

Beyond the Myth of Oversaturation: Unpacking Doctor Unemployment in Pakistan

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Amidst persistent healthcare disparities in Pakistan, a growing misperception frames doctor unemployment as the consequence of an oversupplied workforce. However, closer inspection reveals a more intricate reality: Pakistan continues to fall below international benchmarks, with a physician-to-population ratio that fails to meet the World Health Organization's baseline standard. This shortfall is compounded by systemic inefficiencies—most notably, the geographic centralization of healthcare facilities in urban centers and the premature exit of many female graduates from the medical pathway due to entrenched social expectations. These factors combine to produce an underutilized pool of trained professionals, paradoxically coexisting with underserved populations and understaffed medical infrastructure.

Breaking each of these factors down individually, first you target the population of non-practicing medical graduates, specifically the women. A significant portion of trained female physicians in Pakistan never enter clinical practice—a pattern deeply rooted in societal expectations, marriage pressures, and the undervaluing of long-term female workforce participation (1). A rarely recognized con of such results leads to the category of women, truly aiming for a future full of ambition as doctors, being discouraged due to the so-called saturation and lack of employment opportunities.

Secondly, you come face to face with the deep-rooted issue of the lack of healthcare facilities and their localization to urban areas. Even in the few places where this is not the case, the medical officers present in the rural areas are aiming for opportunities in tertiary care hospitals of urban areas. Providers working in rural areas consistently point to the absence of sustained infrastructure and sociocultural barriers as major impediments to effective healthcare delivery and workforce retention (2).

Workforce retention in the healthcare sector is increasingly challenged by systemic issues such as excessive workloads, inadequate remuneration, and limited institutional support. These constraints are well-documented in urban tertiary care facilities, yet their impact in rural and underserved regions although more significant remain underreported.

It is evident that the current healthcare system struggles not from an excess of medical graduates, but from poor workforce integration and a fragmented infrastructure that cannot absorb the talent it produces (3). This fragmentation is characterized by an inadequate number of tertiary care centers, disproportionately low availability of Basic Health Units (BHUs) and Rural Health Centres (RHCs), and the substandard condition of existing facilities.

A growing misalignment is also evident between the ethical foundations of medical practice and the career trajectories many graduates pursue, with an increasing preference for positions in urban, high-profile institutions, even though such settings are oversaturated and highly competitive, rather than service in areas of critical need. This tendency reflects not only a systemic failure in planning but also a gradual erosion of alignment with the social contract and professional oath that falls under a medical professional's fundamentals.

While structural reform is essential, it must be accompanied by self-reflection within the medical community, understanding that true change only follows when there is individual accountability alongside communal advocacy.

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