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A General Overview of Pakistan
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Introduction

Pakistan (the Islamic Republic of Pakistan; Urdu: Islam-i Jamhuriya-e Pakistan) is a country in South Asia with an area of 796,095 square kilometers and a population of 152.53 million. It is bordered on the west by Iran, on the north by Afghanistan, on the northeast by China, on the east and southeast by India, and on the south by the Arabian Sea. The capital is Islamabad. Pakistan was created at the time of the partition of British India on August 14, 1947, in order to create a separate homeland for Indian Muslims under the leadership of Quaid-e-Azam (Urdu word for great leader) Muhammad Ali Jinnah. Since 1947, the predominantly Muslim (80%) Jammu and Kashmir region, along the western Himalayas, has been disputed between Pakistan and India (Mahmood, 2000). India controls two-thirds of Kashmir and Pakistan the rest. The two countries have gone to war over the territory three times: in 1948-49, 1965, and 1971. The tension with India has led to a constant increase in defense expenditures at the cost of development and welfare budgets (Banuri, et al., 1997a; 1997b; Hussain & Hussain, 1993; Mahmood, 2000).

Physical and Human Geography

The Land

Pakistan is situated in the northwestern part of the southern Asian subcontinent at the western end of the Indo-Gangetic Plain, which is bounded to the north by the mountain wall of the Great Himalayan mountain ranges and their offshoots. It can be divided into six natural regions - the northern mountains, the submontane plateau, the Indus Plain, the Baluchistan Plateau, the western bordering mountains, and the desert area (Memon, 1997).

Climate

As Pakistan is located on a great landmass north of the tropic of Cancer (between latitude 24° and 37° N), it has a continental climate characterized by extreme variations of temperature, both seasonally and daily. Very high altitudes and snow-covered northern mountains make the climate very cold, particularly in northern areas. The Baluchistan Plateau also experiences cold temperatures. Along the coastal strip, the climate is influenced by sea breezes. In the rest of the country, temperatures are normally very high in summer; in the plains, the mean temperature for June is 40° C, and the highest temperatures may exceed 51° C (Pakistan, 2003). In the summer, hot winds called “loo” blow across the plains during the day. The dry and hot weather is broken occasionally by dust storms and thunderstorms that temporarily lower the temperature. Evenings are cool; the diurnal variation in temperature may be as much as 11° to 17° C.

Settlement Patterns

The traditional regions of Pakistan, shaped by ecological factors and historical evolution, are reflected in the administrative division of the country into four provinces: Punjab, Sind, North-West Frontier Province and Baluchistan.
Rural Settlement

Two-thirds of the rural population of Pakistan lives in nucleated villages or hamlets (i.e., in compact groups of dwellings). The concept of a village often tends to be equivalent to an area of land that, together with a village and its satellite hamlets, forms a unit. It is difficult to speak of an average size of a village, for patterns of habitation are complex. Rural areas commonly lack basic facilities such as water, sanitation, electricity, education, and health services. There are great disparities between rural and urban areas and between rich and poor in rural areas (Pakistan, 2004a, Pakistan, 2005a). The rich rural landlords own most of the rural resources, have an elite status, and exercise excessive powers that are mostly unchecked by the legal system. These landlords dominate not only rural areas but also the overall political system in the country (Hussain & Hussain, 1993; Mahomood, 2000, Shaikh, 2000).
Urban Settlement

Islamabad is the capital of the country. The other principal cities are Karachi (capital city of Sind province), Lahore (capital city of Punjab province), Faisalabad, Rawalpindi, Peshawar (capital city of NWFP province), and Quetta (capital city of Baluchistan province). The urban population of Pakistan represents about one-third of the total population (Pakistan, 2004a). Rapid and unplanned urban expansion has resulted in deterioration of living conditions, degradation of physical environment and excessive pressures upon the existing urban facilities (Khan & Bhutta, 2001; Luby et al., 2004; Pakistan, 2005b; Siddiqi, et al., 2004). Water supply and sewerage systems are inadequate, of poor quality, and mostly unhygienic (Pakistan, 2004a; Pakistan, 2005c). Unplanned industrialization has destroyed natural resources. In many places, industry has polluted soil, water and air (ADB, 2005; Illiyas et al., 1997; Pakistan, 2005c). The unplanned and unchecked system of traffic results in air and noise pollution.

Population Characteristics

Pakistan’s population grew at an average of 3% per annum from 1951 until the mid 1980s. Population growth slowed to an average of 2.6% per annum from 1985-86 until 1999-2000 (Pakistan, 2005a). Since 2001-02, the population has grown at an average rate of 2% per annum. In 2004-2005, total population was estimated at 152.53 million, making the country the seventh most populous country in the world (Pakistan, 2005a). The total fertility rate decreased from around 5.4 in the early 1990s to its present value of 4.6 (Pakistan, 2005a; 2005c). The population is denser in the industrialized and agriculturally fertile regions than in the uncultivated areas.

