

Health Sector Reform in Pakistan: Why is it needed?

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Abstract

Objective: The health care system in Pakistan is beset with numerous problems - structural fragmentation, gender insensitivity, resource scarcity, inefficiency and lack of accessibility and utilization. Moreover, Pakistan is faced with a precarious economic situation, burdened by heavy external debt and faltering productivity and growing poverty. These circumstances, on the one hand, underscore the need for innovative health sector reform and, on the other, indicate the complexity of the task involved. The recently announced Devolution Plan of the Government of Pakistan (GOP) that seeks to introduce elected district level local bodies, offers an opportunity to assess the existing publicly funded health care system and introduce far-reaching reforms to make it more efficient and effective.

Study Design: Based on a critical analysis of secondary data from the public domain as well as from various research projects undertaken by the Aga Khan University, the paper intends to present convincing arguments for fundamental health sector reform in Pakistan.

Principle Conclusions: (a) All factors point to the need for a fundamental reform of the health sector in Pakistan; and (b) the Devolution Plan presents an unique opportunity that must be seized to reshape the health care system and make it more efficient and effective (JPMA 52:95;2002).

Introduction

Many countries, both developed and developing, are initiating health sector (HS) reform in varying degrees and forms. Among the developing countries that initiated HS reform in recent years include Philippines, Thailand, South Korea and Malaysia in Asia-Pacific and Nigeria, Uganda and Tanzania in Africa. Results are mixed; however, there is a broad consensus that without reform, the situation would have been much worse¹. The overall goals of HS reform are to enhance efficiency of the health care system, both technical and allocative; to improve the quality of services; and/or to generate new resources for the system^{2,3}. Pakistan has so far introduced little fundamental change in its health care system. In the context of the recently announced Devolution Plan, it is imperative to carefully evaluate the need for health sector reform. The Devolution Plan provides an opportunity to introduce far-reaching changes to make the health care system truly responsive to the needs of people. This paper makes a case for such fundamental HS reform in Pakistan. The extremely precarious and deteriorating economic reality in Pakistan alone demands such restructuring and reorganization of its health care system. Basic performance indicators of the health system also point to this need.

Methodology

The methodology consists of extensive review of available information on the health and social sectors in Pakistan and selected other developing countries. Some of these papers/articles are in the public domain produced by either the countries concerned or by international agencies like the World Bank, the World Health Organization and the United Nations Development Program. Information generated by various research studies conducted by the Aga Khan University, particularly the Community Health Sciences Department, has also been used. In short, the paper is based on critical review of secondary data.

What is Health Sector Reform?

In the broadest sense, the term health system refers to the totality of socio-cultural beliefs and practices, policies, programs, structural arrangements and institutions involved in the production and distribution of goods and services meant to promote health, prevent illness and treat disease. However, the term is commonly referred to the health care system, both public and private. The term reform means “positive change, to change something in order to improve its performance. Health sector reform, therefore, means a meaningful change in the health sector with a view to improve its efficiency and effectiveness.

The overall purpose of health sector reform is to (a) improve/enhance the efficiency of the health sector, both technical and allocative; (b) improve the quality of health care services; (c) generate increased revenue for the health sector and to (d) protect and/or enhance equity. HS reform, therefore, has numerous dimensions such as, financing, organization of service provision, use and demand factor and, most importantly, the package of services to be offered. Reform may encompass one or more of the dimensions or all of them at the same time⁴. The ultimate goal of health sector reform is to improve the aggregate health status of the population. It must be emphasized that health, conceived as “the fullest possible actualization of the human potential”, is viewed as a fundamental social good - an investment that has a direct impact on economic growth and social development. Health and development, in this sense, are interrelated and are essentially two sides of the same coin.

The health sector is affected by broader socio-economic and political changes. As there is change in the broader social, economic, demographic and political environment, the health sector must change and adapt. The need for HS reform in Pakistan must also be predicated on changes in the broader social environment.

• The Rationale for Health Sector Reform

Among numerous factors that call for comprehensive HS reform in Pakistan, five could be singled out for their significance and evidence-based rationale. These are discussed below.

