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State Healthcare Paradoxes: Accessibility, Politics, and Public Health Challenges in Tehsil Kot Addu

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Abstract
Pakistan is a nation with significant structural paradoxes in healthcare, where policy promises in the area of universal care fail to align with lived conditions. The article focuses on healthcare provision in Tehsil Kot Addu, Southern Punjab, in relation to accessibility, politics, and community health matters. According to a mixed-methods research design of surveys, interviews, and secondary data, the study determined that despite the presence of health facilities such as Basic Health Units (BHUs) and the Tehsil Headquarters Hospital (THQ), most are poorly funded, staffed, and geographically inaccessible. Political patronage is also a factor in health care provision because it is more likely that policies will focus on the areas with an electoral advantage rather than on the needs of the population. The public health issues of high maternal mortality, outbreaks of communicable diseases, and inadequate preventive medical care are manifestations of systemic neglect and rural disadvantage. The paper has named three availability versus accessibility, political visibility versus institutional absence, and preventative rhetoric versus curative reality paradoxes that characterize the healthcare environment in Kot Addu. These results indicate that health governance in rural areas should be enhanced, unequal resource distribution minimized, and concern should be focused on prevention to attain meaningful health disparities.

keywords: *Medical access, The patronage system, Health concerns, Rural health, State paradox, Kot Addu, Pakistan.*

Introduction

In most of Pakistan, the right to healthcare is obstructed by access, paradoxes of access, politics, and paradoxes of delivery systems. Such an example is Tehsil Kot Addu, in which healthcare provision in this southern part of Punjab is already mired in structural inequities, politics, and logistics issues. In 2019, Kot Addu was made a district, though the medical infrastructure is lacking drastically. Accessibility is low, and the political interference in the allocation of funds has always remained a point of concern. These barriers reflect the broader healthcare dilemmas of Pakistan. International commitments, the constitution, and policy frameworks suggest universal healthcare, but the actualities of the rural and semi-urban regions reflect the persistence of barriers. Kot Addu exhibits this paradox where the state invests in symbolic development projects and neglects the provision of basic healthcare infrastructure. Even though there are Tehsil Headquarters Hospital (THQ) and Basic Health Units (BHUs), they are not well-equipped, are understaffed, and mismanaged. Therefore, neighbourhoods have been left with unofficial alternatives of private clinics and folk healers. Such a state of affairs shows the gap between availability and accessibility. Most of the facilities are on paper, but are not available to the majority of people in reality.

- **Healthcare at Kot Addu.**
- The distance, cost, quality, and attitude of human beings are the aspects that define healthcare in Kot Addu, and the presence or absence of hospitals, remote location of some rural villages to THQ and BHUs, and poor transport result in the failure to provide timely treatment. Even in such facilities, patients pay high out-of-pocket costs in order to obtain medicines and tests, and this discourages the poorest. Other cultural limitations to women limit their movements because they require a male escort, and they are therefore not attended to in time. Specialists are concentrated in municipalities, leaving behind the local hospitals with a shortage of even basic general physicians. Access is, therefore, determined by the physical, financial, and social barriers.
- **Aspects of Healthcare in politics.**
- In Kot Addu, politics has a significant role in determining healthcare delivery. The allocation of healthcare facilities is done based on political favour, not on the basis of population requirements. Health infrastructure projects are also carried out by politicians as a means of campaigning as they announce upgrades or new facilities to be developed during election periods, and many of these are not completed or are non-functional afterwards. The healthcare staffing practices tend to be influenced by politics instead of merit, which lowers the quality of services and accountability. The practices build distrust of the state-operated institutions and drive communities to expensive privatized options.
- **Public Health Challenges**
- Kot Addu is affected by poverty, poor infrastructure, and inequality, which are major determinants of several social health issues**:**
- Mother and child health: A notable number of women give birth with untrained staff, and as a result, complications arise and emergency cases are referred to distant hospitals in Multan or Dera Ghazi Khan.

