Health Policy 2001:

Health sector reform an

Dr Abdul Malik Kasi

Over the past 50 years, improvements in economic status, public health interventions, education, nutrition, medicine, water and sanitation and technology transfer have resulted in significant gains in health status of the population. The evidence is the improvements in health indicators such as life expectancy and child mortality.

Policies are framed to actualise the missions and visions of the leaderships, fundamental to the needs of the communications and peoples. The new health policy-2001 adopted a process that used the needed scientific rigour for such a product and enjoyed the political support at the highest level. Pakistan is committed to achieve the goal of "health for all"; to verbalise these commitment highest levels of government, the President himself provided the necessary direction and leadership. The policy was discussed with and agreed by all the provincial governors, and health ministers before its approval.

The development plans and policy initiatives undertaken by the government are being supported by the opinion leaders, public health professionals, as well as donors. During their recent visits to Pakistan, the Director General WHO, Regional Director EMRO WHO and Regional Director UNICEF have appreciated the efforts of the government in the health sector specially for eradication of Polio, improving accessibility of PHC services and involving communities for poverty alleviation.

The health policy 2001 provides an overall national vision for the health sector and has been formulated to ensure that "health sector investments are viewed as part of governments' poverty alleviation plans, primary and secondary sectors of health become the priority sectors, and good governance is the basis of overall reforms in health sector". The health policy 2001 is conversant with the confronting challenges and provides logical and rational pathways to reach the goal of health for all.

The vision of the health policy is to provide accessible and affordable health care focusing on promotive, preventive, and curative aspects. To realise the implementation of this vision, ten reform areas have been identified In the health policy 2001 where carefully designed interventions will be carried out to make our health system efficient and effective without a compromise on the principle of equity. The commitment of the government to improve the health sector in Pakistan is evident by the specifying areas, which shall have broad and far-reaching impact on the health system in the country.

The ten identified areas are: reducing widespread prevalence of communicable diseases; addressing inadequacies in primary/ secondary health care services; removing professional/ managerial deficiencies in the district health system; promoting greater gender equity; bridging basic nutrition gaps in the target population; correcting urban bias in health sector; creating mass awareness in public health matters; effecting improvements in drug sector, and capacity building for health policy monitoring.

Reducing communicable diseases

The communicable diseases are easily prevented by simple measures and identifying this the health policy focuses on such diseases to improve the health of the population. Despite successful child survival programmes in the yesteryears, the major burden of disease is still because of communicable diseases. Not all of this is a consequence of childhood illnesses; a significant proportion is a result of emerging and re-emerging infections such as HIV/AIDS and tuberculosis.

The childhood cluster of vaccine preventable diseases is a major challenge for a country of Pakistan's size and the logistic support is a key factor for the vaccination programme. Conclusive negotiations have been finalised with donor agencies to assure the continuous supply of vaccines and other supplies. Government has allocated required funds for needed infrastructure. Tested strategies have been chosen to implement these interventions, which are based on scientific knowledge, field experience, and realistic targets. The national Programme on 'Expanded Programme of Immunisation' (EPI) is being further expanded through introduction of Hepatitis-B vaccine. A national programme for immunising mothers against neonatal tetanus has been launched in 57 selected 'high-risk districts' of the country for next three years to improve the health of the women and children.

Inadequacies in health care services

To improve accessibility and enhance coverage, in the late 1970s and mid 1980s Pakistan constructed anetwork of primary health care facilities. As a result, Pakistan boasts an extensive infrastructure in the public health sector for the delivery of health care that encompasses a system of over 5000 Basic Health Units (BHUs) and over 650 Rural Health Centers (RHCs) in its rural areas. These primary care facilities are supported by almost 700 public sector hospitals, the majority of which are financed by the provincial health departments.

