



FINAL DRAFT
NATIONAL HEALTH POLICY 2009

JULY 2009

MINISTRY OF HEALTH
GOVERNMENT OF PAKISTAN

FORWARD BY THE MINISTER OF HEALTH

ABBREVIATIONS

AI	AVIAN INFLUENZA
AIDS	ACQUIRED IMMUNE DEFICIENCY SYNDROME
BHU	BASIC HEALTH UNIT
BISP	BENAZIR INCOME SUPPORT PROGRAMME
BOD	BURDEN OF DISEASE
CCB	COMMUNITY CITIZEN BOARD
CMW	COMMUNITY MIDWIFE
CPR	CONTRACEPTIVE PREVALENCE RATE
DALYS	DISABILITY ADJUSTED LIFE YEARS
DHDC	DISTRICT HEALTH DEVELOPMENT CENTER
DHIS	DISTRICT HEALTH INFORMATION SYSTEM
DHQ	DISTRICT HEAD QUARTER
DOH	DEPARTMENT OF HEALTH
DOTS	DIRECTLY OBSERVED TREATMENT – SHORT COURSE
EMONC	EMERGENCY OBSTETRIC AND NEONATAL CARE
EPI	EXPANDED PROGRAMME ON IMMUNIZATION
ESDP	ESSENTIAL SERVICE DELIVERY PACKAGE
FATA	FEDERALLY ADMINISTERED TRIBAL AREAS
FBS	FEDERAL BUREAU OF STATISTICS
FLCF	FIRST LEVEL CARE FACILITY
FP	FAMILY PLANNING
GOP	GOVERNMENT OF PAKISTAN
GDP	GROSS DOMESTIC PRODUCT
HIV	HUMAN IMMUNODEFICIENCY VIRUS
HMIS	HEALTH MANAGEMENT INFORMATION SYSTEM
HR	HUMAN RESOURCE
IDUS	INJECTING DRUG USERS
IMNCI	INTEGRATED MANAGEMENT OF NEWBORN AND CHILDHOOD ILLNESS
IMR	INFANT MORTALITY RATIO
ITNS	IMPREGNATED TREATED NETS
LHV	LADY HEALTH VISITOR
LHW	LADY HEALTH WORKER
M&E	MONITORING AND EVALUATION
MCH	MATERNAL AND CHILD HEALTH
MDGS	MILLENNIUM DEVELOPMENT GOALS
MMR	MATERNAL MORTALITY RATIO
MNCH	MATERNAL, NEWBORN AND CHILD HEALTH
MOH	MINISTRY OF HEALTH
MTBF	MEDIUM TERM BUDGETARY FRAMEWORK
MTDF	MEDIUM TERM DEVELOPMENT FRAMEWORK
NCD	NON-COMMUNICABLE DISEASES
NEML	NATIONAL ESSENTIAL MEDICINE LIST
NGO	NON GOVERNMENTAL ORGANIZATION
NWFP	NORTH WEST FRONTIER PROVINCE
OOP	OUT OF POCKET
PHC	PRIMARY HEALTH CARE

PHDC	PROVINCIAL HEALTH DEVELOPMENT CENTER
PMDC	PAKISTAN MEDICAL AND DENTAL COUNCIL
PMRC	PAKISTAN MEDICAL AND RESEARCH COUNCIL
PNC	PAKISTAN NURSING COUNCIL
PPP	PUBLIC PRIVATE PARTNERSHIP
PPRA	PUBLIC PROCUREMENT REGULATORY AUTHORITY
PRSP	POVERTY REDUCTION STRATEGY PAPER
PSLM	PAKISTAN SOCIAL AND LIVING STANDARD MEASUREMENT SURVEY
RHC	RURAL HEALTH CENTRE
SARS	SEVERE ACUTE RESPIRATORY INFECTION
SBA	SKILLED BIRTH ATTENDANCE
STI	SEXUALLY TRANSMITTED INFECTIONS
TB	TUBERCULOSIS
THE	TOTAL HEALTH EXPENDITURE (BOTH PUBLIC AND PRIVATE)
THQ	TEHSIL HEAD QUARTER
U5MR	UNDER FIVE MORTALITY RATE
UN	UNITED NATIONS
WHO	WORLD HEALTH ORGANIZATION
WTO	WORLD TRADE ORGANIZATION

