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Review Article

A Critical Review of Historical, Political, Economic, Social and Global Influences on Health Sector Reforms in Pakistan

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ABSTRACT:

Background: This paper analyzed historical, political, economic, social and global influences on the health sector reforms in Pakistan.

Material & Methods

The article is based on a critical analysis of secondary data from the public domain as well as from international development agencies. It also draws from scholarly articles about the experiences of health sector reforms carried out in other countries.

Results

Historically, ever since the independence of Pakistan, the actual power remained in the hands of elite class, therefore, no meaningful reforms were introduced in the basic socio-political structure of the Pakistani society. Financially, due to high debt burden and the huge military expenditure, the state is shifting its traditional responsibility of providing health services to its masses to the private sector leading to further marginalization of poor and the disadvantaged. Furthermore, social issues such as rapid population growth, unplanned urbanization and emergence of mega cities are putting further pressure on already constrained resources and infrastructure and therefore are a reason and future challenge for health sector reforms in Pakistan.

Conclusions

Two important conclusions can be drawn. One, any reform introduced for the improvement of health status of Pakistani population to succeed, needs to consider the complex socio-political structure of the society. Second, all the historical, political, economic, social, and global factors discussed in this paper reinforces the need for major health sector reforms in Pakistan and it also demonstrates the constraints that the system must overcome in order to initiate any meaningful change.

KEYWORDS:

Health sector reforms; socio-political factors; Developing countries; Pakistan

1 | INTRODUCTION

Pakistan is a federal republic, sometimes known as the Islamic Republic of Pakistan. It came into existence on August 14, 1947, as a result of the division of the former British India. Pakistan's territory include the provinces of Balochistan, Khyber Pakhtunkhwa, Punjab, Sindh, Islamabad Capital Territory (the Federal Capital), and the two administrative regions of Azad Kashmir and Gilgit-Baltistan. It is home to around 241.5 million people and covers an area of 881,913 square kilometres. Aside from the federal and provincial levels of government, the 166 districts in Pakistan are the lowest tier of governance. (Election Commission of Pakistan 2024). [1]

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1.1 | The Health Situation in Pakistan

While people's health in Pakistan has improved over the last few decades, the pace of improvement has not been deemed adequate. Despite the fact that Pakistan's GNP per capita is higher than the norm for low-income nations, the country still falls far behind in several areas. Many factors contribute to Pakistan's poor health performance, including poverty, low education levels, low women's status, lack of clean drinking water in all sectors. 2-3 The problems in the health sector include structural fragmentation, gender insensitivity, resource scarcity, inefficiency, a lack of accessibility and utilization, 4 and a shortage of qualified health human resources, particularly nurses, technologists, pharmacists, and health managers and administrators. [5] Health sector reform is not a notion with a single worldwide definition or any prerequisite for it. [6] The reform agenda is decided by an assessment of existing policies, institutions, structures, and processes, and it addresses concerns such as access, efficiency, cost containment, and population demand. The proportional relevance of these concerns differs between developed, developing, and transitional countries. [7]

Reform often refers to good change, but health sector reform entails more than simply improving health and health care.[8] In 1995, the Harvard School of Public Health's Data for Decision Making (DDM) initiative defined health sector reform as ‘sustained, purposeful, and fundamental transformation'. It is ‘sustained' because it will not be a one-time temporary effort but will result in long-term benefits; 'purposeful' because it will emerge from a rational, planned, and evidence-based process; and 'fundamental' because it will address significant, strategic dimensions of health systems. [8] William Hsiao defines a set of 'control knobs' (finance, payment, organization, regulation, and customer behavior) that determine the major processes and consequences of a health-care system. [9] According to this framework, the primary goal of health reforms is to establish, configure, or alter the control knobs. According to Berman and Bossart, [8] using the aforementioned framework, health sector reforms can be further separated into more fundamental and strategic improvements, known as 'Big R' reforms, and those that are more limited, partial, or incremental, known as 'Little R' reforms. It is also advocated that 'Big R' reforms include at least two of Hsiao's control knobs in initiatives affecting a large section of the health-care system. The 'Little R' reforms affect only one control knob with a limited scope for change. For example, starting a new health insurance system or significantly expanding an existing one can be referred to as 'Big R' reform because it will require significant changes in financing, regulation, and delivery. On the other side, imposing user fees or giving teaching hospitals more autonomy are examples of 'Little R' reforms. Health is intricately linked to realities. Given the foregoing, the purpose of this article is to examine the historical, political, economic, social, and global effects on Pakistan's health-care changes.

2 | MATERIAL AND METHODS

This work is based on a critical review of secondary sources. The majority of the data are available in special studies and annual reports prepared by government departments and international organizations such as the Asian Development Bank, World Health Organization, World Bank, United Nations Children's Fund (UNICEF), and United Nations Development Programme (UNDP). Scholarly literature on health-care reforms in other countries, as well as pertinent reports from national governments and research institutes, were also used.

