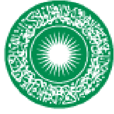

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Health Sector Reform in Pakistan: Future Directions

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Abstract

The health care system in Pakistan is beset with numerous problems - structural fragmentation, gender insensitivity, resource scarcity, inefficiency and lack of functional specificity and accessibility. Faced with a precarious economic situation characterized by heavy external debt and faltering productivity, Pakistan's room to maneuver with health sector reform is quite limited. Although the recently announced Devolut ion Plan provides a window of opportunity, it must go beyond and introduce far-reaching changes in the health and social sectors. Regionalization of health care seivices in an integrated manner with functional specificity for each level of care is an essential step. Integration of current vertical programs within the framework of a need-based comprehensive primary health care system is another necessary step. Most importantly, fostering a public-private partnership to share the cost of basic primary health care and public health services must be an integral part of any reform. Pakistan must also make the health care system more gender sensitive through appropriate training programs for the service providers along with wide community participation in decision-making processes. Relevant WHONVorld BankJUNDP developed tools could be extremely useful in this respect.

The article is based on a critical analysis of secondary data from the public domain as well as from various research projects undertaken by the Aga Khan University. it also draws from the experiences of health sector reform carried out in other countries, particulady those in the Asia-Pacific region. The purpose is to inform and hopefully influence, public policy as the country moves towards devolution (JPMA 52:1 74;2002).

Introduction

In an earlier article (JPMA January 2002), 1 tried to identify the demographic, epidemiological, economic and socio-political factors that underlie the need for fundamental health sector (HS) reform in Pakistan. It was noted that the recently announced Devolution Plan provides an opportunity t o carry out such reform. The overall goals of HS reform are to enhance efficiency of the health care system; to improve the quality of services; to protect or enhance equity; and/or to generate new resources for the system,[1,2]. In other words, it could involve many things -from financing and organization of service provision to the package of services to be offered[3]. Should HS reform in Pakistan involve all these dimensions? In other words, which goal (or goals) should receive priority?

The paper attempts to answer these questions. Many developing countries in Asia and Africa have, in recent years, initiated health sector reform. Particular relevance for Pakistan could be the experience of Asia-Pacific countries -Philippines, Thailand, South Korea and especially the ongoing reform exercise in Indonesia. The experience of the countries that failed to introduce meaningful reform could also be helpful. India, in this respect, is a case in point.

Methodology

The paper is based on critical review of secondary data. Most of the data are available in special studies and annual reports prepared by international agencies like the Asian Development Bank, World Health

Organization, the World Bank, the United Nations Children's Fund (UNICEF), and the United Nations Deveopment ÷rogram ÿUNDP). —cholarly articles on health sector reforms in other countries as well as relevant reports produced by national governments and research institutions have also been used, Information generated by a number of research studies conducted by the Aga Khan University, particularly the Community Health Sciences Department, has also been used. These studies are particularly aimed at developing integrated primary health care systems with a focus on maternal and child health and meaningful community participation.

Health Sector Reform: Purpose and Dimensions

The overall purpose of health sector reform is to improve the aggregate health status of the population. Broadly speaking, HS reform could involve many areas of the health care system including the package of services, the structure and organization of service delivery, financing, and consumer-provider relationship[4]. Although in order to avoid complexity, reform activities could conceivably focus on one particular area at a time, in practice it is difficult to neatly separate these rather interdependent areas. Moreover, HS reform, to be comprehensive, should encompass all these major areas. Nevertheless, two areas have received more attention here - structure and organization of health services delivery and consumer-provider relationship.

The Dev olution Plan: An Opportunity for Health Sector Reform

The National Reconstruction Bureau (NRB), set up soon after the military takeover in October 1999, announced the plan for devolution of power to elected governments at the district level throughout the country. The NRB found the existing system to be "colonial" in nature and perpetuating the "rural-urban divide". It concluded that the current "provincial bureaucratic set-ups are the designated 'controlling authorities' of the local governments and tend to undermine and over-ride them, which breeds a colonial relationship of 'ruler' and 'subject'. The separate local government structures engender rural-urban antagonism, while the administration's role as 'controlling authorities' accentuates the rural-urban divide[5].