Despite such an elaborate network of BHUs and RHCs and the existing higher-level facilities in the country, primary health care activities have not brought about expected improvements in the health status, especially of rural population groups. The problem of accessibility of health services remains as such for a majority of the population. This problem has been recognised at the highest levels of government and the President has taken a personal interest and ordered to strengthen the primary and secondary health care institutions all over the country with a view to provision of health care to a majority of the population, which resides in the rural areas of the country.

The Ministry of Health has taken steps to alleviate this problem and the health policy 2001 addresses it with a new strategy. Accessibility will be improved by expanding the existing cadre of lady health workers to all communities. Trained lady health workers will be utilised to cover the un-served population at the primary level. This would ensure family planning and primary health care services at the doorstep of the population through an integrated community-based approach. Functional primary care facilities would be strengthened and tehsil headquarter and district headquarter hospitals would be fortified with curative and diagnostic equipment and needed staff to ensure that required preventive, emergency, and curative services are available in all districts. The primary and secondary health care institutions will receive enhanced funding from the public budget as well as be the priority for any future foreign assistance. To optimise the resources and improve utilisation a model referral system in selected districts of each province will be developed by 2002, which ultimately will be replicated countrywide by 2005

Removing managerial deficiencies

It is an open secret that our primary care facilities are underutilised. There are many reasons, which contribute to this outcome. Two important ones are absence of doctors and poor management skills of health managers. Under the new health policy, it will be mandatory for all medical officers and those specialists who are not in the medical schools to serve in the rural population for a minimum period of two years. Posting policy will ensure presence of doctors at primary and secondary levels in a district.

Medical graduates after completing their house job will have to be posted on vacant posts in primary and secondary facilities for a minimum period of one year. Medical graduates will be selected for such appointment in an order of priority involving, inter-alia, place of domicile and quota availed for entry to medical college. Medical graduates will receive only provisional registration from PMDC and will be eligible for permanent registration only after completing the mandatory period of rural medical service.

This scheme would be implemented thorough a transparent and competitive reward system. There would be guaranteed benefits for those who serve in rural areas and there would be clear disadvantages in career development for those who miss this opportunity.

sector reform and future vision

Dr Abdul Malik Kasi

greater gender equity; bridging basic nutrition gaps in the target population; correcting urban bias in health sector; creating mass awareness in public health matters; effecting improvements in drug sector, and capacity building for health policy monitoring.

Reducing communicable diseases

The communicable diseases are easily prevented by simple measures and identifying this the health policy focuses on such diseases to improve the health of the population. Despite successful child survival programmes in the yesteryears, the major burden of disease is still because of communicable diseases. Not all of this is a consequence of childhood illnesses; a significant proportion is a result of emerging and re-emerging infections such as HIV/AIDS and tuberculosis.

The childhood cluster of vaccine preventable diseases is a major challenge for a country of Pakistan's size and the logistic support is a key factor for the vaccination programme. Conclusive negotiations have been finalised with donor agencies to assure the continuous supply of vaccines and other supplies. Government has allocated required funds for needed infrastructure. Tested strategies have been chosen to implement these interventions, which are based on scientific knowledge, field experience, and realistic targets. The national Programme on 'Expanded Programme of Immunisation' (EPI) is being further expanded through introduction of Hepatitis-B vaccine. A national programme for immunising mothers against neonatal tetanus has been launched in 57 selected 'high-risk districts' of the country for next three years to improve the health of the women and children.

Inadequacies in health care services

To improve accessibility and enhance coverage, in the late 1970s and mid 1980s Pakistan constructed anetwork of primary health care facilities. As a result, Pakistan boasts an extensive infrastructure in the public health sector for the delivery of health care that encompasses a system of over 5000 Basic Health Units (BHUs) and over 650 Rural Health Centers (RHCs) in its rural areas. These primary care facilities are supported by almost 700 public sector hospitals, the majority of which are financed by the provincial health departments.

Despite such an elaborate network of BHUs and RHCs and the existing higher-level facilities in the country, primary health care activities have not brought about expected improvements in the health status, especially of rural population groups. The problem of accessibility of health services remains as such for a majority of the population. This problem has been recognised at and the President has taken a personal interest and ordered to strengthen the primary and secondary health care institutions all over the country with a view to provision of health care to a majority of the population, which resides in the rural areas of the country.

