

Politics of health reform – Part 1

Dr. Sania Nishtar

Ever since the enactment of major health reforms in the United States, global interest in the subject has burgeoned. For Pakistan, health reform should be an imperative for reasons that have been glaringly apparent. Cases of alleged malpractice by the private sector have soared to new heights over the last several months. There are various versions of healthcare 'bills' circulating as structural solutions to this deep rooted problem, albeit with limited technical potential to impact change and almost no stakeholder buy-in. The menace of spurious drugs and procurement graft relating to medicines has been commanding attention of the superior judiciary. Dilapidation of primary healthcare has been a prime subject of media attention and the Pakistan Medical and Dental Council scuffle continues to smolder.

Although these issues appear to be standalone problems, they are, in effect, deeply interlinked and are cogs in a convoluted chain, which a consolidated attempt at holistic health reform has a high likelihood of unraveling and streamlining.

Two things must be understood about the dynamics of health reform. One, that it has to be an indigenous process. And two, that it is a profoundly political process.

With reference to the former, health systems' issues are closely inter-linked with a country's body politic—so are the solutions. Strategies to be employed in the context of a nation state to remedy its health system's woes are unique to a setting, and whilst lessons from similar countries have relevance, there isn't a perfect fit. Health reform, therefore, means very different things in different contexts.

In the United States, for example, where a publicly-funded system exists alongside a more predominant market system of pooling and provision, reform proposals in the past have centered on many strategies: removal of the private insurance market and establishment of a public option, premium subsidies to help individuals purchase health insurance, medical liability reform, policy options to reduce healthcare costs, etc. Through the recently enacted law under which insurance coverage is being expanded, the country is moving towards addressing the nation's fundamental health sector anomaly—the US is the only industrialized democracy which didn't until now provide universal coverage or financial risk protection to its population, and hence the medical bankruptcies.

Other developed countries that do provide universal coverage, adopt hybrid arrangements vis-à-vis service provision and health financing. In Britain, Spain and Italy, revenues fund healthcare and service provision is largely in the public domain. In Germany, France, Netherlands and Switzerland, the means of financing is predominantly pooling/insurance but service provision is by private doctors whose potential has been harnessed by the state to achieve universal coverage goals. In other countries such as Canada, Taiwan and Australia, there are blended systems with private sector doctors and hospitals but with public insurance. The reform connotation in each of these settings is unique and is interlinked with the body politic and overall prevailing systems of governance in the nation state. In these countries, elements of competition, supplier/buyer roles, patient choice, diversity of providers, freedom for hospitals, stronger commissioning, new payment mechanisms, modalities

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Governance

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The contemporary understanding of health reform in the developing countries has been shaped by reforms introduced by international agencies in the 1990s and have been linked to the concept of neo-liberal reform. These attempts at health reform used a variety of entry points with organisational efficiency as an outcome—introducing insurance, changes in payment systems, decentralisation, alternative modes of primary healthcare delivery, and hospital restructuring are examples of reform initiatives pursued by various countries in the past. Most reform attempts sought to improve the efficiency and quality of primary healthcare by structuring the role of the market in healthcare provision with separation of purchaser and provider functions as a major institutional overhaul. While some of these reform efforts positively impacted access, quality, and efficiency, they also came under criticism due to their perceived ideological conflict with the principles of Health for All. It is critical that in addition to efficiency gain, developing country health reform should also be configured to impact outcomes, with fairness in financing, enhanced responsiveness, and reducing barriers to access as endpoints.

Lessons from around the world in health reform have important insights for reforming Pakistan's health system. The latter can be described as 'mixed' where public provision funded by revenues co-exists with a market system of service delivery, with people accessing care through out-of-pocket expenditures. There are specific options to reform such systems by incrementally increasing and reorganising health financing, harnessing the role of the market to achieve universal coverage goals and reorienting stewardship and regulatory capacity to support that objective. Such changes are transformational but are critically needed to address the unacceptable level of preventable deaths and disease that plague people of this country.

In order to understand what stands in the way of making the needed transformational

changes in Pakistan's health sector, we need to examine the second fundamental point about the nature of health reform in terms of its dynamics being highly political.

In countries with a strong societal political culture and where healthcare accounts for one of the largest areas of spending, health reform is surrounded by hotly-contested political debates. This was evidenced by the difference in opinion between the Conservative and the Labour Party over the introduction of the purchaser-provider split in Britain some decades ago, and more recently has been illustrated by the divergence of views on the type of fixes supported by the Democrats and the Republicans in the US in the last election, with the former leaning towards broadening the base of insurance and the latter supporting open market competition in order to cut costs.

In Pakistan, with the social political culture being weak, there are no 'pressing' public demands for healthcare. The constitution does not explicitly recognise the right to health, although there have been progressive case law interpretations of the 'right to life' as also being inclusive of health rights. These judgments haven't, however, had a knock-on effect with citizens going to courts and demanding that their right to treatment be enforced as has happened in many countries of South America where the right to health is constitutionally recognised.

In Pakistan, the most damaging aspect with regard to the politics of health reform has been the lack of policy consistency. There have been many programmes initiated since the creation of the country, which had the potential to lead to transformational change; if they were sustained and if evidence was used to upscale them. In contrast, a plethora of restructuring pilots was never evaluated, and those who decided on their fate prioritised planning based on what was politically expedient. There is a long list of lost opportunities where public monies were wasted in pilot projects that couldn't be institutionalised and the opportunity to save millions of people from death, suffering and disability was lost.

Reform in the social sectors and in many spheres of governance is a long haul. It cannot come to fruition with the governments changing policy positions ever so often, when they are vying for quick visible outputs in the run up to the next election, when administrative agencies have limited technical capacity and when there is no accountability of politically expedient decisions.

Pakistan must place health reform as a priority on its public policy agenda and tailor it to the local context with respect to economic realities, political circumstances and administrative capacities of local institutions. There are too many people dying as a result of lack of attention thereof.

To be continued

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