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Context for formulating the National Health Policy

Pakistan's health challenges

Amongst the population of Pakistan, the burden of diseases (BoD) can be classified under two broad categories: half due to communicable diseases, reproductive health and malnutrition while the other half due to non-communicable diseases, injuries and mental health disorders. Polio and hepatitis B & C are endemic and Pakistan ranks 6th amongst the 22 highest TB burden countries in the world. In parts of Pakistan, malaria and dengue fever are prevalent and HIV is increasing among some segments of the population. At least one quarter of Pakistani adults are obese, have cardiovascular conditions and over 40% of men are smokers. Injuries and accidents account for more than 11% of BoD. Nutritional disorders are common and particularly effect women and children. Pakistan also needs to be prepared for emerging global diseases like swine flu and other viral infections.

Pakistan has a high fertility rate with 4.2 million new births annually. This rapid population growth will further strain an already overstretched and underperforming health care services delivery system, including deliveries by skilled birth attendants. Efforts made over the years to improve health standards have been partially neutralized by the rapid growth of the population. In addition, gender bias and limited access to health services further compromise health of Pakistanis.

Inspite of some improvement since 1990, the health of the people of Pakistan lags much of South Asia and the improvements have not kept up with the increasing GDP. For example, a GDP of USD 870 per capita in 2007 would predict about 27 excess infant deaths per thousand, 19 excess child deaths per thousand, 36 percent lower births attended by trained personnel, 11 percentage points higher babies born with low birth weight. This profile suggests that these lags make Pakistan a model case for economic "growth without development" indicating an underperforming health care delivery system.

Sub-optimal performance of the health sector in Pakistan is primarily because of low level of health spending. Total expenditure on health as percent of GDP is only about 2 percent of GDP, which is much lower than other countries with similar income levels. The government contributes about a third of this and the remaining 70 percent is paid out-of-pocket by citizens at the points of service delivery.

A number of non-financial constraints have played an equally important role in the underperformance of health systems. Health workers are demotivated and distracted from their work by conflicting interests. Weak governance, imbalance of human resource, lack of equitable service delivery, absence of social safety nets, lack of effective implementation of regulations particularly in a large unregulated private sector are some of these factors having an adverse impact on the performance of the health sector.

Pakistan's commitment to the Millennium Development Goals

Pakistan has made concrete commitments to the Millennium Development Goals (MDGs). Through its major health intervention programs, the Ministry of Health has pursued practical strategies aimed at

- reducing:
 - the under-five mortality rate from an estimated 140 in 1990 to a target of 52 by 2015
 - the infant mortality rate from an estimated 110 in 1990 to a target of 40 by 2015
 - the maternal mortality ratio from an estimated 530 in 1990 to a target of 140 by 2015

- increasing:
 - the proportion of 1 year-old children immunized against measles from an estimated 50% in 1990 to a target of 85% by 2015
 - the proportion of births attended by skilled health personnel from an estimated 20% in 1990 to a target of > 90% by 2015
- combating:
 - TB, Malaria, HIV/AIDS and other communicable diseases..

The 2008 report of the MDG Gap Taskforce revealed that while there has been much progress during the last decade, the delivery on commitments particularly in MDG 4 & 5 has lagged behind schedule. Pakistan has:

- reduced the under-five mortality rate by 25 during the 1990s but has achieved no further reductions in the past decade;
- but also
 - maintained the same infant mortality rate of around 75 in the past decade;
 - slightly increased the proportion of 1 year-old children immunized against measles to 60%;
 - significantly reduced the maternal mortality ratio to 280; and
 - doubled the proportion of births attended by skilled health personnel to 40%

However, these latter gains would still fall short of the targets identified for the remainder of the current timeframe.

