Poverty, Equity and the Social Determinants of Health

1.0 INTRODUCTION

In recent years there has been increasing recognition that the health of people in a given society needs to be addressed holistically and that this requires an understanding of the broader context of health as well as a multifaceted response. The 'broader context' consists primarily of socioeconomic factors that lead to the particular health situation of a society. A central element among these is poverty, which breeds ill health that impedes economic growth. It is also known that poverty and health status are linked with the inequalities that prevail in a society.

Much research has been conducted on the social determinants of health, which complement further the issue of poverty and equity in health. This paper explores these issues in the context of Pakistan's health sector. For the purpose research papers, documents of the government and international agencies have been reviewed.

2.0 POVERTY IN PAKISTAN

2.1 DEFINING POVERTY

Poverty encompasses the totality of deprivation experienced by an individual or group of individuals. It has been defined in many ways. The *Encyclopedia of Social Sciences* suggests that the definition of poverty is 'convention-specific' and distinguishes between 'social poverty' and 'pauperism': the former means economic inequality in addition to social inequality, such as dependence or exploitation, while the latter denotes ones inability to maintain the level conventionally regarded as minimal (Irfan 2003: p 2).

There are different aspects of looking at poverty. In explicit terms, poverty has been defined as the 'absence of sufficient income to be able to procure the minimum amounts of the basic necessities of life' (SPDC: 2004 p 56). The *Human Condition Report 2003* adopts a broader definition: poverty is not just the deprivation of income or consumption expenditure, but it also encompasses lack of access to education facilities, health facilities, employment oppor-

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tunities, participation in political decision-making, social mobilization, access to services, infrastructure, information, etc. In other words it is the deprivation of all or a few items in the goods basket at any point in time. Likewise, the Human Poverty Index (HPI) devised by the United Nations Development Programme (UNDP) includes not only food and non-food items but it also includes access to health care and education facilities (Pakistan Human Condition Report: 2003 page 40).

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In Pakistan, the Planning Commission has defined the official poverty line as a minimum caloric requirement of 2,350 calories per person per day. In monetary terms, this amounts to Rs. 646 per capita per month according to 2001-02 prices. The figures in Pakistan Integrated Household Survey (HIES) show that 33 percent of the country's population is living below this poverty line (SPDC: 2004 p 58).

3.0 THE HISTORY OF POVERTY IN PAKISTAN

Poverty started rising for the first time in Pakistan in the 1960s despite the fact that this period is considered the decade of development for the country. In 1963-64, an overwhelming 40.24 percent of the population was living below the poverty line despite an average GDP growth rate of 6.8 percent (Table 1) (Zaidi S A, 2004). This alarming level of poverty may be attributed to factors such as the war with India in 1965 and subsequent suspension of foreign aid. The concentration of wealth in a few hands is considered another major reason.

Table 1: Poverty and Growth Rates (1960s and 1990s)

Indicator	1963-64	1979	1987-88	1996-97	1998-99	2001-02
Poverty Line, %	40.24	30.68	23	28	30.6	33
GDP Growth, %	6.8	4.8	6.5		4.6	

Sources: SPDC Report 2004;

During the 1970s, another war was fought with India which resulted into separation of East Pakistan from rest of the country. One negative consequence of the war was that the average economic growth rate declined from average of 6.8 to 4.8 percent. Interestingly however, the poverty level dropped and, by 1979, had reached 30.68 percent (Ahmed A 2005). Notably, both urban and rural poverty declined, which may be due to a host of factors including upward revision of the support prices of agricultural crops, pro-worker policies, creation of jobs in the public sector after the nationalization of basic industries, and the large-scale migration of workers for overseas employment (ibid).

The decrease in poverty continued into the next decade and, by 1987-88,

the proportion of people living below the poverty line was 23 percent. During this period, the average growth rate also improved to 6.5 percent. This trend may be attributed to two factors: firstly, inflow of a high level of remittances had continued from the 1970s, and secondly, Pakistan received significant aid money due to its support in the Afghan war (SPDC 04). In the late 1980s, however, poverty started rising once again.

In the 1990s, poverty increased and growth declined. By the end of the decade, percentage of people below poverty line constituted 30.6 percent of the total population, while the GDP growth rate was 4.6 percent. *(ibid)*

In reviewing the history of poverty in Pakistan, it should be noted that, according to SPDC report (2004), there have been slight inconsistencies in the reporting of the poverty line. Moreover, Irfan (2003) argues the three key sources of information about historical poverty incidence in Pakistan- i.e., the Planning Commission, World Bank and independent researchers- have used varying definitions and procedures to arrive at their estimates. This makes it hard to assess the poverty situation at any particular point in time and exceedingly difficult to determine an inter-temporal trend. For example, Irfan (2003) while quoting a World Bank report suggests that it had put the poverty line at a different rate that is not comparable with the corresponding government figure. According to the Bank, the poverty line remained 37.4 percent in 1987-88; subsequently it was 34 percent in 1990-91, 25.7 percent in 1992-93, 24.0 percent in 1996-97, and increased to 32.6 percent in 1998-99.

"Reduction in poverty not only requires a high growth rate over a period of time but substantial decrease in inequality."

3.1 LESSONS ABOUT POVERTY IN PAKISTAN

Two phenomena are clearly evident in Pakistan's poverty experience. Firstly, except for occasional variations, poverty has in general been increasing since 1960. Secondly, a decline in poverty was not only related to an increase in the growth rate in absolute terms. Therefore, it may be concluded that some other factors were responsible for the decline in poverty besides growth rate. An explanation is in order.

The latter phenomenon highlights the fact that reduction in poverty not only requires a high growth rate over a period of time but substantial decrease in inequality. The growth and inequality relationship is well documented. According to the Kuznet hypothesis (1955) inequality increases at initial stages of growth and reduces as the economy grows to higher levels (SDPC: 2004, page 54). This relationship is represented by the famous Kuznet's curve. Since high inequality not only hampers poverty reduction efforts but also hinders economic growth, the trade-off between inequality and growth cannot be ignored (ibid). The argument suggests that poverty reduction cannot be ensured simply by an increased growth rate but distribution function is also necessary to achieve the stated goal.