The Ministry of Health has taken steps to alleviate this problem and the health policy 2001 addresses it with a new strategy. Accessibility will be improved by expanding the existing cadre of lady health workers to all communities. Trained lady health workers will be utilised to cover the un-served population at the primary level. This would ensure family planning and primary health care services at the doorstep of the population through an integrated community-based approach. Functional primary care facilities would be strengthened and tehsil headquarter and district headquarter hospitals would be fortified with curative and diagnostic equipment and needed staff to ensure that required preventive, emergency, and curative services are available in all districts. The primary and secondary health care institutions will receive enhanced funding from the public budget as well as be the priority for any future foreign assistance. To optimise the resources and improve utilisation a model referral system in selected districts of each province will be developed by 2002, which ultimately will be replicated countrywide by 2005

Removing managerial deficiencies

It is an open secret that our primary care facilities are underutilised. There are many reasons, which contribute to this outcome. Two important ones are absence of doctors and poor management skills of health managers. Under the new health policy, it will be mandatory for all medical officers and those specialists who are not in the medical schools to serve in the rural population for a minimum period of two years. Posting policy will ensure presence of doctors at primary and secondary levels in a district.

Medical graduates after completing their house job will have to be posted on vacant posts in primary and secondary facilities for a minimum period of one year. Medical graduates will be selected for such appointment in an order of priority involving, inter-alia, place of domicile and quota availed for entry to medical college. Medical graduates will receive only provisional registration from PMDC and will be eligible for permanent registration only after completing the mandatory period of rural medical service.

This scheme would be implemented thorough a transparent and competitive reward system. There would be guaranteed benefits for those who serve in rural areas and there would be clear disadvantages in career development for those who miss this opportunity.

For example, for those specialists who are not in teaching institutions, minimum service of two years in rural medical service would be a requirement before they are considered for promotion from BPS-18 to BPS-19 and there shall not be any exception to this rule. Similarly, it will be a pre-requisite for a district health manager to have a masters degree either in public health or in health management and to keep them abreast about new management knowledge they will undergo compulsory in-service training in leadership skills, total quality management and analytical techniques.

Promoting gender equity

Despite high burden of women and children diseases in Pakistan, health sector is dominated by male health care providers. New health policy is designed to promote gender quality in health sector. A number of steps in this direction have been proposed. Number of female health workers, especially lady health workers will be increased to 100,000 by the year 2005. Under the women health project, 'women friendly hospitals' are being established in twenty districts with a focus on reproductive health needs. Focused reproductive health services to childbearing women through a life cycle approach will be provided at their doorsteps. This will ensure provision of Safe Motherhood facilities to the majority of mothers, thereby enhancing child survival rates. More job opportunities with improved career structure are going to be introduced for all cadres of female health workers.

Bridging basic nutrition gaps

Despite overall gains in the health status, a significant proportion of our society is mal/undernourished. Concrete steps will be taken to improve the present state of affairs. Vitamin A supplementation will be provided annually to all under five children along with OPV on national immuniaation days, provision of iodised salt will be ensured along with introduction of fortified flour and vegetable oil and vitamin-B and folic acid tables will be distributed to deserving persons, especially pregnant women.

Regulating the private sector

Quality of care in Pakistan, both in the public and private hospitals have been questioned both by providers and consumers as well as donors and opinion leaders. Quality assurance programs will be introduced in all hospitals, and at all diagnostic facilities. Medical education, particularly in private sector will be properly regulated to ensure the availability of a high trained and professional health care force in the country.

Health education campaigns

Prevalent illiteracy in the country, especially among the female and poor remains a barrier in implementation of public health interventions. Health education campaigns will be intensified with a specific target population in mind and with well thought out strategies. Specifically TV/radio authorities will be asked to air programmes dedicated to health and nutrition, in close collaboration of health and education ministries. Appropriate interpersonal skills training will be imparted to family health workers as well as under the family planning and primary health care training programmes.

