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The Impact of Economic and Socio-cultural Context upon Health Policy Outcome in Pakistan

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Abstract

The analysis of economic and socio-cultural context is an important component of health policy analysis because contextual factors significantly influence the health policy process and the overall health of population. Such an analysis also helps in understanding the health policy process and its success. This article presents an analysis of economic and socio-cultural contextual factors in Pakistan and their impact upon the health policy process in the country. The study used secondary data in order to analyze health policy context in the country. The main findings are that in spite of its reasonable economic growth Pakistan allocates minimum resources to health sector in order to combat increasing health problems and improve quality of life. The country also experiences the low status of women in the society, a low literacy level and high corruption. It is concluded that economic and socio-cultural context in the country significantly influence resource allocation for health policy and its implementation and therefore affect the health status of the people in Pakistan.

Keywords: Health Policy Context Analysis: Health Outcomes, Pakistan.

Introduction

Analysis of economic and socio-cultural context analysis is an important component of health policy analysis because contextual factors significantly influence the health policy process and the overall health of population directly and indirectly (Frenk, 1995; Gonzalez, 1997; Walt and Gilson, 1994; WHO, 1998). Paying attention to contextual factors helps in understanding the role of the state, society and market forces influencing health agenda building, health planning and implementation, and even more important health outcomes (Collins et al., 1999; Hinebusch, 1993; Toye, 1993; Walt & Gilson, 1994; Wismar & Busse, 2002). Contextual factors can be categorized as political, economic, socio-cultural and demographic. This article focuses upon the impact of the economic and socio-cultural context on health policy outcome in Pakistan, since these factors are considered most relevant in developing countries.

In developing countries economic factors, such as the distribution of wealth, production, distribution and consumption processes, income, housing, and employment, significantly influence the health of the population. Many health policies and programs are doomed to fail because of the lack of resources (Perkins & Roemer, 1991; Toye, 1993). The problem of scarce resources also implies the existence of great differences in the access to health care between the rich and the poor and the presence of a well-developed private system that serves only the rich (Abbasi, 1999a; Bhutta, 2001; Green et al, 2001; Hjortsberg & Mwikisa, 2002). The poor must resort either to the government-paid sector of the health care system that is often badly equipped and performs poorly in term of quality of care or to the private healers who render health services of very questionable quality (Abbasi, 1999b; Islam & Tahir, 2002; Khan & Bhutta, 2001). The consequences for life expectancy and mortality between groups may be enormous.

Economic and socio-cultural factors affect the health policy environment, and influence the socio-political behavior of the people and the flow of resources for health development (de Leeuw, 1999; Hasan, 1999; Johansson et al., 2001). Many studies report clear relationships between health and culture, explaining the links (positive or negative) between various lifestyles and people's attitudes to participate in the health policy process (Hasan, 1999; Mooney, 1994). Similarly, poverty, illiteracy, and low status of specific groups (women, minorities,

and ethnic groups) in the society have been identified as contributing factors to the high mortality and morbidity in developing countries (Green et al, 2001; Hjortsberg & Mwikisa, 2002; Khan & Bhutta, 2001). The problem of corruption in the developing countries also makes health policies ineffective. Several organizations including the World Bank, the International Monetary Fund (IMF), and Transparency International have highlighted corruption and its impact upon the policy process in developing countries (Zemenides et al., 1999). This article analyzes how the economic and socio-cultural factors affect the health policy process and the health status of the people in Pakistan.

