Pakistan's National Health Policy: Quest For A Vision

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Acronyms

AKU	Aga Khan University
BoD	Burden Of Diseases
BHU	Basic Health Unit
CBO	Community Based Organization
CMH	Commission on Macroeconomics and Health
CBD	Community Based Development
DALYs	Disability Adjusted Life Years
DFID	Department For International Development
DHQ	District Headquarter Hospital
DOTs	Directly Observed Therapy
EPI	Expanded Programme of Immunization
FATA	Federally Administered Tribal Areas
GDP	Gross Domestic Product
GNP	Gross National Product
GATS	General Agreement on Trade in Services
GAVI	Global Alliance for Vaccination and Injections
GATT	General Agreement on Trade and Tariff
HDI	Human Development Index
HMIS	Health Management Information System
HSR	Health System Research
I-PRSP	Interim-Poverty Reduction Strategy Papers
IMR	Infant Mortality Rate
LHV	Lady Health Visitor
MDGs	Millennium Development Goals
MCH	Mother and Child Health
MMR	Maternal Mortality Ratio

MSU	Multi Support Unit
NWFP	North Western Frontier Province
NGO	Non-Governmental Organization
NCHD	National Commission on Human Development
PSDP	Public Sector Development Programme
PRSP	Poverty Reduction Strategy Papers
PMA	Pakistan Medical Association
PHC	Primary Health Care
PMRC	Pakistan Medical & Research Council
PIDE	Pakistan Institute of Development Economics
PIHS	Pakistan Integrated Household Survey
RHC	Rural Health Centre
SPDC	Social Policy & Development Centre
SAP	Social Action Programme
SIUT	Sindh Institute of Urology and Transplantation
THQ	Taluka Headquarter Hospital
TBA	Trained Birth Attendant
TOR	Terms Of Reference
TRIPS	Trade-related Intellectual Property Rights
UNDP	United Nations Development Programme
USA	United States of America
UN	United Nations
UNICEF	United Nations Children Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization
WB	World Bank
WTO	World Trade Organization

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Author

Foreword

Health policy studies are very rare in Pakistan. Previously researchers have shown little interest in this topic due to their focus only on management science in health decision making in general. However, lately, it has been recognized that decision making itself is one of the important dimensions of health care to be looked into when health status of the population is being assessed. With this growing recognition, health policy is becoming the focus of attention among researchers.

The impact of policy formulation and its implementation must reflect through health outcomes. Since health outcomes are affected by multiple factors therefore, the impact of health policies on such outcomes is difficult to assess. However, it is a bitter truth that Pakistan's health status indicators are poorer in comparison with other countries in South Asia as reflected in about 16 percent higher infant mortality rate than the average for other South Asian countries. Similarly, Pakistan is ranked lower in the Human Development Index by UNDP as compared to all other major South Asian countries.

With this background, the present study covers important aspects of health policy formulation and implementation in Pakistan based on interviews of senior officials in the public sector, international organizations and members of the civil society. Furthermore, significant emphasis has been given to discussing linkages between health and development in the context of Pakistan. This is indeed the main crux of the study. That includes conceptual framework on 'health policy as intervention for under-development'. The issues at the level of formulation and implementation also prove the importance of social and economic determinants of health.

Pakistan is a signatory to the Millennium Development Goals set by UN. However, to achieve these goals we need to frame proper policies with participation from all the stakeholders. This research is commendable in that sense it has made a beginning in that direction. However, it needs to be followed by further work in other areas which have direct and indirect effects on the health status of the population.

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Preface

NEED TO BE FILLED

Dr. Zafar Mirza

About the book

This book is based on my research conducted during last year on the subject. There are different sections and important features of this book which I would like to describe here briefly so as to facilitate the readers.

Chapter one introduces the topic, rationale and objectives of the study. Evolution of health policy and planning is an important component of the study. In this regard history of health planning has been traced right from Bhore Committee 1946 to devolution plan, 2001 in chapter two. Existing studies on health planning have been reviewed in chapter three.

Methodology of the study has been described in chapter four. Though, every reader may not be interested in reading methodology however, it is important from academic and research circles point of view. Research findings have been described in greater detail in chapter five which includes policy process; salient features of health policies of 1990, 1997 and 2001; and assessment of the performance of these policies.

Five criteria have been developed to analyze a policy document. All three policy documents have been assessed according to these criteria in chapter five. Thirteen issues at the level of formulation as well as implementation have been identified in the same chapter. Later on, reasons behind these issues have been discussed in chapter six.

A model has been developed to show health policy as intervention for underdevelopment in chapter six which argues that how health policy could be a tool for achieving development goals. Chapter seven contains conclusion and recommendations.

This study was conducted during July-September 2003. Since then, some trivial developments have taken place. However, keeping in view the important nature of discussion and evidence in the research it was decided not to make changes at the time of publication pertaining to these developments. Another issue was availability of reliable data during conducting research. Therefore, some figures may vary at different points, however, relevant references have been provided.

Dr. Talib Lashari
September 2004

Executive Summary

The need for health sector reform, emphasis on better health outcomes through poverty reduction efforts, process of devolution and participation in achieving Millennium Development Goals set by the United Nations are a few important factors that have triggered debate on contemporary health policies in Pakistan. The debate revolves around whether the policies are relevant and have a responsiveness which will work towards achieving better health for the population.

The term 'health policy' has been defined in many ways by different researchers. Bjorkman elaborates that policy is not what people (or a government) say will be done, but rather what has been done. Policy is an empirical record of the past and not just an insubstantial goal for the future. Moreover, he divides policy into two types: normative policy which asserts and assesses preferred objectives or goals for the future and; empirical policy which monitors the practices of the present and the record of the past.

Considering health policy objectives it cannot be ignored that socio-economic factors greatly affect health, hence, health status of the population has close linkages with other sectors. McKeown and Brown, in attempting to better understand why health improved in Britain explored factors influencing the major decline in mortality after 1840. They concluded that improved level of prosperity and nutrition were the major reasons behind that decline.

With this background, assessment of health in Pakistan shows that the country has fairly poorer health indicators than other developing countries in the region. On Human Development Index (HDI) Pakistan's ranking has moved from 138 in the previous report to 144 out of 175 in 2003. According to UNDP report Pakistan's expenditure on health is 0.9% of the GDP which is comparable only with India's. Keeping in view the dismal record of health indicators it would be worth mentioning that since 1993, two studies were conducted by the World Bank (in 1993 and 1998) and in 2003 a report was presented after a consultative workshop on MCH jointly organized by different agencies. These studies underlined the need for many corrections in the health sector.

Understanding evolution of health planning in Pakistan facilitates in exploring the nature of decision making over a half-a-century. The evolution process can be characterized by different milestones. These include, formation of Health Survey and Development Committee 1943-1946; Five-year Plans - a policy instrument 1955-1998; Efforts to

formulate health policy 1970-2001; Alma-Ata Conference 1978; Social Action Programme 1993-96; Millennium Development Goals 2000; Poverty Alleviation 1990s and onward; the role of private sector; and Devolution Plan 2001.

History of fifty-six years of health planning in Pakistan is marked by different initiatives at different times however; it has always lacked a consistent and coherent process. Despite the development of strong planning instruments the desired level of health status has not been achieved.

Different available studies on the topic have discussed flaws in health planning and have demonstrated that health sector reform must shape a health policy which ought to be based on consensus and strive for efficiency, equity and generation of more resources for health.

According to a set process, health policy formulation in Pakistan takes place in the Federal Ministry of Health and at the Planning Commission. While planning and implementation rests with the provinces. Responsibilities are further divided up to districts under the newly devolved setup. In order to understand this process and identify the issues, key informed interviews were conducted. The interviewees were drawn from the Ministry of Health; Planning Commission and other relevant federal ministries and departments. The National Commission on Health and Development; international agencies like World Bank and World Health Organization who play their role in the shape of financial aid and technical cooperation respectively; professional associations; civil society/NGOs like PMA, SPDC; and provincial health departments of Sindh and NWFP were also consulted during the study.

The policy process takes place through a set hierarchy of steps at the Ministry of Health. Ideally, there are nine major steps in the policy process right from formulation up to implementation and monitoring. Initially, information is collected by the Ministry of Health from Biostatistics Unit and Health Management Information System (HMIS). After this, preparatory meetings are being held where all the four provinces are represented. Through such meetings key areas are identified, on which consensus is developed and the first draft is prepared. This draft is sent to the Planning Commission and the Ministry of Finance where consultations take place and the draft is finalized. The final draft is then sent to the Cabinet which gives its approval after discussion. The five-year plan is formulated based on the policy document. Subsequently, projects are designed. Public Sector Development Programme (PSDP) is developed afterwards. The

provincial governments bear the responsibility for implementation. These steps are followed by monitoring and evaluation.

Over the last decade three health policy documents were produced by succeeding governments. Each policy was set to be implemented over a period of ten years but last two policies could not complete that stipulated time therefore, it is hard to establish that what the impact of these policies was. However, a review of each policy reveals that the health policy-1990 set its targets for the year 2000, under which Infant Mortality Rate (IMR) was to be reduced from 120 to 50/1000 live births. However, it was reduced to 90 in 2000 currently it is 85. Life Expectancy increased from 56 years to 63.7 years in 2000 for which target of the policy was above 60 years. The allocation to health sector has remained dismally low at 0.7% of GDP against the target of 5%.

The 1997 Policy set its guidelines for the next ten years along with some ambitious targets. As per the targets IMR was supposed to be 40/1000 live births in 2003, which is 85 currently. Maternal Mortality Ratio (MMR) was to be reduced to 200/100,000 live births by 2003 which is being estimated at 350 presently. Life expectancy at birth was to be increased to 65 which is 63 years. Routine immunization rate is below the target, i.e. 53% against a target of 80%. Polio was to be eradicated by the year 2000, which is yet to be achieved. Skilled health personnel were to attend 70% of the pregnancies which is 19% currently.

The policy of 2001 was announced in haste and lacks many important components. According to the implementation plan of the Department of Health, Sindh, the National Health Policy -2001 is simply a plan of rapid improvements in the health sector and does not fall in any category such as policy, plan or programme/project. Moreover, some official reports suggest some progress on the agenda set by the 2001 policy. For instance health expenditure has increased from 0.70% of GDP in 2000-01 to 0.78% of GDP in 2002-03.

Keeping in view the diverse characteristics of policy documents discussed by various researchers, it was critical that some criteria be set to facilitate the assessment of the accuracy of health policy documents in Pakistan. The Bhore Committee Report, J W Bjorkman and Carol Barker have discussed in detail the appropriateness and accuracy of policy documents in general terms. On the basis of that discussion five basic criteria were established for this analysis. Thus, the policy should:

a. contain empirical record of the past, situation analysis/need assessment, future plan with implementation and estimates.
b. be evidence based relying on Burden of Disease/HMIS.

c. address health system with inter-sectoral approach.
d. look into cost-effectiveness of goals, objectives and targets.
e. have a clear definition of roles of federal; provincial and districts tiers.

All three policy documents were assessed according to above mentioned criteria. In conclusion no document could fulfill all the criteria; rather these have been partially fulfilled.

After detailed understanding of the policy process and the assessment of impact and formulation of policy documents, issues in policy were identified with the help of data analysis. Reasons behind these issues have been discussed separately. The issues are briefly described below:

1. Historically, in Pakistan the process of policy making has been based on an informal approach. Through this approach officials in the hierarchy decide about the health priorities for which they use informal mechanisms. According to a renowned economist of the country and head of a leading social sector NGO: "Decision-making takes place in a routine way, files come and they have to be taken care off. Here one cannot see any bold initiative which can change things for the better." Therefore, in Pakistan priorities are not set according to pre-determined mechanisms. What is more important is who the decision maker is at that point in time.

2. The association of health with development is well established. In that perspective health is seen as a developmental issue and not as a medical issue. Inter-linkages of health with other sectors are part of the broader agenda of development. Pakistan's health policy does not address development and the determinants of ill-health. Although a few efforts have been made to link development and poverty with health policy. And at least that is being documented through the Poverty Reduction Strategy.

3. The role of international funding agencies has grown over the last two decades in Pakistan. The views analyzed from economic perspective suggest that, since 1987-88 the country has had a very high fiscal deficit and because of that, a very high balance of payments deficit existed, which essentially led to seeking more foreign resources. In health perspective, role of international agencies is crucial in supporting preventive programmes but those are running vertically.

4. For a viable policy, the role of stakeholders cannot be underestimated. Unfortunately the stakeholders are not playing their due role because of various reasons.

5. It is clear that health planning has kept on promoting curative aspect of service delivery. Thus, the health sector serves the elite class well leaving poor and other vulnerable sections of society unattended. This is a major obstacle in the improvement of health status.

6. Pakistan spends a very low percentage of GDP on health, which is even lower than other low income countries, apparently reflecting lack of political will on the part of the governments. Indeed, the government's health expenditures on health declined between 1991/92 and 1997/98, from 0.76 to 0.71 percent of GDP respectively and remain less than one percent till date.

7. There are many risks involved in imposing user charges. Without any alternate mechanism such as risk pooling; subsidized services for the poor; special vouchers for unaffordable or mandatory health insurance, this would be an unjust step.

8. World Trade Organization (WTO) regulates international trade. It has established General Agreement on Trade and Services (GATS). The main theme which emerged during the study is that at national level, much needed preparations for this new process are not in place. In addition, there is lack of skill development on this issue though, initial discussions have been held in the Ministry of Health.

9. A significant challenge in Pakistan is the inability of successive governments to implement any policy; and whatever is implemented is hampered by several problems. The issue of governance is important among these problems. A participant stated, "There are serious issues at implementation stage. Policies are planned and documents prepared but these mostly fail at implementation level and the reason is that there are certain managerial in-capabilities; inefficient funding mechanism; centralization of the programme and lack of training"

10. Centralized implementation is one of the key issues. The policy process does not determine the tiers of federal;

provincial and district governments and neither are their roles defined.

11. Unfortunately, Pakistan has a very fragile political setup. Frequent changes in the government hamper the policy process. As aptly put by an interviewee "in the government there is no continuity of policies, these change from person to person."

12. One of the major reasons for failure in implementation is lack of community participation. It is emphasized in the documents that the community would be involved in the process of planning and implementation but a lot more still needs to be done.

13. Implementation is not based in terms of achieving results and nobody is accountable for delivering results in the system. Each person assumes office does his/her job without considering the results for which he/she is responsible. So there is lack of accountability for results and lack of accountability to the people. The agreed monitoring and evaluation mechanisms are being ignored.

World Health Organization's Commission on Macroeconomics and Health (CMH) produced in its report a model on 'Health as an Input into Economic Development', another model originally developed by Rodriguez-Garcia and Goldman (1994) was further modified by Dr. Fazli Hakim Khattak in his research work under the title 'Health-Development Link: Health is central to the Development process'. These both models were studied for this research and after modification a conceptual framework was developed for this study under the title 'Health Policy as intervention for Under-development'. The conceptual framework appreciates the fact that the root causes for under-development are economic, social and political factors. The economic factors include low productivity, lower growth rate, poor economy; social factors include illiteracy, unemployment, and poverty; political factors include fragile political system, lack of political will and instability. Under-development also creates these economic and social problems. In this scenario, a health policy is a better option for development. Andrain stated that poorer health outcomes resulting from social inequality can be reduced by health policy and reform. Therefore, a health policy could be a tool for intervention for under-development.

Since the last decade successive governments had formulated three health policies. Additionally, the last fifty-six years' health planning through five-year plans and various reform commissions show that a breakthrough is yet to be made and poor health status calls for more vigorous action. Progress can be made with strong political will and efficient use of minimum resources. For example in its recent report UNDP noted, the state of Keralla, India has health indicators similar to those of the United States. Cuba, Costa Rica, Botswana, Iran and Sri Lanka are the other examples to be quoted. Therefore, for a development centered and sustained health improvements, a comprehensive, dynamic, participatory and evidence based health policy is now over due.
Health policy documents available so far are laudable efforts but the quest towards a health policy representing the broader needs of the people is still on.

Therefore, it is recommended that health policy making be decentralized. For evidence based policy formulation Burden of Diseases study should be conducted; HMIS should be strengthened; consistency of policy should not be compromised; good governance must be ensured. A Multi-Sectoral 'National Commission on Health and Development' may be established which must be headed by the President or the Prime Minister with a view to ensure high degree of political will. An effective impact of devolution of power can be ensured through community participation which can be linked to decentralization of health policy formulation, planning and implementation. In this context it is recommended that in the jurisdiction of each BHU, Village Health Committees (VHC) be formed under supervision of Medical Officer, BHU and Nazim, Union Council. Efficient use of available expenditure is important. In this regard cost-effective measures suggested by various studies may be discussed and applied. It is recommended that some reputable NGO or agency may be invited to conduct third party monitoring and evaluation. It is high time that private sector may be streamlined into national health care.

Civil society can be very effective in conducting policy related research and advocacy activities. It is recommended that the Ministry of Health assess opportunities and challenges as a result of WTO agreements of GATS and TRIPS.

CHAPTER ONE

Introduction

1.1 Background

The need for health sector reform, emphasis on better health outcomes through poverty reduction efforts, process of devolution and participation in achieving Millennium Development Goals set by the United Nations are a few important factors that have generated debate on contemporary health policies in Pakistan. The debate centers around whether the policies are relevant and have a responsiveness which will work towards achieving better health for the population.

Furthermore, there exists a realization that better management alone can not address the failures taking place; instead a dynamic policy process is a pre-requisite for improving the health status of the population. Another factor which supports the emphasis on policy studies are the linkages between health and socio-economic conditions. There is sufficient evidence that investing in health results in the economic development of a country. For example, the World Bank's World Development Report of 1993 (1), states that because good health increases the economic productivity of individuals and the economic growth rate of countries, investing in health is one means of accelerating development. Many indicators of development, which are related to the well-being of the population, such as mortality, poverty and hunger are also considered measures of health. Hence, health is at the center of development and that compels planning and implementing a well-thought-out health policy containing specific components.

The term 'health policy' has been defined in many ways by different researchers. Barker (2) suggests that policy gives content to the practices of the health sector. Policies are expressed in a whole series of practices, statements, regulations and even laws which are the result of decisions about, how we will do things. Bjorkman (3) further elaborates that policy is not what people (or a government) say will be done, but rather what has been done. Policy is an empirical record of the past and not just an ethereal goal for the future. Moreover, he divides policy into two types: normative policy which asserts and assesses preferred

objectives or goals for the future and; empirical policy which monitors the practices of the present and the record of the past. In other words, policy should be the combination of normative and empirical components. Niessen et al (4) defined policy as those actions of the governments and other actors in society that are aimed at improving the health of populations. Ideally, there should be a cycle of policy formulation, its implementation, and assessment.

Considering health policy objectives it cannot be ignored that socio-economic factors greatly affect health, hence, health status of the population has close linkages with other sectors. McKeown and Brown, in attempting to better understand why health improved in Britain explored factors influencing the major decline in mortality after 1840. From their analysis the bulk of change in mortality could not be explained through medical interventions because there were no effective interventions for the major causes of death during most of this period. McKeown and Brown thus concluded that the bulk of the decrease in mortality in Britain was due to improved prosperity and better nutrition (5).

McKeown's and Brown's conclusion fits the scenario perfectly for Pakistan where high rates of infant mortality and maternal malnutrition and poverty go hand in hand. In Pakistan, health indicators remain weak relative to its per capita income of $ 440 (6). The infant mortality rate[1] of 85 and child mortality rate[2] of 110 per 1000 live births are the highest in South Asia. Total fertility rate[3] of 4.8 children per women is also highest next only to Bhutan. One out of 30 women dies in childbirth; and malnutrition among women and children is widespread. Preventable or readily treatable diseases cause much of this mortality and morbidity. Furthermore, the health sector has an urban and curative bias, and is characterized by low and inefficient public spending; uneven public and private service quality; lack of consumer protection and education; lack of risk pooling mechanisms and a weak regulatory framework (7). Persisting poverty has further deteriorated the health status. Pakistan Population Assessment 2003 has reported the poverty line at 35.2%, with 31.7% in urban and 39.8% in rural areas of the

[1] Infant Mortality is defined as probability of dying before the first birthday expressed per 1,000 live births. (Pakistan Population Assessment, 2003, GOP & UNFPA)

[2] The probability of dying between birth and age 5, expressed per 1,000 live births. (WDR, WB 1993)

[3] The number of children that would be born to a women if she were to live to the end of her childbearing years and bear children at each age in accordance with prevailing age-specific fertility rates. (WDR, WB, 1993)

country. While according to an independent source, 38% of Pakistan's population is living below the poverty line (8). Consequently, UNDP's Human Development Report of 2003 ranks Pakistan at 144 under the category of low human development countries (9).

1.2 Demographic trends

According to the first Census of Pakistan conducted in 1951, the total population of the country was 34 million which has increased to 134 million in the last Census conducted in 1998 (10). According to census figures Punjab contains 55.6%, Sindh 23%, NWFP 13.4%, Balochistan 5.0%, and FATA has 2.4% while federal capital Islamabad has 0.6% of the total population of the country. The age and sex composition shows that 43% of Pakistan's population is under the age of 15 years which adds to a high dependency ratio. The country's rural population is 67.5% and 32.5% is the urban population. However, urban population is growing at the rate of 3.5 percent, with a growing and huge demand for civic amenities. Karim (11) summarized that the demographic scene in Pakistan has three distinct features: its annual growth rate is one of the highest in Asia; during the first half of the 20th century the areas now constituting Pakistan had a constant inflow of population from other parts of the sub-continent; and more recently with the striking shift in the location of population through internal migration from rural areas to cities. Since the International Conference on Population Development (ICPD) held in 1994, Pakistan has shown some progress in the field of population and development. The population growth rate has declined considerably to 2.16. The total fertility rate has declined from more than 5 per women in 1990 to 4.8 in 2001. Contraceptive Prevalence Rate (CPR) has risen from 18 percent in mid-1990s to 28 percent by 2002 (12).

Reports indicate that other development indicators are showing slow progress. For instance, according to the 1998 Census, the literacy rate is 45 percent, while female literacy is even lower at 30 percent (13). Officially the unemployment rate is 8%; however, if underemployment is included into this figure then it becomes 15% (14).