(a) Political/Social

Pakistan has a checkered political history. It was born in 1947 when the colonial British rule ended in India. Within quarter of a century, Pakistan got dismembered when its eastern wing emerged, following a brief civil war, as Bangladesh. Since 1947, Pakistan had only about nine years of civilian rule. It tasted its first military takeover in 1958, the second in 1969 and the third in 1977, after a brief interlude of civilian rule following the dismemberment of the country. A not-so-civil civilian rule was reintroduced in 1988 only

to face repeated disruptions. Finally, Pakistan experienced another military takeover in October 1999, barely a year before the start of the new millennium.

Since independence Pakistan had three constitutions - all to be either abrogated or “put in abeyance” by the military rulers. Since the violent death of its last military ruler in 1988, the country experienced a series of interim and elected governments that ended with the last military takeover in 1999. These historical facts “are some of the many indicators of persistent political instability”⁵. Needless to say, this political instability adversely affected all sectors of the Pakistani society - from foreign affairs, to finance to education, health care and social services.

In short, in fifty years of its existence, Pakistan failed to coalesce as a nation or attain political stability. This failure in creating a viable polity must end. Pakistan needs a clean break from its past. It needs a fresh start. The Devolution Plan, if implemented properly, could bring much needed political structural reform in Pakistan, thereby offering an opportunity for HS reform.

(b) Demographic

Like all other developing countries, Pakistan has also experienced, what is commonly called, demographic transition - falling death rates, falling birth rates and a resulting fall in the overall population increase which, in the long run, leads to aging of the population. However, compared to most other developing countries, Pakistan’s population growth rate remains relatively high - 2.8% during the 1990s⁶. The population of Pakistan increased from 33.1 million in 1951 to 65.3 million in 1972. According to the 1998 Census, Pakistan had a population of 130.6 million. In other words, the between 1972 and 1998, the population of Pakistan doubled. The population growth rate of Pakistan is still much higher than India, Indonesia, Bangladesh or Egypt (Table 1).

Table 1. Population size and growth rates: six largest developing countries.

Countries	Population (Millions)	Population Growth Rate (%)
	1999	1990-99
India	998.1	1.8
Indonesia	209.3	1.5
Pakistan (11)	152.3	2.8
Bangladesh	126.9	1.7
Nigeria	108.9	2.5
Egypt	67.2	2.0

Source: World Health Organization. World Health Report 2000.

If the present growth rate continues, the population of Pakistan will double again in 24 years.

The answer for this high population growth rate in Pakistan lies in the failure of the family planning movement. The Contraceptive Prevalence Rate (CPR) in Pakistan is much lower than in many developing countries, including Bangladesh, China, Indonesia and Iran. Consequently, the total fertility rate in Pakistan remains higher than in most other developing countries^{6,7}. Pakistan started its family planning program in early 1960s. However, due to oscillating political commitment from one regime to another, it failed to become institutionalized. The fluctuating population growth rates from one census to another testify to this failure. According to the 1961 Census, the annual population growth rate in Pakistan was 2.44%; it increased to 3.89% (1972 Census) and then declined to 2.86% in 1981 Census. The 1998 Census found the annual population growth rate to be 2.47%, still higher than that in 1961.

This still rapidly growing population has serious implications for the health care system. On the one hand, it places increasing demand on scarce health care resources; and, on the other, it makes economic development much more difficult to sustain. Appropriate health sector reform, therefore, is needed to effectively address these twin challenges - increasing demand for health care services accompanied by severe pressure on static or declining resources.