Methods

This study used secondary data analysis in order to analyze economic and socio-cultural context in Pakistan. The analysis is based on the study of policy documents, financial reports and economic surveys focusing upon resource allocation and the execution of health policy in the country. Economic factors have been derived mostly from the annual budgets, financial reports and evaluation reports of the Ministry of Finance, Pakistan over the period 1995-2005. In some cases economic factors have also been found from the evaluation reports and surveys of the Ministry of Health. Furthermore, socio-cultural factors have been derived from evaluation reports of the Ministry of Health, Surveys of the Planning and Development Division, Pakistan and reports/surveys from the offices of the international agencies that have extended their support to develop health in Pakistan over the period 1995-2005. For health outcome reports of the Ministry of Health, international agencies, particularly the World Health Organization, the World Bank and UNICEF over the period of 1995-2005, were used. Besides the document analysis, interviews were conducted with the one hundred and fortyfour actors involved in the health policy process at various levels in Islamabad and provincial head quarters of the provinces (Karachi, Lahore, Peshawar and Quetta). These actors included politicians, health ministers (current and former), policy makers, civil servants, physicians, public heath professionals, health managers and representatives of health-related associations including Pakistan Medical Association and Pakistan Medical and Dental Council.

Economic Context

Pakistan's economy has gathered momentum during the last five years, particularly in the fiscal year 2004-05. Pakistan’s real GDP growth of 8.4 percent in 2004-05 positioned the country as the fastest growing economy after China. Acceleration in growth accompanied by a pick-up in industrial production and agriculture, an upsurge in investment, and strengthening of the external balance of payments have been the hallmarks of economic performance (Pakistan, 2005a). The country succeeded in attaining growth in real GDP, large-scale manufacturing, a better performance in services and growth in per capita income. Pakistan also experienced a strong rebound in investment: an increase in credit to the private sector; rising levels of economic activity; a reduction in the fiscal deficit; growth in exports; and a decline in the public and external debt burden (Pakistan, 2005a).

A disturbing feature of the economic context in Pakistan is a persistent dichotomy between a respectable rate of economic growth and only a marginal improvement in social indicators. The country has maintained an average growth rate of GDP of 6% during the past three decades. In an inter-country comparison, according to the data compiled by the IMF on the GDP growth rate, Pakistan performed better than most other developing countries in the Asian region (IMF, 2005) as shown in the Table 1.

Table 1. Growth Performance in the Asian Region (Real GDP Growth %)

Region / Country	2001-02	2002-03	2003-04	2004-05	Average
Afghanistan	-	4.1	5.5	7.5	5.4
Bangladesh	4.8	4.9	5.4	5.4	5.1
India	4.0	4.7	7.4	7.3	5.85
Indonesia	3.5	3.7	4.1	5.1	4.1
Iran	5.4	7.2	5.9	6.3	6.2
Malaysia	0.3	4.1	5.2	5.7	3.8
Pakistan	3.1	5.1	6.4	8.4	5.75
Sri Lanka	-1.5	3.9	5.5	5.2	3.3
Thailand	2.1	5.4	6.7	6.1	5.1

Source: CIA, 2005; IMF, 2005

In spite of its better economic performance and reasonable economic growth the country allocates minimal resources for health development. For example, the average share of the health sector in the national budgets during 1994-1997 was 0.8 percent of the total GDP (Pakistan, 2003). During 1998-2002 the share of health sector in the national budgets dropped to 0.7 percent and from 2003-2005 it fell further to 0.6 percent of the total GDP (Pakistan, 2003, 2005a). A governmental document stated that the government has committed itself to increasing health expenditures to 2 percent of the GDP by 2010 (Pakistan, 2004b). However, in June 2005, the government did not increase its health expenditure in the annual budget for 2005-06, maintaining 0.6 percent of the GDP for health sector as in the recent past (Pakistan, 2005b).

International organizations have commented that Pakistan falls in that category of countries where economic advances are being made but resources or policy deficiencies are blocking progress towards achieving several health and welfare goals (UNDP, 2002; 2004; WHO, 2003; Word Bank, 2004). In the inter-country comparison, according to the data compiled by the World Health Organization (WHO), governmental expenditure on health in the other developing countries in the Asian region are higher than in Pakistan as shown in the Table 2.

Table 2. Average Health Expenditures in the Asian Region (1999-2003)

Country	Per capita total expenditure on health average exchange rate (US$)	Total expenditure on health as % of gross domestic product
Afghanistan	9.2	6
Bangladesh	11	3.5
India	27.2	5.8
Indonesia	19.4	2.8
Iran	70.4	6.1
Malaysia	125.4	3.4
Pakistan	14	0.7
Sri Lanka	30.6	3.6
Thailand	75.2	3.8
Average	42.8	3.9

Source: Pakistan 2004a; WHO, 2005.

