Health policy analysis

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General Introduction

Introduction

Academic literature on health policy analysis has increased considerably in the nineties. The importance of health policy analysis is widely acknowledged and viewed as an instrument to act more effectively to combat health problems and improve life conditions (Ham, 1992; Sabatier 1998, Sutton 1999, Walt & Gilson, 1994; Wuyts, 1992). Health policy analysis helps in understanding how policy makers set objectives, make decisions on health priorities and take actions (Barker, 1996). It also explains how policy context (political, economic and socio-cultural) influences the health policy process and its outcomes (Brewer & Leon, 1999; Sachs, 2001). Furthermore, health policy analysis can help in understanding important stages of the health policy process such as agenda building and policy formulating, planning, monitoring and evaluation and which factors as well as actors affect the process.

In many developing countries, various international health programs including Health For All (HFA) and Primary Health Care (PHC) did not achieve their targets during the last three decades (WHO, 1998a; 1998b; 1998c; 1998d). International agencies tried to improve health conditions by integrating international health programs and strategies with national health policies but did not succeed due to various factors related to health policy content, context and process (de Leeuw, 2000; McKee et al., 2000; Walt & Gilson, 1994). More recently WHO has emphasized the importance of economic development, i.e. reduction of poverty, as the basis of health promotion and – vice versa – the economic benefits of investment in effective health policy (Sachs, 2001). However, it is not easy to prove the effectiveness of health policy on a general level (Nolte & McKee, 2003). The intention of this study is not to demonstrate direct links between health policy and health policy implementation on health outcomes. The aim is to demonstrate how various factors and processes in the Pakistani society and political system influence the health policy process.

There are various approaches to health policy analysis. Among these approaches, policy analysis experts have frequently used rationalistic and behavioral 'models'. This introductory chapter will explain why health policy analysis is important and which model is used to analyze health policy in Pakistan. Next, research questions will be formulated, concentrating on health policy analysis in Pakistan during the last decade. To execute this analysis we have used various data sources and methods, which will be explained at the end of this chapter, followed by an overview of the chapters. But first we explain why Pakistan was chosen as a case to analyze health policy in developing countries.

The case of Pakistan

In Pakistan, health care is based on the biomedical model as developed in the Western world in the last century and on traditional (folk) medicine as in many developing countries. The delivery of health care is based on the Beveridge model, inherited from the British. During the last decades, various governments in Pakistan have formulated explicit health policies for a specific period with objectives and planned actions (Pakistan, 1990; 1997; 2001). This makes it possible in theory to analyze what priorities were set in health care policy, to describe what actions were taken to prevent disease, and to analyze whether health promotion was designed in accordance with modern health paradigms.

Another phenomenon, which makes the situation in Pakistan relatively unique, is its strong economic growth during the last years. Generally, in developing countries, one of the largest problems in executing health policy objectives is the lack of resources and the dependency of sponsors (Sachs, 2001). In Pakistan, this situation is relatively favorable. At the same time, it should be noted that political, environmental and cultural factors also play a major role in the health policy process in Pakistan. In this study, we intend to describe what the content of the health policy has been during the last decade, how this policy was executed, and which factors and actors played a major role in executing this policy.

The Importance of Health Policy Analysis

Modern health paradigms assert that all public policies should take into account the health rights and interests of the public by making healthy choices easier and unhealthy choices more difficult (de Leeuw, 2000; Lucas, 1997; Milio, 1988a; 1988b). In this regard, health policy helps to set the parameters for the mode and character of industrial and agricultural production, corporate management, and individual behavior and to influence the environment in the direction of modern health paradigms (de Leeuw, 2000; McKee et al., 2000; Milio, 1988a). Modern health paradigms denote new ecological perspectives of disease prevention and health promotion in policy making by paying attention to all important determinants of health such as human biology, lifestyles, environment (physical, political, economic and socio-cultural) and health care organization.

