Social Determinants of Health

(Issues and challenges in Pakistan)

Introduction:

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.

Human welfare and development is a basic right of each individual as highlighted in the Constitution. Pakistan is also a signatory to the Alma Ata Agreement which sets Millennium Development Goals, according to the essence of public health. Whereas Health is affected by social position and the underlying inequality in a society. There is an established correlation between social and health inequality.

The health of nations is affected by absolute deprivation associated with low economic development such as lack of clean water, adequate nutrition, housing and education and general sanitary conditions; relative deprivation or inequitable distribution of income and broader social inequalities such as income and gender inequalities. Most health inequalities in socio-economic and gender groups are, avoidable. These influences are often referred to by people working in the health sector as the social determinants of health. Recently, it has been shown that much of the global burden of disease and health inequalities are caused by these social determinants. Countries such as Sweden have viewed their own health inequalities as unacceptable and initiated policy measures to mitigate them; the WHO Macro-Economic Commission on Health is also aimed at promoting this concept within countries.

The social determinants of health are closely linked to levels of poverty. Recent efforts in this area – the establishment of a legal, policy and fiscal framework for institutionalizing the delivery of targeted anti-poverty interventions in Pakistan through grants, microfinance banks and targeted subsides – are encouraging and offer hope for improving outcomes. The data on social determinants shows that anti-poverty policies have their limitations in reducing unjust health disparities. It is critical to take this into consideration while integrating health outcomes into social and development-related policies.

The links between nutrition, ill health and poverty are well known. Ill health contributes to poverty due to the catastrophic costs of illness and reduced earning capacity during and after illness. Therefore, health is an entry point towards prosperity and reduction of poverty. It is critical to move towards a system which will enable us to address the challenges and prevent households from falling into poverty. Therefore Health sector investment in Pakistan is viewed as part of the government’s poverty alleviation endeavor.

The Social development is the effective intervention and instrument to achieve the sustainable growth and desire able development for optimizing the welfare of the people through quality improvement in laiz standard. On one hand this embark for the inter-sectoral collaboration and pull out Health from isolation and on the other hand, Human Resource Development (HRD) with its alignment and capacity building for the efficient use of resources in the social sectors, particularly education, knowledge and health.

Health Challenges:

Pakistan suffers from an unacceptably high infant and maternal mortality, a double burden of diseases and inadequate facilities with pace of population growth. Slow progress in the indicators in relation to maternal health, child health and their morbidity and mortality are major concerns in the progress towards Millennium Development Goals. In addition to the high morbidity and mortality, the more human losses in terms of mental and physical health are caused by the violence and terrorism.

Strengthening and improving the performance of health delivery system are essential for efficient implementation of priority health programs and attainment of the MDGS. However the devolution being focus of good governance, the challenges are to build the capacity of the Health System at all levels responding to the requirements of the devolved health system. The priority challenges are:

i. Control of communicable diseases.
ii. Improved child and maternal health.
iii. Prevention and control of non-communicable diseases.
iv. Control and management of accidents and trauma.
v. Control of environment and unhealthy social habits.

A paradigm shift required in the future plan to meet these challenges as follow:

i. Ensuring universal coverage of an essential package of health interventions without economic, geographical, social, gender or cultural barriers.
ii. Overcoming social and economic inequities.
iii. Promotion of result-based monitoring.
iv. Provision of quality health care and ensuring gender sensitive and patient-centred services.
v. Ensuring good governance, promotion of meritocracy and transparency.
vi. Promoting evidence-based decision making at every level of the health system so that policy development and actions derived from policies are relevant, feasible, resource-appropriate and culturally and socially acceptable.
vii. Strengthen the devolved health system and clearly define the areas of waste by the Federal, Provincial, and District Governments.

Financial Issues:

The level of investment in health, despite the recent rapid increase in resource allocation by the government, is still very low as compared to the requirements. In addition, our health system has failed to attract foreign assistance (6% only). 75% of health financing is out of picket expenditure, and private health sector is catering for 80% of health care delivery, is still unregulated. Attainment of Millennium Development Goals is a national commitment which supplements the efforts of poverty reduction by 2015, but the existing resource constraints do not allow to provide the required funds to the Health System for the appropriate delivery of health services.

The health-financing trend during the last five years indicates a considerable jump in health investment, which doubled the capital outlay on development side, and tripled the non-development expenditures. However, this has been standing as a spontaneous question because of the low management capacities in Health Sector, absence of focus on the program objectives and more involvement in the procurement of Supply and Logistics. The black incentives to the interest groups have created transparency and accountability problems, and wind-up in the in-effective and inefficient use of funds.

