

REVIEW ARTICLE

POLITICAL AND ECONOMIC UNFAIRNESS IN HEALTH SYSTEM OF PAKISTAN: A HOPE WITH THE RECENT REFORMS

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Background: For the last few years, Pakistan's health system has faced numerous challenges pertaining to human resource and its deployment, resource allocation among the different tiers of the health care system, infrastructure development and unfair access to care. The enactment of the recent constitutional amendment has made the health system's situation even more uncertain than before. **Methods:** A detailed literature review was carried out to understand fairness and responsiveness in health systems. The findings of the review were then compiled particularly in the wake of recent constitutional amendment defining health sector reforms in Pakistan. **Results:** Various levels, features and components of health system of Pakistan were looked into in view of understanding the extent of 'fairness', 'responsiveness' and 'adequacy'. Healthcare financing; geographic distribution of health care facilities; human resources in health; access to health services and essential medicines; the allocations to urban and rural segments; and finally understanding the health positioning in national agenda and priorities were examined for this purpose. **Conclusions:** In the post-devolution scenario, provinces must think systematically how to deal with the capacity issues to manage different components of health care system. Nonetheless, as a country, collective actions would be required to avoid any pitfalls, while approaching Millennium Development Goals by 2015.

Keywords: Unfairness, Health system, Devolution, Millennium Development Goals

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INTRODUCTION

The term unfairness has many facets such as the inequities in the health care delivery and access; inadequate financing and resource allocation for health; inefficient management of health services; and lack of accountability with regard to performance.¹ When the health system of a country treats its people differently in spite of the fact that they could have similar needs for the healthcare, it is considered as unfair.² The financial barriers further affect the health outcomes of the population since they play an important role in determining the health seeking behaviour and health services utilization.³ Non-financial barriers to access are also imperative as most of them are socially and culturally embedded in the society. That is why an inter-sectoral approach to public health has been long advocated for addressing all the social determinants of health. Moreover, the system involved in delivering the healthcare should be efficient and responsive, which guarantees good quality services to satisfy its consumers.^{4,5}

Historically, most of the policies in Pakistan have been made by the bureaucrats and the technocrats and not by the peoples' elected representatives.⁶ Therefore, beneficiaries of these policies have always been the elites in urban and the feudal in rural areas of the country. These policies have struggled to deliver health, nutrition, education, employment opportunities for the masses in the country. Another reason for this dismal state of affairs had been the concurrent but

indistinct distribution of responsibilities between federal and provincial tiers of the government, resulting in a nominal ownership of the system. The Government of Pakistan passed a constitutional amendment, abolishing several federal ministries and thus health with few other portfolios was devolved completely to the provinces. This is actually an effort to revitalise the original constitutional position of health which is a provincial legislative subject. The other logical objective was to give the provinces the autonomy to strategize for their respective health sectors which have evident variations in terms of population size, political and social set up, and the structure and quality of healthcare delivery system.

This paper has been developed to highlight some important issues of health system of Pakistan which have created an element of unfairness in the past, as well as it will attempt to analyse whether this constitutional turnover could be a window of opportunity to address the long standing issues in the health sector.

METHODOLOGY

A critical review of the literature was carried out on the documents developed around themes of fairness and responsiveness in health systems. In the first stage, peer reviewed articles were searched on Medline using MeSH terms such as health system, fairness, responsiveness, health policy, developing countries, etc. Then Google Scholar and EndNote[®] were used as other search engines for accessing the papers, surveys and reports of Government of Pakistan and development partners working in the country. Having determined the dynamics

of the health system of Pakistan, eventually the findings of the review were then compiled specifically in the wake of the constitutional amendment in Pakistan. This literature review however could have been more robust if there were more original research material available and accessible for analysis.

Health in Pakistan:

The health indicators of Pakistan show a high population growth rate, high infant and maternal mortality, and high incidence of low birth weight babies. These indicators are not improving as in case of Bangladesh, Sri Lanka and India. Pakistan ranks 125th out of 180 countries in the UNDP’s Human Development Index (HDI), which measures the wellbeing of people by keeping in view their life expectancy, literacy, education and standard of living. According to the UNDP’s 2010 report, Pakistan is facing enormous challenges including poverty, poor health facilities, illiteracy and a continuously rising figure of population.⁷ One reason could be that Pakistan’s spending on health is far less than the WHO’s recommended figure of US\$ 34 for low and middle income countries.⁸ An average man spends around US\$ 17 per year on health in Pakistan; out of which US\$ 13 is out-of-pocket private expenditure. Being a struggling economy, Pakistan has always been able to allocate less than 1% of GDP to health. Ironically, of this meagre budget, 80% is consumed by the secondary and tertiary care services, serving only 15% of the population. In contrast, only 15% is spent on primary health care services, which are supposed to cover 80% of the population.⁹ In addition, poor financial, structural and human resource management has made the situation even bleaker, over the years. Majority of the users of government health facilities are not satisfied because of non availability of medicines, long distances to the facility and inappropriate attitude of the staff.¹⁰