- **Communicable Diseases:** Dengue, hepatitis, and diarrheal diseases are widespread as a result of unsafe water, lack of sanitation, and preventive measures.
- **Non-Communicable Diseases:** The increase in the number of cases of hypertension, diabetes, and cardiovascular illness is poorly diagnosed and treated because of the absence of local facilities.
- **Mental Health:** Depression and anxiety are rising because of unemployment and poverty, yet no specialized services exist.

The paradox lies in preventive versus curative care: while prevention could reduce disease burdens, the state invests primarily in reactive, curative approaches.

Theoretical Lens: Paradoxes in State Healthcare

Healthcare in Kot Addu demonstrates contradictions between policy rhetoric and lived realities. Pakistan has formally adopted Sustainable Development Goal 3 ("Ensure healthy lives and promote well-being"), but inequality persists. The study highlights three paradoxes:

- **Availability vs. Accessibility:** Facilities exist in name but remain out of reach.
- **Political Visibility vs. Institutional Absence:** Politicians promise services, but institutions fail to deliver.
- **Preventive Rhetoric vs. Curative Reality:** Policy emphasizes prevention, but practice is reactive and curative.

Problem Statement

Although Kot Addu has a healthcare infrastructure, structural barriers hinder its effectiveness. Access, quality, and equity are undermined by political favoritism, resource mismanagement, and weak preventive systems. This study critiques the paradoxes of state healthcare, especially how accessibility, politics, and public health challenges intersect to shape lived realities.

Research Objectives

- To analyse the paradox of availability versus accessibility of healthcare facilities in Tehsil Kot Addu.
- To examine how politics influences healthcare provision.
- To identify key public health issues in the community.

Research Questions

- What is the difference between availability and accessibility, and how does it impact healthcare delivery in Kot Addu?
- How does politics affect the functioning of health facilities?
- What community health issues highlight the paradoxes of healthcare in Kot Addu?

Literature Review

Healthcare systems are highly intricate international intersections of access, politics, culture, and structural issues. All these go hand in hand in such paradoxes that define the provision of health care institutions and quality in certain places, such as Tehsil Kot Addu in Southern Punjab. This review of the literature focuses on the international context of medical care, provinciality in Pakistan, Pakistani politics, and the reasons why certain health problems in the population are still an issue in rural areas. It also interacts with theoretical traditions, specifically, critical medical anthropology, health equity theories, and biopolitics, to position these paradoxes. The review ends with the development of a conceptual framework that guides the study.

Healthcare is a resource that is disproportionately distributed worldwide. In high-income countries, there is a general problem of never having enough funds to cover both the cost and equity problem, but in low- and middle-income countries (LMICs), there are more basic barriers of inadequate infrastructure, of medical practitioners, and of referral systems. According to WHO (2022), more than half of the world population lacks access to the necessary healthcare services, with most of the burden being concentrated in Africa and South Asia. Sub-Saharan Africa has rural health posts that are constantly understaffed, which leads to delays in patterns of care seeking. Quite on the contrary, research by Okeke (2019) demonstrates the tendency of families in rural Nigeria to postpone medical check-ins due to the distance of commuting, which instead leads to consuming local remedies before going to the hospital. This situation resembles the healthcare-seeking behaviour in rural Punjab, including Kot Addu, where traditional healing is integrated into the biomedical treatment. Healthcare reforms that emphasize decentralization (as in the Unified Health System in Brazil) also resulted in uneven rural access to services, but also created inequities in financing and administration. In India, the National Rural Health Mission was launched, and it was hoped that more women would be convinced to give birth in hospitals and the number of those dying during delivery would be reduced. Despite some improvement, the program was not doing well in the aspects where the number of health workers was insufficient to address the demand (Gupta & Das, 2020). These and other stories around the world encourage us to remember that the rise of access to healthcare may come with new issues. Such contradictions as an even greater number of people having access to health facilities with still high service gaps is not exclusive to a single nation. Instead, they are citing structural issues that are destroying most of the health systems.