1.3 Socio-economic Situation

In Pakistan, for the most part of the last fifty-six years, feudal relations of production [4] have prevailed while the state apparatus has been reluctant to accept the changing world scenario and has not been able to transform society into an egalitarian one. However, new technological and economic changes which emerged at global level have affected Pakistan's situation as well. Class composition has gone through many changes. Large landowners do exert political influence in areas that

[4] Feudalism is a mode of production in which there is a partial separation of the direct producers from the means of production (largely the basis of agricultural production, land and the means to work on that land). (Zaidi S A. Issues in Pakistan's Economy 1999).

they dominate, however, they have diminishing political representation and strength. Lately, traders, small and large industrialists, transporters, educated and semi-educated urban dwellers, capitalist farmers, and small-scale manufacturers dominate the economy, and are now trying to cash in on their economic strength for political power (15). They are however not necessarily progressive in nature, consequently lack of political resolve is the by-product, which hampers development in all sectors of the economy including health.

Zaidi (15) argues that by the last decade structural changes have transformed the base of the economy. Pakistan was an agricultural country at the time of Independence, as 53% of GDP was contributed by this sector. Now agriculture contributes merely 24% towards GDP, while manufacturing is up to 26.4%. The service sector has replaced agriculture as the dominant sector of the economy, contributing almost half of the total GDP.

There are mixed opinions on economic performance. The Economic Survey of Pakistan 2002-03 has reported GDP growth rate at 5.1 percent per anum, but independent researchers differ on the figure, suggesting GDP growth rate at 4.6 percent. According to the Budget Analysis by Social Policy and Development Centre, the government has cut development expenditures during the current fiscal year from Rs.134 billion to Rs. 120 billion. Despite claims of increasing growth rate, issue of income distribution has not been addressed. In fact income distribution over 1988-1999 worsened; with real incomes of the top ten percent of households increasing by 27 percent and that of the bottom 10 percent decreasing by 16 percent. Just between the years 1999-2001, seven million more people were pushed into poverty due to drought and macroeconomic policies (14).

In a historical perspective Pakistan has been successful in reducing poverty over the decades since Independence. Absolute poverty, Head Count Ratio based on caloric intake, generally declined from 46.5% in 1969-70 to 17% in 1987-88. Since then however a reversal has taken place. This is because of problems with the economy during the 1990s (16). Though, efforts were made to reduce poverty but economic growth was not adequate enough to respond to such efforts. Consequently, in November 2001, the government initiated the Interim Poverty Reduction Strategy of Pakistan (I-PRSP) which aims at reducing poverty through achieving economic growth and social development. The full PRSP will be completed shortly, however; a draft summary is available. In the draft document poverty under Basic

Needs Approach[5] has been estimated at 32.1% in 2000-01. The Poverty Reduction Strategy is based on accelerating economic growth and maintaining macroeconomic stability; investing in human capital; augmenting targeted interventions; expanding social safety nets; and improving governance (17).

1.4 Burden of Diseases (BoD)

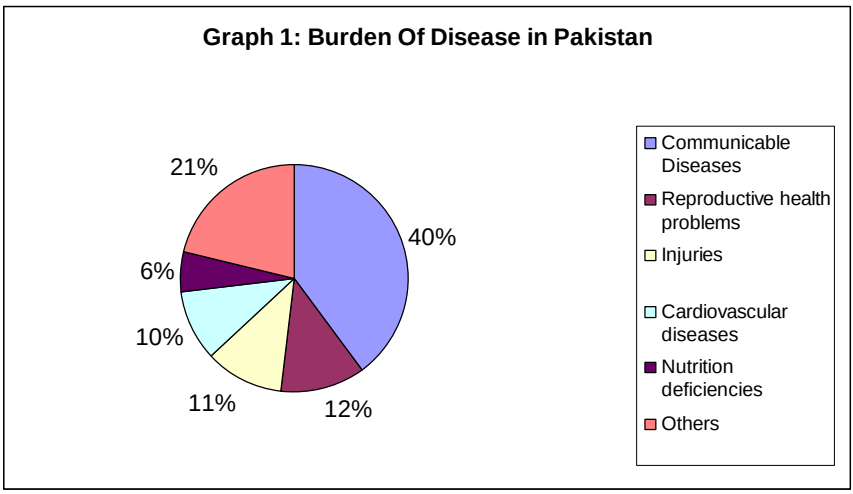
Any discussion on a health policy must start with a sense of the scale of the health problems. These problems are often assessed in terms of mortality, but that indicator fails to account for the losses that occur besides death such as becoming handicapped or due to pain or other disability (18).

The Burden of Disease (BoD)[6] is a relatively recent concept. The World Bank introduced this new measure of disease burden in 1993, and for that purpose a joint study with WHO was conducted regarding Pakistan. The World Bank has estimated that total BoD in Pakistan in the early 1990s was at about 350 Disability-Adjusted Life Years (DALYs) per 1,000 population per year.

[5] The Planning Division has adopted an official poverty line based on a caloric norm of 2350 calories per adult equivalent per day. Basic Needs Poverty Line approximate per capita expenditure of Rs. 670/month in 1998-99 rising to Rs. 748/month in 2000-01. (Draft PRSP – summarized version – PRSP secretariat Ministry of Finance, GOP, May 2003)

[6] Burden of Disease is measured by combining losses from premature death, defined as the difference between actual age at death and life expectancy at that age in a low mortality population; and loss of healthy life resulting from disability. BoD is measured in units of disability-adjusted life years (DALYs) – WB, WDR: 1993.

Figure 1:



Source: *Siddiqi S, Inaam H, Larik Z, et al A critique of MCH Policy in Pakistan: Implications for the future, 2003, Cosultative Workshop on MCH, Jan, 2003.*

Although, quite gradually chronic diseases are emerging as a challenge, communicable diseases are still responsible for about 58% of the disease burden (including reproductive health problems and nutrition deficiencies) (See Figure I). Despite many pledges to address preventable diseases, this finding suggests flaws in successive health policies in order to address communicable diseases. This inspite of the fact that these are the categories for which medical science has been most successful. Effective and affordable prevention and treatment interventions, have been identified and developed which generally require only modest levels of skills and resources (19).

1.5 Rationale for the Study

The prevailing situation concerning health and related sectors as discussed in preceding sections poses a serious challenge to the well being of the population and its overall productivity and progress. Despite efforts by the government, Pakistan is not at par with other developing countries in the region with regard to its health and social indicators (20) as shown in Table 1.

Table 1: Health and Social Indicators, Pakistan, SARC and neighboring countries

Country	HDI	Life Expectancy at Birth	Adult Literacy (15 & above)	Pop. Living Below Poverty Line	IMR *	MMR **	Mortality under 5 ***	Pop. Growth Rate	Health Exp. % GDP

Pakistan	144	60.4	44.0	32.6	84	-	109	2.8	0.9
BD****	139	60.5	40.6	33.7	51	400	77	2.4	1.5
Bhutan	136	62.5	47.0	-	74	380	95	2.3	3.7
China	104	70.6	85.8	4.6	31	55	39	1.3	2.0
India	127	63.3	58.0	28.6	67	540	93	2.0	0.9
Iran	106	69.8	77.1	-	35	37	42	2.7	2.7
Nepal	143	59.1	42.9	-	66	540	91	2.3	1.6
Sri Lanka	99	72.3	91.9	25.0	17	90	19	1.3	1.8

Source: *Human Development Report 2003, UNDP. * IMR: Infant Mortality Rate/1000 live births.*
*** MMR: Maternal Mortality Ratio/ 100, 000 live births. **** Mortality under 5: Mortality*
*of children under 5 years of age per 1000 live births. ***** BD: Bangladesh.*

The recently released UNDP's Human Development Report 2003, shows that Pakistan has fairly poorer health indicators than other developing countries in the region. On Human Development Index[7] (HDI) Pakistan's ranking has declined from 138 in the previous report to 144 out of 175 in 2003, while that of India and Bangladesh are now ranked 127 and 139 respectively. According to the report, Pakistan's expenditure on health is 0.9% of the GDP which is comparable only with India's.

The World Bank (20) argues that, poor health is in large measure a consequence of poverty, reflecting low income, poor sanitation, inadequate water supplies, and low level of education especially among women. But poor health in Pakistan is also indicative of major shortcomings in its health policy, and particularly denotes a failure to design and deliver the kind of health care that could be cost-effective as well as improve the health of most of its population. This argument suggests that contemporary health policy in Pakistan has failed to improve the health status and there are gaps in its design. Siddiqi et al (6) suggested that health policies and programmes in Pakistan have often set ambitious levels of health targets without adequate concern for the distributional aspect of health status and services.

[7] Human Development Index (HDI) is a summary measure of three dimensions of human development: living a long and healthy life; being educated; and having a decent standard of living. The countries are divided into three groups – high development with HDI above 800, middle development with HDI above 500 and low development with HDI below 500. (Khan A H, Why the big fall in HDI ranking? Dawn, September 02, 2003).

In addition, a few other factors also initiated this study on health policy. As mentioned above, the government is reviewing the current health policy which is being considered in the perspective of the PRSP. Since 1993, two studies were conducted by the World Bank (in 1993 and 1998) and recently a report was presented after a consultative workshop on MCH jointly organized by different agencies. These studies underlined the need for many corrections in the health sector. Therefore, a need was felt to assess health policies. Another factor pointing towards need of policy studies is Millennium Development Goals (MDGs) set by the UN. MDGs are gradually becoming a parameter of the national health status which provides basis for an assessment of a country's health planning.

Finally, there is a common misconception that policies are good but the true problem lies with the pace of their implementation. This needs to be assessed with a view to determining whether policy formulation and planning are the areas of prime concern or the problems are with implementation only. Therefore, analyzing Pakistan's health policy will lead to a much needed insight into these factors. It is noteworthy that the 1990s decade has distinct features as far as health and population sectors are concerned. During this period three policies were announced. Besides, few important studies looked critically into planning in the health sector. Hence, an analysis of these health policies would add extremely useful information to the current debate.

1.6 Objectives

The main Objective of the study was to analyze issues and constraints in the formulation and implementation of Pakistan's national health policy. However, main objective was further divided into Sub-objectives. These were to describe the link between development and health policy; to describe political resolve regarding health policy process; to describe the evolution of health policy and planning in Pakistan; and to suggest measures to address these issues.

CHAPTER TWO

Evolution of Health Policy and Planning

Williamson et al (21) have defined planning as a managerial activity that determines fundamental purpose of an organization; analyzing the environment; setting objectives; deciding on specific actions needed to reach the objectives; and then adapting the original plan as feedback on results is received.

The origin of health planning in Pakistan can be traced by referring to initial public health measures taken by authorities in the Sub-continent well before the creation of the country. The public sector provision of health services was introduced by the British for their employees and the urban population. Prior to that, the system of traditional medicine was practiced and is still being practiced (See Appendix I). After launching of vaccine against smallpox by Jenner, a Superintendent General for Vaccination was appointed and in 1880 the Government of India introduced an act to assign powers to vaccinate. Perhaps that was the initial commitment by the government which later on led to eradication of small pox.

Ilyas (22) has listed five major landmarks in the history of health planning in the Subcontinent:
1859: Appointment of Royal Commission to enquire into the health of the army in India.
1880: Introduction of an act to delegate powers to vaccinate.
1904: Report of the Plague Commission following outbreak of plague in 1896.
1919: Reform introduced by the Government of India Act, 1919.
1935: Reforms introduced by the Government of India Act, 1935.
1943: Health Survey and Development Committee (Bhore Committee).

2.1 Health Planning in Pakistan: Different Milestones

Evolution of health planning in Pakistan can be characterized by different milestones. These include, formation of Health Survey and Development Committee, 1943-1946 (although chronologically this is pre-partition, the work of this Committee influenced policy in Pakistan for a number of years and any discussion on the history of health planning in Pakistan cannot exclude it); Five-year Plans - a policy

instrument 1955-1998; Efforts to formulate health policy 1970-2001; Alma-Ata Conference 1978; Social Action Programme 1993-96; Millennium Development Goals 2000; Poverty Alleviation 1990s and onward; the role of private sector; and Devolution Plan 2001. Another important aspect is the curative nature of the health sector which has been discussed at the end of this chapter. In the following sections these milestones are discussed with a view to trace the history of health policy and planning.

2.2 Health Survey and Development Committee (Bhore Committee) 1943-46: A historical landmark

The description of the health planning in the Sub-continent would remain incomplete without mentioning the Health Survey and Development Committee popularly known as the Bhore Committee. The Committee formed by the Government of British India in October 1943, at the verge of independence, was the first step towards organized health planning. The Committee was chaired by Sir Joseph Bhore and consisted of thirty eminent public health officials and physicians as members. The Committee's report was published in March, 1946 and is comprised of two volumes. The report resembled the Beveridge Report of 1942 in UK which led to the creation of the National Health Service under the British welfare state. Unfortunately, the Bhore report could not make a similar impact in this part of the world due to lack of willingness on the part of successive governments.

While explaining health, the Committee emphasized (23) that "a nation's health - a positive state of well-being in which mind and body are able to function to their fullest capacity - is perhaps the most potent single factor in determining the character and extent of its development and progress". Suitable housing, sanitary surroundings and a safe drinking water supply were deemed as pre-requisites for a healthy life. The elimination of unemployment, the provision of a living wage, improvement in agriculture and industrial production, the development of village roads and rural communications, were set by the Committee as most urgent tasks emphasizing that a frontal attack upon one sector alone could only end in disappointment and a waste of money and efforts. Thus, emphasizing that health is integrated with development.

Through its recommendations, the Bhore Committee defined the role of central and provincial governments:

- Center should promote the development and co-ordination of provincial health activities mainly by the provision of machinery for mutual consultation in the formulation of national health policy.

- ? Center should help provinces by a system of grants-in-aid and by offering technical advice.
- ? A Central Board of Health should be established with Minister Health as chairman and provincial ministers of health as members; The Board should provide a forum for health policy formulation based on the largest measure of agreement between the center and the provinces.

The Committee presented a long term and a short term plan for the implementation of its recommendations. Initially, two five-year plans were suggested by the Committee, which outlined four critical components of the plan. These included periodic review; priority to rural needs - an equity concept; modification in the plan according to local needs – promoting dynamism; and cooperation of the people – concept of community participation.

The Committee stressed the need for periodic review of the implementation to ascertain progress and to make necessary adjustments and changes according to the field experience gained during the process. In this connection the Committee made it conditional to review the first five-year plan at the fifth year of its commencement, thus, making evaluation of the plan a mandatory step. The Committee recognized that ninety percent of the people were living in rural India and these were the back bone of the economy, therefore, it specifically addressed their health needs which reflected equitable distribution of health care resources. The Committee had a clear concept of decentralization when it wrote: "we have no intention of attempting to draw up any rigid or unalterable blue-print for automatic adoption by the provincial governments in the country. We are merely suggesting a minimum target and ways and means of attaining it without unnecessary delay. We realize that local conditions, needs and circumstances may call for certain modifications in our suggestions". That shows the dynamism and decentralized nature of the plan which very rightly rejected a top down approach. Community participation was another critical factor in the plan. The Committee stressed the need for people's participation and stated that "in our view we shall be building on unstable foundations if we hope to secure any rapid or lasting improvement in health conditions without arousing the living interest and enlisting the practical cooperation of the people themselves. Unless they realize the benefits … success must remain an elusive dream. While purely official effort may by itself not prove entirely sterile, it cannot possibly yield the results which we may reasonably hope to attain with the active, enthusiastic and enduring support of the people themselves." All these critical points mentioned by the Committee regarding the implementation of the plan are still valid and hold true for health planning purposes.

The long term plan constituted eight broader aims. Some of these included:

- ? No individual should fail to secure adequate medical care - curative and preventive, because of inability to pay for it - and general public health measures;
- ? Services should be placed as close to the people as possible; health institutions should provide the widest possible cooperation between health personnel and the people;
- ? Special provision for certain sections of the population, e.g., mothers, children, the mentally deficient etc.

From these long term objectives it is easy to understand that these encompass the themes of affordability; accessibility; equity; and community participation. Looking back after 56 years towards these broader objectives of the Bhore Committee, we find that these issues are still un-resolved by our health sector therefore, the Bhore Report remains most relevant to the current health planning process in Pakistan.

In its short term programme the Committee presented recommendations for the next ten years. These included, a province-wide health organization providing for both preventive and curative health care. This would include in each district: primary health units; secondary health units; and the district health units. Furthermore, the Committee while emphasizing on the preventive aspect had recommended, "we are fully aware of the need for extending medical relief to all those who are suffering from disease. Nevertheless, when the problem of building of nation's health is viewed in its true perspective, we are compelled to come to the conclusion that the health programmme should be developed on a foundation of preventive health work and that such activities should proceed side by side with those concerned with the treatment of the patient." This recommendation provided the basis for a health sector looking towards national health goals based on a preventive approach.

In the case of Pakistan we are still struggling to promote the preventive aspect in the national health policy. Although, the Bhore Committee recommendations are still relevant to our conditions the fact remains that these were never fully implemented, even though it remains the most comprehensive health policy ever formulated even before the creation of Pakistan. Interestingly, after Independence, the Government, by making minor changes in the nomenclature, adopted the proposals of the Bhore Committee in its totality and submitted it amidst the original Colombo Plan application for foreign aid (3). Looking towards the comprehensive; dynamic; participatory and

preventive approach of the Bhore Committee Report, it can be safely concluded that had its proposals been adopted in its true spirit after the independence of Pakistan, there would have been dramatic improvement in the health status of the population. However, successive documents emanating after Independence relied on mere lip service instead of practical efforts.

2.3 Five-year Plans

Since 1955, the five-year plans have remained at the core of economic planning in Pakistan. As far as health is concerned, the country has had no comprehensive health policy. However, since the 1970s certain serious efforts were initiated for policy formulation. Therefore, historically, the most powerful 'policy instrument' in Pakistan has not been the health policy but the medium-term five year plans formulated by the Planning Commission, which set the health sector priorities for the whole country (6). Initially, economic planning was done by the Development Board later renamed as Planning Commission. The government appointed various reform commissions and held health conferences to carry out health planning as a back up to the five-year plans (Table 2). Important among those were three annual conferences held since 1947; Reform Commission of 1959; and the Health Study Group of 1969.

Table 2: Significant events in Health Planning

Event	Year
All Pakistan Health Conference	1947
All Pakistan Health Conference	1951
All Pakistan Health Conference	1956
Medical Reform Commission	1959 (report published in 1960)
Health Study Group	1969 (report published in 1970)
System of local health services in rural area	1969
Nutrition Survey of West Pakistan	1965-66 (report in 1970)
Rural Health Centers scheme	1961
Peoples Health Scheme	1972
Health made provincial subject	1973
Eradication of Smallpox	1976
Ist National Conference on Medical Education	1976
Concept of Primary Health Care	1976
School Health Services Programme	1980
Decentralization of Health services in Punjab	1990
National Health Policy	1990
Social Action Programme	1993-1996
National Health Policy	1997
National Health Policy	2001

Source: *Five-year plans; Health economics and planning by Fazli Hakim Khattak*

It is worth mentioning that the tradition of setting up reform commissions; organizing health conferences and emphasis on

preventive measures were inspired by the Bhore Committee. But this enthusiasm remained in the confines of the commissions and conferences and did not apply itself to implementation.

By the time the first five-year plan was presented in 1955 (24) there was no significant improvement in the health status of the population. In 1947, about 3 million people in cities only had protected water supply which rose to 5 million by 1951. Similarly, there was only one medical college at the time of Independence which increased to 6 in 1955.

Table 3: Health Sector achievements during three decades (1950-70)

Item	1949-50	1959-60	1969-70
Doctors	3000	12000	21000
Nurses	1000	3000	5000
Hospital beds	17000	27000	39000

Source: *Five year plans*

As shown in Table 3, the number of doctors increased nine fold from 3,000 in 1949-50 to 21,000 in 1969-70, the number of nurses increased five fold from 1,000 in 1949-50 to 5,000 in 1969-70 and hospital beds were almost doubled from 17,000 to 39,000 during the same period. However, this increase was not sufficient to cater to the needs of the population.

Despite repeated reiteration by the successive plans regarding preventive measures, practically curative care alone remained on the agenda. This is evident right from the beginning as in the First Five Year Plan which shows low priority for out reach health staff needed for dissemination of information regarding preventive health measures.

There remained continued contradiction between the need for low cost and simple technologies and the financial aspirations of health professionals in the system. Most of the health professionals were trained in, and attracted by, capital-intensive high-technology medicine in anticipation of lucrative urban practice. In short, the assumptions and values held by a majority of influential health professionals differ from those on which primary health-care is based (3). Furthermore, availability of foreign aid and other considerations tended to favor vertical programmes meant for combating particular diseases at the expense of strengthening the general health services.

Eight five-year plans were presented encompassing the period 1955 to 1998. While the 9th Five-Year Plan was shelved due to political instability.

2.3.1 A Brief Review of Five-Year Plans

The First Five-Year Plan (1955-60) contained a detailed Programme for the health sector, but the implementation of the Programme was unsatisfactory due to lack of qualified personnel and delays in disbursement of funds. Thus, only about 50% of the total plan allocation of Rs. 287 million was utilized.

During the Second Plan (1960-65) there was improvement in health performance. Three new medical colleges were established in East Pakistan (now Bangladesh), nearly 200 Rural Health Centers were planned to be set up (25). A Programme for eradication of malaria was launched during the plan period. Another dramatic success was made in a move against smallpox. The entire population of East Pakistan was vaccinated against small pox resulting in a decrease in the cases from 79,000 in 1958 to about 50 cases in 1964.

At the time of presentation of the Third Five-Year Plan (1965-70) the health indicators had improved to some extent but were not satisfactory on the preventive side. The ratio of nurses was 1 for 32,000 population; one lady health visitor was available for 115,000 population; IMR was 155/1000 LB (26). The Third plan set some health targets to achieve. However, those were not achieved completely. The number of LHVs was to be increased up to 1,700 but only 950 were recruited. Some 547 new RHCs were planned during the plan period but only 230 were established (27).