The government is cognizant that there are other determinants of health, such as illiteracy, unemployment, gender inequality, social exclusion, food insecurity, rapid urbanization, environmental degradation, natural disasters, lack of access to safe water and sanitation that aggravate Pakistanis' health status. The ministry of health has the human resource capacity and is willing to assume a leadership role wherever deemed necessary in initiatives that remove these barriers for the betterment of health and eradication of diseases. The effectiveness of health initiatives will only be maximally achieved if the ministry of health is able to reach out to and help coordinate the activities of other authorities responsible for education, sanitation, water supply and environment. The democratically elected government acknowledges the expectations of the citizens for better health and recognizes that Primary Health Care (PHC) is the only practical approach to improve health of our population. The Government is committed to fulfill these needs by strengthening the health systems to respond better and quickly to the challenges of an evolving Pakistan, resulting in a healthy nation. In formulating this Policy the Government paid particular attention to the domestic imperatives and its commitment to pursue and achieve MDG's

Health Policy of the Government

Vision

The vision of the National Health Policy is to improve the health and quality of life of all Pakistanis, particularly women and children, through access to essential health services

Goal

The goal of the national health policy is to remove barriers to access to affordable, essential health services for every Pakistani

Policy Objectives

To achieve the above stated goal of removal of barriers to essential health services, the Government of Pakistan adopts the following six Policy Objectives to reform and strengthen critical aspects of its health systems to enable it to:

1. Provide and Deliver a basic package of quality Essential Health Care Services
2. Develop and manage competent and committed health care providers
3. Generate reliable health information to manage and evaluate health services
4. Adopt appropriate health technology to deliver quality services
5. Finance the costs of providing basic health care to all Pakistanis
6. Reform the Health Administration to make it accountable to the public

The Ministry of Health recognizes that provinces have varied needs and expectations regarding health and that each Department of Health is fully capable of identifying as well as delivering appropriate health care to their populations. It is in this spirit that the federal ministry will support and facilitate the provinces in implementation of their strategies by providing relevant financial and technical resources to ensure that essential health service package is accessible to all the citizens. The national health policy has been formulated with the primary objective of resonating with the expectations of Provinces. It is designed to contribute to advancing and strengthening the **provincial health strategies**.

Policy Objectives and Actions by the Federal Ministry and Provincial Departments of Health

1. Development and Provision of an essential health services package

Challenges

The health care services provided through primary health care outlets (primarily but not restricted to Basic Health Units and Rural Health Centers) and secondary or tertiary facilities are currently unreliable due to inappropriate staffing and skills mix, inadequate infrastructure including limited water and electricity and lack of essential medicines, equipment and supplies. Standards of services vary considerably in quality and attitude of health care providers and are not patient-centered. Although the Primary Health Care (PHC) services provided are primarily curative, they are poorly defined and not comprehensive or standardized. Referral pathways to higher level curative and diagnostic care are not formalized and preventive care is limited to in-facility immunization and antenatal care. Essential medicines are inadequately stocked and erratically provided.

A major strength of health care services in Pakistan is very strong outreach via about 95,000 Lady Health Workers (LHWs) and an increasing number of community midwives (CMWs). The roles of LHWs were expanded to identify pregnant women, providing them with multivitamin supplements, referring them to antenatal care services at BHU/RHC and participating in immunization days, in addition to their basic function of providing family planning services along with basic health care. There is currently a proposal to expand the number of LHWs so that they can reach underserved areas, and for adding male workers to help them in difficult areas and to deliver immunization in children. However these and other similar interventions through vertical programs will only be effective if district health systems are strengthened and improved. Though national health programs have their advantages – mainly in terms of quickly rolling out essential services - they must be devolved to provincial/district level to assure their eventual sustainability via ownership at local level. Their integration into minimal essential health package could serve such a purpose providing an opportunity for community involvement, contribution, participation and oversight.