Table 2 shows that average per capita expenditure on health (average exchange rate in US$) in the Asian region is US$42.8 and total expenditure on health is 3.9% of GDP, whereas, in the case of Pakistan, the average per capita expenditure on health is US$14 and total expenditure on health is 0.7% of GDP. Table 2, shows that in Asian region Pakistan allocates minimum financial resources for the health sector in spite of its better economic position. This indicates that health development in Pakistan is not a priority. Such an unfavorable economic context of particularly low governmental expenditures for health has led to severe resource constraints for the health sector. As a consequence, health policy implementation is difficult and health projects suffer from delays in their preparation and successful implementation. The resource constraints also increase the dependency of the Ministry of Health on donors in implementing international health strategies and programs. For example, Pakistan has been highly dependent on donors for the implementation of vertical programs including Health for All (HFA) and Primary Health Programs (PHC). Donor dependence for these vertical programs prevents long-term health planning, creates uncertainties regarding the amount and flow of financial resources and disturbs implementation (Abbasi, 1999a; Bhutta, 2001a; Khan & Bhutta, 2001).

According to the United Nations Development Program (UNDP), Pakistan was 134th in the Human Development Index (HDI) in 2002, 138 in 2003 and 144 in 2004 (UNDP, 2002; 2003; 2004). The World Bank disclosed in its annual report for 2004 that Pakistan's economy has grown more than other low-income countries, its social sector growth in comparison has lagged (World Bank, 2004). Other developing countries in the Asian region have better health indicators than Pakistan despite their lower rate of economic growth (World Bank, 2005) as shown in the Table 3.

Table 3. Health Indicators in the Asian Region in 2005

Country	Life Expectancy	Infant Mortality Rate per 1000	Mortality Rate Under-five per 1000
Afghanistan	42.9	163	-
Bangladesh	62	46	69
India	63	63	87
Indonesia	67	31	41
Iran	69	30	41
Malaysia	73	7	7
Pakistan	64	74	98
Sri Lanka	74	13	15
Thailand	69	23	26
Average	68	35	47

Source: CIA, 2005; World Bank, 2005.

The Socio-Cultural Context

The socio-cultural context for health policy in Pakistan may be characterized by the low status of women, the low literacy level and corruption.

Low Status of Women

The constitution of Pakistan states that there will be no discrimination on the basis of gender. The government has also signed the Universal Declaration of Human Rights and ratified the Convention on the Elimination of all forms of discrimination. However, in practice, women in the country suffer from low status in the society, a suppressive attitude, various types of harassments, sexual assaults and domestic violence (HRCP, 2004). Male domination has become culturally sanctioned and gender-based subordination has become ingrained in the consciousness of both men and women in Pakistan. Pakistani society still attaches enormous importance to the well being of their male children while considering daughters to be a shameful burden (Wallerstein, 1998). The female economic activity rate is 36 per cent in the country, as compared to the South Asian average of 43 per cent (UNDP, 2004). As for the female participation in decision-making at every level, only 9 per cent of the administrators, senior officials and managers in Pakistan are women (UNDP, 2004).

Rapes, sexual assaults and domestic violence result in an increasing number of suicides, suicide attempts, and psychological problems among women in Pakistan (HRCP, 2004; Khan & Reza, 1998; WHO, 2002). Sexual violence and rapes mostly go unreported because of the socio-cultural stigma, the trauma associated with such violence and the complicated legal system. Rape in police custody is widespread but goes unreported and regulations protecting women are ignored with impunity (HRCP, 2004). Domestic violence results in many women dying or suffering permanent disabilities and severe injuries. There are repeated incidences of "stove burns" (suicidal and homicidal acts) and honor killings particularly in the rural areas (HRCP, 2004).