This is the era of advocacy, marketing, and sharing resources. Greater participation of NGOs and civil society Organisations will be sought in mass awareness campaigns to enhance the dividends from the available technology and interventions.

Quality medicines

Equity remains a foremost parameter of the new health policy. Efforts would be made to ensure the availability of quality drugs at affordable price to all 'segments of society, especially to those who are poor and needy. The present regime is fully cognizant of the economic conditions of the poor and needy and all development plans, including the pharmaceutical industry are pro-poor, and client focused. The government is doing everything possible to ensure the affordable and quality medicines to the people of Pakistan, while observing the global marketing and trade obligations.

An example of such effort is that government has successfully negotiated a deal with the pharmaceutical industry for our national EPI programme, and the industry has agreed to voluntarily reduce 10% prices of Hepatitis-B vaccine compared to Market Retail Price (MRP). We are very pleased to declare that desite the much bigger economy of scale of Indian pharmaceutical industry, of those medicines, which are 'most frequently prescribed medicines' both in India and in Pakistan 65% are cheaper in Pakistan.

Formulation of policies is not an end in itself but it is a means towards a promising end/goal. The goal for the present regime is a happy, healthy, and prosperous nation. Formulation of a health policy is one of the positive steps in this direction. Efficient, culturally appropriate, effective, and affordable interventions and programs are a sine-non-qua for a sustainable health system. The Ministry of Health is fully aware of the responsibilities and would continue to ensure that it is a key partner in the poverty reduction focused country development. A policy analysis and reforms unit is being established in the Ministry of Health, which will monitor the accomplishments of health policy and provide direction for further reforms in health sector.

The writer is the Federal Minister for Health

Health Policy 2001:

Health sector reform ar

Dr Abdul Malik Kasi

Over the past 50 years, improvements in economic status, public health interventions, education, nutrition, medicine, water and sanitation and technology transfer have resulted in significant gains in health status of the population. The evidence is the improvements in health indicators such as life expectancy and child mortality.

Policies are framed to actualise the missions and visions of the leadership, fundamental to the needs of the communications and peoples. The new health policy-2001 adopted a process that used the needed scientific rigour for such a product and enjoyed the political support at the highest level. Pakistan is committed to achieve the goal of "health for all"; to verbalise these commitment highest levels of government, the President himself provided the necessary direction and leadership. The policy was discussed with and agreed by all the provincial governors, and health ministers before its approval.

The development plans and policy initiatives undertaken by the government are being supported by the opinion leaders, public health professionals, as well as donors. During their recent visits to Pakistan, the Director General WHO, Regional Director EMRO WHO and Regional Director UNICEF have appreciated the efforts of the government in the health sector specially for eradication of Polio, improving accessibility of PHC services and involving communities for poverty alleviation.

The health policy 2001 provides an overall national vision for the health sector and has been formulated to ensure that "health sector investments are viewed as part of governments' poverty alleviation plans, primary and secondary sectors of health become the priority sectors, and good governance is the basis of overall reforms in health sector". The health policy 2001 is conversant with the confronting challenges and provides logical and rational pathways to reach the goal of health for all.

The vision of the health policy is to provide accessible and affordable health care focusing on promotive, preventive, and curative aspects. To realise the implementation of this vision, ten reform areas have been identified In the health policy 2001 where carefully designed interventions will be carried out to make our health system efficient and effective without a compromise on the principle of equity. The commitment of the government to improve the health sector in Pakistan is evident by the specifying areas, which shall have broad and far-reaching impact on the health system in the country.

The ten identified areas are: reducing widespread prevalence of communicable diseases; addressing inadequacies in primary/ secondary health care services; removing professional/ managerial deficiencies in the district health system; promoting greater gender equity; bridging basic nutrition gaps in the target population; correcting urban bias in health sector; creating mass awareness in public health matters; effecting improvements in drug sector, and capacity building for health policy monitoring.

