and equity*: equity in workforce planning; and workforce sustainability, security and dignity. Participants identified main barrier to reform is not in an absence of policy but in weak implementation, input based accreditation and poor coordination among regulatory bodies.

Conclusion: Stakeholders called for a shift from input based to outcome-based accreditation built on a nationally agreed definition of competence, a shared inter agency governance platform, documented clinical supervision and simulation, and workforce protection measures.

Keywords: medical education; accreditation; governance; competency-based; health workforce; Pakistan; reforms

Introduction

Health professions education (HPE) worldwide is under pressure to produce graduates who are competent, adaptable and responsive to the needs of their health systems. The Lancet Commission on the education of health professionals argued that curricula and institutions had not kept pace with changing health needs, and called for competency based, systems-oriented education supported by strong governance.[1] Competency-based medical education (CBME) and entrustable professional activities (EPAs) have since become the dominant frameworks for defining what graduates should be able to do.[2,3]

Quality assurance is central to this agenda. Accreditation, licensing and revalidation are the main mechanisms through which regulators assure the public of graduate competence[4], and the World Federation for Medical Education (WFME) specific standards set expectations for outcome-focused, continuously improving programmes.[5] These mechanisms now carry international outcomes: since 2024, graduates seeking certification by the Educational Commission for Foreign Medical Graduates (ECFMG) must have appeared in a medical school accredited by accreditation council recognized by WFME.[6] The reliability of a country's accreditation system therefore right away affects the mobility of its graduates.

Pakistan demonstrates these pressures, as its medical and dental education sector has expanded quickly, with a large and growing share of institutions in the private sector. Responsibility for HPE is distributed across several bodies, including the Pakistan Medical and Dental Council (PM&DC), the Higher Education Commission (HEC), the College of Physicians and Surgeons Pakistan (CPSP), degree-awarding universities and provincial health commissions. At the same time, many graduates intend to migrate[7], and violence against healthcare providers has been recorded as a workplace concern.[8] These pressures sit within a global shortage of health workers that makes retention a policy priority.[9]

Much of the debate on HPE reform in Pakistan takes place within individual institutions or agencies, and published evidence rarely captures the views of regulators, institutional leaders, educators, junior doctors and the diaspora together. Health policy analysis in low- and middle-income countries has shown that reforms succeed or fail through the interaction of their context, content, process and actors, not through technical content alone. Understanding how different stakeholders explain the gap between policy and practice is therefore essential to designing reforms that can be implemented.

This study aimed to explore multi-stakeholder perspectives on training capacity, educational quality, governance, regulation and international recognition of HPE in Pakistan, and to identify the reforms stakeholders considered most important.

Methodology

We conducted a qualitative descriptive study using a focus group discussion. Qualitative description was chosen because the aim was to describe the range and pattern of stakeholder views in terms close to the data, to inform policy recommendations directly, rather than to develop new theory[10]. The study is reported according to the Consolidated Criteria for Reporting Qualitative Research (COREQ).

The FGD was convened as part of the Health and Education Summit Pakistan (HESP) 2026, which held three themed FGDs in its medical stream: Theme 1, understanding the healthcare and HPE landscape; Theme 2, strengthening policy, governance and system performance; and Theme 3, driving innovation, sustainability and global excellence. This paper reports the Theme 2 FGD. It took place on 4 August 2026 at Rashid Latif Khan University Medical College Lahore, in a hybrid format with participants attending in person and online via Zoom.

Participants were selected by purposive, maximum-variation sampling to collect the perspectives of the main stakeholders in medical and dental education: regulatory and senior academic leaders, heads of institutions, medical and dental educators, junior doctors, a representative of a public health university, physicians practicing abroad and a participant with cross-sector experience. Potential participants were approached through formal invitation letters sent by post and email, followed up by telephone. Fifteen stakeholders were invited; one declined, and the remaining 14 attended and contributed to the discussion (Table 1).