Generally, national health policies in developing countries suffer from various weaknesses and do not offer appropriate solutions to many health problems in accordance with the comprehensive principles of modern health paradigms (Goldsmith, 1988; Ham, 1992; Heidenheimer, et al., 1990; McKee et al., 2000). These health policies in developing countries tend to address infectious diseases (malaria, tuberculosis, diarrhea, etc.) by following the biomedical model of health, whereas behavioral and environmental health problems such as HIV/AIDS, cancer, diabetes, (road traffic) accidents and drug addiction are not addressed comprehensively in accordance with the principles of new public health and health promotion (WHO, 1998b; 1998c; 2004). Health policy analysis describes the contextual factors, including political, economic, socio-cultural and demographic aspects, which affect the health policy process and its health outcomes directly and indirectly (Collins et al., 1999; Gonzalez, 1997; Walt & Gilson, 1994; Wismar & Busse, 2002).

Health policy analysis contributes to understand how policy makers set priorities in health care and plan actions in order to address increasing health problems. It analyzes important stages of the health policy process - including agenda building and policy formulation, planning, monitoring and evaluation - to determine which factors and actors affect the process. This knowledge can help in finding effective ways of policy formulation, planning, implementation, monitoring and evaluation. Health policy analysis can also help in understanding the role of actors and interest groups involved in the health policy process.

Approaches in Health Policy Analysis

Policy analysis means different things to people. For some, policy analysis mainly concerns policy content, while others argue it is more concerned with policy context and process. Traditionally, there are two approaches to policy analysis: the "rationalist" and the "behaviorist" approach. Within these two approaches again the variety is large and accents may differ. We describe some main approaches.

The rationalist or idealistic approach or 'linear model' tends to focus more on the content of the policy and is more value oriented - since it analyses how policy-making should be undertaken (Ranney, 1968; Sutton 1999; Van Herten & Gunning-Schepers, 2000a; 2000b; Walt & Gilson, 1994). Policy making is seen as a problem solving process, where decisions are made on sequential phases, i.e. problem definition, alternative approaches to solve the problem, choosing the best approach and implementing it (Sutton, 1999). Rationalists believe that the focus upon content analysis adds significantly to the breadth, significance, and reliability of the discipline's special body of knowledge (Barker, 1996; Kickbusch, 1996; Van Herten & Gunning-Schepers, 2000a; 2000b). Accordingly, clear goals can be formulated, based on the analysis of health needs, health hazards and their determinants. This approach enables analysts to evaluate past and present policies more objectively and offers a prescriptive and ideal model of how policy-making ought to be undertaken. It offers a way of improving the effectiveness of policy-making by explicitly identifying values and goals before making policy choices and selecting the best policy options based on comprehensive information about the costs and consequences of each (Ranney, 1968; Sutton 1999, Walt, 1994; Walt & Gilson, 1994). The rationalist approach is also linked to various scientific and technical tools, such as Program Evaluation Review Technique (PERT), Management by Objectives (MBO) and Program Planning and Budgeting (PPB).

Unlike rationalism, the behaviorism approach (also called incrementalism) argues that it is essential to pay more attention to the process and the context within which policies are formed and implemented (Sutton, 1999; Walt, 1994; Walt & Gilson, 1994). According to this approach analysis of policy process helps in understanding why many health problems are not solved, why policies are not implemented effectively and why health policies do not achieve their targets (Brewer & Leon, 1983; Jenkins-Smith & Sabatier, 1993; Sabatier, 1993; 1998; 1999; Walt & Gilson, 1994). It is among others a 'political process', which outcomes are 'evolutionary' and not rational or 'logical' (Juma & Clarke 1995). So, for behaviorists the understanding of contextual factors, including political, socio-cultural and economic ones, are critical in any policy analysis (Collins et al., 1999; Navarro, 2000; Saltman, 1997). Understanding such factors should lead to the best choice of strategies for implementation in a specific community.

Within the behaviorism various processes or factors may be seen as crucial in understanding the outcome and various theories are developed. Sabatier (1998, 1999), Jenkins-Smith (1990) and Jenkins-Smith & Sabatier (1993, 1994) demonstrate the usefulness of the advocacy coalition framework (ACF) for understanding the factors, which influence the policy process at least in western policy making. The ACF has generated considerable interest because it emerged out of: (a) a search for an alternative to the stages heuristic (Jones, 1987) that was then dominating policy studies, (b) a desire to synthesize the best features of the 'top-down' and 'bottom-up approaches to policy implementation (Sabatier, 1986), and (c) a commitment to incorporate technical information into a more prominent role in theories on policy proc-

esses (Sabatier, 1998). The goal of the ACF was to provide a coherent understanding of the major factors and processes affecting the overall policy process. In the mid eighties Sabatier, interested in the role of technical information, and Jenkins-Smith, who had quite independently developed a similar conception of the role of scientific information in public policy, revised the framework of the ACF several times together with other scholars (Jenkins-Smith,1990; Jenkins-Smith & Sabatier 1994; Sabatier & Jenkins-Smith 1993, 1998; Sabatier, 1998).