Pakistan lags behind the neighbors in immunization coverage. Gap between access to health services for the poor and the affluent and geographic differences are large. The quality of care in public facilities is low resulting in low utilization of public health facilities. Moreover, slow progress in achieving maternal and child health and reduction in their morbidity and mortality are major concerns in the progress towards achieving Millennium Development Goals (MDGs).

In Pakistan, like other developing regions, some health programs have been very progressive and doing well but many of them are left without impact assessment by the third party. This of course involves the issues of effective monitoring and evaluation in Social Sector including Health. The other strong reason for low affectivity is the lack of coordination between the top (Central Planning level) and implementation at the bottom (community levels). The devolved health system has not been fully launched, and still wondering for success. This issue is due to un- awareness of the general public about devolution and its success. In deed, ‘Economics of Devolution’ is the next field, open for research and analysis to identify financial paradigm for strengthening of the Health system. Moreover this will require proper capacity building of the government functionaries, and community representatives in villages and union councils and also in the parliament.

Challenges in the Macro-Economic and Poverty Reduction Sectors:

Pakistan is striving hard to achieve macro-economics stability in the face of bourgeoning pressure on public finance. The structural problems are: low tax GDP ratio, increasing recurrent expenditure due to higher untargeted subsidies and inadequate monitoring and evaluation of development expenditure. Moreover, financing of fiscal deficit through bank borrowing has been an area of concern in view of drying-up foreign sources and low domestic savings. Framework for Economic Growth envisages attaining fiscal discipline through broadening the tax net, enhancing the tax compliance, improving the

service delivery, minimizing the untargeted subsidies, restructuring of Public Sector Enterprises (PSEs) and result based management of development expenditure.

Socio-Economic deprivation, health deteriorations, and frequent transaction of violence and extremism are the major products of poverty which are rooted in the unequal distribution of wealth. This is due to the absence of inter sectoral coordination and collaboration within the Social Sector including Health, Education, Higher Education, Nutrition, Women empowerment and marginalized access to justice in the country. Despite the considerable efforts, the economic growth policies are not inter-linked with the Social Sector.

The most compelling facts for formulation of Framework for Economic Growth (FEG) were preparing to reap the fruits of demographic transition, low and declining productivity and long standing search for macroeconomic stabilization. These three factors are impeding growth as well as breeding poverty. The pillar of FEG aims at skill development, employability and productivity of population especially youth, which in turn would result in poverty alleviation.

The poor are lacking both human and financial capital, public policies that help poor to build their human capital; better manage their risks, and improve access to credit, are key for making growth more inclusive. Access to finance plays key role in this effort, as well as reducing the time it takes for business startups through removal of red-tape and artificial restrictions. The focus of FEG on productive youth and community development will help poverty alleviation and generating inclusive growth. This will remove the inequities in Health System by providing more resources, and their efficient use.

Microfinance has been recognized widely as a strategy to combat poverty by providing financial services to the excluded poor that enables them to become economically active. The micro-credit programs offer a small loan to the beneficiaries for self-employment that enhance their income streams, and eventually make them self-reliant and move out of poverty. Although microcredit has been the main thrust in the past, today micro-finance compasses a wide range of financial services such as credit, savings, insurance and remittances. Micro-finance is a powerful anti-poverty instrument as it is cost effective and sustainable, and also because donor money is recycled and reused to benefit many like Benazir Income Support Program (BISP).

Post Devolution Impact:

In pursuance to 18th Amendment of the 1973 Constitution, Health Sector has been devolved to the provinces with absolute administration and financial autonomy. Accordingly, Ministry of Health was abolished on 30th June, 2011. The following residual functions have been assigned to various Ministries/Divisions including Planning &Development Division, Cabinet Division, Inter-Provincial Coordination Division, Capital Administration & Development Division, Economic Affairs Division and Interior Division. The health functions retained at the federal level are:

- National Health Planning.

- Coordination (with provinces and international development partners),
- Funding of Vertical Programs in Health Sector.
- Regulation of Pharmaceuticals Sector.
- International Health Regulations.
- Dealing with International Agreements and MoUs.
- Training Abroad.

Although vertical programs in health sector have been devolved to the provinces, upon their request and in pursuance to the decision of CCI, funding for these vertical programs during the 7th NFC Award shall be catered to by Federal Government.

- **Post-devolution:** provinces are to pick up vertical projects of health and population after expiry of the 7th NFC Award activities, for that they have to take pro-active measures, lack of evidence based planning and decision making.
- Weak management and governance systems particularly at district and sub-district levels.
- Partially functional logistic and supply system.
- Poorly motivated and inadequately skilled as well as compensated staff.
- Lack of adequate supportive supervision.
- Low level of public sector expenditure and its inequities distribution.

