Health on Political Agenda in Pakistan

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In April 1987 the Pakistan People's Party (PPP) released a well-researched and scholarly document entitled the People's Health Scheme, which together with Benazir Bhutto's speech at that time may be taken to comprise the party's health manifesto. Can the PPP hope to implement it successfully in the event it comes to power?

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THE People's Party has issued a 72-page document entitled the People's Health Scheme. The document was released on April 30, 1987, at a function attended by Benazir Bhutto, whose speech is also included in the document of the party. Given its inclusion, one assumes that it is also part of the document, as it does indeed raise a number of very relevant points.

Before I proceed to the contents of the documents, there are some things which need to be said about the presentation of the document. I have been most impressed by the document, for it is one written by a group of professionals who seem to know their stuff well. The document has numerous references to statistics and publications from the government and international sources, thus giving it great credibility and authenticity. The statistics have not been presented just for the sake of the exercise and a very intelligent and well-researched methodology has been used.

The People's Party is the only political party which has openly and courageously expressed its views on numerous issues, all in published form. Whether one agrees with the contents of the published stands of the party, or with the ideological approach of the party, is something different, but at least we have the opportunity to know its stands and then make a decision for ourselves. Further, despite the fact that some of their published documents have come in for a lot of stick (the Awami budget, the Labour policy), the party has continued the process of making its attitudes public, all backed up by hard facts. It goes to the credit of the People's Party to be able to organise teams of experts on various subjects and then to publish and make public their views.

In her speech which serves as a preface to the document, Bhutto has raised some relevant points about the health system in the country today. She has lamented the plight of doctors, their unemployment and poor renumeration; the role of the last PPP government has been discussed and Benazir has cited the opening of medical colleges, large hospitals, and expansion of facilities under Bhutto; she has clearly understood the causes of ill health when she says "Good health is less the work of doctors and hospitals than of advances in public health. We need improvement in clean water and sanitation; improvement in housing and nutrition"; she has also understood the need for a healthy and educated society in order to build for growth and progress. She has also recognised the fact that of the 10,000 medicines produced in Pakistan, only 250 are needed, as recommended by the World Health Organisation. She has promised to supply the minimum number of essential medicines at very low prices and intends to keep in line with the WHO recommendations.

The salient features of the main report are as follows:

(i) To decentralise the entire health set-up by creating elected District Health Officers — democratisation at the local body level.

(ii) The upgrading of public health services.

(iii) A broadening of the social security scheme.

(iv) The private health sector will be given incentives to improve and enlarge its scope and will be completely separated from the public health sector. General practitioners will be given soft loans for buildings, equipment and cars.

(v) All medical graduates will be given jobs as soon as they finish their house jobs and rural service.

(vi) A National Formulary for drugs based on the WHO list will be introduced and these will be made available even in the smallest villages of Pakistan.

(vii) The obsolete Mental Health Act shall be replaced and new laws according to the present needs will bemade.

(viii) Laws relating to quackery shall be strictly implemented.

(ix) Hikmat and Homoeopathy will be formally organised.

This seems to be a rather comprehensive programme which should be a positive step towards providing 'Health For All' by the year 2000. It is not the purpose of this article to either belittle the programme of the People's Health Scheme, or to find faults with it, or to point out all that could have been said and which was not mentioned in the document (the role of multinational corporations in the provision of drugs). The purpose is to analyse the programme, which on paper seems to be quite good, within the broader social, economic and political structure of Pakistan, for one cannot look at health, or education, or employment, out of a wholistic context.

It is my contention that the problems of health care in the country are linked directly to the prevailing social, economic and political system that determines the alloca-

tion of resources within or outside the health sector. It is this class system which is responsible for the lack of adequate infrastructural and health facilities in rural areas and urban slums and this class system is also responsible for the reluctance of doctors to practise in these areas. Very briefly and in a simplified manner, we can identify five basic issues in the health sector today which affect the distribution and availability of health care.

Urban and Class Bias

The first point regarding the health system which strikes us is that despite the fact that 70 per cent of the population lives in rural areas, most of the medical and health facilities are found in the cities. For example, 85 per cent of the practising doctors work in urban areas giving a doctor : population ratio of 18.01 for urban areas and 1:25.829 in rural areas. In Sind, the rural doctor : population ratio is 1:57.964. For nurses, this ratio in Sind is an astonishing 1:58. Similarly, 23 per cent of the hospitals in the country are located in rural areas and only 8,754 beds are available for a population of 60 million.

