

# Health in Executive Committee of the National Economic Council (ECNEC)

Dr. Sania Nishtar

The configuration of the four health projects presented to August the 23<sup>rd</sup>'s Executive Committee of the National Economic Council (ECNEC) meeting raise some broader issues that need to be the substrate of contemporaneous conceptual thinking with reference to health and health sector allocations in Pakistan. Agreed that there can be no generalizations with respect to the patterns observed in the presentation of health cases to ECNEC; accepted that ECNEC also sees – and approves – the likes of mega budgeted primary health care and preventive interventions and acknowledged that the four projects presented must have been reflective of provincial and district health needs. The purpose here is not to debate the merit of these but to galvanize a thought process and flag the broader questions of priorities for resource allocations in the health sector, the manner in which these priorities are set and the criteria according to which these priorities are determined. Clarity in addressing these questions is a priority now more than ever given the recent increase in budgetary allocations for health.

Is it a matter of chance that only tertiary care focused curative projects gain access into discussion portfolios at ECNEC or is it that such visible and tangible projects have a higher likelihood of being blessed in planning circles; what bearing does this have with respect to the policy positions of prioritizing prevention as part of national health planning; do provincial governments actually sign up to policy positions stated by the Federal Government given that they regard 'health as a provincial subject' and most importantly, where does the ideal balance between the prevention-cure-allocation-distribution pitch in Pakistan's setting and *why* are questions that need to be debated. All of the projects tabled at ECNEC were incidentally from NWFP and all of them were deferred. Three out of the four agenda items on the portfolio related to hospitals, which primarily roll out the curative personalized model of health care. When viewed within the context of the State's mandate to deliver health (at least its priority services) as public goods, this brings to the forefront the debate over the nature of some curative services as qualifying to be termed as 'public goods' given that clinical services are thought of as being highly discretionary. The proponents of prevention argue that prevention services, on the other hand are more homogeneous, less discretionary and more cost efficient. Such resource allocation debates are often seen at DDWP and CDWP meetings within ministries and the Planning Commission respectively and are frequently the subject of dialogue between the government and NGO lobbyists. However sadly in such settings, powerful clinicians which make a strong argument for investments in curative care – often tertiary – and the public health community which lobbies for prevention support are often seen as operating within silos with the common denominator being the desire to cut budgets off each others platter. What is infrequently understood is the level of balance that has to be achieved and the reason why it is imperative to do so both within the context of the 'public health prevention imperatives' on the one hand and with reference to the States 'responsibility to deliver curative services at least to a certain segment of the society', on the other.

Balance dictates that whereas prevention and health promotion need to be delivered as public goods and prioritized, there is also valid justification to invest in hospitals given that if left to the private market, curative care,

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## A healthy debate

Health projects that were debated but deferred by a recent ECNEC meeting show how priorities in allocating money for health sector need to be thoroughly revised

By Dr Sania Nishtar

**T**he nature of four health projects presented to the Executive Committee of the National Economic Council (ECNEC) held on August 23 raises some broader issues that need to be the substrate of contemporaneous conceptual thinking with reference to health and health sector allocations in Pakistan. Agreed that there can be no generalizations with respect to the patterns observed in the presentation of health cases to ECNEC; accepted that ECNEC also sees – and approves – the likes of mega budgeted primary health care and preventive interventions and acknowledged that the four projects presented must have been reflective of provincial and district health needs. The purpose here is not to debate the merit of these but to galvanize a thought process and flag the broader questions of priorities for resource allocations in the health sector, the manner in which these priorities are set and the criteria according to which these priorities are determined. Clarity in addressing these questions is a priority now more than ever given the recent increase in budgetary allocations for health.

**U**rging on policy positions set by the federal government that they must 'lead a provincial subject' and, read accordingly, where does the ideal balance between the prevention-cure-allocation-distribution pitch in Pakistan's setting and *why* are questions that need to be debated. All of the projects tabled at ECNEC were incidentally from NWFP and all of them were deferred. Three out of the four agenda items on the portfolio related to hospitals, which primarily roll out the curative personalized model of health care. When viewed within the context of the State's mandate to deliver health (at least its priority services) as public goods, this brings to the forefront the debate over the nature of some curative services as qualifying to be termed as 'public goods' given that clinical services are thought of as being highly discretionary. The proponents of prevention argue that prevention services, on the other hand are more homogeneous, less discretionary and more cost efficient. Such resource allocation debates are often seen at DDWP and CDWP meetings within ministries and the Planning Commission respectively and are frequently the subject of dialogue between the government and NGO lobbyists. However sadly in such settings, powerful clinicians which make a strong argument for investments in curative care – often tertiary – and the public health community which lobbies for prevention support are often seen as operating within silos with the common denominator being the desire to cut budgets off each others platter. What is infrequently understood is the level of balance that has to be achieved and the reason why it is imperative to do so both within the context of the 'public health prevention imperatives' on the one hand and with reference to the States 'responsibility to deliver curative services at least to a certain segment of the society', on the other.