The FGD was moderated by an Associate Professor and notes were taken by two note takers at a private medical college in Lahore. The moderator had no prior relationship with any of the participants. Before FGD, participants received a study information describing purpose of the study, sequence and themes of FGDs, and discussion questions.

A semi-structured discussion guide, objectives and literature on HPE quality and governance was developed by the team and reviewed by the research faculty of private medical college, it contained 16 open questions. The moderator introduced each question and invited in-person and online participants to respond in turn, with follow-up prompts to clarify and deepen responses. In the final segment, participants gave structured, brief contributions to the closing questions in a rapid round.

The discussion was audio recorded, with participants' consent. A co-author checked the transcript against the recording for accuracy. The two note takers recorded non-verbal cues, group dynamics and contributions from online participants. The FGD lasted approximately three hours.

Data were investigated using the Framework Method[21], which matches applied policy research because it holds a pre-set topic manual alongside emergent issues, creates an auditable trail from raw data to themes, and aids systematic comparison across different participants and questions. Analysis followed five stages. In familiarization, the analysts read the full transcript and field notes repeatedly and recorded initial impressions. In identifying a thematic framework, a provisional framework was built deductively from the two sections of the guide and refined inductively as recurring concepts emerged, such as input-based accreditation and workforce dignity, which were not asked about directly. In indexing, the transcript was coded line by line, producing 27 codes; the coding was checked by the two note-takers and reviewed by all co-authors. In charting, codes were summarized in a matrix of themes against guide questions and participants. In mapping and interpretation, patterns and relationships across the matrix were used to define the final themes. Coding and charting were carried out in MAXQDA.

The Health Policy Triangle was then applied as an interpretive lens over the themes, organizing them into four interacting dimensions: context, content, actors and process to explain not only what reforms participants proposed but why previous reforms had stalled. The study had a focused aim, a highly specific sample of senior and frontline stakeholders with direct experience of the issues, an established analytic framework and a long, dialogue-rich discussion, all of which increase information power. Because the FGD was a single, time-bound national convening, saturation was not an aim. Credibility was supported by maximum variation sampling, triangulation of the transcript with notes, dependability and confirmability by an audit trail from codes to charting matrix to themes, analyst triangulation and reflexive notes; and transferability by a detailed description of the setting and participants.

Ethical approval was obtained from the RLMC Institutional Review Board IRB/119/2026. All participants received information about the study and gave written and verbal informed consent before the discussion, including consent for recording and for the use of anonymized

quotations. Participants are identified by codes (P1–P14); institutional details have been generalized to reduce the risk of identification.

Table 1. Participant characteristics (n = 14)

Code	Stakeholder group / role	Mode
P1	Senior medical educator with regulatory experience (CPSP)	in person
P2	Clinician Public Sector	in person
P3	Principal, public-sector medical college	in person
P4	Medical educator, institutional leadership	in person
P5	Junior doctor	online
P6	Dental educator / dentist	in person
P7	Medical educator	in person
P8	Physician practicing in the United States	in person
P9	Diaspora physician, APPNA representative	online
P10	Cross-sector (industry/development projects) professional	online
P11	Representative, public health sciences university	online
P12	PMDC representative	online
P13	YDA representative	in person
P14	HEC representative	online

APPNA: Association of Physicians of Pakistani Descent of North America.

Results

Fourteen participants took part, including senior educators and institutional heads, medical and dental educators, junior doctors, physicians and a cross-sector professional (Table 1). Analysis produced 27 codes, which were organized into nine themes across three domains (Figure 1). Participants broadly agreed that Pakistan's difficulty lies less in a shortage of institutions or regulations than in a shortage of enforced, outcome-based standards and of coordination among the agencies responsible for them. Junior doctors placed particular weight on pay, security and dignity, whereas senior and regulatory participants tended to frame problems in terms of systems and processes.