The Devolution Plan is an answer to these "two structural and systemic disjoints". It is meant to introduce "one coherent structure in which the district administration and the police arc answerable to the elected chief executive of the district". Although local elections are being held in stages, the precise structural framework of the local government envisaged at the district level is yet to be fully spelled out. Nevertheless, NRB is emphatic in declaring that "The Local Government is based on five fundamentals: devolution of political power, decentralization of administrative authority, deconcentration of management functions, diffusion of the power-authority nexus, and distribution of resources to the district level. It is designed so that the genuine interests of the people are served and their rights safeguarded. The new system will create an enabling environment in which people can start participating in community welfare and be the masters of their own destiny"[5].

The Devolution Plan, it should be noted, has used four different terms to refer to the soon-to-be introduced governance system: devolution (political power), decentralization (administrative authority), deconcentration (management functions), and diffusion (power-authority nexus). These terms indicate different levels of decision-space to be accorded to different aspects of the new local government. While the intended decision-space (in the planned devolution exercise) is much wider in terms of political power, it is much narrower in the sphere of management functions[5]. These functional issues will definitely be further discussed and refined as the devolution process is implemented.

The devolution exercise, undoubtedly, will have significant implications for the health sector. It calls for the abrogation of the 'division' as an 'administrative tier' necessitating the abolition of the existing position of Divisional Director General of Health. The Plan creates a powerful position of District Coordination Officer (DCO) representing the provincial bureaucratic structure at the district level. Although the elected Zila Nazim will be the executive head of the district with some limited supervisory 'control' over the DCO (such as, premature transfer, performance appraisal), it is the DCO

who would oversee all government services at the district level. According to the Devolution Plan, health services to be delivered at the district level include: Public Health, Environment, Basic and Rural Health Units, Child and Women Health, and Population Welfare. The Medical Superintendent(s) of hospitals will also function under this office"[5].

It is apparent that the Devolution Plan will bring significant changes in the way health care services are managed and delivered at the district level. The Plan, therefore, presents a unique opportunity to usher in more comprehensive health sector reforms. Theoretically speaking, decentralization and/or devolution is expected to make the health care system more responsive to the needs of local population, facilitate mobilization of resources at the local level, and help ensure greater community participation[6]. It is also expected to make the system more oriented towards primary health care. The success or otherwise of the devolution plan in Pakistan must be assessed in reference to these generally accepted benefits of decentralization. It seems that in order to make the health care system more efficient, effective, equitable and sustainable, reform efforts in Pakistan must go beyond the parameters of the devolution plan.

Health Sector Reform in Pakistan: What needs to be done

(a) Paradigm Shift: From Providing Health Care to Producing Health

Pakistan, like many other countries, has traditionally emphasized the provision of health care services. Consequently, the focus is on curative care, both at the tertiary level and at the domain of primary health care. Not surprisingly, according to some estimates, Pakistan spends 85 percent of its health care budget on tertiary health care that is used by about 15 percent of the population. On the other hand, only 15 percent of the health care budget is spent on primary health care services that are used by 85 percent of the population[7]. Most of the primary health care funds are also earmarked for the provision of curative care through beds at the Rural Health Centres and/or Tehsil Fleadquarter Hospitals. Illness prevention and/or health promotion services, such as, antenatal care, immunization, and health education receive scant attention or funds. In short, the focus is on the provision of health care services. Since 1970s, there is a growing recognition that a signification proportion of disease and illness that afflicts us is a consequence of conscious behavioral choices that we make. The Lalonde Report in Canada, published in early 1970s, is perhaps the best example of a public study that eloquently emphasized this point. The Report, therefore, advocated shifting of resources from curative care to health promotion[8]. Smoking and drug use, for example, are conscious behavioral choices that have serious health consequences. Likewise, from obesity to cardiovascular diseases and diabetes - a number of health problems could be traced back to lack of physical exercise. Physical exercise, needless to say, is a behavior over which we have or could have complete control. Personal hygiene, to a great extent, is also a product of our behavioral choice. A health care system, to be efficient and effective, must place significant emphasis on influencing and positively changing these individual behavioral choices. At the same time, emphasis must be placed on the provision of sanitation, safe drinking water, and healthy environment. These two sets of factors, behavioral changes and safer environment, create a foundation for better health. In other words, the health sector in Pakistan is in need of a fundamental paradigm shift - from the provision of health care services to producing health.