Health promotion, as defined by the Ottawa Charter, is the process of enabling people to increase control over and to improve their health. Several conferences as a follow-up to the Ottawa meeting have been in harmony with the principles embodied in this concept. Health promotion involves the population as a whole in the context of their everyday life.

A useful starting point to scale up health promotion interventions within the country is to develop health promotion interventions in pilot settings. In addition to providing local evidence of effectiveness, such pilot settings can also enable the building of capacity in relevant areas such as assessment of issues and needs, planning interventions, priority setting and evaluation within the framework of community health promotion. Ottawa had previously been part of the “Healthy City/BDN as UNDP and WHO initiatives and programmes.

Responding to increasing concern about these persisting and widening inequities, WHO established the Commission on Social Determinants of Health (CSDH) in 2005 to provide advice on how to reduce them. The Commission's final report was launched in August 2008, and contained three overarching recommendations as follows:

- 1. Improve daily living conditions
- 2. Tackle the inequitable distribution of power, money, and resources
- 3. Measure and understand the problem and assess the impact of action

Moreover, the Rio Political Declaration of 2011 confirmed Member State commitment to take action to address the social determinants of health in five areas:

- Adopt improved governance for health and development
- Promote participation in policy-making and implementation
- Further reorient the health sector towards promoting health and reducing health inequities
- Strengthen global governance and collaboration
- Monitor progress and increase accountability

Health as Catalyst:

The Commission on Social Determinants of Health (CSDH) was established to support countries and global health partners to address the social factors leading to ill health and inequities. It drew the attention of society to the social determinants of health that are known to be among the worst causes of poor health and inequalities between and within countries.

In the final report of the Commission, the WHO reports that inequities are killing people on a “grand scale” This concludes that Health care is an important determinant of health. Lifestyles are important determinants of health. In order to achieve its goals, the Commission on Social Determinants of Health focused on the following:

- **Country action**
  The Commission supported countries to develop policies that address the social causes of poor health and inequities.
- **Civil society**
  Civil society organizations from all regions provided vital inputs to the Commission's work.
- **Knowledge networks**
  The networks collated knowledge and evidence to support policy design and action.

Health Sector, in the past has suffered due to its isolation from other development sectors. The activities of income generation and economic nature have been given preference, whereas health, nutrition, education, population and women development were neglected in terms of assigning priority resulting in low funds allocation. The resource constraints and lack of consideration by the global and national decision makers placed it on poor track. This resulted in poor health being always treated with medicine without solution of the root cause. It is dawn fact that the root cause of malnutrition, anemia and low Weight births lies in food scarcity and lack of resources for better food – a problem got rooted into food and agriculture sector.

WHO and its member states have acknowledged that major determinants of ill health fall outside the scope of health sector and are mainly related with socio-economic and cultural aspect like poverty, illiteracy and over population and congested housing. These inhibiting factors adversely affect the development as well as quality of life and health status of the communities. WHO, therefore, resolved in helping the consolidated action of global efforts to reduce poverty. After successfully launching of an integrated Basic Development Needs (BDN) Programme in some of the regional countries, the Eastern Mediterranean Regional Office of the World Health Organization introduced BDN in Pakistan during 1995.The BDN Programme aimed at achieving a better quality of life, with an ultimate goal of attaining good health. It was an integrated socio-economic development based on full community involvement, community organization and self reliance through self-management and self-financing by the people. It was a self-sustained people oriented development strategy based on bottom up planning, which offers vital support to inter-sectoral collaboration for correcting urban-rural imbalances, transformation of social life style and overall human development.

Communicable diseases, malnutrition and limited reproductive health services constitute important sources of ill health in Pakistan. Worldwide, communicable disease cause about 60% of deaths and 64% of disability adjusted life years (DALY) loss among the poorest 20% compared to 34% and 44% respectively among the entire global population. In Pakistan where a significant proportion of the population is affected by poverty, the situation is comparable, as only four communicable diseases account for 70% of childhood mortality. This illustrates the importance of giving high priority to integrated human development strategies that aims to improve the health of the poor and promote education, gender equity and poverty reduction, which constitute the core of the BMN/BDN(Basic Development Needs) programme package.

In studying the interface of poverty and health, the primacy of the income expenditure definition of poverty is changing. The WHO concept that ill health is both a cause and consequence of poverty and UNDP’s assessment of poverty in terms of human development index, along with leading world thinkers are advocating a definition of poverty based on the capacity of the poor to improve their condition where health and education status are important for them like income. The government of Pakistan has moved toward this wider base of poverty definition. This growing new conceptualization of poverty, will focus on basic human needs, an important role in forging unity among sectors and people and in supporting the mobilization of human development forces in the country.

