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Health and Nutrional Economic Growth in Pakistan: A Systematic Review

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Abstract

In this short report I want to explain about the economic growth in Pakistan. Here I explain the health and nutritional economic growth in Pakistan almost last ten years. Government of Pakistan made different policies for the development of nation. These policies include health policies, medical treatment, HIV control programmes etc. These all policies helps for the prosperity of Pakistan.

Index terms— HIV, malaria, development, policies.

ost people want to lead healthy lifestyles. There is much that people can do individually to protect their health including driving safely, wearing seatbelts, avoiding tobacco smoke and air pollution, exercising regularly, eating healthy food and having regular checkups. But many health risks are also influenced by community factors, including transportation and land use planning decisions. Health plays the key role in determining the human capital. Better health improves the efficiency and the productivity of the labor force, ultimately contributes the economic growth and leads to human welfare.

Access to good health can contribute positively to the economic and social development of a country. Thus, key issues that impact the health status of people ought to be addressed through a diverse set of policy tools comprising short and long term measures to secure better health outcomes. The people of Pakistan have grown healthier over the past three decades. The vision for the health sector comprises a healthy population with sound health, enjoying good quality of life through the practice of a healthy life style. In order to achieve this vision, significant measures have been taken toward disease prevention, health promotion, and greater coverage of immunization, family planning, and provision of female health worker services.

To attain better, more skillful, efficient and productive human capital resources, governments subsidies the health care facilities for its people. In this regard, the public sector pays whole or some part of the cost of utilising health care services. The size and distribution of these in-kind transfers to health sector differs from country to country but the fundamental question is how much these expenditures are productive and effective? It very much depends on the volume and the distribution of these expenditures among the people of different areas of the country.

Lamiraud, et al. **??**2005) argued that social health protection is an important instrument aiming at fair burden sharing and reducing barrier underlining access to health care services. Another good reason for the government spending in delivering basic health care services is to reduce burden of the diseases (BOD) in the productive years of the life. The social rate of return and the BOD force the policy-makers to transfer the public resources towards basic health care facilities.

According to the Economic Survey of Pakistan (2005-06), the government spent 0.75 percent of GDP on health sector in order to make its population more healthy and sturdy. **??**Islamabad) and Mehbub ul Haq Human Development Centre. A large number of the studies have employed the Benefit Incidence Approach (BIA) on household data for their analysis. Findings reveal that public sector expenditures are either progressive or regressive and the share of the different income group differs depending upon the delivery of the benefits of the public expenditures across region, caste, religions, gender etc., see Christian (**??**002 The studies which exhibit public sector expenditures are progressive such as Younger (1999), in Ecuador used combination of benefit and behavioural approaches showed that public expenditures improves the health indicators in the developing

countries. In cross country analysis, Gupta, et al. (??002) used 56 country data and concluded that the increase in public expenditures on health reduces the mortality rates in infants and children. Study by ??oor and Butt (2005) shows that socio-economic factors play an important role in determining the health care expenditure in Pakistan.

The share of health expenditure in total public sector expenditure is the most significant variable affecting health status in a country. Moreover, literacy rate and GDP growth are also essential variables, which illustrate a positive relationship with health care expenditure. Other set of studies that establish the regressiveness of incidence of public sector spending such as Norman ??1985) concluded that increased government expenditure on health services eventually benefits more to the upper income than the lower income groups.

Castro-Leal, et al. ??2000) analysed the public spending on curative care in several African countries and found that the public sector spending favours mostly the better-off rather than the poor. Hamid, et al. (??003) study covers 56 countries analysis from the period 1960-2000 in which benefit incidence approach (BIA) was used, resulted in, on average spending on health is pro rich particularly in sub-Saharan Africa but is well targeted and progressive only in the western hemisphere. Some points need further consideration; the first point about the impact of the level of public expenditures on human capabilities is a debated point, because not all studies have found an empirical link between the two. The connection between lucratively addressing poverty issues and spending is not first and foremost a function of the percent of GDP that is committed to total spending on health and, but depends on the intra-sectoral allocation to health spending. Evidence shows that infant and child mortality rates become lowest in countries with high shares of health care spending devoted to primary (preventive) health care facilities. Second, the fiscal policy-makers meet head-on the nature and magnitude of fiscal incidence.

