Non-communicable diseases: evidence-policy disconnect

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World Bank's report 'Tackling Non-communicable Diseases in South Asia' made headlines in Pakistan, yesterday. This is an important subject and its significance should be appreciated by policymakers. The report highlights the magnitude of burden attributable to a set of diseases, widely prevalent throughout all countries of south Asia—diseases which are linked by common risk factors, are largely preventable through cost effective interventions, but which have remained outside of traditional public health planning. It is now well established that certain heart diseases, stroke, diabetes, and some cancers and chronic lung conditions are the biggest global killers. In Pakistan they are the leading preventable cause of death, disease and disability in the adult population. These diseases have enormous social and economic costs with a serious negative impact on human and economic development. They impede progress toward the UN Millennium Development Goals, particularly toward poverty reduction and lead families into the medical-poverty trap. Yet, the prevention and control of Non-communicable diseases (NCDs) is outside of mainstream public health planning in Pakistan. It is neither part of the development agenda nor poverty reduction strategy plans. Lack of attention to NCDs is the greatest paradox in public health. Now that there is a beginning of global attention toward this issue, it is important that commensurate action be stepped up to address this challenge.

The NCDs issue can also be used as a lens to examine broader governance challenges related to the use of evidence in policy and planning in the country. Data from the Pakistan Demographic Surveys (PDS) is a case in point. PDS is a sample surveillance system, which measures vital events (births,

deaths) annually and is conducted by the Federal Bureau of Statistics (FBS), Government of Pakistan. Surveys have been conducted sequentially since 1992 and results have consistently shown that NCDs are the major killers in the adult population. The percentage of deaths attributable to NCDs increased from 34.1% in 1992 to 59% in 2005 according to respective surveys. This compelling evidence was consistently paralleled with lack of priority accorded to NCDs in planning and resource allocation decisions. Public health planning in Pakistan remained dominated by infectious diseases and NCDs remained outside of mainstream planning.

Attempts were made previously in Pakistan through public-private collaborative efforts to plan strategically in this area and a national plan of action was published. This effort was acknowledged in World Bank's report as the first integrated national plan of action from within the developing countries. Implementation was thwarted largely since NCDs were not part of the official health policy in Pakistan and remained outside of donors' priorities. NCDs were the blind spot of the 2001 National Health Policy, while data and evidence from the state's own data collection engine, FBS, continued to point toward an escalating trend. This, highlights a fundamental disconnect between evidence and policy. Disconnect could also be visible in other areas and does not auger well for appropriateness of the policymaking process. The gap must be bridged to eliminate the influence of arbitrariness in the decision-making process.

There is also another policy issue at the margins of this discussion—efforts underway to restructure FBS as an autonomous organization through an Act of Parliament. Reconstruction along these lines is needed so that this key agency, responsible for data and evidence can be isolated from interference and manipulation. Ensuring independent functioning of autonomous agencies has been Pakistan's predicament. Governance challenges in this space need to be

addressed. Alongside, it is also critical to ensure that mechanisms are in place to bridge the current evidence-policy disconnect.

Turning back to NCDs, Pakistan needs to recognize what it means in policy and planning terms to institutionalize their prevention and control in its health and development systems. NCDs are linked by certain risk lifestyle factors—tobacco use, lack of physical activity, unhealthy diet and alcohol use. Biological factors add to the risk—obesity, high blood pressure and abnormal cholesterol levels. As these are related to individual behaviors, people need to take responsibility. However, policy action is necessary to create supportive environments. This is where solutions to prevent NCDs are different from what Pakistan's health sector is familiar with. These solutions lie largely outside the health sector and involve trade policy, taxation, international regulation, the agriculture and environment sectors, general working and living conditions, cross border smuggling and functioning of the local government system. Cutting unhealthy fats from the diet, lowering salt, promoting exercise at the individual and community level, in work place and schools, making urban environments conducive for physical activity, overcoming barriers for women to participate in physical activity in our conservative culture, controls on tobacco advertising, price regulation, promoting healthier eating etc., are all public health interventions to curb NCD risks. These are outside the remit of traditional health planning but now need to be at the heart of public health strategies. Pakistan's public health system needs to create institutional arrangements with a mutli-sectoral construct and scope beyond the health sector to enable effective inter-sectoal action in this space. On that note it is sobering to recognize that the current capacity and resources in the system to enable that are extremely limited.

There is a health care dimension to NCDs as well, which entails ensuring availability and access to cost-effective

medial and screening interventions to those who need them. The country needs to step-up evidence-based interventions, which have been demonstrated as having the potential to effectively treat individuals with disease and protect those who are at high risk of developing them. There is need for building capacity at the health systems level and reorienting health systems towards chronic care with attention to human resource, service delivery, surveillance and access to essential medicines. Services related to NCDs need to be integrated in primary healthcare and essential services packages. All this is likely to be a challenge for Pakistan's under performing public health system, where capacity constraints abound. Failure to eradicate polio is an indicator of these constraints.

Let us also be reminded that Pakistan's health governance system is currently in flux. The MOH will be abolished in 4 months from now and the fate of the local government system, the functioning of which determines the effectiveness of health service delivery, is still undecided. This a time of great challenges for health—but this is also an opportunity.

An unprecedented discourse is currently underway to reshape federal-provincial and provincial-district interfaces with a view to devolving health under a new constitutional framework. While this big ticket restructuring fundamentally opens many avenues for reforming health service delivery, it also offers opportunities to integrate NCDs within in the public health system. Efforts to mainstream NCDs into country health planning can have a significant knock-on effect on health systems and can be an entry point to reform itself.

Pakistan needs to gear up planning in this area. In September 2011, United Nations General Assembly Special Session on NCDs will be convened. Pakistan must showcase something substantial in the run up to that watershed event.

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