Health care systems in transition III. Pakistan, Part I. An overview of the health care system in Pakistan

Abdul Ghaffar, Birjees Mazher Kazi and Mohammad Salman

Keywords: system, health, policies, Pakistan

Introduction

Pakistan, which occupies the easternmost part of the Giginist–Euphrates and Indus basin, is a country with strong cultural traditions, going back to the early Indus Valley civilization of Moen-jo-Daro and the Graeco-Buddhist Gandharan cultures. Pakistan became independent in 1947 and occupies an area of 852 392 km². It is located on the Arabian Sea, bordered by India to the east and Iran to the southwest, and Afghanistan and China to the north. Administratively, Pakistan comprises four provinces [Punjab, Sindh, North Western Frontier Province (NWFP) and Baluchistan], and four federal territories (the Federally Administered Tribal Areas, Federally Administered Northern Areas, Islamabad Capital Territory and the state of Azad Jammu and Kashmir). Each province is divided into districts, which are the main administrative units. Districts themselves are further divided into sub-districts, called Tehsils or Talukas.

After independence, three powerful social factions became pre-eminent: the military, the civil service and politicians. Over the last three decades, the country has oscillated between military governments and democratically elected but fragile civilian governments. As a result, many government policies have been made by and for the civil servants and politicians, who are either rich landlords or belong to the small coterie of rural or urban elites. This has resulted in neglect of the social sector of Pakistani society, despite periods of relatively strong economic growth. Attaining sustainable improvements in health has proved a difficult goal to achieve, and health and other social indicators remain low even compared with neighbouring countries with poorer economies than Pakistan (Table 1).

Health and population characteristics

Pakistan is the seventh most populous country in the world, with a population of 135 million people. It is a nation that has made economic progress but is struggling to find a road towards sustainable development. The health and population characteristics in Pakistan are high fertility, low life expectancy, a young age structure, high maternal and child mortality, high incidence of infectious and communicable diseases, and wide prevalence of malnutrition among children and women. The country is undergoing a demographic transition, which is characterized by a change from high mortality and high fertility to lower mortality but still relatively high fertility.

Burden of disease

In Pakistan, pulmonary tuberculosis in adults continues to be a major public health problem, acute respiratory tract infections are common and malaria remains a potential threat. However, injuries, cardiovascular diseases, cancer and diabetes are emerging as major public health problems. Pakistan is at the beginning of an ‘epidemiological transition’, as a result of which it will need to face not only the challenges generated by infectious diseases, but also an increasing burden as a result of non-communicable diseases.

Health care provision

Under the Pakistani constitution, health is primarily the responsibility of the provincial governments, except in the federally administered territories. The Federal Government is, however, responsible for planning and formulating national policies.
health policies, although the responsibility for implementation rests largely with the provincial governments. The federal Ministry of Health is responsible for the implementation of some vertical prevention programmes on AIDS and malaria, and extended programmes for immunization.

Health care provision in Pakistan comprises private and public services. The private sector serves nearly 70 per cent of the population, primarily a fee-for-service system and covers the range of health care provision from trained allopathic physicians to faith healers operating in the informal private sector. Neither private nor non-government sectors work within a regulatory framework and very little information is available regarding the extent of the human, physical and financial resources involved.

The public sector comprises more than 10,000 health facilities ranging from Basic Health Units (BHUs) to tertiary referral centres. At present, a BHU covers around 10,000 people, whereas the larger Rural Health Centres (RHCs) cover around 30,000–45,000 people. In Pakistan, Primary Health Care (PHC) units comprise both BHUs and RHCs. The Tehsil Headquarters Hospital covers the population at sub-district level whereas the District Headquarters Hospital serves a district, as its name suggests. Currently there are 22 tertiary care facilities in Pakistan, which are mostly teaching institutions located in the major cities.

Less than 30 per cent of the population uses the facilities of the PHC units and some studies indicate that, on average, each person visits a PHC facility less than once per year. The reasons for their under-utilization, as identified by both managers and consumers, are the relative lack of health care professionals and especially women, high rates of absenteeism, poor quality of services and inconvenient location of PHC units. In addition, the Pakistan army, railways, departments of local government and some autonomous organizations provide health care to their employees, who form a significant portion of the population.

**Health care planning and financing**

Planning for health care in Pakistan comprises a formal planning process, which revolves around the production of 5–15 year long-term plans, short-term annual development plans (ADP) and annual recurrent budgets. The Federal Ministry of Planning and Development, popularly known as the Planning Commission, is primarily responsible for long-term and strategic planning, and the Ministry of Health and Provincial Health Departments design their plans in line with the overall policies of the Planning Commission.

