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Unpacking the Elite Capture of Pakistan's Healthcare System

Pakistan's Healthcare System: Captured by the Elite?

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Abstract

Pakistan currently ranks 154 out of 189 countries according to the UNDP's Human Development Index. In this paper, we use a 'political settlements analysis' to understand how the distribution of political, economic and social power explains this ranking and the inequity in Pakistan's health system. We investigate elite power struggles over the last seven decades to explain how ad hoc policy-making, instability, patronage politics, and rent-seeking have led to a maldistribution of resources, lack of oversight, and inequitable access and service provision for a burgeoning population. We argue that these factors have had two consequences: the privatisation of healthcare; and the opening up of a considerable sphere of influence to the donor community to direct state policy. Despite promising ongoing reform efforts, we conclude that Pakistan's health system will remain hamstrung by the constraints of a political settlement in which elites with short-term horizons bargain for influence rather than developing an inclusive, consensus-based approach to improving governance outcomes for citizens.

Keywords: political settlements; healthcare system; Pakistan; military; patronage; donors; universal health coverage; neo-liberal; privatisation; pandemic; polio.

Introduction

Despite slight improvements in human development indicators over the past decade, Pakistan's progress continues to lag behind comparable countries across a host of

development indicators. Pakistan's Human Development Index (HDI) value of 0.557 for 2019 ranks it at 154 out of 189 countries, as compared to 131 (0.645) for India and 133 (0.632) for Bangladesh.[1] The Pakistan government acknowledges that 'national health security is increasingly threatened' due to malnutrition, environmental degradation, lifestyle changes and a high population growth rate.[2] The country's health system suffers from poor funding and a lack of accessibility, staffing and facilities, as well as a shortage of good quality disease surveillance and consistently measured and available data on disease incidence. The lack of essential services is endangering significant portions of the population, with 18 percent remaining food insecure, a situation exacerbated by poor sanitation and the lack of potable drinking water and decent housing.[3] Aside from tuberculosis, malaria and AIDS, the need for polio eradication is especially urgent since Pakistan is now one of only two countries that harbour the wild polio virus.[4]

We contend that, while Pakistan's health sector is underfunded, it suffers even more from skewed priorities, maldistribution of available resources (infrastructural, human, medical and financial) and instability, all of which are consequences of the 'political settlement' between competing elites in the country and shifts in it over time. A political settlement is the 'distribution of power across political and economic organizations in a

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[1] UNDP, 'The Next Frontier: Human Development and the Anthropocene: Pakistan', Human Development Report 2020, pp. 1–7 [2–3] [http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/PAK.pdf, accessed 3 Sept. 2021]. Note to copy-editor: this reference is correct

[2] Finance Division, Government of Pakistan, *Pakistan Economic Survey 2019–20*, pp. 1–516 [216] [http://www.finance.gov.pk/survey/chapter_20/PES_2019_20.pdf, accessed 25 Oct. 2020].

[3] *Ibid*., p. 226.

[4] Poliovirus or wild polio virus has three naturally occurring strains, two of which have been eradicated. Type 1 wild polio virus is endemic in Pakistan and Afghanistan. See WHO, 'Two Out of Three Wild Poliovirus Strains Eradicated' (24 Oct. 2019) [https://www.who.int/news-room/feature-stories/detail/two-out-of-three-wild-poliovirus-strains-eradicated, accessed 3 Sept. 2021].

society'.[5] Pakistan's political settlement is determined by bargaining between its political, military, bureaucratic and business elites[6] and religious groups, that switch between competitive clientelism during periods of procedural democracy[7] and authoritarian clientelism during periods of military rule. Building on the political settlements argument made by Dawani and Sayeed about Pakistan's pharmaceutical sector,[8] we argue that these clientelist political settlements have allowed for the sustained capture by the elite of various sectors of the economy, the political sphere and social life, with serious negative consequences for the delivery of healthcare to the citizen.

Akbar Zaidi has argued that the inequity in Pakistan's health system is the result of class bias, evident in the privileging of urban areas for infrastructure and resources and the concentration of most healthcare facilities in district towns or cities, a reflection of the priorities of the dominant classes.[9] Certainly Pakistan's healthcare system is, even to the casual observer, 'highly inequitable…[and] curative'.[10] A political settlements framework

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[5] Mushtaq H. Khan, 'Anti-Corruption in Bangladesh: A Political Settlements Analysis', SOAS Anti-Corruption Evidence (ACE) Research Consortium Working Paper 03, 2017 (London: SOAS University of London, 2017), p. 20 [https://ace.soas.ac.uk/working-paper-3/, accessed 20 Apr. 2021]. A political settlements approach has been used to analyse the health sector in a number of developing countries—see, for example, Tim Kelsall, 'Political Settlements and the Implementation of Maternal Health Policy in the Developing World: A Comparative Case Study of Rwanda, Ghana, Uganda and Bangladesh', Effective States and Inclusive Development Working Paper 137, 2020 [https://www.effective-states.org/wp-content/uploads/working_papers/final-pdfs/esid_wp_137_kelsall.pdf, accessed 3 Sept. 2021].

[6] For more analysis of Pakistan's elites, see Rosita Armytage, *Big Capital in an Unequal World: The Micropolitics of Wealth in Pakistan* (Oxford: Berghahn Books, 2020).

[7] Procedural democracy, in contrast to substantive democracy, refers to a form of democracy in which democratic procedures, such as elections, are followed but do not produce results that are representative of the people's will.

[8] Kabeer Dawani and Asad Sayeed, 'Anti-Corruption in Pakistan's Pharmaceutical Sector: A Political Settlement Analysis', SOAS Anti-Corruption Evidence (ACE) Working Paper 025, July 2020. Is there a web address for this? https://ace.soas.ac.uk/wp-content/uploads/2020/07/ACE-WorkingPaper025-PakistanPharma-200701.pdf

[9] S. Akbar Zaidi, 'The Urban Bias in Health Facilities in Pakistan', in *Social Science and Medicine*, Vol. 20, no. 5 (1985), pp. 473–82.

[10] S. Akbar Zaidi, *The Political Economy of Healthcare in Pakistan* (Lahore: Vanguard Books, 1988), p. 3.

allows us to understand why this inequity has persisted even as government regimes have changed and class structures have shifted, and how different elites at different times have captured control of the state. An explanation rooted in the distribution of economic, political and social power shows that ad hoc policy-making and resource distribution, rent-seeking[11] and instability (driven by regime, institutional and leadership changes) have built class and urban biases into the healthcare system. These factors make any periodic successes in terms of health service delivery short-lived and unsustainable.

This paper begins with the inequities that define Pakistan's healthcare system. We then lay out the context and nature of the country's political settlements from the early days of independence when landed elites dominated, through the years of repeated military interventions, to the present day dominance of the private sector in the provision of health care. The political economy of Pakistan has been defined throughout by chronic instability and the neglect of the health needs of its citizens. We go on to address two consequences of this inequitable healthcare system: the privatisation of healthcare; and the influence of the international donor community. We conclude on a pessimistic note in light of the COVID-19 pandemic: while reforms have never been more essential, they require inclusive, consensus-based policy-making to be successful.

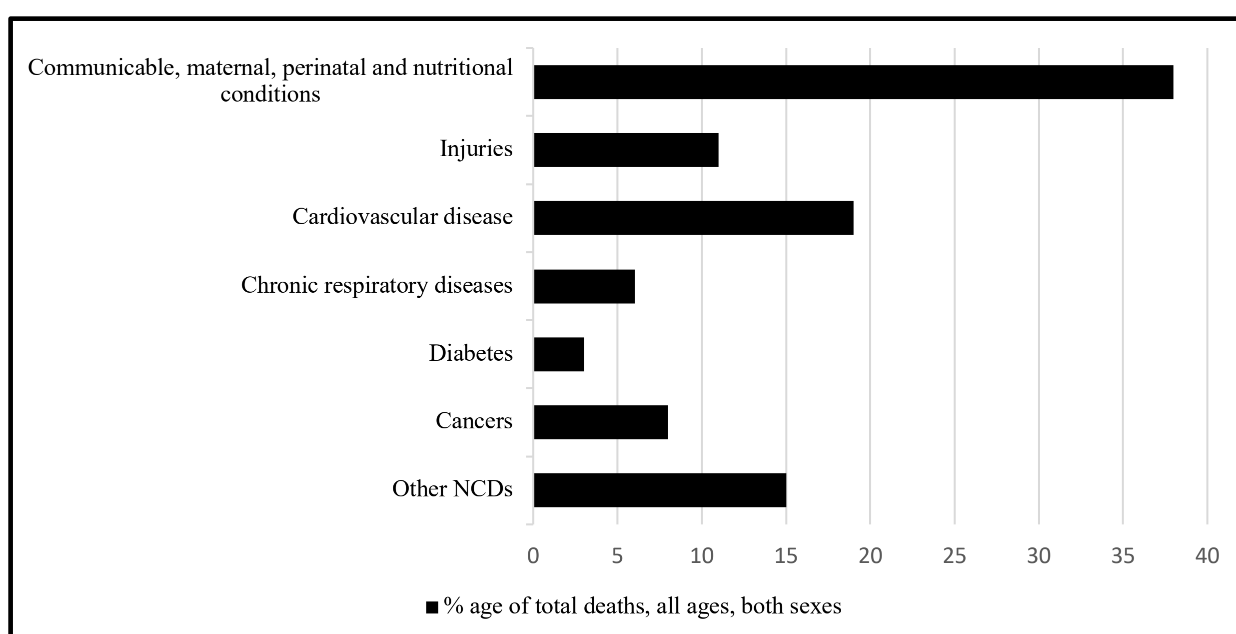
Pakistan's unequal healthcare system

Pakistan's healthcare system operates on three tiers, established in the 1980s. The Basic Health Units (BHUs), the primary tier, provide basic preventative and curative services in each union council, the smallest administrative unit in Pakistan. BHUs are staffed by a doctor and a midwife, each serving roughly 20,000 people. The next tier is the Rural Health

[11] Rent-seeking describes an eco-political process in which wealth is gained without the beneficiary making any contribution to the processes of production that generated that wealth.