Reducing communicable diseases

The communicable diseases are easily prevented by simple measures and identifying this the health policy focuses on such diseases to improve the health of the population. Despite successful child survival programmes in the yesteryears, the major burden of disease is still because of communicable diseases. Not all of this is a consequence of childhood illnesses; a significant proportion is a result of emerging and re-emerging infections such as HIV/AIDS and tuberculosis.

The childhood cluster of vaccine preventable diseases is a major challenge for a country of Pakistan's size and the logistic support is a key factor for the vaccination programme. Conclusive negotiations have been finalised with donor agencies to assure the continuous supply of vaccines and other supplies. Government has allocated required funds for needed infrastructure. Tested strategies have been chosen to implement these interventions, which are based on scientific knowledge, field experience, and realistic targets. The national Programme on 'Expanded Programme of Immunisation' (EPI) is being further expanded through introduction of Hepatitis-B vaccine. A national programme for immunising mothers against neonatal tetanus has been launched in 57 selected 'high-risk districts' of the country for next three years to improve the health of the women and children.

Inadequacies in health care services

To improve accessibility and enhance coverage, in the late 1970s and mid 1980s Pakistan constructed anetwork of primary health care facilities. As a result, Pakistan boasts an extensive infrastructure in the public health sector for the delivery of health care that encompasses a system of over 5000 Basic Health Units (BHUs) and over 650 Rural Health Centers (RHCs) in its rural areas. These primary care facilities are supported by almost 700 public sector hospitals, the majority of which are financed by the provincial health departments.

Despite such an elaborate network of BHUs and RHCs and the existing higher-level facilities in the country, primary health care activities have not brought about expected improvements in the health status, especially of rural population groups. The problem of accessibility of health services remains as such for a majority of the population. This problem has been recognised at the highest levels of government and the President has taken a personal interest and ordered to strengthen the primary and secondary health care institutions all over the country with a view to provision of health care to a majority of the population, which resides in the rural areas of the country.

The Ministry of Health has taken steps to alleviate this problem and the health policy 2001 addresses it with a new strategy. Accessibility will be improved by expanding the existing cadre of lady health workers to all communities. Trained lady health workers will be utilised to cover the un-served population at the primary level. This would ensure family planning and primary health care services at the doorstep of the population through an integrated community-based approach. Functional primary care facilities would be strengthened and tehsil headquarter and district headquarter hospitals would be fortified with curative and diagnostic equipment and needed staff to ensure that required preventive, emergency, and curative services are available in all districts. The primary and secondary health care institutions will receive enhanced funding from the public budget as well as be the priority for any future foreign assistance. To optimise the resources and improve utilisation a model referral system in selected districts of each province will be developed by 2002, which ultimately will be replicated countrywide by 2005

Removing managerial deficiencies

It is an open secret that our primary care facilities are underutilised. There are many reasons which contribute to this outcome. Two important ones are absence of doctors and poor management skills of health managers. Under the new health policy, it will be mandatory for all medical officers and those specialists who are not in the medical schools to serve in the rural population for a minimum period of two years. Posting policy will ensure presence of doctors at primary and secondary levels in a district.

Medical graduates after completing their house job will have to be posted on vacant posts in primary and secondary facilities for a minimum period of one year. Medical graduates will be selected for such appointment in an order of priority involving, inter-alia, place of domicile and quota availed for entry to medical college. Medical graduates will receive only provisional registration from PMDC and will be eligible for permanent registration only after completing the mandatory period of rural medical service.

This scheme would be implemented thorough a transparent and competitive reward system. There would be guaranteed benefits for those who serve in rural areas and there would be clear disadvantage in career development for those

Health 14/08/01 F.P.

nd future vision

For example, for those specialists who are not in teaching institutions, minimum service of two years in rural medical service would be a requirement before they are considered for promotion from BPS-18 to BPS-19 and there shall not be any exception to this rule. Similarly, it will be a pre-requisite for a district health manager to have a masters degree either in public health or in health management and to keep them abreast about new management knowledge they will undergo compulsory in-service training in leadership skills, total quality management and analytical techniques.