Pakistan's poverty history offers plenty of evidence in support of the Kuznet hypothesis. SPDC's multivariate regression framework analysis of time series macro data for 1979-2002 reveals that poverty is the function of economic growth and distribution. The findings suggest that there is a positive correlation between per capita GDP and income inequality. This implies that as GDP rises, inequality also rises, and secondly, reduction of inequality is more likely to reduce poverty than increased growth. These conclusions highlight the central role of inequality in the prevalence and incidence of poverty (SPDC page 61).

Analysis of data on poverty further clarifies this argument. During the 1960s, the poverty line remained 40.24 percent on average, despite an impressive growth rate of 6.8 percent. On the other hand, in the 1970s, there was a significant decrease in poverty to 30.68 percent despite a slower growth rate of 4.8 percent. These figures de-link poverty and growth which shows if inequality is not considered, growth alone would not reduce poverty thus, placing inequality at center of poverty reduction efforts.

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It is argued that one percent decrease in inequality is likely to reduce poverty by 8.5 percent, a one percent increase in per capita income is expected to reduce poverty by only 3.6 percent. It points out that the level of inequality is a major determinant of poverty as per analysis of data for the last 23 years (ibid).

Thus it is evident that inequality generates more poverty, and equitable distribution promises significant reduction in poverty. Moreover, in the case of growth, poverty tends to increase unless the growth is sustained over a period and coupled with a distributive function. Therefore, targeting inequality is crucial to reduce poverty.

3.2 THE POVERTY REDUCTION STRATEGY PAPER (PRSP)

Over time, various efforts have been made to reduce poverty in Pakistan. A belated response among these is Pakistan's Poverty Reduction Strategy Paper (PRSP), 2003, which aims to target poor segments of the population. One of the key actions identified by PRSP as part of its poverty diagnosis is empowering the poor through political and economic inclusion (PRSP, GoP 2003). However, concrete steps in this regard have yet to be taken. Moreover, the UN Millennium Project (2005) argues that targeting the poor is the first but not the only step in reducing poverty and that poverty will need to be addressed in a broader perspective.

Despite hectic efforts carried out by the relevant ministries in development of PRSP, it is believed that it required more extensive consultations with all stakeholders. The health chapter of the document needed in-depth analysis of the issues in particular the equity issues which are crucial in poverty reduction.

4.0 INCOME, ASSET AND SOCIAL INEQUALITY IN PAKISTAN

Inequality may be described in terms of income inequality, asset inequality and social inequality, i.e., access to health, education, employment and social safety nets.

Income Inequality: The phenomenon of 1960s - high growth, high poverty - resulted into prominence of income inequality in research. (Kemal A R 2003, pp 87). Kemal (2003) pointed out the relationship between income inequality and democracy, citing Bollen and Jackman (1985), which maintained that democracy, could reduce the possible negative effects of inequality. Interestingly however, like growth, income inequality rises at the initial stages of democracy. Referring to Gradstein and Milanovic (2000), Beilz (1982), Bourgrignon and Verdien (1997), Acemoglu and Robinson (1998) and Aberto Chang (2001), Kemal (2003) argues that income inequality rises initially as democratic institutions start functioning but falls as democracy matures. The reason is that, initially, the elite use democracy to formulate policies for themselves, but as education spreads, policy formulation shifts in favour of the majority, which lowers the level of income inequality.

Various studies suggest that income inequality in Pakistan has reached an alarming level. It is argued that every rupee increment in GDP accrues 48 paisas to the richest 20 percent of the population and 7 paisas to the poorest 20 percent (SPDC, 2004 pp 68). In other words, the income share of the highest 20 percent is 47.6 percent while that of the lowest 20 percent is 7.0 percent (ibid, p 69). The disparity regarding income has widened over a period of 15 years at the start of which this ratio was 43.5 percent and 8.8 percent respectively.

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Asset Inequality: When poverty is viewed in terms of asset ownership, it becomes evident that people who do not own a landed property are poorer in both rural and urban areas. In rural areas, people who do not own houses are poorer than people who do own them. In the case of urban areas, the relationship between poverty and house ownership little varies due to confounding effects of *kachi abadis,* especially in urban areas of Sindh and community ownership in case of rural areas of Balochistan, where property is community-owned.

An estimated 31.82 percent of the population without ownership of land and 17.90 percent of people with owning land are currently living below the poverty line (SPDC, page 61). In urban areas as well, more people who do not own property are living below the poverty line. As per country aggregates, more people who do not own a house or land are living below the poverty line than people who do have these assets (ibid).

Social Inequality: Inequality in Pakistan is also visible in terms of health, education, employment and livelihoods. Rising inflation has gradually pushed a significant proportion of the population further into the poverty trap. SPDC estimates reveal that, between 1988 and 2002, in the lowest population quintile, expenditure on food items increased from 44.6 percent of family budget to 55.9 percent; expenditure on health doubled from 2.7 percent to 5.4 percent; and expenditure on education rose from 0.7 percent to 2.7 percent (SPDC, 2004).

5.0 EQUITY CONCERNS IN HEALTH

5.1 EQUITY AND INEQUITY

"Inequity in a society encompasses the distribution of resources as well as availability of opportunities."

The poverty and health nexus is widely recognized and it is beyond doubt that 'poverty breeds ill-health and ill-health maintains poverty' (Wagstaff A. 2002). Despite overwhelming evidence, however, it seems to be difficult for many developing countries to target this root cause of ill health through conventional methods that lack inter-sectoral approach.

Inequality and inequity have been defined by various researchers. In the context of health, inequalities are described as 'differences in health between groups independent of any assessment of their fairness', while inequities are defined as 'a subset of inequalities that are deemed unfair' (Evans T, Whitehead M et al. 2001). Fairness, in turn, is a broader and multidimensional concept that includes equity (Daniels N, Bryant J, K S Khan et al, 2002).