Centre, located in towns to provide expanded services and handle small-scale surgeries, normally day procedures. Finally, the hospitals at the *tehsil* and district levels provide a full range of medical services and specialist care. However, the uptake of government medical services in Pakistan is generally low because of a lack of accessibility, the unavailability of medicines and 'uncooperative' staff.[12]

Figure 1:
Proportional mortality 2018



Source: WHO Pakistan Health System Profile 2018 https://rho.emro.who.int/sites/default/files/Profiles-briefs-files/PAK-Health-System-Profiles-2018.pdf

As Figure 1 shows, Pakistan faces a double burden from communicable and non-communicable diseases (NCDs). Premature deaths from non-communicable diseases accounted for just over half of all deaths in 2018, while communicable/infectious diseases accounted for 37 percent of all deaths, and injuries for another 11 percent.[13]

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[12] WHO EMRO, Health System Profile: Pakistan (2007), p. 11. [http://digicollection.org/hss/en/m/abstract/Js17305e/, accessed 3 Sept. 2021].

[13] WHO EMRO, Health System Profile: Pakistan (2018) [https://rho.emro.who.int/sites/default/files/Profiles-briefs-files/PAK-Health-System-Profiles-

Though the production of the healthcare workforce is likely to grow in the coming years with the proliferation of public and private medical colleges and universities,[14] Pakistan's health professionals are too few for the needs of its 220-million-strong population. According to the WHO, Pakistan has 11.18 medical doctors per 10,000 population and 4.83 nurses per 10,000 population,[15] compared to 9.28 and 23.89 for India and 6.37 and 3.92 for Bangladesh respectively. Despite seeming to do better than other parts of South Asia, there are persistent drains on Pakistan's existing and potential workforce. While the 'brain drain' siphons off medical professionals attracted to careers abroad, a domestic brain drain removes female professionals from the workforce. Some 60 percent of trained women doctors do not practise medicine because their families object,[16] even though the Pakistan Medical and Dental Council found in 2017 that the gender ratio of medical students is 2:1 in favour of women.[17] Until now, however, the government has made little effort to harness the potential of women doctors by bringing them into the professional workforce. The government has sought to address staffing issues, particularly in rural areas, by giving doctors residences, better salaries and better supervision.[18] Government doctors are also permitted to conduct private practice in parallel with their public employment, while in some provinces loans have even been provided to

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2018.pdf, accessed 26 Oct. 2020]. Note that mortality estimates in Pakistan are marked by a high degree of uncertainty since no records of cause of death are maintained at any level.

[14] There are 114 medical colleges and universities in Pakistan, the majority privately owned, that produce 15,000 doctors each year. Wajahat Bokhari, 'Medical Colleges in Pakistan—Too Few or Too Many?', *The Daily Times* (21 Sept. 2019) [https://dailytimes.com.pk/469531/medical-colleges-and-doctors-in-pakistan-too-many-or-too-few/, accessed 25 Sept. 2020].

[15] WHO Global Health Observatory, 'Global Health Workforce Statistics Database' [https://www.who.int/data/gho/data/themes/topics/health-workforce, accessed 26 Apr. 2021].

[16] *Pakistan Economic Survey 2019–20*, p. 216.

[17] Ayesha Masood, 'Influence of Marriage on Women's Participation in Medicine: The Case of Doctor Brides of Pakistan, in *Sex Roles*, Vol. 80 (2019), pp. 105–22 [https://doi.org/10.1007/s11199-018-0909-5, accessed 26 Apr. 2021].

[18] Muhammad Ashar Malik *et al.*, 'Did Contracting Effect the Use of Primary Health Care Units in Pakistan?', in *Health Policy and Planning*, Vol. 32, no. 7 (2017), pp. 1032–41 [https://academic.oup.com/heapol/article/32/7/1032/3793093, accessed 3 Sept. 2021]. Note to copy-editor: Effect is correct in title

encourage doctors to set up private practices.[19] With little or no regulation, however, malpractice and negligence[20] are widespread, 'rarely documented' and almost never penalised.[21]

Though the WHO argues that the maldistribution of primary health care services and staff is the true reason for what appears to be the 'serious underfunding' of Pakistan's health sector,[22] Pakistan has increased spending on health over the past few years from 0.56% of GDP in 2012-13 to 0.97% in 2017-18.[23] In the financial year 2019–20, the federal and provincial governments together spent 1.1 percent of Pakistan's GDP on health, half of the allocation for education and about a third of that for defence.[24] However, there is a considerable amount of catching up to do since Pakistan has invested little in health over the decades, with an annual average of between approximately 0.6 and 0.8 percent of GDP spent on health from 1970 onwards.[25] Despite GDP growth rates comparable to East Asian countries between 1960 and 1994, successive authoritarian and democratic regimes failed to invest in social welfare, including healthcare.[26] We argue that the explanation for this lies in the continued jockeying between factions of Pakistan's political and economic elite to control state resources for their own benefit.

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[19] 'Health Foundation Directed to Provide Loans to GPs', *Dawn* (12 Jan. 2018) [https://www.dawn.com/news/1382422, accessed 28 Oct. 2020].
[20] These range from surgical errors when items are left inside the surgical cavity to overprescribing medicines.
[21] Muhammad Ashar Malik, 'Universal Health Coverage Assessment Pakistan', Global Network for Health Equity (GNHE) (December 2015), p. 6 [https://ecommons.aku.edu/cgi/viewcontent.cgi?article=1203&context=pakistan_fhs_mc_chs_chs, accessed 25 Oct. 2020].
[22] WHO, 'Pakistan: Health Systems Profile' (2018).
[23] Finance Division, Government of Pakistan, *Pakistan Economic Survey 2018–19*, pp. 1–503 [172] [https://www.finance.gov.pk/survey/chapters_19/Economic_Survey_2018_19.pdf, accessed 25 Oct. 2020]. See also, Table 5.
[24] *Pakistan Economic Survey 2019–20*.
[25] *Ibid*., 'Statistical Appendices', pp. 6–7.
[26] Shehla Zaidi *et al.*, 'The Political Economy of Undernutrition', National Report Pakistan (2013) [https://ecommons.aku.edu/pakistan_fhs_mc_chs_chs/194/, accessed 25 Oct. 2020].

What's past is prologue—1958 to 2021

Pakistan's first military coup was declared by Field Marshal Ayub Khan in 1958. Under the military the emphasis was on the Green Revolution, migration and urban development; as a result, the power of the landed elite was challenged throughout the 1950s and 1960s as the so-called 'intermediate classes' climbed the economic ladder. They established themselves in business, many in the informal sector, fuelled by remittances from Pakistanis working in the Gulf.[27] Ayub Khan's 'decade of development' led to capital accumulation and the concentration of wealth in the hands of a few industrial families.[28] On the healthcare front, the period was marked by outbreaks of malaria, smallpox and cholera, particularly in the eastern wing of the country. The handling of these epidemics was shaped by the One Unit Plan which divided Pakistan into two administrative units—East and West—and the tussle for power and administrative autonomy between them.

In 1971, East Pakistan seceded to become Bangladesh, and in 1973, Pakistan became a federation with four provinces under a new Constitution. Health became the joint responsibility of the centre and the provinces but in practice, the centre took charge of policy design and development, while the provinces were responsible solely for implementation. However, 'formal mechanisms for review or revisioning of health policy were never developed on a national level', and spaces for stakeholder dialogue were limited.[29] The division of responsibilities meant that implementation was uneven across the country;

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[27] Aasim Sajjad Akhtar, 'The Overdeveloped Alavian Legacy', in Matthew McCartney and S. Akbar Zaidi (eds), *New Perspectives on Pakistan's Political Economy: State, Class and Social Change* (New Delhi: Cambridge University Press, 2019), p. 64.
[28] Christopher Candland, 'Institutional Impediments to Human Development in Pakistan', in Amita Shastri and A. Jeyaratnam Wilson (eds), *The Post-Colonial States of South Asia: Democracy, Development, and Identity* (New York: Palgrave Macmillan, 2001), p. 273.
[29] WHO EMRO, Pakistan Health Systems Profile 2007, p. 9.

planning was lacking, particularly for epidemic control programmes like malaria.[30] Moreover, Pakistan's provinces were unable to develop any financial independence because they continued to have only limited tax-generating capacity, remaining reliant on funds from the centre.[31]

The dynamics of the security state

In 1977, General Zia declared martial law and the Constitution was suspended. While the landed elites had retained their clout by adapting to new political and economic realities, Zia's patronage of the intermediate or business classes led to the rise of a new political elite at the elections of 1988.[32] Zia also narrowed the space for civil society, instead using the religious Right to great effect to acquire legitimacy for new structures of power.[33] This had serious consequences for the health sector when he suspended the population control programme in 1977, setting back access to reproductive health services. The consequences of this policy decision are still being felt—Pakistan's population doubled between 1972 and 1998,[34] and continues to grow at over 2 percent per annum, the highest rate in the region.[35]

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[30] J. De Zulueta, S.M. Mujtaba and I.H. Shah, 'Malaria Control and Long-Term Periodicity of the Disease in Pakistan', *Trans R Soc Trop Med Hyg.*, Vol. 74, no. 5 (1980), pp. 624–32, doi: 10.1016/0035-9203(80)90153-4. PMID: 7210113. Note to copy-editor: this reference is correct

[31] Katharine Adeney, 'A Step Towards Inclusive Federalism in Pakistan? The Politics of the 18th Amendment', in *Publius: The Journal of Federalism*, Vol. 42, no. 4 (2012), pp. 539–65 [https://doi.org/10.1093/publius/pjr055, accessed 26 Apr. 2021].

[32] Hassan Javid and Mariam Mufti, 'Candidate–Party Linkages: Why do Candidates Stick with Losing Parties', in Mariam Mufti, Niloufer Siddiqui and Sahar Shafqat (eds), *Pakistan's Political Parties: Surviving Between Dictatorship and Democracy* (Washington, DC: Georgetown University Press, 2020), pp. 144–61.

