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Article:	**Policy Impact of 18th Amendment on Health Governance and Service Delivery in Pakistan**
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ABSTRACT

Globalisation and digitalisation trends increased the awareness among public for quality care in health. Healthcare industry is fast growing industry throughout the world due to many reasons mainly are climate and environmental changes, market competition, availability of alternate and improved health facilities and solutions, occurrence of pandemics and many others. Article 25 of the UN Universal Declaration of Human Rights -1948 ensures the right of adequate health facilities to all humans. The WHO constitution ensures physical and mental health with the social well-being of everyone. Good health and well-being is the third Goal set under the 17 Sustainable Development Goals. In Pakistan, health sector mainly controlled through federal health ministry. On 19th April 2010, 18th amendment was unanimously passed by the parliament under which health become provincial subject. The provinces are improving healthcare facilities through legislation, execution, monitoring with increase in resources, budget and infrastructure. This research is mainly focused to seek the performance of provincial governments in improving health governance and service delivery in their respective provinces. For this specific research purpose, rational choice theory was used by adopting Roemer Model of Health Services System Developed by Milton I. Roemer in 1984.

Keywords: Health System Governance, Healthcare Delivery and Constitutional Development.

1. Introduction

According to Article 25 of the UN-Universal Declaration of Human Rights – 1948, Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care (Holst, 2023). WHO Constitution enforced on 7 April 1948 declared health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"(Nannini & Burci, 2023). By considering the importance of healthcare, health is declared as a fundamental right of citizens by almost all international organizations (Menicucci & Machado, 2023), thus provision of basic health facilities is the fundamental right of every citizen without any discrimination (Hervey & McHale, 2022). The objective of the World Health Organization is to provide the best possible health facilities to all people (Pacific, 2023). All countries in the world are playing an important role in defining policy targets in healthcare by ensuring the provision of the best possible healthcare facilities to their citizens at large (Barr, 2023).

Pakistan is the fifth most populous country and second largest Muslim country in the world with a population exceeding 242 million. Pakistan is a country with a diverse population, culture, weather and climate therefore healthcare needs are very complex and vary from one area to another for which effective health policy, governance and delivery are essentially required (Baig et al., 2021). Pakistan is very much concerned about the provision of basic health facilities to its citizens as good health and well-being are given priority under agenda item No.3 out of 17 goals set under the National Initiative for Sustainable Development Goals (Bexell & Jönsson, 2022). National Health Vision – 2025 is aimed to improve the health conditions of the people of Pakistan especially the women and the children in line with the WHO framework (Organization, 2022) in the following areas: i) Increase in health financing; ii) Improvement in health governance and healthcare delivery; iii) Increase in health workforce; iv) Implementation of health management information system (HMIS); v) Efficient use of medical and digital technology; vi) Availability of clinical support includes medicine, surgical, labs and diagnostics supplies; vii) Use of telemedicine; viii) Improvement in basic infrastructure; and ix) Ensuring cross-sectoral linkage (Imlach et al., 2022).

After independence in 1947, Pakistan adopted the same policies and line of action in accordance with The Bhore Commission-1946 by declaring health as a provincial subject. In the 1950s, Pakistan initiated vaccination programs like BCG and took steps for the eradication of malaria and other infectious diseases under WHO instructions. During the 1960s, serious efforts were taken on the directions of WHO to control and eliminate TB, leprosy and smallpox. Again, in the 1970s, Pakistan followed WHO instructions in controlling malaria and diarrhoea with the introduction of an immunization program. During this decade Lady Health Visitors were inducted to decrease maternal-child diseases. In the 1980s, special efforts were made to control AIDS along with control of rheumatic fever etc. In the 1990s, Pakistan introduced National Health Policy in 1997 with the devolution of powers relating to health was shifted to the district level. World Bank program (Social Action Program), WHO program (eradication of polio), launching of lady health worker program and other international funded programs were initiated to control AIDS, Polio, TB and Malaria etc. In 2001, the Government of Pakistan restructured the National Health Policy to achieve the goals set by UN Millennium Development Goals (MDGs) after being a signatory in 2000 by adopting 16 targets and 37 indicators fixed by UN MDG for achieving the eight goals by 2015 (Akram Muhammad et. al.,

2017). In 2001, the National Health Policy was introduced with a focus on the eradication of Hepatitis, Blindness, provision of clean drinking water, MCH etc. On 19th April 2010, the 18th Constitutional Amendment was passed under which the health sector became a provincial subject. In June 2011, the Federal Health Ministry was devolved with the transfer of planning and Budget/fund allocation to Provincial Governments. In April 2012, the Ministry of National Health Regulation and Services was established at the federal level.

