Review Article

# Universal Healthcare Access in Pakistan

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**Abstract**

If we are to improve the living conditions of Pakistan's population, it is imperative to develop means by which health care and related facilities are provided on a universal, all-inclusive basis. It was to this end that a symposium was held on 20th of December, 2018 at King Edward Medical University, Lahore, with the support of the KE faculty and alumni. This article explores the key features of Universal Healthcare, based upon clinical vignettes from the author's personal experiences.

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## Introduction

It is a painful reality that Pakistan has not lived up to its promise to serve its population. This country remains at the bottom end of the world human development indices, ranking within the 10 lowest HDIs in Asia in 2018. We may attribute this to many factors both inside and outside the country, in an attempt to rationalize the situation, but ultimately, we must ourselves unearth the solutions to try to improve the lot of millions of people who live here.

The countries in region have surged ahead in providing a better quality of life for their citizens; for example, Bangladesh, a nation that was widely considered to be deprived and underprivileged at the time of its independence, is far ahead of us in this regard, even though their per capita income is still inferior.

## Vignette 1: Two Young Patients

I undertook my medical house job in the West Medical Ward of the Mayo Hospital in 1986. I looked after a 10-year-old child who had been admitted with acute respiratory distress due to myasthenia gravis. She was treated with anti-cholinesterase medication and made a good recovery. She required a thymectomy which her family arranged for her in the USA. She did well.

At the same time, there was another girl of the same age, who had come in with diabetic keto-acidosis. At that young age, she had already developed complications of diabetes, because she could not afford to buy insulin. It is very unlikely that she survived for long.

## Equity

Clinicians in Pakistan regularly come into contact with tragic instances of deprivation and inequality; it is difficult not to be affected emotionally by such situations. As a result, there are a lot of efforts by medical professionals to help their patients through spending out of their own pocket or by raising funds on a charitable basis. These efforts, although noble in their intent and often lifesaving, are inadequate for a population as large as ours, and cannot be all encompassing. As long as health care access is based on charity and acts of individual kindness alone and not backed by robust institutional support, there will continue to be stories of tragedy and loss. To provide equity of access across the socio-economic spectrum, it should be incumbent on those in positions of

responsibility to ensure adequate mechanisms for service delivery. A majority of the world's nations treat healthcare access as a fundamental human right. In my view, it is impossible to ensure universal access based on philanthropy alone. Abject poverty wreaks havoc with people's lives, especially when they are in need of medical care. This problem may only be resolved collectively.

### Vignette 2: A Story of Two Hospitals

In the 1980s, and 1990s I worked in Sir Ganga Ram Hospital, Lahore as a medical registrar. We had a total of 25-30 beds. We actually had an almost equal number of doctors, including a professor, an associate professor, and assistant professor, a senior registrar, three registrars and fifteen house officers.

A friend had been appointed as the district surgeon in Qasur, a hospital of similar size, in terms of the number of beds. I visited him and found that his ward was full, with in some instances, two patients sharing a bed. He was alone in his evening ward round and told me that the one house officer he had was running a private practice at that time.

He also took me to see his medical ward, where there were no patients, and the beds had been stacked, one on top of the other, to protect them from dust.

### Access

Having access to medical care, which may be obtained easily in times of need, is a key feature of universality. For countries like Pakistan, healthcare provision can be poor in particular areas, both in terms of infrastructure, and workforce. The above vignette highlights the problem of maldistribution of workforce; although it is important to train doctors to high standards, concentrating training posts in big hospitals in urban centres is not an appropriate approach. The priority should be placed upon patient care, when spending the tax rupees. While the public-sector health system in Pakistan is resource constrained, poor distribution of resources due to organisational and planning failure accentuates the problem.

The revolution in communication technology and the high uptake of internet use and smart phones in Pakistan allows medical consultation via telemedicine, nationally and internationally. Technology also allows for data collection for disease surveillance and demographics, with much greater ease. We must develop and strengthen mechanisms to gather and use health data.

### Vignette 3: A PhD doctor in Karachi

A colleague who is a surgical consultant in the UK contacted me. Her uncle was unwell in Karachi. He had a Bilroth II gastrectomy in the past and had developed a common bile duct stone, leading to life threatening cholangitis. He had an ERCP procedure attempted in one of the most reputable hospitals in the city, but without success. He was told that palliative care was the only option. I was able to recommend a friend who could undertake the procedure and remove the stone.