Equity is basically a distributive aspect of equality that attempts to achieve a fairer distribution of social benefits by treating people differently. This notion is well described by Aristotle (322-384 BC), who said 'Equals should be treated equally and unequal should be treated unequally'. This principle of distributive equality was captured by Campbell et al in the following words: 'People are treated in as fair a manner as possible by ignoring irrelevant differences between them but taking account of relevant differences' (Avis M, Robinson J et al 1999). The International Society for Equity in Health (ISEqH) defines equity as 'The absence of potentially remediable, systematic differences in one or more aspects of health across socially, economically, demographically, or geographically defined population groups or subgroups' (Starfield B, Maciko J A, 1980-2001).

Inequity in a society encompasses the distribution of resources as well as availability of opportunities. Evans and Whitehead (2001) have argued that structural inequities in the distribution of control over resources and opportunities to gain control are at the heart of inequities in health. For example, in many developing countries, the poor have the least access to potable water and pay higher prices than the wealthy for water of poorer quality. Conversely, a social context may be judged 'fair' if it provides for an appropriate minimum wage, progressive taxation, and universal access to care. The issue of control over resources is deeply linked to vulnerability to conditions pertaining to health.

Inequities comprise a cross-cutting issue and the failure of policy-makers to address them is a point of concern. It draws attention to the inability and-most of the time unwillingness of health policy-makers to act. This may be due to rigid distinctions between sectors (ibid) that result in failure of the health policy to incorporate social disparities.

Health Policy in Pakistan has traditionally overlooked this issue; little work has been done to address equity issues in health. Few studies on inequities in health that have been conducted were mostly spearheaded by civil society.

5.2 SOME EXAMPLES STUDYING EQUITY ISSUES

In Pakistan few attempts have been made to address the issues of equity in health. We may find some projects on equity or little research addressing aspects of equity in the context of Pakistan. These include Benchmarks of fairness for health systems; Tawana Pakistan project etc. As yet work on equity in Pakistan is basically the partnerships between academics, civil society organizations and government institutions with an aim to address inequities in health by focusing on research activities. However, some of these partnerships are not limited to research only but instead have a focus on service delivery as well which provides a practical example that addresses equity issues. A brief description of these partnerships is in order.

There is quite a frequent discussion on Benchmarks of Fairness. These benchmarks were originally developed in United States with an aim to assess and generate debate about comprehensive medical insurance reforms proposed in the US in the first Administration of President Clinton. However, benchmarks addressed some of the generic questions regarding any reforms (Daniels N, Bryant J, Khan KS et al. 2000). Owing to this reason and in order to adapt the benchmarks for use in different health systems, teams were formed in Colombia, Mexico, Pakistan and Thailand. There are nine benchmarks of fairness.

A recent project on Benchmarks was focused at sub-district level in Sindh. A sub-district was chosen due to a specific reason. The Government of Pakistan committed itself to health sector reform. One of the important steps in this regard is devolution. Under the devolved structure, districts have been placed as third tier for health services delivery. The main aim of this reform process is to make service provision more responsive and accountable (Mahmood et al 2004). The rationale for focusing the Benchmarks work in a district is to support this process. That is a viable option as the district health system provides complete system where utility of the tool may be tested (ibid). During the project period, health professionals, NGOs and communities were involved with a view to explore the fairness perspective in the local context. This innovative idea would unfold possible solutions regarding inequity issues in health sector at district level through indigenous wisdom that may be utilized for analysis at a macro level.

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The Tawana Pakistan project is being provided technical facilitation by Aga Khan University. This is a project of the Ministry of Women Development, Social Welfare and Special Education. According to the Government of Pakistan the objectives of the program include improvement the nutrition level of girls at school going age, enhancing and sustaining enrolment, reducing the gender gap in school enrolment, developing community participation and ownership and involving local NGOs and the private sector. Preliminary outcomes show that this project has equity related potential in a way that it empowers the women and deprived communities that enhances gender equity and community empowerment.

Peoples Health Movement is a global forum that strives for rejuvenation of the Alma Ata Declaration and gives voice to unheard voices of the people. PHM was launched in Pakistan during July 2004 (PHM Pakistan 2004). PHM focuses on issues of right to health and equity in health through organized action of public health professionals and people at grass roots level.

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Some researchers and academics from Pakistan have become part of The Global Equity Gauge Alliance (GEGA). The Alliance was established to support an approach to monitoring health inequalities and promoting equity within and between societies. GEGA consists of country groups that are called 'Equity Gauges'. The alliance is involved in advocacy at a global level with support from MedAct and Peoples Health Movement (PHM) (Mahmood et al 2004).

6.0 THE SOCIAL DETERMINANTS OF HEALTH: EVIDENCE IN LITERATURE AND CONTEMPORARY SITUATION IN PAKISTAN

There is considerable level of health inequalities between countries and within countries. Marmot M (2005) suggests the response to these inequalities has been provided at three levels. The first level was to put more efforts into control of major killer diseases and to improve health systems. Second, a belated response is to deal with poverty and; the third is to complement development of health systems and reducing poverty: to take action on social determinants of health.

The World Health Organization's Commission on Social Determinants of Health (see Box 1) has explained that 'social determinants'are the conditions in which people live and work. They are the 'causes behind the causes' of ill health. They include poverty, social exclusion, inappropriate housing, shortcomings in safeguarding early childhood development, unsafe employment conditions, and lack of quality health systems. (WHO Commission on Social Determinants of

Health, 2005). Moreover, the evidence supports the notion that the socio-economic circumstances of individuals and groups are equally or more important to health status than medical care and personal health behaviors, such as smoking and eating patterns. Social determinants are the best predictors of individual and population health structure, lifestyle choices and interact with each other to produce health. Therefore, they have direct impact on the health of the people (*ibid* 2005). It is argued that a focus on material conditions and control of infectious disease must not be to the exclusion of social determinants (Marmot M 2005). It is further argued that treating existing diseases is urgent and will always receive high priority but should not be to the exclusion of taking action on the underlying social determinants of health *(ibid)*.

"Although it might be obvious that poverty is at the root of much of the problem of infectious diseases, and needs to be solved, it is less obvious how to break the link between poverty and disease."