(b) Regionalization of Health Care Services

A health care system must be sustainable -financially and organizationally - within a geographically specified region. It also must encompass a spectrum of services that meets the essential health care needs of the population. In short, with an emphasis on primary health care, the system must include appropriate secondary and tertiary levels of care. While the province must retain the overall responsibility for health services to its people, it should establish regions to decentralize the health care system. A region may consist of a number of districts with a population large enough to sustain an integrated health care system. A region shall contain a spectrum of health services, programs and facilities that are symbiotically and functionally related to form a rather independent 'system'. Given

the fact that the existing districts in Pakistan were created by the British colonial power as 'administrative units', they are unlikely to serve as regions as conceived here.

While the province would provide the broad policy guidelines, independent health boards should be responsible for the provision and management of health services within the regions. Initially, the provincial government could form the Regional Health Boards, composed of community leaders as well as professionals. In the long run, the people could democratically elect the members of these boards. Through legislation, the composition of the regional boards could be regulated to ensure representation from different segments of the population. The creation of regions with a relatively large population base would make it possible to develop a sustainable integrated health care system encompassing the entire spectrum of services. On the other hand, the creation of regional health boards would make the health care system independent of the government and bureaucratic inefficiency. While the regional health boards would receive public funds (from the provincial and federal governments) on the basis of a composite population-based formula, they should have the freedom, within broad policy guidelines, to generate new resources for health care, including user fees. Regions could also introduce appropriate social insurance schemes. While Canada (most provinces) and most of the Western European countries provide examples of successful regionalization of health care services, a large number of developing countries in Asia, Africa, and Latin America are also moving in this direction through a process of decentralization[9].

Regionalization and the creation of independent regional health boards also imply delegation of authority rather than simply decentralization (administrative) or devolution (political decentralization). The Regional Health Boards would be relatively autonomous parastatal entities with their own administrative structures. The federal and provincial governments would delegate the authority to the regional boards to provide a comprehensive spectrum of health care services through necessary legislative changes. However, due to practical limitations, most complex tertiary level care (for example, highly specialized surgical procedures, or medical services) could be concentrated in one (or few) regions. While the Boards provide services, governments (federal and provincial) retain the functions of setting broad policy guidelines, and of monitoring and evaluation. Public funding to these regional boards must be based on a complex formula that underscores the principle of equity and minimizes the risk of inter-regional disparity in terms of either the extent or the quality of services provided. The regional boards, it should be noted, would compete with each other for health human resources, particularly for qualified physicians, surgeons and administrators. In order to ensure a 'level-playing field' of competition among the regional health boards, the regions should not be too unequal in terms of such factors as population size, level of urbanization, and basic facilities. Each region, therefore, should be constituted in such a way that it contains a sizeable urban centre. The production of appropriate and adequate number of different kinds of health human resource, however, should remain outside the purview of the regions. Different levels of government and the private sector jointly perform this function. Likewise, the production of medicines and other health technologies remain with the private sector.

Compared to the planned devolution of health services to the district level local government, the proposed regionalization will have three advantages. Regions will have (i) a large enough population base to create a self-contained, integrated health care system comprising the full spectrum of services; (ii) independence from the government and, by extension, from bureaucratic inertia and inefficiency and needs and more representation.