According to Kingdon (1984, 1995) the policy process moves through a number of distinct phases but not in an orderly way. Interaction between policy makers and executive officers is an important aspect (Juma & Clarke 1995, Mukanda 1992, Panday 1989). According to de Leeuw (2000) the policy process is complex because policy making is increasingly a matter of (exchange of) information and communication. The opportunities and abilities of participants in a policy network to communicate and to exchange information, expertise and other resources, determine whether policy is made and what is its content (Laumann & Knokke, 1987). Other policy scientists take an even more extreme view by characterizing the policy process as complex, disordered and coincidental and hardly open to analysis (Hoogwood & Gunn, 1984, Kingdon 1984, 1995). Kingdon (1984, 1995) has studied policy making at federal level in the USA and has developed the 'Theory of Stream'. This theory considers three streams of agenda building, i.e. a problem stream, a political stream and a policy stream, where each stream has its own typical process rather independent from each other. In the problem stream the process is characterized by problem recognition. Various factors focus the attention on a problem or issue of concern and its importance. In the political stream the process is determined by fluctuations in politics through the influence by people, political parties and ideologies of politicians that can either include or exclude certain issues from the agenda. In the policy stream the process includes the presentation of ideas and the development of alternatives. Proposals are selected on the basis of criteria like feasibility, harmonization with dominant norms and susceptibility of politicians. Within this wide variety of (sub) theories and models the choice has to be determined by the research questions and by the circumstances the research has to be executed (availability of data, existing institutions, established procedures etc.).

There is also some debate about 'models' and 'theories', which usability again might be related with infrastructure and circumstances of the place/context of the investigation. Some believe that a model is a representation of a specific situation whereas a theory provides a "denser" and more logically coherent set of relationships (Ostrom 1994; Sabatier, 1999; Stinchcomb, 1968). A theory considers a connection and/or pattern between a set of variables and usually specifies how relationships may vary depending upon the values of critical variables (Ostrom 1994; Sabatier, 1987; 1999; Stinchcomb, 1968). For example, the work of Sabatier (1993), (1998) and (1999) presented how theories can be used in analyzing policy process in developed countries. In developing countries, the policy process is different, for example the relationship and interaction between policy makers and executive officers influences the implementation process considerably and may change the goals and outcomes (Juma & Clarke 1995; Mukandala, 1992; Panday, 1989). In developed countries the role of well organized interest groups and stakeholders is more pronounced.

We believe that in analyzing health policies in Pakistan and other developing countries many theories and models (like of Kingdon and Sabatier) are not appropriate because political, economic and socio-cultural context in which policy process takes place in the developed world is different than developing countries. In developed countries interest groups are better

organized, various processes like in problem stream and policy stream are less connected with each other and mechanism to 'defend' the interests are based on formalized procedures and democratic embedded. In case of developing countries in analyzing health policies problem stream and policy stream are strongly connected, procedures are not established and interest groups are absent and/or not organized. Even more important may be to pay attention upon the policy content in developing countries because health policy content indicates what outcomes may be expected for the health status of the population, where health status are bad. It makes clear which priorities are set, which policy tools and programs are believed to achieve the policy's goals and objectives (Barker, 1996; Kickbusch, 1996; Odiorne et al., 1980; Ranney, 1968; Van Herten & Gunning-Schepers, 2000a). The later is part of the rational approach.