(c) Epidemiological

The relationship between demographic transition and epidemiological transition has been aptly documented⁸. In World Bank's 1993 publication Disease Control Priorities in

Developing Countries, authors Jamison, Mosley, Measham, and Bobadilla⁹ argued that with economic development, mortality from infectious diseases in a country declines and so declines fertility. Declining mortality and fertility, in turn, leads to aging of the population; and with this shift in the population pyramid, an epidemiological transition sets in, whereby chronic diseases emerge as the major contributors to mortality. It is apparent that a full-fledged demographic transition is yet to take place in Pakistan. For example, between 1970-75 and 1995-2000, the total fertility rate in Pakistan declined by only about 29% - from 7.0 (1970-75) to 5.0 (1995-2000). However, during the same period, the TFR in Bangladesh declined by almost 56%; and in Iran by 57%¹⁰. Consequently,

Pakistanis. Nevertheless, chronic diseases are already taking an increasing toll. For example, according to the International Diabetes Federation, Pakistan has one of the highest rates of diabetes in the world. In Pakistan, according to its 2000 estimates, more than¹¹ per 100,000 adults (20-79 year olds) are affected by diabetes. This is second only to Hong Kong (12 per 100,000 adults). In comparison, in 2000 India had less than 6 per 100,000 adults afflicted with diabetes. Hypertension, according to a survey conducted by the Pakistan Medical Research Council in 1994, is an emergent problem already afflicting almost 19 percent of the population over 15 years of age¹². By all estimates, cardiovascular diseases are also on the rise in Pakistan. According to the World Bank, non-communicable diseases in Pakistan currently account for 38 per cent of the total burden of disease¹³.

The health sector in general and the public health

care system in particular, is yet to respond credibly to these epidemiological changes. While the Primary Health Care system is still trying to cope with the basic demands of maternal and child health, the vertical programs are all geared towards communicable diseases. Non-communicable diseases like hypertension and diabetes thus, remain largely outside the purview of public health policy. Without significant reorganization and re-orientation of the health sector, these new emerging challenges cannot be effectively addressed.

(d) Economic

Economic factors are perhaps the most compelling arguments for health sector reform. Among the countries of the sub-continent, Pakistan's economic performance over the last decade had been the worst. Between 1985 and 1998, Pakistan's total external debt increased from \$ 13.5 billion to \$ 32.2 billion.

Table 2. External debt and debt service: countries of the sub-continent.

Country	External Debt		As % of GNP		Total Debt Service	
	Total US \$ Millions				As % Exports	
	1985	1998	1985	1998	1985	1998
India	40,951	98,232	17.7	23.0	22.7	20.6
Bangladesh	6,870	16,376	32.1	37.1	22.4	9.1
Pakistan	13,465	32,229	43.9	52.8	24.9	23.6

Source: UNDP. Human Development Report 2000.

As Table 2 indicates, the external debt of Bangladesh and India also increased during the same period. However, while total debt service of Bangladesh in 1998 amounted to only 9.3 percent of its exports, Pakistan's debt service in 1998 was equivalent to almost 24 percent of its annual export⁸.

A look at Pakistan's budget aptly demonstrates the precariousness of its economy. For the fiscal year 2000-01, Pakistan had a budget outlay of Rupees 716,124.30 million; and it spent Rupees 305,824.1 million - or 42.7 percent of the total on debt servicing¹⁴. Defense took 18.64 percent of the budget, while economic, social, and community services combined could only take 3.07 percent (Table 3).

**Table 3. Pakistan's budget 2000-01: deepening economic crisis
(in Millions of Rupees).**

Sector	Budget Outlay	As % of Total
Economic Services	3,285.2	0.46%
Social Services	11,789.0	1.65
Community Services	6,850.4	0.96
Law and Order	10,121.6	1.41
Grants to Provinces	44,157.2	6.17
Civil Government	80,176.8	11.20
Public Sector Development	120,432.5	16.82
Defense	133,487.5	18.64
Debt Servicing	305,824.1	42.71

Source: Government of Pakistan, Ministry of Finance. Budget 2000-01

Table 4. The health systems: increasing private sector role.

	Expenditure on Health Care		Per Capita Expenditure (\$)		Total (\$)
	Public (%)	Private (%)	Public	Private	
Bangladesh	46	54	6	7	13.0
Egypt	27	73	12	32	44.0
India	13	87	4	19	23.0
Indonesia	37	63	8	10	18.0
Nepal	26	74	2	6	8.0
Nigeria	28	72	8	22	30.0
Pakistan	23	77	4	13	17.0
Uganda	35	65	5	9	14.0

Source: World Health Organization, The World Health Report 2000.

