

# Health Policy – chinks in the armor

Dr. Sania Nishtar

The NEWS International  
Monday, July 14, 2008

## Health policy – chinks in the armour

Dr Sania Nishtar

In the midst of all the overarching challenges the country faces, sectoral policy and strategy appears to be relegated to the background; the latter cannot be mainstreamed in any case without sound institutional governance, which is also a determinant of the currently prevailing broader issues.

Let's take the example of health where the government's initiative to formulate a new national health policy could be the starting point for the much needed reform within the health sector. Certain sound technical choices can be made and if evidence-based strategies are adopted to synergize a technically robust and administratively feasible agenda, a viable basis for restructuring the health system can be made. However, the issue is not at the level of 'technical choices' but with the manner in which institutions govern policy change; there are two critical impediments at this level; first, the ability of state institutions to build on evidence and secondly, their ability to ensure that policy reforms introduced, are taken to fruition over the long term.

A historical review demonstrates that health institutions have faltered at both these levels. Many attempts have been made to reform the sector over the last 61 years. Each time with change of government, institutions back track on initiatives, programs are rolled back and planning begins once more, often regardless of costs or technical merit. Health reform is a long haul challenge. If our institutions do not build their capacity to develop and safeguard a long

term vision for the introduction and implementation of reforms, little will be achieved as we continually revisit old ground. Let's review evidence in support of this statement.

In 1947 Pakistan adopted a curative care approach to health with a focus on producing doctors and setting up civil hospitals; evidence-based recommendations of the Bhore Commission Report (1946), which underscored the importance of prevention were not given due priority. In the 1970's, in compliance with the principles of health for all, as stated in the Declaration of Alma Ata, Pakistan established an extensive network of health facilities to deliver primary health care. Unfortunately though, we failed to budget appropriately for sustainability and to analyze the private sector's impact on the viability of the state's health delivery system. Today, according to the Pakistan Social and Living Measurement Survey, Basic Health Units (BHUs) serve less than 2% of the population. Despite many efforts in the 80s and 90s as part of the Family Health Project, the Social Action Programme I and II and other initiatives, BHUs could not be revived, largely because of the inability to deploy and sustain solutions, over time. More recently, there have been other attempts to restructure. Both the 'contracting-out' and 'reform of directly managed services' models in Punjab had some technical substance but lessons learnt from evaluations got lost in political

turf battles. During the 90s, successive governments introduced vertical national public health programs following the design stipulations of international donors and international public private partnerships. There has since been an inflow of re-

sources through GAVI, Global fund for AIDS, TB and Malaria, Stop TB, Roll Back Malaria, and others. On a positive note, successive governments have continued with these programs as a result of which they have been able to make some level of improvement in public health outcomes. Their effectiveness can be enhanced further if evidence is factored into planning and problems created by their vertical orientation are addressed by integrating them within the provincial-district accounting and accountability channels. The importance of long-term sustained action should be clear to successive governments from their experiences with the Lady Health Worker

program, which despite its weaknesses has had a positive impact as a result of being followed through over time.

Let's turn to hospitals now, where many interventions have been tested in different provinces; the controversial hospital autonomy legislation in NWFP established the Employees Social Security Institute in 1967 based on the US model, just a year after it was introduced in the USA. Today the same scheme in the US forms the backbone of Medicare, whereas Pakistan only covers 0.84 million employees in the private sector, with

many opportunities for expansion untapped. Enhancing revenues as a means of financing health was tested in the SAP years and more recently as part of the increase in fiscal space in the last five years; limited ability within the system to expend and target funds was found to be a key impediment to achieving envisaged outcomes; however, lessons learnt have not been mainstreamed into planning.

Every government wants to introduce health insurance and appears to address the subject de novo, the writer has addressed this subject in these columns on June 28, 2008 to propose a way forward building on the many un-leveraged

opportunities for expansion untapped. Enhancing revenues as a means of financing health was tested in the SAP years and more recently as part of the increase in fiscal space in the last five years; limited ability within the system to expend and target funds was found to be a key impediment to achieving envisaged outcomes; however, lessons learnt have not been mainstreamed into planning.

Every government wants to introduce health insurance and appears to address the subject de novo, the writer has addressed this subject in these columns on June 28, 2008 to propose a way forward building on the many un-leveraged

opportunities for expansion untapped. Enhancing revenues as a means of financing health was tested in the SAP years and more recently as part of the increase in fiscal space in the last five years; limited ability within the system to expend and target funds was found to be a key impediment to achieving envisaged outcomes; however, lessons learnt have not been mainstreamed into planning.

Every government wants to introduce health insurance and appears to address the subject de novo, the writer has addressed this subject in these columns on June 28, 2008 to propose a way forward building on the many un-leveraged

opportunities for expansion untapped. Enhancing revenues as a means of financing health was tested in the SAP years and more recently as part of the increase in fiscal space in the last five years; limited ability within the system to expend and target funds was found to be a key impediment to achieving envisaged outcomes; however, lessons learnt have not been mainstreamed into planning.

In the midst of all the overarching challenges the country faces, sectoral policy and strategy appears to be relegated to the background; the latter cannot be mainstreamed in any case without sound institutional governance, which is also a determinant of the currently prevailing broader issues.

Let's take the example of health where the government's initiative to formulate a new national health policy could be the starting point for the much needed reform within the health sector. Certain sound technical choices can be made and if evidence-based strategies are adopted to synergize a technically robust and administratively feasible agenda, a viable basis for restructuring the health system can be made. However, the issue is not at the level of 'technical choices' but with the manner in which institutions govern policy change; there are two critical impediments at this level; first, the ability of state institutions to build on evidence and secondly, their ability to ensure that policy reforms introduced, are taken to fruition over the long term.