Promoting gender equity

Despite high burden of women and children diseases in Pakistan, health sector is dominated by male health care providers. New health policy is designed to promote gender quality in health sector. A number of steps in this direction have been proposed. Number of female health workers, especially lady health workers will be increased to 100,000 by the year 2005. Under the women health project, 'women friendly hospitals' are being established in twenty districts with a focus on reproductive health needs. Focused reproductive health services to childbearing women through a life cycle approach will be provided at their doorsteps. This will ensure provision of Safe Motherhood facilities to the majority of mothers, thereby enhancing child survival rates. More job opportunities with improved career structure are going to be introduced for all cadres of female health workers.

Bridging basic nutrition gaps

Despite overall gains in the health status, a significant proportion of our society is mal/undernourished. Concrete steps will be taken to improve the present state of affairs. Vitamin A supplementation will be provided annually to all under five children along with OPV on national immuniaation days, provision of iodised salt will be ensured along with introduction of fortified flour and vegetable oil and vitamin-B and folic acid tables will be distributed to deserving persons, especially pregnant women.

Regulating the private sector

Quality of care in Pakistan, both in the public and private hospitals have been questioned both by providers and consumers as well as donors and opinion leaders. Quality assurance programs will be introduced in all hospitals, and at all diagnostic facilities. Medical education, particularly in private sector will be properly regulated to ensure the availability of a high trained and professional health care force in the country.

Health education campaigns

Prevalent illiteracy in the country, especially among the female and poor remains a barrier in implementation of public health interventions. Health education campaigns will be intensified with a specific target population in mind and with well thought out strategies. Specifically TV/radio authorities will be asked to air programmes dedicated to health and nutrition, in close collaboration of health and education ministries. Appropriate interpersonal skills training will be imparted to family health workers as well as under the family planning and primary health care training programmes.

This is the era of advocacy, marketing, and sharing resources. Greater participation of NGOs and civil society Organisations will be sought in mass awareness campaigns to enhance the dividends from the available technology and interventions.

Quality medicines

Equity remains a foremost parameter of the new health policy. Efforts would be made to ensure the availability of quality drugs at affordable price to all 'segments of society, especially to those who are poor and needy. The present regime is fully cognizant of the economic conditions of the poor and needy, and all development plans, including the pharmaceutical industry are pro-poor, and client focused. The government is doing everything possible to ensure the affordable and quality medicines to the people of Pakistan, while observing the global marketing and trade obligations.

An example of such effort is that government has successfully negotiated a deal with the pharmaceutical industry for our national EPI programme, and the industry has agreed to voluntarily reduce 10% prices of Hepatitis-B vaccine compared to Market Retail Price (MRP). We are very pleased to declare that despite the much bigger economy of scale of Indian pharmaceutical industry, of those medicines, which are 'most frequently prescribed medicines' both in India and in Pakistan 65% are cheaper in Pakistan.

Formulation of policies is not an end in itself but it is a means towards a promising end/goal. The goal for the present regime is a happy, healthy, and prosperous nation. Formulation of a health policy is one of the positive steps in this direction. Efficient, culturally appropriate, effective, and affordable interventions and programs are a sine-non-qua for a sustainable health system. The Ministry of Health is fully aware of the responsibilities and would continue to ensure that it is a key partner in the poverty reduction focused country development. A policy analysis and reforms unit is being established in the Ministry of Health, which will monitor the accomplishments of health policy and provide direction for further reforms in health sector.