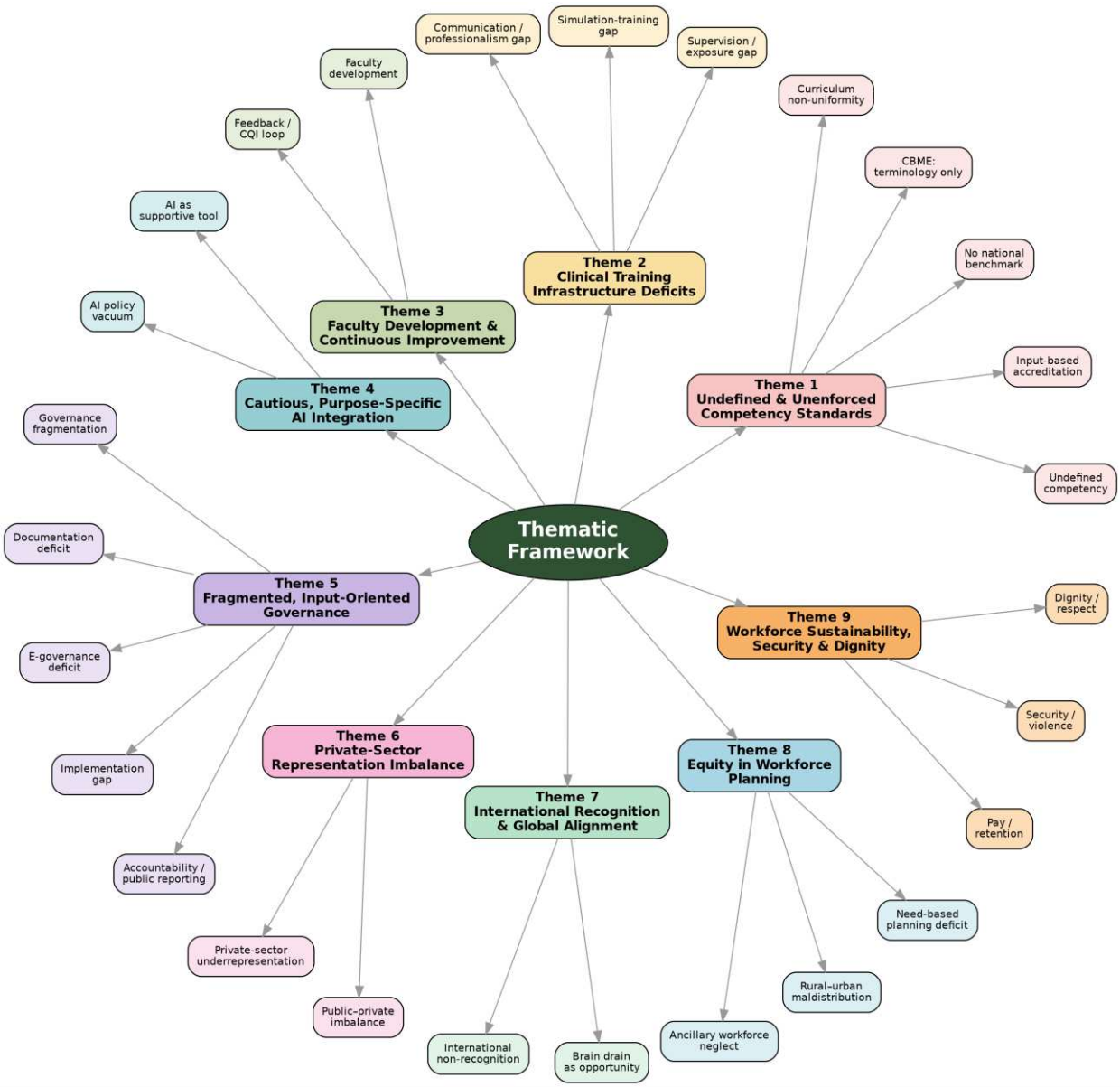


Figure 1. Thematic map linking the 27 codes to the nine themes

Domain A: Educational quality and competence

Theme 1. Undefined and unenforced competency standards

The most convergent finding was that competence had no agreed, enforced national definition. A senior educator argued that competencies were "not undocumented, they are actually undefined" (P1). Participants described accreditation as an audit of inputs ;beds, faculty numbers and infrastructure, rather than of what graduates could do:

"We come in and we count the beds and then we go away, unchecked." (P1)

Without a shared outcome criterion, each institution establishes its own standards: "we do not have such national benchmarks with consensus" (P2), and "there is no set pattern of curriculum; every university has a different curriculum" (P3). many educators felt that CBME had changed terminology rather than practice, talking about curricula adopted from Western sources and translated without the consistency in teaching, assessment and faculty (P1).

Theme 2. Deficits in clinical training infrastructure

Junior doctors and dental educators discussed and identified concrete gaps in hands-on training. A junior doctor mentioned that "supervisor involvement is near to zero in Pakistan" (P5), and a dental educator added to that "structured simulation-based education is lacking in our country" (P2). Communication, ethics and professionalism were said to be part of curriculum only on paper, but how they are taught and assessed are "not enough" (P2).

Theme 3. Faculty development and continuous quality improvement

Participants identified faculty capacity, rather than curriculum documents, as binding constraint on quality; in the words of one participant, good teachers produce good students (P11). Participants proposed a formal, continuing cycle of standard-setting, stakeholder feedback, revision and uniform implementation in place of one-off reforms (P1, P6).

Theme 4. Cautious, purpose-specific integration of AI

There was consensus that AI should support, not replace, clinical reasoning, and that its use should be adapted to each specialty (P1, P4, P7). Participants noted a policy vacuum: "PM&DC currently does not have a comprehensive policy" on AI in education (P3), which left adoption to individual institutions and made it uneven between urban and rural, and public and private, settings.

Domain B: Governance, regulation and recognition

Theme 5. Fragmented, input-oriented governance

PM&DC, HEC, CPSP, the Ministry of Health and provincial health commissions were described as working in silos: "there is no common platform where all stakeholders can come together" (P7). Weak documentation and limited digitization were seen as undermining coordination and accountability (P1, P10, P11), and participants called for e-governance and public reporting of institutional outcomes (P2, P10). Several participants stressed that the core problem was implementation, not a lack of policy:

"It is a matter of implementation not developing more policies." (P8, P9)

Theme 6. Private-sector representation and public–private imbalance

A senior educator estimated that the private sector carried out around 80% of training and service work but held a minority voice in regulatory and academic decision-making (P1). He proposed moving towards balanced distribution, near 50:50 representation. This point of view was supported strongly by other participants.

Theme 7. International recognition and global alignment

Participants reported real barriers to recognition of Pakistani qualifications, particularly in dentistry, where graduates were described as needing extensive further examinations and courses to practice in the UK or US (P6). Participants attributed these barriers to inconsistent competence assurance at home rather than to graduate ability, noting that Pakistani graduates performed well once working in better-resourced systems abroad (P9). A diaspora physician reframed migration as an opportunity for structured knowledge exchange, drawing on two decades of diaspora engagement in curriculum reform, while noting that earlier initiatives had gained limited lasting traction (P9).

Domain C: Workforce and equity

Theme 8. Equity in workforce planning

Discussion tended to center on doctors and dentists, and one participant explicitly redirected attention to nurses, midwives and technicians: "we have not really talked about good ancillary

health care services" (P8). Participants argued that new institutions were concentrated in cities rather than where need was greatest, and that "the institutions that we produce have to be need based" (P8).

Theme 9. Workforce sustainability, security and dignity

This theme ran through the whole discussion and dominated the closing round. Junior doctors and clinicians framed pay, legal protection from workplace violence and professional dignity as more immediate drivers of attrition and migration than curriculum design (P5, P7, P12). "Pay increase should be done" (P12) was paired with calls for security legislation and for "mutual respect between doctors and patients" (P7).