### Quality

We must ask the questions: why does the quality of care vary in different hospitals within the same city? Why is there no referral system or consultation with colleagues? Public access to information about physician and hospital outcomes is lacking, as well as the practice of self-audit, communication and referral among doctors.

There are outstanding examples of high quality in practice in or country. One such example is the Shaukat Khanum Hospital. It is fair to say that they have achieved internationally reputable standards, acknowledged by the world accrediting bodies. This is due to sheer discipline, clear focus and dedication of determined professionals, committed to achieving the best outcomes for their patients.[1]

Another impressive example that I am familiar with is the endoscopy unit in the Lahore General Hospital. Thanks to excellent and enlightened leadership, they have built a world class unit in the public sector, overcoming all the problems of resource constraints, bureaucratic hurdles and resistance to change by entrenched interests. They have opened up to the international faculty, especially expatriates working in the UK and the US, and have invested on training the junior doctors to a very high degree of proficiency. These examples should be followed and replicated.

### Vignette 4: Two elderly female patients

In late 1980s, I worked in the coronary care unit in

local teaching hospital. We had a patient, who had been admitted with a myocardial infarction and was drowsy due to opiate analgesia. She was given a bed pan by a male 'sweeper', as this nursing duty was not performed in our hospital by nurses. To protect her privacy, he stood back and drew the curtains. She fell out of the bed and broke her wrist. Her son, who was a lecturer in an elite university was understandably distraught and would sleep in the hospital corridor, as long as his mother remained with us.

A few years later, I was working as a newly appointed consultant, in the medical admissions unit in the UK. I reviewed a lady, who told me that her son was also a doctor and worked in London. She later told me that he was the president of the Royal College and would come visiting later that day. Nobody ever asked me for any special treatment.

## Professionalism

If anyone falls ill in Pakistan, especially when requiring hospital admission, it causes huge disruption to the whole family. Most of the nursing care is provided by the family: the food is usually brought from home, family members have to take turns to be at the bedside. Even in the private sector, there are very few hospitals which provide complete medical and nursing care, obviating the need for family to be present. This is due to a shortage of trained personnel, particularly nurses, but also due to a culture of non-performance by such nurses of some of the essential duties of patients' personal care, including hygiene and feeding.

## Funding Healthcare

Britain can be held up as an example of universal access to quality health care in the developed world at no direct cost to the patient. The care is free at the point of delivery, without any out-of-pocket expense. The care providers in hospitals are employed by the government, while general practitioners are independent and are paid a per capita fee annually, based on a national contract, for the patients registered with them.

The Canadian system is based on universal insurance by the government. The healthcare providers are autonomous, but they don't charge the patient; instead, they are reimbursed by the government. The health-card system that Turkey has successfully developed, and which Pakistan is in process of developing is similar to this model.

In the US, most health care is funded by private insurance. For the deprived sections of the society, including the elderly and armed forces veterans, there are state and federally funded programmes. It is perhaps the most expensive and unequal healthcare system in the developed world.

Closer to home, in Sri Lanka, the government makes an effort to provide healthcare, free at the point of delivery. About 50% of primary curative services are provided by private practitioners. The majority of inpatients are treated in government hospitals. Sri Lanka has a devolved system of state run health care, with a consistent expenditure of 1.6 to 1.8 per cent of GDP on healthcare.[2]

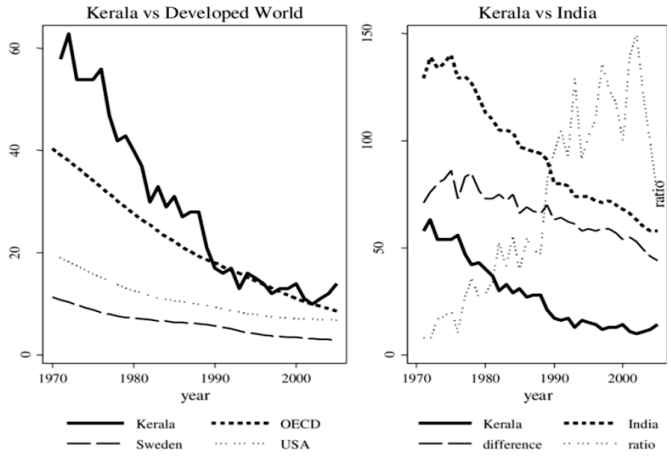


**Figure:** *Comparison of Variations in Health with Human Development Outcomes in different Regions*

India has a mixed system of healthcare delivery, with strong government and private sector health care provision. They have a very highly trained medical work force, which is making an international impact. However, there are quite striking regional variations in health and human development outcomes, with the southern states performing far ahead of the rest of the country. It would be instructive for Pakistan to study their social and health care policy.