To assess the impact of social determinants on health, Siddiqui and Mahmood (1994) has conducted a cross-country analysis of the period 1960 to1990. For the purpose secondary data has been analyzed using generalized least squares (GLS) method of estimation. Life expectancy at birth and infant mortality rate have been used as indicators of health status. While through an equation[1] , affects of GDP per capita, health expenditures per capita (HE-PC), urbanization (Urb.), literacy (Lit), female literacy (Flit), population per physician (Phy), population per nurse (n) and caloric intake (Cal) per day have been estimated on health status. One of the key findings of the study suggests that literacy level plays a significant role in improving health status. Same results have been shown in the studies of Grosse and Perry (1983) and Hitiris and Posnett (1992). The study further informs that GDP per capita has become an important factor in improving health status in low and high income countries. This needs to be discussed further. Marmot (2005) argues that although it might be obvious that poverty is at the root of much of the problem of infectious diseases, and needs to be solved, it is less obvious how to break the link between poverty and disease. Income poverty provides, at best, an incomplete explanation of differences in mortality among countries or among subgroups within countries. Greece for example, with a GNP at purchasing power parities of just more than US$17,000, has a life expectancy of 78.1 years; the USA, with a GNP per capita of more than $34,000, has a life expectancy of 76.9 years. Costa Rica and Cuba stand out as countries with GNPs less than $10 000 and yet life expectancies of 77.9 years and 76.5 years respectively. It is further argued that Kerala and China have good health status, despite low incomes. Therefore, he suggests that a social determinants perspective is crucial because these are the social, economic and political processes that shape the health systems and their outcomes.

1. HS= f (GDP, HE-PC, Urb., Lit., Flit., Phy., n., Cal.)

BOX 1: WHO COMMISSION ON SOCIAL DETERMINANTS OF HEALTH

Much of the profound inequity in peoples' health within and between countries is socially determined. It arises from the circumstances in which people live and work. The three-year, high-level Commission on Social Determinants of Health will leverage change in policy and institutional practice by turning existing knowledge on social determinants into actionable global, regional and national policy agendas.

The Commission on Social Determinants of Health has been established by World Health Organization. The Commission was formally launched by Chilean President and Director General of WHO jointly on March 18, 2005 in Santiago, Chile. Prof. Michael Marmot, Director of the International Centre for Health and Society, and Professor of Epidemiology and Public Health, University College London will chair the 17- member Commission. Other members also include Dr. Amartya Sen, Lamont University Professor and Professor of Economics and Philosophy at Harvard University. Prof. Frances Baum, a past National President of the Public Health Association of Australia. She is the regional representative for the People's Health Movement (PHM) in Australia and the Pacific, and a member of its Global Steering Committee.

The Commission will not only review existing knowledge but also raise societal debate and promote uptake of policies that will reduce inequalities in health within and between countries.

The Commission's aim is, within 3 years, to set solid foundations for its vision: the societal relations and factors that influence health and health systems will be visible, understood, and recognized as important. On this basis, the opportunities for policy and action and the costs of not acting on these social dimensions will be widely known and debated. Success will be achieved if institutions working in health at local, national, and global level will be using this knowledge to set and implement relevant public policy affecting health. The Commission will contribute to a long-term process of incorporating social determinants of health into planning, policy and technical work at WHO.

Source: Lancet 2005; 365, 1099-104 & WHO website of the Commission (http://www.who.int/social_determinants/en/)

6.1 SOCIAL DETERMINANTS AND HEALTH SECTOR

A review of public policies of developed countries revealed that although the reason behind formulation of public policies was not necessarily to focus on health those were nevertheless contributing towards better health outcomes: taxation and tax credits, old-age pensions, sickness or rehabilitation benefits, maternity or child benefits, unemployment benefits, housing policies, labor markets, communities and care facilities (ibid). Sweden has set its new public health strategy stating that social conditions would be created to ensure good health for the entire population (ibid).

An inference may be drawn on the basis of discussion in this section that only health sector interventions or strategies cannot ensure an improved health status but it is crucial that all social policies may be devised in such a way that they would implicitly contribute towards health gains.

The conventional medical model of health presents the solution of ill health only through combating diseases and looks into etiology, diagnosis and

treatment of diseases. Thus, covers biological and genetic factors. In fact, health is beyond this conventional way of thinking. Alternatively, the public health model includes social, economic and environmental factors of health besides provision of health care services. Hence, this model draws our attention towards social determinants of health. A healthy environment, adequate income, meaningful and valued social roles, secure housing, higher levels of education and social support are all associated with better health and wellbeing. The Queensland Government in Australia has presented a framework for addressing the social determinants of health and wellbeing. The framework states that health is a matter that goes beyond the provision of health services as people's health cannot be separated from the social, cultural and economic environments in which they live and work. There are four broad determinants of health including socioeconomic and structural determinants; community context; individual factors and; population health outcomes. These determinants are influenced by global forces, government policies and culture *(A framework for addressing the social determinants of health and well-being. Web link accessed on April, 2005)*. Another report has presented a list of social determinants. That includes income inequality, social inclusion and exclusion, employment and job security, working conditions, contribution of the social economy, early childhood care, education, food security and housing (The Social Determinants of Health: an overview of the implications for policy and the role of the health sector. Web link accessed on April 20, 2005).

"Health is a matter that goes beyond the provision of health services as people's health cannot be separated from the social, cultural and economic environments in which they live and work."

In a global context some global factors also have been playing their role in determining health. In this regard five factors should be mentioned. (See Box 2). These include decline of the welfare state; rise of transnational corporations which pressure governments to reduce cost and thus maximize their profits - leading to more taxes and less opportunities for health and education locally; decline of institutional and government structures that worked to mitigate social exclusion and conflicts between business and workers; recession of the 80s and 90s that forced to cut the expenditures on health and education to reduce deficit; market driven political ideologies that see the individual as responsible for his or her place in a market economy with limited or no protection.

BOX 2: GLOBAL TRENDS INFLUENCING HEALTH THE WORLD OVER

- The decline of the social welfare state, which supported progressive tax structures, and social and employment programs to protect workers, families and people who needed assistance
- The rise of transnational corporations that pressure nations and businesses into reducing costs and maximizing profits at the expense of the worker
- The decline of institutional and government structures that mitigated against social exclusion and conflicts between business and labour

- The recessions of the early .80s and .90s, which led to the systematic cutting of budgets and rapid policy changes in the health, social and education sectors, in order to reduce deficits
- The growth of market-driven political ideologies that see the individual as responsible for his or her place in the market economy and little or no room for governments to provide social protection for individuals and groups that require assistance.

