

## **On the Privatisation of Health Care in Pakistan**

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### **I. INTRODUCTION**

One of the manifestations of underdevelopment is malnutrition and unhygienic living conditions. These contribute to lowering productivity levels of labour thereby affecting both industrial and agricultural output. This gives rise to other problems such as unemployment, and underemployment which leads to falls in family income and a consequent decline in living standards. The cycle is then repeated.

However, till the early 1970s most LDCs did not give due weightage to the improvement of health conditions as they felt that resources would be better utilised in the directly productive sectors of the economy, for example, agriculture and industry to name two. However, the last twenty years has seen, through the basic needs approach, the role that health can play in promoting development. Expenditures in the health sector came to be seen as investments in human capital. The benefits of such investment became apparent from the improvement in the quality of human resources which was reflected by increases in productivity of the labour force as well as by increasing the length of the expected working life of labour. Thus the provision of better health facilities has a two-fold effect: first it increases the productivity of the existing labour force and, second it increases the quantity of human resources available in the future by increasing the length of working life. Keeping this in view, the Government of Pakistan's policy with regard to the provision of health can be summarised in a five-point agenda:

- (i) To provide effective, efficient and affordable health services to every citizen by the year 2000;
- (ii) a three-pronged strategy based on the prevention of disease the promotion of health and the provision of curative and rehabilitative services would be followed;
- (iii) complete coverage of the population for various immunisation programmes would be aimed at;

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- (iv) to encourage and promote the participation of individuals and communities in various health-related activities; and
- (v) such activities (point iv. above) would be integrated with the community and national development efforts.

Table 1 below gives a comparative picture of social indicators of selected developing countries in South and South East Asia. It can be seen that Pakistan's performance lags behind most of the other developing countries listed in the table. Only Nepal and Bangladesh have a record worse than that of Pakistan.

Table 1

*Social Indicators*

	Per Capita Income (\$ per Annum) (1990)*	Life Expect- ancy at Birth Rate (1990)*	Infant Mortality Rate (per 1000 Live) (1990)*	Crude Birth Rate (per 1000 Population) (1990)*	Crude Death Rate (per 1000 Population) (1990)*	Under Five Mortality Rate (per 1000 Born Alive) (1989)*
Iran	2490	63	88	45	9	64
Pakistan	380	56	103	42	12	162
Sri Lanka	470	71	19	20	6	36
Thailand	1420	66	27	22	7	35
China	370	70	29	22	7	43
India	350	59	92	30	11	145
Malaysia	2320	70	20	30	5	30
Philippines	730	64	41	29	7	72
Indonesia	570	62	61	26	9	100
Bangladesh	210	52	105	35	14	184
Nepal	170	52	121	40	14	193

Sources: \*World Development Report 1992.

\*\* Data taken from Table 34, Family Planning and Child Survival Programme as Assessed in 1991, The Population Council, New York (p.174).

Expenditure on health also is much less than what other countries spend. On average, Pakistan's expenditure on health has remained below 1 percent of the GNP<sup>1</sup>. For example Nepal, Bangladesh, Bhutan and Sri Lanka spend more on health than Pakistan. Central government expenditure in these countries on health is 4.8 percent for Nepal, 5.3 percent for Bhutan, 4.8 percent for Bangladesh and 5.4 percent for Sri Lanka. (*World Development Report, 1992*). The figures are for 1990. If we look at development expenditure as opposed to non-development expenditure then the amounts spent is substantially low in the case of Pakistan.

In fact, the national average expenditure on health is approximately Rs 80 per annum<sup>2</sup>.

<sup>1</sup>Government of Pakistan, *Economic Survey 1991-92*. Finance Division, Economic Advisor's Wing, Islamabad.

<sup>2</sup>Government of Pakistan, *Economic Survey 1991-92*. Finance Division, Economic Advisor's Wing, Islamabad.

Given the poor performance of the health care system in the country and the increasing pressure on the budget this paper discusses the possibility of privatising this system, at least the first level health care facilities, such as the basic health units, as a possible solution to meeting the requirements of the people for health, particularly in the rural areas. The assumption being that the private sector is more efficient than the public sector. After an introductory section the paper overviews briefly the current health status in Section II. Section III looks at the institutional framework of the health care delivery system in the country. Section IV discusses privatising this system and the questions of efficiency and equity that arise because health is not an ordinary commodity, and Section V presents the conclusions of the paper.