This research study adopted a mixed-method approach. The data for qualitative research was obtained from professionals through 10 in-depth interviews and by conducting two FDGs attended by 24 field experts against three research questions. Firs research question relates to analysing the performance of provincial governments in the improvement of health governance and healthcare delivery after the 18th amendment since 2010. The second research question was focused on analyzing the efforts of provincial governments in impeding the role of bureaucracy and politicians in health affairs after the 18th Amendment. The third research question relates to the efforts of federal and provincial governments for effective resource production in the health sector, increase in budget and economic support required to the health sector, and management and organization of programs in the health sector. The objectives of this research study were to explore the effects on health governance and its delivery after implementing the 18th amendment in 2010 with the provincial government's role in impeding the unnecessary role of bureaucracy and politicians in health affairs and efforts of provincial governments in resource production, management, organization of programs and budget allocation for health. The study adopted the Roemer Model of Health Services System Developed by Milton I. Roemer in 1984 by following the Rational Choice Theory.

2. Literature Review

2.1. Conceptualizing Health Governance

Health system governance become an important subject in research and academia (Buse et al., 2023). The objective of health governance is to improve health conditions by ensuring protection from infections, diseases and health-related catastrophes (Debie et al., 2022). Health system governance is mainly dependent on social, political and economic stability influenced by local traditions, norms, culture, ideologies, and religious and spiritual practices (Mpofu & Machina, 2022). Health system governance is concerned with the actions and means adopted by the society to organize itself in the promotion of health and protection from health hazards of its population (Debie et al., 2022). The stewardship in health system governance is linked with financing, resource availability and healthcare delivery (He et al., 2022). The term stewardship in health governance is defined as effective oversight, incentives, policy frameworks, regulations and accountability by the WHO (Organization, 2021). With reference to political ideology, health governance is influenced by transparent rules and regulations, effective command and system of transparency and accountability (Pyone et al., 2020). Health system governance is described as an aggregation of some normative values like transparency and equity in health system in the existing political system of any country (Lokot et al., 2022). Health system governance as a subject received increasing attention during recent research as major international and development partners are considering health system governance as the most important factor for human development (Biddle et al., 2020). In accordance with the recent literature, health system governance is further elaborated by its concepts, principles, dimensions, components and attributes. The research on health governance is more specific

towards the policy and principles of governance being adopted to ensure improvement in health governance (Gao & Yu, 2020). The existing literature on frameworks for assessing health governance suggests the operational requirements of health governance which are being implemented by different countries and other healthcare institutions for effective healthcare delivery (Tandon et al., 2020). Health governance is implemented through different levels mainly in three areas: i) at macro-level through healthcare operators; ii) at meso-level by decisions through institutional level; and iii) at micro-level with execution and operation by hospital management for daily operations (Wiig et al., 2020).

2.2. Conceptualizing Healthcare Delivery

Healthcare as an industry is considered the biggest industry in the service sector all over the world (Karatas et al., 2022). The fast and rapid innovation with the introduction of new technologies in healthcare delivery triggered the competition in open markets with financial flow in the health industry (Kang et al., 2021). Human intelligence supported by the latest technology and R&D made revolutionary changes in healthcare (Erol et al., 2020). Like other industries, the healthcare industry is improved with some challenges of market competition, provision of services, compromise of healthcare facilities, basic support services, clinical and diagnostic management, telehealth and service areas (Narang, 2021). Globalization in healthcare with added facilities other than healthcare has affected the public at large with treatment through very high costs and out of reach for the general public (Kaye et al., 2021). The scholars are strongly advocating for value proposition in health with cost-effective benefits along with the provision of best health and clinical management (Ducatman et al., 2020). There are a number of viewpoints to ensure improvement in the healthcare industry (Farouk et al., 2020). Some of the scholars are advocating that healthcare management be primarily focused on the betterment of diseases over other support services a very cost-effective rates affordable to the common public (Crowley et al., 2020). Other scholars are in favor of system improvement in the healthcare industry (Coccia, 2021). Some scholars strongly support improvement in quality of service in healthcare which increases patient satisfaction (Fitzpatrick, 2022).