In other words, of every 100 Rupees that the Government of Pakistan spends, almost 43 Rupees go towards servicing the debt, not in paying it off.

Such an economic condition is making Pakistan more dependent on loans from transnational agencies like the World Bank and the International Monetary Fund. Fresh loans, on the one hand, increases the debt burden and the budget outlay needed to service it, reducing the availability of funds for other sectors. On the other hand, increasing debt burden also contracts or shrinks the decision-space of the government regarding the economy as a whole. As the World Bank or IMF dictates conditions for new loans and/or demands 'structural adjustments', economic policies become more and more 'hostage' to outside forces.

Moreover, economic constraints force the government to spend less on social services or health, which is often filled in by the private sector. The Government of Pakistan spends about 0.8 percent of its GDP on health care,¹⁵ which is lower than that in Bangladesh (1.2 percent) or Sri Lanka (1.4 percent), but marginally higher than that provincial governments are heavily dependent on the federal in India (0.7 percent). 1- however, Pakistan spends a much higher percentage (6.1%) of its Gross Domestic Product on the military than its neighbors (India 2.4%; Bangladesh 1.7%) or most other developing countries (Indonesia 2.4%; Egypt 5.7%; and Sri Lanka 4.6%) do. It could be noted here that, although in Pakistan health is a provincial subject, the transfer of funds for financing the health care system. According to a recent review conducted by the Social Policy and Development Centre, provinces are becoming increasingly more dependent on federal funds for the health care system. During 1990s, federal transfer accounted for between 85 percent and 90 percent of the total expenditure on health care, compared to about 60 percent to 70 percent during the 1970s¹⁶.

In short, the worsening economic situation and increasing debt burden are severely limiting the government's ability to invest in health. As the provinces, faced with their own economic problems, are becoming more dependent on increasingly poorer federal government, Pakistan must look for innovative alternatives to finance the health care

system. Again, the need of the hour is meaningful health sector reform.

(e) Systemic

The economic situation discussed above is primarily responsible for one of the most important systemic issues faced by the health care sector in Pakistan - a growing role of the private sector. Pakistanis as a whole spend an equivalent of SI 7 per head per year on health care. Almost 77 percent of this money (\$13) is out-of-pocket private expenditure⁶. Except India, the share of private expenditure in the total health expenditure is higher in Pakistan than in most other developing countries.

Another systemic anomaly is the under-utilization of publicly funded health facilities by the population at large. According to the World Bank study cited earlier, only about 20 percent of the population in Pakistan use the government health care system even for their primary health care needs. Beds in Rural Health Centres, Basic Health Units or Taluka Hospitals also remain largely underutilized¹³. The private sector, thus, is playing an increasing role in the provision of health care services in Pakistan. However, this growing importance of the private sector and its implications for the health care system as a whole so far received little attention from policy makers. It is imperative that through appropriate reform, the public-private partnership be strengthened in order to make the health sector more integrated and effective.

This under-utilization of the government health care system also raises questions about its quality and efficiency. Government health centres often lack appropriate staff, equipment, medicines and other facilities. Scarcity of women health professionals, particularly in rural areas, has been identified as a persistent problem. One limited survey carried out in Sindh found only about 25 percent of the Rural Health Centres to have trained female professionals to respond to the obstetric needs of women¹⁷. The World Health Organization recently ranked health systems of all member states in terms of different criteria and a composite index of "overall health system performance". Out of 191 countries, the health system of Pakistan ranked 122 on overall performance; that of India ranked 112, and that of Bangladesh and Sri Lanka ranked 88 and 76 respectively⁶. It is apparent that Pakistan's public health care system needs improvement. Improving the quality of its services through appropriate resource allocation - human, financial and technical - must be taken up as an important and urgent issue.