## **II. EXISTING HEALTH STATUS**

Pakistan's system of health care is a combination of preventive and curative services provided by both the public as well as the private sector. However, the performance of the system in meeting the requirements for health is far from satisfactory as health facilities and the provision of health care in the country are quite inadequate. Not only is this the case, but more disturbing particularly in the rural areas is the point that where health facilities exist, these are underutilised. The reasons for such a state of affairs to exist are several. First, the rural population is averse to being treated by western allopathic medicine and second most of the public health facilities that are available provide poor quality treatment. Doctors and other health care personnel are often absent from their posts. Medicines are in short supply, equipment suffers from lack of maintenance and there are not enough female medical personnel for female patients. In addition, the lack of funds and bad management contribute to the further deterioration of such health facilities. Urban-based facilities also suffer from the same problems but not to the extent as the rural facilities.

Currently Pakistan has a high infant mortality rate, (90 per 1000); according to PDHS 1990-91 alongwith a low death rate (11 per 1000). The rate of population growth is also very high.

The high infant mortality rate is due to the prevalence of such diseases as diarrhoea, malnutrition and poor sanitation. Maternal mortality is also high. This is due largely to lack of facilities available at the time of child birth (2-3 per 1000 live births). The crude death rate is 11 per 1000. The main causes of death being diarrhoea and pneumonia among young children and accidents, tuberculosis and cardiovascular diseases among the rest of the population. What is also important to note is that some 45 percent of the population is below 15 years of age.

Illnesses that are common among children are measles, whooping cough, tetanus, and gastrointestinal problems. Tuberculosis also is fairly widespread. Thus it is important that greater attention should be paid to the medical and health problems of this age group.

Other diseases that have emerged as important in recent years include cancer and cardiovascular ailments. Deaths from cancer are rising steadily, the incidence rate being 40 to 50 per 100,000 of population. AIDS, an highly communicable disease, may also pose problems for public health. The number of people with AIDS is not known.

Malnutrition among the young is also a severe problem giving rise to problems like anaemia, goiter, keratomalacia, rickets, scurvy osteo malacia, etc.

Health hazards from an environmental point of view also exist. These relate to the most inadequate supply of potable water, lack of arrangements for the disposal of excreta and garbage, human and otherwise, and lack of food hygiene. Only 53 percent of the urban and 10 percent of the rural population have access to sewerage facilities. Similarly, only 80 percent of the urban population have access to safe water supply; for rural areas the figure is 40 percent. Industrial pollution is also beginning to contribute to the problems of public health. Again health facilities are largely concentrated in the urban areas; rural areas where two-thirds of the population live are thus neglected.

### III. INSTITUTIONAL FRAMEWORK

This section describes in brief the institutional framework for health services in the country. The constitution has declared health to be a provincial subject with the provincial governments being responsible for administering as well as providing a health care delivery system. The federal government's responsibility is to formulate health policy. However, in practice, there is a great deal of interaction between the federal and provincial governments in the field of health. The following are the responsibilities of the Ministry of Health at the federal level:

- (i) To formulate and coordinate health plans;
- (ii) to promote health facilities for central government servants in Islamabad;
- (iii) to set up medical schools/colleges, particularly at the post-graduate level;
- (iv) to keep a check on the quality of professional education in the medical field;
- (v) to supervise quality control over drugs being manufactured/distributed in the country;
- (vi) to prevent the spread of communicable diseases, as well as to provide services for mental illness and retardation; and
- (vii) to act as a link between foreign aid donors and projects being executed by them in the country.

The health departments which extend down to the tehsil/tluka level in the provinces are responsible for providing health services to the people. In addition, the provincial health departments are responsible for managing federal programmes

such as malaria control, EPI<sup>3</sup>, and CDD<sup>4</sup> etc. These departments also plan and manage personnel and physical resources as well as supervising teaching hospitals and special institutions. These departments are also tasked with the training and continuing education of health personnel.