Response

The federal health ministry will work with the provincial health authorities to agree on a national package of essential services for primary care outlets as well as an outline for more comprehensive packages for higher levels of care, primarily focusing on preventive care, maternal and child health, and nutrition. These will define the types of curative, preventive and promotion services to be provided nationally and the appropriate staffing levels, skills mix, and adequate resources to deliver them at the prescribed standards. The defined services will also outline pathways for referral and handling of emergencies. Emergency Obstetric and Neonatal (EmONC), Integrated Management of Neonatal and Childhood Illnesses (IMNCI) and family planning services will be priority areas for health facilities. A costing exercise will be conducted to estimate the resources needed to implement these services. The Federal Health Ministry will support the provincial and district governments in monitoring its implementation for effectiveness.

Existing and proposed health interventions activities and in particular the national health program services will be reintegrated into the national package of basic PHC services provided and delivered by the district primary care outlets. Community level health services will be provided via the extension or outreach

services from BHUs and RHCs. This will promote better planning for and coordination of health services provision and delivery, more effective deployment and use of resources, and accountability for verifiable health outputs and outcomes.

The provision and delivery of these PHC services will be carried out by a reliable, performance-oriented and committed health workforce, and an adequate supply of essential medicines, equipment and supplies. The services provided by BHUs or RHCs must gain the trust of communities by ensuring community participation in their governance and by removing all barriers to access. Defining standards of care in the package will also ensure the quality of services by allowing standardized monitoring.

Priority actions

Pakistan federal and provincial health authorities will develop and implement a nationally agreed package of essential services for primary care outlets including outreach services, referral and emergencies. This minimum essential care package would set the basis for standards of care, human resource requirement, appropriate health technology, financial outlays, essential drug lists and will also form the basis for public private partnerships in health sector.

Pakistan federal and provincial health authorities will integrate complementary health intervention activities into the package of health care services provided and delivered by primary care outlets at district level. This may also be utilized in mainstreaming the alternative systems of care being practiced in the country, such as the Unani, Ayurvedic and Homeopathic systems.

Provincial health authorities will, according to the national package, ensure appropriate staffing of the BHUs and RHCs, sufficient operational resources to deliver the services, and adequate provision of essential medicines and medical supplies.

Pakistan has a large private health care sector and network of clinical laboratories which are largely unregulated. The federal ministry in collaboration with provincial health departments will conduct surveys to develop a deeper insight into this area and the federal ministry will create a model for regulations in the Islamabad Capital Territory which could then be replicated by the provincial authorities. A separate establishment is envisioned to undertake this vital function.

Federal Ministry of Health will ensure development of a system for monitoring quality of services and facility accreditations, in collaboration with the Pakistan National Accreditation Council (PNAC), in order to create a model which could then be adopted by provinces.

2. Human Resource Development and Management

Challenges

Human Resource in health care is not appropriately planned in Pakistan, with the result that there are more doctors than nurses, dearth of trained midwives, urban concentration, brain drain from rural to urban areas and abroad, along with other issues related to curriculum, quality of graduates and their continuing supervision. The service structure for health workers is poorly defined it, favors tenure over competence, largely ignores technical capacities and does not allow incentives or rewards for performance.

The conduct of education for medical, nursing and related cadres is mostly conventional and does not utilize recent developments in the field of medical education. Though curricula have been revised from time to time, in majority of cases they are not locally contextualized and are not based on competencies and skills. There is no organized system for continuing medical education for any health providers who are also largely unsupervised and at times ill equipped with newer knowledge/skills to tackle emerging diseases. This holds true for management cadres as well.

The types and quanta of services delivered by a primary health care facility currently depend solely on the number and categories of health providers present at that facility. The main reason cited for a non-functional BHU is almost always the absence of a doctor. Consequently providers deliver the types and standards of services that are most beneficial to them and not necessarily the types and standards of services required of them, or of the facility, or demanded by the patient/client's health conditions.