Source: *The Social Determinants of Health: An overview of the implications for policy and the role of the Health Sector. http://www.phac-aspc.gc.ca/ph sp/phdd/pdf/overview_implications/01_overview_e.pdf*

Commission on Macroeconomics and Health (2001) and York University Conference papers (2002) have argued about the key strategies to be adopted by relevant ministries of health in this regard. The Commission's report suggests that an effective health policy requires a detailed understanding of local conditions - ecological, social, demographic, economic and political - that all affect health. The report further suggests that beyond the reform of the health sector, health policy should address at least four areas. These are underlying infrastructure and technology for health; ecological conditions; social conditions, including education and gender equality and; globalization (See Box 3) (CMH Report 2001). The York University Conference on Social Determinants of Health (2002) has suggested six key strategies regarding social determinants of health in the context of Canada (see table 2) yet many of them are relevant to developing countries' context. These include frameworks regarding policies that reduce inequalities related to income, race, gender, ethnicity, geographic location, age, ability; promotion of full employment, job security and healthy working conditions; protect universal access to a high quality health system; protect and maintain a high quality public education system; uphold and ensure the right to housing and food and; reduce income disparities by ensuring minimum wages and level of social assistance with a view to access the basic necessities for healthy living.

Table 2: Selected Social Determinants of Health and suggested actions

Social Determinants of health	Required Actions
Inequality	Addressing inequalities related to income, race, gender, ethnicity, demographic, age
Employment	Job security, healthy working conditions
Universal Access to Health care	High quality health system
Education	High quality public education system
Housing and Food	Right to housing and food
Income disparity	Minimum wages, social safety nets

Source: York University Conference on Social Determinants of Health (2002)

Box 3: Socio-economic Areas to be Addressed by a Health Policy: Evidence from WHO Commission on Macroeconomics and Health

An effective health policy requires a detailed understanding of local conditions - ecological, social, demographic, economic, and political - that all affect health, and that need to be addressed in a public health strategy. Important investments and behavioral changes are needed in many key areas beyond the health sector itself. And beyond health sector reform, health policy should address at least the following four areas:

Infrastructure and technology for health: Even before the advent of some of the most potent health interventions of the 20th century, such as immunization and antibiotics, life expectancy began to rise and morbidity to decline in western Europe and North America. These gains were achieved through improvements in what Fogel has termed the "health infrastructure," including improved access to clean water; urban sewage and garbage disposal services; pasteurized milk and other safety precautions in food preparation and storage, and increased nutrient intake, especially following improvements in agriculture technology and productivity; and reduced transport costs of bringing food to urban centers.

Ecological conditions: Many diseases are heavily conditioned by the physical ecology of a country. Diseases depend on temperature, rainfall, availability of clean water supplies, the presence of specific disease vectors such as mosquitoes, density of habitation, and exposure to environmental risks. Therefore, costs and strategies may differ markedly according to ecology, and intervention strategies must be tailored to local ecological conditions.

Social Conditions: Social conditions matter enormously in determining health. Literacy, for example, particularly female literacy, contributes importantly to good health. Some societies ensure widespread literacy. Others deny literacy to girls, and still others deny literacy to ethnic minorities or low status social groups. Thus ethnic divisions, social stratification and gender discrimination may play a large role in the success or failure of disease control. Women's social status is a major determinant of health outcomes. Women have been shown in many societies to invest the household's scarce economic resources in their children's health and education than do men. Societies that limit girls' access to education pay a price in poorer health, and thereby in poorer economic growth.

Globalization: Globalization overall offers potential health benefits to the entire world. A more integrated global market is likely to increase the rate of innovation and diffusion of technological advance. Still low-income countries face at least four policy challenges arising from globalization. First, globalization has probably intensified the problem of brain drain from the poorest countries. Second, with increased competition for internationally mobile capital, many governments are finding that they must lower tax rates to compete internationally for investment. These tax cuts may, on balance, be beneficial for economic growth, but they make it harder for governments to finance public expenditures for health. For instance, China, took decisions that required local health centers to cover an increasing fraction of their budgets out of market revenues, thus excluding the poor from access to essential services. Third, globalization is most likely increasing the pace of international transmission of diseases. Studies suggest that even modest increase in international linkages across populations (e.g., due to tourism, migration, or business travel) could substantially increase the rate of transmission of infectious diseases. Fourth, globalization is undercutting many local cultural patterns, related for example to diet and drug use. A rapid increase is being witnessed in unhealthy practices such as high-fat-content foods, increased tobacco use, and increased use of illicit drugs (which may also be major channels for transmitting AIDS, hepatitis C, and other blood-borne diseases).

Source: Macroeconomics and Health: Investing in Health for Economic Development. Report of the WHO Commission on Macroeconomics and Health. WHO. 2001. pp 73

6.2 ROLE OF PAKISTAN'S HEALTH SECTOR

In Pakistan, policy makers argue - albeit rightly - that socio-economic conditions are beyond the control of health sector and secondly, the social determinants of health would require a lot of time to be addressed. Hence, on that pretext they think that health sector needs to take corrective measures only within its domain. Both these notions apparently seem to be correct statements. But, when these notions are seen in the context of available evidence, it is proved that sustainable improvement in health status is possible only through actions of different sectors i.e. socio-economic and political reform besides health care provision. There are practical examples in this regard. Lashari (2004 a) while quoting Mecknown's study argues that the historical decline in mortality in Great Britain in 1840 became possible through sanitation, safe drinking water, nutrition and over all prosperity in society. The same is true now for the developing world. The state of Kerala in India has achieved impressive health status and some of the indicators are comparable to the developed world mainly due to an egalitarian society, higher level of literacy, socio-economic reforms including land reforms, social justice, inclusion of health on the political agenda through social reform movements etc. (Lashari, 2004 b). Similarly, Sri Lanka has achieved its impressive health status due to multi-sectoral actions. Similar situations prevail in Costa Rica and Cuba in the developing world.