The policy choices necessitate the knowledge about which groups are prone to pay for and which groups are expected to benefit more from public sector expenditure. Policy-makers have many questions concerning how to alleviate the burden of taxation for the poor and about how to increase the efficiency and efficacy of the public sector spending on health? How to target public spending in order to improve the conditions of the poor? The incidence analysis provides some critical information to facilitate policy-makers regarding equal distribution of income and improvement of efficiency and efficacy of the public policy.

Ample literature is available to understand the questions regarding the nature of incidence of the public sector expenditure in developing as well as developed countries. Most of the studies have been conducted on old data-sets taken from household surveys which have not been updated. These studies are deficient in comparisons of incidence among the cross countries on one hand and in-comparability of the cross country results on the other hand. Moreover, the impact on different groups such as gender and region has not been taken into consideration in the case of Pakistan, as emphasised by Seldon and Wasylenko (1992).

Nevertheless, the literature considering the incidence of the public sector expenditure and its distribution in Pakistan is scarcely available. The current study is being initiated to explore the nature of incidence of public sector expenditures in Pakistan on health sector by using the primary data of the Pakistan Social and Living Standards Measurement Survey (PSLM), 2004-05, collected and published by the Federal Bureau of Statistics, Pakistan.

By using current data, the current research highlights the present scenario of incidence of the public spending on health and indirectly provide the guideline to what extent health policy targets have been successfully achieved, who benefit how much, which kind of inequalities exist in distribution of benefits of government expenditure on health, region and income wise. Additionally, by calculating the inequalities in the distribution of the benefits of expenditures, the study provides policy recommendations to enhance the effectiveness and efficacy.

1 a) Health Indicators

The most recent data on health performance of other South Asian countries suggest that Pakistan lags behind in infant mortality rate (at 63 per 1000 live births) and the under 5 year's mortality rate (at 86.5 per 1000 live births). These indicators continue to remain high mainly on account of un-healthy dietary habits, water borne diseases, malnutrition and rapid population growth. However, the average life expectancy at 66 years compares well with India, Nepal and Bangladesh.

Pakistan is committed towards achieving the millennium development goals.

2 Source: Planning & Development Division c) Targets and Achievements during 2011-12

The targets for the health sector during 2011-12 included establishment of 10 rural health centres (RHC), 50 basic health units (BHUs) and renovation of 20 existing RHCs and 50 BHUs. The manpower targets include the addition of 5,000 doctors, 500 dentists, 4,000 nurses, 5,000 paramedics and 550 traditional birth attendants. Under the preventive program, about 7.5 million children were targeted to be immunized and 22 million packets of oral rehydration salt (ORS) were to be distributed during 2011-12.

The achievements in the health sector during 2011-12 included the establishment of 7 rural health centers (RHCs), 30 basic health units (BHUs) and renovation of 15

3 d) Health Programs

In pursuance of the 18th amendment to the constitution of Pakistan, the health sector has been devolved to the provinces and the federal Ministry of Health has been abolished. However, national planning in the health sector and cooperation with the provinces and international development partners is vested with the Planning and Development Division. All the vertical health programs have also been devolved to the provinces. However, upon request of the provinces, the Council of Common Interests (CCI) in its meeting held on 28th April 2011 decided that the federal government (Planning and Development Division) shall fund these programs till currency of the 7th NFC award at a predefined share. Accordingly, the following national health programmes continue to be financed by the federal government in the post devolution scenario till 2014-15.