(iii) greater responsiveness to local meaningful local community

In the context of Pakistan, the feasibility of having strong regional Boards, especially elected ones, can be seriously questioned. However, regionalization of health services itself can be effectively carried out. Elected Boards could emerge in the long run in response to community pressure. Perhaps a more interesting debate should take place on the range of services to be provided by the regional health Boards. In some countries, the provision of most basic public health services remain a responsibility of

the government; while regional Boards assume the responsibility for the provision of secondary and tertiary levels of care. New Zealand is an example in this regard. Following a "deconcentrated" model of decentralization, the Department of Health through its District Health Offices provides health protection and promotion services in New Zealand. Elected Hospital Boards provide secondary and tertiary health care services in New Zealand[10]. Following this model in Pakistan could be appealing. However, it runs the risk of fragmentation of health care services and, to some extent, duplication of efforts leading to inefficient use of scarce resources. With effective planning, policy guidelines, and monitoring and evaluation by the government, the regionalization of health care services (along with Regional Health l3oards) is a viable option for Pakistan. Regional Health Boards would also promote and help institutionalize the essential concept of provider accountability.

(c) Elimination of Structural Fragmentation

The public health care system in Pakistan currently suffers from serious structural ambiguity. For example, while provision of health care is primarily a provincial responsibility, the federal Ministry of Health administers the National Program on Family Planning and Primary Health Care. At the district level, the District Health Officer (DHO) represents the provincial government and provides leadership to the publicly funded healthcare system. On the other hand, a separate federal officer, the District Coordinator, looks after the National Program. The National Program, it should be emphasized, provides vital primary health care and family planning services at the village level through over 45,000 Lady Health Workers (LHW). In other words, the DHO enjoys no control over the provision of primary health care and family planning services. This structural fragmentation makes it difficult to coordinate health care services at the district level. It also frustrates the development of an integrated referral system encompassing all levels df service.

This structural fragmentation needs to be eliminated. A single office at the district level should exercise direct supervisory control over all types of primary health care and family planning services. Within the framework of the existing system, such a controlling office must be part of the provincial bureaucracy. The Indonesian health care system had also been suffering from structural fragmentation. At the district level, it had one health officer representing the central Ministry of Health, and another representing the provincial government. Each office had different functions; although most services were under the control of the province. Through its recently introduced devolution plan (1999) that took effect in January 2001, Indonesia is in the process of eliminating this structural fragmentation and making one office responsible for health care services at the district level11. Pakistan must also address this structural fragmentation and bring all health care services under the supervision of the DHO who is part of the provincial bureaucratic setup.

(d) Establishing Functional Specificity

Functional specificity of different service providers backed by an integrated and effective referral system is essential for system efficiency. For example, a hospital should provide secondary level care; it should not become a centre for primary health care services. Quite often, due to the inefficiency or inaccessibility of other elements of the health care system, people use the hospital for primary health care services. Lack of an effective referral system could also lead to such use (rather misuse) of different elements of the health care system. Such use, on the one hand, promotes inefficiency and, on the other, hinders the maturity of the underutilized part of the system.

In Pakistan, Basic Health Units (BHU) and Rural Health Clinics (RHC) are designed to provide a comprehensive array of primary health care services, including health protection and promotion services. The National Health Policy as well as other official proclamations emphasized the centrality of BHU and RHC in the provision of primary health care services throughout the country12. However, as the World Bank's and other reports indicate, BHUs and RHCs remain underutilized[7,13,] while people line up in secondary hospitals for basic primary health care services (these are also underutilized). Numerous factors are responsible for this state of affairs. Lack of appropriate and adequate resources -

both human (absence of trained health professionals, particularly women health professionals) and material (such as medicines, diagnostic tools) at the BHUs is perhaps the most critical factor. Quality of services and attitude of service providers are also particularly wanting.