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3 | RESULTS

3.1 | Historical Influences

The broader institutions of the economy and society are closely intertwined with the health care system and its associated services. [10] Issues outside of health care often have an impact on health care. Foreigners have influenced the health care system in nations that are ruled by foreign powers.

3.2 | Pre-Independence

Pakistan's present health care system, like that of many former colonies, is influenced by the one that British colonial authorities set up in British India (Indo-pak subcontinent) before/during WWII in 1947. Early in sixteenth century East India firm, a trading company, the British colonization of India lasted until 1947, when India and Pakistan gained their independence. [11] According to Zaidi (1994), [10] "every aspect of Indian life, including medical and public health services, was subordinated to the commercial, political, and administrative interests of the imperial government in London.". Over time, educational and medical facilities that had previously been exclusive to outsiders were accessible to the local elite who had been co-opted as administrators.

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Before long, a considerable number of local professionals with British training emerged and worked closely with British officials. When the colonies acquired their independence, this elite group of experts was set up to take over. This was achieved in the health system by creating the prestigious Indian Medical Service (IMS) under British rule and ignoring indigenous/traditional medicine. [11,12] They thereby ensured that elite medical experts remained to rely on them, which allowed them to maintain considerable control over the nation's health systems when colonial rule ended. [11] But according to Zaidi, [10] the British gave the local elite control over civil, military, administrative, and educational services in addition to medical services. They consequently left behind societies that had been drastically altered by this experience, and they continued to have strong social, cultural, political, and educational ties to their previous masters in spite of their apparent freedom.

3.3 | Post-Independence

The policies of their colonial predecessors were upheld by the new government after gaining independence. The only change was in administration, when local officials replaced foreigners, but otherwise, colonial-era health organizations and institutions continued to dominate society. It is reasonable to say that the previous pattern is still in place and that, despite independence, the health-care system has not changed substantially. [12] Pakistan currently has a health care system with the following important features because of its post-colonial experiences and its decision to follow the capitalist path of modernization and development without considering the growth of the social sector. [13]

• There are several issues as a result of the existing health care system's emphasis on curative care at the expense of primary and preventative care.
• Inequitable across social classes and geographical areas.
• Urban and hospital-based.
• Focused on doctors; there are more doctors than other support staff.
• There is no attention on community or preventative care in the medical education system, which instead emphasizes surgical and medical expertise.

Because of this curative bias, there is a heavy reliance on pharmaceuticals supplied by foreign multinational pharmaceutical companies, who have the market power to affect prices and health policy. [14] Because of this historical neglect of social services, particularly health care, the government implemented health reforms, the outcome of which remains unknown.

3.4 | Political Influences

3.4.1 | Pakistan, The Elitist State

Industrialist, bureaucracy got lands and hild actual power. [16] Pakistan's political history shows that the country's fundamental sociopolitical structure has not changed since British administration, even though several civilian and military governments have occasionally held powerstatus quo remained even any party remain in power.. This is because the elite class has always held the majority of the real power. Dr. Ishrat Hussain, [16] a former governor of the State Bank of Pakistan, asserts that Pakistan is actually an elitist state. As a result, Pakistan has not seen any significant reforms, and the established upper class has consistently thwarted attempts to impose change.

3.4.2 | Capitalist Model of Development

Another key political issue that has influenced the implementation of any serious reforms is that, like most other third-world nations, Pakistan adopted a capitalist economic model of development shortly after its independence. [13] The premise that faster prosperity would automatically reduce poverty through a trickle-down effect is not supported by Pakistan's recent experience. Instead, there has been an increasing disparity between the wealthy and the impoverished. As a result of these politically motivated economic measures, around 73.6 percent of people live below the poverty level (based on a $2 per day criterion) (Alam, 2007). [17] According to Dr. Ishrat Hussain, [16] It is increasingly evident that the advantages of economic expansion have not been distributed equitably. The results have not been encouraging, despite the government's use of decentralization and poverty-targeted initiatives to distribute benefits.

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3.4.3 | Role of Medical Professionals in Health Policy-Making

Unlike in affluent countries, medical experts have not played an appropriate role in health policymaking in Pakistan. Although professional groups such as the Pakistan Medical Association (PMA), Young Doctors Association (YDA), and Provincial Doctors. Association (PDA) exist (Only in Khyber Pakhtunkhwa province), they appear to play a minor role in health policymaking. One cause for this is Pakistan's centralized planning system, which does not involve much contact with medical specialists. 18 Although no formal research has been conducted on this topic, the popular perception is that the private health sector is unregulated, with health professionals holding major stakes in private clinics, hospitals, high-tech diagnostics, and even private medical schools and pharmaceutical companies. Given these enormous stakes, they are least interested in working with and confronting the government to implement serious health changes in Pakistan. These political-economic structural concerns not only require real reforms, but will also provide a hurdle to any current or future reform initiatives in Pakistan.