The period of the Fourth Five-Year Plan 1970-78 can be divided into two parts. During first part (1970-72) development expenditures allocated fell to Rs. 59 million, consequently, many programmes were scrapped. But in the second part 1972-78 the health expenditure rose to Rs. 684.34 million (27). Remarkable progress was made in the expansion of health facilities and significant steps were taken in health related fields. Health expenditure was 0.47% of GDP in 1970-72 which rose to 0.72% in 1977-78 (3). The period was marked with serious efforts to formulate the national health policy. Extensive deliberations took place, which resulted into a health policy which represented a significant shift from earlier strategies. Malaria control programme was revived and the process of its integration with health services was introduced. Pakistan was declared free from smallpox on 18th December, 1976. The number of RHCs increased from 86 to 289, community health workers (Health Guards) were introduced in Northern Areas of Pakistan. The number of medical colleges rose from 6 to 15 and the capacity for enrolment rose from 900 to 4,000 annually. The number of nurses increased from 5,400 to 9,711 and LHVs from 1,881 to 3,250. Drug Act was introduced in 1976 which modified the

Generic Drug Scheme of 1972. Despite these efforts the preventive aspect remained inadequate.

The Fifth Five-Year Plan was presented in 1978 (28). During the plan period 625 RHCs and 4,596 BHUs were planned, but 206 RHCs and 1,617 BHUs were built. The target for IMR was set to be reduced from 105/1,000 LB to 79, but it could only achieve the figure of 100. Life expectancy at birth was 54 years for males and 53 years for females which was expected to rise up to 60 and 59 years respectively but again failed to do so. Targets could not be met in other areas as well like numbers of doctors, nurses, paramedics and community health workers etc. These figures are a reflection of bad planning and no thought given to ground realities. This over ambitious health planning was bound to fail.

During the Sixth Plan 1983-88 (29), most of the Union Councils were provided BHUs. However in some areas, due to lack of proper incentive, the Sixth plan could not meet its goals, which included the creation of a cadre of health managers, patronage of traditional medicine and expansion of private sector. Again one concludes that these health goals were not based on proper estimates.

The Seventh Five-Year Plan was presented in 1988-93 (30). The plan proposed some very challenging indicators to be achieved during the life of the plan. These included reduction in IMR from 80 to 60, increasing life expectancy from 61 years to 63 years; to protect all newborns from neo-natal tetanus by immunizing all females of 15-44 years with tetanus toxoid; to prevent occurrence of first degree malnutrition; eliminate second and third degree malnutrition and reduce the incidence of anemia in expectant mothers to less than half. But, these ambitious targets were not achieved in their entirety. However, some gains were made under the Expanded Programme of Immunization. While reviewing the Seventh plan; the Eighth five-year plan stated that the health status of the nation was characterized by a high rate of population growth of around 3% per anum and IMR of 86/1000 live births. The major killers were diarrhea and pneumonia in children, complications of pregnancy in women of child bearing age etc.

The Eighth Five-Year Plan (1993-98) (31) was presented in a situation when over the previous period, health policy and planning had given priority to building infrasturcture and concentrating on curative care neglecting the preventive side. The Eighth Plan concentrated on maternal and child health. During this period Social Action Programme (SAP) was launched. As a result some progress was made. A comprehensive document of the National Health Policy was produced

in 1990 and efforts had been made to implement that policy. In this connection, there seemed to be a considerable level of political commitment. A health policy implementation committee was formed by the Prime Minister who directed that an implementation report should be submitted to the PM's office at regular intervals. Nevertheless, changes could not be made regarding an increase in health expenditures and emphasis on preventive measures.

2.4 Towards a National Health Policy

As discussed earlier, the efforts to formulate a national health policy secured momentum during the 1970s. The Peoples Health Scheme announced by the government in 1972, called for a vastly increased expenditure for health (32). The policy emphasized on rural health facilities and preventive aspect of health care. As part of implementation, new hospitals and medical colleges were established. Pakistan Medical Association (PMA) opposed the scheme on the grounds that it lacked provisions regarding medical professionals except for other reservations. After discussions with the government, the PMA came up with an Alternative Peoples Health Scheme. This scheme recommended that more emphasis should be given to prevention; priorities should be set within the health sector, for example components of primary health care including child health, supply of potable water, sewerage system etc. In October 1973, the Planning Commission set national guidelines which further emphasized on rural health facilities. These guidelines were further influenced by a health planning exercise conducted by WHO in 1975.

The decade of the seventies can be regarded as the starting phase of a serious debate and consideration regarding health policy formulation. However, not until 1988 were efforts once again made to formulate a national health policy. This was after a long period of Martial Law. After detailed deliberations, a health policy was presented in 1990 that set its objectives to be achieved within ten years. But after dissolution of the government in 1996, the implementation on the policy could not be undertaken. In 1997, the new government announced its health policy for the next ten years, however, after two years the government was dissolved and the successive government presented its health policy in 2001 which also set its objectives to be achieved within the next ten years. However, poverty alleviation efforts of the government backed by the international community and critique on the policy have compelled the government to revise the 2001-policy. This policy is now being reviewed.

2.5 Alma Ata Declaration 1978

The World Health Organization (WHO) and UNICEF jointly organized a conference held at Alma Ata, in Kazakhstan (former Soviet Union) on September 12, 1978. This conference led to a historical declaration calling for qualitative change in the approach to health of the people in developing countries. The Alma Ata declaration was signed in the aftermath of the two world powers' confrontational approach towards health during the Cold War. The former Soviet Union criticized the vertical approach (an approach of targeting diseases through separate programme but remaining within domain of health care system) of the USA regarding eradication of Malaria in the fifties and called for an integrated approach for elimination of diseases. Litsios (33) states that the criticism of the eradication campaign began in the early 1960s … as it became more and more evident that eradication was impossible, the Soviets took the lead in calling for a review of the campaign. That review took place in 1969 and essentially led to the abandonment of the eradication goal. Since then holding of an international conference on basic health care was placed on the agenda of the WHO and finally saw the light of day in 1978. Although, Pakistan is a signatory to the Alma-Ata declaration but in reality little progress has been made in that direction. The Declaration while clearly stating that "economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries…"(34), it also emphasizes the right as well as duty of people to participate in the planning and implementation of health care. According to the Alma-Ata Declaration, political will of the government is needed to mobilize the resources for Primary Health Care (PHC). Besides other issues the Declaration points out equity, community participation and multi-sectoral action as some of the essentials of PHC.

Alma-Ata was the first health related international declaration binding on Pakistan since its Independence, and also on other member states, which created a new thought process for policy formulation. The first health policy after this significant event came in 1990. The policy recognizing the importance of PHC and 'Health for All by the year 2000' approach announced, "this policy intends to translate the ideals of Alma-Ata into reality to help build a healthy, confident nation, full of vigor and vitality, ready to take on the challenges that lie ahead." (35) Since then two more policies have been announced but the fulfillment of the moral fiber of Alma-Ata is still a far cry from reality.

2.6 Social Action Programme (SAP)

In the beginning of the nineties a need was felt to address the dismal performance in the social sector which was evident from poor health

status and poor health services. The Government of Pakistan with the assistance of the World Bank and other donors started the massive Social Action Programme in 1993/94. The first phase was completed at the cost of Rs. 106.4 billion. Whereas, SAP-II (1997-2002) was launched with an estimated cost of Rs. 498 billion. SAP focused on improvement in primary education; primary health; rural water supply; and sanitation and population welfare. Though SAP was successful in achieving more expenditure for primary health care but was less successful in achieving one of its objectives of increase in non-salary budget. It is estimated that the ratio of non-salary to current budget was the same (0.30) in 1996-97 as in 1993-94. SAP failed to achieve its target on IMR which had been set as 65 but remained at 82 in 2002 (16). However, SAP provided a major jolt to Pakistan's health planning and diverted attention of health planners and the government towards primary health care for the first time in concrete terms.

2.7 Millennium Development Goals (MDGs)

SAP was followed by a major resolve in the form of the Millennium Development Goals (MDGs), set by UN and other international agencies in the year 2000. Pakistan is a signatory to the MDGs (See Annexure II). Of eight broadly stated goals and 18 specific targets to be achieved by the year 2015, six are directly related to health (36). MDGs have important policy implications as Pakistan will have to enhance financial as well as implementation capacities to meet the targets.

Table 4: MDGs Targets for Pakistan

Indicators	1990	MDG* Targets up to 2015	Current Position
Reduce Child Mortality			
Under five mortality Rate (/1000 live births)	140	47	105
Infant Mortality Rate (/1000 live births)	120	40	82
Proportion of fully immunized children (12-23 months) (%)	25	>90	53
Improve Maternal Health			
Maternal Mortality Ratio (/100,000 live births)	550	140	350
Births attended by skilled birth attendant (%)	N/A	90	24
Contraceptive Prevalence (%)	12	55	30

Source: *Progress on Agenda for Health Sector Reform, May 2003, Ministry of Health.*
**MDGs: Millennium Development Gaols.*

A few of the targets that Pakistan has to meet include (See Table 4): reduce IMR from the 1990 position of 120 to 40 in the year 2015. In 2003 the IMR is stated to be 82. It is worth recording here that different sources have reported the IMR, at 84 or 85, figures which have been

quoted in this document elsewhere. Reduce under five mortality rate from 140 to 47 which is 105. Reduce MMR from 550 to 140 in 2015; currently estimated to be 350. Ninety percent births should be attended by skilled Birth Attendants by 2015; and CPR should be 55%. Therefore, MDGs have the potential to become a new parameter of health performance in the future. The health planning hardly reflects responsiveness in this regard. However, according to official statistics, a slight and gradual increase in health expenditure has been noted through 2000-01; 2001-02; and 2002-03 which stand at 0.7%, 0.74% and 0.78% respectively. While the current UNDP report has noted it at 0.9%.

2.8 Poverty Alleviation

Poverty alleviation efforts by the government are recently being carried out. The draft PRSP has been prepared and is under active consideration. On that basis necessary changes in the health policy document may be required so that the health policy is in line with poverty alleviation goals.

The Poverty Reduction Strategy of the Government of Pakistan through its enhanced socio-economic development, in which improved health is part of the overall strategy, is currently the main instrument for reducing poverty and thereby inequalities.

Extreme poverty is a major constraint of the poor health status of the population in developing countries like Pakistan. Bringing in new resources as part of health sector reform would be difficult if the poverty cycle is not broken. Government of Pakistan's Interim Poverty Reduction Strategy Paper (I-PRSP) (37) underlines the realization by the government that additional income alone, either through jobs or financial assistance, would not eliminate poverty unless the causes of poverty are addressed and eliminated. Therefore, restoring economic growth; income distribution; social justice; and improving access to basic needs such as primary education, preventive health care, and population welfare services, are essential for winning the fight against poverty.

2.9 Devolution of Power and Responsibility

The Devolution Plan has been implemented and district governments have been made functional. This is the third tier in health planning and implementation. With implementation mostly taking place at district level now planning will also be the district government's responsibility. It is a major step towards decentralization of the health sector. But due to lack of financial and unambiguous administrative powers the system

is not delivering its full anticipated results. This issue is further discussed in coming chapters.

2.10 Role of the Private Sector

In Pakistan the private sector is a major contributor with 77% share in health expenditures (38). However, it is a predicament of the country's health sector that such a huge stakeholder is not integrated into public health planning. The private sector has relied on traditional as well as modern allopathic health care delivery. At present there are 106 big hospitals, 520 small hospitals, 20,000 general practitioners, 300 maternal homes, 340 dispensaries, 420 laboratories and 254 NGOs imparting health care in the private health sector under the Allopathic system (36). While in traditional Homeopathic, Unani, Ayurvedic medicine system there are 73,878 Homeopaths, 45,799 Hakims and Tabibs and 537 Vaids (39) respectively.

Despite such a vast network, private sector resources have not been tapped in the context of its decisive role in the improvement of health. The private sector is crucial and health policy cannot be limited to the public sector alone. Therefore, the health policy's objective should be to attain a division of labor between the public and private health sectors. This objective has been overlooked by the health planners.

2.11 Preventive vs. Curative

Historically, Pakistan's health sector has given more attention to curative care, therefore, it has not addressed the root cause of morbidity and mortality which combined together has hindered national development. This trend has pushed the country into the ranks of low income countries partly because of less productive human capital. Bjorkman (3) contends that the total impact of the whole expenditure on health services has been small because so much has been spent on responding to health problems with curative action rather than taking preventive services to the people. This has been demonstrated repeatedly and is now an indisputable fact that the most skilled curative services may make only a temporary impact on health if the basic causes of ill health are not remedied at their source.

It is reported that about 60 percent of the recurrent budget is consumed for salaries while the remaining 40 percent is spent on primary, secondary and tertiary care. Within the figure of 40 percent, primary care's share is meager and the irony of it is that even this amount is not efficiently utilized. Khattak (40) argues that non-salary items usually present an indicator to quantify the PHC system or evaluate its quality. The non-salary expenditures of the PHC facilities of all four provinces

show that PHC suffers due to shortage of funds. The budget for PHC facilities in 1999 in the Punjab province reveals that 30%, which is the major share of the budget goes to electricity bills, followed by 24% to medicine and 4.2% for maintenance. Repair and maintenance in the whole province is impossible with such a insufficient amount and results in deterioration of the buildings, and medical equipment resulting in further deterioration in the provision and quality of health services. During this period, Sindh province spent 78% of non-salary budget of PHC facilities on medicines; while maintenance budget remained quite low at 3.8%. Balochistan province has been spending the lowest amount on non-salary items of PHC. Total spending during 1996-97 was Rs. 10.8 million, which decreased from Rs. 22.3 million in 1994-95. In the North Western Frontier Province (NWFP) medicine was allocated 56.4% while maintenance was allocated 11.5% during 1993-97. A recent study conducted in the NWFP, (41) has estimated that 88% of all health expenditures are related to curative care and at the most 12% to promotion and prevention within the health sector.

The conclusion is that fifty-six years of health planning in Pakistan are marked by different initiatives at different times however; it has always lacked a consistent and coherent process. Despite the development of strong planning instruments the desired level of health status has not been achieved. This failure requires an in-depth analysis. More specifically health policy studies would provide clear answers and is now a critical necessity.

CHAPTER THREE

Review of Existing Studies

Health policy studies have not been on the agenda for the better part of the country's history. Barker (2) describes such a phenomenon in general terms that health policy studies have perhaps not been popular, because the health field has been overshadowed by those who believe in management science. However, as discussed earlier there is recently a growing acceptability for policy studies because of a number of factors (see Chapter one). Although, there are many studies which have been conducted on health sector addressing the topic to some extent.

Different versions of health policy could be described in Pakistan's context. The five-year plans have remained strong instruments of policy planning. Different reform commissions set up by the government also reinforced the five-year plans in decision-making. There are only a few documents which could be considered as separate health policy documents. These include the Peoples Health Scheme of 1972 and the National Health Policies of 1990, 1997 and 2001.

Bjorkman (3) has thoroughly discussed the health policies in Pakistan in his two lectures delivered in 1986 and 1988. He provides basis and direction for health policy study. He noted that Pakistan still lacked an unambiguous health policy. The analysis of policy by researchers and health practitioners can be described from three aspects: (i) do these documents fulfill the criteria of policy documents? (ii) What has been their impact on the health of people? And (iii) which component is missing in these documents? In addition, there is also much debate on health sector reform which is reflected in literature. This chapter looks into literature from these aspects.

A lot of discussion on linkages of health with other sectors has taken place. As health issues cannot be viewed in isolation from planning for development, it is thus important for better health that agricultural production be increased, level of education improved, and particularly, poverty reduced (3). In this scenario, health policy often emerges as a neglected aspect of development economics. Activities that help to improve health range much wider than mere provision of medical care. Pakistan's health sector can be described simply as: "a highly inequitable, western oriented curative care model which certainly does not fulfill the requirements of a very great majority of the people of

Pakistan" (42). Although, written almost 15 years back, this description still holds true today in many respects. Pakistan's health sector is moving very slowly towards improvement as compared to other developing countries with similar socio-economic conditions.

The other important issues that should be addressed in a health policy are: an existing ambiguity towards the role of private sector; segregation of reproductive health in two ministries; inadequate attention paid to nutritional status; neo-natal and peri-natal mortality as a major contributor to the overall IMR; strategies for providing financial risk protection to the poor, mothers and children.

Primary Health Care has become an important criterion on which health policies are being judged. A consultative workshop on Maternal and Child Health was held in January 2003 organized by the Ministry of Health, UNICEF, UNFPA, USAID, AKU, PMRC, and DFID. Its report (43) provides a critique of health policy from the MCH perspective and identifies some of the important challenges and issues in the health policy as well. According to the report, health policies in Pakistan have often set ambitious levels of health targets without adequate concern for the distributional aspects of health status and services. Health indicators are poorest in the lowest income quintiles and in the rural areas. Although, universal health coverage was one of the targets of the 1990 health policy, and reference has been made to equity and distributional aspects of health in the 1997 and 2001 health policies, many believe that health policies are rarely based on indigenous thought process.

A World Bank report on Pakistan (44) points out that poor health status is in part explained by poverty; low level of education (especially for women); low status of women in the large segments of society; inadequate sanitation; and potable water facilities. But it is also related to serious deficiencies in health services, both public and private. Therefore, recognizing determinants of health, this report provides two aspects of the problem which give rise to possibilities of solution at two levels. One is at the level of broader social change and the other is institutional reforms.

The impact of policies is blemished by many issues which these policy documents do not address. Karim and Zaidi in their paper (45) on public sector governance in Sindh province of Pakistan in the health and population sectors have identified the following issues in the health sector. There is low utilization of public facilities and the impact of preventive services is low. There are weaknesses in the referral system and patients mostly tend to crowd into the Rural Health Centers (RHCs) for outpatient visits, rather than utilizing the more peripherally

located Basic Health Units (BHUs), thereby pre-empting the referral chain. Other important issues include fragmented urban health services; problems related to public expenditure; issues related to development projects like overlapping, gaps in planning and implementation, vertical programmes, dependency of provinces on federal government for funding which delays the projects; problems and imbalance in human resources; lack of regulation of private sector; problems with planning process; issue of access; poor community involvement. These issues with the persisting problem of population explosion further complicate the situation.

During the decade of 1980s Pakistan's health sector continued to reflect the importance given to curative measures and allocation of resources between different types of goods and services. Taking into consideration the argument by Bjorkman, commentator Blomqvist (3) has suggested a model like "Bare-footed doctors of China" by upgrading the training facilities for traditional "healers" in rural areas to enable them to provide common drugs along with simple forms of Western medicine.

Zaidi (15) has discussed issues in the health sector in Pakistan in detail. He spelled out a few of the major issues which the health sector was facing during the decade of the 80s such as a dearth of health facilities in rural areas; unemployed doctors despite the acute shortage of trained medical personnel; the 'brain drain' of medical graduates; medical graduates unable to work in simple rural settings and their undue dependence on sophisticated technology; pharmaceutical companies enriching themselves at the expense of the common man; lack of potable water and adequate sewerage in slums and rural areas. He further explains that the problems of health care in the country are linked directly to the prevailing social, economic and political system that determines the allocation of resources within or outside the health sector. Therefore, the need for structural reform was being advocated.

The World Bank conducted a study in response to the national debate on health sector reform. (44) In April 1998 the study concluded that "there is a broad consensus in Pakistan that the health sector is in need of fundamental reform in order to achieve a better impact on the health status of the population". The study confined itself to three key areas of public policy in the health sector: the setting of priorities for the use of public revenues; management of problems in the government health services and possible reforms; and weaknesses in private health services and suggestions for improving the beneficial effects of these services.

The debate on health sector reform has generated a great deal of interest among stakeholders with a view to adopting new changes. Islam (46) has described the goals of health sector reform to be enhancing the efficiency of the health care system; to improve the quality of services; to protect or enhance equity; and/or to generate new resources for the system. In other words, it could involve many things from financing and organization of service provision to the package of services to be offered. He emphasizes priority setting from among these factors and notes that the ongoing devolution plan could be an opportunity for carrying out health sector reforms in the country. In this regard he suggests formation of regional health boards.

The importance of various stakeholders in health planning is well established. Bjorkman recognizing the role of various stakeholders has explained that in the case of health provision by the state there are four actors: the political leaders; the administrators; the professionals; and the patients.

The literature reviewed has discussed flaws in the health policy at both the stages of policy formulation and implementation and has demonstrated that health sector reform must shape a health policy which ought to be based on consensus and strive for efficiency, equity and generation of more resources for health. Literature reviewed provides some information about existing knowledge on the topic.

CHAPTER FOUR

Study Procedure

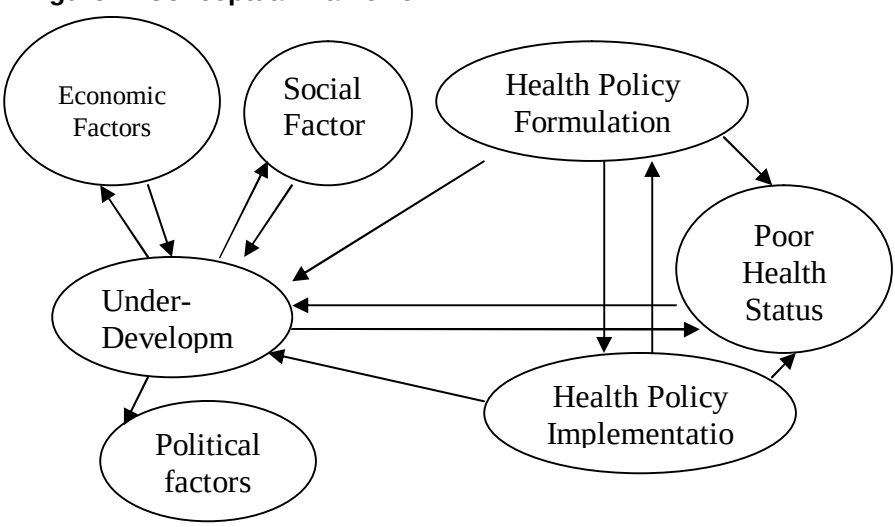
4.1 Study Design

This study is based on qualitative assessment. Lacey et al (47) while quoting Pope and Mays, 1996, argue that qualitative methods, using narrative and observation rather than numerical data, are increasingly being used in health care settings where they are seen to reach the parts other methods cannot reach.

4.2 Conceptual Framework

A conceptual framework has been developed after modification (See Figure 2) that has been utilized to facilitate this study.