Health Policy Triangle synthesis

Mapping the themes onto the Health Policy Triangle (Fig 2) suggested that reform had stalled less because of weak content, participants noted that many of the same proposals had recurred for a decade or more (P9). Participants therefore proposed ten reforms, each linked to the stakeholders responsible for implementing it (Fig 3).

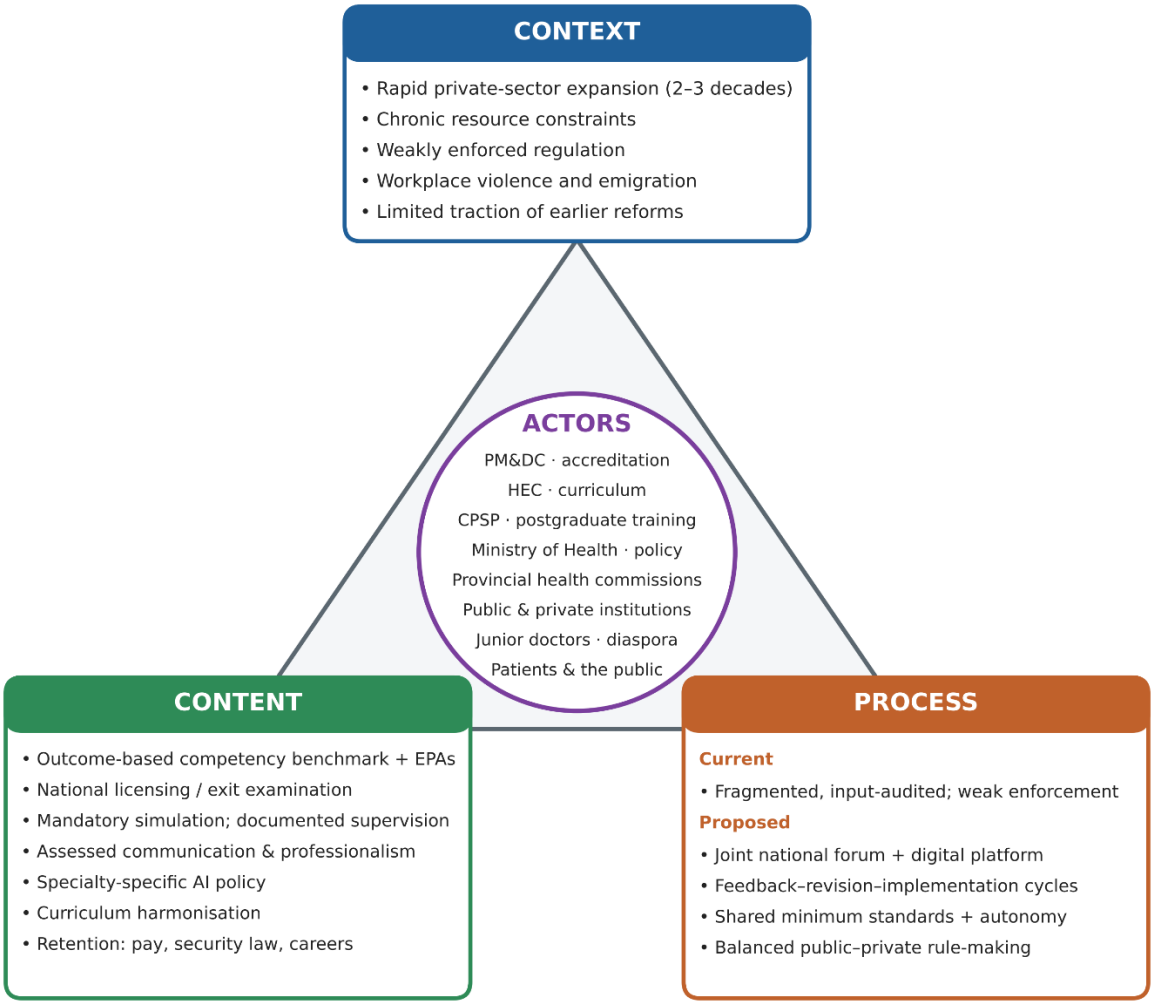


Figure 2. Themes mapped to the Health Policy Triangle

AI, artificial intelligence; CPSP, College of Physicians and Surgeons Pakistan; EPA, entrustable professional activity; HEC, Higher Education Commission; PM&DC, Pakistan Medical and Dental Council.