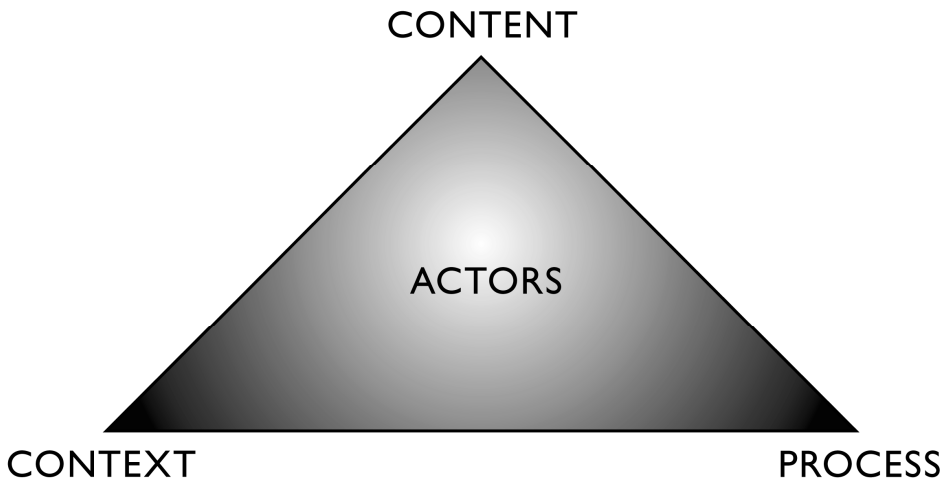
In analyzing health policies developing countries need a comprehensive approach but not a detailed set of connected concepts (theory) because their problems have to be solved within a more unfavorable policy context, within a often centralized system and with lack of procedures and resources (Janovsky, 1996; Walt, 1994; Walt & Gilson, 1994). We believe that the model of Walt & Gilson (1994) can be a helpful tool to analyze health policies in Pakistan because the model has been specifically designed for analyzing health policies in developing countries.

The model of Walt and Gilson

Walt & Gilson (1994) considered the work of many scientists in developing their analytical model. For example, in reviewing the work of Perkins & Roemer (1991), Mackintosh (1992) and Toye (1993), they highlight the role of the state in influencing markets. They also review the work of Migdal (1988) and Hinebusch (1993), which suggests paying more attention to social context and to considering a balance of power between state and society. Similarly, Hyden (1983) and Liddle (1992) argue that socio-cultural factors are an important part of the health policy context. Many others (Collins et al., 1999; de Leeuw, 1993; Wismar & Busse, 2002) also believe that the health policy context also includes the political system, the power structure, the role of government and its institutions, socio-cultural and economic environments, demographic characteristics, the health status of the population, and the role of community.

The model of Walt & Gilson (1994) does not reject nor fully support either of the traditional approaches (rationalism and behavioralism). It juxtaposes both the approaches and incorporates their views by arguing the importance of policy content, context, and process. Furthermore, this model argues to include the role of actors (or interest groups) in analyzing policies (see Figure 1). Next we will explain the main concepts used in the preferred model to analyze health policy in Pakistan.

Figure 1: Model for Health Policy Analysis (Walt, G., & Gilson, L., 1994)



Actor Analysis

In every (public) policy, actors play various roles in all the stages of policy process, such as agenda building, policy formulation, planning, implementation, monitoring and evaluation. Some refer to actors as policy elites and decision makers (Nakajima, 1997a; Walt & Gilson, 1994) while others prefer to call them stakeholders (de Leeuw, 1999; Siddiqi et al, 2004). Sabatier (1998) has developed a framework in which the role of individual actors and interest groups play a central role. This framework applies to situations where 'some degree of coordinated dissent from the policies of the dominant coalition' (Sabatier 1998, p. 121) is possible. In analyzing the role of actors, some scientists tend to limit their focus of attention only to the actors within government hierarchies (Mackintosh, 1992; Toye, 1993). Others argue that actors outside the government should also be included because many actors outside the governmental hierarchies directly and indirectly influence health policy process (Abbasi, 1999a; 1999b; Bhutta, 2001 ; Bhutta et al., 2003; Green et al., 2001; Siddiqi et al, 2004).