Pakistan must make a concerted effort to improve the basic institutions for primary health care services. Appropriate (and adequate) human resources with a gender balance are perhaps the most important issue that needs to be addressed. Available facilities must also reflect the expressed health care needs of the population at large. Similarly, services and facilities at the secondary level hospitals (Tehsil Headquarter and District Headquarter Hospitals - THQs and DHQs) must also be improved so that they can perform their specific functions effectively. Restoring functional specificity to different levels of the health care system, therefore, should be part of the health sector reform strategy in Pakistan.

(e) Public-Private Partnership

The private health care sector in Pakistan is composed of physician-practitioners (more than 20,000 across the country primarily based in small clinics), maternity homes, dispensaries, diagnostic laboratories, and for-profit hospitals (usually of small size). There are also some large tertiary hospitals in the private sector, concentrated mostly in big cities. Numerous non-government organizations, funded through philanthropy or donor agencies, also provide various types of health care services. Pharmacies (more than 11,000) or other outlets selling drugs over-the-counter also form part of the private sector[7].

The private sector in Pakistan is largely unregulated in terms of standards of practice and quality of service. Most dangerous is perhaps the lack of regulations governing the qualifications of physicians that made it possible for anyone with rudimentary knowledge on medicine (working as an assistant in a clinic for a few years, for example) to practice medicine. Another serious problem is the lack of regulations governing over-the-counter sell of drugs. Any credible health sector reform must address these fundamental issues. Regulations and their strict enforcement are required. Similarly, there is a need to renew the legal framework guiding the traditional systems of medicine (primarily, the Unani system).

However, the health care system in Pakistan is beset with another phenomenon - increasing privatization. Due to their financial problems, governments in most developing countries are "downloading" health care services to the private sector. In Pakistan, the private sector accounts for 77% of the total health care expenses. Pakistan spends $17 per capita on health, and $13 of this amount comes from out-of-pocket expenses,[4]. In other words, the public sector contributes only 23% of the total expenditure on health. This private sector dominance of the health field has two implications. On the one hand, it raises the issue of equity: does it hinder the accessibility of the poor to the health care system? On the other, it demonstrates the fact that people do spend considerable amount on health and that there is a need to explore how these funds could be used more effectively.

In Pakistan, little attempt has ever been made to introduce social insurance for health care. Social insurance is limited to employees of the government, semiautonomous organizations, and members of the armed forces. There is no social insurance scheme in which people at large can participate. The amount of out-of-pocket money being spent on health clearly indicates that there is a strong possibility of successfully introducing social insurance in Pakistan. It will require a strong partnership with the private sector. In this respect, the experience of Thailand and Philippines could be useful. Thailand introduced a "Health Card11 program in 1983 in its rural areas as a model voluntary social insurance scheme. Initially, it was geared towards the provision of maternal and child health services. Under the scheme, participants would prepay a fixed premium and receive services for a year. Service providers render their services to the cardholder at an agreed on price, which may not always cover the cost of services provided. Likewise, the management of the funds receives a fixed percentage of the scheme's revenue to cover its cost. A village level committee would manage the funds collected. The scheme underwent numerous changes over the years and by early I 990s expanded its scope to cover unlimited