A historical review demonstrates that health institutions have faltered at both these levels. Many attempts have been made to reform the sector over the last 61 years. Each time with change of government, institutions back track on initiatives, programs are rolled back and planning begins once more, often regardless of costs or technical merit. Health reform is a long haul challenge. If our institutions do not build their capacity to develop and safeguard a long term vision for the introduction and implementation of reforms, little will be achieved as we continually revisit old ground. Let's review evidence in support of this statement.

In 1947 Pakistan adopted a curative care approach to health with a focus on producing doctors and setting up civil hospitals; evidence-based recommendations of the Bhore Commission Report (1946), which underscored the importance of prevention were not given due priority. In the 1970's, in compliance with the principles of Health For All, as stated in the Declaration of Alma Ata, Pakistan established an extensive network of health facilities to deliver Primary Health Care. Unfortunately though, we failed to budget appropriately for sustainability and to analyze the private sector's impact on the viability of the state's health delivery system. Today, according to the Pakistan Social and Living Measurement Survey, Basic Health Units (BHUs) serve less than 2% of the population. Despite many efforts in the 80s and 90s as part of the Family Health project, the Social Action Programme I and II and other initiatives, BHUs could not be revived, largely because of the inability to deploy and sustain solutions, over time. More recently, there have been other attempts to restructure. Both the 'contracting-out' and 'reform of directly managed services' models in Punjab had some technical substance but lessons learnt from evaluations got lost in political turf battles.

During the 90s, successive governments introduced vertical national public health programs following the design stipulations of international donors and international public private partnerships. There has since been an inflow

of resources through GAVI, Global fund for AIDS, TB and Malaria, Stop TB, Roll Back Malaria, and others. On a positive note, successive governments have continued with these programs as a result of which they have been able to make some level of improvement in public health outcomes. Their effectiveness can be enhanced further if evidence is factored into planning and problems created by their vertical orientation are addressed by integrating them within the provincial-district accounting and accountability channels. The importance of long term sustained action should be clear to successive governments from their experiences with the Lady Health Worker program, which despite its weaknesses has had a positive impact as a result of being followed through over time.

Let's turn to hospitals now, where many interventions have been tested in different provinces; the controversial hospital autonomy legislation in NWFP, the Punjab Act on Hospital Decentralization Reform, the Sindh experience with establishment of District Health Boards, and unsuccessful attempts to introduce hospital based private practice in NWFP. The emphasis in all of these has been on cumbersome statutory and governance rearrangements. Exceptions notwithstanding, simple evidence based interventions such as delegation of financial and administrative authority to trained managers and fully autonomous boards has not been tested in the truest sense.

In relation to health financing, contrary to what is generally believed, many options have been tested. Pakistan established the Employees Social Security Institute in 1967 based on the US model, just a year after it was introduced in the USA. Today the same scheme in the US forms the backbone of Medicare, whereas Pakistan only covers 0.84 million employees in the private sector, with many opportunities for expansion untapped. Enhancing revenues as a means of financing health was tested in the SAP years and more recently as part of the increase in fiscal space in the last five years; limited ability within the system to expend and target funds was found to be a key impediment to achieving envisaged outcomes; however, lessons learnt have not been mainstreamed into planning.

Every government wants to introduce health insurance and appears to address the subject *de novo*; the writer has addressed this subject in these columns on June 28, 2008 to propose a way forward building on the many un-leveraged programs currently on ground. The needed complex organizational changes and restructuring of social welfare, can only be implemented through long term evidence-based reforms.

Let's turn to institutional and decentralization reforms where many examples of missed opportunities can be cited: these include efforts as part of SAP in the 90s to decentralize social services, albeit in a centralized government system, the management intervention in Sheikhpura under the Family Health Project, establishment of District Health Authorities and District Health Management Teams in 1996, and setting up of District Health Governments in 1997 under SAP II. Despite these efforts consolidated recorded evidence is not in the public domain and lessons learnt cannot be factored into planning. Each of these is a legacy of backtracking on what could have been a viable intervention if followed. It is feared that the same will happen to the Devolution 2002 initiative. Another case in point are efforts to integrate the ministries of health and population. Since the 1970s, successive governments have attempted to constitute committees, commissions, boards, sign MoUs and issue joint calls to integrate. Yet each time new avenues are explored. The word limits on this opinion preclude a reference to similar examples in pharmaceutical, human resource and other domains but each has a similar story to tell.

The lessons learnt from these examples can be summarized in a nutshell; over the last 61 years, there have been a number of attempts to mainstream change in the health sector. Governments have adopted options with subsequent governments disregarding them. Institutions have had limited capacity or time to consolidate lessons learnt. Those in technical and administrative roles in ministries and departments do not appear to have the voice, or tenure security needed to make it implicitly binding on incoming governments, to conform planning and action with evidence. Consequently, every government starts *de novo* as plans in the pipeline are rolled back, resulting in significant wastage of tax-payers money. Regrettably there is no mechanism to hold governments accountable for such actions. Although the case of health has been showcased in this opinion, the story resonates with similar experiences in other sectors as well.

The question of developing a new health polity therefore has to be addressed within the context of a long term vision for reforming a sector. It is important not only to develop a consensus of all the political and technical stakeholders on the technical modalities but also a mechanism to safeguard a vision over time; failing that, the policy will remain a wish list.

*The author is the founder and president of the think tank, Heartfile. E mail: [sania@heartfile.org](mailto:sania@heartfile.org)*