Walt & Gilson (1994) include the role of actors in health policy analysis and consider the work of many scientists highlighting the role of actors in different regions of the world. They reviewed the work of Lindenberg (1989), who highlights how the governments of Panama, Costa Rica and Guatemala managed support in their favor by narrating the positive side of structural adjustment policies (SAPs) and in overcoming opposition to the SAPs in the mid-1980s. Koehn (1983) believes that civil servants play an important role in policy making in Nigeria due to their greater expertise and continuity. Gulhati (1990) and Whitehead (1990) included political leaders, tribal and religious leaders, civil servants and foreign donors in analyzing the role of actors in Africa. They concluded that - besides the political leaders and civil servants - tribal leaders, religious leaders and donors significantly influence the policy process in Africa. Bery (1990), Brown (1989), Mukandala (1992), and Panday (1989) suggest that relationships between various actors should also be considered in analyzing the role of

actors. In summing up the various papers, Walt & Gilson (1994) argue for analyzing the role of actors as "Individuals" and as members of "Groups" within and outside the government.

International agencies and donors such as the World Bank, IMF, WHO and many others also influence overall policy environment, health policy and health in various ways. They constitute an important part of the actor analysis (Curtis & Taket, 1996; Janovsky, 1996). Donors contribute resources for health in developing countries and put extensive pressure upon those countries to implement changes (Cliff, 1993; Cohen et al., 1985; Justice, 1987). For example, WHO's Health For All (HFA) strategies provided the policy basis for the main social target of governments and a better understanding of appropriate policy mechanisms for effective implementation (Curtis & Taket, 1996). The World Bank has taken on an important global role in health policy process by its efforts in alleviating poverty, improving nutrition and providing external funding for the health sector in developing countries (Abbasi, 1999a; 1999b; Green, 1995; Walt, 1994).

Content Analysis

Policy content refers to a particular policy goal or set of goals and the particular actions planned to achieve those goals (Raney, 1968). Focusing on content helps policy makers in identifying, comparing, and evaluating competing policy proposals as well as in building agenda, making policy decisions, and fixing health goals (Abel-Smith, 1994; Altenstetter & Bjorkman, 1981; Barker, 1996; Baum, 1982). Content analysis also helps in finding solutions for health problems by considering not only health care services but also other determinants of health, which can be influenced, particularly environment and lifestyle. Furthermore, it improves the understanding of policy outcomes and provides information for policy makers regarding the technical skill, reliability and effectiveness of various means and the interrelations between different goals (Kickbusch, 1996; Odiorne et al., 1980; Van Herten & Gunning-Schepers, 2000a).

Modern health paradigms require that attention be paid to health policy content in promoting health systematically and effectively. For example, in 1978 the WHO initiated its Health For All (HFA) strategy by recommending that new policy directions and specific health targets to be added to the policy content (Odiorne et al., 1980; WHO, 1998a). It helps in setting a systematic relationship between the content of the policy and the responsibilities of government and stakeholders (Van Herten & Gunning-Schepers, 2000b). However, whether the content of health policy does contribute to better health outcomes is a much more complicated question and not easy to answer (Nolte & McKee, 2003).

Context Analysis

Health policy does not take place in a political vacuum but is embedded within a political, administrative, economic, socio-cultural, and demographic context. Contextual factors are considered critical elements influencing the policy process and the overall health of a population directly and indirectly (Frenk, 1995; Gonzalez, 1997; Saltman, 1977; WHO, 1998c; Zwi & Ugalde 1989). For example, many developing countries suffered high mortality and morbidity as a consequence of violent political conflicts, civil wars and repeated changes of government (Horton, 1999; Lanjouw et al., 1999; Navarro, 2000; Zwi et al., 1996). The economic

context significantly influences the health policy process and health outcomes (Green et al, 2001; Hjortsberg & Mwikisa, 2002; Sachs, 2001; Siddiqi, et al., 2004). A well-functioning health care system and successful health policy implementation need a regular flow of resources. If a country is very poor, its resources for health care will inevitably be very restricted. The economical context also influences health in other ways. For instance, developing countries often suffer from serious nutrition problems, which are a direct consequence of poverty and strongly influence the health status of the population (Sachs, 2001).