The public health care system also suffers from some structural problems. While health is a provincial subject and the provinces provide most health care services, the National Program on Family Planning and Primary Health Care is administered by the federal Ministry of Health. The National Program provides basic primary health care services to the women and children in the villages through locally hired Lady Health Workers (LHWs). While LHWs are part of the federally administered National Program, the Basic Health Units (BHUs) and Rural Health Centres (RHCs) - other pillars of the primary health care system - are managed by the provincial Departments of Health. The overall responsibility of managing the health care system at the district level lies with the District Health Officer (DUO) who is part of the provincial bureaucracy. DUO has no control over the National Program or jurisdiction over the LHWs. This structural ambiguity needs to be addressed through appropriate health sector reform.

Conclusions

Pakistan is at a critical phase of its history. Political instability and failed attempts at developing a democratic polity mark the first fifty years of its existence. It needs a clean break from its past. The Devolution Plan, if carried out successfully, presents an opportunity to usher in a more democratic governance system. The devolution exercise will bring fundamental change in the way government services, including health, are delivered and managed. Like other government services, it will make health a responsibility of the newly created local governments. The Devolution Plan, thus, presents an opportunity to introduce fundamental changes in the health care delivery system in order to make it more efficient and effective. In short, it presents a window of opportunity to introduce appropriate health sector reforms.

The goals of health sector reform are to improve the technical and/or allocative efficiency of the health care system, enhance the quality of services, and make the system more equitable. It has numerous dimensions - from financing to organization of services to the package of services to be delivered. Depending on the circumstances, health sector reform may encompass one or more of these dimensions or all of them simultaneously. The "need" for HS reform is dictated by demographic, epidemiological, economic, political, and structural (systemic) factors. In case of Pakistan, all these factors - demographic, epidemiological, economic, and systemic - stress the need for HS reform. With a slower than expected demographic transition, Pakistan's population is still growing rapidly. Epidemiologically, its health care system must face the twin burden of communicable and non-communicable diseases simultaneously. Economically, the country is on the verge of collapse. A fast growing debt burden is seriously restricting government's choice and its ability to invest in health. Consequently, the private sector is taking a greater role, the practical and policy implications of which are yet to be fully recognized and addressed.

The structural problems of the health care system also require serious attention. Under utilization, lack of quality, and scarcity of human, financial and technical resources are persistent problems. Structural ambiguity created by the lack of integration of services offered by the federal and the provincial governments is a critical issue adversely affecting health care. In short, Pakistan is in need of a far-reaching health sector reform. The Devolution Plan presents a unique opportunity to introduce fundamental changes in the health sector. Planners and policy makers should seize this opportunity.

References

1. Asian Development Bank. Health sector reform in Asia and the Pacific: options for developing countries. Manila: ADB, 1999.
2. Cassels, A. Health Sector Reforms: Key issues in less developed countries (Discussion Paper No. 1.) Geneva: WHO, 1995.
3. Berman, P Health sector reform in developing countries: making health development sustainable. Boston: Harvard School of Public Health, 1993.
4. Freak, J. Dimensions of health system reform. HI Health Policy, 1994;27: 19-34,
5. Burki Si. Pakistan: fifty years of nationhood. Lahore: Vanguard, 1999, pp.9293,
6. World Health Organization. Geneva: WHO, 2000.
7. Pakistan Population Census Organization. Census of Pakistan-1998, Bulletin 1. 1998.
8. United Nation Development Programme. Human Development Report 2000.

9. Mosley, WH. The health sector in developing countries: problems for the 1990s and beyond". Annual Rev. Public Health, 1990; 11:335-58.
10. Jamison, DT, (Eds.). Disease control priorities in developing countries. World Bank, 1995.
11. International Diabetes Federation. The Economist, (November 11)., 2000.
12. Pakistan Medical Research Council. Health profile of the people of Pakistan, National Health Survey of Pakistan 1990-94. Islaniabad; PMRC, 1998.
13. World Bank. Pakistan - Towards a health sector strategy. Health, Nutrition and Population Unit, South Asia Region, Washington, DC: World Bank, 1997.
14. Pakistan Government of, Ministry of Finance. Budget 2000-01.
15. World Bank. World development report 1998/99.
16. Social Policy and Development Centre. Annual Review 1998.
17. Aga Khan University. Family health project assessment report (unpublished) 2000.