"Health care provision cannot be segregated from other factors affecting health."

On the basis of evidence, it can be stated categorically that health care provision cannot be segregated from other factors affecting health. In other words, irrespective of the jurisdiction of health sector, the agenda of social determinants of health aiming at uplifting of health status should be unfolded, with MoH taking the lead. MoH can play a potential role in coordinating multi-sectoral efforts. Being an agency responsible for health it is naturally expected of MoH to raise its voice in championing the cause of health and seek all possible ways to improve sustainable health status. Health sector should advocate for broader health goals in the attainment of sustainable health status besides focusing on health care provision. Besides, it is important that health care issues should be addressed by the Ministry so that issues of availability of services, human resource and quality of care are addressed. That would provide MoH a bigger and credible voice to talk of social determinants. However, a stronger role at overall governmental level is a pre-requisite for a healthy public policy response to the needs of health of the population.

The York Conference (2002) has attributed some role to MoH. That can also be adapted by MoH in Pakistan. There are three aspects of this role i.e. leader; influencer and; communicator and knowledge broker. The Ministry of Health has a direct leadership role to play in addressing the health and long-term care needs of population. Secondly, in many cases, the health sector can act as an influential catalyst, advocate, mediator and collaborator in reaching a win-win situation that convinces other sectors to develop public policies and assign public resources to improve the social determinants. Thirdly, the health sector can communicate with

the public and with decision makers about the impact of policies in labor, finance, housing and other sectors on health, well being and productivity.

6.3 SOCIAL DETERMINANTS OF HEALTH IN PAKISTAN

The discussion in this paper on social determinants provides sufficient evidence regarding the issue. In the context of Pakistan, there is a need to develop a list of main determinants that should be explored. Many determinants discussed in this section are relevant to Pakistan. For instance, poverty, social exclusion, education; water; sanitation and public health measures; housing; employment; lack of health care facilities and quality of care. These determinants will be discussed briefly in the context of Pakistan.

6.3.1 POVERTY

An overall analysis of poverty has been presented in this paper. In this section, poverty and health cycle would be discussed briefly along with social exclusion. Hussain A (2003) has analyzed poverty in UNDP's National Human Development Report. The report suggests that communicable diseases; reproductive health problems and; nutritional deficiencies together account for 60 percent of the burden of diseases inspite of the fact that all three types are preventable and treatable; the incidence of diseases and mortality remains high. This is indicative of high levels of poverty (causing poor nutrition, and unhygienic living conditions within the household). A survey conducted for the UNDP report revealed that the high prevalence of disease amongst those who are slightly above the poverty line is a major factor in pushing them into poverty. Those who are already poor get pushed into deeper poverty as a result of loss of income and high medical costs resulting from illness. The data shows that on average 65 percent of the extremely poor were ill at the time of the survey and they had on average suffered from their current illness for ninety-five days. Another manifestation of being poor is social exclusion regarding access to health care. More women are less educated or uneducated due to poverty and consequently there is more likelihood that infants born to the least educated mothers have twice the risk of dying within the first year after birth compared to more educated women (ibid). Being poor also hinders the level of immunization as compared to the rich. According to PIHS data referred in UNDP report there is strong correlation between income levels of household and immunization rates. For example during year 1999, 75 percent of the children under age 12 to 23 months in the upper income quintile were fully immunized as against only 25 percent in the lowest income quintile (ibid). This means poor have less protection against diseases resulting in manifold future risks that would push a family into deeper levels of poverty.

"Being poor also hinders the level of immunization as compared to the rich."

W Philip T James, Nelson M et al (2005) have argued that social class differences in health are seen at all ages, with lower socioeconomic groups having greater incidence of premature and low birth weight babies, heart disease, stroke, and some cancers in adults. Risk factors in the lower socioeconomic group

include lack of breast-feeding, smoking, physical inactivity, obesity, hypertension, and poor diet. Education and health have strong positive linkages. Sidiqui and Mahmood (1994) estimated that literacy is the most important and statistically significant variable. At present, the literacy rate in Pakistan is 43 percent for both sexes (Pakistan Human Condition Report 2003). There are sharp disparities in case of male/female and rural/urban ratio regarding literacy. According to PIHS 2000-01 reported by Pakistan Human Condition Report 2003, literacy rate in males is 58 percent while in females is 32 percent. In case of rural areas the literacy rate is 38 percent and for urban areas it is 64 percent. Twenty one percent of females in rural and 56 percent in urban areas are literate (ibid). However, a recent report by SPDC (2004) has reported literacy rate at 49.6 percent for both sexes. While 37.7 percent female and 60.9 percent male are literate. However, the general consensus is that the literacy rate in Pakistan is at an alarmingly low level. The gender gap regarding literacy level is not only due to cultural issues but also mainly due to non-availability of appropriate school facilities e.g. toilets for girl children. Hussain A (2003) suggests that making educational facilities available to girls and women at a relatively faster pace is likely to significantly reduce the gender gap in literacy rate. The available data shows that Pakistan has to go a long way to achieve universal literacy level. And also much needs to be done to achieve female literacy levels comparable to male literacy.

"Making educational facilities available to girls and women at a relatively faster pace is likely to significantly reduce the gender gap in literacy rate."

6.3.2 WATER, SANITATION AND PUBLIC HEALTH MEASURES

Water, sanitation and public health measures are among a few of the crucial factors that determine the health of the population. However, lack of safe drinking water has significantly increased the burden of diseases. According to figures only 60 percent of the population has access to adequate drinking water. In case of rural and urban areas this ratio is 53 percent and 83 percent respectively (Pakistan Human Conditions Report 2003). Sanitation and drainage facilities are also important determinants of health. 39 percent of the population has access to sanitation and drainage facilities while this ratio in case of rural and urban population is 27 and 59 percent respectively. These figures show that a bulk of the population is still living without basic necessities.