Table-1: Comparison of health outcomes in Pakistan with countries in the region

Country	Life expectancy (2008)	Infant Mortality Rate per 1000 (2009)	Mortality rate under 5 per 1000 (2009)	Annual Growth rate (%) (2009)
Pakistan	66.5	65.1	95.2	2.1
India	63.7	30.1	78.6	1.55
Sri Lanka	74.1	18.5	12.9	0.94
Bangladesh	66.1	59.0	69.3	1.29
Nepal	66.7	47.5	71.6	1.28
China	73.1	20.2	29.4	0.66
Thailand	68.9	17.9	15.1	0.62
Philippines	71.1	20.5	27.2	1.96
Malaysia	74.4	15.8	11.3	1.72
Indonesia	70.8	29.9	31.8	1.14

Source: World Bank, US Census Bureau, Planning Commission Pakistan

A positive side of the picture, however, is that the private sector has rapidly grown in Pakistan, plugging in the gaps in curative and preventive service

delivery to the poor. Nonetheless, since most of the private sector operates for profit, it has had its negative consequences too, for instance creating inequities in health care access in the society.

An overall unfairness prevailing in the healthcare system and affecting large segment of the population can be discussed and analysed further as below:

1. Financial unfairness:

In 2004–05, the public sector was spending Rs. 375.00 (US\$ 6.4) per head on health of Pakistani population, out of which Rs. 80 (US\$ 1.3) per person was shared by donors and international agencies. As much as US\$ 16 originated from the private sector and almost all of this is in the form of direct individual out-of-pocket payments.¹¹ Despite the fact that country is lagging behind *vis-à-vis* MDG targets, Pakistan still spends 0.67% of its GDP on health that too reflecting allocation disparities and no mechanism for alternate financing or safety nets for the poor. Though historically, health received a small share of the annual budget¹² but the budget allocated in 2009–2010 was even 27% less than the preceding year. The allocations for Family Planning, Primary Health Care (PHC), and Expanded Program on Immunization (EPI) were cut down.¹³ This is also on record that a large proportion of the budget of health sector goes to the non-developmental fund and expenditures.¹⁴ This situation calls for an action against the unfairness in financing with not only an increment in the allocations but also to address the disproportions in the developmental and the non-developmental budgets.

2. Unfair geographical distribution of health facilities:

Physical access is still one of the most major problems as evident from the fact that the nearest tertiary care hospitals for the people of the remote Gilgit-Baltistan are about 600 Km away at a travel time of 16 hours through Karakorum Highway with no air ambulance facilities.¹⁵ The access problem is also faced by the people of geographically remote areas of Balochistan, the largest but a grossly underdeveloped province, having a widely dispersed population.¹⁶ Similarly, all over the country, only 33% of the population lives in the range of 5 Km from a health facility.¹⁷ It is a documented fact that when the population clusters are situated at a distance of more than 5 Km from a Basic Health Unit (BHU), it results in low utilization of health facilities.¹⁸ Despite the establishment of more than 5,200 BHUs and 550 Rural Health Centres (RHCs) all over Pakistan for the provision of Primary Health Care to the people, the universal coverage is still to be achieved.

3. Unfair deployment of human resource:

Skilled personnel in health care provision are critical to achieve the health related Millennium Development Goals (MDGs) as they contribute toward improvement of all health outcomes. Lady Health Workers (LHWs)

have limited effectiveness especially due to population to health worker ratios and also due to its limited capacity to deliver preventive services mostly.¹⁹ This issue has been resolved to some extent by training and deploying community midwives for conducting deliveries. Very few sanctioned posts for the female workers, difficulty in their recruitment and a high attrition rate has resulted into a gender imbalance among health care providers. One study observed that 40 out of 100 rural health facilities had a sanctioned post for lady doctor but only three of these could be filled.²⁰ All health facilities providing EmOC services should have at least one lady doctor on the staff. However, another study conducted in Punjab and Khyber Pakhtoonkhwa recorded that they were available in only 42% of the facilities. On an average, 78% of higher level health facilities had lady doctors as compared to only 28% primary level facilities in Punjab and Khyber Pakhtoonkhwa.²¹ This has resulted into a non-engendered health care system, leading to unfairness in health service delivery to the women living in 70% rural area of the country. Lack of security, basic amenities of life and minimal wages to skilled health work force at primary level, immensely affect their motivation. Some of the consequences are quite evident such as holding dual jobs, absenteeism and the 'ghost worker' phenomenon.⁹