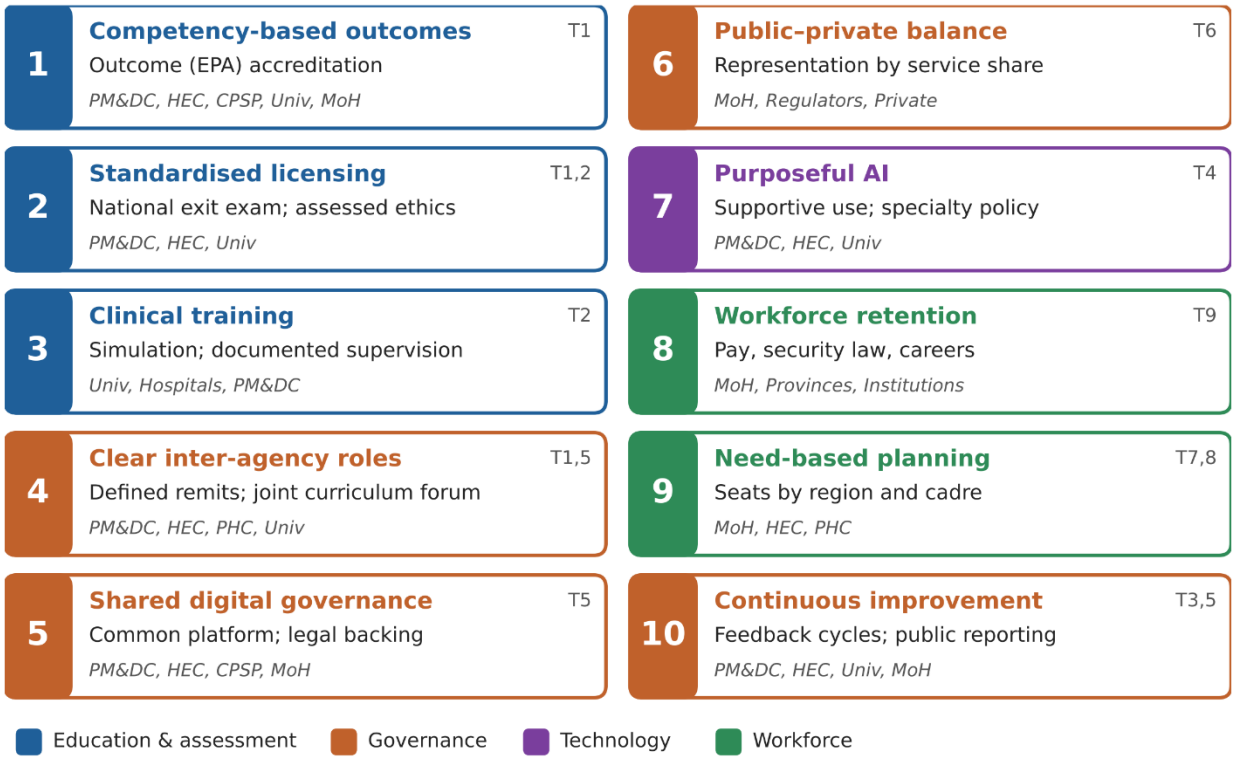


Figure 3. Priority reforms proposed by participants

Discussion

This national multi-stakeholder FGD found broad agreement that the central weakness of HPE in Pakistan is not a lack of institutions or regulations[11] but the absence of an agreed, enforced definition of graduate competence, combined with input-based accreditation and fragmented governance. Participants linked these upstream problems to downstream consequences; also addressed in a study in 2025[12]. Viewed through the Health Policy Triangle, the findings suggest that implementation processes and the exclusion of key stakeholders, rather than policy content, explain why earlier reforms had limited effect.