The lack or shortage of drinking water is one aspect of the issue; the other aspect is contamination of available drinking water. The Federal Secretary, Ministry of Science and Technology while giving a presentation to the Public Accounts Committee (PAC) of the National Assembly on April 27, 2005 revealed that most of the people in the country were drinking contaminated water (Daily Dawn, April 28, 2005). He further stated that results of a survey on water quality conducted in 22 cities of the country were not encouraging, and in some cases 100 per cent water contamination had been detected. In southern Punjab and Sindh, the arsenic levels in water were dangerously high. A few projects had been launched in some schools in Sindh with the help of UNICEF and WHO to provide arsenic-free drinking water to school children. Moreover, latest reports suggest a breakout of gastroenteritis and other dis-

eases of the abdomen being reported in district Jacobabad of Sindh province due to consumption of contaminated water and unhygienic fruits, food and drinks. Same reports had been coming from district Larkana few days ago. Another English paper Daily Times has reported from Multan quoting a survey that over 1.2 million people living in 50 union councils of Multan were under threat of disease outbreak due to contamination of water with sewerage lines. The Water and Sanitation Agency (WASA) has spotted 28 places of water supply as potentially dangerous. An independent engineer was of the view that WASA did not care for the smooth flow of drains and the system was corrupted because influential people had constructed shopping malls over the sewerage lines (Daily Times, April 28, 2005).

6.3.3 HOUSING

Housing is one of the important determinants of health. A house in its most general sense is a human-built dwelling with enclosing walls and a roof. It provides shelter against precipitation, wind, heat, cold and intruding humans and animals. When occupied as a routine dwelling for humans, a house is called a home. (Dictionary.LaborLawTalk.com).

As described in definition, a house is a source of shelter, a shield against environmental hazards and against harsh weather conditions. It provides a sense of peace and calm to all members of a family - a pre-requisite for proper and healthy living. It provides prevention from diseases and a place to take rest during curing of diseases. However, data reveals that in Pakistan appropriate housing facilities are not available to the citizens of country. Though, urban areas have more housing facilities that include cemented houses, provision of electricity, gas, piped water, bathrooms etc. but population influx has put pressure on these facilities. The rural population tends to migrate towards cities for getting employment, education and better living opportunities. This has resulted into a sizable number of the population living in squatter settlements. As shown in table 3 about 39 percent of the population is living in such settlements.

Table 3: People living in Katchi abadis and slums in cities and available facilities

Indicator	Percentage	Year
People living in katchi abadis and slums	39	Mid-1990s
Electricity in urban areas	93	1989
Inside piped water	60	1989
Gas	41	1989
Kitchen	63	1989
Latrine	84	1989

Source: Zaidi S A. Issues in Pakistan's Economy. 2000. Oxford.

It is important to note that the housing sector in Pakistan has great employment generation potential and is thus crucial for poverty reduction. However, a critical aspect is the availability of a house for every citizen. A renowned economist of Pakistan, emphasized during a research interview two years ago with the author, that each and every citizen of Pakistan should be provided a piece of land or plot by the state as a basic right to build his/her own house. Moreover, this year's Economic Survey of Pakistan has mentioned that as per National Housing Policy 2001, the Government is working on a 'Housing for All' program (Pakistan Economic Survey 2004-05).

At present there are 19.3 million housing units for a population of 148.7 million. The shortfall was 5.5 million units by the end June 2004. It is estimated that 570,000 housing units are required annually but the actual supply is 300,000 showing annual shortfall of 270,000 units. Out of the total available housing units in the country 23.2 percent units are being utilized on rent in urban areas as reported in Census of 1998 (ibid). This has financial implications on the budget of middle, lower middle and poor households. Moreover the present shortage of housing units may be attributed to low financing of housing sector. Pakistan spends nearly 1 percent of its GDP on housing which is far below than actual demand which was placed at Rs. 70 billion. In developing countries such funding ranges from 10-15 percent of GDP (ibid).

"It is important to note that the housing sector in Pakistan has great employment generation potential and is thus crucial for poverty reduction. However, a critical aspect is the availability of a house for every citizen."

6.3.4 EMPLOYMENT AND LIVELIHOOD

Discussion on employment must include the concept of livelihood. Because a level of livelihood determines inequality in a given society. The people are at the centre of livelihood not the resources or the assets. Therefore, understanding livelihood begins with understanding how people structure their means of living, for instance, how they use capabilities, assets and activities in a flexible manner (Ligutti Rural Support Program, 2005). Securing livelihood needs availability of assets and resources which combine with opportunities to create livelihood. Assets include skills, capabilities and talents, ability to work, time, health and network of relationships while resources include money or land.

Employment is on of the sources of livelihood thus, main source of income generation. It provides a household with opportunity to help in reducing poverty and fulfils health care costs of a family. Total number of employed labor force[2] in Pakistan in the year 2004 was estimated at 41.32 million. Out of this, the number of employed in rural areas is 27.91 million and in urban it is 13.4 million. This shows more employed people in rural areas. It is estimated that the agriculture sector absorbs 42.1 percent of the total work force. A disturbing figure is that women have far less involvement in the work force compared to men thus; they have lesser participation in economic activity resulting into lesser degree of women empower-

2. Employed Labor Force is defined as all persons of ten years and above who worked at least one hour during the reference period and were either "paid employees" or "self-employed" (Pakistan Economic Survey 2004-05)

ment and less income in hand to look after wellbeing of the family especially children. According to estimates, out of the total Refined Activity Rate (RAR)[3] of 43.3 percent, ratio of men and women was 70.3 percent and 14.3 percent respectively (ibid).

Pakistan has considerable ratio of unemployed population which concerns policy makers and researchers alike. At present 8.27 percent of the labor force is unemployed[4] (ibid). The unemployment in case of rural and urban has risen from the level of 2001. In 2001 percentage of unemployed was 7.82. As per comparison of rural and urban areas, 6.94 percent of unemployed people belonged to rural areas in 2001 which has risen to 7.55 percent during the last four years. In the case of urban areas unemployment, the ratio in 2001 was 9.80 percent which has slightly increased to 9.92 percent in 2004 (ibid). These figures show about 3 percent increase in overall unemployment over the period thus, resulting into decrease in ability to avail health care which may result into less productivity and more poverty - a clear way to the vicious cycle of poverty and ill health.