Pakistan's healthcare is a shambles of providers. On the one hand, there are state-financed hospitals; on the other hand, a combination of privately-operating clinics and traditional doctors that is mostly unregulated. The predominant issues of the relative inadequacy of investment in health are among the most urgent. The spending on healthcare in the country is (Economic Survey (2023) barely 2.2 per cent of the GDP, by far less than what is offered by the World Health Organisation, 6 per cent.

Cities like Lahore, Karachi, and Islamabad are constructing hospitals, universities, and special treatment. Meanwhile, small Basic Health Units (BHUs) or Rural Health Centers (RHCs) are widespread in the country districts, such as Kot Addu. The majority of these facilities are abandoned, short of physicians, medicine, and even primitive facilities. Studies in Punjab alone suggest that one-third of BHUs can be out of operation at a given special time, usually because of staff absence or understaffing. (Akhtar, 2021). The easiest medical advice to families in such areas may be a drive-or not a drive at all.

To close such loopholes, efforts have been initiated. The Sehat Sahulat Program was initiated to offer health cards. Here, poor families can get free medical treatment in hospitals. Even though this has helped some households. Research has shown that the majority of rural households are not benefiting. To complete it all, the enrollment process in the vast majority of cases is connected to political connections (Shah & Raza, 2022). In areas like Kot Addu, where there are already below provincial literacy levels, some of the worst families are being deprived even of the help that they are expected to get.

Healthcare delivery is a large dimension of politics. The elites or the politicians are in the driving seats. They are known as the gatekeepers to the resources of the state in the rural Punjab. An examination by Javid (2018) indicates that the allocation of physicians, distribution of medicines, operations of rural hospitals, and everything is influenced by local politicians. It is a system of patronage that can be witnessed in Kot Addu, where certain groups have existed.

Countries such as Kot Addu have different problems. Child and maternal health indicators are very distressing. According to the Punjab Health Department (2022) maternal mortality is 40 percent higher in rural Punjab than in urban areas. Immunization is also poor, with only 68 percent of rural children being fully vaccinated, against 84 percent in urban areas.

Other chronic problems are Poor sanitation and contaminated drinking water, which result in waterborne illnesses like diarrhea, hepatitis, and typhoid.

Seasonal floods interfere with access to health facilities. In the 2022 floods, most areas in Southern Punjab were submerged, leaving people to use mobile clinics operated by NGOs. A doctor-patient ratio in Pakistan is approximately 1 to 1,200 nationally; in rural Punjab, it may be as low as 1 to 2,000 to 3,000 (Pakistan Medical Commission, 2022). This leads to excessive waiting periods, poor quality of consultation, and the use of quacks.

Although biomedical growth has taken place, indigenous medicines continue to play a key role in health-seeking behavior in Kot Addu. Those who visit hakeems, herbalists, and spiritual healers have conditions as simple as fever or infertility.

Kleinman (1980), in his theory of explanatory models, provides the explanation of this dependence: patients make sense of illness in terms of their cultures and aim to be cured according to their perceptions. The integration of biomedical treatment with traditional remedies is common (hybrid healthcare).

A patient with hepatitis could also be taken to a government hospital and be prescribed antiviral medicine, and at the same time be taking herbal tonics at a local hakeem. This hybridity brings both resilience and risk, since certain cures produce negative interactions with contemporary drugs.

Theoretical Perspectives

The research is framed in several theoretical perspectives:

1. Critical Medical Anthropology - paying attention to structural inequalities (poverty, class, gender, geography) as a determinant of access to healthcare, Singer (2004). Gendered inequalities are perpetuated as women in Kot Addu require the consent of male relatives to obtain care.

2. Biopolitics by Foucault (1976): Health is a discipline of power that the state controls in its populations. This restriction is discriminatory and disproportionate in rural locations, where urban centers are given priority until emergencies such as epidemics occur.