Figure 2: Conceptual Framework



***Adopted and modified**: Macroeconomics and Health: Investing in Health for Economic Development, Commission on Macroeconomics and Health 2001; Khattak Fazli Hakim, Economics of Health Sector*

Reforms in Pakistan (Original Source: Rodriguez-Garcia and Goldman 1994), 2001

From Mckeown's concept of 'classification of diseases according to origin' to Bhore Committee of British India and up to Alma Ata declaration, and the most recent strategies of the Poverty Reduction Strategy Papers, the whole body of knowledge emphasizes that health status and development are interdependent. Poor health status leads to under-development and under-development leads to poor health status. Therefore, in the above conceptual framework (figure 2), it is suggested that the best intervention possible is in the shape of feasible and cost-effective health policy formulation and implementation based upon development approach.

4.3 Sample Size

Generally, qualitative studies use smaller groups of people for research and are informed by sharing of information by those groups (47). Two methods have been used in this study. This includes key informant interviews and document review. In this regard minimum sample size required for a qualitative study is 15 (48) whereas, 18 interviews were conducted.

4.4 Study setting and the participants

Health policy formulation in Pakistan takes place in the Federal Ministry of Health and at the Planning Commission. While planning and implementation rest with the provinces, responsibilities are further divided up to districts under the newly devolved setup. The participants were drawn from the Ministry of Health; Planning Commission and other relevant federal ministries and departments. The National Commission on Human Development (NCHD); international agencies like World Bank and World Health Organization who play their role in the shape of financial aid and technical cooperation respectively; professional associations; civil society/NGOs like PMA, SPDC; and provincial health departments of Sindh and NWFP have been consulted for the study.

The data collection process was undertaken mainly in the federal capital where policy formulation takes place. In order to look into implementation issues and to meet some of the stakeholders, interviews were also conducted in Karachi and Peshawar. These categories have been selected with a view to represent all stakeholders who are being

involved at formulation or implementation or both stages of the health policy.

4.5 Study Period

The study was conducted during July - September 2003.

4.6 Data Collection Methods

The study utilized the following two methods of data collection:

- ? Review of documents and literature
- ? Semi-structured interviews with key informants

4.6.1 Documents Review

The following documents were consulted:

- ? National health policy documents presented in 1990, 1997 and 2001.
  - To analyze and compare indicators
- ? Documents of the Planning Commission regarding health (i.e. five year plans)
- ? Social Action Program (SAP) documents
  - To examine the progress in planning primary health care in the 1990s.
- ? World Bank, World Health Organization, United Nations Development Program, Asian Development Bank reports regarding health
  - To assess the role of development and donor agencies in policy making.
- ? Social Policy and Development Centre reports regarding health
  - To examine the independent point of view.
- ? Documents related to political economy of health
  - To assess factors governing policy
- ? Health Survey and Development Committee report 1946
  - To look into evolution of health policy in historical context.

4.6.2 Semi-structured interviews of the Participants

One of the most important techniques of data collection in qualitative research is interviewing the stakeholders. Therefore, detailed semi-structured interviews were carried out with individuals on certain questions (List of questions at Appendix III). Those individuals, who know more about the topic, are called key informants proved to be helpful in getting information (49). For semi-structured interviews, 'Doing Qualitative Research: A Practical Handbook' by David

Silverman was referred to. In order to maintain the quality of interviewing technique, Whyte's Six Point Directiveness Scale was also used (See Table 5) (50)

Table 5: Whyte's Directiveness Scale for Analysis Interviewing Technique

No.	Directiveness Points	Remarks
1	Making encouraging noises	1 = Least directive
2	Reflecting on remarks made by the informant	
3	Probing on the last remark by the informant	
4	Probing an idea preceding the last remark by the informant	
5	Probing an idea expressed earlier in the interview	
6	Introducing a new topic	6 = Most directive

Source: *Qualitative interviews in health research; BMJ Group.*

4.7 Plan of Analysis

The basic objectives of data analysis are to order and display summaries of findings in such a way that their interpretation becomes meaningful and conclusions can be drawn. To achieve these objectives advanced software titled Nvivo (51) was used for analytical purposes. Nvivo is a comprehensive software programme for qualitative data analysis.

CHAPTER FIVE

Research Findings

5.1 Results

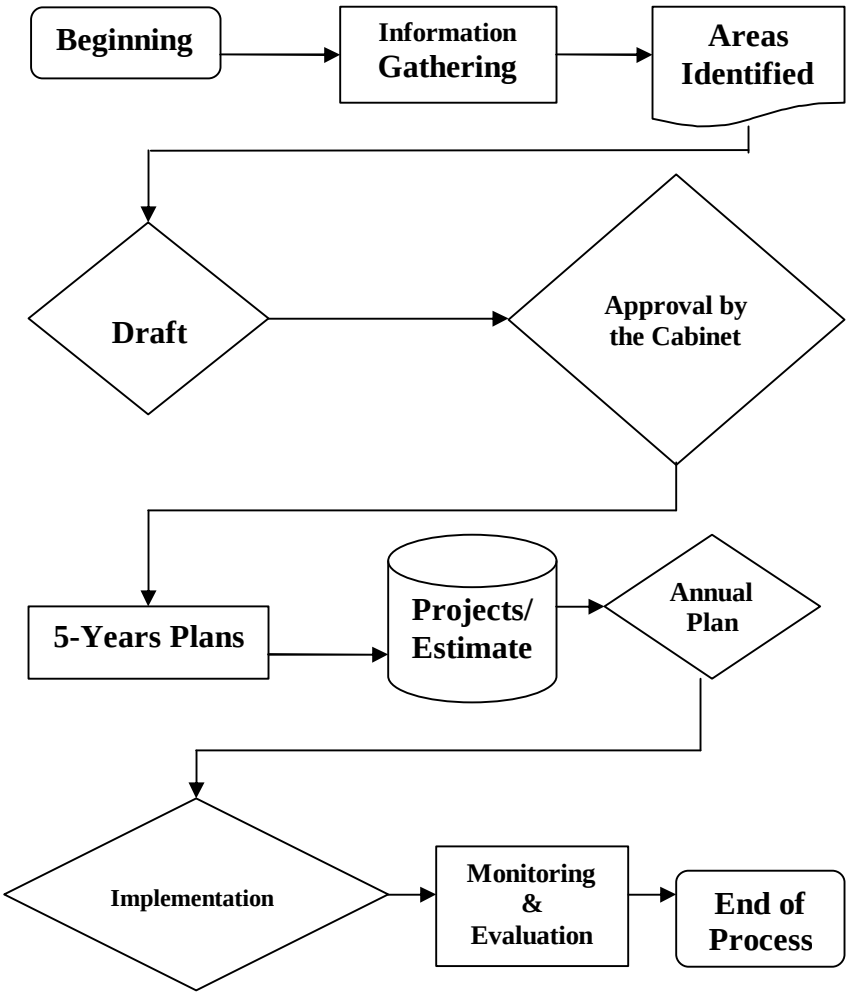
This chapter is divided into two sections. In section one the policy process and the main features of three health policies 1990, 1997 and 2001 have been discussed. For the purpose of analysis, the year 1990 is taken as the baseline year and health indicators for the year 1997, 2001-02 are compared with this year. Basically the indicators given are meant to assess whether changes in the indicators were due to policy interventions or due to other related factors. The second section of the chapter is based on analysis of the information obtained through interviews.

SECTION I

5.2 Policy Process

The policy process takes place through a set hierarchy of steps at the Ministry of Health (See Appendix IV). There are nine major steps in the policy process right from formulation up to implementation and monitoring (See the Flow Diagram, figure 3). Initially, information is collected by the Ministry of Health from Biostatistics Unit and Health Management Information System (HMIS). After this, preparatory meetings are being held where all the four provinces are represented. Through such meetings key areas are identified, on which consensus is developed and the first draft is prepared. This draft is sent to the Planning Commission and the Ministry of Finance where consultations take place and the draft is finalized. The final draft is then sent to the Cabinet which gives its approval after discussion. The five-year plan is formulated based on the policy document. Subsequently, projects are designed which include development as well as recurrent budgets. Public Sector Development Programme (PSDP) or the Annual Plan is developed afterwards. The provincial governments bear the responsibility for implementation. These steps are followed by monitoring and evaluation.

Figure 3: Flow Diagram: Health Policy Process



Source: *Ministry of Health, Government of Pakistan*

However, the fact remains that despite so many layers of consultations, policy development is highly centralized with little participation from the major stakeholders. For instance, there is no or perhaps an insignificant role being played by the legislatures and the policy is not discussed in Parliament. Other stakeholders like district authorities, civil society, and the community at large rarely play any role. On top of this there is conflict of opinion on the extent to which provinces play

their roles. However, the pharmaceutical industry and medical professionals do participate in the process. For example medical community was consulted during formulation of 1990-policy. Despite the existence of this elaborate process the policy of 2001 was nevertheless planned in a centralized manner without adhering to the process.

The other controversy is regarding disintegrated nature of policy components. Green and Rana (52) suggested that a common criticism of health sector planning in Pakistan is that it is competent at planning but not at implementation. Behind this observation lies a mistaken assumption that the two processes (i.e. planning and implementation) are separable as if they were two distinct entities. Hence, planning is not realistic and implementation therefore inherently handicapped.

5.3 Salient Features of Policies

The salient features of three policies have been given in matrix 1, which contain vision, goals, objectives and targets of the policies. Each policy was set for the next ten years to implement. However none of these policies were implemented in their entirety in the stipulated time, except for 2001- policy whose implementation is yet to be seen in due course of time. (See Appendix V)

Matrix 1: Salient features of policies

Features	1990	1997	2001
Vision	Not specified	- The 2010 vision for health sector development is one of comprehensive and quality health care for all segments of society. - To reduce the burden of ill health which is easily preventable. In addition to a strong PHC programme, a highly organized and well equipped tertiary level care will be available at affordable prices.	- National vision for health sector is based on "Health-For-All" approach. - To implement the strategy of protecting people against hazardous diseases; of promoting public health; and of upgrading curative care facilities. -Measures, programmes and projects as means for enhancing equity, efficiency and effectiveness. - It will require commensurate investments and interventions by the Provincial Governments for improving health infrastructure and services. The Federal Government will continue to play a supportive and coordinative role in the key areas like communicable disease control programme.
Goals	- To provide healthcare cover to the entire population of the country within the shortest possible time.	- To ensure basic services and promote a better quality of life for attaining maximum national development. The achievements expected by the year 2010.	Not specified
Objectives	- To make	- To address the	- Reduce widespread

	primary health care available to all citizens without discrimination throughout the country. - To decentralize the administrative structure of the health care system by creating Management Boards. - To establish Public Health Services including schools of public health and programmes of family planning, nutrition, and water supply. - To broaden the scope and jurisdiction of Employees Social Security Institutions. - To improve and enlarge the scope of private health sector by giving incentives and by regulating it through provincial commissions.	health problems in the community, by providing promotive, preventive, curative and rehabilitative services to which the entire population has effective access. - To bring about community participation through creation of awareness, changing of attitudes, organization and mobilization. - To improve utilization of health facilities by bridging the gap between the community and health services. - To expand the delivery of reproductive health services including family planning in urban and rural areas of Pakistan. - To gradually integrate existing health care delivery programmes like EPI, malaria control, nutrition and MCH within PHC. - To improve the nutrition status of mothers and children and reduce the prevalence of	prevalence of communicable diseases. - Addressing inadequacies in primary/secondary health care services. - Removing professional/managerial deficiencies in the District Health System. - Promoting greater gender equity. - Bridging basic nutrition gaps in the target population. - Correcting urban bias in the health sector. - Introducing required regulation in private medical sector. - Creating mass awareness in Public Health matters. - Effecting improvements in the drug sector. - Capacity-building for Health Policy Monitoring.

	General Practioners to be involved in the main stream. - A list of Essential Drugs to be introduced. - Unani system of medicine and Homeopathy to be recognized.	malnutrition - To promote proper inter-sectoral action and coordination at all levels.	
Targets	- To make primary health care available to the entire population with the minimum goals being achieved. - Immunization against diphtheria, tetanus, whooping cough, measles, poliomyelitis and tuberculosis. - Drug packets for treatment of 22 common diseases to be made available in villages and BHUs. - Cadre of trained personnel to be created for attending pregnancy,	- Infant Mortality Rate 86 in 1998 would bring down to 40 in 2003 and 20 in 2010. - MMR which was estimated at 350 in 1998 would be brought to 200 in 2003 and 90 in 2010. - Life expectancy at birth, 62 in 1998, would be increased to 65 in 2003 and 69 in 2010. - Children below one year would be immunized as 65% in 1998, 90% in 2003 and 100% in 2010. - Polio would be eradicated in year 2000. - Trained personnel attending pregnancy would be 20% in 1998, 70% in 2003, and 100% in 2010. - Doctors: 75000 in 1998, 133,000 in	**Key Area 1:** - Immunization coverage will be increased to 80% by 2005 and full coverage reached by 2010. - Polio cases will be reduced to less than 100 by the end of 2001 with WHO Certification achieved by 2005 - Hepatitis B coverage will be available in 70% of districts by 2002 and 100% by 2003 providing 17.3 million doses annually over next 5 years - Full DOTs coverage of TB will be achieved in all districts of the country by 2005. The detection rate will be 70% and cure rate 85% by then. It will reduce TB prevalence by 50% by 2010. - Malaria cases would be reduced by 50% by 2010. Plasmodium Falciparum cases will be kept at less then 40% of

	child birth and caring for children up to at least one year of age. - To enhance nutritional status so that: - At least 90% of newborn infants have a birth weight of at least 2,500 grams. - At least 90% of children have a weight for their age that corresponds to the reference values. - To achieve infant mortality rate for all identifiable subgroups at below 50/1000 live births. - To achieve life expectancy at birth of over 60 years. - To spend at least 5% of the GNP on health with resources distributed equitably between urban and rural areas.	2003, and 142,000 in 2010. - Dentists: 3000 in 1998, 6000 in 2003, and 15000 in 2010. - Nurses: 24,810 in 1998, 35,000 in 2003, and 50,000 in 2010. - Paramedics: 115, 000 in 1998, 170,000 in 2003, 215,000 in 2010. - TBAs: 50,000 in 1998, 60,000 in 2003, and 65,000 in 2010. - Community Health Workers: 45,000 in 1998, 75,000 in 2003, and 100,000 in 2010.	all malaria infections. **Key Area 2:** - 100,000 Family Health Workers will be recruited and trained by 2005 to cover the entire target population. - Rationalization study of RHCs/BHUs will be completed by 2002. - 58 Districts and 137 Tehsil Hospitals will be upgraded over a period of 5 years. **Key Area 3:** No targets or time frame fixed. **Key Area 4:** - By 2005, 100,000 Family Health Workers will be duly trained as community workers and developed in the field. - The number of nurses will increase from 23,000 to 35,000 by 2005 and 55,000 by 2010. **Key Area 5:** - Reduce low birth weight babies from 25% to 15% by 2010. - Vitamin A supplementation will be provided to approximately 30 million children every year. No separate targets and time frame given for rest of the key areas. However, implementation modalities are discussed.

5.4 Profile of Health Status since 1990s

As mentioned earlier, Pakistan's health status is lower than other countries in the region that have the same income level. During the last thirteen years three policies were announced. Each policy sets different achievement targets covering the subsequent ten years. However, these policies superseded each other before they could complete their full tenure. The first policy got seven years for its implementation; the second policy four years, before being overtaken by the 2001 policy. The health indicators are shown in tables below to assess the outcome. Due to these frequent changes, impact of these policies is difficult to assess. Thus there are other factors also involved in improvement of health indicators over the period.

Table 6: Health Indicators 1990-2001/02

Indicators	Baseline Year 1990	Outcome Indicators		
		1996-97	2000-01	2002
Life Expectancy at birth (years)	56	60.1	63.7	63
Infant Mortality Rate/1,000/lb	120	105	90	85
Routine immunization coverage-TT	25%	-	51%	53%
< 5 Mortality Rate/1,000/lb	140	111	111	110
Maternal Mortality Ratio/100,000/lb	550	-	350	350
Proportion of Births Attended by Skilled Health Personnel (%)	18.8	18	19	-
Annual Population Growth Rate (%)	2.57	2.6	2.4	2.16
Total Fertility Rate (per women)	6.2	5.4	-	4.77
Contraceptive Prevalence Rate (%)	11.8	23.9	27	30
Dependency Ratio %	91	88	83	87.3
Literacy Rate (%) Male/Female	34	43 (1998)	49	55
Female Literacy (% 15 & above)	22.4	32 (1998)	29.8	41
People living below poverty line (%)	34	24	34	35.2*

Sources: *A critique of MCH policy in Pakistan, Consultative workshop, 2003;*
Pakistan Population Assessment 2003;
Social Development in Pakistan, 2001;
Economics of Health sector reforms in Pakistan, Fazli Hakim Khattak;
Progress on Agenda for Health Sector Reforms, 2003, MOH;.
Annual Report of Director General Health, 2000-01;
MCH & Family planning in Pakistan- planning for the future, 2003;
**Independent sources: 38% which is quoted in this study elsewhere.*

The Health Policy-1990 set its targets for the year 2000, under which IMR was to be reduced from 120 to 50/1000 live births. However, it was reduced to 90 in 2000 currently it is 85. Life Expectancy increased from 56 years to 63.7 years in 2000 for which target of the policy was above 60 years. The allocation to health sector has remained dismally low at 0.7% of GDP against the target of 5% (See Table 7).

Table 7: Health Expenditure (Rs. in Billion)

Baseline Year 1990 as % GDP	Fiscal Years	Total Budget	development	Recurrent	As % of GDP
0.76	1995-96	16.35	5.741	10.44	0.8
	1996-97	18.34	6.485	11.857	0.8
	1997-98	19.66	6.077	13.587	0.7
	1998-99	20.81	5.492	15.316	0.7
	1999-00	22.08	5.887	16.190	0.7
	2000-01	24.28	5.944	18.337	0.7
	2001-02	25.05	6.688	18.717	0.7

Sources: *Health Sector Study: Key concerns and solutions, World Banks*
Pakistan Population Assessment, 2003, UNFPA, Govt. of Pakistan

The 1997-Policy set its guidelines for the next ten years along with some ambitious targets. As per the targets IMR was supposed to be 40/1000 live births in 2003, which is 85 currently. MMR was to be reduced to 200 by 2003 which is being estimated at 350 presently. Life expectancy at birth was to be increased to 65 which is 63 years. Routine immunization rate is below the target, i.e. 53% against a target of 80%. Polio was to be eradicated by the year 2000, which is yet to be achieved. Skilled health personnel were to attend 70% of the pregnancies which is 19% currently.

Table 8: Health Personnel

Indicators	Baseline year 1990	Outcome Indicators		
		1996-97	2001	2002
Doctors	55,572	78,470	91,823	96,248
Nurses	18,150	28,661	40,019	40,019
Lady Health Workers	-	43,000	55,127	70,000
TBAs	-	57935	58,259	-
Paramedics	-	*115,000*	-	-

Sources: *Statistical Bulletin, July 2003, Federal Bureau of Statistics*
Annual Report of Director-General, 2000-01
Progress on Agenda for Health Sector Reforms, 2003, MOH

The number of doctors was to be raised from 75,000 to 133,000 in 2003 which is 96,248 (See Table 8). Number of nurses was to be raised to 35,000 which was achieved and reached 40,019 in 2001. Number of

Traditional Birth Attendants was to be raised to 60,000 which had been raised up to 58,259 in 2001.

Table 9: Social Services Indicators

Indicators	Baseline Year 1990	Outcome Indicators		
		1996-97	2000-01	2002
Water Supply population coverage **(%)**	52		63	65
? Urban				
? Rural	80		85	85
	45	43	53	55
Sanitation Population coverage **(%)**	22		38	40
? Urban				
? Rural	55		59	58
	10	20.5	25	28

Sources: *Annual Plan 2003-04*
Fazli Hakim Khattak, Economics of Health sector reforms in Pakistan,
S Akbar Zaidi, Issues in Pakistan's Economy.

As discussed previously, the policy of 2001 was announced in haste and lacks many important components. According to the implementation plan of the Department of Health, Sindh, the National Health Policy -2001 is simply a plan of rapid improvements in the health sector and does not fall in any category such as policy, plan or programme/project (53).

Table 10: Health Facilities

Indicators	Baseline Year 1990	Outcome Indicators		
		1996-97	2000-01	2002
Hospitals	756	865	879 (1999)	906
Dispensaries	3,795	4,523	4,583	4590
MCH Centers	1,050	853	855 (1999)	862
RHCs	459	513	541	550
BHUs	4,213	5,121	4,507	5,308
TB Clinics	220	262	272	285
Total Beds	72,997	89,929	97,945	98,264
Population per Bed	1,505	1,504	1,443	-

Source: *Annual Report of Director General Health 2000-01*

However, this policy is yet to be implemented. It might be reviewed by the government and it is expected that a renewed version of this policy would be presented. Moreover, some official reports suggest some progress on the agenda set by the 2001 policy. For instance health expenditure has increased from 0.70% of GDP in 2000-01 to 0.78% of GDP in 2002-03.

5.5 Five Criteria for Policy Analysis

The definition of health policy has been discussed in this document elsewhere. Keeping in view the diverse characteristics of policy documents discussed by various researchers, it was critical that some criteria be set to facilitate the assessment of the accuracy of health policy documents in Pakistan. The Bhore Committee Report (23), Bjorkman (3) and Barker (2) have discussed in detail the appropriateness and accuracy of policy documents in general terms. On the basis of that discussion five basic criteria were established for this analysis. Thus, the policy should:

a. contain empirical record of the past, situation analysis/need assessment, future plan with implementation and estimates.
b. be evidence based relying on Burden of Disease/HMIS.
c. address health system with inter-sectoral approach.
d. look into cost-effectiveness of goals, objectives and targets.
e. have a clear definition of roles of federal; provincial and districts tiers.

5.5.1 Policies and Criteria

Contemporary health policies are increasingly becoming a focus of health related research. Therefore, in subsequent paragraphs we look at the policy documents according to five criteria listed above.

5.5.2 Health Policy 1990

The Health Policy of 1990 was a well written document which covered many areas of health sector and provides understanding of the problems in general. However, the policy lacked an empirical account of the past and specifically what happened in the 1980s. The document did however record the public sector health expenditures during the 1970s and 80s. Need assessment was covered by an account of the problems prevailing during that period but lacked data to assess the accuracy of argument and magnitude of the problems. An implementation plan was provided in brief without estimates. It acknowledged the fact that there was lack of data, which could have facilitated evidence based policy. PHC approach and public health services along with development and inter-sectoral approach also merited a mention. The mechanisms to be used for decision-making for a health system approach do not make an appearance. The cost of alternate interventions was not calculated and benefits were not discussed regarding the suggested interventions. In addition, there was no mention about the roles of federal, provincial and district tiers.