The writer is the Federal Minister for Health

Health
Dawn
17-7-09

Healthcare challenges

Lt. Gen. (Retd) Prof. M. Afzal Najeeb

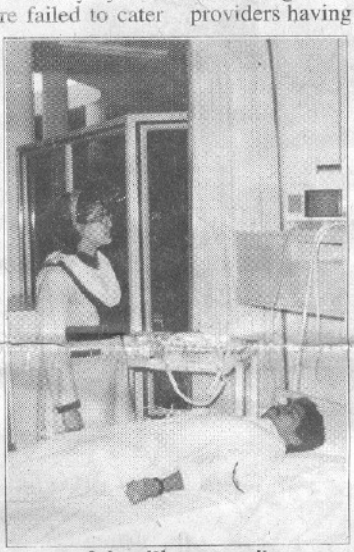
A comprehensive and sustainable national health policy (NHP) has eluded us for the past five decades and most of the time adhocism has been the basis of our health planning. The pre-partition Bhore Committee Report was followed in Pakistan as such and it took us over a decade to realise that the emerging realities of a new country demanded fresh thinking. The recommendations of innumerable conferences, commissions, task forces and projections of Health Division of Planing Commission in each Five year Plan were, however, at best only partially implemented for short periods by successive regimes.

The NHP, announced in 1998, did not address the real issues. It was in any case never implemented. The District Health Authorities established in some places in Punjab during the same period failed to alleviate the lot of indigent and deserving patients. The monitoring being carried out under the present regime has been meaningless and the health reforms envisaged under the District Devolution plan of the National Reconstruction Bureau have yet to be evaluated. A Health Insurance Scheme has recently been introduced after a gestation of two decades.

The reasons for this sate of affairs include political instability, economic constraints, lack of overall national direction, adhocism in planning, gross mismanagement and corruption. The social sector has been the worst casualty and health has been the lowest priority in our development plans.

Considerable growth in healthcare has inevitably taken place over the years both in the public and private sectors. A number of new hospitals, especially institutes, undergraduate medical colleges and postgraduate centres have been established, and the District Headquarters Hospitals have been upgraded along with mushrooming of private clinics/laboratories in big and small towns. However, all this has been unplanned and haphazard. The health delivery system (HDS) has therefore failed to cater for the minimum requirements of the fast multiplying population.

Seventy percent of our rural and fifty percent of the urban population does not get safe drinking water, and about 90 million are without elementary sanitation facilities and around 60 million lack access to basic health care. The ratings for health services in Pakistan, according to an international classification,



A healthcare unit

ble to the poor.

The latest attempt to regularise the private practices of healthcare professionals was bound to fail. It was ill-planned and did not provide any relief. It is already being tacitly withdrawn. There is widespread confusion among the decision-makers, the medical profession and the general public regarding the exact role and responsibilities of the state in the provision of healthcare.

Healthcare infrastructure development has been haphazard. A large number if BHUs have become ghost units. Highly expensive sophisticated bio-medical imported equipment has perished lying unutilised in stores. The sectoral development of preventive/curative and primary/secondary/tertiary care facilities has been uneven. The curative sector, especially the high tech centres, have been preferred at the cost of public health and primary care infrastructure. The Social Action Programmes have failed to achieve the desired objectives.

Prevention of disease and promotion of health are as important as curative health care. Extended programmes of immunization, anti-malaria campaigns, maternal and child health programmes and campaigns for the control of many communicable diseases have achieved varying degrees of success. However the national programmes for prevention of non-communicable diseases viz, diabetes, cardiovascular disorders and cancer affecting millions of people, have not been properly organised. Glamorous commercials on cigarettes are flashed on PTV with an insignificant warning at the bottom. The hazards of environmental pollution to the health of the nation have yet to be fully appreciated.

The private sector mostly for profit started over-taking in healthcare during the last couple of decades. It is now providing major share of primary as well as tertiary health care. There are more Labs and MRI units in the private than in the public sector. Foreign commercial healthcare providers having run out of patients in their own countries are looking for patients in the developing countries. However the private sector like the public sector has been ill-planned and there is no regulatory control over its quality, profit margins and ethical standards.