Local government institutions also provide health care facilities. There are divided into rural and urban areas. Rural local government institutions consist of District Councils, Tehsil Councils and Union Councils. The urban local government institutions include a Metropolitan Corporation, Municipal Corporations, Municipal Committees, Town Committees, and Cantonment Boards. Combating infectious diseases receives top priority for the urban bodies. The functions for the rural local bodies are defined by the directives of the provincial governments as laid down from time to time. No specific functions have been allocated for the union councils. District councils, however, have their responsibilities clearly defined. Their tasks include preventing and curing infectious diseases, enforcing vaccination; maintain and manage first aid centres; establish and manage health centres, both for maternity cases as well as for infants and children; the training of traditional birth attendants; to manage and maintain health centres based on indigenous medicine; to promote sanitation and public health as well as educating people in public health. Thus it can be seen from the preceding discussion that, in theory, a reasonably strong institutional establishment exists in the health sector to provide health care to the people, both in the urban as well as rural areas.

On the other hand, health care services provided by the private sector have been increasing in recent years. This can be seen by the large number of clinics that have established themselves largely in the urban areas. These clinics treat some 50 percent of all patients. It is estimated that 70 percent of the urban population live within a distance of one km. from a clinic. Currently there are approximately some 15,000 private hospital beds and some 1000 private clinics in Pakistan<sup>5</sup>. However, the quality and service offered by these clinics range from the extremely shoddy to the above average. This may be due to the lack of a regulatory mechanism in the country capable of controlling the level and degree of services offered by these clinics. In addition, this sector has a large number of people who are unqualified yet dispense medical services on a largely illiterate public. Again, there is a need for regulation in this area.

#### IV. PRIVATISATION

As mentioned earlier, Pakistan has a health care system that is provided both by the public as well as the private sector. The system of health care provided by the public sector is subsidised, making it accessible to the lower income groups and

<sup>3</sup>EPI = Expanded Programme for Immunisation.

<sup>4</sup>CDD = Control of Diarrheal Diseases.

<sup>5</sup>World Bank (1986) Pakistan Economic and Social Development Prospects. Volume II: The Social Sectors. (Report No.5692-PAK)

thus more equitable. The private sector is more market oriented, thus access to health care is limited to people who can afford to pay. Drug prices also are controlled to some extent with some basic drugs being cheap enough for these to be available to a larger number of people.

Although the number of hospitals (in urban areas) and basic and rural health centres (in rural areas) have increased since Independence, this increase has been insufficient both in quantity as well as quality to meet the health requirements of the people. Again, the number of doctors, nurses, dentists and other paramedical staff has also increased but the per capita availability of these personnel is still quite below internationally accepted norms. The health system is urban biased as well as being curative oriented.

Given this state of affairs it was recently proposed that parts of the health care delivery system be privatised. Initially it has been suggested that some 30 percent of the basic health units located in the rural areas of the country be privatised<sup>6</sup>.

Privatisation has both a narrow and a broad meaning. In its narrow formulation it means the selling of state enterprises to private parties. In its broad context, privatisation refers to a strategy whose objective is to radically reduce government regulation of the free market, thereby promoting unrestricted competition.

One of the so-called advantages of privatisation is the use of the price mechanism as it operates within the demand-supply framework in the allocation of resources. In such a case prices can be made use of as a signalling device in determining priorities in the health system. The conventional wisdom is that the free-market mechanism helps in the optimum allocation of resources which implicitly implies that resources are allocated efficiently. Thus privatisation is another word for efficiency the benefits of which are reflected in better-quality services, reduction in unit costs and increases in demand, all within the competitive dynamic framework of the market, which benefits both producers and consumers.

Thus in other words, hospitals would bill patients according to the type and length of their illnesses. Similarly, doctors would charge accordingly. People who require medical care could go to the hospital or doctor of their choice, assuming that they are capable of paying the relevant charges. In such a scenario it is assumed that the question of freedom of choice and the availability of the necessary information would be sufficient to identify those health care services that are efficient. Inefficiency would be reflected in higher prices. Thus in the demand and supply framework of the market, high prices would result in a fall of demand. In this way inefficient suppliers of health care would be driven out and only the efficient users left. Thus, the market allocates health care efficiently.

<sup>6</sup>Daily *The News*, December 6, 1992, Islamabad.

### **(a) The Uniqueness of Health as a Commodity**

However, this can be questioned. Three points come to mind which make it difficult for health to be treated as an ordinary commodity. The first is uncertainty of demand, the second is imperfect consumer information and the third is externalities. These factors are responsible for making the market allocation of health care services inefficient.