Ethnic Composition

The population is a complex mixture of indigenous people. Many racial types have been introduced by successive waves of migrations from the northwest as well as by internal migrations across the subcontinent of India. Aryans, Persians, Greeks, Pathans, and Mughals came from the northwest and spread across the Indo-Gangetic Plain, while the Arabs conquered Sind. All left their mark on the population and the culture of the land (Memon, 1997). In 1947, when Pakistan and India became independent, there was a massive migration of millions of Muslim refugees to Pakistan from different parts of India. At the same time there was also a massive migration of Hindus and Sikhs from Pakistan to India (Mahmood, 2000). Immigrants from both the sides suffered from multiple problems. Migrating refugees were attacked, killed, looted, raped and tortured by the local people on both sides. It was the worst communal violence and crime that India and Pakistan ever experienced, and it led to a huge loss of life, health and resources. It also led to hostilities between both sides, made two neighboring countries into enemies, and ultimately destroyed peace in the region (Mahmood, 2000; Memon, 1997, Shaikh, 2000).

Linguistic Composition

Pakistan is in general linguistically heterogeneous, and no single language can be said to be common to the whole population. Each of its principal languages has a strong regional focus.
Every province has its own language: Punjabi is spoken in Punjab, Sindhi in Sind, Pushto in NWFP, and Balochi in Baluchistan. Urdu is the national language although it is not indigenous to Pakistan. It is the native language only of immigrants from India who are mostly settled in Karachi and Hyderabad (Mahmood, 2000; Memon, 1997). However, Urdu is used as a common language for communication in every part of the country. Urdu is very similar to Hindi, the official language of India. Although the two languages have a common base, in its literary form Urdu emphasizes words of Persian and Arabic origin, whereas Hindi emphasizes words of Sanskrit origin. Urdu is written in a modified version of the Persian and Arabic script (written from right to left), whereas Hindi is written as Devanagari script from left to right. Urdu has strong associations with Muslim nationalism (Mahmood, 2000; Memon, 1997).

**Religions**

Almost the entire population in Pakistan is Muslim. The number of Hindus in Pakistan was greatly reduced as a consequence of their migration to India in 1947. Hindus, Sikhs, and Christians constitute only a tiny percentage (0.7%, 0.5% and 1.5% respectively) of the population (Mahmood, 2000; Memon, 1997).

**Economy and Education**

Pakistan's economy has gathered momentum during the last five years, particularly in the fiscal year 2004-05. Pakistan’s real GDP growth of 8.4 % in 2004-05 positioned the country as the fastest growing economy after China (Pakistan, 2005a). There are also reasonable amounts of mineral, biological, water, hydroelectric and other power resources available in the country. A disturbing feature of the economy is a persistent dichotomy between a respectable rate of economic growth and only a marginal improvement in social indicators. In inter-country comparison, Pakistan is economically better off than many other countries in Asia (Pakistan, 2005a).

Although the profile of educational achievement has been improving, it is still low. The literacy rate is 54 %. However, male literacy rate is estimated at 64 % and female at 36 % (CIA, 2005; Pakistan, 2005a). According to UNESCO (2005), the adult (15 and above) literacy rate in Pakistan is 53.4 % for males and 28.5 % for females, which contrasts considerably with most other countries in the South Asian region. About 34 % of the literate population has received education at less than the secondary level, 4 % at the higher secondary level and 3 % at university degree level and above (Pakistan, 2005a). The total number of students in Pakistan’s higher educational system is approximately 475,000. The enrolment rate for the age group of 17-23 years is 2.6 % compared to 10 % in India and 68 % in South Korea (Pakistan, 2005a).

**Culture and Arts**

Pakistan’s cultural heritage dates back more than 5,000 years to the age of the Indus civilization. But the emphasis on Islamic ideology has led to a strong identification with Islamic culture. Family organization is strongly patriarchal and most people live in large extended
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families. A woman’s status in society is low, and her role is restricted to performing domestic chores and fulfilling the role of a dutiful wife and mother. Pakistan offers a world of beauty, archaeology and history. There are many Hindu Tiraths, dating as far back as 3,000 B.C. Buddhist religion and culture as well as the Indus Valley Civilization flourished here 5000 years ago (Chaturachinda, et al., 2004; Pakistan, 2002). The ruins of Taxila, Moenjo-daro and Harappa tell the tale of a highly artistic and cultured people. Mughal monuments are also strewn all over the country. Pakistani craftsmen are also well known for producing high-quality products in clay, stone, fabrics, carpets, wood, metal, jewelry and leather. The country has been the cradle of a civilization that dates back more than five millennia. Over the centuries, successive waves of migrations from the northwest as well as internal migrations across the subcontinent brought Aryans, Persians, Greeks, Arabs, and Mughals to the region. From their earliest arrival, Muslims built cities, forts, palaces, mosques, madrassas (religious schools), tombs and mausoleums (Chaturachinda, et al., 2004; Pakistan, 2002).