This 'urban bias' in health (and almost all other) facilities exists due to a few reasons. For one, the ruling class, whether, bureaucrats, military personnel, industrialists, and even absentee feudal landlords, live in cities and enjoy the fruits of 'development'. Secondly, organised, articulate and politically active groups, such as trade unions, students and professionals, who live in urban areas, have also acted as pressure groups and raised their voices to demand social infrastructure. The elite, the middle classes, and the politically 'noisy' sections of society live in the cities and, thus, it is largely this section which determines the allocation of resources. The 'natural' outcome will be an 'urban bias'.

It must be emphasised, however, that this 'urban bias' is an impressionistic bias and only reflects the geographical location of health services. There exists a deeper and more fundamental bias which is main determinent of access to health facilities. This is the class bias. The facts reveal that not all urban inhabitants have equal access to health facilities, nor are all ruralites equally discriminated against. It may be easier for a feudal landlord to have access to good health care than for a slum dweller in a large city, A 'basti' dweller may have 'apparent' access, in the sense that he may know of existing facilities, but it is not likely that he will be able to afford the high cost of quality private care. At the same time, the quality of care at a government hospital OPD which is available to him, where a doctor has less than 60 seconds for a patient, is indeed questionable. Similarly, for residents within cities, great differences in access exist. Those with money can afford the 'best and latest' technology and have immediate access to facilities, while the majority, like our slum dweller mentioned above, faces innumerable hurdles.

Thus, despite the apparent urban bias, we can conclude that irrespective of geographical location, it is class location which determines access to health facilities.

The purpose of medical education is to produce medical personnel who can work effectively in the existing model of health care in a country. Thus, the doctors produced after six or seven years of training in Pakistan are those who work best in the setting described above: one that is urban-care oriented, and work in the interests of the richer inhabitants of the country.

Medical students in Pakistan are taught from books written in and for the developed countries. The diseases our students learn about are more specific to developed capitalist nations than to underdeveloped ones. For example, they learn from their books that cardiovascular disease and cancer are the main killers, while the real situation in Pakistan is that parasitic and infectious diseases are responsible for 54 per cent of all deaths, while diseases of the rich and of western countries (heart disease and cancer) account for less than 2 per cent of deaths. The teaching methods and books leave such a profound influence on the students that they begin to believe that one of the main causes of death in Pakistan is indeed cardiovascular problems!

Not only does the diagnosis of the disease come from western sources, so does the appraoch to care and cure. The developed country curative care approach is copied in underdeveloped countries where the emphasis turns to urban-based hospitals. The teaching faculty plays a contributory role in accentuating this 'cultural imperialism'. Professors go to the west for training and urge their students to do the same to acquire skills in disciplines such as neuro-surgery and plastic surgery. When (if) these doctors return, they become even more aliented from the masses of their country, who live in urban slums and rural areas. Firstly, they lose touch with common ailments which afflict the poor, such as gastroenteritis and tuberculosis, and can deal best with the diseases of the rich. Secondly, and more importantly, the western-trained doctors are available to only a select few who can afford their high fees.

In underdeveloped countries like Pakistan, where most diseases are of a communicable and preventable nature, the emphasis should be on training doctors who are well-versed in primary health care techniques. Yet, the course in community medicine in medical schools is taken very lightly by students and teachers, who have no real community experience. Often one finds examples where qualified doctors are unable to cope with simple and common problems, such as snake-bite. The training and practical experiences of medical students are solely dependent on their interaction with patients who come to their

urban hospital, again, for a curative approach, when a preventive one may be preferable.

The explanation for this inappropriate medical education is quite straightforward. Since it is the ruling class which essentially determines the dynamics of the health sector, it is also responsible for the production of a specific kind of doctor. This ruling class requires a doctor who works best in a hospital-based curative-care setting and can deal effectively with the diseases of the rich of Pakistan, which are similar to those common in the developed countries. Consequently, the curriculum in medical colleges is designed to produce the desired product.

An important outcome of this type of education and training is the 'westernisation' of doctors. Since doctors in Pakistan are taught about 'western diseases', most doctors can, after some acclimatisation, work easily in hospitals in the developed countries. Our system of medical education has been a major reason for the medical 'brain drain' from Pakistan, with nearly 50 per cent of our doctors practising outside the country.

Had the curriculum been designed to suit the needs of the poor masses of Pakistan, with more emphasis on conditions in rural areas and urban slums, this problem would not exist. At present, given their medical education and doctor migration, the UDC's are subsidising the West!