4. Unfairness due to issues of access to healthcare services: Many people would bypass the first level health facilities because of unavailability of good quality services, inappropriate behaviour of the staff or shortage of essential medicines.²² The government facilities utilization studies show 0.3 to 0.7 consultations per person in a year, which is less than the minimum standards of around two visits per year.^{23,24} The state of primary health care could be responsible for explaining this phenomenon. There is a huge network of private practitioners (formal and informal) which are more interested to serve in the urban areas for better monetary or professional prospects.²⁵ There are also disparities among the provinces, in terms of population's access to health care; Punjab being slightly better off as compared to the other provinces because of its relatively more effective management. In this scenario, women and children are the ones who suffer the most. The status of women's health in Pakistan could be determined by the class, urban rural division, tribal or feudal conservatism and the socioeconomic status of the family. All these factors could contribute to a limited access to the obstetric services and health care seeking for children.²⁶ Most of the women are not allowed to access the healthcare facility until accompanied or permitted by a male family member. Dearth of female health care providers adds to the gravity of the situation, depriving the women from their basic human right to access health with dignity.²⁷ One of

the serious consequences to quote is that 70% of the women of reproductive age cannot receive assistance from a skilled birth attendant at the time of child birth; the situation of course is even worst in the rural areas.^{28,29}

5. Unfairness due to poor access to essential medicines:

Access to essential medicines is not only dependent on health system financing, but mainly on retail prices, distribution systems, dispensing modalities and their shelf-availability. Health systems of developing world generally have poor control over the cost, dispensing regulations and the availability of essential medicines.³⁰ In Pakistan, majority of the people seek health care from the private sector and thus the entire cost is to be borne out of pocket. Over 70% of the health expenditures are funded through private sector out of which 9 over 10 is out of pocket health expenditures by private households.^{31,32} The public sector facilities always have a limited stock of essential medicines and this is one of the main reasons for under utilization of the government services.²⁶ The manufacturing and production of essential medicines is by and large controlled by the private sector. There are 400 pharmaceutical companies in Pakistan; with investment of around US\$ 1.18 billion. Out of these, 30 companies are multinationals, enjoying over 53.3% of market share³³ Local companies too generate lot of foreign exchange, but when it comes to facilitating access to medicines for the local poor, it is negligible. This sector hardly demonstrates any social responsibility.

6. Unfairness due to urban-rural divide:

There is a strong urban bias in Pakistan in terms of establishment of health facilities and practice of doctors. Despite the fact that a majority of population lives in the rural and peri-urban areas, the public as well as private health facilities are concentrated in urban areas of the country. The government has invested heavily in urban-centred health facilities and neglected the primary health care centres in the rural country side. The elected public representatives and feudal leaders ignored the needs of the large proportion of the population, jeopardizing their health and wellbeing.² Allocations to the districts had been decided mostly on the political priorities and not on the basis of disease burden, population need or the level of development of the area.³⁴ Following a capitalist or a market driven growth, the health sector in Pakistan has grown predominantly responding to the needs of the classes, not masses. The system of medical education in Pakistan, and the role of the government, both share the responsibility in this context.³⁵ Both institutions fail to inculcate the moral responsibility among young doctors to go and serve the rural and under-served poor segments of population.

7. Unfair prioritisation of health policy and health research issues:

The health policy process, health research and health agendas for programs in Pakistan have been under a strong influence of the federal bureaucracy, the development partners, and the international financing institutions. The communities, NGOs and academia are seldom consulted in spite of the fact that they have actually a tremendous potential to inform these policies. As a result of this top down approach, health policies and programs failed to meet the needs of the population to be served.²⁴ Therefore, the health indicators in Pakistan have been lagging behind the targets of MDGs because the health policies and programs do not encompass the wide range of social and economical determinants of health.³⁶ For instance, no policy document addresses the major issues around women's lives in Pakistan such as early-age marriage, mental illness, gender-based violence and sexual abuse. All of these issues lead to adverse health outcomes affecting the mothers and subsequently their children.²¹ Policy makers, planners and the decision-makers had minimal understanding of health policy and systems research.³⁷