3. Health Equity Models Marmot (2005): Focus on the so-called social determinants of health, including education, income, and environment. Low literacy, agricultural dependency, and environmental risk to floods interact in Kot Addu to create enduring health disparities.

Conceptual Framework

The theoretical framework of this research is a combination of accessibility, politics, and cultural practices. It implies healthcare paradoxes in Kot Addu are due to the overlap of Poor accessibility

because of infrastructural and resource limitations. Interference in the allocation of services by politics. Environmental and poverty-related health issues of the population

Although the literature on healthcare issues facing Pakistan is extensive, several studies concentrate on the macro realities of Kot Addu but do not address the micro realities. The current literature generalizes rural Punjab or investigates urban health inequalities. This paper tries to fill that gap by conducting a synthesis of survey information, face-to-face interviews, and critical discourse analysis to gain a better insight into the daily healthcare issues that the local social and political realities of Kot Addu dictate.

Research Methodology

The study employs a qualitative research approach with a strong emphasis on qualitative results. Although hospital capacity, doctor-to-patient ratios, or the rate of vaccination are valuable numbers, they cannot reflect the reality of everyday life influenced by culture, politics, and community life. To find out these lived experiences, the research was based on participant observation, rapport building, sampling techniques, in-depth interviews, FGDs, and discourse analysis. With the help of these methods, researchers heard directly what health workers, policymakers, or patients struggle with and what decisions they make. This multi-cultural population is critical to the representation of voices among service users, service providers, and regulators. Participants were sampled using a purposive & Snow ball sampling technique, 20 in-depth interviews (10 participants in the community, 5 healthcare workers, 5 policymakers). 4 focus group discussions (FGDs) among women, youth, and the elderly. Such a combination of sampling guarantees a breadth as well as depth in data collection.

Qualitative data gives a comprehensive view of the healthcare paradox in Kot Addu. The methodology enables the researcher to be rigorous and relevant by employing purposive and snowball sampling, utilizing thematic and statistical analysis, and maintaining ethical integrity.

Results and Discussion

Analysis of data responses reveals that the majority of respondents live over 20 kilometers from the nearest major health facility, creating a considerable degree of physical barrier to visiting. The other challenge is transportation: 70 percent of the respondents interviewed owned their own vehicles or relied on informal transportation such as rickshaws or tractor trolleys in emergency cases. This slows down access and, in extreme cases, it is a cause of death.

Affordability is another contributing factor. Half of the interviewed individuals testified that they cannot afford regular checkups or treatment at the private clinics. A large population is left with no option but to trust the public sector, whether it is poorly equipped or not. These findings were supported by interview data. One of the female respondents said:

"Although the hospital is near my home, as a woman, without a male relative, I cannot visit it."

This is the dichotomy of availability and accessibility. Facilities are available in the official records, but they are of little use to ordinary citizens. The Majority of the respondents said that election promises of upgrades or equipment delivery to hospitals are usually announced before elections, but are not usually fulfilled after. Interviews pointed to a general distrust of political officials. A school teacher remarked:

"Physicians are allocated based on whoever is in power. Drugs are marketed to the poor who end up in the clutches of the private drugstores."

This is the paradox of the presence of politics as opposed to the invisibility of an institution. The healthcare concerns are treated as a campaign tool to demonstrate visibility, but the real institutions are poor, poorly run, and typically ignored after election wins.

There are a number of acute health problems. The biggest problem is maternity care. Half of the female respondents indicated that they would turn to traditional birth attendants due to the lack of women workers in their local Basic Health Unit. This indicates both the presence of structural gaps and the gendered barriers associated with the government of health care.

Communicable diseases are very high. More than half of the respondents had reported cases of hepatitis, malaria, or dengue in their homesteads recently. Flooding and the absence of sanitation and local outbreaks accompany these conditions following seasonal rains.