The health system is currently not conducive to nurses, midwives and allied health professionals playing pivotal roles in ensuring the provision and delivery of effective primary health care services in the absence of doctors. Health authorities have yet to be convinced that PHC services can be successfully provided and delivered by nurses, midwives and allied health professionals making up local teams with the relevant staffing complement and skills mix.

Response

The national and provincial authorities will comprehensively plan and forecast their human resource requirement for next 10 years according to the proposed services in the respective areas and take robust short term and long term steps to achieve the balance in manpower. Medical and allied health education would be gradually tailored according to local needs i.e. primarily focused on the delivery of primary care services, training in the community settings and a shift to competency based curriculum.

The government recognizes the need for specialist care and will encourage more post graduations in relevant fields particularly for nursing graduates. There is a requirement of establishing departments of family medicines and medical education in each teaching institution. Incentives will be used to boost performance, to address "brain drain" and for rural placement of essential health personnel. Linkages will be encouraged between teaching hospitals and district health services all across the country to boost the quality of services provided at district facilities.

Provincial health authorities will adapt the national package of essential health services to specify the relevant staff complement and the appropriate skills mix. The provision and delivery of services in a BHU would not necessarily rely on the presence of a medical doctor but will address staffing needs with innovative solutions including the use of "physician expanders".

Provincial health authorities will develop, implement and maintain a database of health human resource, available health staff and at a minimum those staff operating in the BHUs and RHCs across the province. In addition to being used for promotion, posting and transfers, this database should contain data relating to nurses, midwives and allied health professionals trained using government stipends that can be used to identify potential regional staffing.

Federal and provincial health authorities will initiate nationwide campaigns to promote the permanent roles that nurses, midwives and allied health professionals may play in providing and delivering effective PHC

services to the public. The campaigns will also be aimed at encouraging female health workers to join their local BHU or RHC. The campaigns should also encourage communities to come forward and propose local professionals whom the community trusts and considers worthy of being a staff member of the local BHU or RHC.

A national Nursing Policy and national Human Resource for Health Policy will follow this document.

Priority actions

Federal and Provincial Health authorities will forecast human resource needs based on requirements outlined in essential health services package and provincial strategies.

Federal and Provincial health authorities will direct and facilitate the teaching institutions in reorienting their curricula and training to being competency-based with enhanced exposure to the community and with responsiveness to the local needs and compliance with international standards. A system of continuing medical education for specialists, primary care physicians and other health personnel will be developed and implemented and this system will link performance to retention of registration of the provider in their specialty.

To improve rural health care services, each district will be linked to a teaching institution so that the latter can provide technical support and supervision to the former. All medical graduates will be recommended to be posted to rural centers for a period of at least 6 months after graduation. The Pakistan Medical and Dental Council will ensure that those undergoing post graduate training also rotate through district health centers.

Provincial health authorities will appoint and retain relevant cadres of appropriate health personnel with special focus on staffing district primary care outlets and on recruiting women.

Provincial health departments will track human resources for health by establishing a database of doctors, nurses, midwives and allied health professionals working in the BHUs and RHCs across each province and those in training funded by the government.

3. Generate reliable health information to manage and evaluate health services

Challenges

Health information systems currently in use in Pakistan are fragmented and vertical. They either respond to and serve primarily the health programs that created them or are inaccurate. Consequently health indicator data may collated through various systems and may be duplicated, sometimes with conflicting results. In this environment, data generation is parochial and is manipulated to serve special interests and thereby compromising the robustness of the data collation systems, discouraging data sharing or exchange and losing trust of stakeholders. The Health Management Information System (HMIS) of the 1990s covered primarily PHC facilities and the OPD of THQ hospital. It is still in use but is due to be replaced with the District Health Information System (DHIS) which has been upgraded to also include hospitals.

Inaccurate and unreliable data continue to limit their use for planning for and monitoring and evaluation of health services provision and delivery. At the service delivery points such data may be crucial for the day-to-day management of health services. Data are seldom useable unless they are analyzed and converted to information that is targeted at the needs of its user. This information may then be utilized as evidence for

decision making. This capacity needs to be built at district, provincial and federal levels. District managers seldom have adequate capacity to analyze and utilize the local information appropriately. This is further compromised by the use of unreliable data regarding services provided or about disease burden.