number of visits to physicians and facilities and medical cost coverage. Instead of a village, a District Health Coordinating Committee now administers the scheme at the district level. Enrollees can buy either a family card or an individual card. The prepaid premium varies according to the general economic status of the province in which the district is located. Coverage also varies from province to province. “Among the five provinces, Maha Sarakham had the highest percentage of coverage for the population in the participating areas (23 percent), followed by Rayong, Chiang Mai and Lampang,[15].
In’ 1972, like many other developing countries, Philippines established the Medicare Program, a compulsory insurance scheme for wage-sector employees. The Medicare Program covers inpatient charges as well as physician service charges incurred during hospitalization. However, unlike other countries, Philippines’ Medicare Program is managed by a government agency called the Philippine Medicare Commission (PMCC). The PMCC is almost completely self-financing, and receives very modest public subsidy. Currently, Medicare covers about 40% of the Philippine population[16].
Bangladesh also has at least two social insurance schemes for health care, one founded by the Ganashasthya Kendra or Peoples’ Health Centre (popularly known as GK), and the other by the internationally acclaimed Grameen Bank. GK started its health insurance scheme back in 1970s in a rural area about 40 km from the capital city of Dhaka. Subscribers receive not only primary health care, but also services from a secondary level referral hospital whenever needed. The Grameen Bank, on the other hand, introduced a health insurance scheme in 1990s in response to the demands of its fast growing clientele across rural Bangladesh. Its prepaid health plan provides subscribers access to door-to-door services by paramedics at the village level, to a Health Centre for ambulatory primary health care, and also to the services of a hospital within 30 to 50 km. Both these social insurance schemes are managed by the private sector, rather small in terms of population covered, and provider-driven[17].
Nevertheless, they represent genuine attempts at improving the accessibility of the poor to basic health care services. Thailand’s Health Card Program, the Philippines’ Medicare Program, and the health insurance schemes of the GK and of the Grameen Bank in Bangladesh are examples of innovative health financing mechanisms that need to be seriously reviewed and considered. These are also examples of successful public-private partnership. Pakistan, as part of its health sector reform strategy, should introduce a Health Card scheme that covers essential primary health care services and secondary level hospital care. The private sector, especially NGOs could play a leading role in this regard. The Regional Health Boards, suggested earlier, could also manage such a voluntary insurance scheme.

(f) Healthy Public Policy

Usually health is defined narrowly and, consequently, health related policies and programs are assumed to be the exclusive domain of the Ministry of Health. In recent decades, scholars have emphasized the inter-sectoral nature of health and the need for healthy public policies. It has been pointed out that policies in agriculture (e.g. on the use of fertilizers or pesticides), or in transportation (e.g. on the use of seat belt), or in housing, education, or industry have significant implications for human health. All policies, therefore, must take into account their impact on human health. Accountability for health, thus, is a prerequisite for any public policy across all sectors. In short, the goal is not simply policies for health, but for healthy public policy. “Healthy public policy is the policy challenge set by a new vision of public health. It refers to policy decisions in any sector or level of government that are characterized by an explicit concern for health and an accountability for health impact”[18].
Pakistan is yet to adopt such a holistic approach to health and healthy public policy. However, such an approach must be part of the overall health sector reform strategy. All departments at different levels of government must coordinate their policies in the context of their potential impact on human health. “An explicit concern for health and accountability for health impact” must become the essential foundation for all public policies in Pakistan. An interdepartmental committee could be formed for this purpose. It would be the task of the interdepartmental committee to review and assess public policies prior to their implementation.

(g) Engendering the Health Care System

The strong patriarchal nature of the Pakistani society is reflected in the women's health status. Women's health status in Pakistan is arguably worse than that of men. It has one of the highest maternal mortality rate among the countries with a similar per capital income. More women suffer from malnutrition than men do. Female literacy rate in Pakistan is one of the lowest in the world, showing a disastrously 2 percent in most of Balochistan - the most underdeveloped province in the country[19]. Violence against women, along with the practice of "honor killing" is widespread. The health care system in Pakistan has so far failed to effectively address these problems.

The health care system has few resources available for women. A recent survey found that only about 25 percent of the Rural Health Centres have qualified female health professionals available[13]. In 1994, the federal government launched the ambitious National Program on Family Planning and Primary Health Care (previously called the Prime Minister's Program). As part of this National Program, government promised to hire more than 100,000 Lady 1-Iealth Workers (LHW) to provide family planning and primary health care services at the village level. The target was to have one LHW for every 1,000 population by 1998 (that would require some 140,000 LHWs). However, as of June 2000, the National Program has recruited only about 45,000 Lady Health Workers - or about 45 percent of the target set for 1998 and only 32 percent of the need (as per 1/1000 ratio). LHWs, stationed at the village level, is often the only qualified health human resource available and accessible to women in rural areas. Needless to say, the shortage of LHWs is a critical problem.