Bangladesh's progress, which has been rapid, makes clear the effectiveness of giving a significant role to women in the delivery of healthcare and education, combined with the part played by female employees in spreading knowledge about effective family planning (Bangladesh's fertility rate has fallen

sharply from being well above five children per couple to 2.2 – close to the replacement level of 2.1)[3].

Pakistan has a mixed system of provision of health care, with the majority of patients having to payout of pocket, both for inpatient and outpatient care. Large government and semi government institutions, such as the armed forces have excellent provision of health care for their members. Private sector employers are obliged to provide health care contributions for their employees if they employ above a certain number. This system is managed through a government run social security programme[4].

In recent years, the federal and provincial governments have started the health card schemes, which are essentially health insurance provided by the government, where the patients can choose their care providers. There is a large private sector with instances of high quality care, though there is a considerable variation in standards.

## Human Development, A Regional Comparison

In the South Asia region, Pakistan trails in all outcomes while Sri Lanka is the leader.

## Welfare State

A publicly funded universal healthcare system cannot run in isolation. It must be integrated within a social welfare system, including universally accessible and affordable education. It is, for example, well recognised that the birth rate reliably decreases, depending on gains in female education provision[10]. The government must respond to these fundamental needs of the population and be held accountable by them and answerable to them.

It is imperative to consider the national priorities, to decide where to spend our national revenues. That requires some tough decisions – one example is the subsidy to loss-making public enterprises and the high defense expenditure.

**Table 1:** *Comparison of Human Development Indicators Among different Countries*

| | Pakistan | India | Bangladesh | Sir Lanka | UK |
|---|---|---|---|---|---|
| IMR[5] | 70 | 41 | 33 | 8 | 4 |
| GDP $[6] | 5,527 | 7,056 | 3,869 | 12,811 | 43,877 |
| Life Expectancy[7] | 66 | 68 | 72 | 75 | 81 |
| Fertility Rate[8] | 3.1 | 2.3 | 2.1 | 2.1 | 1.8 |
| Literacy Rate%[9] | 56 | 69 | 73 | 93 | NR |

IMR: Infant mortality per thousand (2010-15)
GDP:Gross domestic product

**Table 2:** *Comparison of Current and Comparative Use Of financial Resources*

| Rupees in billions | Current use | Comparative use |
|---|---|---|
| 40 | Annual subsidy to the PIA | Cost of providing a health card worth Rs 5 lakh, to all poor families in the country |
| 200 | The accumulated loss of Pak Steel Mills | The total health budget of Punjab |
| 20 | The cost of 2 modern F16 aircraft | The total health budget of Balochistan |

## Conclusions

Pakistan is severely underperforming in human development outcomes in comparison with its neighbours in South Asia. It is also uniquely placed in many aspects to improve on this situation – it has a long tradition, as well as exceptional institutions for health education. The country's physical infrastructure is rapidly developing and of a relatively good standard, including road networks, internet connectivity and smart phone ownership. It has managed large scale income support projects such as Benazir Income support programme.

What is needed is an overarching vision and a plan, for universal healthcare provision, which first and foremost, requires political will.

This universality must be inclusive of people from across all social classes, geographical regions and must provide a high quality of care. This can only be achieved by social and public activism to support the people in power to this end, while also holding them accountable. Such activism requires participation of health professionals but importantly, it must also involve print, electronic and social media, to propel this message into the public consciousness.

## Key Points

- The health care provision for the Pakistani population is woefully inadequate and lags behind most other countries in the region.
- Pakistan has a tradition of good medical education and practice of modern medicine which

needs to be more widely available.

- There are opportunities for development in health care, as the physical and communication infrastructure is rapidly evolving.
- There is a large voluntary and private health care sector which needs to be effectively integrated into a universal health care model.
- Political action and activism are necessary ingredients of progress.

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