Developing appropriate plans that can be implemented requires information on health status in conjunction with other social development indicators, such as literacy and employment rates, housing and basic social security. ‘Needs assessment’ for health care programmes in Pakistan is usually based on the size of the population in an area. The specific needs of that area or community are often not taken into account directly, nor are issues such as access to services (roads, transport, climatic conditions) and disease patterns. Similarly, the issue of equity – or other broader notions of fairness, a basic principle of the Alma Ata declaration – is usually not considered. To assess levels of equity requires knowledge of the distribution of social indicators and not just their means or aggregates, the form of most planning information currently available.

Whereas the private sector is primarily a fee-for-service system, the public health sector at present generates a negligible amount of resources through token user charges. The main source of financing of the public sector is the government. Capital investment in the public sector is financed through Annual Development Plans (ADPs) that also include external funding derived from foreign aid (overseas funding) from both bilateral and multilateral organizations. The Federal Government substantially finances provincial development budgets, but the provinces make independent decisions regarding allocation of funds over various sectors. The provincial non-development budgets are funded from provincial government revenues, although the Federal Government covers existing deficits through non-obligatory grants. Although public sector spending on health has always remained less than 1 per cent of GNP, per capita health expenditures have increased enormously in the last 15 years. The total percentage of GNP spent on the health sector in Pakistan ranges between 3 and 4 per cent, with 2–3 per cent of GNP spent on private health care.

---

**Table 1 Comparative indicators of health and social development**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pakistan</th>
<th>India</th>
<th>Bangladesh</th>
<th>Nepal</th>
<th>Sri Lanka</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality rate (1990)</td>
<td>88</td>
<td>65</td>
<td>77</td>
<td>85</td>
<td>15</td>
</tr>
<tr>
<td>Total adult literacy rate (%) (1995)</td>
<td>38</td>
<td>52</td>
<td>38</td>
<td>28</td>
<td>90</td>
</tr>
<tr>
<td>GNP per capita (1997)</td>
<td>490</td>
<td>390</td>
<td>270</td>
<td>210</td>
<td>800</td>
</tr>
<tr>
<td>Public expenditure on health (% of GDP)</td>
<td>0.8</td>
<td>0.7</td>
<td>1.2</td>
<td>1.2</td>
<td>1.5</td>
</tr>
<tr>
<td>Population percentage below poverty line ($2 a day)</td>
<td>57</td>
<td>88.8</td>
<td>–</td>
<td>86.7</td>
<td>41.2</td>
</tr>
<tr>
<td>Percentage of total population with access to health services</td>
<td>55</td>
<td>85</td>
<td>45</td>
<td>48</td>
<td>–</td>
</tr>
<tr>
<td>Percentage of total population with access to safe water</td>
<td>74</td>
<td>81</td>
<td>97</td>
<td>63</td>
<td>57</td>
</tr>
</tbody>
</table>
Table 2 Human resources development in health care, since 1960.\textsuperscript{a,13}

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor:population ratio</td>
<td>1:7400</td>
<td>1:6916</td>
<td>1:2940</td>
<td>1:1642</td>
</tr>
<tr>
<td>Nurse:population ratio</td>
<td>1:32000</td>
<td>1:23376</td>
<td>1:7561</td>
<td>1:5199</td>
</tr>
<tr>
<td>Hospital beds:population ratio</td>
<td>1:3200</td>
<td>1:1662</td>
<td>1:1678</td>
<td>1:1610</td>
</tr>
</tbody>
</table>

Development of human resources

Since independence, the Federal Ministry of Health and the provincial health departments have been responsible for the planning, production and management of human resources in the health care sector. At a national level, 12 postgraduate medical colleges, 18 medical colleges, five dental colleges and three nursing colleges now exist.\textsuperscript{7} Recently, the private sector has also shown a greater interest in the development of human resources, and eight new undergraduate and two postgraduate medical colleges have been established in the private sector.\textsuperscript{7} The quality of public and private medical education is similar, despite the fact that the training in the private sector is considerably more expensive.

The development of human resources has been biased towards the production of physicians rather than other health care providers, especially nursing staff. World-wide, the nurse:doctor ratio is generally 3:1; however, in Pakistan the converse exists and the ratio is 1:3.\textsuperscript{4} Analysing the increased number of medical and nursing personnel and the number of beds since 1960 (Table 2), one observes a bias towards curative care, which further increases the disparity between primary health care facilities and tertiary care institutions.

Recent initiatives

The relatively poor state of health and social indicators has prompted a rethinking of national health policy guidelines and the initiation of the Social Action Programme Project (SAPP). The state of Pakistan’s national finances has always resulted in reduced expenditure on health, particularly on the non-salary portion of the budget. This has led to a decline in the quality of care and service provision, as a result of a reduction in the development of human resources and non-availability of drugs and supplies.

Social Action Programme Project (SAPP)

SAPP is a national programme to improve provision and quality of basic social services by addressing issues of access to services, standards, accountability and responsiveness to clients, and sustainable expenditure. The central focus of SAPP is to strengthen the policy-making and management capacity of the line departments and increase expenditure, especially on the non-salary portion of the budget. SAPP was launched by the Government of Pakistan in 1992–1993 in collaboration with the provinces, federal areas and donor organizations to bring an accelerated, co-ordinated and concerted improvement in social indicators, primarily focusing on four key social sectors: (1) primary health care; (2) primary education; (3) rural water supply and sanitation; and (4) population welfare.