Socio-cultural factors such as the status of women, religious and cultural values, literacy level and corruption pervade the health policy environment and influence behavior (de Leeuw, 1999; Hasan, 1999; Johansson et al., 2001; Klijn, 1992; Sachs, 2001). There are obvious relationships and clear links (positive or negative) between health and culture because lifestyles are significantly influenced by cultural values. Culture also influences the attitude of people in playing their role in the collective efforts of society to prevent disease and promote health (Hasan, 1999; Maxwell, 1981; Mooney, 1994). A low status of women and illiteracy has been identified as contributing factors to high mortality and morbidity in developing countries (UNDP, 2005; WHO, 2004; Word Bank, 2004). Several organizations, including the World Bank, the IMF, and Transparency International, have highlighted corruption and its impacts upon the policy process in developing countries (Transparency International 2004; Zemenides et al., 1999). The problem of corruption in the health sector makes health policies ineffective and contributes to mortality and morbidity in developing countries (UNDCP, 2003; Waxman, 2003).

Process Analysis

Through health policy process, a government, society, institutions and/or professionals set their activities and allocate their resources. Generally, the policy process is divided into different stages or phases such as agenda building, planning, implementation, monitoring, evaluation and feedback (Barker, 1996; Falcone, 1980; Jenkins-Smith & Sabtier, 1993; Sabatier, 1993; 1998; 1999; Walt, 1994). Policy processes in the developing countries are often characterized by many weaknesses and failures (Falcone, 1980). Policy elites in developing countries often build the health agenda and formulate health policies without recognizing important health problems (Bhutta, 2001; Green et al., 2001; WHO, 1998d). Consequently, many health problems do not effectively get on the policy agenda (Kingdon, 1984; Lee et al., 1998; Milio, 1988a; 1988b). In some countries, policymakers even seem to deny the existence of serious health problems or the multiple factors determining them (Bracht, 1999; Hogwood & Gunn, 1984).

In developing countries, health planning repeatedly leads to health plans that appear to be implemented not at all or only partly. Planning documents often offer health objectives without providing enough details on how objectives will be realized (Ali, 2000; Green et al., 1997; Siddiqi et al, 2004). Health planning is often not flexible, participative or integrated with other decision-making processes (Bjorkman, 1986; Green et al., 1997). The links between planning and implementation are weak (Al-Jalaly, 1991; Green et al., 1997).

Many health policies in developing countries are not implemented properly due to power conflicts, lack of political support, lack of resources and lack of reliable data (de Leeuw, 2000; Lee et al., 1998; Leger, 2001; Van Herten & Gunning-Schepers, 2000a; Walt & Gilson,

1994; WHO, 1998b). The monitoring and evaluation of health policies and programs in developing countries is subject to various problems. Modern methods and techniques - such as rapid assessment, mini-surveys, cluster surveys, lot quality assurance sampling, focus groups, and Delphi panel - are not used regularly in monitoring and evaluating health policies (Cibulskis & Inzard, 1996; Hogwood & Gunn, 1984; Janovsky, 1996).

Research Questions

Using the model of Walt & Gilson (1994), a health policy analysis is carried out for Pakistan. This analysis intends to describe what the content of the health policy has been during the last decade in Pakistan, which contextual factors played a major role in executing this policy, and how this policy process was executed. This results in the following research questions.

1. What is the content of the National Health Policy (2001) of Pakistan? More in particular, this question will focus on: a) which health problems are addressed; b) whether major changes in priority occur; c) whether the content is in accordance with the principles of modern health paradigms including the HFA strategy.
2. How do contextual factors (political, economic and socio-cultural) influence the health policy process and health outcomes in Pakistan?
3. How is the health policy process (i.e. agenda building, planning, implementation, monitoring and evaluation) executed in Pakistan and how does this affect health outcome?

Methodology

To answer these research questions, various data sources and methods were used. Many authors, including Burnard & Hannigan (2000) and Crabtree & Miller (1992), propose using both qualitative and quantitative methods in obtaining research information. Of course, the choice of method needs to be based upon the aims of the study and the research questions. In policy-oriented research, a combination of methods may be applied in exploring a phenomenon from different perspectives (Paley, 2000). The strength of such a research method is its ability to deal with a broad variety of evidence, documents, data and observations. However, there are concerns related to objectivity and generalizability (Seaman, 1998; Yin, 1989)

Given the aims, scope and research questions of this policy analysis, quantitative and qualitative research methods were used to gain insight into the health policy content, context and process in Pakistan. Quantitative data were derived from health statistics, nationally and internationally. The content analysis is based mainly on secondary data in the form of previous studies on health policy analysis, official reports of health ministries and departments in Pakistan, international agencies, and reports of seminars and conferences on health policy. We used qualitative research methods to obtain insight into health policy priority setting, context (political, economic, socio-cultural, and demographic) and policy process (agenda building, planning, implementation, monitoring and evaluation). Our research methods included observations, recordings and open interviews. Characteristics of this type of research are non-manipulation of variables and simply focusing on studying a phenomenon as it occurs in reality (Crabtree & Miller, 1992).