[33] Akhtar, 'The Overdeveloped Alavian Legacy', p. 69.

[34] A. Islam, 'Health Sector Reform in Pakistan: Why is it Needed?', in *Journal of the Pakistan Medical Association*, Vol. 52, no. 3 (Mar. 2002) [https://mail.jpma.org.pk/article-details/2143, accessed 26 Apr. 2021].

[35] World Bank Development Indicators [https://data.worldbank.org/indicator/SH.XPD.CHEX.PC.CD?locations=8S, accessed 20 Apr. 2021].

Zia's regime received considerable military and economic aid from the United States following the USSR's invasion of Afghanistan in 1979. As a result the military developed significant business interests that continued expanding, making it the ultimate arbiter in all decision-making.[36] During the 1990s, a decade in which not a single government completed its elected term, fiscal decision-making space was limited due to a significant proportion of the budget being used to pay off interest on debt and on the military budget, with the latter consuming nearly 25 percent by 1998–99.[37] The demands of national security meant that the space for social development kept shrinking even under civilian regimes, and the long shadow of military rule never faded in terms of its impact on the allocation of resources to the security establishment. Roy has labelled this period as one of 'competitive clientelism',[38] with elite factions competing to win state power via ruling coalitions marked by short-term horizons and limited enforcement capabilities.[39]

From a health policy standpoint, several programmes were introduced and funded, only to lose momentum or collapse once the government changed.[40] The Social Action Programme, for example, was initiated in 1992 to improve development outcomes across education, health, water and sanitation, and family planning. However, no comprehensive

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[36] See Ayesha Siddiqa, *Military Inc.: Inside Pakistan's Military Economy* (London: Pluto Press, 2007); for military spending figures compared to development expenditure, see Ayesha Siddiqa-Agha, 'Political Economy of National Security', in *Economic & Political Weekly*, Vol. 37, no. 44/45 (2002), pp. 4545–9.
[37] Candland, 'Institutional Impediments to Human Development in Pakistan', p. 275.
[38] Pallavi Roy, 'Pakistan: A Crisis of Legitimacy and Liberalization 1980–2010', Working Paper for the Institutions and Long-Term Growth SOAS-AFD Research Project (London: SOAS, University of London, 2013) [https://eprints.soas.ac.uk/22132/1/Working%20Paper-Pakistan%20A%20Crisis%20of%20Legitimacy%20and%20Liberalization%201980-2010%20(1).pdf, accessed 15 Apr. 2021].
[39] Mushtaq H. Khan, *Political Settlements and the Governance of Growth-Enhancing Institutions* (London: SOAS University of London, 2010) [https://eprints.soas.ac.uk/9968/1/Political_Settlements_internet.pdf, accessed 15 Apr. 2020].
[40] Shehla Zaidi *et al.*, 'Primary Care Systems Profiles & Performance (PRIMASYS) Pakistan Case Study, WHO' [https://www.who.int/alliance-hpsr/projects/AHPSR-Pakistan-061016.pdf, accessed 20 Apr. 2021].

planning ever took place for health or education, and the funds available at the district level were instead used for political constituencies or misappropriated, with few checks and balances to prevent such activity.[41] The programme that has perhaps been the most sustainable with the most impact is the Lady Health Workers Programme, introduced in 1994 to provide basic health services at the citizen's doorstep. Despite its substantive impact, however, evaluations of the programme have noted the inadequacy of inputs (such as equipment, medications and support services) that have affected the ability of these key frontline health workers to carry out their duties.[42]

In 1999, martial law was declared once again, and General Musharraf took over, shifting the political settlement to 'vulnerable authoritarianism'.[43] Though his talk of 'enlightened moderation' appealed directly to Pakistanis' aspiration to be middle class, modern and global, Musharraf adopted strategies similar to Zia's, exiling the existing political leadership and engineering a new political class beholden to him.[44] But the Musharraf era was shaped first and foremost by 9/11 and its ramifications, which affected Pakistan's trajectory for subsequent years, particularly with regard to the economy and the dominance of the military establishment. Following 9/11, Pakistan received a substantial amount of civil and military aid and debt relief from the United States, leading to a brief

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41 Candland, 'Institutional Impediments to Human Development in Pakistan', pp. 271–2.
42 UNICEF, 'Lady Health Worker Programme, Pakistan Performance Evaluation Report', (2019), p. 5 [https://www.unicef.org/pakistan/media/3096/file/Performance%20Evaluation%20Report%20-%20Lady%20Health%20Workers%20Programme%20in%20Pakistan.pdf, accessed 20 Apr. 2021].
43 Roy, 'Pakistan: A Crisis of Legitimacy and Liberalization 1980–2010'; and Mushtaq H. Khan, *Political Settlements and the Governance of Growth-Enhancing Institutions*. Note to copy-editor; there are a number of authors named Khan in this paper
44 Ali Cheema, Asim Ijaz Khwaja and Adnan Qadir, 'Decentralization in Pakistan: Context, Content and Causes', KSG Faculty Research Working Paper Series RWP05-034 (April 2005) [https://www.hks.harvard.edu/publications/decentralization-pakistan-context-content-and-causes, accessed 23 May 2021].

economic boom. However despite the inflow of aid, the Musharraf regime did not invest in citizens or services. The health budget declined from 0.8 percent to 0.7 percent of GDP between 1999 and 2002 and continued to slide till it reached 0.51 percent in 2005–06 (Table 1).[45] Meanwhile, the military government controlled the distribution of wealth generated by rent-seeking behaviour, directing much of it into consumption and speculation, mainly in land and real estate development and the stock market, and into 'politically networked' sectors such as construction, automobiles, sugar and textiles.[46]

Table 1:
Public sector health expenditure (federal and provincial) PKR billions FY 2000 to 2008

Fiscal Years	Total Health Expenditures	Development Expenditure	Current Expenditure	Percentage Change	Health Expenditure as % of GDP
2000-01	24.28	5.94	18.34	9.90	0.72
2001-02	25.41	6.69	18.72	4.70	0.59
2002-03	28.81	6.61	22.21	13.40	0.58
2003-04	32.81	8.50	24.31	13.80	0.57
2004-05	38.00	11.00	27.00	15.80	0.57
2005-06	40.00	16.00	24.00	5.30	0.51
2006-07	50.00	20.00	30.00	25.00	0.57
2007-08	60.00	27.22	32.67	20.00	0.57

Source: Pakistan Economic Survey 2009-10, Chapter 11
http://www.finance.gov.pk/survey/chapter_10/11_Health.pdf

Islamist groups, elite politics, and Pakistan's polio programme

After 2004, the country's growth declined, and in 2007 there was a balance of payments crisis. Another boom–bust cycle began in 2008 and the political settlement returned to competitive clientelism. However, despite the greater political inclusiveness of the political

[45] M.M. Khan and W. Van den Heuvel, 'The Impact of Political Context upon the Health Policy Process in Pakistan', in *Public Health*, Vol. 121, no. 4 (2007), pp.278–86.
[46] Dawani and Sayeed, 'Anti-corruption in Pakistan's Pharmaceutical Sector', pp. 13–15; and Siddiqa, *Military Inc.: Inside Pakistan's Military Economy*.

settlement that emerged from the 2008 general election, heralded by a coalition government made up of the major political parties, the exclusion of the military and religious groups led to instability.[47]

Islamist groups exercise a considerable degree of influence amongst communities, particularly in the Pashtun belt in the northwest of the country. They have had a particularly negative impact on immunisation programmes, especially polio. Attacks on vaccinators and refusals to vaccinate children are driven, in part, by persistent conspiracy theories alleging that the vaccine is a ploy to sterilise the Muslim population; anxieties including 'fear of sterility; lack of faith in the polio vaccine; scepticism about the vaccination programme; [and] fear that the vaccine might contain religiously forbidden ingredients'.[48] Moreover perceptions of vaccines were particularly negatively impacted when it emerged that America's Central Intelligence Agency (CIA) had planted a spy in an immunisation campaign to aid its capture of Osama bin Laden in 2011.[49]

However, Pakistan's polio campaign has also been impacted by shifts in the political settlement. For example, the difficulty in establishing a public political consensus on something as serious as polio eradication is a consequence of the shift in Pakistan's political settlement which took place with the 2018 general election. With the military playing an interventionist role in the run-up to the election,[50] the result is an authoritarian clientelist

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[47] Dawani and Sayeed, 'Anti-corruption in Pakistan's Pharmaceutical Sector', pp. 13–15.
[48] A.R. Khowaja *et al.*, 'Parental Perceptions Surrounding Polio and Self-Reported Non-Participation in Polio Supplementary Immunization Activities in Karachi, Pakistan: A Mixed Methods Study', in *Bulletin of the World Health Organization*, Vol. 90, no. 11 (2012), pp. 822–30.
[49] Monica Martinez-Bravo and Andreas Stegmann, 'In Vaccines We Trust? The Effects of the CIA's Vaccine Ruse on Immunization in Pakistan', CEPR Discussion Paper No. DP15847 (Feb. 2021) [https://ssrn.com/abstract=3795231, accessed 20 Apr. 2021].
[50] Hassan Javid and Mariam Mufti, 'Electoral Manipulation or Astute Electoral Strategy? Explaining the Results of Pakistan's 2018 Election', in *Asian Affairs: An American Review* (2020), DOI: 10.1080/00927678.2020.1855033.

political settlement[51] and a hybrid government (led by Imran Khan and his Pakistan Tehreek-e-Insaaf Party[52]) that works closely with the military but has limited autonomy on key issues of governance. The government has been further constrained by an economic downturn that led to Pakistan's 13th IMF bailout. Such a distribution of power imposes significant constraints on decision-making through representative channels, a pattern evident in the military's leading role in numerous aspects of the COVID-19 pandemic response and the bypassing of existing constitutional structures designed to build political consensus.[53]

Table 2:
Wild polio virus cases across Pakistan 2015–2021

	2015	2016	2017	2018	2019	2020	2021
Punjab	2	0	1	0	12	14	0
Sindh	12	8	2	1	30	22	0
Khyber Pakhtunkhwa	33	10	1	8	93	22	0
Balochistan	7	2	3	3	12	26	1
Azad Jammu and Kashmir	0	0	0	0	0	0	0
Gilgit-Baltistan	0	0	1	0	0	0	0
Total	54	20	8	12	147	84	1