One would think that, given the poor health status of the population and the poor distribution of facilities, a feature like doctor unemployment would be quite unheard of in Pakistan. But this is not the case. At present, government sources themselves claim that more than 11,000 doctors are unemployed in the country. On the one hand, the country is faced with this unemployment, while on the other, the infant mortality rate is 125 per thousand and the doctor-population ratio in rural Sind is 1:57964.

The crisis of the unemployed doctors has been brewing for a number of years and has only just exploded. Given the policy of successive governments towards health care, this crisis should have been anticipated. Governments have been obsessed with the urban-based curative-care approach and have accordingly built medical schools to provide for the main pillar of the system, the doctor. This one-sided approach to health care has backfired: by not building medical infrastructure to absorb the entire output from medical schools, the doctors have ended up without jobs. Had a more balanced approach been followed, and had facilities been built in accordance with the distribution of population, the doctors may have been able to find jobs, and some may have even considered moving out of the larger cities. Today the situation is indeed ironic and sad that despite the shortage of doctors in the country, the government has advised the unemployed doctors to seek employment in the Middle-East.

In Pakistan more than 7,500 medicines are produced de ite World Health Organisation recommendations that onl '50 are enough for underdeveloped countries. Significant 85 per cent of total pharmaceutical production in Paki. n is controlled by 15 MNCs!

There are two main reasons for this state of affairs, which is quite common in most underdeveloped countries. Firstly, in a country which supports a doctor-oriented curative-care model, the doling out of medicine becomes an essential requirement of the system. Doctors must have plenty of medicines to give to their patients. If, on the other hand, the approach to health care in Pakistan was prevention-oriented, with intervention taking place much earlier, the need for medicines would decrease and the cure would also be cheaper. The second reason for the continued prominence of pharmaceutical MNCs in UDCs is the link these MNCs maintain with the doctor community and with the state bureaucracy. Many MNCs sponsor international seminars with the ostensible aim of promoting medical science but which are essentially conducted to promote their own product. In many countries doctors are given numerous perks to promote certain medicines. Links with the bureaucracy are strengthened and influence is exerted to ensure favourable treatment in the case of pricing and production.

In the case of Pakistan, little research has been carried out on the pharmaceutical industry and it is time that some scholars took upon themselves the task to do so. It is important not only to know the profit that the MNCs made each year, but also to expose any unethical practices that they indulge in.

In 1978, a revolution took place in the field of health care. More than 130 countries signed a declaration in which they promised to give their people adequate health care by the turn of the century. Pakistan was one of the signatories to the Alma Ata Declaration.

Eight years have gone by since the signing, and only 14 years are left before this century comes to an end. Yet any impartial observer would be distressed by the status of health of the people of Pakistan. Not only have no significant changes been made in the last eight years, given the present trend none can be expected in the next 14. At best one can expect some small cosmetic changes within the warped health care structure in Pakistan, but no real indications exist for the overhauling of the structure itself.

Thus, it is quite clear that health care is a reflection of the social, economic and political structure prevalent in a country. If a small ruling clique controls the resources of a country and little or no participation by the people is

(Continued on page 32)

(Continued from page 27)

tolerated, then the health sector will reflect this pattern, with health for a few and not for all. To bring about a revolution in health, it becomes necessary to bring about a revolution in society. The experience of socialist-oriented societies shows that once they have changed the pattern of the distribution of resources within the society, they have been able to change the pattern of health care, making access more equitable. Apart from socialist countries, some social democratic nations with a long history of participation by the masses have also provided adequate health facilities to their people and the resulting improvement in their health status is quite enviable. Thus, one cannot expect significant improvement in the health sector in Pakistan without substantial participation of the masses in the workings of society, and without substantial changes in the power structure as it exists today.

So, where does the well-meaning People's Health Scheme fit into all this? The People's Party is a populist party which means that it cannot and will not change the basic economic and political power structure as it exists in the country today. Thus, one cannot expect that it will drastically change either the health system or substantially increase the accessibility of health services. It is true that under the Bhutto regime, the expenditure on health care was much greater than it has been since 1977. But, caught up in a pseudo socialist-populist trap, the policies followed looked good only on paper. The eight medical colleges built in the country were created to appease the noisy middle classes. Had the government really been sincere it would have built rural health centres and basic health units instead of these great buildings called medical colleges. (For the cost of one medical college, 251 rural health centres or 556 basic health units could be built which would serve 5.56 million people - all of whom live in rural areas!).

Thus, the People's Health Scheme is a step in the right direction, and one can assume that some changes on the margin will indeed be made. However, meaningful radical change in the health sector, which would truly and honestly serve the people, will only come about once the existing social, political and, most importantly, economic relations are broken.