The Policy of 1990 was regarded as the first health policy in the country in different analyses. This policy included many proposals with potential implications including the need to establish a PHC approach; MCH; MIS; departments of traditional medical practice in medical colleges and; attracting doctors to serve in rural areas etc. In conclusion, the policy has discussed the health problems of the country besides suggested interventions. Nevertheless, it did not meet the above mentioned criteria fully; although it did partially fulfill the first and third criteria.

5.5.3 Health Policy 1997

The health policy of 1997 was introduced in a situation when the Social Action Programme (SAP-1) had already been implemented and SAP–II was soon to be implemented. Therefore, health issues were the focus of attention of international organizations and the government at the same time.

The policy discussed the past progress and provided figures about health status and health expenditures. But it too lacked need assessment based on evidence. The implementation process was discussed and financial requirements for the next five years were estimated. However, it did not mention Burden of Diseases or other data for decision-making. It gave much attention to health systems and inter-sectoral approach, but, inter-sectoral approach was limited up to discussion in terms of role of NGOs, CBOs and the community. It suggested a programme of Basic Minimum Needs for development but cost-effectiveness of alternate strategies was not discussed, which made its feasibility hard to establish. Highly ambitious targets were set. For example IMR was expected to be 40/1000 live births by the year 2003. Regarding defining the roles it provided details on decentralization and establishment of District Health Authority. But it remained ambiguous as there was no clarity about the role of provinces which gave rise to the fears of centralization of another kind. In conclusion, the policy was well written and discussed broad spectrum of health problems with future plans but it still did not fulfill all the criteria. It partially fulfilled the first, third and fifth criteria as discussed above.

5.5.4 Health Policy 2001

The government announced its new health policy in December 2001. This document is a broad statement about ten key areas. It does not contain any discussion about the past nor provides any analysis about the present situation. The Policy is not based on any data which could

provide rationality to its priorities. Burden of Disease or HMIS based assessment are ignored. Although, in the key features of policy it is stated that health sector investments are viewed as part of the government's Poverty Alleviation Plan. There is no mention about health systems approach or inter-sectoral collaboration. This would have contributed to poverty alleviation. Cost-effectiveness of the implementation plan has not been estimated. Therefore, the targets seem to be too ambitious. The Policy does not fulfill any of the criteria mentioned.

To conclude, Pakistan has had many health planning documents, health reform commissions and five-year plans. These three health policy documents have been added to that list. In line with the criteria developed in this document, Pakistan's health policy does not fully transform itself into a comprehensive, dynamic; evidence based; rational and feasible policy. The documents remain piecemeal efforts towards moving in this direction. The health policy's highly centralized nature and basis on estimates instead of reliable data, demonstrates that it lacks the necessary base for implementation. Hence, the problem is not only implementation but formulation and planning as well. As formulation and planning are not cost-effective and feasible therefore, implementation becomes even more challenging.

SECTION II

5.6.1 Data Analysis Findings

The key personnel who were interviewed represented the Ministry of Health; the Planning Commission; National Commission on Human Development, Departments of Health in Sindh and NWFP; International Organizations (World Bank and World Health Organization); leading NGOs working in the social sector, Pakistan Institute of Development Economics (PIDE), Social Policy and Development Center (SPDC); Ex. government-officials and officials of pharmaceutical industry. (See Appendix VI)

Keeping in view the objectives of the study, six broad exploratory themes were included in the questionnaire to facilitate discussion. The exploratory themes were:

1. Evolution of health policy and planning
2. Role of stakeholders
3. Policy's link with development

4. Issues in prioritization and decision-making for policy formulation
5. Issues in implementation
6. Effects of WTO/GATS on health policy

The matrix regarding data analysis (See Appendix VII) is divided into three columns. The Nvivo software which facilitated the analysis of the data divides the data into nodes and sub-nodes. The nodes column lists the six broad themes. The column of sub-nodes contains significant views of the participants. Each point in the sub-nodes category represents a participant, while, each sign of plus (+) denotes one participant supporting the same opinion. In the third column those themes are listed which emerged from each node and sub-node. The themes that the majority of the participant's brought up and discussed were the ones chosen for inclusion here.

Analysis on Nvivo software presented a graphical presentation of emerging themes. Each graph or model contains one broad theme/node at the center with its serial number. Different views or sub-nodes have been shown generating from the node. Numbers of each sub-node and node are given in front of each sub-node. By clicking on each sub-node in the graph a report was generated containing names of participants and their views regarding that particular sub-node. The emerging themes will be discussed in the next section.

5.7 Emerging Themes

A. Issues at the level of Policy Formulation and Planning

5.7.1 Prioritization of issues for policy making

The formulation of health policy is the most important stage where decisions are being made about what would be the focus of attention in the next five to ten years. Therefore, the importance of evidence based policy formulation based on the needs of the people is quite crucial. Historically, in Pakistan the process of policy making has been based on an informal approach. Through this approach officials in the hierarchy decide about the health priorities for which they use informal mechanisms. According to a renowned economist of the country and head of a leading social sector NGO: "Decision-making takes place in a routine way, files come and they have to be taken care off. Here one cannot see any bold initiative which can change things for the better." Therefore, in Pakistan priorities are not set according to pre-determined mechanisms. What is more important is who the decision maker is at that point in time. There is less consideration on what needs to be financed or on the mechanisms to look into that. For example Burden of Disease (BoD) has not been estimated or in general, HMIS is not being used for planning purposes. However, some officials are of the view that the policy is evidence based as some estimation is done prior to making decisions. Lately, the government has made commitments to achieve MDGs goals set by the UN. Hence, these goals, to some extent, are becoming the driving force behind priority setting. In addition, WHO is interested in working jointly to improve HMIS so that rational health policy planning and management is achieved

5.7.2 Lack of Inter-link between Policy and Development

The association of health with development is well established. In that perspective health is seen as a developmental issue and not as a medical issue. Inter-linkages of health with other sectors are part of the broader agenda of development. A health official described the linkages as follows: "sectors of education, health, sports and culture are integrated and they create opportunities; competition; richness and enlightenment." Such recognition might have compelled policy experts and decision makers to link health with poverty reduction strategies in Pakistan. The WHO Country Representative for Pakistan described the new dimension of health perception of this international health organization: "Transformation of health sector responsibility from a service delivered by trained professionals only to a health system where you have other partners who are equally engaged and equally interested in development. This is the new dimension of WHO which calls for a partnership dimension for health."

Pakistan's health policy does not address development and the determinants of ill-health. Although, a few efforts have been made to link development and poverty with health policy. And at least that is being documented through the proposed Poverty Reduction Strategy. But, for creation of an effective link it is necessary to develop inter-linkages with other sectors which actually work to achieve improvement in the health status. These include inter-linkages with education, water and sanitation and public health engineering, sports and culture so that these linkages can produce integrated and combined outcomes and outputs. MoH officials are of the view that for the first time in the country's history such a health policy document is coming up.

5.7.3 Role of the Donors

The role of international funding agencies has grown over the last two decades in Pakistan. The views analyzed from economic perspective suggest that, since 1987-88 the country has had a very high fiscal deficit and because of that, a very high balance of payments deficit existed, which essentially led to seeking more foreign resources. However, the influx of international aid was reduced after the collapse of the Soviet Union. Therefore, one possible way to reduce the deficit was that we could either reduce our total expenditures or to finance through borrowing from International Financial Institutions (IFIs). In return IFIs wanted to know how Pakistan was going to improve the situation. In the absence of home driven credible alternative plans by the country, they took it upon themselves to suggest ways to reduce the deficit. However, in 1996-97 Pakistan government came out with a home driven policy package. After reviewing it, IMF admitted that Pakistan had been able to meet the targets, thus showing the importance of governmental commitment. For example Pakistan has adequate reserves for the next year and it does not need IMF financing currently, therefore it is not bound by the programme any longer. Therefore, if the government comes with strong and viable indigenous thinking it is possible that its projects may be approved by the financial institutions concerned. In this regard one interviewee pointed out that a higher level of preparedness is required for negotiations with IFIs, which is lacking in our present scenario. One reason for this is that people at the helm of affairs are over burdened with other assignments. On the other hand there is a culture of secrecy of information which hinders civil society to take part in such efforts. In this situation policies including the health policy are mainly dependant on donors.

5.7.4 Role of the Stakeholders

For a viable policy, the role of stakeholders cannot be underestimated. Common people who are the clients of health care delivery system; their representatives/legislatures; officials of Ministry of Health; medical professionals; NGOs; international organizations working in the field of health and the pharmaceutical sector are the stakeholders in a policy making process. Unfortunately these stakeholders are not playing their due role because of various reasons.

The prime concern is that generally policy is announced by the Cabinet which ideally should be discussed in the Parliament first. However, some official circles believe that politicians are usually least interested in such a technical exercise. To some extent this is correct but the fact remains that legislatures can genuinely reflect the needs of the people and provide a basis for proper planning and ownership of policy. As far as common people are concerned, they are not involved in the process though the latest devolution process provides renewed hope in this direction although it is yet to show results. Civil society and the NGO sector have a limited role to play in policy making. On the other hand their role in implementation has increased. However, there seems a concern about the seriousness of NGOs' commitment to policy issues. Some participants pointed out that the NGOs sector was involved in development of SAP but their performance remained low. In a more recent development NGOs have been involved in PRSP consultations but it's not clear whether their inputs were taken seriously or even included in the recommendations. Overall there is a top down approach rather than a bottom up approach regarding the role of stakeholders and decision-making. However, there is growing recognition in the official circles about this important factor.

5.7.5 Curative Aspect

It is clear that health planning has kept on promoting curative aspect of service delivery. Thus, the health sector serves the elite class well leaving poor and other vulnerable sections of society unattended. This is a major obstacle in the improvement of health status. Another factor contributing to the emphasis of the health sector on the curative side is the medical education system which produces doctors alienated from or ignorant of community health concepts. As a result, doctors are extremely reluctant to serve in rural areas and particularly those who get post-graduate degrees from foreign universities then want to settle in cities and opt for lucrative private practices. As a result rural health services are not fully functional. Thus, such a maximization of profit in medical practice by the doctors has further strengthened curative aspect of the health care in Pakistan.

5.7.6 Resource Allocation

Pakistan spends a very low percentage of GDP on health, which is even lower than other low income countries, apparently reflecting lack of political will on the part of the governments. Indeed, the government's health expenditures on health declined between 1991/92 and 1997/98, from 0.76 to 0.71 percent of GDP respectively. If expenditure on the population welfare programme is added then it becomes 0.82 to 0.78 respectively. However, over the period the share of Federal Ministry of Health increased from 14 percent in 1991/92 to 17 percent in 1997/98 mainly because of Prime Minister's programme for Family Planning and Primary Health Care. But, there was considerable inflation during that period. Consequently, that increase could not make any difference. Another factor to be considered in terms of resource allocation was Social Action

Programme (SAP). One of the objectives of SAP was to increase health expenditure with special emphasis on non-salary inputs. However, this objective was met with little success. The SAP expenditure as a proportion of total government health expenditures rose up to 50 percent in the period 1994/95-1996/97. In the following year it increased approximately from 55 to 58 percent. Although, SAP was a high profile programme that made some progress in terms of intra-sectoral increase in expenditures yet the total health expenditure declined as mentioned above suggesting that the social sector has remained a low priority area. The role of private sector in this regard is still underestimated while the fact remains that it accounts for a major portion of funding while public sector bears lesser expenses. Interviewees pointed out that whatever resources are allocated these are misused thus depriving the people of a fair chance to get health services.

5.7.7 User Fees

Most of the interviewees talked about user fees[8]. They were of the view that there are many risks involved in imposing user charges. They explained that without any alternate mechanism such as risk pooling; subsidized services for the poor; special vouchers for unaffordable or mandatory health insurance, this would be an unjust step. One official described that user fees contributes five to ten percent in the public sector expenditure so it is not a big amount. Even then, if it is introduced, social protection measures must be taken before that. One interviewee strongly opposed the imposition of user fees and added that user fees are already in place and are being charged from patients in public sector hospitals.

5.7.8 World Trade Organization (WTO)

Globalization of trade is the manifestation of the market economy which is at its turning point after the demise of the socialist block in the sense that new trade blocks are emerging. The World Trade Organization (WTO) is organizing world trade and setting rules in this regard. This includes General Agreement on Trade and Services (GATS). The main theme which emerged is that at national level, much needed preparations for this new process are not in place. In addition, there is lack of skill development on this issue though, initial discussions have been held in the Ministry of Health. The WHO is working with the government in this direction. It is insisting on pharmaceutical reforms in the shortest possible time.

It is assumed that after execution of WTO led policies the local pharmaceutical industry would be affected and prices of medicine will go up. Another negative impact would be that the government will lose whatever control it has on

[8] User Fees are defined as payment for health services at the time of illness, often levied on essential interventions (Report of the Commission on Macroeconomics and Health, WHO).

multinational pharmaceuticals. But one of the interviewees explained that as pharmaceutical industry is already deregulated and is functioning freely so there is no extra impact of WTO in health sector, rather WTO's impact is over exaggerated, because WTO does not require privatization of service sector. One interviewee felt that WTO is not an issue for Pakistan because we are still struggling with our basic issues. Some interviewees explained positive impacts of service related agreements under WTO. For example there may be foreign investment in the hospital sector particularly health insurance. A recent example of baby Noor Fatima was quoted who has undergone heart surgery in a hospital in Bangalore, India. Another example of provision of vaccines through Global Alliance on Vaccination and Injections (GAVI) was quoted in this connection.

B. Issues at the level of Implementation

5.7.9 Governance

A significant challenge in Pakistan is the inability of successive governments to implement any policy and whatever is implemented is hampered by several problems. The issue of governance is important among these problems. A participant stated, "There are serious issues at implementation stage. Policies are planned and documents prepared but these mostly fail at implementation level and the reason is that there are certain managerial incapabilities; inefficient funding mechanism; centralization of the programme and lack of training" besides, there are staffing problems like absenteeism; lack of availability of medicines; and lack of basic equipments etc. In addition service delivery is over lapping, for example BHU; Urban Health Centre; RHC; MCH; THQ; DHQ are performing identical tasks and are not always working for specific areas. This is more true in the case of DHQs and THQs (working as First Level Care Facility) thus, requiring bricks and mortar not delivering actual services.

5.7.10 Centralized implementation

Centralized implementation is one of the key issues. The policy process does not determine the tiers of federal; provincial and district government and neither are their roles defined. This problem gets further aggravated at district level where necessary administrative and financial powers are not delegated to the districts. Consequently, a bottom up approach in planning and implementation is lacking. There is much talk of devolution. District elected governments have been put in place but the major constraint is delegation of necessary financial and administrative authority. For that purpose it was decided by the previous Cabinet, headed by the President, that the new elected government would implement important structural reforms in this direction. But that decision is still pending. Furthermore, there are some risks attached to devolution including issues of efficiency, equity, skill development and capacity building.

5.7.11 Lack of Continuity

Unfortunately, Pakistan has a very fragile political setup. Frequent changes in the government hamper the policy process. As aptly put by an interviewee "in the government there is no continuity of policies, these change from person to person." So policy or the mechanism for policy matters little, instead it depends on whosoever has the authority at the time as that person will decide what is to be done. The announcement of three health policies since 1990s without considering their stipulated tenure for implementation is an example of lack of continuity. Frequent transfers and postings is another issue which hampers proper implementation.

5.7.12 Community participation

One of the major reasons for failure in implementation is lack of community participation. It is emphasized in the documents that the community would be involved in the process of planning and implementation but a lot more still needs to be done. The establishment of the district governments is a positive step but an assessment of the mechanisms for community involvement would establish whether these are effective or not.

5.7.13 Accountability and Monitoring

Implementation is not based in terms of achieving results and nobody is accountable for delivering results in the system. Each person assumes office does his/her job without considering the results for which he/she is responsible. So there is lack of accountability for results and lack of accountability to the people. The agreed monitoring mechanisms are being ignored.

CHAPTER SIX

Reasons behind the Issues

The issues analyzed in the previous chapter need to be looked into further from the perspective of reasoning. Therefore, before recommending solutions reasons behind these issues have been documented. Detailed explanation of some of the issues has been included where necessary.

6.1 Prioritization of issues for policy making

Planning decisions in Pakistan are mostly guided by unaided intuition rather than based on reliable data showing comparative costs and benefits of alternatives (3). Such perception based policy formulation relies mainly on estimates and often continues past practices rather than doing a need assessment in the prevailing situation. In such an environment, Pakistan needs to invest some of its scarce resources in acquiring better information about its health care system. It is hard to imagine how health planning can occur without a minimum of credible data (3). This dilemma is due to the absence of a framework for analyzing the health sector issues. For instance there is lack of Health Systems Research (HSR) in the country. Another reason could be the lack of recognition for Health Economics[9] which can provide a base for a policy integrated with development. It is important to note that much of the policy debate focuses on health care but not the health system, which is a vehicle for organized response to the conditions of the population.

Therefore, irrational decision-making regarding health policy takes place due to three reasons: Health does not get priority in overall decision-making process, health expenditures hardly differ from previous budget; within the health sector, there is no proper use of minimal resources and; decision-making takes place in isolated manner without including all stakeholders i.e. legislatures and civil society etc. Effective policy-making requires a planning system. The system should provide an explicit framework for assessing needs and then allocating resources efficiently (52). For example study on Burden of Disease or in general terms HMIS can provide a systematic approach to allocate scarce resources for optimal use. The need for BoD study is being felt at higher circles and evidence based policy formulation is being advocated but the ground reality is that practical steps in that direction are yet to be taken (44).

[9] Application of theories and techniques of economics to the health sector (Fazli Hakim Khattak, Economics of Health Sector Reforms in Pakistan, 2001).

Lastly, the most important reason for lack of evidence based policy is the elitist and hierarchical nature of state institutions, which is reflected on the health sector as well. Burden of Disease (BoD) Study would lead to information regarding the overwhelming burden of morbidity and mortality in poor strata of society in rural as well as squatter and low income settlements in cities and vulnerable population. While, the government works under numerous constraints, one of which is to please the ruling classes and other vociferous sections living in the urban areas (15). Hence, prioritization remains highly hierarchical that does not allow evidence driven approach which would pinpoint the real issues to be prioritized – the issues of the poor, marginalized and vulnerable.

6.2 Health Policy and Development

Development is defined as "the process of improving the quality of life through changes that result in: higher standards of living; increased purchasing power; greater political participation; access to basic goods and services; and increase in productivity" (40). These changes are a challenging task as policy makers often face difficulty in their quest of meeting targets in an ill-suited administrative system which is yet to be reformed. In case of the health sector, the problem is more than just difficulties of structural reforms. Pakistan's socio-economic system is based in favor of the upper class, leaving the majority of population trapped in the cycle of poverty; illiteracy; unemployment; and other manifestations of under-development. This phenomenon is not new, "at the time of independence, it was only the elite who had easy access to the best hospitals and doctors in the country. The common people had to make do with exceptionally poor government facilities. This is largely the situation even now" (15). The situation gets aggravated due to the limited purchasing power of the poor and increasing cost of seeking health care.

There are other dimensions of this apathy. The political analysis (54) of association of health and development shows that ruling circles in South Asia tend to emphasize preventive aspect of services which is pro-development. However, in practice this is not the case for several reasons. First, at the macro-level of policy making, the relevant governments have other goals that take precedence over health services. Thus, we find much greater emphasis on defense and other non-development sectors. Second, is the neglect of investment in basic health services and a badly coordinated administration. Consequently, medical associations and publicly financed medical schools follow medical training based on Western curriculum. Third, neglecting the poor at the early stages of national development. Fourth, due to vertical programmes, attention is usually diverted from the need for a comprehensive system of primary, secondary, and tertiary units for delivering health services.

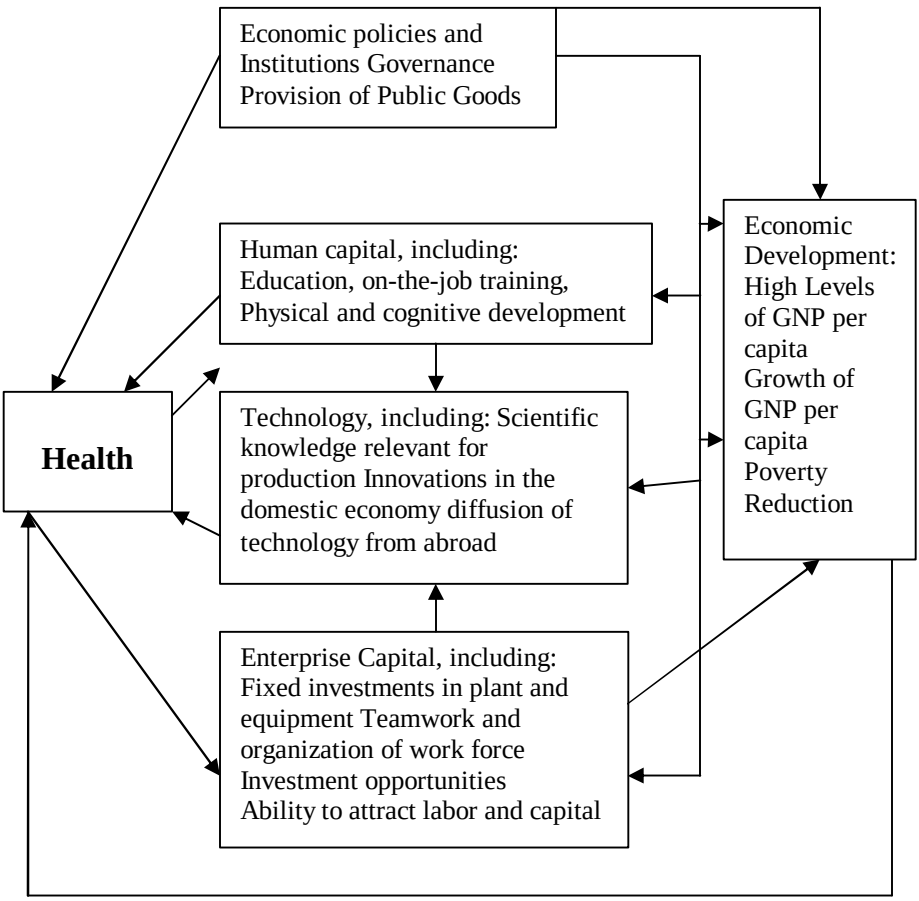
The World Health Organization had established a Commission on Macroeconomics and Health (CMH) in the year 2000 to assess the place of health in global economic development. The Commission (55) argues that low Infant Mortality Rate (IMR) - as a proxy for overall disease conditions - leads to

higher GDP growth rate and higher IMR leads to lower GDP growth. For example countries with an IMR between 50 and 100 have annual average growth of 3.7 percent per year, whereas similarly poor countries with an IMR greater than 150 have average growth of only 0.1 percent per year. Similarly, it is estimated that each 10% improvement in life expectancy at birth is associated with a rise in economic growth of at least 0.3 to 0.4 percentage points per year. Another interesting contention is that a high IMR was found to be one of the main predictors of subsequent collapse of states (through coups, civil war, and other unconstitutional changes in regimes).