The multinationals pharmaceutical companies are having a bonanza in Pakistan by selling drugs at 4-5 times the price being charged by them in India and Bangla-

point a dismal picture, eighty nine percent of preventive and promotive services are insufficient or worse, while on the curative side 82 percent of primary, 86 percent of secondary and 77 percent of tertiary care is poor or insufficient.

Pakistan has the distinction of ranking around 100th in the world in Human Resource Development in general. According to the World Bank Book of Social indicators of development for the developing countries Pakistan is short of doctors for its present population. The shortage of specialists, nurses, dentists and medical technologists is even more acute. The situation shall be worse in 2020, when our population is likely to double.

The main factors influencing a person's health is income, lifestyle, environmental pollution, occupational risks and the quality of available healthcare. Healthcare is a basic human requirement to raise life expectancy, reduce the burden of disease and disability, increase productivity and improve the quality of life. Pakistan like other developing countries has the double burden of rampant communicable diseases and the fast increasing non-communicable diseases. However, a third dimension has recently been added to this scenario.

"Chronic Conditions" – a new definition for persistent infectious diseases like TB and HIV/AIDS as well as traditional non-communicable diseases including cardiovascular diseases, diabetes, cancer, asthma, mental disorders and ongoing structural/physical impairments, has been recognised as an entity by the WHO. The rise in Chronic Conditions is a global phenomenon due to aging of the population and Pakistan too is having this additional burden to contend with.

The Government was the biggest overall provider of secondary and tertiary healthcare, with a major contribution of general practitioners in primary care. However there has been a drift towards partial funding of public sector healthcare facilities over the years. No government could make a policy declaration of its inability to provide healthcare, but privatisation of tertiary care institutions like JPMC, NICVD, PIMS, NICH, NIH as well as basic healthcare units (BHUs) has been under active consideration of the Government for a long time.

In the meantime service/user charges were gradually increased. The recently made autonomous hospitals are required to raise funds from zakat/donations and more so by marketing their facilities to the affording patients. The cost of treatment for the poor has risen and these hospitals have become increasingly inaccessi-

India and Bangladesh. They have a monopoly on sixty percent of the drug market amounting to approximately Rs 30 billion per year. The total number of drugs registered in Pakistan is a staggering figure and many of them are substandard, harmful or useless.

The over-all quality of medical education under graduate and post graduate- has unfortunately declined. The Pakistan Medical and Dental Council, Nursing Council and the College of Physicians and Surgeons which set the standards, have failed to fulfil their mandates. It may be pertinent to note that the autonomy granted in the Punjab was specific to the hospitals making no mention of any reforms in the essential component of the complex viz, the affiliated colleges.

None of the public sector institutions have acquired University status so far while in the meantime a number of medical universities have been established in the private sector. There has also been a mushrooming of medical and dental colleges some of them are substandard and a few outrightly spurious. Research which is the lifeblood for development in any scientific discipline has suffered from utter neglect. The Pakistan Medical Research Council gets an annual grant which is 40 times less than what is given to its counterpart in India.

There are several alternative/complementary systems of medicine prevalent in Pakistan. They provide cheap service at the doorstep in rural areas but lack quality control. Attempts to integrate them in the national HDS have not been fruitful. Quackery is still flourishing with a large body of quacks distributed all over the country. They were registered in the eighties mainly for considerations other than professional.

Health remains a concurrent subject between the Federation and the Provinces, the arrangement gives rise to duplication apart from delays due to red-tapism at two levels. Not infrequently disparate signals emanate from the Federal Ministry and four provincial Departments of Health. A proposal to establish a medical Education Authority and a Medical Licensing Board in Punjab has been on the anvil for some time and the Sindh Government is asking for restructuring of PMDC with most of its functions to be delegated to proposed provincial bodies.

There is hegemonic bureaucratic control in planning and administration of health care with only marginal involvement of the professionals. Medical managers and administrators are not given due recognition and there are insufficient facilities/incentives for training in these specialties.