Increased prevalence of non-communicable diseases among the older population also occurs. The old respondents aged above 40 years had untreated hypertension or diabetes due to the inability to afford regular checkups. Lastly, mental health is a new but invisible crisis. Respondents acknowledged the presence of stress, anxiety, or depression symptoms, but there were no counseling or psychiatric services in their localities.

Nadia Bibi shared:

"Fever is tolerable, but stress is not. No one treats it. It is just people saying, Pray more or work harder."

This is the paradox of preventive rhetoric and curative reality. Some policies purport to focus on prevention, yet the reality of the services is reactive and crisis-based. As Muhammad Mazhar stated:

"Pharmaceutical companies in Pakistan do not have any checks and balances, and some are not even registered. These companies do business with the assistance of the state, and they offer a kickback to the health ministry. Everything is taking place under the auspices of the Pakistani government."

Most of the households were using both biomedical and traditional remedies. The central role is still played by herbal treatments, hakeems, and spiritual healers, particularly where state healthcare falters. Herbal remedies are usually applied in the treatment of hepatitis, infertility, and general weakness. Spiritual healing, Quran verses, and amulets are preferred in the treatment of psychological and chronic diseases. Usage of modern biomedical services is restricted to emergencies, accidents, and severe diseases.

One male farmer explained:

"When the doctor is available, we visit the hospital, but as an alternative, we resort to hakeems because at least they (hakeems) hear us and bring some medicine."

According to Ghulam Haider:

"People utilize traditional medicines because they are poor, they don't know anything regarding getting health, they are afraid of modern practices, and they believe in folk wisdom."

The integrity of the traditional and the modern systems is evidence of the cultural irony of trust in hybrid practices, where individuals operate in both systems to address the inadequacy of state health institutions. Combined, the trends demonstrate how political agendas, structural gaps, and cultural realities collide to create deep inequalities in access to healthcare among people.

The study identified three major paradoxes, i.e., the lack of availability versus accessibility, the lack of political visibility versus institutional absence, and the lack of preventive rhetoric versus curative reality. All these paradoxes are firmly entrenched in the structural and cultural reality of rural Punjab.

Health facilities are available and accessible in Kot Addu, but the majority of people cannot access them because of distance, cost, and sex. This is similar to the theory of health equity proposed by Marmot (2005) that asserts that geographical determinants of health, including literacy and poverty, are critical determinants of health outcomes. The observation that political leaders leverage healthcare facilities to secure political votes is consistent with what Javid (2018) noted in his report that, in rural Punjab, healthcare provision has been reduced to a patronage instrument instead of a social service. Since healthcare is an award, rather than a right, as a matter of practice, it reinforces inequalities. In an actual sense, policies promoting preventive health services, immunization, and maternal care are fragmented and crisis-oriented services. This paradox echoes the critical medical anthropology paradigm created by Singer (2004), which bases the formation of incompatibility between policy discourse and real-life conditions on structural inequalities.

Most of the respondents said they were traveling more than 20 kilometers simply to access a major health facility, which underscored the fact that the rural population is habitually abandoned. The same trends are observed in other countries, and specifically, people in remote settings experience the most significant obstacles to healthcare in Sub-Saharan Africa and South Asia (Okeke, 2019; WHO, 2022). Poor transport connections and cultural barriers, including the need to have a man with them when seeking care, contribute to these problems in Kot Addu. This helps Kleinman (1980) explain models of illness, demonstrating how patients perceive accessibility in a physical, cultural, and gendered manner. The incidence of political interference turned out to be a hallmark of the healthcare paradoxes in Kot Addu. According to the results of the survey, two out of three people felt that healthcare was allocated according to favoritism, and not need. This observation supports the argument of Shah and Raza (2022) that even the most progressive initiatives, such as the Sehat Sahulat Card, do not usually reach marginalized populations because of political patronage and their unawareness.

The example of Kot Addu can be used to explain the Foucault (1976) idea of biopolitics, when the state controls the population unequally. Healthcare is turned into an instrument of control, yet it is distributed selectively, as a political loyalty rather than universal rights.