Gender discrimination in Pakistan leads to malnutrition among pregnant and lactating mothers and a higher child mortality rate for girls than for boys (Khan & Bhutta, 2001; Rehman et al, 2004; WHO, 2004). One woman in 38 dies during pregnancy or childbirth in Pakistan, compared with a regional average of one in 230. Up to 13% of these deaths are the result of unsafe abortions (Wallerstein, 1998). According to World Health Report 2004, the probability of dying (per 1000) among under five-year-olds is 105 in case of males and 115 in case of females (WHO, 2004).

According to several studies (Khan, 1996; Khan & Raza, 1998; Pakistan, 2005a), the low status of women in Pakistan hinders female participation in health development, results in high morbidity among women, and may lead to the implementation failure of immunization programs, women's health programs and family planning programs. Restrictions on the mobility of women to obtain access to health and social services, women's restricted decision-making power, and their incapability to negotiate with their partners for safer sexual practices contribute to women's HIV vulnerability (UNDP, 2004). According to United Nations Drug Control Program (UNDCP), the low status of women in Pakistan can lead to drug abuse and other health problems (UNDCP, 2002; 2003). As a consequence of the overall low status of women and particularly their low health status in the country, there is an unusual population ratio between men and women (women 48.1 % and men 51.9 %) (Pakistan, 2005a; UNDP, 2004).

Low Literacy Rate

Pakistan has a low literacy rate particularly among women. According to the Economic Survey of Pakistan, the literacy rate is 54 percent. However, the male literacy rate is estimated at

64 percent and female at 36 percent (Pakistan, 2005a). According to UNESCO, the adult literacy rate (15 and above) in Pakistan is 53.4 for males and 28.5 for females, which contrasts considerably with most other countries in the South Asian region. In Bangladesh male is 50.3 and female 31.4, in India male is 61.9 and female 35.9, in Iran male is 83.5 and female 70.4, in Nepal male is 61.6 and female 26.4 and in Sri Lanka male is 94.7 and female 89.6 as shown in Table 4 (UNESCO, 2005).

Table 4. Socio-cultural Indicators and GDP per capita in the Asian Region in 2005

Country	GDP per capita % growth	Literacy rate ≥ 15		Corruption Perceptions Index	
		Male	Female	Rate (1-145)	CPI-score (1-10)
Afghanistan	-	51	21	-	-
Bangladesh	3.5	50.3	31.4	145	1.5
India	6.4	61.9	26.4	90	2.8
Indonesia	2.8	92.5	83.4	133	2.0
Iran	4.4	83.5	70.4	87	2.9
Malaysia	3.2	92	85.4	39	5.0
Pakistan	3.3	50.3	28.5	129	2.1
Sri Lanka	4.3	94.7	89.6	67	3.5
Thailand	6.1	94.9	90.5	64	3.6
Average	4.22	76.6	62.1	95.2	2.9

Source: CIA, 2005; Transparency International, 2004; UNESCO, 2005; World Bank, 2005.

The low literacy rate in Pakistan particularly among women has been identified as one of the factors that disturb the implementation of various health programs and projects (Bhutta, 2001; Bhutta et al, 2003; Luby et al, 2004; Qazi, 2002). For example, it is one of the reasons why reproductive health programs could not achieve their targets (Bhutta et al, 2003; Luby et al, 2004). A low literacy rate particularly among women creates difficulties in creating awareness to prevent HIV/AIDS, activate participation and develop healthy lifestyles (Pakistan, 2005a; UNDCP, 2003; UNDP, 2005; USAID, 2005). Women's low literacy rate also disturbed immunization programs (Pakistan, 2005a). Pakistan's National Health Policy (NHP) 2001 intended to increase immunization coverage of children and mothers to 85 percent by 2003-04 and full coverage by 2010 (Pakistan, 2001). According to a governmental report, at June 2005 the expanded program of immunization had attained immunization coverage of 50 percent due to restrictions on the mobility of women to obtain access to health and their low level of literacy (Pakistan, 2005a). Gender disparities in educational enrolment and women's low literacy level present obstacles for HIV/AIDS prevention efforts in general; it is much harder to reach women than men with information (UNDP, 2005).