Response

Federal and provincial health authorities will agree on common approaches to institute national health information systems that standardize the collection, collation and analysis of routine health information data across Pakistan. They will ensure that the information system of various national programs will be reviewed, rationalized and integrated and the resulting combined systems be established and made operational within an agreed timeframe not delaying past 2010. The federal government will initiate a national integrated disease surveillance system in the hepatitis program as a model to be followed for other diseases and conditions.

Federal and provincial health authorities will ensure that the DHIS is implemented and made operational by 2010. They will ensure that rules and regulations be developed and implemented to protect the sanctity of data entered into or exported from the DHIS.

From 2010 onwards, federal and provincial health authorities will require health authorities to carry out health planning and reporting of monitoring of health programs based on the use and analysis of health data provided by the DHIS.

Priority actions

Federal and provincial health authorities will make the DHIS operational by 2010. This will include integration of all national programs as well as non communicable conditions. A national Health Information Resource Center is envisioned for this purpose.

Federal and provincial health authorities will establish data flow protocols and facilitate the use of appropriate technologies for increasing the efficiency of the information system.

Federal, Provincial and district capacity to utilize the information for evidence based decision making will be enhanced appropriately.

Federal and provincial health authorities will require that health plans to be funded by government and reports of health programs and monitoring and evaluation that is funded and considered by the government would be based on the use and analysis of data provided by the DHIS.

4. Adopt appropriate health technology to deliver quality services

Challenges

Health facilities across Pakistan are variable in the way that they are built, set up and equipped. The infrastructure often suffers from a not fit-for-purpose building, limited utilities such as water, electricity, waste management and building/ground maintenance. Lack of appropriate, relevant and functional medical equipment further limit performance. Unsafe blood transfusions and poor laboratory standards are also a challenge. New or additional medical equipment are repeatedly requested without a mechanism for asset management leading to misuse or disrepair of such equipment.

The national package of essential services will identify the type and quantum of equipment needed to deliver the defined services for a specific health facility. The provision of such equipment would require the facility to deliver the services that such equipment was intended for. In the case where a particular service is not or could not be delivered the corresponding equipment would also be deleted. The provision of equipment would also require the facility to maintain verifiable asset registration and maintenance with an identified proportion of the budget allocated for equipment routine maintenance, repairs and consumables. Medical and non-medical equipment has a finite working life. Health facilities delivering health care services using outdated and/or non-fully functional equipment are compromising service quality and patient safety.

Medical supplies, diagnostics, drugs and biologicals are also considered appropriate technologies. These too will be defined in the essential service package. The current mechanisms to determine the appropriateness of supplies, diagnostics, medicine and biologicals are not evidence based. There is a requirement to develop the capacity at federal, provincial and district levels to be able to carry out technology assessments and base decisions on relevant evidence about use of technologies. This capacity needs to be coupled with relevant regulations, in place, for effective implementation.

Response

The government recognizes that health care, clinical laboratories, pharmaceutical and medical device regulations are essentially required to be in place for effective implementation in public and private sector. A pharmaceutical and medical device policy is in the offing which will also address regulation of Unani, Ayurvedic and Homeopathic medicines. The policy will be compliant to international obligations. .

Provincial health authorities will be requested to provide the recommended set of equipment and other health technologies for a health facility may it be primary care outlet or higher level facility, in accordance with the national package of essential health services. To improve the health facility management, development of Biomedical Engineering discipline will be encouraged and health facilities will be provided with Biomedical maintenance cover. Provincial health authorities will be required to replace medical equipment at the end of their working life to assure service quality and patient safety.

In order to build capacity for evaluation of technology based on evidence, health technology assessment cells at federal and provincial levels are required and will be established.

Priority actions

The federal and provincial governments will ensure that appropriate regulations are in place for control of drugs, devices, diagnostics and biological across the country ensuring quality and patient safety.