Looking at the first point, health care is a commodity the demand for which occurs unexpectedly. Normally people cannot predict when they will fall ill and thus it becomes difficult to plan their expenditure for such a situation. Secondly, the market for health information is specialised—not every one knows what is available. Patients go to particular physicians after building up a relationship of trust and thus may be unaware of better information from other sources. This would result in patients going to their regular doctors and physicians whenever they fall ill instead of searching out better alternatives. Thus, this information imbalance gives considerable monopoly power on those who supply medical services.

The third point is externalities, which is an important one. An externality can arise when the consumption (or production) of a commodity affects a third party who has had no part in the decision to consume (or produce) that commodity. An externality can be both adverse or beneficial. The provision of health care services, particularly in the area of communicable diseases like small pox, cholera, tuberculosis etc. can result in external benefits. Thus, a vaccination programme that reduces the spread of a communicable disease benefits not only the people vaccinated but also the community as a whole as it reduces the probability that others will also get the disease. If charges were imposed under the market system for vaccination against a communicable disease people would balance the private benefits to be obtained as reflected in the reduction in the probability of their getting the disease against the private costs to be incurred. These costs relate to the level of the charge and the inconvenience and possible risk from the vaccination. If the perceived costs are greater than the person will not get vaccinated thereby increasing the danger to others of contracting the disease. In such a case, the external benefits have to be considered. These may be greater than the private costs. If this had been the case it would have been more efficient for the individual to have been vaccinated. Yet under the market system this did not happen. Even if these problems were overcome and the market approach, as stressed in privatisation policies followed, efficiency is not the sole objective of society, equity considerations are also important.

### **(b) Equity and Health**

Three definitions of equity come to mind. The first definition that can be used to define an equitable allocation of a commodity is in terms of a minimum standard—that is, there should be a minimum standard of treatment for those who require it. A second definition emphasises full equality, that is, everyone should

consume the commodity equally. This is a broader definition and in the health care context it refers to as equal treatment for equal need. A third definition of equity deals with the issue of equality of access. This concerns the cost and sacrifices that people have made to get medical care—for example, some people by living nearer a medical facility have quicker and easier access than those who live farther away from it. Thus the cost in time and money to reach such a facility is greater for those who live further away from it. Thus, this form of equality of access implies equality of personal or private cost.

Therefore, to recapitulate, equity has three aspects: a minimum standard of treatment, equal treatment for equal need and equality of access. Private markets will be unable to satisfy these conditions—for example the poor may not be able to purchase the treatment they require or even to afford some form of health insurance. Again, the market mechanism is not capable of ensuring that everyone is able to obtain a minimum standard of treatment or, for that matter, to bring about equal treatment for equal need. Finally with regard to the third aspect, that of equality of access, the rich would have greater ease of access by being able to purchase better quality health care. To obtain the same level of health care the poor would have to make a greater sacrifice because they would be spending a larger proportion of their income or health. For the provision of health care services, therefore, one has to take into account both efficiency as well as equity considerations.

## V. CONCLUSIONS

As mentioned earlier in the introduction to this paper, health is an important as well as a significant input in national development. Health care does not only benefit private individuals but also benefits communities. In other words, health care assumes the quality of a public good with improved health reflecting a positive relationship on the productivity of the labour force. It should, therefore, not be treated as an ordinary consumer good. However, health care can be provided by both the public and private sectors at a cost. For the private sector these costs have to be covered and prices set accordingly. These prices have not only be set at such a level as to cover cost but also to make a profit and in addition, ensuring quality of service. A judicious blend of both efficiency and equity is necessary in the provision of health care services, particularly for the rural areas which have a negligible health coverage.

Thus it is important for developing countries, like Pakistan to have a health care policy that is effective. In Pakistan's case there is an agenda for health policy as outlined in the introduction to the paper. However, its effectiveness is open to doubt. One of the first steps of such a policy is to bring about an appreciable reduction in the mortality rates which are quite high. This implies that preventive measures which are more cost effective than curative measures have to be taken to control the spread of communicable diseases such as amoebic dysentery, diarrhoea, hepatitis, tuberculosis etc. which are largely caused by the lack of hygienic living



conditions. Such measures can only be taken by public sector agencies by constructing sewerage and waste disposal facilities as well as providing the basic amenities in the shape of clean drinking water etc. To bring about such a result all means should be mobilised to this end. Thus both preventive and curative medicine have to be given their due importance. Medical education is also important. Only such a comprehensive approach to health care policy would enhance its effectiveness.