Table 1
Comparison of health spending across countries

Country	Health spending			Public spending on health			OOP share of health spending
	Per capita (US $)	Share of GDP	Per capita (US $)		Per capita (US $)	Share of GDP	Per capita (US $)
Afghanistan	67	11.8	7	Afghanistan	67	11.8	7
Bangladesh	36	2.3	7	Bangladesh	36	2.3	7
India	69	3.5	19	India	69	3.5	19
Myanmar	58	4.7	10	Myanmar	58	4.7	10
Nepal	48	5.6	12	Nepal	48	5.6	12
Pakistan	**45**	**2.9**	**14**	**97**	**3**	**-**	**60**
Sri Lanka	159	3.8	71	96	1	3	50

Source: The WHO Global Health Expenditure Database (GHED) 2017.

3.5 | Economic Influences

The most pressing issue for successive Pakistani governments is how to provide healthcare for the country's 241.5 million inhabitants, the majority of whom cannot afford the necessary treatment The long history of public underinvestment in health is one of the main problems facing Pakistan's healthcare system. [19,20] Pakistan's health spending per capita is poor, particularly in comparison to its neighbours in the region. In South Asia, the only country with lower health spending per capita is Bangladesh (Table 1). 21 Due to Pakistan's historically low levels of state health spending, the private sector now makes up 70% of all health spending and over 80% of the delivery of primary healthcare services, creating a situation where the private sector has a comparatively larger role in the larger healthcare system. 22 Pakistan's out-of-pocket (OOP) expenditures continue to be greater than those of most of its comparators due to a systemic over-reliance on the private sector for the delivery of health services and almost no risk pooling in public health spending (Table 1).21

3.6 | High Debt Burden

The large debt burden has been recognized as a key factor for health care changes in Pakistan, as well as in many other developing nations. 22 Pakistan's external debt was 34.4% of its GNP in 2022, up from 23.3% in 2015. In Bangladesh, this accounted for 20.3% of GNP in 2022, as it did 18.6% in 1996. Tanzania and Nigeria had total external debts of 40.5 percent and 21.4 percent of their GNP, respectively, in 2022, compared to 38.9 percent and 8.6 percent in 2015 (Table 2). 24 Some nations have such massive debt loads that interest payments take up a large portion of their budget, leaving little money for other social services like healthcare and education. For instance, Pakistan spends a large share of its budget on paying down its external debt. This debt burden severely limits developing countries' ability to finance crucial health services. As a result, governments in developing nations are attempting to delegate traditional health-care responsibilities to the private sector. As a result, in most developing nations, the private sector is becoming more involved in health care delivery.25

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Table 2
The debt burden - selected developing countries (2015 and 2022)

Country	Ext. Debt (% of GNP) 2015	Ext. Debt (% of GNP) 2022
Pakistan	**23.3**	**34.4**
Bangladesh	18.6	20.3
Tanzania	38.9	40.5
Nigeria	8.6	21.4
Cambodia	53.3	80.4
Tajikistan	52.5	55.3
Kenya	31.3	37.2
Nepal	16.8	22.3
Vietnam	36.0	37.7
Zambia	60.6	98.4

Source: World Bank 2024

3.6 | Increased Defence Spending

Another significant motivation for health-care reform in most developing nations, including Pakistan, is growing defence spending. Table 326 depicts public sector expenditure on health and defence in various low-income nations, which has been increasing and continues to do so now. Pakistan and India spend a lot of money on defence but very little on health. This historical neglect has resulted in low human development in many countries, as well as a deteriorating health-care system.

Table 3
Public expenditure on health and the military (as a % of GDP) - selected developing countries

Country	Health		Defence	
	2015	2021	2015	2021
Pakistan	**0.7**	**0.8**	**3.0**	**2.9**
Bangladesh	0.4	0.4	1.2	1.2
India	**0.9**	**1.1**	**2.3**	**2.2**
Nigeria	0.6	0.5	0.4	1
Sri Lanka	1.6	1.9	2.4	1.9
Zimbabwe	1.6	0.9	1.9	0.8
Egypt	1.6	1.7	1.7	1.1

Source: World Bank 2024

3.7 | Increasing Private Sector Role In Health Care

According to latest World Bank estimates, the private sector provides around 80% of overall health-care expenditures in Pakistan. 21 People are more inclined to pay for hospital services than to invest in initiatives that promote health and prevent disease because the private sector is more interested in building and running for-profit hospitals rather than investing in preventive health services. This transfer in health-care burden from the public to the private sector has a significant impact on primary health-care services. As a result, health is becoming more of a private item that can be traded as a commodity and will only be available to those who can afford it. Therefore, the burden on the underprivileged and impoverished is growing as a result of this privatization process. Furthermore, the rapidly developing private health industry is mainly uncontrolled. Although the private sector has never been reviewed, issues such as provider-driven overconsumption of health care, over prescription, and overuse of diagnostics are well documented. 5 Furthermore, concerns exist over the standard of care given by the private sector and the costs they demand, as there is no limit on provider fees in Pakistan. All of these are significant concerns with far-reaching repercussions for Pakistan's health-care reform efforts.