In short, the gender bias of the health care system is painfully evident. Few managers or health policy makers are women; and appropriate and adequate services for women are painfully absent[7,19]. Women have little participation in the decision making process involving the health care system. The low socio-economic status of women and the overall conservative feudal character of the broader society reinforce the gender bias of the health care system. Although 38 of every 1000 women die prematurely during pregnancy or childbirth, the system hardly reacts to this challenge. No health sector reform in Pakistan would succeed without addressing this critical gender bias of the system.

A four-pronged approach needs to be adopted to effectively address this critical issue. First, concerted efforts should be made to recruit more women managers, administrators, and policy makers. A target should be set to have women occupy at least 40 percent of the top positions within the health care system by 2010 and reaching parity by the year 2020. Second, appropriate facilities and professional staff should be made available in all health centres. Priority should be placed on having emergency obstetric services available in all Rural Health Centres. Third, the two WHO/World Bank/UNDP developed training tools should be adopted to make all levels of health care providers sensitive to women's issues, on the one hand, and on the other, making women aware of their health needs and rights so that they could actively participate at the grass root level in articulating their demands. The two tools are the Health Workers for Change, and the Healthy Women Counseling Guide[20]. All professional, paramedic and frontline staff working within the health sector must undergo training using the tool "I-Iealth Workers for Change". This will make them and the healthcare system more sensitive to women's health issues, and improve the client-service provider relationship. This tool is geared towards making the service providers better understand the inherent gender bias of the system and in making them respect and appropriately respond to women's health needs. The "Healthy Women Counseling Guide" is an excellent tool that can be used to train underprivileged women better understand their health care needs and articulate them in order to demand better services from the healthcare system. Training in this tool raises the awareness of women and helps them participate in decisions affecting their lives. In other words, while the former tool makes the service providers better understand women's health needs, the latter makes women better articulate their demands and participate in the decision-making process. These two tools, in short, would engender the health care system in Pakistan. Massive training using these tools should be an essential part of any health sector

reform effort. Lastly, Pakistan must abolish all laws patently discriminatory to women and start strictly enforcing laws that could protect women against violence.

(h) Good Governance, Freedom and Development

No reform strategy could avoid the issue of good governance, which is perhaps, the biggest challenge facing Pakistan. Good governance is at the core of development and permeates all sectors of the social, economic, and political system. It involves, on the one hand, creating a system of governance that is efficient, transparent, and accountable, and on the other, democratic, giving people the freedom to participate in the political process. Transparency and accountability are essential ingredients of good governance as they are instrumental in preventing corruption - the anathema to good governance. Good governance, as the World Bank has emphasized, is central to sustainable and equitable development[21]. Defining corruption as the "abuse of public office for private gain[11], the World Bank also emphasized the critical need to create a corruption free society so as to ensure development[22].

Pakistan, historically speaking, failed to eliminate corruption or to introduce good governance. Corruption, for example, had been the root cause of failure and fall of successive governments in Pakistan since late 1960s. 1-lowever, their removal did not end corruption or created conditions for good governance. Corruption and poor governance continue to take a heavy toll. The state's failure "in all areas associated with good governance, sometime spectacularly", is at the heart of Pakistan's continued dismal record in terms of key development indicators across all sectors - education, social services, health, economic growth, and political freedom[23,24]. It is imperative that Pakistan makes a concerted effort to break out of this vicious cycle.

Following the Nobel Laureate Amrtya Sen[25], it can be forcefully argued that Pakistanis require political freedoms, economic facilities, social opportunities, transparency guarantees, and protective security to break this cycle of corruption and underdevelopment. Political freedoms include the right to "determine who should govern and on what principles", freedom of the press, and freedom of association, and of expressing dissent. Economic facilities "refer to the opportunities that individuals respectively enjoy to utilize economic resources for the purpose of consumption, or production, or exchange." Social opportunities, according to Amrtya Sen, "refer to the arrangements that society makes for education, health care, and so on, which influence the individual's substantive freedom to live better." Transparency guarantees "deal with the need for openness that people can expect: the freedom to deal with one another under guarantees of disclosure and lucidity." Transparency is instrumental in "preventing corruption, financial irresponsibility and underhand dealings." Protective security refers to the social safety net provided by the society that prevents "the affected population from being reduced to abject misery, and in some cases even starvation and death. The domain of protective security includes fixed institutional arrangements such as unemployment benefits and statutory income supplements to the indigent as well as ad hoc arrangements such as famine relief or emergency public employment to generate income for destitutes[25]."