Keeping this in view the private sector can play a positive role in the provision of health care services if it is carefully regulated by the state. This is important if the price structure of services provided by the private sector is to be affordable for the majority of the people. Efficiency and equity considerations have thus to be kept in mind when determining this price structure.

Currently doctor and specialist fees are reasonably high so that low-income groups are prevented economically from receiving treatment. Apart from prices it is important that the quality of service should also be ensured for which a regulatory framework is essential. In Pakistan there is no framework that regulates the private sector. Thus differentials in the quality as well as the prices of services exist. Thus, in the health sector if a policy of privatisation has to be followed, it has to be regulated with the enforcement of regulations being stringently followed to meet the objective of equity for both urban as well as rural areas.

The government also has an established institutional framework involved in the delivery of health care services. The efficiency of this framework, particularly in the rural areas, leaves a lot to be desired. Perhaps suitable administrative and management reforms coupled with an incentive package aimed at encouraging medical personnel to work in rural areas would be a more cost-effective way to improve on the health care delivery system than privatising parts of it. This alternative should be seriously considered.

In the end, complete access to health care for the rural and urban areas especially for the poor is a utopian dream until and unless some form of a social security system is devised. In Pakistan *Zakat* is collected and distributed but it is not sufficient to meet all requirements. Some form of health care insurance should be introduced by the government to enable the lower income groups to have access to health care services. Thus a strategy should be adopted in which the privatisation of the health care sector should only be taken after due consideration about the peculiarities of the commodity 'health'.

## **Comments on "On the Privatisation of Health Care in Pakistan"**

It is a very interesting paper addressing a crucial area. It begins with a useful comparison of Pakistan with a few other developing countries in terms of human development indicators such as per capita income, life expectancy, etc.

The following are some suggestions of how the paper can be strengthened:

Table 2 presents data for total expenditure on health for development and recurrent expenditures. But, there is no comparison using data of other countries, which would have been useful, which is the purpose in this part of the paper.

Toward the end of Section I, the author makes the assumption that the private sector is more efficient in providing health care. This does not follow from the analysis above, that is, the comparison with other countries. It would be really useful to know if the other countries that are reviewed, have a private sector that is active in health, and if so, what was the process that led to the private sector being more active in those countries.

In Table 3, the author lists all the diseases that occur in Pakistan. However, he states that these occur not because of the lack of medical care, but due to other problems such as inadequate potable water, and lack of hygiene. It is not clear how the privatisation of health care will lead to the cessation of these other problems.

In the section on privatisation, the author does not address what is probably the biggest limitation even in the public health care system; that is the provision of health facilities in rural areas. He proposes the privatisation of rural health facilities. However, it is very difficult to attract health practitioners to rural areas, simply because of the lack of basic infrastructure facilities. The author makes a useful suggestion later on in the paper that the government provide special incentives for health care practitioners to work in the rural areas in the public sector. Once again, it would be useful to look at the example of other developing countries to see how they have addressed the privatisation of rural health facilities, and the provision of staff in these facilities.

The argument on demand and supply of health care needs to be strengthened, since it seems to be presented weakly and without much authority.

The author goes on to say that public resources released, once health care is privatised, can be used "elsewhere in the economy". Unfortunately, in Pakistan, these will very probably be used in defence expenditure and debt servicing. It is difficult to foresee a rate of privatisation of health care, even within the next decade, that would justify a cut back in public funds for health care.

At the end of Section IV (a), the author talks about vaccination for immunisation not occurring under a private health care system. It is precisely in these areas where a good public health system can contribute. The author has

presented all scenarios as an either/or situation. However, it would be possible and advisable to encourage the private sector in delivering health care, but for the public sector to continue to provide those services that are probably public goods, such as immunisation.

At the end of Section IV (b), the author makes the case against privatisation in that the rich would be able to afford better health care, at less real cost, than the poor. However, this is the case anyway, with or without privatisation.

At the end of the paper, there are several pages of tables, which have not been referred to anywhere in the text.

Finally, I think that the discussion is good, but a hypothesis needs to be clearly stated at the beginning of the paper. The conclusion is unclear; if privatisation has problems, as does the public sector, then how do we proceed. The discussion is too either/or vis a vis public or private health care provision. It should be possible to have a judicious use of both the public and the private sector for the provision of health care in Pakistan. The paper can make a useful policy contribution by researching this direction as well.

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