6.2.1 Health Policy as Intervention for Under-Development

Lindbladh et al (56) state that it is frequently asserted in debates on research that the socially unequal distribution of health- as well as social differences in health – related behavior- cannot be affected without tackling the underlying socio-economic inequalities. The Commission on Macroeconomics and Health (CMH) developed a model to show health as an input into economic development. Figure 4, illustrates that economic output is a function of policies and institutions on the one hand and factor inputs (human capital …) on the other. Health affects human capital and enterprise capital. Furthermore, health itself is affected by the prevailing policies and institutions, the level of human capital (since education, for example promotes health), the level of technology in the society, especially in the health sector itself, and on the very growth in income and poverty reduction that better health produces (55).

Figure 4: Health as an Input into Economic D evelopment



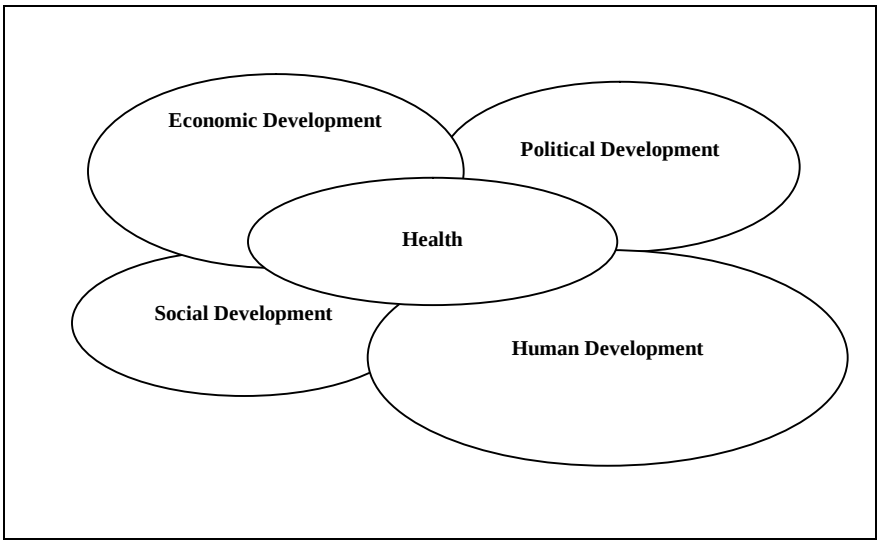
Source: *Macroeconomics and Health: Investing in Health for Economic Development: Report of the Commission on Macroeconomics and Health (CMH).*

Furthermore, Khattak (40) has discussed the linkages between health and development in Pakistan using the model developed by Rodriguez-Garcia and Goldman (1994) which shows health-development interlink (Figure 5). Ignoring the health-development link can result in important losses to health and other components of development. It is contended that the countries with weakest conditions of health and education have a much harder time achieving sustained growth than do countries with better conditions of health and education (55).

Following the model in figure 5, a few areas have been suggested for in-depth study so as to facilitate work on health policy under Health Sector Reforms (HSR). Areas to study are: inter-sectoral and macroeconomic issues; inter-

sectoral resource allocation and equity issues; financial planning; scarce resources; high level of uncertainty; loose organizational loyalty; and donor pressure.

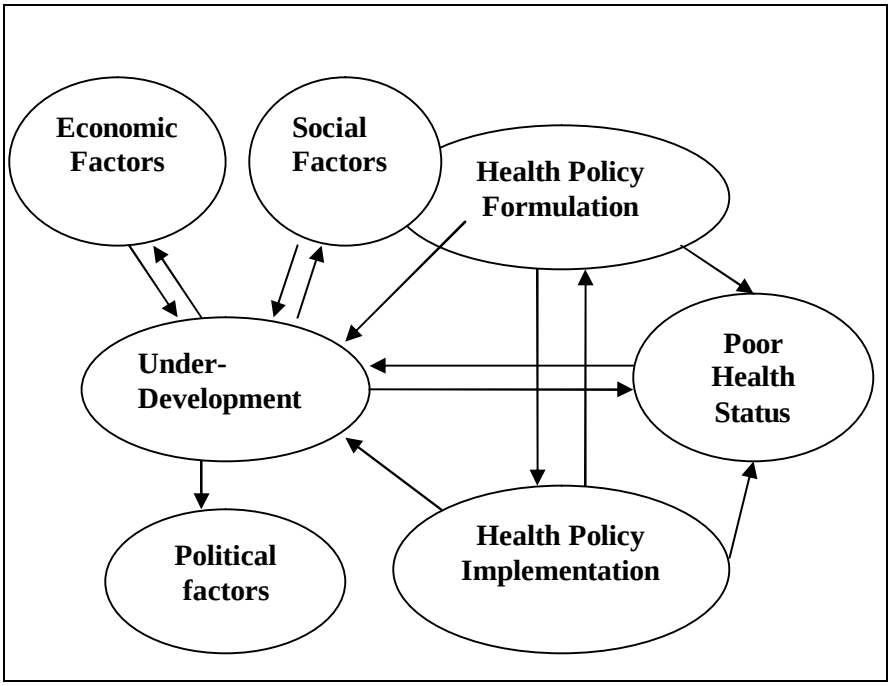
Figure 5: Health Development-Link: Health is Central to the Development Process



***Source**: Khattak Fazli Hakim, Economics of Health Sector Reforms in Pakistan (Original source: Rodriguez-Garcia and Goldman (1994)*

These models prove that specifically development oriented interventions are needed for improving health status of the population. These models were modified for this study and a new model has been developed (see figure 6).

Figure 6: Conceptual Framework: Health Policy as Intervention for Under-Development



Sources: *Macroeconomics and Health: Investing in Health for Economic Development, Commission on Macroeconomics and Health, 2001; Khattak F H, Economics of Health Sector Reforms in Pakistan (Original source: Rodriguez-Garcia and Goldman 1994), 2001*

Figure 6, illustrates that poor health status and under-development are inter-linked as established in previous two figures and related discussion. The root causes for under-development are economic, social and political factors. The economic factors include low productivity, lower growth rate, poor economy; social factors include illiteracy, unemployment, and poverty; political factors include fragile political system, lack of political will and instability due to national and international scenario. Under-development also creates these economic and social problems. In this scenario, a health policy is a better option for development. Andrain (57) stated that poorer health outcomes resulting from social inequality can be reduced by health policy and reform. Therefore, a rational health policy formulation and implementation could be a tool for intervention regarding under-development and poor health as shown in the figure. In this regard, health policy could become an intervention through following steps:

? A comprehensive, evidence based and participatory health policy formulation.

- ? Health policy should establish links with other sectors on the basis of Integrated Primary Health Care[10] (IPHC) as per the Alma-Ata Declaration.
- ? Health policy focusing on development (economic, social and political dimensions of health)
- ? Developing practical modalities for preventive aspect
- ? Increasing the public expenditure on health
- ? Minimum resources available to health sector may be efficiently used.

One approach regarding inter-linkages with development can be Basic Development Needs (BDN) - a micro level development programme established by WHO. It is estimated that in BDN project areas service delivery is better, the EPI coverage is much better, malnutrition is reduced, the use of antenatal and postnatal services is better. Another dimension is that of 'Tawana Pakistan', a project of Ministry of Women Development Social Welfare and Special Education which is technically supported by AKU. Through this project school nutrition programmes lead to empowerment of local communities especially girls and women in poor districts of the country leading to improved literacy, health and development level. However, the fact remains that a sustained change could be possible through a development focus at macro level.

Such steps for policy-making require strong political will. Health policy as intervention for under-development would improve health status, longevity, and productivity and will increase GDP which is a determinant of economic growth.

6.3 Role of International Aid and Development Agencies

The role of international aid and development agencies has become essential due to lower public sector spending on health; lack of streamlining of private expenditure on health and the government's inability to invest in preventive programmes. Donor agencies' role has its pros and cons. Their role has three different dimensions: All out acceptance of IFIs policies is due to lack of indigenous commitment to thinking for policy making; lack of preparedness to negotiate on the part of the government; and the donors' agenda isolated from ground realities. However, there are different views regarding donor funding. A Washington based World Bank official is of the view that Pakistan lacks indigenous thinking for different projects. If planning according to ground realities existed this institution had no objection to adopting such a policy. She

[10] The operationalization of PHC goals has been grouped into three broad categories: Selective PHC; Comprehensive PHC; and Integrated PHC. Integrated PHC can be explained in a way that when health programme, along with the essential PHC components like Growth Monitoring, Oral Rehyderation Therapy, Breast Feeding, Immunization (GOBI) and services like maternal care etc., also starts integrating other health related sectors like water, sanitation, female literacy, etc. The programme can be labeled as an integrated PHC programme. (PHC Training Manual, CHS, Aga Khan University)

stated that the World Bank wants to encourage indigenous thinking. As discussed earlier aid agencies have been playing a vital role in much needed preventive programmes, though vertical programmes against selected diseases funded by these agencies have limited the scope of these programmes.

In the field of technical cooperation the World Health Organization has a specific role in the area of technical cooperation which has proved to be beneficial. In this connection WHO is also assisting in establishing a Health Policy Unit in the Federal Ministry of Health. Currently this unit has been established and it is at its initial stages functioning.

6.4 Role of Stakeholders

The role of stakeholders in Pakistan is marred with several problems. These include: reluctance on the part of official circles for sharing information and providing opportunities to participate in health policy formulation; lack of necessary skills and interest on the part of some of the stakeholders which include public representatives; and NGOs. It is argued that participation of stakeholders is crucial for successful planning (52). On the contrary, often, it is assumed that policy planning is a mere technical process centered on epidemiological analysis while it is necessarily a combination of technical and political skills. Planning which lacks political process has potential to result in failure. It is further argued that 'technical process approach' has produced a narrow understanding of needs which has often resulted in low utilization of services (52). Consequently, public services utilization level is very low in Pakistan. Pakistan Integrated Household Survey (PIHS) 1995-96 results show that a government health provider was consulted by only 20 percent of persons seeking health care for illness or injury in the 30 days preceding the survey. Prior to this, similar results were noted by PIHS/1991 survey (44). Thus, health policy is not only the domain of health decision makers and health providers but it is the domain of other related sectors as well. The health sector on its own can meet only a fraction of the health needs of the population to whom it delivers services. Some needs such as clean drinking water, safe jobs, roads and housing can only be met through other sectors (52). Therefore, the role of stakeholders is important from inter-sectoral collaboration aspect as well.

Some official circles believe that some of the stakeholders lack the required skills to foster a participatory policy process or to make a valuable contribution towards that process. This argument cannot be rejected as a whole on the pretext that it comes from official circles. However, to identify a potential role for legislatures; civil society and the community in the policy making process, the following three level mechanism could be considered which has been presented by Reich (58): First, the policy change process needs to be approached through politics. Second, engagement in policy change requires political skills. And third, collaboration across policy arenas requires management of the political process. He connects political will for policy reform with motivating the political leaders to exercise their will-power. Recently health policy analysts concerned with developing countries have given increasing attention to the

importance of stakeholder analysis. This need can be fulfilled by developing specific skills. Therefore, Reich (58) suggested a software tool called Policy Maker Software (See Appendix VIII) which enables different stakeholders to conduct advocacy regarding the policy process and to motivate policy planners and the leadership in favor of priority issues. Policy Maker (59) is an assessment method for analyzing and managing the process of public policy and provides practical advice on, how to manage the political aspect of public policy. The method helps decision-makers improve the feasibility of their policy. The process is carried out through five main analytical steps. The software helps to define: policy content; players; opportunities and obstacles; strategies and the impact of strategies.

6.4.1 Private Health sector

The private sector is highly profit oriented and the commercial part of the overall health sector. The important role being played by the private sector in Pakistan implies that health policy cannot be made without linkages with this sector. But traditionally the private sector has had little to do with health policy. The World Bank (44) argues that the beneficial impact of the private sector is diminished by a number of weaknesses. To list a few: quackery; insufficient preventive care; no regulatory functioning mechanism for consumers; and concentration in urban areas. Keeping in view the difficulties for the public sector to cater to the needs of health care, it is important to take initiatives to bring the private sector into the mainstream of health care. However, Mahmood (60) explains that the private sector can play a positive role in the provision of health care if it is carefully regulated by the state. For instance, fee structure in the private sector is unreasonably high and unaffordable by the poor and lower middle classes. Therefore, an equitable and efficient fee structure is necessary to enhance affordability and availability of private health services for poor and low income earners. Some self-regulatory mechanism should also be introduced for quality assurance in the private sector to ensure safe practices.

6.5 Devolution

A need for fundamental reform was emphasized during a workshop regarding SAP-II in July 1996. The World Bank (44) in 1998 argued for more radical decentralization[11] in Pakistan's health sector. Furthermore, the World Bank suggested establishment of district and provincial health boards; enhancing the role of NGOs; working towards greater community involvement; decentralization and human resource development. Devolution[12] is one of the

[11] Transfer of real decision-making authority to make policies, carry out management functions, and use resources. (Pakistan, towards a health sector strategy, WB, 1998).

[12] Devolution is the transfer of powers to completely separate, existing governmental units, such as provinces/states, districts, or municipalities. (Pakistan towards a health sector strategy, WB, 1998).

main options under decentralization. Therefore, since October 1999, the National Reconstruction Bureau started devolution reforms and formally, on August 14, 2000, the Chief Executive of Pakistan announced plans for the devolution of power to local governments (40).

However, despite several efforts devolution has not resulted in positive change as yet. There are two basic reasons for that: a) Elitist dominance; and b) Lack of delegation of financial and administrative authority. Platteau (61) has argued that the move to put participation and empowerment of the poor squarely on the agenda is especially noticeable in the case of the World Bank which has made Community Driven Development (later on called Community Based Development-CBD) one of the corner stones of its Comprehensive Development Framework. The World Development Report 2000/01 duly reflected this shift of approach. Based on such an approach there is much emphasis on devolution. However, an important constraint of devolution has been further argued by Plaatteau suggesting that other side of the coin is that local governments or communities may be more prone to capture by local influential, and thus less accountable than central governments (or external donors) and, if that is the case, decentralization can also be subject to misappropriation and targeting failures. This type of capture of devolved structure has been termed 'elite capture'. Pakistan's present district governments present just such a picture where most of the elected Nazims, right from Union Council up to district level are local influential. The second, problem is inaction on the part of the central government to delegate necessary powers, mainly financial powers to the districts. A decision of the previous cabinet is pending regarding such issues. It had been decided that the essential structural reforms would be carried out by the newly elected government. But still there is no decision in this regard. In the meantime, there is confusion between provinces and different districts' government functionaries.

6.6 Resource Allocation

Market failures justify the use of public funds to pay for services. This includes existence of public goods[13], externalities[14]. In the case of public goods, these would not be available unless the government organizes their provision. Health education is a good example in this regard. In the case of externalities, private consumption may be less than socially optimal without government subsidy. For example communicable diseases generally have positive externalities, i.e., they

[13] Public goods are defined as: i) the consumption of a given unit of the good by one individual does not preclude consumption of the same unit by other individuals; and ii) it is not possible to exclude any individual from their consumption. (WB 1998)

[14] The beneficial or harmful effects that market exchanges have on people who do not participate directly in those exchanges. Also called 'spillover' effects. (Gold M, Siegel J et al, Cost-effectiveness in Health and Medicine, Oxford University Press, 1996)

generate benefits not only for those directly treated but for others as well (44). However, prevailing resource constraint is the main obstacle in the increase of public funding for health. One main aspect is higher allocation for expenditures on debt servicing and defense (4.5% of GDP) (62). During the Fiscal year 2003-04 budget expenditure for both the sectors amounted to 64.5% of total budget (14). Therefore, these expenditures are the main reason for the lower allocation for social sector spending. Secondly, there is lack of political will on the part of the successive governments and the leadership. Thirdly, even the minimum resources available are not efficiently used. Despite a lot of emphasis by civil society and recognition in government circles of the need to increase health expenditures it is yet to be enhanced. With this background, inefficient use of available resources becomes an issue of prime importance and needs to be looked into, apart from the fact that, political will is weak. This has two dimensions: priorities on where to spend funds are not clarified and there is misuse of funds in different ways. Hasan (63) argues, the major policy debate in Pakistan, in this context, should address the problem of re-allocating the limited resources among inputs in the most economical way. The World Bank categorized three types of services to get top priority regarding allocation of funds. These categories are: health education; control of communicable diseases; and maternal and child services (including family planning).

Table 11: Proportion of health expenditures and population served by type of services, 1994

Services	Population Served (%)	Share of Public Sector health Expenditures (%)
Primary Health Care	90	15
Secondary Health Care	9	45
Tertiary Care	1	40

Source: *Health Section: Planning and Development Division, 1994*

However, according to 1994 figures it is estimated that there is highly inequitable distribution of health resources in Pakistan. It is evident from the figures (see Table 11) regarding primary, secondary and tertiary care share in the budget. Tertiary level care is supposed to serve one percent of the population while 40 percent of the expenditures are spent at that level of care. Secondary health care has to provide services for 9 percent of the population while its share in public sector budget is 45 percent. Primary health care is meant to serve 90 percent of the population but these services get only 15 percent of the health budget. In 1998, the World Bank (44) conducted cost estimates for preventive and curative services by type of facility. The estimates are: at BHU level cost share of preventive is 42.1%, and share of curative is 57.9%; at RHC level share of preventive is 15.4% while of curative is 84.6%; at THQ level share of preventive is 7.9% and curative is 92.1%; at DHQ level preventive share is 4.2% and share of curative is 95.8%. Figures show that at each level curative care has more share in the cost and as it goes up cost increases disproportionately.

Tinker (64) referred to National Health Survey and stated that maternal and prenatal conditions and communicable diseases account for half the country's BoD. The research on alternative interventions has demonstrated that reproductive health services are among the most cost-effective, along with intervention for childhood diseases. But, there is lack of serious efforts to adopt such cost-effective measures rather the emphasis is on curative care. However, there is a significant shift in 2001 policy that emphasized more on primary and secondary level care which is yet to be seen in practice.

In addition, in July 2003, the World Bank initiated an annual survey on intermediate level social indicators including six health indicators through Core Welfare Indicators Questionnaire (CWIQ) survey. According to a letter by the Government of Pakistan (65), the mechanisms regarding CWIQ for collecting data will include an annual Core Welfare Indicator Questionnaire survey (CWIQ) which is being developed with assistance from the World Bank. This will be timed to provide input into the formulation of local, provincial, and federal budgets; the first CWIQ results will be available in January 2004, providing input for the fiscal year 2004/05 budgets. This will complement expenditure controls at the local level to ensure that the devolution process actually improves social service delivery. Therefore, this process would enable financial resources to be reallocated in order to emphasize on primary and secondary health services.

Other component of in-efficient use of available resources is misuse of funds. This becomes a problem due to rent-seeking behavior. World Bank (44) argues that some of the rent-seeking behaviors are difficult to document, it appears that various kinds of rent-seeking behaviors are widespread. For example in health facilities staff reportedly sells government-provided medicines and other supplies.

Hammer and Berman (66) described that countries can achieve the largest improvement in health status by allocating limited resources to the provision of treatments for those diseases which have the highest health impact per dollar spent. Cost-effective measures within present budget allocation are not only possible but have been proved by research. Hasan and Pasha (63) stated that it is important to note that all this reallocation of resources is feasible within the projected actual budget and, interestingly enough, it will also lead to efficiency gains in the order of 8 to 10 percent for the entire public health system. Through such measures more doctors and nurses could be hired on attractive salary package keeping in view present situation of unemployment among health professionals and their reluctance to serve in rural areas. Furthermore, new health facilities could be built in rural areas through this reallocation.

6.7 General Agreement on Trade and Services under WTO

The General Agreement on Trade and Tariff (GATT) had remained a vehicle of setting the parameters of international trade until 1970s. However, some new restrictions adopted by the developed world afterwards created trade barriers for

the developing countries. This was a shift from GATT rules. As a result World Trade Organization (WTO) was formed in 1995 after the Uruguay Round (See Appendix IX).

The WTO aspect is an issue in the health policy because of its two components: General Agreement on Trade and Services (GATS); and Agreement on Trade-related Intellectual Property Rights (TRIPS). The GATS has set multilateral rules for tradable services. Mahmood (67) argues that participation in the GATS enables Pakistan with a greater access to lower cost/higher quality service inputs, and increased market for its own competitive service exports, such as construction and professional services. In the health sector Pakistan has qualified medical doctors who can provide competitive services internationally. This may increase competitiveness within country as well. However, a major risk attached to that is of accelerated 'brain drain'. This immense loss to the country is already happening as competent medical professionals leave the country. Foreign investment in the health sector is another area of interest, for instance, health insurance. But, this depends mostly on the investment climate[15] in the country. Ingredients of investment climate are macroeconomic stability and openness; good governance and strong institutions and; quality of infrastructure (68). Therefore, it is an urgent task to establish an investment climate for gaining new opportunities in a globalized world.