Arya also highlighted in her study that complex systems have a lot of variables, the call to move from counting inputs to assessing outcomes is consistent with international thinking on quality assurance[13], which positions accreditation and licensing as guarantees of graduate performance rather than institutional capacity[14]. CBME rests on explicit, shared outcome definitions, typically operationalized as milestones or EPAs, this point corelates with the point of cooper that how important is to be proficient with set of abilities[15]. Participants' description of CBME adopted "in terminology only" reflects this missing foundation: without a nationally agreed definition of competence and assessments aligned to it, a competency-based curriculum cannot be enforced or evaluated. The recognition barriers participants described give this issue added urgency, because international bodies now tie graduate eligibility to the quality of national accreditation systems; also correlate with the work of Dangler[16].

Participants' emphasis on faculty capacity echoes evidence that CBME and simulation-based education depend on trained faculty and deliberate design, Quazi also emphasized on training of faculty[17]. determined clinical supervision and access to simulation were concrete, feasible targets, as was the formal teaching and proper assessment of communication and professionalism. The suggestion for continuous and proper feedback revisions mirrors the

WFME emphasis on renewal and improvement.[18] On AI, participants' cautious "tool, not replacement" stance and their concerns about policy gaps are consistent with need for medical education to prepare learners to use AI critically rather than depend on it.[19,20]

The governance findings are best understood through the Health Policy Triangle, also used in a study in Sindh.[21] Health policy research in low- and middle-income countries has multiple times shown that reforms halt when mainly focuses on technical component while the process of decision-making and the interests of participants are neglected.[20] Participants described exactly this pattern: many recommendations had circulated for years, but responsibility was divided across departments without a shared platform, documentation was weak and some stakeholders including the private sector, junior doctors and non-physician cadres had very limited voice.[22] A national coordinating platform with clear agenda, and more inclusive standard-setting, may therefore matter as much as any single technical reform.[19]

Migration intentions among Pakistani graduates are well documented in the literature.[23] Participants suggested that curriculum reform alone will not retain graduates if pay, security and professional respect are not addressed, this includes a view consistent with global workforce strategy, which treats working conditions and retention as core policy pillars.[24] The diaspora perspective was that migration can be reframed as structured knowledge exchange, which offers a constructive complement, provided such enrollments and engagement is institutionalized rather than dependent on individual initiatives.[25]

Four implications follow. First, regulators and universities should jointly assess and define national graduate outcomes, using an EPA framework, and redesign accreditation to assess them. Secondly, a standalone inter-professional platform with defined roles for PMDC, HEC, CPSP, the Ministry and provincial commissions should coordinate standards, data and reporting details. Third, institutions should be required to document clinical supervision and provide simulation-based education, supported by structured faculty development. Fourth, workforce policy should address security legislation, remuneration and career structures alongside educational reform, and plan for nurses, midwives, allied health professionals and technicians as well as doctors.

Limitations

Data come from a single three-hour FGD, therefore triangulation with the other two HESP FGDs is planned.

Conclusions

Stakeholders from across Pakistan's HPE system agreed that improving quality requires a nationally agreed, enforced definition of graduate competence, outcome-based accreditation, documented clinical supervision and simulation, faculty development and a coordinated governance platform. They also made clear that educational reform will not retain graduates unless their pay, security and dignity are addressed. Future reform efforts should give as much attention to implementation processes and the inclusion of under-represented stakeholders as to the content of new policy.

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Human Ethics and Consent to Participate declarations: This study was conducted as per the ethical principles of Declaration of Helsinki (World Medical Association), Ethical approval was obtained from IRB committee of Rashid Latif Medical College with reference number

IRB/119/2026, Informed consent was obtained from all the participants before the conduction of FGD. Participation was voluntary and participants could withdraw at any time.

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