The review of the literature included a review of modern health paradigms, international health programs and strategies including Primary Health Care (PHC) and Health for All (HFA). The literature review helped in identifying ways to combat disease and improve health by considering all the major determinants such as lifestyles, and the physical, socio-cultural, political, economic and demographic environment. Scientific literature was collected from different sources including ministries, departments, offices, libraries, academic and research institutes in Pakistan, the Netherlands and Switzerland.

Regarding the method of open-ended interviews one hundred and fifty-two actors involved in health policy process at international, national, provincial and district (local) level were personally interviewed. These interviewees included elected representatives (including current and former health ministers), policy makers, civil servants, field officers, representatives of the NGOs, representatives of the professional associations and representatives of international health organizations as shown in the table 1.

Table 1. Actors involved in Health Policy Process at various levels in Pakistan

Actors	**Level**			
	International	Federal	Provincial	District
Representatives of International agencies	4	6	4	NA
Elected representatives	NA	4	8	15
Civil servants	NA	8	12	10
Field officers/administrators	NA	NA	12	22
Representatives of Professional associations	NA	4	7	12
Representatives of the NGOs	NA	4	5	15
Total	4	26	48	74

These interviewees were visited in their offices, homes and public places during 2000 and 2005. In these years, Pakistan was visited regularly, and every year a few months were spent conducting field research. The interviewed international actors include: the officials of WHO, the World Bank, the Asian Development Bank, UNICEF, and UNDP. In the analysis, the interviews of the international representatives living outside Pakistan are mostly not used, since these interviews were held to get an overall picture in international health policy and were less focused on specific situations in Pakistan. The interviewed representatives of professional organization and the NGOs include: Pakistan Medical Association (PMA), Pakistan Medical and Dental Council (PMDC), All Pakistan Para Medical Association, Public Health Association of Pakistan, Human Rights Commission of Pakistan, APWA, Sungi Foundation and Women Organizations.

Overview of the Study

The study is composed of eight chapters.

Chapter 2 provides some basic information on Pakistan, covering physical and human geography, economy, national resources, political, administrative and social conditions, education,

cultural life, history, the health system and, finally a brief overview of health policy. This overview helps to understand overall health conditions and the health policy environment.

Chapters 3 and 4 provide answers to the first research question on the content of the health policy. Chapter 3 presents a brief overview of the National Health Policy (2001) of Pakistan by highlighting the various goals and targets of the policy. It particularly focuses on the extent to which NHP 2001 has followed important principles of HFA strategy. The relevance of this policy document is analyzed from the perspective of HFA. Chapter 4 describes the occurrence of health problems such as HIV/AIDS, cancer, diabetes, accidents, and drug addiction in Pakistan. It also highlights contributing factors such as socio-cultural, environmental and infra-structural factors

Chapters 5 and 6 provide an answer to the second research question, the context. Chapter 5 deals with political structure and political context in which health policy is embedded in Pakistan. It describes the political system - with its frequent changes of government, strong centralization and weak institutions. It also explains how the political context influences health policy process. Chapter 6 describes the economic and socio-cultural policy context in Pakistan. It presents the economic growth of Pakistan, the share of the health sector in national budgets, the status of women in society, the literacy level and corruption level. It also presents the impact of the economic and socio-cultural context on the health process and health outcome.

Chapter 7 provides an answer to the third research question, the health policy process. It presents an analysis of the important stages of the health policy process in Pakistan - such as agenda building and policymaking, planning, implementation, monitoring and evaluation - and identifies various problems existing in these stages of the process. The main problems, which affect the health policy process, are described, and suggestions are offered to improve the health policy process.

The final chapter presents an integrated overview of the answers to all the research questions, the main conclusions of this research study, and an analysis of the strong and weak points of the study. It ends with recommendations for health policy in Pakistan.

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