Provincial health authorities will provide the required health technologies including drugs, diagnostics, equipment and biologicals to facilities according to the recommendations in the national package of essential health services and ensure continuous supply/replacement of each item to assure service quality and patient safety. A National Blood Transfusion Authority will be established to ensure safe transfusion services.

Health technology cells will be established at federal and provincial levels to carry out assessments for appropriate drugs, devices, biological and supplies and the provincial health authorities will provide these to facilities in accordance with the recommendations in the national package of essential health services and

ensure continuous supply/replacement of each item to assure service quality and patient safety. Security of contraceptive commodity supply for outreach health workers will be assured and diffusion of birth spacing programs through health outlets would be encouraged by introduction of new technologies such as newer injectables and implants.

5. Enhancement of health budgets and provision of social safety nets

Challenges

The overall health spending in Pakistan is very low level even when compared with other low income countries. The total annual health expenditures are Rs. 186 billion (USD 3.1 billion or nearly USD 19 per capita) or about 1.9% of the national GDP (The National Health Accounts of Pakistan 2005). Of these the government spends nearly Rs. 60 billion (0.6% of the GDP, USD 6 per capita), while much of the remainder are out of pocket payments by citizens at points of care. These latter payments are mostly for curative care and over 80% of all health spending goes for treatments and only 16% for prevention services (Towards a Health Sector Strategy, World Bank 1998). This disproportion in spending hides the fact that the proportion of household income that is spent on health increases with poverty; with poorer households spending more on health. Health expenditures also account for 52% of all catastrophic spending by households in Pakistan (Household Income and Expenditure Survey of Pakistan, 2005), depicting the inequity of how health is paid for. Finally, donor funding is around Rs. 3.6 billion (USD 60 million annually or USD 0.4 per capita) annually and accounts for about 2% of national health spending. The official donor assistance that is allocated to health is around 8%. At these levels, Pakistan lags other low income countries where donor assistance averages about 14% of health spending. Regionally, around 22% of health funds in Bangladesh are contributed by donors.

The WHO suggests that governments in developing countries spend about 1.4% of their GDP on health. This allocation should ensure a basic essential package of health services, which in a developing country should cost USD 25-50 per capita at 2000 prices. This means that the Government of Pakistan must at least double to triple its health funding in the near term to achieve the minimum against internationally acceptable standards of health care.

Health care financing may also provide a social security net for poor citizens. A number of modalities have been suggested to achieve this goal. Different modalities of health insurance and subsidies have been suggested as have payments to poor citizens for availing services (cash transfers). With a few and limited exceptions in the private sector, none of these are being implemented in Pakistan.

Response

Federal and provincial governments will standardize the per capita cost of providing and delivering a basic package of primary care services to its citizens and use this as a basis for health budget forecasts and allocation.

Federal and provincial governments will develop joint strategies aimed at enhancing Official Development Assistance (ODA) funding and will coordinate the expenditure of external (ODA) resources to minimize duplication and wastage. They will monitor and evaluate the performance of the ODA and indigenously funded health interventions and programs to elicit maximum gains and to minimize waste and pilferage. Funding from government and external sources should be integrated and accountable for the purpose of services delivery and the performance of such dually funded programs be evaluated as discrete entities irrespective of their funding configuration.

By providing a basic set of essential health services, the government will free up disposable income for households that they can apply to their other needs. In this way the government will provide some degree of social security to poor Pakistanis while staying within the current implementation framework for health care delivery.

Priority Actions

Federal and provincial governments will allocate budgets for health on the basis of per capita costs as determined by costing out the delivery of a nationally contextualized package of primary health care services.

Federal and provincial governments will jointly decide on the types and levels of funding for health care services to feed into the development of financing schemes that will ensure equitable access to health care services by the poor and vulnerable citizens.

Federal and provincial governments will account for the output and financial performance of health programs as discrete entities irrespective of their funding configuration.