Source: Pakistan Polio Eradication Programme https://www.endpolio.com.pk/polioin-pakistan/polio-cases-in-provinces

[51] Mushtaq H. Khan, 'Anti-Corruption in Bangladesh'; and Dawani and Sayeed, 'Anti-Corruption in Pakistan's Pharmaceutical Sector', p. 14.
[52] Formed in 1996 with the aim of ensuring justice, Pakistan Tehreek-e-Insaaf Party remained out of the corridors of power till it embraced individual interest groups prior to the 2018 election and abandoned any commitment to consistent ideological positions. See Tabinda Khan, 'Pakistan Tehreek-e-Insaf: From a Movement to a Catch-All Party', in Mariam Mufti, Niloufer Siddiqui and Sahar Shafqat (eds), *Pakistan's Political Parties: Surviving Between Dictatorship and Democracy* (Washington, DC: Georgetown University Press, 2020), pp. 60–75.
[53] Nazish Brohi, Danyal Adam Khan and Mosharraf Zaidi, 'Stress Testing Pakistani Federalism: Lessons from the Covid-19 Pandemic Response', Tabadlab Working Paper 06, Centre for Governance Systems, Tabadlab (2021), pp. 1–58 [20] [https://www.tabadlab.com/wp-content/uploads/2021/03/CGS-Tabadlab-Stress-Testing-Federalism-in-Pakistan-March-11.pdf, accessed 20 Apr. 2021]. Note to copy-editor: this reference is correct

Despite significant funding by international donors and the Pakistan government for polio eradication, polio cases surged in 2019 compared to previous years, the majority of them in Balochistan and Khyber Pakhtunkhwa (KPK). According to the International Monitoring Board (IMB) of the Global Polio Eradication Initiative based in Geneva, one of the major reasons was that 'political consensus on the importance of eradicating polio in Pakistan has been lost' and the issue became 'a political football'.[54] In subsequent reports, the IMB noted that an all-party National Strategic Advisory Group had been formed in 2019 to establish a consensus on polio eradication, but the group never met,[55] resulting in mixed messaging regarding the government's commitment to 'unambiguous and non-partisan' efforts to eradicate polio. In July 2020 the idea was dropped entirely, indicating the damage done to health programming by rapid shifts in leadership.

The personalisation of party politics and patronage

Perhaps the foremost consequence of military interventions in politics has been the weakening of political parties in Pakistan. Non-partisan elections[56]and party engineering, unconstitutional interruptions to democratic rule, and constitutional tampering have resulted in political parties that are heavily centralised around their founders, have little or no

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[54] International Monitoring Board of the Global Polio Eradication Initiative, 17th Report, pp. 8, 13 [https://reliefweb.int/sites/reliefweb.int/files/resources/17th-IMB-report-20191115.pdf, accessed 20 Apr. 2021].

[55] International Monitoring Board of the Global Polio Eradication Initiative, 19th and 18th Reports, p. 36 [https://reliefweb.int/sites/reliefweb.int/files/resources/19th-IMB-Report-FINAL.pdf], and [https://polioeradication.org/wp-content/uploads/2020/08/20200816-IMB-18th-Report-FINAL.pdf, accessed 20 Apr. 2021].

[56] Non-party elections, where elections take place amongst individuals without stated party affiliations, have frequently been used in Pakistan as a means of weakening political parties. See Niloufer Siddiqui, Mariam Mufti and Sahar Shafqat, 'Introduction: Pakistan's Political Parties in an Era of Transition', in Mariam Mufti, Niloufer Siddiqui and Sahar Shafqat (eds), *Pakistan's Political Parties: Surviving Between Dictatorship and Democracy* (Washington, DC: Georgetown University Press, 2020), pp. 1–22.

ideological or policy vision, and lack roots in the electorate. Consequently, parties (and their members) function with short-term horizons, shaped by clientelist political settlements, seeking to maximise electoral and personal gains during the windows of opportunity offered by democratic rule.

By and large, politicians have little interest in or commitment to broader legislative or policy work, a trend best exemplified in declining attendance in the National Assembly, particularly on the part of party leaders whether in government or opposition.[57] In a performance appraisal of the National Assembly between 2015 and 2016, the Free and Fair Elections Network (FAFEN) reported that agenda items concerning public service issues such as 'missing health facilities' remained unaddressed.[58] The lack of focus on policy was also reflected in party manifestoes. All the major parties reiterated similar commitments to increasing spending on health, improving maternal and child health, eradicating polio and so on, but there has been little attempt to prioritise these tasks or outline concrete plans for how these ends will be achieved.[59]

Government oversight of service delivery has also been seriously lacking in Pakistan, allowing it to continue with little supervision. In 2012 FAFEN conducted multiple rounds of health institution monitoring in selected districts; in reviewing the facilities and performance

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[57] Free and Fair Election Network, 'FAFEN's Report on Attendance and Quorum in National Assembly of Pakistan' (June 2013–March 2018) [https://fafen.org/wp-content/uploads/2018/04/FAFEN-National-Assembly-Attendance-Report-2018-14th-National-Assembly-Open-Parliament-Pakistan.pdf, accessed 20 Apr. 2021].

[58] Free and Fair Election Network, 'Annual Performance Appraisal (2015–16)', FAFEN Parliament Monitor [https://fafen.org/wp-content/uploads/2016/06/FAFEN-Parliament-Monitor-National-Assembly-of-Pakistan-Annaul-Report-3rd-Year.pdf, accessed 20 Apr. 2021].

[59] Shahid Javed Burki, 'Manifestoes and Political Preferences in Pakistan', ISAS Special Report No. 12–24 (April 2013) [https://www.files.ethz.ch/isn/163653/ISAS_Special_Report_12_-_Manifestoes_and_Political_Preferences_in_Pakistan_24042013153648.pdf, accessed 20 Apr. 2021].

in District Headquarter Hospitals, Basic Health Units (BHUs), Tehsil Headquarter Hospitals, Rural Health Centres and dispensaries across the country, it found elected representatives' oversight to be lacking across the board.

While military rule and intervention has damaged the development of representative political institutions and debilitated civil society, Akhtar argues that as a result, people too developed a 'common sense approach to politics, seeking out patrons as a means of navigating the rigours of state and market, formal and informal'.[60] The politics of patronage therefore came to define every aspect of life in Pakistan, including the provision of and access to healthcare. In particular, it has shaped constituency politics and service delivery. At the constituency level, political representatives act more like local government officials, drawing support by providing targeted services to particular groups.[61]

One typical outcome of such influence is the ability to hand out public sector jobs, including appointments to the state medical system—a key means of patronage to win votes in rural constituencies and the cause of chronic absenteeism. Callen *et al*. found that doctors who reported a connection to a local politician were more likely to be absent from work. Their survey of 850 BHUs found that appointed medical officers were not present at 67.7 percent of the facilities and that oversight by district bureaucrats was weak. Of the senior officials they interviewed, 44 percent reported coming under political pressure to not penalise employees for failing to turn up at their workplaces, or to appoint doctors to their preferred posts, and that such interference was higher in non-competitive constituencies.[62] In effect,

[60] Akhtar, 'The Overdeveloped Alavian Legacy', p. 71.

[61] Zahid Hasnain, 'The Politics of Service Delivery in Pakistan: Political Parties and the Incentives for Patronage, 1988–1999', in *The Pakistan Development Review*, Vol. 47, no. 2 (2008), pp. 129–51.

[62] These are constituencies where a politician does not face significant competition for their seat in an election. Michael Callen *et al*., 'The Political Economy of Public Sector Absence: Experimental Evidence from Pakistan', Working Paper No. 22340 (2016), National Bureau of

politicians' influence has serious consequences for performance and service delivery in the health care system.

Equally, politicians win over and retain voters by eschewing public goods for personalised service delivery. This can have serious ramifications for the distribution of health (and other kinds of) government services. For example, Hasnain argues that the province of Sindh, unlike Punjab, spent more on fresh recruitment and new infrastructure than on improving existing facilities in health and education throughout the 1990s.[63] Recruitment and new buildings attract the attention of voters and are easily linked to particular politicians rather than more ephemeral improvements in service delivery, making them useful for distributing patronage and garnering votes. But such inputs have not improved outcomes. Therefore, though Sindh has more government hospitals, beds and dispensaries than Punjab (Table 3), citizens there tend to prefer private facilities.[64] The physical accessibility of government facilities is perhaps one important reason for this, with the WHO noting that while 75 percent of Punjab's rural population has a hospital or dispensary within 10 kilometres, the number drops to 66 percent in Sindh, 60 percent in Khyber Pakhtunkhwa, and only about 33 percent in Balochistan.[65]

Table 3:

Economic Research [https://doi.org/10.3386/w22340, accessed 27 Oct. 2020]; and Michael Callen *et al*., 'Improving Public Health Delivery in Punjab, Pakistan: Issues and Opportunities', *The Lahore Journal of Economics*, Vol. 18: SE (Sept. 2013), pp. 249–69 [https://projects.iq.harvard.edu/files/epod/files/improving_public_health_delivery_in_punjab_pakistan.pdf, accessed 3 Sept. 2021]. Note to copy-editor: this reference is correct

[63] Hasnain, 'The Politics of Service Delivery in Pakistan'.

[64] World Bank, 'Policy Note—Pakistan: "For Better Quality and More Integrated PHC Services through Harnessing the Private Sector in Sindh Province: Options Paper"' (2019), p. 3 [https://openknowledge.worldbank.org/bitstream/handle/10986/32005/For-Better-Quality-and-More-Integrated-PHC-Services-through-Harnessing-the-Private-Sector-in-Sindh-Province-Options-Paper.pdf?sequence=1&isAllowed=y, accessed 20 Apr. 2021].