"Although, a large number of doctors cannot find employment in the public sector however, the fact remains that there is yet shortage of human resources in the health sector. In case of nurses and paramedics this shortage is felt very seriously."

6.3.5 HEALTH CARE FACILITIES

Lastly, lack of or shortage of health care facilities in public sector and poor quality of those services is one of the main determinants of health. Pakistan Economic Survey (2004-05) describes that the health sector is suffering from considerable inadequacies and deficiencies, namely, unhealthy environment, insufficient resources, ignorance, lack of awareness and inaccessibility to health services. Health infrastructure may be described as strong but its functionality has suffered seriously. At present there are 108,062 registered doctors, 5,530 dentists and 46,331 nurses in the country (see table 4). Although, a large number of doctors cannot find employment in the public sector however, the fact remains that there is yet shortage of human resources in the health sector. In case of nurses and paramedics this shortage is felt very seriously. The urban bias in provision of health care facilities has further deteriorated the situation. According to estimates out of 1, 00583 beds available in all type of facilities only 19,904 are located in rural area health facilities (Human Condition Report 2003). While about 70 percent of the population is living in rural areas, most of the health personnel have been located in urban areas. For example, Zaidi (2000) has argued that 85 percent of all practicing doctors work in cities, which comes to a (theoretically) favorable doctor-population ratio of 1:1801 for the urban areas and 1:25,829 for the rural areas. This skewed nature of facilities has put a great burden over urban facilities which are working beyond their capacity. Despite these factors Pakistan's health indicators have improved over time, but nevertheless cannot be compared with countries in the region with the same per capita income level. This is mainly attributed to a few important factors i.e. curative nature of services; overwhelming presence of private sector without proper regulation resulting into unafford-

3. RAR is the percentage of the labor force in the population of persons 10 years of age and above (Economic Survey 2004-05)

4. Unemployment is defined as all persons ten years of age and above who during the period under reference were a) without work i.e. were not in paid employment or self-employed, b) currently available for work i.e. were available for paid employment or self-employment and c) seeking work i.e. had taken specific steps in a specified period to seek paid employment or self-employment (Economic Survey 2004-05).

able and un- standardized services; poor quality of public sector facilities; inequitable access in terms of social, demographic and gender perspective and an exclusive nature of health system which caters more to influential as compared to poor and marginalized; lack of monitoring, feedback and accountability and; no community participation in shaping health care etc. Above all the country spends less than one percent of its GDP on health that is further marred with low level of spending and disbursement issues.

Table 4: Human Resource facilities in Health Sector 2001-2004

Indicator	2001-02	2002-03	2003-04
Registered doctors	96,248	101,635	108,062
Registered dentists	4,622	5,068	5,530
Registered nurses	40,114	44,520	46,331
Population/ doctor	1,516	1,466	1,404
Population/dentist	31579	29,405	27,414
Population/nurse	3639	3,347	3,296
Hospitals	–	–	906
BHUs		–	5,290
RHCs	–	–	5,52
Dispensaries	–	–	4,554
Hospital Beds	–	–	98,684
Population/bed ratio	–	–	1,536

Source: Pakistan Economic Survey 2004-05

7.0 RECOMMENDATIONS

The detailed discussion in this paper requires identifying of some areas for action regarding poverty, equity and the social determinants of health. The following actions are being recommended:

- Keeping in view the discussion on poverty, equity and the social determinants of health a new role for Ministry of Health should be envisaged. This requires the role of advocate, communicator and influencer in order to convince policy makers in the social sector and top political leadership of the country to formulate policies that would be responsive to health aspects. In this regard some groundwork needs to be done. A reasonable option is to formulate a 'National Health Policy Framework' addressing

all the aspects of health with a view to making a strong case regarding a multi-sectoral action for health outcomes. That is also important in the perspective of achieving Millennium Development Goals (MDGs) and poverty reduction (PRSP) targets.

- The reduction of poverty is a pre-requisite for sustainable improvement in health status and productivity. Besides, it is evident that efforts targeted towards creating equality would substantially reduce poverty. Therefore, concerted efforts may be initiated to address issues of equality. A holistic approach should be adopted to address the various issues. At macro level: income and asset distribution should be the starting point.

- Employment generation in the public and private sectors should also be given priority. Traditional business and trade activities should be fully protected e.g. small flour mills, cotton ginning mills in rural areas, rural artisans, handicrafts, vegetable growing etc.

- Village to market roads may be built on priority basis to provide opportunity to farmers taking their produce to markets on time which is source of their livelihood. Road network will also serve the purpose of linking people to schools and hospitals.

- Health care financing mechanisms should be studied and needed reforms should be introduced so that equity in financing should be ensured in a way that financing should be sensitive to social, demographic and gender disparities.

- For equitable access to health care, facilities should be linked to communities through road networks along with adequate supply of essential drugs and availability of human resource.

- Prospects of a national social insurance scheme may be studied with a view to starting such a program. In this regard a study was conducted by ADB last year that may become the basis of such an initiative.

- District health system should be restructured in the context of devolution in a way that all facilities in a district be interlinked through a referral system backed by full collaboration between health care personnel and involvement of communities.

- In order to achieve universal literacy level including female literacy, steps may be taken on urgent basis, as literacy level is one of the major determinants of health.

- Safe drinking water is basic necessity of people, therefore, minimum quality standards may be established, all existing drinking water sources may be tested against those standards. A well-planned strategy should be chalked out to meet the drinking water requirements and its availability in the country.

- After declaring owning a house as a right of every citizen - as does housing policy of the Government of Pakistan, efforts should be stepped up to fulfill the required needs of housing units. In this connection the first requirement is to allocate needed funding in this regard. Regulations should be introduced regarding property and renting procedures so as to enable low income citizens to have a shelter at low cost. This may be coupled with the government's efforts to build low cost houses for the poor and low-income earners.

- To encourage women to become part of economic activity steps should be taken to provide social protection to women with a view to creating opportunities for them at the work place.

- Health sector reforms that are already under way should be evaluated and made time bound so as to deliver the required results with maximum benefits to the masses in general and the poor, women and children in particular.

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