Corruption

Corruption is another economic and socio-cultural factor that affects health policy implementation in Pakistan. The Corruption Perceptions Index (CPI) 2004 of the Transparency International (TI) presents the level of corruption in the 145 countries of the world by indicating 10 as a highest clean score. Finland was rated top with the highest CPI score of 9.7 out of a clean score of 10 whereas Bangladesh was bottom with a CPI score of 1.5. Pakistan was ranked 129th with a CPI score of 2.1 as shown in the Table 3 (Transparency International, 2004).

Several international organizations, including the World Bank, the IMF, and Transparency International, have demonstrated their concern about corruption in Pakistan and its negative impact upon the development of the country (Khan, 2005; Zemenides et al., 1999).

The health sector is among the top six key sectors in Pakistan that are seriously affected by the corruption (Waxman, 2003). Numerous charges of corruption and misuse of public authority against civil servants working in health ministries, health managers and physicians appear in the press regularly. Factors responsible for corruptions in health sector include: weak judicial system, lack of accountability, low salaries, non-recognition of performance and lack of motivation particulraly among professionals working in rural areas (Khan 2005; Khan & Van den Heuvel, 2006; Zemendis et al, 1999). Health sytem is centralized that harrdly leaves a space for wider partricipation and health professionals working in the public sector do not feel themselves accountable for their performance to the people (Khan 2005; Khan & Van den Heuvel, 2006; Zemendis et al, 1999).

Corruption in the health sector significantly affects health policy implementation and health outcomes in various ways. For example, corrupt health officials working in the health ministries and hospitals purchase outdated medicines, accept bribes and kickbacks for purchasing low quality medical equipment and technologies, steal public equipment and medicines meant for poor patients (Khan 2005; Waxman, 2003). There are repeated complaints of bribery, misuse of resources (including ambulances), and sale of public equipment in government hospitals (Khan, 2005; Mwaffisi, 1999; Waxman, 2003). As a result the health sector loses its scarce resources and health policy implementation is distorted. There are complaints of doctors, nurses and other health professionals being absent from Rural Health Centers (RHCs) and Basic Health Units (BHUs).

Corruption has eroded the capacity of the health sector to ensure that other public policies and the activities of the other sectors are aligned to health development in the country. According to the reports of UNDCP and other studies, corruption negatively affects efforts to combat the drug abuse, violence and crime and road traffic accidents (Agha et al, 2003; Emmanuel et al., 2004; UNDCP, 2003). There are many illegal pharmaceutical factories operating in homes and backyards. They manufacture low standard medicines by using labels of established pharmaceutical firms (including international ones) and change the dates of the expired medicines (Khan, 2005; PDTL, 2005; Waxman, 2003). According to a report of Pakistan Drug Testing Laboratory (PDTL), about 91 medicines of 60 national and multinational manufacturers were found to be counterfeit and harmful. These counterfeit drugs included antibiotics, painkillers and drugs for ulcers, cancer, heart disease, tuberculosis, asthma, mental problems, and fever as well as pediatric drugs. The same report also revealed that about 90,000 people have died due to counterfeit drugs in the past five years (PDTL, 2005).

Conclusion

Economic and socio-cultural factors influence health policy process in various ways in Pakistan. The country has maintained a reasonable economic growth; however, its public health expenditures are low. This has led to resource constraints for health sector and results in health policy implementation failures. As a consequence the country has lagged behind in terms of its health indicators compared with many other developing countries, which are economically poorer than Pakistan. Suppressive attitude towards women leads to murders and

severe injuries of women. Gender discrimination hinders the participation of women in disease prevention and health promotion, which ultimately results in high morbidity, high child mortality and the failure of health policies and programs in the country. Corruption leads to low quality in the human resources for health, to the low quality of drugs and medicines and of the health services, and ultimately to implementation failures in health policies and programs. The low level of literacy particularly among women hampers awareness raising to prevent disease, to stimulate participation, to protect the environment, and to develop healthy lifestyles. It particularly disrupts immunization programs, family planning programs, and the health of mother and child in the country.

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