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being cost intensive and rival in consumption would be excludable for the poor creating serious access issues. The State cannot relinquish its responsibility to cater to the needs of those that require curative care particularly the segment of our population which qualifies to be benefited under Article 38 of the Constitution of the Islamic Republic of Pakistan. This realization should also be instructive for the current restructuring arrangements of the State's infrastructure in health with particular reference to hospital autonomy and BHUs restructuring. Though these are steps in the right direction, there should be a fundamental difference between *privatization* which is what cannot be recommended for the State's health infrastructure and *mainstreaming the role of the private sector* for improved management, and enhancing efficiency, which is what should be promoted. Within these settings, the State's funding should be used through appropriate waiver and exemption mechanisms to ensure that the poor are not excluded from care. This understanding must also guide the impending GATS-driven liberalization of services, which have traditionally been in the public domain. As curative services are – and will continue to be – mainstreamed on free market principles as a result of the prevailing market dynamics, the States health sector must ensure that access issues for the poor are minimized and mitigated and within this context, a myriad of options can be explored for alternative health financing arrangements and appropriate regulation framed. Health cannot be left to the free market. The fact of the matter is that the State's hospitals – notwithstanding their gaps and inefficiencies – are the only sanctuary for the poor, at least a certain percentage.

Within this context therefore, what is underlying connotation within the frequent criticism generated in the health sector relating to the sizable chunk of health allocations, which go to serve hospitals particularly in the provinces? Is the undertone one of cutting the budget for hospitals and diverting them to prevention? Perhaps not.

The connotation should be to enhance allocations for prevention and health promotion to achieve a balance that is desirable rather than divert money from hospitals which do play a role in providing affordable care and physical access to clinical services – though of questionable quality – to the excluded vulnerable and difficult to reach populations, which are and should be the prime targets for government subsidy. And with reference to hospitals such criticism should be constitutively directed to ensure that these 'allocations' are 'utilized effectively' and are not pilfered. It also must be ensured in particular that the high cost services that hospitals can offer do actually benefit the poor, as opposed to the non poor who are likely to use their political influence to ensure that public spending for these expensive hospitals is maintained – often at the expense of services that could have a real effect on the poor. And lastly perhaps the connotation is also one of strongly voicing the need to integrate prevention into the mandate of clinical services, and move away from the silo operations given that these are inseparable – a suggestion of relevance to the Peshawar Institute of Cardiology for which over 1000 million are likely to be allocated in the next ECNEC meeting.

And now with reference to the fourth project tabled at the ECNEC meeting, there can be no argument to support allocations to build infrastructure to support a medical school that has been running without any physical infrastructure for the last five years! But then extrapolated to the broader context of resource allocation priorities in the area of health related human resources, the current doctor to nurse ratio of 2.7:1 and doctor to paramedic ratio of much lower is instructive given that it is clearly opposed to the conventional global norm which advocate a doctor:nurse ratio of 1:4. These qualitative considerations and the established qualitative and deployment related gaps and absence of a continuing medical education program highlights a clear direction to invest in a specific line of human resource from qualitative, quantitative and deployment-related perspectives. At a broader level this underscores the need for decisions on human resource to be based on providing sustainable public health solutions rather than political expediency.

The discussion on priority setting cannot be complete without a reference to the criteria for priority setting within the public health prevention framework. Here if priorities for resource allocations are based on prevailing disease patterns then it may be worthwhile to note that infectious and non-communicable diseases contribute 38% and 37% of the disease burden respectively – an equal disease burden. This criteria alone calls for major shifts in allocation trends even if the other criterion – the potential for preventability – is not factored into the equation, the addition of which would make the argument much stronger. The need is also reiterated if another criterion is applied based on the manner in which health links in with over-arching social sector directions of the country such as poverty eradication. The current health related poverty reduction strategy mirrors the MDG objectives with a

focus on maternal and child health and infectious diseases on the premise that these are more frequently encountered in the poor. That is indeed the case. But we also need to be clear on how poverty eradication can link in with the health agenda in economic terms. And in line with this diseases that affect the economically productive workforce; ailments that undermine the income generating power of a household; diseases that have the potential to perpetuate an acute poverty crisis and contribute to major costs of care and put of pocket payments should also merit a consideration. A recently reported population-based cross-sectional survey, has shown that 37.4% of the households spend an average of Pak Rs. 405 on the treatment of communicable diseases whereas 45.2% of the households spend an average of Pak Rs. 3935 on the treatment of non-communicable diseases over the last one year. These data show that a significantly higher percentage of households spend more on treatment of non-communicable diseases compared with communicable diseases.

All said and done in relation to priorities for allocations ‘within health sector’; but perhaps what is more important to deliberate upon in a very broad sense relates to how health factors into the equation of priorities in a much larger picture where there are other competing interests. That will be left to a viewpoint which merits a much richer discussion – one that space will not permit this time round.

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