Rural households are faced with a triple burden of maternal health, communicable diseases, and the increased burden of non-communicable illnesses. The use of untrained birth attendants is subject to both structural deficiencies and gender inequities. Likewise, through high prevalence of hepatitis, malaria, and flood-related diseases, the relationship between environmental susceptibility and health outcomes is demonstrated.

This is reminiscent of the results of Gupta and Das (2020) in India, where even well-planned rural health interventions failed because of the lack of personnel and unforeseen local difficulties. It appears to be the case in Kot Addu, where, unless there is a significant investment and change, the rural healthcare is not going to be any better than a bunch of band-aids on a bleeding wound, and it is incapable of addressing the needs of the population.

Popularization of local medicines and the application of biomedicine are evidence of the cultural diversity of healthcare in Kot Addu. Even though this hybrid approach may be quite beneficial in terms of comfort and care continuity, it may also pose the risk of misdiagnosis and dangerous drug interactions. According to Dr. Shahid.

"Nobody can deny the existence of traditional as well as modern healing practices. The government takes no action against fake practitioners because the present government health system cannot accommodate the majority of patients at their hospitals. Nowadays, the majority of practitioners are here to take advantage of the simple ordinary man, yet lok wisdom is also undeniable."

This dual dependence supports the theoretical work of Kleinman (1980) and Singer (2004), who both believe that cultural structures and structural inequalities determine health-seeking behaviors.

Notably, there is local resilience in hybrid healthcare, too: where state institutions are failing, communities generate adaptive strategies to address illness. However, the idea of resilience must not dull the need of the state to provide equitable and uniform healthcare.

When examining healthcare in Kot Addu, it becomes apparent that social, economic, and political factors are all significant contributors to the experiences of people. These layers can be made sense of by using concepts in critical medical anthropology, health equity, and biopolitics.

The critical medical anthropology work by Singer (2004) reveals how inequalities entrenched over a long period of time deny many individuals any actual access to care. Marmot outlines the health equity perspective by noting that the place one resides, the amount one earns, and the level of education one has are all factors that determine whether the person is able to access a doctor or even get treatment. When Foucault (1976) introduced the concept of biopolitics, he reminded us that healthcare could also serve as a method through which authorities could control and influence communities.

The combination of these concepts enables us to view healthcare in Kot Addu not only as a network of hospitals and clinics, but as a living reality that is defined by culture, politics, and structural constraints. It provides a more humanized image of why some humans are left behind and others are better served..

Conclusion & Recommendations

The healthcare situation in Kot Addu is a microcosm of larger contradictions that are evident in rural Pakistan: there are clinics, but people are unable to access them; there are health promises during the election campaigns, but no follow-through; there are policies about prevention, but most services address the issue only when they appear; and communities are inventive about coping mechanisms, but the solutions are not reliable or safe.

Ultimately, this research concludes that there is no way these healthcare contradictions can be resolved unless there are structural changes. To maximize access and quality, policy should be both equitable, responsive, and tuned to local culture, so that the people of Kot Addu-and others like them can receive the care they deserve. Unless such reforms are implemented, the rural population, such as in Kot Addu, will still have to shoulder the responsibility of the unequal and politicized healthcare system.

The results indicate that to achieve better healthcare in Pakistan, the local facilities should receive support and resources like Basic Health Units (BHUs). These facilities should also be kept under a keen eye to ensure that they are indeed in operation and that they are fulfilling the requirements of the community. Recruitment, transfers, and distribution of medicine should be made transparent to limit the politics of patronage. In the rural facilities, female employees should be hired to help in the reduction of maternal and child health gaps. Policies should not ignore traditional remedies, but through regulation, safe indigenous practices should be introduced into biomedical care. Kot Addu has a high risk of disasters, such as floods, and will need mobile health units and resilient infrastructure to maintain continuity of care in times of disaster.

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