Political and Administrative Context

The emergence of a democratic society in the country has often been disrupted by the repeated change in governments. Governor-generals, presidents and chiefs of the army have repeatedly dissolved elected governments and parliaments. No elected civilian government has ever transferred power to another civilian government; all have been replaced through non-electoral instruments and imposition of military rule. On average, military regimes have tended to last for a decade, while civilian regimes lasted three years or less (Newberg, 1997; Noman, 1997; Shaikh, 2000). The military abolished the national assemblies in 1958, 1969, 1977, and 1999 (Shaikh, 2000). The Governor General also abolished the national assembly in 1953. Furthermore, Presidents dissolved national assemblies in 1988, 1990, 1993, and 1996. As a result, the political system is weak and unstable (Khan & Van den Heuvel, 2005a; Mahmood, 2000).

Pakistan’s four provinces are divided into divisions, districts and tehsils (sub-districts), which are run by a hierarchy of administrators, such as the Divisional Commissioner, the District Coordination Officer (DCO), and Assistant Commissioners. The key level is that of the district, where the DCO shares a few powers with the elected district “Nazim” (means head in Urdu language). This centralized administrative system was imposed during the former British colonial system (Hussain & Hussain, 1993; Newberg, 1997; Noman, 1997). It works as a top-down model of delegation of powers from the central government to the governmental functionaries at the district and local level. People and their representatives hardly play a role in this centralized system. Every new government either dissolves the local councils or simply does not regularly organize new elections. It makes the people powerless, blocks their participation, and makes the system of accountability ineffective (Husain & Hussain, 1993; Newberg, 1997; Noman, 1997; Shaikh, 2000).

The Health System

Pakistan inherited a highly centralized health care system from the former British colonial power. The government is responsible for providing free national health care services to all citizens, including hospital care free of charge, and such services exist in almost all cities and towns (Pakistan, 2005a). Complete and reliable statistical data on governmental expenditures
on health do not exist. A major difficulty in determining the size of public and private health expenditures is how to determine the boundaries of health care and which expenditures to include (CIA, 2005; Pakistan, 1994). Human health resources include physicians, nurses, pharmacists, dentists, environmentalists, social scientists, public health professionals, and other persons promoting health.

Due to its colonial past, health policies in Pakistan are influenced by the British health reports. In October 1943, the then British Government of India appointed a "Health Survey and Development Committee" (the Bhore Committee). The committee published its report on March 1, 1946, with its contents markedly resembling the 1942 Beveridge Report in the UK that led to the creation of the National Health Service and other institutions of the British welfare state (Bjorkman, 1986; Khan & Van den Heuvel, 2005a). The main principles underlying the Bhore Committee proposals for future health services development included the idea that no individual should lack adequate medical care because of an inability to pay. Health consultants were to be provided with the laboratory and institutional facilities necessary for proper diagnosis and treatment of all sick people. The Bhore Committee also placed a strong emphasis upon prevention. It recommended that medical and preventive health care services be provided as close as possible to the people. After independence, the fledging Government of Pakistan adopted most of the proposals of the Bhore Committee, including provision of free medical treatment to all sick people and an emphasis upon disease prevention.

In the following years, a series of commissions and expert panels examined the health sector development process in Pakistan. A Medical Reforms Commission, appointed on November 24, 1959, issued several reports from January to April of 1960 (Bjorkman, 1986; Khan & Van den Heuvel, 2005b; Pakistan, 1994). These reports recommended the take-over of municipal hospitals and envisaged the district as the apex of a pyramid of health services radiating down through sub-districts to dispensaries. The Rural Health Centers (RHC) scheme was introduced in 1961 in order to provide basic health facilities and a graded system of medical care across rural Pakistan. Several years later, on June 24, 1969, a new Health Study Group was appointed, which published its report in March 1970 (Khan & Van den Heuvel, 2005b; Pakistan, 1994b). This report recommended the development of autonomous hospital authorities, a stronger emphasis upon preventive care, the reorganization of paramedical services, and the integration of several vertical programs into health care.

In March 1972, the government announced the "People's Health Scheme" with an emphasis on prevention and development of facilities in rural areas. The Planning Commission formulated a set of national guidelines to reflect the priorities of this scheme in October 1973. These guidelines were further influenced by the government and the World Health Organization in order to streamline health planning. Finally, in 1978, Pakistan formally adopted the strategy of the World Health Organization's "Health For All (HFA) by the Year 2000" (Ali, 2000; Pakistan, 1997). The government announced its first plan for a national health policy in January 1990 (Pakistan, 1997).