[65] WHO EMRO, Pakistan Health Profile 2015, pp. 1–45 [27] [https://rho.emro.who.int/sites/default/files/Profiles-briefs-files/EMROPUB_EN_19266-PAK.pdf, accessed 25 Oct. 2020].

Health facilities and population by province in 2019

	1 Hospital for	1 Dispensary for	1 Bed for
Punjab	282,807 people	85,546 people	1,822 people
Sindh	101,239 people	16,987 people	1,240 people
Khyber Pakhtunkhwa & former FATA	128,245 people	36,138 people	1,460 people
Balochistan	92,119 people	21,505 people	1,583 people
Islamabad	222,889 people	24,765 people	780 people

Source: Compiled by the authors from Hospitals, Dispensaries, and Beds by Province, Pakistan Bureau of Statistics https://www.pbs.gov.pk/sites/default/files//tables/rename-as-per-table-type/Hospital%20Dispanceries.pdf and Provisional Census Results 2017, Pakistan Economic Survey 2019-20, Statistical Appendices, p. 138 http://www.finance.gov.pk/survey/chapter_20/PES_2019_20.pdf. Population count does not include Azad Jammu and Kashmir and Gilgit Baltistan.

The health impact of inequality

Stark evidence of the impact of these inequalities on the health of citizens can be seen in a range of indicators which parallel inter-provincial indicators of wealth, literacy and status.[66] The latest Demographic and Health Survey (DHS) 2017–18 reveals that, regionally, 80 percent of children in Punjab are fully vaccinated[67] compared to just 29 percent in Balochistan, 49 percent in Sindh, 55 percent in Khyber Pakhtunkhwa, and 30 percent in the Federally Administered Tribal Areas (FATA).[68] In the case of malaria, the disease burden falls squarely on the underdeveloped districts of Balochistan, Sindh and Khyber Pakhtunkhwa

[66] See for example, Nasir Iqbal and Saima Nawaz, 'Spatial Differences and Socio-Economic Determinants of Health Poverty', in Pakistan Institute of Development Studies Population & Health Working Paper Series, PIDE-CPHSP-1 (2015); and Fowad Murtaza *et al*., 'Child Health Inequalities and Its Dimensions in Pakistan', in *Journal of Family & Community Medicine*, Vol. 22, no. 3 (2015), pp. 169–74.

[67] These children are fully vaccinated against a group of diseases including TB, polio, measles, diphtheria, tetanus, pertussis, hepatitis B, pneumonia, meningitis and rotavirus.

[68] *Pakistan Demographic and Health Survey 2017–18* (Islamabad: National Institute of Population Studies, 2019) [https://dhsprogram.com/pubs/pdf/FR354/FR354.pdf, accessed 20 Apr. 2021].

where 90 percent of the country's cases occur in 56 of their cumulative 99 districts (Table 4).[69]

Table 4:
Malaria prevalence by province

	Percentage population (2017 census)*	Provincial Ranking by Per Capita Income 2013-14**	Malaria incidence (%)***
Punjab	53	1	0.2
Sindh	23	3	32
Khyber Pakhtunkhwa	15	2	32
Former federally Administered Tribal Areas	2	-	19
Balochistan	6	4	17

Note: Islamabad, Federal Capital Territory, is not included in these statistics

Sources: *Pakistan Province Wise Provisional Results of Census 2017. Pakistan Bureau of Statistics. http://www.pbs.gov.pk/sites/default/files/PAKISTAN%20TEHSIL%20WISE%20FOR%20WEB%20CENSUS_2017.pdf; ** Hafiz A. Pasha. Growth of the Provincial Economies. Institute for Policy Reforms. December 2015. https://ipr.org.pk/wp-content/uploads/2016/04/GROWTH-OF-PROVINCIAL-ECONOMICS-.pdf; *** Pakistan Malaria Annual Report 2019. Directorate of Malaria Control http://dmc.gov.pk/documents/pdfs/Pakistan%20Malaria%20Annual%20Report%202019%20(002).pdf

Maternal and childhood malnutrition is also very high, mostly in southern Pakistan; this compares with the wealthier population of the more developed Punjab province which has a greater prevalence of obesity amongst women, a 'disease' of the well-to-do.[70] And while overall 7 percent of children in Pakistan are wasted and 38 percent are stunted, considerable provincial variation is evident.

Stunting correlates with wealth—57 percent of children amongst the poorest wealth quintile are stunted, whereas 22 percent are stunted at the highest wealth quintile; it also correlates with the mother's educational level—48 percent of children of mothers with no education are stunted compared to 16 percent of children of a mother with higher educational

[69] *Pakistan Economic Survey 2019–20*, p. 220.
[70] Mariachiara Di Cesare *et al.*, 'Geographical and Socioeconomic Inequalities in Women and Children's Nutritional Status in Pakistan in 2011: An Analysis of Data from a Nationally Representative Survey', in *The Lancet Global Health*, Vol. 3, no. 4 (2015), pp. E229–E239.

levels.[71] Vaccination patterns too correlate with poverty[72] and socio-economic inequality.[73] They reflect an urban bias with 71 percent of children from urban areas being fully immunised compared to 63 percent in rural areas.[74] Urban centres like Islamabad, Lahore and Karachi also spend considerably more on health services, resulting in higher levels of citizen satisfaction for the services provided than in, for example, Balochistan.[75] This reflects what Malik (and Akbar Zaidi before him) referred to as the 'concentration of public spending on tertiary care and urban areas'.[76]

Experiments with devolution and local government

Arguably, decentralisation of power down to the local level might lead to more equitable funding and distribution of resources. Pakistan has made numerous experiments with local government and with attempts to devolve health to the district level in particular, once in the 1990s and again in the 2000s.[77] The most significant reform took place in 2010,

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[71] *Pakistan Demographic and Health Survey 2017–18*.

[72] Owais Raza *et al*., 'Differential Achievements in Childhood Immunization Across Geographical Regions of Pakistan: Analysis of Wealth-Related Inequality', in *International Journal for Equity in Health*, Vol. 17, no. 122 (2018) [https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-018-0837-6#citeas, accessed 3 Sept. 2021]. Note to copy-editor: this reference is correct

[73] S. Zaheer, S. Kanwal and K. Shafique, 'Trends in Socioeconomic Inequalities in Childhood BCG Immunization Coverage in Pakistan', in *European Journal of Public Health*, Vol. 30, no. 5 (Sept. 2020), pp. 1101–262.

[74] *Pakistan Demographic and Health Survey 2017–18*.

[75] Faraz Khalid *et al*., 'Assessing the Efficiency of Sub-National Units in Making Progress Towards Universal Health Coverage: Evidence from Pakistan', in *Health Systems & Reform*, Vol. 6, no. 1 (2020) [https://www.tandfonline.com/doi/full/10.1080/23288604.2019.1617026, accessed 3 Sept. 2021]. See also Danish Khan, 'The Political Economy of Uneven State-Spatiality in Pakistan', in Matthew McCartney and S. Akbar Zaidi (eds), *New Perspectives on Pakistan's Political Economy: State, Class and Social Change* (New Delhi: Cambridge University Press, 2019), pp. 130–52.

[76] Malik, 'Universal Health Coverage Assessment: Pakistan', p. 6; Zaidi, 'The Urban Bias in Health Facilities in Pakistan'.

[77] Sania Nishtar *et al*., 'Pakistan's Health System: Performance and Prospects after the 18th Constitutional Amendment', in *The Lancet*, Vol. 381 (2013), pp. 2193–206 [http://dx.doi.org/10.1016/ S0140-6736(13)60019-7, accessed 26 Apr. 2021].

with a constitutional provision that fiscal transfers from the federation to the provinces could not be less than the transfer for the previous year, and with significant administrative powers devolved from the centre to the provinces. While in theory devolution makes elite capture more difficult due to the existence of multiple centres of power at the federal and provincial levels, in Pakistan the process of administrative and fiscal devolution remains incomplete, in part due to the provinces' low capacity to generate their own revenue and their continuing reliance on the federal government for funds. As a result, though political elites have found some room to manoeuvre by establishing 'provincial strongholds',[78] they remain committed to competing for power and resources at the federal level.

The initial period of devolution was fraught, particularly when it came to vaccine and drug procurement and regulating health professionals, because there was no federal ministry left to provide national coherence to policy and process.[79] After a period of confusion, the Ministry of National Health Services, Regulations and Coordination (MNHSRC) was formed in 2012 to co-ordinate national health policy and vertically-integrated programmes funded by the federal government, for example the Lady Health Worker Programme, the Expanded Programme on Immunization, and programmes for tuberculosis and malaria control, etc.). However, the MNHSRC has been criticised for not playing an effective role in developing co-ordinated strategies for the provinces, preferring to engage with decentralised departments only when there was a crisis or a new initiative.[80]

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[78] Hassan Javid, 'Winning "Friends" and "Influencing" People: Democratic Consolidation and Authoritarianism in Punjab', in *Commonwealth & Comparative Politics*, Vol. 58, no. 1 (2019), pp. 139–59.
[79] *Ibid*.
[80] Shehla Abbas Zaidi *et al*., 'Health Systems Changes after Decentralisation: Progress, Challenges and Dynamics in Pakistan', in *BMJ Global Health*, Vol. 4, no. 1 (2019), pp. 1–8 [https://gh.bmj.com/content/4/1/e001013.full.pdf, accessed 3 Sept. 2021].