DISCUSSION

Pakistan, in spite of the progress made in other walks of life, still represents noticeable health inequalities among the poor and the rich, and a system where the distribution of health expenditures has a propensity to benefit the privileged class in the country. Total budget of the province of Balochistan has been less than that of two tertiary care hospitals under the Federal Ministry of Health. The province has only one MRI machine as compared to 3 MRIs in the public sector hospitals of Islamabad/Rawalpindi to serve quite well-off population of the twin cities including the elite bureaucracy.³⁸ The devolution of 2001 which aimed to increase the accountability, could not prove to be of any significant benefit to the public health programs. Districts did not took the responsibility of the low profile preventive programs and decided on for high visibility projects such as construction of the new hospitals; some of which are still non-functional due to lack of staff and equipment.⁵ It would be desirable that provincial governments with administrative and financial authority now develop mechanisms to safeguard the financial access factor for the poorest of the poor to enable their health care seeking. Pakistan's health sector is characterised by an imbalance in the health workforce, with insufficient numbers of physicians, health managers, nurses, paramedics and skilled birth attendants.³⁹ Like most developing countries, urban bias is quite striking in Pakistan in terms of the availability of health facilities and the human resource in these health facilities. The reasons for this could be that the ruling

class mostly resides in the cities, and secondly, the monetary incentives are very lucrative as compared to earnings in a village. In this political and economic milieu, a major share of the budget for health sector is consumed by the big urban and peri-urban health establishments. This would certainly affect the accessibility and the availability of essential medicines for the poor who could be served through primary rural healthcare facilities. Provincial health departments must establish government community pharmacies and dispensaries, which would be a very practical solution for addressing the complex issue and poor people, will be saved from purchasing expensive drugs from the open and unregulated retail market. Similarly, the human resource deployment in the rural and the urban areas and at various levels of health facilities seems to be driven by the economic and the political factors. Human resource policy for primary health care must be strategised, developed, and implemented according to the socio-cultural dynamics of the respective communities. Mainstreaming the local private and traditional health providers by building their capacity to deliver basic services could be another option, in this regard. Besides, the overall quality of life will have to be raised to attract trained health professionals to serve difficult areas. Provincial autonomy opens a window of opportunity to not only ensure a fair distribution of the health facilities by establishing new centres at places where they are needed the most but also balancing the doctor population ratio all over the country by either incentivising them under their service rules or contracting the health facilities to NGOs with the same understanding. Modern techniques and technologies are now available to carry out geographic mapping of the health facilities and the government must use the same for ascertaining the future population projections and for establishing new health infrastructure. Unfairness in giving least priority to the health systems research shows the lack of vision of the state regarding health of the nation. This is the time to not only motivate the provincial stakeholders to but also to build their capacity to understand research and to use evidence for decision making in priority areas for the improvement of health care delivery. In the wake of millennium development goals of 2015, government must reflect more political commitment and action oriented strategies to come out of the vicious cycle of unfairness, which has disabled the health system of Pakistan to deliver the desired results.⁴⁰

In brief, three major steps would be required to minimise the element of unfairness in the larger health system, as recommended by WHO in 2010 World Health Report.⁴¹

- i. Making more funds available for health sector to not only improve technologies and interventions but to make them more accessible.

- ii. Introducing social protection and health insurance mechanisms to reduce direct payments at the time of availing services.
- iii. Removing inequities and imbalances in the use of already meagre resources by stopping waste of money and using it for improving the quality of care and overall efficiency.

CONCLUSION

It is evident that the unfairness in the health system of Pakistan is multi-faceted, having a geographic, social, economic and perhaps an overarching political dimension. This long standing situation has eventually led to widespread health disparities and inequities across the population. Despite all odds, Pakistan as a country has demonstrated improvement in some indicators such as life expectancy, maternal and neonatal health, immunization coverage, child health etc. For the future roadmap, the country needs to have a sizable amount of a resource pool both financial and human, but also a political commitment to utilise these in a transparent and an equitable manner. The current constitutional amendment to handover policy making, administrative and financial powers in health sector to the provinces could be a breakthrough to redress all types of unfair situations in the health care system. The provinces must think systematically how to deal with the capacity issues to manage different components of health care system: vertical programs; research and evidence generation; information management; human resource management; financing; drug registration and regulation. The federation however must give a unified health policy and vision to the nation, a focused stewardship for the health system and a central coordination mechanism for all the provinces to avoid any further pitfalls while approaching the MDGs by 2015. Curtailing corruption and by instigating a transparent and accountable system while de-bundling the powers to provinces, Pakistan can achieve fairness and equity by all means and ensure security of the entire population with a special emphasis on the vulnerable, who need most prompt and responsive healthcare.

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