The other component with reference to WTO is TRIPS. This pertains to protection for intellectual property. The fulfillment of requirements under TRIPS would ensure foreign investors that a country is committed to protection of their intellectual property rights. However, developing countries have been facing difficulties during the process. Therefore, recently WTO approved legal changes to the TRIPS agreement that will make it easier for poor countries to import generic prescription drugs if they are unable to manufacture them (69). Pakistan's national pharmaceutical industry can get benefits due to this decision if it undertakes reforms that are also advocated by WHO. Currently, all drugs marketed in Pakistan are required to register under section 7 of Drugs Act, 1976 (39). Total 1339 new registrations were issued during the year 2000-01, out of which 1128 for local manufacturing and 211 for import. Again, for local manufacturing 1092 registrations were granted to national pharmaceuticals while 36 to multinationals. It is likely that under GATS import of cheaper medicines might start from India and China, on the other hand, multinationals might shift to countries which are conducive regarding raw material and investment climate. These issues have policy implications.

Despite pros and cons attached to the WTO regime, two aspects are important to note. Pakistan lacks preparedness; and the new challenges to WTO itself arising from the Cancun meeting. First, as Hussain (70) quotes World Trade Review

[15] Investment climate means the policy, institutional, and behavioral environment, both present and expected, that influences the returns and risks associated with investment. (Nicholas Stern, Former Vice President WB, ABCDE keynote address, Washington D. C., May 2001)

stating that it has apprehensions on competence and capability of officials in Pakistan to handle complex issues relating to WTO. The situation calls for an appropriate policy decision but it was found that Pakistan is lagging behind with reference to achieving targets set by the WTO. For instance, Pakistan has missed two deadlines of March 31st and June 30th, 2003 regarding the service sector. Second, recent meeting of WTO at Cancun, Mexico collapsed due to rift between rich and poor nations. Lopez (71) argues, this rift would accelerate tendency of rich nations towards replacement of multilateralism as envisaged by WTO with bilateral agreements and trade blocks – a paradigm shift from WTO principles. If that happens then the world may end up again with the situation which made GATT ineffective.

6.9 Governance

Islam (46) states that good governance is at the core of development. It involves, on the one hand, creating a system of governance that is efficient, transparent, and accountable, and on the other, has democratic dispensation, giving people the freedom to participate in the political process. Transparency and accountability are essential ingredients of good governance. The issues of governance and management have widely affected the efficiency of health care facilities. There are various reasons for these issues which need to be addressed. Professionals/staff absenteeism occurs because the training of physicians is clinical oriented rather than public health oriented. BHUs are located in far flung areas where medical officers are reluctant to stay. Bribery to stay out of such postings is common. Frequent transfers and postings is another issue which happens due to the tendency among professionals to be posted at some lucrative placement or in cities where financial benefits are relatively more through private practice. Political interference regarding recruitments, observance of rules and regulations and postings is endemic. Politicians get involved in these matters to build up their constituencies. The reason behind this is the fragile nature of democratic institutions whereby voter awareness is still a dream. That is one extreme, the other extreme is that government officials work in highly isolated manner from communities and the people, and are not answerable to them in any way. They do not own the problems persisting in a community. Therefore, their responses do not change the lives of the people. Balancing both these extremes is the ideal scenario.

The different health facilities are doing identical jobs; therefore, effective and efficient delivery of services is difficult. The reasons of doing identical activity is the lack of a referral system, lack of quality care, lack of medicines and equipment along with skilled personnel.

6.10 Centralized implementation

High hopes have been pinned on the devolution process which is now functioning. It may be the vehicle for a bottom up approach for planning and implementation. But due to ambiguity in delegation of powers including administrative and financial powers, implementation is not properly taking

place. So, there is confusion regarding the role of different tiers. For example according to the Constitution, health was a provincial subject but the implications of that for the functions of national and provincial levels had not been finalized. However, provincial list was abolished under concurrent list in the Constitution, which made health a responsibility of Federal as well as provincial governments. Under such an arrangement, federal government would be responsible for development of guidelines; standardization of policies; matters related to drugs and vaccines and inter provincial coordination of health matters while the actual health services delivery including implementation of preventive programmes rests with provincial health departments and district health authorities functioning since August 14, 2001. However, there are exceptions whereas; federal government manages some vertical programmes and many hospitals and institutions.

6.11 Lack of Continuity

Lampton (72) states that one characteristic of mobilization in China is to provide uniformity in policy direction. However, the situation is different in the case of Pakistan where, lack of continuity of policies is an important issue. For example health policies announced since 1990s could not complete their stipulated ten years time for implementation. With every change of government the policy also gets changed. This tendency by successive governments to pander to their constituencies and to take biased decisions on critical matters of state has been this country's recurrent tragedy. This is directly responsible for the lack of progress made on all fronts, including health indicators which should be the first and foremost priority of any government.

6.12 Community participation

Karim and Zaidi (45) contend that the need of community involvement has been featuring on policy documents over the past decade and have been highlighted repeatedly in development plans, however in reality progress is almost non-existent. There are several reasons, one reason is that officials and service providers responsible at the operational level have as yet done little work on community participation and ignore the process of mobilization and involvement. Community participation is likely to be achieved if concerted efforts are made through devolved system.

6.13 Accountability and Monitoring

Despite a structured mechanism of monitoring placed in the planning process, it does not function. It is the weakest area of the policy. Efforts were being made to facilitate monitoring and evaluation under SAP. For this purpose Multi Support Unit (MSU) was established. However, the MSU began a beleaguered life, directly attributable to an article in its ToR which stated that MSU would not act unless requested by the government. As a result MSU confined itself to assist provinces with formulating their annual operational plans (73). This

example provides some indication that mechanisms for monitoring and evaluation are not strong enough and some times even donors do not exert sufficient influence. Other reasons for the lack of monitoring are non-availability of logistics support and rent seeking behavior which further undermines accountability.

CHAPTER SEVEN

Conclusion and Recommendations

7.1 Conclusion

Since the last decade successive governments had formulated three health policies. Additionally, the last fifty-six years' health planning through five-year plans and various reform commissions show that a breakthrough is yet to be made and poor health status calls for more vigorous action. Progress can be made with strong political will and efficient use of minimum resources. For example in its recent report UNDP (9) noted, the state of Kerala, India has health indicators similar to those of the United States – despite a per capita income 99% lower and annual spending on health of just $28 a person. Cuba's per capita income is a small fraction of that in the United States, yet it has the same infant mortality rate. In the 1980s Botswana made advances in education and health unexpectedly based on its income level. Furthermore, Iran and Sri Lanka have made exemplary progress in the field of health.

As discussed in the preceding chapters, health cannot be seen in isolation therefore, multi-sectoral intervention aimed at overall development more focused on poverty reduction can enhance the status of health. A profile of poverty in Pakistan (74) refers to the level of income distribution. In 1990-91, household income share of lowest 20% was 7.3% while highest 20% had income share about 44.5% of total income. More recently SPDC report (75) states that in 1999 income share of lowest 20% was 7.8%. This was further imbalanced in the case of rural and urban where it was 8.7% and 6.6% respectively. While the income of highest 20% was 46.5%.

Pasha et al (62) argued that a three pronged poverty reduction strategy will have to be adopted, consisting of, first, increased economic opportunities for the poor, second, their empowerment and, third, access to welfare and support through development of appropriate social safety nets.

In this background, it is important to note that an inherent approach of health policy based on medical model[16] rather than public health model[17] just targets

[16] The emphasis on curative health services, little concern with the overall pattern of allocation of resources, a desire to provide 'state-of the-art' care, and the measurement of outcomes in terms of changes in the health status of individual patients. (WB 1998)

diseases. While just attacking diseases but not poverty is like beating about the bush. Furthermore, just subsidizing the services or distributing food items at the time of catastrophic situations will not serve the purpose. It is mandatory for poverty reduction efforts - directed towards health and development - to be successful. In order to achieve that level of success, people should be empowered through participation in political process, stable and stronger democracy, agrarian reforms, industrialization, freedom of expression, freedom of political association, education, health, shelter and equal opportunities and such empowerment should be sustainable.

For sustainable reforms process Stern (76), (former Chief Economist World Bank) has rightly argued that a country should be in the driving seat and reform programmes forced from outside with weak societal commitment, are likely to fail. Therefore, aid must be used to finance the costs of change, not the costs of not changing.

In this whole scenario, health policy of Pakistan is in quest of a vision. Health care is only one factor aiming at improvement in the health status of the population. The evidence presented in this study shows that health is beyond health care. It has social and economic dimensions. We must recognize the fact that all developed countries of the world did not achieve success in health through only medical interventions but it was social progress and prosperity of society and individuals that changed the scene. Same is true for some developing countries and regions that have achieved success comparable to developed world. Hence, the vision for Pakistan's health policy lies in development agenda. And that how the country addresses social and economic determinants of health. Better and sustained health outcomes are bound to unfold if a strong political will is shown in this regard.

Therefore, with such an overall development concept in mind; a comprehensive, dynamic, participatory and evidence based health policy is now over due. Health policy documents available so far are laudable efforts but the quest towards a health policy representing the broader needs of the people is still on.

[17] The emphasis on preventive interventions, obtaining maximum impact on the health status of communities for the resources available, the use of appropriate technology rather than 'state-of the-art', and measurement of outcomes in terms of changes in the health status of the population at large. (WB 1998)

7.2 Recommendations

7.2.1 Decentralization of Health Policy Process

Making health policy formulation a centralized function has not served the purpose. Moreover, after the devolution, efforts regarding implementation need to be more concentrated at district level. As yet, policy formulation is a federal function, while implementation rests with the provinces. Therefore, it is recommended that health policy making be decentralized. Federal government may provide basic guidelines in line with national and international commitments including defining the role of different tiers. Hence, the national health policy formulation should start at provincial level with active involvement of the districts. The districts should send their need assessment to the province where a preliminary draft should be prepared in the light of districts reports for presentation at the federal level. Different provinces may have different needs and different perceptions of planning. Hence, this process would create sense of ownership in the provinces as well as districts where actual implementation has to take place. Federal government should coordinate between provinces so that policy formulation is facilitated. Besides, capacity building at provincial level would be pre-requisite for this recommendation to implement. In this regard it is suggested that besides proposed Health Policy Unit in the federal Ministry of Health, similar units may be established in the provinces.

7.2.2 Strengthening of Policy Process

For evidence based policy formulation BoD should be calculated; HMIS should be strengthened; referral system should be established; health systems research should be given priority; consistency of policy should not be compromised; good governance must be ensured. All these steps do not require huge funds they just need political will; necessary infrastructure for these priorities is already there.

7.2.3 National Commission on Health and Development

Health status will be enhanced only when development is focused. Government is also committed to achieve targets and goals set by the Millennium Development Goals. Therefore, it is recommended that a Multi-Sectoral 'National Commission on Health and Development' may be established which must be headed by the President or Prime Minister with a view to ensure high degree of political will. The prime task of the commission should to set a vision for health policy. Ministry of Health should be the coordinating agency, while other ministries and organizations related to health and development may be represented along with civil society; medical associations; and private health sector. Such commissions exist in other countries as well. This commission

would work for achieving improved health status and development which has also been suggested through conceptual framework of this study. The commission would enable all ministries to pool their resources (social sector allocations) in such a way that these would be spent to achieve broader health and development goals making the prospects of reaching the so far elusive goal of economic prosperity a step further. In addition, this would provide an opportunity to balance low health expenditure as a percentage of GDP. It is further suggested that the BDN model developed by WHO, currently under implementation in a few areas of the country be replicated throughout country.

7.2.4 Village Health Committees (VHCs)

An effective impact of devolution of power can be ensured through community participation which can be linked to decentralization of health policy formulation, planning and implementation. Community participation will also facilitate 'trickle down' effects of proposed national efforts for health and development. In this context it is recommended that in the jurisdiction of each BHU, Village Health Committees (VHC) be formed under supervision of Medical Officer, BHU and *Nazim*, Union Council. The VHCs would work for promotion of health; would motivate community to participate in campaigns like polio, malaria, TB; work for mother and child health; and reproductive health etc. The village councilors, lady health workers and other outreach health staff would also participate in VHCs.

7.2.5 Effective use of Health Expenditures

There is an urgent need to increase health expenditure from its present less than one percent level. However, despite commitment by the government to increase health expenditure it is still awaited. Therefore, efficient use of available expenditure becomes more important. In this regard cost-effective measures suggested by various studies may be discussed and applied which may increase efficacy gains up to 8 to 10 percent. In this regard more funds must be diverted to three priority areas including health education; communicable diseases; and MCH services. This must be reinforced with effective accountability, monitoring and evaluation mechanisms.

7.2.6 Third Party Monitoring and Evaluation

Experience has shown that despite sophisticated structures for monitoring and evaluation, practically it does not take place. The other criticism is that health policy is input oriented which does not consider output. Therefore, a concerted effort is needed in this regard. It is recommended that some reputable NGO or agency may be invited to conduct third party monitoring and evaluation. It should have two components: conducting monitoring and evaluation with submission of report and; train and build capacity of provincial/local health authorities and CBOs to conduct this exercise periodically on their own.

7.2.7 Private Sector Inclusion

It is high time that private sector may be streamlined into national health care from two dimensions: to tap private sector resources to enhance health status and; to regulate private sector in order to check irrational use of drugs, injections and interventions which is responsible for increasing the burden of diseases, and to formulate a fee structure for private practice. Furthermore, it should aim at establishing public-private partnership. SIUT Karachi, Khyber Medical College, Abbotabad and many other successful examples can be cited in this connection. A joint committee of public, private and NGO sectors may be formed which should present its preliminary report in three months.

7.2.8 Advocacy for Policy

The involvement of civil society and other stakeholders in the policy process is of utmost importance. Civil society can be very effective in conducting policy related research and advocacy activities. In this document Policy Maker Analysis Software has been described, and it should be used by civil society as well as government for policy advocacy in order to achieve the desired policy framework.

7.2.9 Assessment of Opportunities and Challenges due to WTO

It is recommended that the Ministry of Health assess opportunities and challenges as a result of WTO agreements of GATS and TRIPS. For this purpose, the Health Policy Unit which is being established in MoH should coordinate with WHO and ministries of finance and trade to suggest necessary reform in pharmaceutical industry and health sector not only in order to avail opportunities but to prepare to face the challenges rising from WTO agreements.

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APPENDICES

Appendix I

Traditional Medicine

The government has granted recognition to the Traditional System of Medicine (Homeopathic Ayurvedic) by enacting the Unani, Ayurvedic and Homeopathic Practitioners Act of 1965. According to the Act, the purpose of this legislation is:

1. To promote and popularize these systems of medicine.
2. To regulate education and research in these areas
3. To provide for registration of practitioners of these systems.

Homeopathic System of Medicine

A National Council of Homeopathy has been established, which is functioning as a corporate body. 117 Homeopathic Teaching Institutions have been recognized within the country, which are producing qualified Homeopaths. At present there are 73,878 registered practitioners of Homeopathy throughout country. During the year 2001-02 a sum of Rs. 600,000 has been provided to the National Council for Homeopathy and Rs. 14,00,000 for recognized colleges as annual Grant-in-aid. Efforts are being made to formulate Drug Act for regulating/manufacturing, sale standardization etc. of traditional medicines.

Unani System of Medicine

The Unani or the Greek Arabic System of Medicine is one of the most popular traditional medicine systems in the sub-continent. Practitioners of this system are known as Tabibs or Hakims. The Government has established National Council for Tibb under the Unani, Ayurvedic and Homeopathic Practitioners Act – II of 1965. At present there are 28 recognized Tibbia colleges from where Tabibs are qualifying as practitioners after a four year course. The Government provided Rs. 425,000 to Tibbia teaching institutions and Rs. 800,000 to National Council for Tibb during 2000-01 as annual Grant-in-aid. According to estimates there are 45,799 Hakeems/Tabibs and 537 Vaids in the country registered with the Council. There are 315 Tibbi dispensaries. There is one public sector college for Tibb in Bahawalpur, Punjab. *(Source: Annual Report of Director General Health 2000-01)*

Appendix II

Millennium Development Goals (MDGs)

Millennium Summit 2000 convened by United Nations is a landmark in the history of this global organization. Heads of 189 states and governments attended the summit.

MDGs are defined procedures for a dramatic reduction in poverty and marked improvements in the health of poor. It's a development agenda – including quantitative goals, time-bound targets and numerical indicators.

The history of Millennium Development Goals can be traced well into the 1990s when International Development Goals (IDGs) were set in international conferences through out the decade organized by the UN. MDGs emerged from International Development Goals. Previously there were seven IDGs.

World leaders agreed upon eight Millennium Development Goals at the Millennium Summit 2000. Following are the eight Millennium Development Goals:

- Goal 1: Eradicate extreme poverty and hunger
- Goal 2: Achieve universal primary education
- Goal 3: Promote gender equality and empower women
- Goal 4: Reduce child mortality
- Goal 5: Improve mental health
- Goal 6: Combat HIV/AIDS, malaria and other diseases
- Goal 7: Ensure environmental sustainability
- Goal 8: Develop a global partnership for development

In order to achieve these goals, 2015 has been fixed as a target-meeting year. While year 1990 has been kept as baseline year, which was primarily set by International Development Goals agenda. To meet the MDGs, 18 targets and 48 indicators had been set. Of the eight broadly stated goals and 18 specific targets to be achieved by year 2015, six are directly related to health.

Pakistan is a signatory to the MDGs. Targets for Pakistan are: IMR to be reduced to 40 from the position of 120 in 1990; under 5 mortality to be reduced from 140 in 1990 to 47 in 2015; proportion of fully immunized children (12-23 months) from 25% in 1990 to 90% in 2015; MMR to be reduced from 550 in 1990 to 140; proportion of birth attended by skilled persons to be 90%; CPR would be raised up to 90% in 2015.

Appendix III

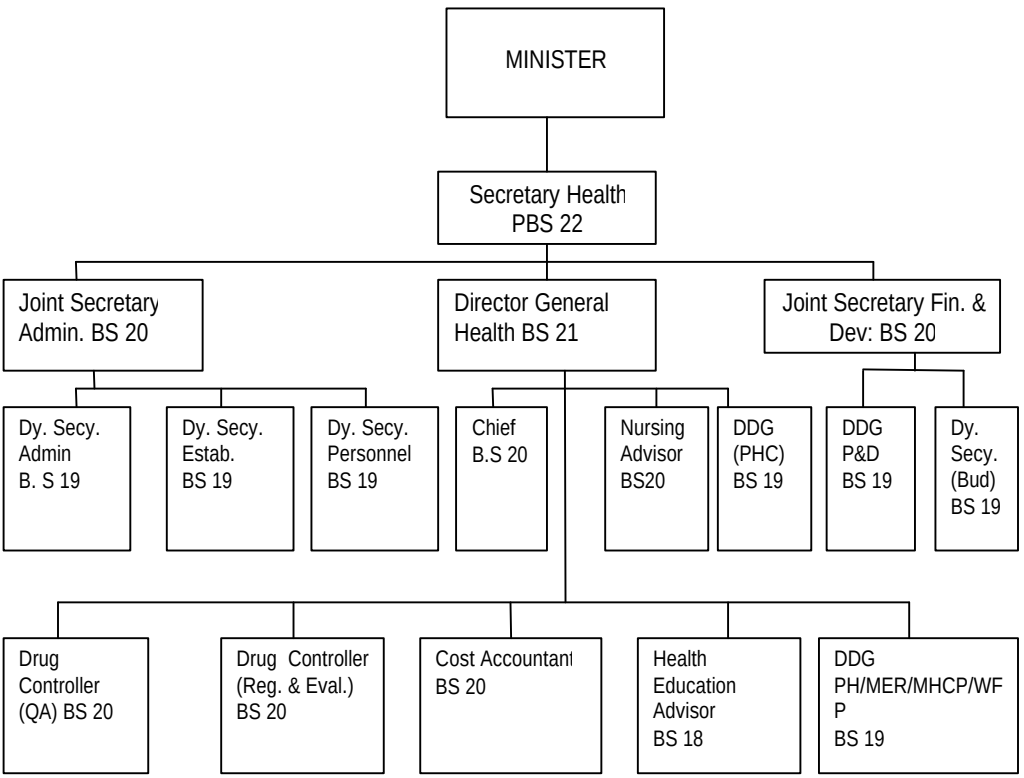
Questionnaire for interviewees

1. Would you please briefly explain the evolution of health policy and planning in Pakistan?

1. Do various stakeholders (e.g. bureaucrats, technocrats, experts, legislatures, common men and civil society) play their due role effectively in planning and implementation?
2. Various researchers have been indicating that health is part of overall development and poverty being major determinant of ill health, other determinants can be outlined as illiteracy, unequal distribution of wealth, environment, lifestyle etc. Does our health policy address those determinants? How could it be linked with development?
3. At the stage of policy formulation how decision-making takes place and how issues are being prioritized?
4. What issues are being faced at the stage of implementation?
5. What effects are being expected on health sector after trade liberalization under WTO/GATS and how those effects may be addressed?

Appendix IV

Organogram of
Ministry of Health, Pakistan



(Source: Ministry of Health)

Appendix V

Salient Features of Health Policies

Health Policy: 1990

The process for policy formulation started in the year 1988. The policy was announced by the Ministry of Health, Special Education and Social Welfare in January 1990.

Goal

The goal of the policy was to provide healthcare cover to the entire population of the country within the shortest possible time. Health expenditure would be enhanced to meet the goal and additional sources of revenue would be identified to finance this policy.

Main Objectives

- ? To make primary health care available to all citizens without discrimination throughout the country.
- ? To decentralize the administrative structure of the health care system by creating Management Boards.
- ? To establish Public Health Services including schools of public health and programmes of family planning, nutrition, water supply, waste disposal, industrial safety and protection from environmental hazards.
- ? To broaden the scope and jurisdiction of Employees Social Security Institutions.
- ? To improve and enlarge the scope of private health sector by giving incentives and by regulating it through provincial commissions. General Practioners will be involved in the main stream.
- ? A list of Essential Drugs would be introduced.
- ? Unani system of medicine and Homeopathy would be recognized.

Major Targets

Following major targets were set to be achieved by the year 2000:

- ? To make primary health care available to the entire population with the minimum goals being:

- Immunization
- Drug packets for treatment of 22 common diseases to be made available in villages and BHUs.
- Cadre of trained personnel to be created for attending pregnancy, child birth and caring for children up to at least one year of age.

- ? To enhance nutritional status so that:

At least 90% of newborn infants have a birth weight of at least 2,500 grams
At least 90% of children have a weight for their age that corresponds to the reference values.

- ? To achieve infant mortality rate for all identifiable subgroups at below 50/1000 live births.
- ? To achieve life expectancy at birth of over 60 years.
- ? To spend at least 5% of the GNP on health with resources distributed equitably between the urban and rural areas.