At the same time, the hasty devolution of power, delays in fiscal transfers from the centre, and significant gaps in provincial infrastructure limited the capacity of provincial authorities to act in the best interests of citizens; health expenditure dropped by nearly 47 percent in FY 2010–11 (Table 5) during the transition period, delaying the provinces' ability to develop capacity to make context-specific policy and implementation plans.[81]

Table 5.
Public Sector Health Expenditure (Federal and Provincial) PKR Billion FY 2008 to 2018

Fiscal Years	Total Health Expenditures	Development Expenditure	Current Expenditure	Percentage Change	Health Expenditure as % of GDP
2008-09	73.8	32.7	41.1	23.21	0.56
2009-10	78.86	37.86	41	6.86	0.53
2010-11	42.09	18.71	23.38	-46.63*	0.23*
2011-12	55.12	26.25	28.87	30.96*	0.27*
2012-13	125.96	33.47	92.49	128.51*	0.56*
2013-14	173.42	58.74	114.68	37.68	0.69
2014-15	199.32	69.13	130.19	14.94	0.73
2015-16	225.33	78.07	147.26	13.05	0.77
2016-17	291.9	101.73	190.17	29.54	0.91
2017-18	336.29	88.27	248.02	15.21	0.97

*Reflects devolution of national health infrastructure as a result of the 18h Amendment
Source: Pakistan Economic Survey 2018-19

When the provinces did develop health sector plans and roadmaps and allocated funds to the health sector, much of this money was spent on ad hoc programming, salaries, the hire of specialists or expanded infrastructure rather than deploying more frontline healthcare workers on better salaries.[82] The high expenditure on salaries is reflected in the jump in

[81] *Ibid*.
[82] *Ibid*., pp. 3–4

current expenditure in FY 2012–13 in Table 5, with Table 6 showing that this expenditure pattern was evident across all the provinces.

Table 6. Percentage of provincial health budgets spent on salary and non-salary items, FY 2009–2014

Province		2009–10	2010–11	2011–12	2012–13	2013–14
Punjab	*Salary*	43	48	53	57	58
	Non-salary	57	52	47	43	42
Sindh	*Salary*	56	58	56	55	56
	Non-salary	44	42	44	45	44
KPK	*Salary*	60	68	72	68	63
	Non-salary	40	32	28	32	37
Balochistan	*Salary*	80	66	70	73	73
	Non-salary	20	34	30	27	27

Source: Shehla Abbas Zaidi *et al.*, 'Health Systems Changes after Decentralisation: Progress, Challenges and Dynamics in Pakistan', in *BMJ Global Health*, Vol. 4, no. 1 (2019), pp. 1–8 [https://gh.bmj.com/content/4/1/e001013.full.pdf].

The devolution of power from the federation to the provinces was supported by political consensus and a constitutional commitment to set up elected district-level governments.[83] However, political and bureaucratic elites resisted meaningful decentralisation of administrative and fiscal powers from the provincial to the district level and, as a result, when elected local governments were introduced in 2015–16, their powers

[83] In the past, Pakistan has had numerous short-lived experiments with setting up local government institutions at the district and lower levels, each with different structures and powers. See Cheema, Khwaja and Qadir, 'Decentralization in Pakistan: Context, Content and Causes'.

had been considerably watered down. [84] Therefore, little changed in terms of inputs for health policy-making and implementation, or in the clientelist and patronage-oriented incentive structures for politicians which shape their perceptions of service delivery. In the absence of fiscally and administratively empowered district-level governments, the state has been unable to develop and implement contextualised, nuanced programming. Context is critical since the inequity of service provision is tied to societal factors that vary from village to village, such as ethnic, religious, and sectarian identities, class, gender, and caste inequalities and linguistic groupings. For example, children in the highest wealth quintile were more likely to be vaccinated (80 percent) compared to children in the lowest wealth quintile (38 percent), despite immunisations being provided free of charge; moreover boys are more likely to be fully immunised (68 percent) compared to girls (63 percent).[85] Women in higher wealth quintiles are significantly more likely to receive prenatal care, have a skilled attendant present at the birth, and are more likely to receive emergency obstetric care, reducing infant mortality for that quintile.[86] In rural areas, where the distance to a government health facility with maternal care help can be 10 kilometres or more, women prefer to go to private healthcare facilities which are closer.[87] However, in rural Punjab, patterns of access to

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[84] S.M. Ali, 'Devolution of Power in Pakistan', Special Report, USIP (Mar. 2018) [https://www.usip.org/publications/2018/03/devolution-power-pakistan, accessed 20 Apr. 2021]. The district level is the main administrative tier below the provincial level in Pakistan.
[85] *Pakistan Demographic and Health Survey 2017–18*.
[86] A.Y. Alam *et al.*, 'Impact of Wealth Status on Health Outcomes in Pakistan', in *Eastern Mediterranean Health Journal*, Vol. 16 (2010), pp. S152–S158. See the IHME data page for Pakistan for child mortality mapped by region [http://www.healthdata.org/pakistan, accessed 3 Sept. 2021].
[87] Rahat Najam Qureshi *et al.*, 'Health Care Seeking Behaviours in Pregnancy in Rural Sindh, Pakistan: A Qualitative Study', in *Reproductive Health*, Vol. 13, no. 34 (2016), pp. nos?. Nishtar *et al*. estimate that 75% of health services in Pakistan are provided by the private sector. However, accurate counts of private healthcare providers in the country are difficult to give since the sector is poorly regulated. See Nishtar *et al*., 'Pakistan's Health System: Performance and Prospects after the 18th Constitutional Amendment'.

maternal healthcare are also mediated by caste-based social hierarchies[88] in addition to wealth, making private healthcare consumption an important status marker and skewing consumption patterns.[89] Such findings are critical to understanding how best the state should respond to improve access to healthcare for citizens, particularly for the marginalised such as minority groups, refugees and internally displaced persons impacted by terrorism and political violence, and disasters such as floods and earthquakes, where regular state programming is disrupted. The federal government's response must opt for contextualised programming rather than a one size fits all approach if it is to ensure the wellbeing of its citizens.

The privatisation of healthcare

Pakistan's failure to provide universal, quality, accessible health care has compelled needy patients to use their savings, borrow at high interest rates from private lenders, or sell their assets to afford medicines, get referrals from private doctors, and pay bribes to gain access and treatment in overburdened public health services.[90] Pakistan scores below average on the WHO's universal service coverage index,[91] a measure of the match between outputs (health service coverage and financial protection) and inputs (per capita health spending) by division.[92] Surgical costs, in particular, can lead to impoverishment or exhaust household income for significant proportions of the population (Table 7), while another major source of out-of-pocket

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[88] These are locally known as *biradari* or *zaat* and are dependent on occupational hierarchies and linked to notions of purity.
[89] Zubia Mumtaz *et al.*, 'Signalling, Status and Inequities in Maternal Healthcare Use in Punjab, Pakistan', in *Social Science and Medicine*, Vol. 94 (2013), pp. 98–105. On caste in Pakistan and India, see Hassan Javid and Nicolas Martin, 'Democracy and Discrimination: Comparing Caste-Based Politics in Indian and Pakistani Punjab', in *South Asia: Journal of South Asian Studies*, Vol. 43, no. 1 (2020), pp. 136–51, DOI: 10.1080/00856401.2020.1691831.
[90] Malik, 'Universal Health Coverage Assessment: Pakistan'.
[91] Khalid *et al.*, 'Assessing the Efficiency of Sub-National Units in Making Progress Towards Universal Health Coverage'.
[92] A division is the administrative tier below a province and is comprised of a number of districts.

spending is medicines or vaccines because private facilities charge for them.[93] In 2018, out-of-pocket payments by individuals and families amounted to over 70 percent of total health expenditure in the country.[94]

Table 7. **I**mpoverishing and catastrophic health expenditures

Risk of catastrophic expenditure for surgical care (% of people at risk) 2017	53.9
Risk of impoverishing expenditure for surgical care (% of people at risk) 2017	29.9
Proportion of population pushed below the $1.90 ($ 2011 PPP) poverty line by out-of-pocket health care expenditure (%) 2015	0.87
Proportion of population spending more than 10% of household consumption or income on out-of-pocket health care expenditure (%) 2015	4.46
Proportion of population spending more than 25% of household consumption or income on out-of-pocket health care expenditure (%) 2015	0.49

Source: World Bank Development Indicators for Pakistan
https://data.worldbank.org/indicator/SH.XPD.CHEX.PC.CD?locations=8S

One of the most promising reforms to counter impoverishing health expenditures is a health insurance plan named the Sehat Sahulat Program launched by Imran Khan's Pakistan Tehreek-e-Insaaf (PTI), first in the province of Khyber Pakhtunkhwa in 2015 and then at the federal level in 2018.[95] Modelled on India's Rashtriya Swasthya Bima Yojana (RSBY) Insurance Programme, the government subsidises poor households (living on less than $2 per day) to go to selected public and private hospitals, allowing the hospitals to retain 75 percent of earnings. In 2021, the programme covers all eligible households in Khyber Pakhtunkhwa, and the scheme is being rolled out in other parts of the country with the exception of Sindh

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[93] Pakistan Bureau of Statistics, *National Health Accounts, Pakistan 2015–16* (Pakistan Bureau of Statistics, Government of Pakistan, 2018), pp. 1–114 [46–7] [https://www.pbs.gov.pk/sites/default/files//NHA-Pakistan%202015-16%20Report_0.pdf, accessed 25 Apr. 2021].
[94] WHO, 'Pakistan Health Systems Profile' (2018).
[95] Ikram Junaidi, 'PM Re-Launches Health Scheme Under New Title', *Dawn* (5 Feb. 2019) [https://www.dawn.com/news/1461909, accessed 26 Oct. 2020].

because the provincial government of the Pakistan People's Party is yet to sign up to it. In total the programme currently covers 75 million people.[96] However, this is not an entirely new initiative. Health insurance programmes have been introduced by successive governments in Pakistan since 2012, including the Waseela-e-Sehat scheme linked to the Benazir Income Support Programme in 2008 and the Prime Minister's National Health Programme in 2015, only to be abandoned due to financial constraints during economic downturns.[97] It remains to be seen if the PTI government can sustain this programme through the economic constraints of yet another financial crunch and a growing population amidst a pandemic, and the political economy constraints evident in the struggles between political elites over the ownership of such programmes.[98]

Private sector investment and regulation

The lack of public funding has created great opportunities for private investment, with even low-income families attending private clinics and hospitals because of their efficiency and quality. The features of private healthcare facilities vary immensely—many are small or medium enterprises (SMEs) operating locally; some are large non-profit organisations such as Shaukat Khanum Memorial Hospital, opened by current prime minister Imran Khan in 1994; others are commercial ventures that depend on patient fees for revenue.[99] In 2019 some

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[96] Faisal Rifaq, Sonia Riaz and Mohammad Arshad, 'Sehat Sahulat Programme', *The News on Sunday* (2 May 2021) [https://www.thenews.com.pk/tns/detail/828473-sehat-sahulat-programme, accessed 11 June 2021].
[97] Zaheer Abbasi and Sardar Sikander Shaheen, 'Funding Constraints: Success of Sehat Sahulat Programme Remains Uncertain', *Business Recorder* (3 Sept. 2020) [https://www.brecorder.com/news/40016131, accessed 26 Oct. 2020]; and Ikram Junaidi, 'PM Launches Health Scheme for the Poor', *Dawn* (1 Jan. 2016) [https://www.dawn.com/news/1229970, accessed 26 Oct. 2020].
[98] Qadeer Tanoli, 'Shut Down: BISP Closes Three Key "Pro-Poor" Schemes', *The Express Tribune* (5 July 2016) [https://tribune.com.pk/story/1137223/shut-bisp-closes-three-key-pro-poor-schemes, accessed 23 May 2021]; and Junaidi, 'PM Re-Launches Health Scheme Under New Title'.
[99] Shehla Zaidi, 'Beyond Health PPPs', *Dawn* (15 Apr. 2019) [https://www.dawn.com/news/1476218, accessed 23 May 2021].