4 e) Food and Nutrition

The links between malnutrition, ill health and poverty are well known. Disease contributes to poverty due to the costs of illness and reduces earning capacity during and after illness. Good health is a first step towards prosperity and reduction of poverty. It is therefore, critical to move towards a system which will address health challenges and prevent households from falling into poverty due to poor health. In Pakistan, health sector investments are viewed as part of the government's poverty alleviation endeavors. This chapter discussed the state of health and nutrition in Pakistan. An overview of the National Health Policy and its primary objectives are presented, followed by a discussion of the state of health indicators, expenditures, and facilities in Pakistan. The targets and accomplishments for the 2011-12 are described, followed by a special focus on cancer treatment and the government's response to dengue outbreaks. The chapter highlights the challenges of narcotics trafficking and growing incidence of drug addiction in Pakistani society.

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Figure 1:

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[2] Health and Nutrional Economic Growth in Pakistan: A Systematic Review

Ministry of Health
Malaria Control Programme; Tuberculosis and HIV/AIDS Control Programme; National Maternal and Child Health Programme; the Expanded Programme Immunisation; Cancer Treatment Programme; Food and Nutrition Programme, and; the Prime Minister Programme for Preventive and Control of Hepatitis A & B. To effectively address the health problems facing Pakistan, a number of policies emphasis better health care services. These include: Health related Millennium Development Goals; Medium Term Development Framework; Poverty Reduction Strategy Papers; National Health Policy, and; Vision 2030. In spite of these policies, to overcome the health related problems in Pakistan seems suspicious and distrustful.
The communicable diseases are still a challenge and the statistics reveal that the nutrition and reproductive health problem in communicable diseases are still liable for the 58 percent of the BOD in Pakistan. Non-communicable diseases (NCD), caused by sedentary life styles, environmental pollution, unhealthy dietary habits, smoking etc. account for almost 10 percent of the BOD in Pakistan.
A comprehensive review of literature, research materials, articles and evaluation reports is done to assess the existing situation and policy debate. This includes documents and reports available from World Health Organisation (WHO), United Nations Children's Fund (UNICEF), Asian Development Bank (ADB), Centre for Poverty Reduction and Income Distribution (CRPRID), Poverty Reduction Strategy Papers (PRSP),

Figure 2:

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Country	Life expectancy 2011	Mortality rate	Infant mortality rate	Population growth rate (%)
Pakistan	65.99	86.5	63.26	2.03
India	66.80	62.7	47.57	1.34
China	74.68	18.4	16.06	0.49
Indonesia	71.33	35.3	27.95	1.07
Bangladesh	69.75	47.8	50.73	1.57
Sri-lanka	75.33	16.5	9.70	0.93
Malaysia	73.79	6.3	15.02	1.58
Nepal	66.16	49.5	44.54	1.60

Source: World development report 2011

b) Health Expenditure

Table 0 2

Fiscal year	Public expenditure	Percentage change	Health expenditure % of GDP
2000-2001	24.28	9.9	0.72
2001-2002	25.41	4.7	0.59
2002-2003	28.81	13.4	0.58
2003-2004	32.81	13.58	0.58
2004-2005	38.00	15.8	0.57
2005-2006	40.00	5.3	0.51
2006-2007	50.00	25.0	0.57
2007-2008	60.00	20.0	0.57
2008-2009	74.00	23.0	0.56
2009-2010	79.00	7.0	0.54
2010-2011	42.00	-47	0.23
2011-2012	55.12	31.24	0.27

Figure 3: Table 0 1

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Sub-sectors	3 : Physical achievements 2011-2012 Targets	Estimated achieve-ments	Achievements %
A. Rural Health Programme			
New BHUs	50	30	60
New RHCs	10	7	70
Strengthening/ Improvement of BHUs	50	35	70
Strengthening/ Improvement of RHCs	20	15	75
B. Hospital Beds	5000	4000	80
C. Health Manpower			
Doctors	5000	4300	86
Dentists	500	450	90
Nurses	4000	3000	75
Paramedics	5000	4500	90
TBAs	550	500	91
Training of LHWs	10000	9500	95
D. Preventive Programme	7.5	7	93
Immunization			

Figure 4: Table 0

Figure 5:

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