6. Governance and Accountability

Challenges

Health care services in Pakistan are available from public and private providers, but the types, quantum and quality of services do not always meet people's needs. The provision of essential health services remains the responsibility of government but the reforms envisioned under the National Health Policy of 2001 which focused almost entirely on the public sector, did not produce improved health outcomes. Delivery of those services is increasingly being delegated to the non-governmental organizations and private providers as a strategy to improve the effectiveness and efficiency of services.

However, the assessments of various delivery models piloted in Sindh and Punjab have yet to be fully evaluated or understood. Schemes like the People's Primary Healthcare Initiative (PPHI) have shown some positive results towards improving health of ordinary citizens. Increasing involvement of groups that are not primarily working for profit may be a possible future strategy.

Outsourcing management of health service (contracting out) at various levels to non state entities is a possible innovative solution that has been successfully applied around the world. When applied correctly, usually with the government in a monitoring and the contractor in an implementation role it has allowed for more effective programs and for improved governance. A further innovation may be the use of supply (such as paying for performance) and demand side incentives to enhance quality of services provided or to improve coverage of services. All of these innovations are contingent upon the presence of a strong monitoring and evaluation framework at every tier of the health system strengthening programs to achieve the above objective.

Over the years, the government has ceased to be the principal provider of essential health care. In this respect, the most recent data (Pakistan Social and Living Measures 2005) credibly show that when people are sick, they increasingly turn to the private sector for medical care. While this may be acceptable in principle, the market for health related services in Pakistan is completely unregulated. Regulating private health sector and providing appropriate incentives is need of the hour. Without adequate regulation and in the absence of appropriate incentives the private health sector is unlikely to make health care provision more efficient.

External influences and patronage do play a significant role in influencing the agenda for health policy, administration and health services delivery down to the lowest level health facility in our country. The federal and provincial health authorities must rebuild their stewardship of the health system through professional independent advice for technical governance of health services, planning, provision and delivery.

Though government is sensitive to the larger agenda of research and development in health sciences in general, research on health systems in specific must be prioritized. This and other health related areas are to be outlined in the upcoming national strategy for research for health and will enhance the quality of evidence available to improve the health of the nation. Once the strategy is finalized it is imperative that the government provide facilitation, resources and ownership for such efforts.

Response

Federal and provincial health administration will jointly review their respective constitutional and legislative roles and responsibilities with respect to health care services provision and delivery with a view to defining national approaches to govern the health system. A concerted effort to strengthen the health systems at district, provincial and federal level will be undertaken particularly for undertaking robust monitoring and evaluation activities. This will also include an institutional effort to facilitate research and development activities.

Federal and provincial health authorities will jointly assess and evaluate the various models piloted across Pakistan to recommend viable and expandable schemes that can be implemented in response to this national health policy. Federal and provincial governments will jointly consider approaches that would insulate and isolate health care services provision and delivery from undue influences to ensure equitable access to health care services by every Pakistani.

Priority actions

Federal and provincial health governments will assist their health administration in developing national approaches to govern the provision and delivery of health care services across Pakistan.

Federal and provincial health authorities will, on the basis of their assessment of the piloted models, recommend to the government sustainable systems to ensure effective provision and delivery of health care services to all Pakistanis.

Federal and provincial governments will assist their health authorities to undertake public service reform to enable them to provide and deliver health services professionally in an atmosphere free of political interference and be more accountable to the communities they are serving.

Government's Commitments to Pakistanis

The National Health Policy of Pakistan of 2009 seeks to improve the health of the nation. Despite global financial constraints, national economic down turn and inefficiencies of the health system, the policy will harness existing resources to reduce the burden of disease in Pakistan and overcome barriers to access to health care for the very poor. It will do so by defining and delivering a set of basic health services for all by optimizing available funds use, improving health manpower, gathering and using reliable health information to guide program effectiveness and design by strategic use of emerging technology. To achieve these objectives the policy will be guided by the Poverty Reduction Strategy Paper and Pakistan's international commitments such as to the Millennium Development Goals.