Unadulterated democracy coupled with a credible investment in the social sector - in education, health, and the environment - are essential steps that Pakistan must follow. While democracy would provide the freedom of participation in the decision-making processes for the people at large, access to basic education and health care would provide them with the capability to participate in the economy as productive members of the society. In the context of Pakistan, human capability expansion would also mean the abolishment of all forms of bonded labor, along with societal guarantees of access to basic education and health care. In a comprehensive sense, good governance must incorporate these fundamental elements. Health sector reform or any other reform would fail to realize its full potential without a commitment to, and concrete actions toward, ensuring freedoms to citizens in all aspects. "The organizing principle that places all the different bits and pieces into an integrated whole is the overarching concern with the process of enhancing individual freedoms and the social commitment to help bring that about"[25]. Freedom, in this sense, is a means as well as an end of development. To quote

Amartya Sen, “development is indeed a momentous engagement with freedom’s possibilities”[25]. Pakistan must rise to this challenge.

Conclusion

Pakistan is in critical need of comprehensive health sector reform. The Devolution Plan, as announced, is clearly inadequate; however, it provides an opportunity to introduce far-reaching health sector reform. The paper outlines eight principles that could form the basis of such health sector reform in Pakistan.

So far as the health care system is concerned, Pakistan is in need of a fundamental paradigm shift - from provision of health care to producing health. Health protection and promotion through behavioral change and adequate environmental safeguards must receive priority. With a view to provide a larger population base that can sustain a full spectrum of health care services - from primary to tertiary levels of care - Pakistan could regionalize its health care system. A region would combine a number of districts giving it a larger population base. Moreover, in each region, an independent Regional Health Board, representing professionals as well as other segments of the population, would administer health care services. While initially the provincial government could nominate the Regional Health Boards, in the long run, they could be elected. The role of the government would be limited to financing the health services, providing broad policy guidelines, and monitoring and evaluation. In short, there would be a separation between the service provider (Regional Health Boards) and the service financier (government) which is likely to enhance the accountability of the system.

The existing structural fragmentation of the health care system needs to be eliminated so that all services could be placed within the purview of a single organizational framework. Likewise, functional specificity of different elements of the system should be reinforced. A public-private partnership for strengthening the health care system is also a critical issue need. The private sector, especially the NGOs, could take particular interest in initiating social insurance schemes for health services emulating the examples of Thailand, Philippines, and Bangladesh. Pakistan must adopt the principle of healthy public policy. An interdepartmental committee could be formed to ensure that an explicit concern for health and accountability for health impact become the essential foundation for all public policies in Pakistan.

Engendering the health care system must become one of the central focuses of any health sector reform in Pakistan. Along with more resources for women’s health, the health care system itself needs to be more gender sensitive. Comprehensive training for all health professionals and frontline service providers in the two relevant tools developed jointly by UNDP, World Bank, and WHO could be extremely useful in this respect. The system must also make women aware of their health needs, help them articulate their needs, and demand appropriate services.

Perhaps the most daunting task is to introduce good governance, the most fundamental prerequisite for any reform effort to succeed. Without fundamental freedoms -political, social, and economic - the people of Pakistan could hardly attain their full potential. Pakistanis require political freedoms, economic facilities, social opportunities, transparency guarantees, and protective security to break the cycle of corruption and underdevelopment. Unadulterated democracy coupled with a credible investment in the social sector is essential steps for Pakistan. Health sector reform would fail to realize its full potential without a commitment to and concrete actions toward ensuring freedoms for the people.

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