Major Salient Features

Universal health cover, free of charge to those who cannot afford to pay for it; democratization of health administration; and provision of trained health manpower:
Training programme for 100,000 Village Health Workers (VHWs).
Drug schedule for hospitals and health care facilities
Health insurance schemes
Health Management Boards and Committees established.
Family planning made an effective and mandatory part of the health care programme.

Implementation of Programmes

- ? Basic Health Services established on an integrated basis including measures for improving agriculture, increasing clean water supply, sanitation, electrification, roads, schools and grain storage. In other words it will be a part of a holistic approach ie “total development”.
- ? The community involved at the outset in identifying its needs, choosing the sequence and in implementing and supervising the programmes.
- ? Modern record keeping, medical audit system and health information reporting system introduced. The aim will be to acquire essential information for management and evaluation purposes.

? Educating people in healthy life styles to provide back up support to all programmes.

Health Policy: 1997

This policy was prepared by the Ministry of Health and approved by the Federal Cabinet on December 17, 1997

Guidelines up to 2010

The Government of Pakistan is committed to achieve the goal of health For All through PHC. It aims to create a platform for social change to improve the quality of life of the people, through this approach. The new health policy is based on a concept of health with its physical, mental and social dimensions, where health is an important indicator of quality of life and national development.

The 2010 vision for the health sector development is one of comprehensive and quality health care for all segments of society. It aims at reducing the burden of ill health from preventable causes. In addition to a strong PHC programme, a highly organized and well equipped tertiary level care will be available at affordable prices. The ultimate goal of all health programmes would be to ensure basic services and promote a better quality of life for attaining maximum national development. The achievements expected by the year 2010 through implementation of the new Health Policy initiatives are given in the following table:

Table: Targets for Year 1998, 2003 and 2010

Index	1998	2003	2010
Infant Mortality Rate	86	40	20
Maternal Mortality Rate	350	200	90
Life Expectancy at birth	62	65	69
Children below 01 year fully immunized (%)	65	90	100
Expectant mothers fully immunized against tetanus (%)	60	80	100
Eradication of Polio	Year 2000		
Trained personnel attending pregnancy and birth (%)	20	70	100
Low birth weight babies (%)	25	10	05
Oral Rehydration Therapy use (%)	70	90	100
Iron Deficiency Anemia (%) ? Women ? Children	40 30	20 20	5 5
Goiter Prevalence Rate (GPR) (%)	15	10	1.0
Doctors	75000	133,000	142,000
Dental Surgeons	3,000	6,000	15,000
Nurses	24,810	35,000	50,000
Paramedics	115,000	170,000	215,000
TBAs	50, 000	60,000	65,000
Community Health Workers (Female)	45,000	75,000	100,000

Source: *National Health Policy: 1997*

The Major Objectives

? To address the health problems in the community, by providing promotive, preventive, curative and rehabilitative services to which the entire population has effective access.

? To bring about community participation through creation of awareness, changing of attitudes, organization and mobilization of support.

? To improve the utilization of health facilities by bridging the gap between the community and health services

? To expand the delivery of reproductive health services including family planning in both the urban and rural areas of Pakistan.

? To gradually integrate existing health care delivery programmes like EPI, malaria control, nutrition and MCH within PHC.

? To improve the nutrition status of mothers and children and reduce the prevalence of malnutrition

? To promote proper inter-sectoral action and coordination at all levels.

Main Strategies

? Strengthen the district health system to deliver the essential elements of PHC and provide the necessary support mechanism in terms of training and logistics to effectively supervise the performance of health workers at all levels.
? Ensure satisfactory staff levels at RHCs/BHUs and promote the deployment of female workers as a human resource capacity building for the district health system.
? Improve the functions of referral system to ensure equitable accessibility to emergency, secondary and tertiary health care services.
? Ensure direct and effective community involvement and bring about coordination and collaboration between health and other government sectors and NGOs.
? Introduce alternative approaches to financing health care through the involvement of the private sector and the national health care schemes.
? Integrate all vertical programs into PHC at the operational level to create an effective district health services system based on comprehensive PHC.
? Deliver reproductive health services including family planning in all health activities and at the household level through home health care.
? Promote innovative control strategies for the prevailing communicable diseases such as tuberculosis, viral hepatitis and Acute Respiratory Infections and diarrhoeal diseases, and undertake the control of major prevalent non-communicable diseases.
? Planning would be decentralized to the grass-roots level and community would be given active participatory role.

Four Priority Areas

The ultimate aim of this health plan is to improve the levels of health in the population.

1. Most Serious Health Problems

First priority will constitute a concerted effort on the most serious health problems, from the prospective of mortality and morbidity indicators. These health problems include: diarrhoeal disease; acute respiratory infections; immunizable diseases and malnutrition. These conditions are prevalent because of the high rate of poverty, large families and contaminated environments, as well as inadequate health services system, while the high maternal mortality is prevalent due to preventable complications during pregnancy. Primary health care is considered to be the key intervention for achieving health for all. To attain the best outcome during this planning period, several priority programs have been delineated to constitute the thrust of district, provincial and national health services delivery. A package of managerial support is also considered to ensure their successful implementation.

2. Risk of Population Trap

The promotion of extensive reproductive health services including family planning through a comprehensive package of community and family based PHC health services will be the key for realizing this objective.

3. Poverty and Ill-health

Poverty is the underlying cause of ill-health and for a considerable proportion of the people, survival acquires the greatest urgency. In such a situation there is little that health intervention can do to improve health conditions. To address poverty related high morbidity and mortality, the Ministry is aiming to launch an integrated community based, inter-sectoral, total development programme of Basic Minimum Needs. It will address the comprehensive needs of the community such as food, water, shelter, health, education and income through social and income generating activities. This will improve the health and social indicators.

4. Involvement of Private Sector

To start a process of developing policies and intervention plans for involving the private sector so that it can play a significant part in the health sector. Specific innovative operational strategies are considered in this plan.

Health Policy: 2001

This policy was announced in December 2001, by the Ministry of Health. It identified ten key areas in which intervention is being carried out for the next ten years. The policy was titled as 'The Way Forward' and the 'Agenda for Health Sector Reform'.

Key Features

- ? Health sector investments are viewed as part of Government's Poverty Alleviation Plan.
- ? Priority attention is accorded to primary and secondary sectors of health to replace the earlier concentration on tertiary care.
- ? Good governance is seen as the basis of health sector reform to achieve quality health care.

Vision

- ? National vision for health sector is based on "Health-For-All" approach. The new health policy aims to implement the strategy of protecting people against hazardous diseases; of promoting public health; and of upgrading curative care facilities.
- ? Measures, programmes and projects as means for enhancing equity, efficiency and effectiveness.
- ? It will require commensurate investments and interventions by the Provincial Governments for improving health infrastructure and services. The Federal Government will continue to play a supportive and coordinative role in the key areas like communicable disease control programme.

Ten Specific Areas of Reform
Targets and Time Frame for 5 key areas

Key Area 1: Reduce widespread prevalence of communicable disease;

- ? Immunization coverage will be increased to 80% by 2005 and full coverage reached by 2010.
- ? Polio cases will be reduced to less than 100 by the end of 2001 with WHO Certification achieved by 2005.
- ? Hepatitis B coverage will be available in 70% of districts by 2002 and 100% by 2003 providing 17.3 million doses annually over next 5 years
- ? Full DOTs coverage of TB will be achieved in all districts of the country by 2005. The detection rate will be 70% and cure rate 85% by then. It will reduce TB prevalence by 50% by 2010.
- ? Malaria cases also will be reduced by 50% by 2010. Plasmodium Falciparum cases will be kept at less then 40% of all malaria infections.

Key Area 2: Addressing inadequacies in primary/secondary health care services

- ? 100,000 Family Health Workers will be recruited and trained by 2005 to cover the entire target population.
- ? Rationalization study of RHCs/BHUs will be completed by 2002.
- ? 58 Districts and 137 Tehsil Hospitals will be upgraded over a period of 5 years.

Key Area 3: Removing professional/managerial deficiencies in the District Health System

No targets or time frame fixed.

Key Area 4: Promoting greater gender equity

- ? By 2005, 100,000 Family Health Workers will be duly trained as community workers and developed in the field.
- ? The number of nurses will increase from 23,000 to 35,000 by 2005 and 55,000 by 2010.

Key Area 5: Bridging basic nutrition gaps in the target population

- ? Reduce low birth weight babies from 25% to 15% by 2010.
- ? Vitamin A supplementation to approximately 30 million children a year.

No separate targets and time frame has been given for rest of the key areas. However, implementation modalities are discussed. Rest of the key areas are:

6. Correcting urban bias in the health sector
7. Introducing required regulation in private medical sector
8. Creating mass awareness in Public Health matters
9. Effecting improvements in the drug sector
10. Capacity-building for Health Policy Monitoring

Appendix VI

Table: The Interviewees

Number	Designation	Organization
International Organizations		
1	Country Representative, Pakistan	World Health Organization(WHO)
2	Senior Health Specialist	World Bank, Pakistan Mission
3	Economist, (also Deputy Chief MOH)	WHO
Public Sector Organizations		
4	Chairman	National Commission on Human Development (NCHD)
5	Director	CRPRID, Planning Commission
6	Deputy Director General (Development)	Ministry of Health
7	Deputy Director General (PHC Cell)	Ministry of Health
8	Chief Health	Planning Commission
9	Director	Pakistan Institute of Development Economics (PIDE)
10	Consultant	Ministry of Health
11	Secretary Health	Department of Health, NWFP
12	Additional Secretary Health (Dev.)	Department of Health, Sindh
13	Consultant	National Reconstruction Bureau
14	Ex. Secretary	Planning Commission
15	Ex. Secretary Health	Government of Sindh
International NGOs, Civil Society		
16	Managing Director	Social Policy & Development Center (SPDC)
17	Regional Vice President for South Asia	Commonwealth Medical Association
Pharmaceutical Sector		
18	Associate Director (Rtd.)	A MNC (Pharmaceutical)

Appendix VII

Matrix: Nodes, Sub-Nodes and Emerging themes from analysis using Nvivo software

Matrix: Nodes, Sub-Nodes and Emerging themes from analysis using Nvivo software

Nodes	Sub-Nodes	Emerging themes
1. Evolution of health policy and planning	**1.** Health planning as part of Five-year plans + + + + **2.** There was no health policy till 1990 + + + **3.** There is no health policy + + + **4.** Emphasis remained on curative aspect + + + + **5.** For the last two decades policy is influenced by the donors + + + **6.** Health planning has remained ill-suited and curative + + + + + + + + **7.** There was no proper policy till 1970 + +	Donor influence Curative aspect
2. Role of Stakeholders	**1.** Stakeholders are invited for policy process + + + + **2.** Stakeholders don't play their role + + + + + + + **3.** Collaboration between stakeholders is inadequate+ + + ++ **4.** There is selective involvement +	Stakeholders don't play their role Collaboration is inadequate between stakeholders
3. Policy is linked with development	**1.** Policy is not linked with other sectors + + + + + + **2.** Health can't be seen in isolation + + + + + + **3.** There is no link between ill health and its determinants in the policy document. **4.** There is link between poverty and health + + + + + + + + **5.** Link between poverty and health is important + + + + + + **6.** Policy focuses on poverty reduction + + + + **7.** Poor health is the major cause of poverty + + + + + + **8.** Policy endorses poverty reduction efforts + + + + **9.** Health is linked to development + + + + + + **10.** Policy addresses development + **11.** Ill Health plays major role in creating poverty + + + + **12.** Policy doesn't address development + + + + **13.** Policy is not responsive to	? Policy doesn't address development ? Health is linked to development

	development + + + + +	
4. Issues in prioritization and decision making for policy	**1.** Prioritization is made by available data + + + + + **2.** Most of the budget is spent on defense + + + **3.** There is no systematic way of prioritization + + + + + + + + + **4.** There is informal approach regarding prioritization + + + + **5.** Prioritization through official forums + + **6.** Legislation **7.** User fees **8.** Devolution + + + + + + + **9.** Role of donor + + + + + + + + + +	? No systematic way of prioritization and decision- making
5. Issues in implementation	**1.** Managerial in-capabilities + + + + + + + + + **2.** Funding mechanism ++ **3.** Centralized implementation + + + + + + + + **4.** Lack of training + + **5.** Different tiers doing identical activities + + + **6.** Inadequate resource allocation + + + + + **7.** Issues of governance + + + + + + + **8.** Incentives for staff + + **9.** Way of setting priorities + + **10.** Lack of staff skills + **11.** Lack of accountability + + **12.** Lack of monitoring + + **13.** Frequent transfers and postings + + + **14.** Misuse of resources + + + + **15.** Lack of community participation + + + + + **16.** Poor HMIS and inadequate dissemination+ + + **17.** Lack of continuity+ + + + **18.** Dichotomy of official and political will + + +	? Governance and management ? Centralized implementation ? Resource allocation and misuse ? Lack of continuity of policies ? Community participation ? Accountability and monitoring

6. Effects of WTO/GATS on health	**1.** Local markets will be affected + + + **2.** Cost of medicine will go up+ + + **3.** No work has been done on WTO+ + + **4.** Ministry of Commerce is not fully prepared **5.** Effects on local market regarding cost and production **6.** No serious work conducted+ + + **7.** Area of essential drugs would be affected + **8.** Pharmaceutical reforms needed+ + **9.** Foreign investment (hospitals; insurance) **10.** Government won't be able to restrict pharmaceutical industry **11.** Its positive for health+ + **12.** Need for skill development on the issue + **13.** Need to review health policy **14.** Prices of imported medicine will go up **15.** Health will become expensive **16.** WTO doesn't require privatization of health **17.** Pharmaceutical sector is already deregularized **18.** WTO is not an issue	? Local pharmaceutical industry will be affected ? Cost of medicine will increase ? Preparations lacking ? Pharmaceutical reforms needed ? Positive effects on health ? Over exaggeration

Note: Each point represents one person; besides, each sign of + represents one person.

Appendix VIII

Policy Maker Software

Managing the policymaking process is a difficult task. How do you get others to accept your policy or implement a decision? *Policy Maker* helps you comprehend the political dynamics of policymaking, and plot a path to victory by helping you analyze systematically who your supporters are, why your policy may face opposition, and what strategies might help you be more effective. In short, policymakers who confront complex political problems need Policy Maker 2.3 software. This easy-to-use tool can help you analyze, understand, and create effective strategies to promote your point of view on any policy question.

Policymaker can be used in a group as a tool for strategic planning among key advisors, or as an instrument for seeking consensus or agreement among different players or as a policy advocacy or lobbying tool. *Policymaker* has been used around the world by government officials, advocacy groups, private companies, international agencies, and the faculty members of major universities.

The Process: Policymaker is carried out through five main analytic steps. The software helps you to define:

- **Policy Content:** Define and analyze the content of your policy. Identify the major goals of the policy, and specify a mechanism that is intended to achieve each goal. Determine whether the goal is already on the agenda.
- **Players:** Identify the most important players and analyze their positions, power, and interests, and assess the policy's consequences for the players. Also, analyze the networks and coalitions among the players.
- **Opportunities and Obstacles:** Assess the opportunities and obstacles that affect the feasibility of your policy, by analyzing conditions within specific organizations and in the broader political environment.
- **Strategies:** Design strategies to improve the feasibility of your policy, by using expert advice provided in the program. Then, evaluate

your strategies, and create alternative strategy packages as potential action plans.

? **Impacts of Strategies:** Estimate the impacts of your strategies on the positions, power, and number of mobilized players--the three factors that affect the feasibility of your policy. Compare the future and current Position Maps and Feasibility Graphs to show the impacts of your strategies. Monitor the implementation of your strategies and compare the results to your predictions.

Experiences: *Policymaker* has been developed through the training of high-level decision-makers and through extensive field testing in policy environments around the world, including: the health of school children in Ghana; a project for setting health priorities in the city of Cambridge, Massachusetts; the introduction of a major health initiative in Tanzania; and health insurance policy for school children in Egypt. These experiences demonstrate that *Policymaker* is an effective tool for describing the political processes involved in public policy, for explaining how past decisions were made, and for proposing strategies to manage the political dynamics of policy decisions.

The *Policymaker* method is based on five analytical steps: policy content, players, opportunities and obstacles, strategies, and impacts of strategies. The program displays each step in the process as a series of buttons which lead to a window for each step.

Once you have defined your policy, *Policymaker* asks you to define who the critical players are. By evaluating the positions, power, and other attributes of the players with *Policymaker*, you can construct a working model of your political landscape.

After you have analyzed the players who may be affected by your policy, *Policymaker* can display this information in easy-to-read reports, tables, and diagrams. One major table, the Player Table, allows you to see all your players sorted and color coded on the basis of their position you have entered information on the players positions, The Position Map shows you how the players are positioned in a color-coded table, with your supporters on the left, and your opponents on the right and with power coded in black, gray, and white. In addition, once you have defined strategies, and have estimated their impacts, you can use the comparison feature of the Position Map to view a future scenario showing the potential impact of your strategies.

The Feasibility Graph displays a quantitative assessment of the relative strength of all supporters versus all opponents, and the potential to mobilize players currently in the non-mobilized category. The assessment is based on the assumption that political feasibility is determined by three main factors: - the strength of the position a player takes (low, medium, or high support or

opposition), - the power of a player (high, medium, or low power), and - the number of players who are mobilized to support or oppose a policy. The Feasibility Graph displays either a bar chart or a pie chart.

The Feasibility Graph assesses the political feasibility of your proposed policy by calculating a value for each player that combines the Position, Power, and Votes, according to an algorithm that you can customize.

After *Policymaker* has guided you through several analytic steps (to identify how players are allied, estimate your policy's most important consequences, and assess opportunities in the overall political environment), you are ready to formulate strategies to increase your policy's chance of success.

Policymaker helps you design your strategies by providing a series of expert suggestions, which you can customize.

Your strategies can be aimed at changing the power of supporters and opponents or shifting their positions to your advantage. They also can be directed at moving those who have yet to choose a position, who were assessed as non-mobilized.

Policymaker helps you evaluate your strategies to estimate the probability of success and judge how feasible your policy might be.

The International Development Research Centre, of Canada, used *Policymaker* to assess the feasibility of a multi-million dollar project in Tanzania to set health priorities at the district level.

Based on this successful application, the International Development Research Centre provided a grant for the enhancement and improvement of the *Policymaker* software and method.

The Inter-American Development Bank contracted to apply *Policymaker* to assess the feasibility of major reforms in the health systems of two Latin American countries.

The Action Programme on Essential Drugs at the World Health Organization is using *Policymaker* in a nine-country comparative research project on the assessment of national pharmaceutical policies.

A major multinational company has purchased a site license for *Policymaker* to use in strategic planning, especially interactions between business and government.

Policymaker has been used in a series of courses for health professionals, including the Harvard International Health Leadership Forum, whose participants are Ministers of Health and other top decision makers, as well as courses for mid-level technical officials from governments, international agencies, and non-governmental organizations.
(Source: Michael R. Reich, Harvard Center for Population & Development Studies Cambridge)

Appendix IX

World Trade Organization

The World Trade Organization (WTO) is the only global international organization dealing with the rules of trade between nations. At its heart are the WTO agreements, negotiated and signed by the bulk of the world's trading nations and ratified in their parliaments. The goal of the organization is to help producers of goods and services, exporters, and importers conduct their business.

The system was developed through a series of trade negotiations, or rounds, held under GATT. The first rounds dealt mainly with tariff reductions but later negotiations included other areas such as anti-dumping and non-tariff measures. The last round - the 1986-94 Uruguay Round - led to the WTO's creation.

The negotiations did not end there. Some continued after the end of the Uruguay Round. In February 1997 agreement was reached on telecommunications services, with 69 governments agreeing to wide-ranging liberalization measures that went beyond those agreed in the Uruguay Round.

In the same year 40 governments successfully concluded negotiations for tariff-free trade in information technology products, and 70 members concluded a financial services deal covering more than 95% of trade in banking, insurance, securities and financial information.

In 2000, new talks started on agriculture and services. These have now been incorporated into a broader agenda launched at the fourth WTO Ministerial Conference in Doha, Qatar, in November 2001.

The work programme, the Doha Development Agenda (DDA), adds negotiations and other work on non-agricultural tariffs, trade and environment, WTO rules such as anti-dumping and subsidies, investment, competition policy, trade facilitation, transparency in government procurement, intellectual property, and a range of issues raised by developing countries on the difficulties they face in implementing the present WTO agreements. The deadline for the negotiations is 1 January 2005.

The WTO has nearly 150 members, accounting for over 97% of world trade. Around 30 others are negotiating membership.

Decisions are made by the entire membership. This is typically by consensus. A majority vote is also possible but it has never been used in the WTO, and was extremely rare under the WTO's predecessor, GATT. The WTO's agreements have been ratified in all members' parliaments.

Organization

The WTO's top level decision-making body is the Ministerial Conference which meets at least once every two years. The Fifth WTO Ministerial Conference was held in Cancun, Mexico from 10 to 14 September 2003.

Below this is the General Council (normally ambassadors and heads of delegation in Geneva represent, but sometimes officials sent from members' capitals) which meets several times a year in the Geneva headquarters. The General Council also meets as the Trade Policy Review Body and the Dispute Settlement Body.

At the next level, the Goods Council, Services Council and Intellectual Property (TRIPS) Council report to the General Council.

Numerous specialized committees, working groups and working parties deal with the individual agreements and other areas such as the environment, development, membership applications and regional trade agreements.

The WTO Secretariat, based in Geneva, has around 550 staff and is headed by a director-general. Its annual budget is roughly 155 million Swiss francs. It does not have branch offices outside Geneva.

Agreements

GATS

Banks, insurance firms, telecommunications companies, tour operators, hotel chains and transport companies looking to do business abroad can now enjoy the same principles of freer and fairer trade that originally only applied to trade in goods.

These principles appear in the new General Agreement on Trade in Services (GATS). WTO members have also made individual commitments under GATS stating which of their services sectors they are willing to open to foreign competition, and how open those markets are.

TRIPS

The WTO's intellectual property agreement amounts to rules for trade and investment in ideas and creativity. The rules state how copyrights, patents, trademarks, geographical names used to identify products, industrial designs, integrated circuit layout-designs and undisclosed information such as trade secrets — "intellectual property" — should be protected when trade is involved. *(**Source:** WTO website)*