The 1990 National Health Policy (NHP) stated that Pakistani people pay a heavy toll of life from diseases, many of which are easily preventable, and that improvements were needed in the area of clean water, sanitation and housing as well as birth control (Pakistan, 1990). The NHP 1990 intended to give a higher priority to the neglected health sector and upgrade the medical education and health care system. It stated that government would devote more attention to environmental protection, sanitation, clean water supplies and housing in order to
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prevent disease. The NHP 1990 intended to provide universal health coverage in accordance with the strategy HFA 2000. In line with the HFA initiative, the NHP policy document identified the following main objectives (Pakistan, 1990):

- Health services should be effective, efficient, affordable and acceptable.
- Efforts to deal with health should include disease prevention, health promotion and curative services.
- There should be universal coverage for health services.
- Individuals and communities should participate in health activities that promote self-reliance and reduce dependence.
- Health activities should be integral to community and national development.

To attain its objective, particularly of making Primary Health Care (PHC) available to all, the NHP policy program aimed to control child and maternal mortality by increasing the coverage for immunization against major childhood diseases (measles, tetanus, whooping cough, diphtheria, and tuberculosis) through establishing public health services. It also aimed to combat anemia among women of childbearing age, provide adequate antenatal care and better maternity practices, and to ensure an adequate level of nutrition for children and women of childbearing age. Furthermore, health care professionals would be trained in the area of pregnancy, childbirth, and childcare. Drug packages for treatment of common diseases would also be provided in the rural areas (Pakistan, 1990). Outlays for health in the national budget would be increased, and additional sources of revenues would be identified to finance this policy.

On an organizational level, the NHP 1990 planned to decentralize the health system and to provide Primary Health Care (PHC) services via basic health units (BHUs) and rural health centers (RHCs) in rural areas. In urban areas, PHC services would be improved by training more physicians and other PHC professionals (Pakistan, 1990). To reduce infant/child mortality and child diseases such as congenital infection, tetanus, measles, whooping cough, diphtheria and diarrhea, services would have to be improved in the areas of nutrition, immunization against childhood diseases, and maternal and child health care. In addition, public education and awareness programs would be launched in the area of maternal and child health and family planning. Family planning services would be provided through health outlets, and health programs would be integrated with family planning programs (Pakistan, 1990).

The next National Health Policy (1997) stated that renewing and upgrading health policy in accordance with modern health paradigms was one of its basic objectives and that the previous health policy had not adequately covered all areas of PHC and the Health For All (HFA) strategy. It also aimed to make health service more responsive to current health needs in accordance with HFA. It identified many emerging health problems, including HIV/AIDS, cancer, diabetes, (road traffic) accidents, violence and crime, mental health and tuberculosis. To combat these health problems, a greater focus would be needed on the prevention of disease and promotion of health in accordance with modern health paradigms (Pakistan, 1997).

Policymakers made it clear that the government was committed to achieving the goal of health for all through better governance. Good governance was to be the cornerstone of health development. Human resource development needed to be rationalized, the private sector given greater responsibility, and local communities empowered (Pakistan, 1997). The health sector had to be regulated to make it more responsive to current and future challenges. Vulnerable and disadvantaged groups in society would be given priority. New laws would be legislated
and existing laws amended to implement the government’s commitment to various international conventions including: convention for the rights of children (CRC), convention on the elimination of all forms of discrimination against women (CEDAW), Health for All (HFA), etc. The ultimate aim of the new health policy was to improve the level of health across the entire population by providing universal health care coverage through an integrated PHC approach (Pakistan, 1997).

In the area of PHC planning, the 1997 policy document aimed to increase training opportunities, improve health management, develop a health information system, integrate priority health programs, decentralize the health system and strengthen the PHC network. The policy intended to combat non-communicable and chronic diseases by focusing on lifestyle. It intended to launch mass media awareness campaigns focusing on a healthy lifestyle in order to control and prevent cardiovascular diseases, blindness, diabetes, cancer, burns, injuries, and drug abuse. It also called for providing special training to health professionals in the area of public health and health promotion. In the area of disease control and prevention, the 1997 policy document specified several priority health programs, including an expanded program of immunization (EPI), a family planning program, a maternal and child health program (MCH), a program for reproductive health, a malaria control program, a tuberculosis (TB) control program, a national AIDS control program, and a cancer control program (Pakistan, 1997).

The government of Pakistan launched its third National Health Policy (NHP) in 2001 by acknowledging the need for a comprehensive health policy to address health problems and improve life conditions (Pakistan, 2001; 2004b). The 2001 NHP is the current health policy document for Pakistan. It aims to reform the health sector in order to prevent disease, promote health, and improve the overall health status of the population in line with the principles of HFA (Pakistan, 2001). A brief overview and analysis of its contents will be presented in Chapter Three and Chapter Four.
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References