66 percent of rural and 76 percent of urban people visited private facilities for routine consultations.[100] According to an International Finance Corporation survey of SME private hospital owners around the country, income for these small businesses is generally good: just 3 percent reported a decrease in earnings in 2010–11.[101] About 75 to 80 percent of Pakistan's health services are private, including qualified doctors and traditional healers in the informal market,[102] primarily as a result of inequitable public service provision, particularly at the primary care level.[103] Across the country, respondents to the Pakistan Social and Living Standards Measurement Survey (PSLM Survey) noted that government facilities were too far away or not available at all, or lacked female staff, or offered unsuitable appointment times, or there was a lack of trust in their abilities or services.[104] For instance, private facilities and practitioners were the choice for the majority of pre- and post-natal consultations and for over a third of births. Furthermore, the 2018–19 PSLM survey found that 59 percent of medical consultations for young children suffering from diarrhoea were with private medical practitioners.[105] Interestingly, surveys of this nature do not include military medical facilities as a response option, even though they attract a considerable number of civilian patients. A

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[100] Shehla Zaidi, 'Private Sector in Health', *Dawn* (11 Feb. 2019) [https://www.dawn.com/news/1463125, accessed 25 Oct. 2020].

[101] International Finance Corporation, 'Health and Social Work—Private Sector Hospitals', World Bank Group (2011) pp. 12–13 [https://dnb.sbp.org.pk/departments/ihfd/Sub-Segment%20Booklets/Health%20and%20Social%20Work-Private%20Sector%20Hospitals.pdf, accessed 23 May 2021].

[102] Shehla Zaidi *et al*., 'Role and Contribution of Private Sector in Moving Towards Universal Health Coverage in the Eastern Mediterranean Region', Agha Khan University, Karachi (Jan. 2012) [https://ecommons.aku.edu/cgi/viewcontent.cgi?article=1193&context=pakistan_fhs_mc_chs_chs, accessed 25 Oct. 2020].

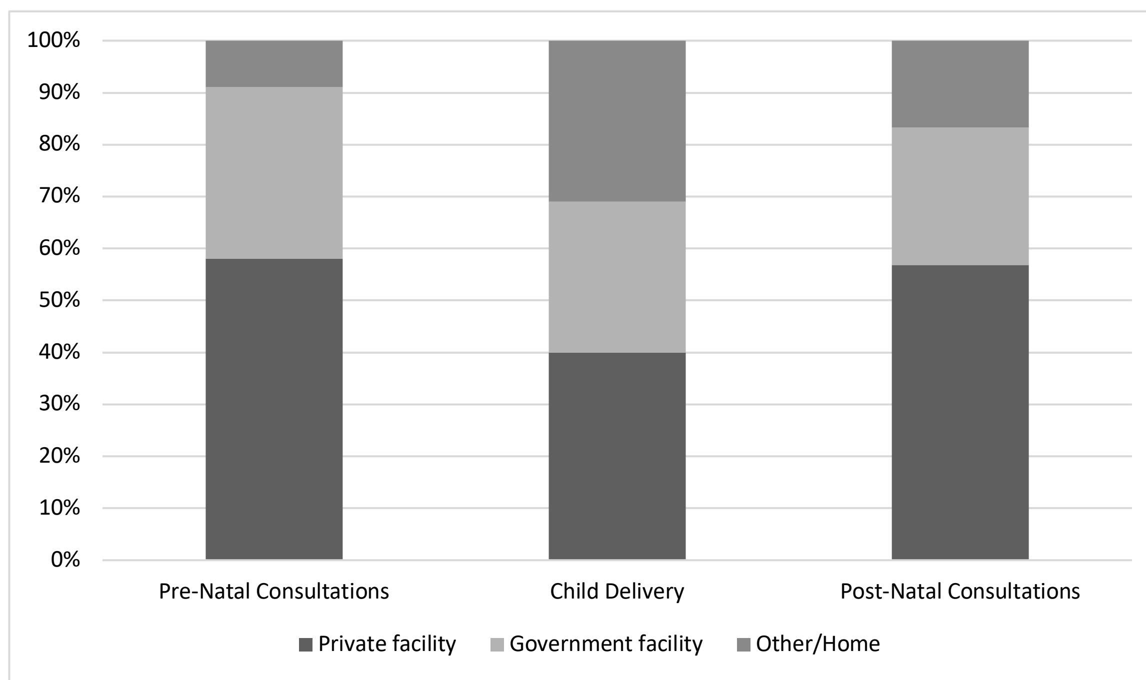
[103] Tahir Ali Javed and Shahid Amin, 'Health Sector Reforms Programme in Punjab: A Primary Healthcare Initiative', in *Clinical Medicine*, Vol. 7, no. 1 (2007), pp. 19–22.

[104] Pakistan Bureau of Statistics, 'Pakistan Social and Living Standards Measurement Survey (PSLM) 2018–19', p. 82 [https://www.pbs.gov.pk/content/pakistan-social-living-standards-measurement-survey-pslm-2018-19-national-provincial, accessed 26 Apr. 2021].

[105] *Ibid*.

National Health Accounts report from 2015–16 noted that 42 percent of public sector health expenditure was spent through the military health care system.[106]

Figure 8. Type of medical care sought for pre- and post-natal consultations and childbirth



Source: Pakistan Social and Living Standards Measurement Survey 2018-19, page 82-85 https://www.pbs.gov.pk/sites/default/files/pslm/publications/pslm2018-19/pslm_report_2018-19_national_provincial.pdf

Addressing the problems in public sector healthcare requires concerted efforts informed by local-level decision-making if the government is not to completely abdicate its primary healthcare responsibilities to the private sector. Aside from the cost of seeking private health care, poor regulation makes it difficult to identify 'quacks'. The dynamics of local social structures, patronage politics and the absence of state commitment to healthcare for all allows quackery to thrive. Local interest groups and politicians, competing for influence, protect these quacks whenever health regulators take some action to control malpractice and fraud at the

[106] Federal Bureau of Statistics, Government of Pakistan, 'National Health Accounts 2015–16', p. xii. Family employment in the military is not a condition for accessing medical facilities run by the Pakistani armed forces.

district level. As a result, private practitioners claiming to be 'medical professionals' may have no formal medical education, degrees or training. One estimate suggests that there are 70,000 to 80,000 unqualified medical practitioners working in the most developed province, Punjab.[107] These so-called 'professionals' prescribe and make their own medicines, which many qualified health professionals believe have caused renal failure and other fatalities.[108] Lack of hygiene is another problem in this sector and has been identified as a major cause for the spread of hepatitis and AIDS, including the surge in HIV cases amongst children in Larkana, Sindh.[109]

Poor regulation also makes it difficult to include the private sector in national strategies and specific vertical programmes controlled by the federal government. For example, though Pakistan has the fifth-highest incidence of TB in the world and is estimated to rank fourth for prevalence of multidrug-resistant tuberculosis,[110] the National TB Control Programme has struggled to include the private sector in strategies and protocols.[111] Similarly, for malaria eradication, the Directorate of Malaria Control finds it difficult to enforce national treatment guidelines in private facilities.[112]

The consequences of limited legislative oversight, inadequate regulation, poor policy design and development, and patronage-based constituency-level service provision is that the setting of priorities often takes place on the advice of donors. As Nishtar *et al.* point out, the

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[107] Raja Khalid Shabbir, 'Of Fake Doctors and Fake Clinics', *The Express Tribune* (24 Apr. 2019) [https://tribune.com.pk/story/1957612/6-fake-doctors-fake-clinics, accessed 25 Oct. 2020].
[108] Shershah Syed, 'Health: The Lure of the Quacks', *Dawn* (5 Nov. 2018) [https://www.dawn.com/news/1443342, accessed 25 Oct. 2020].
[109] Helen Ouyang, 'The City Losing its Children to HIV', *The New York Times* (31 Mar. 2021) [https://www.nytimes.com/2021/03/31/magazine/pakistan-hiv.html, accessed 25 Apr. 2020].
[110] WHO, Pakistan Tuberculosis Brief [http://www.emro.who.int/pak/programmes/stop-tuberculosis.html, accessed 26 Oct. 2020].
[111] P. Metzger *et al.*, 'Tuberculosis Control in Pakistan: Reviewing a Decade of Success and Challenges', in *Eastern Mediterranean Health Journal*, Vol. 16 (2010), pp. S47–S53.
[112] Directorate of Malaria Control, 'Pakistan Malaria Annual Report (2019)', p. 10 [http://dmc.gov.pk/documents/pdfs/Pakistan%20Malaria%20Annual%20Report%202019%20(002).pdf, accessed 26 Apr. 2021].

international donor community has been 'the driving force' for most health policy work and reform planning in Pakistan,[113] including the push for privatisation and public–private partnerships (PPPs) under an IMF Structural Adjustment Program in 1998. However, such a degree of donor involvement and the absence of political ownership and responsibility brings with it a separate set of issues and constraints.