Prime Minister’s Programme for Family Planning and Primary Health Care

To improve the use of PHC units and make the system more efficient and effective, the government launched a community-based programme in 1994, known as the Prime Minister’s Programme for Family Planning and Primary Health Care (PMP). This programme aims to extend outreach services to communities, by bringing services to their doorsteps, through the appointment of Lady Health Workers (LHWs). These LHWs are a vital link between the community and health facilities. They provide essential services in the areas of reproductive health, mother-and-child health, health education, treatment of minor ailments and referral of high-risk patients to health care facilities. Each LHW is a member of the local community and responsible for around 1000 people. The programme currently covers around a third of the population, but there are plans to extend it universally after the completion of an independent evaluation by the UK Department for International Development (DFID).

Health care reforms under consideration

The Government of Pakistan is launching a number of other initiatives to improve the health status of the people of Pakistan. The rationale is to involve all the stakeholders, not only in the decision-making process, but also in the implementation of any new programmes. This is to ensure the effectiveness and sustainability of the public sector programmes. The following initiatives are under way.

District Health Governments (DHGs)

The government is planning to establish District Health Governments to improve the implementation of health care provision in the public sector. The philosophy of this initiative is a ‘decentralized health system approach with small management units at the district level’.\textsuperscript{14} Under this initiative, a District Health Management Team will be set up at district level, headed by a chief executive, who will be employed on a performance-based contract. The members of the DHG are to comprise health officials, public representatives, opinion leaders, members of local non-governmental organizations (NGOs) and officials of other related departments such as Family Planning and Public Health Engineering. The DHG will have the full administrative and financial autonomy to hire and fire staff and to generate, retain and use allotted funds. The performance of the DHGs will be monitored by independent external evaluators.
Hospital autonomy

The government has launched a similar initiative for tertiary care hospitals in which an Institutional Management Committee will be set up in each hospital to operate as a board of directors under the supervision of a chief executive. The Committee will make decisions about the management of the facility and its finances. The rationale is that 'managerial and financial autonomy, coupled with performance agreements and clearly delineated managerial accountability should improve the quantity and quality of services provided by hospitals'. An important feature of this initiative is that the chief executives, both for hospitals and DHGs, would be paid salaries that are competitive with those in the private sector.

Public–private partnerships

In a recent health policy development, in 1997, the government has allocated some funds to a number of Health Foundations. These are organizations that give grants to physicians for the establishment of 'private' hospitals in the rural areas. The funds are provided by the government as a loan with minimal interest, which will provide for the establishment of hospitals and clinics in the private sector, especially in the rural areas.

The management of non-functional primary health care facilities would be given to the local NGOs or community-based organizations (CBOs) under this initiative. This is a separate initiative under which local NGOs and CBOs are asked to manage those public sector health care facilities that are rarely used because of geographical inaccessibility or non-availability of health staff for whatever reason. The government provides the allocated budget for these facilities, and the managing NGOs and CBOs provide incentives for staff and may generate additional funds to make the system sustainable. The government continues to provide its share of the running costs, but the management of the NGOs and CBOs operate these facilities as non-profit organizations. However, the management can introduce user charges to make the system sustainable.

National health card scheme

This is a government-sponsored, prepaid, managed health care scheme for rural and under-served urban areas to be supervised by DHGs through NGOs and CBOs. The management of the NGOs and CBOs will serve as 'intermediary' institutions to sell health cards to families in the areas, negotiate and draw up contracts with health care providers, and manage and supervise the scheme at local level.

Pakistan 2010 programme

In 1998, the Prime Minister launched a strategic knowledge-led development programme in line with the future needs of the country. The major focus of this programme is to establish successfully concepts of good governance in society and produce the required human resources for the social development of the nation. Health, education and information technology have been identified as crucial sectors for future development of the nation. However, under this programme the health sector continues to have policy dialogue with different stakeholders to develop future strategies.

Conclusions

Creation of an integrated primary health care system, delivering essential clinical and minimum public health services, as suggested by the World Bank and advocated by the MOH, should be a key component of health system reforms. The actual contents of such an essential minimum package should depend on the most urgent health care priorities, and available financial and human resources. The political and economic situation in Pakistan is such that it is very important to implement the planned health care reforms, especially the decentralization process being carried out in the Punjab such as DHGs, at least partially or in pilot districts, so that their positive benefits can be established. Health sector reforms should be implemented and results obtained urgently before particular interest groups and bureaucratic inertia undermine the impetus for reforms. For successful implementation and continuation of health sector reforms, the concepts of 'total quality management' and 'good governance' need to become an integral component of health system management.

References


Accepted on 11 October 1999