Conclusion:

Social determinants of Health including the pattern of life cycle right from birth to death pertains to study and analyze the entire human ecology by focusing on birth, growth, living, working environment, and the health system. Covering all these factors a comprehensive strategy, like poverty reduction and integration of health and development should be the utmost priorities of policy makers, and planners.

Five action areas addressing the social determinants of Health call for:

- Improved governance for health and development
- Promote participation in policy-making and implementation
- Reorient the health sector towards promoting health and reducing health inequities
- Strengthen global as well country wise governance and improve collaboration
- Monitor progress and increase accountability

A newly emerged areas to be addressed are violence and terrorism. This significant area needs a proper study and analysis to identify a solution for elimination of this menace. These are adversely affecting the socio- economic growth and development which overshadows all efforts made for poverty reduction. This issue of inequity in health services need to be widely discussed and deliberated at the different forums, the academia, universities and other relevant institutions, in the parliament, and raise all these at the international forums. An integrated strategy for socio- economic development to generate economic growth for poverty reduction through strengthening of health system is required. For all such achievement, Human Resource Development (HRD) shall be one of the major significant area can be attained through strengthening of Health, Education, Women Development, Employment and Housing Sectors. In addition, Public health ambiguities and impediments can be removed through safe drinking water, sewerage, sanitation, Nutrition provision of adequate housing and addressing population welfare issues shall be integrated and linked with the MDGS. This will help achieving the MDGS targets, and also stabilize the country position in the International community.

Recommendations

This Annual Public Health Conference on “Social Determinants of Health” has set the very needed objectives to synthesis and disseminate evidence based research on the SDH: It is more feasible solution but a “research friendly environment” would be required to develop Health Services Academy(HAS), Pakistan Medical & Research Council(PMRC), Planning Commission and Pakistan Institute of Development Economics(PIDE) plus World Health Organization(WHO), United Nations Development Programme (UNDP) World Bank and ADB like agencies would be of worth to enforce and implement the said agenda.

MOH itself is no more existed and now renamed with some functions transferred to the other Ministries and Divisions. This is certainly a smashed face of a Health Institution (MOH). The MOH may be re-instated in its original form. Devolution is better, but a strong macro planning and executing system in form of MOH is best for the country. This will be more viable to restructure the defunct MOH rather to fully abolish it.

Identification of Mechanism to strengthen Individual and Institutional capacities, coordination within and outside the country is required and shall be taken as priority within the Social Sectors. Direct and implement strategies for the initiatives like Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM), Mid Term Development Goals (MDGs), and Polio eradication, and interact with the international community on Social determinants of Health, and global public health agenda another significant tasks to handle in integrated and coordinated way in parity with the provincial attorney.

Monitoring and Evaluation is the weak area, particularly for social determinants of Health. Planning Commission has created a “Social Sector” projects wing working in this area. It requires to establish collaboration with HSA, PMRC and other concerned agencies to enforce the Result Based Monitoring by Supervising the input, output, and match all these with outcomes and analyze the impact. This tripartite collaboration will share the results and the evidences with the all national and International stakeholders. The results may be discussed quarterly to re-define, and refine the interventions for development of the social determinants of health.

References:

1. Barbra McPake (1997), Evaluating Effects of Health Reforms, WHO, Geneva.
2. D.E. Cooper Weil (1990), The Impact of Development Policies on Health, WHO, Geneva.
3. Economic Survey of Pakistan, 2010-11, Finance Division, Islamabad.
4. Medium Term Development Framework (MTDF 205-10), Planning Commission of Pakistan, Islamabad.
5. Social Action Program (SAP) 1998 2003, Planning Commission, Islamabad.
6. NishtarSania, Chocked PIPES (Reforming Pakistan’s Mised Health System) 2010, Oxford University, Karachi.
7. Role of Health System Research on Policy, Planning and Administration, 1997, WHO, Egypt.
8. Amir Japan and Imran, The Changing Profile of Regional Inequality, 2003, PIDE, Islamabad.
9. Haroon Jamal, Poverty and Inequality during the Adjustment December, 2003, PIDE, Islamabad.
10. KhalifBillc, Health status and BDN, 2002, WHO, Pakistan
11. Khattak FH, Economics of Health Sector Reforms’ 2001, Islamabad, Pakistan.
12. Global Food Price Inflation and Developing Asia, ADB, March, 2011
13. Budget Wing, MoF, Islamabad, June, 2012.
14. PC-I Documents of National Programmes (Devolved MoH), CADD, & IPC, Islamabad

Social Determinants of Health

(Issues and Challenges in Pakistan)

Dr. Fazl-i- Hakim Khattak
Director General,
Social Sector, Implementation and Monitoring
Planning Commission of Pakistan

Islamabad, the February, 2013