3.8 | Social Influences

The most important social problems that have exacerbated the need for health sector reform in Pakistan and the majority of other developing nations are population growth, unplanned urbanization, poverty, and environmental degradation. To bring about meaningful change, the system must also get over these challenges.

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3.9 | Population Growth

According to Islam and Tahir, 23 a number of emerging countries, particularly the larger ones, are experiencing population growth, which is expected to continue. As a result, their population is predicted to quadruple over the next fifty to sixty years, putting a pressure on already limited resources. According to the United Nations Population Fund (UNFPA) study, 27 the six greatest developing countries—India, Indonesia, Pakistan, Bangladesh, Nigeria, and Egypt—have a combined population of around 1.9 billion people in 2007, which makes up more than 29% of the world's total. The population of these nations is predicted to double in the next 50–60 years, with an average growth rate of 1.7%.27 A key element of Pakistan's upcoming health sector reform challenge is the country's rapidly growing population, which has placed a great deal of demand on the already scarce resources for the social sectors in general and health care in particular.

3.10 | Unplanned Urbanization

Unplanned urbanization is another significant socioeconomic issue that has prompted health-care reforms in Pakistan and many other emerging nations. According to World Bank estimates, low-income nations' urban populations have grown at a 3.7 percent annual rate over the last 30 years. The urban population in low-income nations grew from 18% in 1970 to 39% in 1991. 28 The nature of urbanization in these countries is the problem, not the fact that it exists in the first place. In contrast to affluent countries, urbanization is caused by rural poverty and deprivation rather than industry or economic expansion. People relocate to cities for better economic opportunities. Every year in rural areas, droughts, cyclones, and floods force the poorest people to migrate to the country's main cities. This rural-urban movement puts further strain on the cities' already limited resources and infrastructure. 28

3.11 | Global influences

Globalisation is a multidimensional process that includes economic, social, cultural, political, and technological components, 29 however, economic globalisation is the primary element and driving force of the globalisation process, and it has the greatest impact on health. Proponents of globalisation commonly believe that increased openness and integration with the global economy have resulted in more direct investment in poor countries, allowing these countries to spend more money on their people's health, resulting in overall health improvement.30 While this appears to be a very plausible scenario, it is not. According to many researchers, such as Cornia and Woodward et al., 29 poor countries are attempting to lower their import tariffs and export taxes in order to attract foreign investment, which has resulted in lower overall revenue levels, limiting these countries' ability to provide even basic health services to their populations. This is evident from the fact that while government spending on education fell from 3.43 percent of GDP to 3.25 percent, government spending on health in low-income nations stayed consistent at 1.12 percent in 1990 and 1.13 percent in 1996. 29

3.12 | Information/Communication Revolution

Another significant global phenomenon that has forced the implementation of health reforms in Pakistan is the information/communications revolution, which is continually boosting tertiary level and high-tech healthcare. Multichannel television rarely airs promotional programming for childhood immunization or safe drinking water. They do, however, emphasize the benefits of high-tech surgery as well as exotic medications such as Viagra. As a result, the communication revolution is once again directing the attention of developing countries' health systems to tertiary level treatment, which is more comprehensive than essential preventive health. 28

3.13 | Transfer of Health Human Resources

Globalization has resulted in an increase in the movement of health-care workers from impoverished to wealthy countries. One estimate has the proportion of economically engaged migrants who have migrated to industrialized nations who are 'highly skilled' at about 65 percent. 31 Because of this high rate of migration, poor countries are losing highly educated and competent individuals to rich ones. A significant proportion of these highly trained category comprises medical professions, whose loss will exacerbate the already compromised health systems of these countries' ability to provide fair health care to their citizens. Although there is scarcity of research in this area in Pakistan, it is widely assumed that the movement of skilled professionals abroad as well as to the private sector within the country has had a negative impact on the implementation of health-care reforms. [31]

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4 | CONCLUSION

Two important conclusions can be drawn from this review study. One, any reform introduced for the improvement of health status of Pakistani population to succeed, needs to consider the complex socio-political structure of the society. Second, the aforementioned historical, political, economic, social, and global elements both support the necessity for reforms in the health sector and highlight the obstacles that must be removed before any significant change can be implemented.

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