External donors

Donor–government relations are characterised by imbalances of power that devalue local expertise and knowledge and concentrate resources and decision-making in the hands of international donors.[114] As a result, donor recommendations for Pakistan's economy have had significant knock-on effects for development spending and programming, and health policies developed and implemented by donors rarely have effective national or local ownership or control.[115]

During the 1980s and 1990s, Structural Adjustment Programs wrought considerable damage on the health system in Pakistan and elsewhere. Bhutta found that if Structural Adjustment Programs were implemented in a setting with poor governance, weak local representation and low accountability caused little improvement in maternal and childhood malnutrition and led to even greater poverty. For instance in the 1980s, Pakistan was meeting most of its vaccine demand through internal production;[116] but in the 1990s, under the constraints of IMF-imposed conditions, domestic mismanagement, economic crises, and the

[113] Nishtar *et al.*, 'Pakistan's Health System: Performance and Prospects after the 18th Constitutional Amendment', p. 2200.
[114] Mishal S Khan *et al.*, 'How Do External Donors Influence National Health Policy Processes? Experiences of Domestic Policy Actors in Cambodia and Pakistan', in *Health Policy and Planning*, Vol. 33, no. 2 (March 2018), pp.215–23.
[115] *Ibid*.
[116] Zulfiqar Ahmed Bhutta, 'Structural Adjustments and Their Impact on Health and Society: A Perspective from Pakistan', in *International Journal of Epidemiology*, Vol. 30, no. 4 (August 2001), pp. 712–6.

move away from industrial production toward greater agricultural export, the pharmaceutical industry became reliant on imports,[117] shutting down 80 percent of its vaccine production units. Production has only recently begun increasing again.[118] Bhutta argues that Pakistan's reliance on imports to meet the needs of the population and its lack of competitiveness in the export market compared to India has driven up the prices of vaccines and medicines. He posits the lack of local manufacturing as one of the factors contributing to the differing infant mortality rates in India and Pakistan.[119] As well, studies about pharmaceutical production in India and Bangladesh show that locally-produced drugs and vaccines are cheaper than the imported products manufactured by multinationals.[120]

Isomorphic mimicry in public–private partnership programmes

In response to the underutilisation of the rural health network, the poor performance of Basic Health Units, and increasing reliance on private health care, the donor community pushed for the state to contract out service provision to NGOs or public–private partnerships. This is an example of 'isomorphic mimicry', 'the tendency of governments to mimic other governments' successes, replicating processes, systems, and even products of the "best practice" examples' promoted by the development community, without taking into consideration domestic contexts and realities.[121] In 1999, Rural Support Programmes run by

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[117] *Ibid*.
[118] Ikram Junaidi, 'NIH to Increase Vaccine Production', *Dawn* (1 October 2016) [https://www.dawn.com/news/1287228, accessed 30 Oct. 2020].
[119] Bhutta, 'Structural Adjustments and Their Impact on Health and Society'; see also Kabeer Dawani and Asad Sayeed, 'Pakistan's Pharmaceutical Sector: Issues of Pricing, Procurement and the Quality of Medicines', Anti-Corruption Evidence (ACE) Research Consortium, Working Paper 012 (London: SOAS University of London, 2019) [http://www.researchcollective.org/Documents/Dawani_and_Sayeed_2019_PakistanPharmaSector-190801.pdf, accessed 26 Apr. 2021].
[120] See papers in this collection on the Indian and Bangladeshi pharmaceutical industries.
[121] Matt Andrews, Lant Pritchett and Michael Woolcock, 'Chapter 2: Looking like a State: The Seduction of Isomorphic Mimicry', *Building State Capability: Evidence, Analysis, Action*

not-for-profit joint stock companies were contracted to take over the management of BHUs in nominated districts, beginning with Lodhran in Punjab. The programme was scaled up nationally in the 2000s and continues today,[122] with Rural Health Centres also being contracted out in some districts, for example in Punjab through the Punjab Health Facilities Management Company. The objective was to improve services available at the primary care level, reduce the burden on larger hospitals, and roll back the responsibilities of provincial health departments. However, Nishtar *et al*. note that there was no baseline data collected on the performances of these BHUs.[123] Therefore, as Malik *et al*. find, Pakistan's Rural Support Programmes had 'no explicit goals or targets' laid out, and neither were their budgets made conditional on the achievement of specific performance indicators, unlike similar reform contracts in the health sectors of other countries.[124] The Rural Support Programmes were allowed to transfer civil servants, recruit managers on contract, determine their salaries, engage the community and improve infrastructure, aided in part by funds from the respective provincial governments. Though contracting out BHUs did increase their use by rural households, specifically for diarrhoea amongst children, the reform could not address structural issues such as costs of travelling to and from health centres and the ongoing gap between public- and private-sector provision in terms of access and quality.[125] In effect, the state needed

(Oxford Scholarship Online, 2017) DOI:10.1093/acprof:oso/9780198747482.003.0003. Note to copy-editor: this reference is all that was available

[122] Provincial governments transfer funds (as grants-in-aid) and management responsibility to the Rural Support Programme. Since they are partly funded by provincial governments, there was no open competition for these contracts. See Malik *et al*., 'Did Contracting Effect the Use of Primary Health Care Units in Pakistan?', pp.1032–41 for more details.

[123] Nishtar *et al*., 'Pakistan's Health System: Performance and Prospects after the 18th Constitutional Amendment', p. 2201.

[124] Malik *et al*., 'Did Contracting Effect the Use of Primary Health Care Units in Pakistan?'.

[125] *Ibid*. See also Willem A. Odendaal *et al*., 'Contracting Out to Improve the Use of Clinical Health Services and Health Outcomes in Low- and Middle-Income Countries', in *Cochrane Database of Systematic Reviews*, Vol. 4, no. CD008133 (2018), DOI: 10.1002/14651858.CD008133.pub2. (Note to copy-editor: this is the correct reference)

to step up to improve healthcare services but failed to do so, falling into the mimicry trap of giving the appearance of greater state capability without actually building state capacity.

In Sindh, a programme to manage health services through public–private partnerships has been heavily criticised by health professionals. Government health staff have little understanding of the model itself and fear that the system is intended to downsize the number of government employees and replace them with new private-sector recruits.[126] The great weakness of the public–private partnership model then, seems to be its failure to involve knowledgeable, local healthcare staff. This was evident in a project that encouraged a model of NGO contracting through open competition to control the spread of HIV/AIDS in Pakistan between 2003 and 2008. That programme ran into many difficulties, had limited local political support on the ground, and the contracted NGOs lacked the required expertise or skills to carry out the work.[127] Qureshi found that this market-based, neo-liberal approach had turned 'government departments into hatcheries of private interest and entrepreneurship'.[128] In the meantime, Pakistan now faces a growing number of new infections and increasing AIDS related mortality with just 21 percent of people living with HIV aware of their status.[129]

Conclusion

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[126] N.N. Khan and S. Puthussery, 'Stakeholder Perspectives on Public–Private Partnership in Health Service Delivery in Sindh Province of Pakistan: A Qualitative Study', in *Public Health*, Vol. 170 (2019), pp. 1–9.

[127] Shehla Zaidi *et al*., 'Context Matters in NGO–Government Contracting for Health Service Delivery: A Case Study from Pakistan', in *Health Policy and Planning*, Vol. 27 (2012), pp. 570–81.

[128] Ayaz Qureshi, 'The Marketization of HIV/AIDS Governance: Public–Private Partnerships and Bureaucratic Culture in Pakistan', in *The Cambridge Journal of Anthropology*, Vol. 33, no. 1 (2015), pp. 35–48 [36].

[129] UNAID, '2020 Global AIDS Update—Seizing the Moment—Tackling Entrenched Inequalities to End Epidemics', pp. 272, 285 [https://www.unaids.org/en/resources/documents/2020/global-aids-report#:~:text=Missed%20targets%20have%20resulted%20in,to%20meet%20the%202020%20targets, accessed 27 Oct. 2020].

Pakistan's public health system is complex, poorly funded and weakly governed. Most of all, though, Pakistan's health system is entangled in patronage politics and is a site for rent-seeking and struggles for power between the country's military, political, bureaucratic and business elites, and religious groups. As such, our political settlements approach, encompassing the specificities of a security state, patronage politics, and regime, institutional and leadership instability, provides an explanation for the maldistribution of health resources, funds and services, and the unsustainability of health care initiatives and programmes. Clientelist bargains for power have led to political, bureaucratic, and military elites and well-networked business and religious elites dominating Pakistan's politics, economy and society. Political settlements analysis provides an explanation for the persistence of these patterns despite changes in regimes, leaders and class structure.

The consequences of factions bargaining for power are visited upon the most vulnerable of Pakistan's 217 million people. At the same time, the preference amongst donors, the development community, and Pakistan's ruling elite for replicating 'best practice' from other contexts without regard for local realities has cut back on the state's provision and regulation of services in order to consolidate the private sector's hold through a model of state-supported entrepreneurship and subcontracting. In effect, the state is abdicating its primary responsibility to private operators, especially as the regulation of the private sector at all levels remains weak, with the burden of costs and mistakes falling on consumers.

Attempts at ambitious healthcare reform by the PTI government (such as the highly contentious and oft challenged reform of medical teaching institutions and of the main regulatory body for the medical profession in the country) have met with considerable backlash, especially due to the lack of stakeholder consultations and parliamentary debate on the proposed plans. Though the PTI government has done well to continue the roll-out of

health insurance and the expansion of cash transfers to vulnerable populations during the COVID-19 pandemic, the state's centralised orientation, the targeting of resources to preferred constituencies, and weak enforcement of a range of regulations have continued unchecked. It is possible that the COVID-19 pandemic will lead to a shift in perspective as to the design and implementation of health sector reform, with improvements in the evidence base used by policymakers and a realisation of the importance of local governments and frontline workers and their contribution to health service delivery. However, though health care reform has never been more urgent and consequential, the odds are that it will remain in thrall to struggles for power amongst Pakistan's political and economic elites.