2.3. Conceptualizing Constitutional Development in Pakistan

After its independence on 14th August 1947, Pakistan adopted the Government of India Act of 1935 with some minor amendments (Akram & Alvi, 2022). After so many deliberations and political negotiations, the Constituent Assembly passed the 1956 Constitution of Pakistan with the concept of One unit with some seats divided equally between East and West Pakistan with residual powers vested to the federal government under Article 109. In October 1958, President Iskandar Mirza abrogated the 1956 constitution and soon after General Ayub Khan deposed him and declared himself as President of Pakistan with the imposition of martial law in the country. The 1962 Constitution was effective from 8th June 1962 with the introduction of the Presidential form of government in Pakistan. The term of the President was fixed for five years with selection through the indirect electoral college of 80,000 Basic Democrats. The 1962 Constitution was abrogated by President Yahya Khan with the imposition of Martial law by him in the country on 25th March 1969 (Amir & Ahmad, 2020). During the government of Zulfiqar Ali Bhutto, 1973 Constitution of Pakistan was unanimously approved by the 5th Parliament of Pakistan on 10th April 1973 with its ratification on 14th August 1973 under which federal parliamentary form of government was introduced on the principle of separation of

powers with all executive authority under Prime Minister and President as ceremonial head of the state. Islam was declared as a state religion with the restriction that parliament cannot make any law against the constitution, however, amendments in the constitution can be made with a two-thirds majority in both houses. In a coup by General Ziaul Haq in 1977, the 1973 Constitution was held in abeyance till 1985. The 8th constitutional amendment was adopted by the parliament of Pakistan in November 1985 under which powers were shifted from parliament and prime minister to the President of Pakistan. Some changes were made in the constitution, especially in Article 58(2)(b) under which the President was empowered to dissolve the National assembly at his discretion. During the PPPP government from 2008 to 2013, the National Assembly passed the 18th amendment in the Constitution on 8th April 2010 by a vote of 292 against 342 members in National Assembly, removing the President's discretionary powers to dissolve the parliament and empowering the Prime Minister as executive head of the state under a parliamentary form of government. Under the 18th Amendment, many changes were introduced with significant changes in the North-West Frontier province being named Khyber Pakhtunkhwa, legislative and financial autonomy to provinces and the ban on becoming the third time Prime Minister and Chief Minister was removed.

3. Methodology

In research methodology, research paradigm provides clear direction, assumption and viewpoint for the desired research with model, pattern and method for conducting desired research (Hennink et al., 2020). Most of the research paradigms are derived from positivism or interpretivism research methodologies. Paradigm is a perspective for knowing the social and physical world in order to perceive the reality (Enworo, 2023), however, some scholars also add axiology in the paradigm. In research, single reality is measured and tested through positive paradigm by applying quantitative approach (Park et al., 2020) and multiple realities are measured and tested through interpretivism approach by applying qualitative approach (Alharahsheh & Pius, 2020). The researchers prefer to use pragmatism paradigm for changing reality under different situations by applying both qualitative and quantitative approach called mixed-method research (Gilad, 2021). Constructive paradigm suggests that there is no single truth and believes on multiple realities with the opinion that people establish their own perception on the basis of their experiences (Pilarska, 2021). Post -positivism suggests that research results can never be objective because of the bias of researcher on result outcomes. Transformative paradigm rejects interpretivism and positivism on the basis that these cannot represent marginalized communities.

The data for this specific qualitative research against three research questions was obtained from 10 in-depth interviews including a Parliamentarian, Health Consultant of COMSTECH, Director of Healthcare Commission, COO of PPHI, Country Director PATHFINDER, Advisor Health, Chief Health HANDS, Provincial Lead Green Star family planning, Head Emergency & Health Services and ED JPMC. Similarly, two sessions of FGDs were conducted each in Karachi and Larkana attended by 24 respondents of different fields including Sindh assembly, PIU, NOVARTIS, AKUH, Getz, SZH, Media, Education, Change Organization, Advocate, businessman, NGO and Civil society. The interviews and FGD audio recordings were audio recorded along with photographs for recording with their permission The process of data collection lasts for 9 months from October 2022 to June 2023. All texts

were transcribed in order. Thematic analysis was applied to identify codes, patterns and themes. NVIVO software was used for qualitative research. Secondary data for qualitative research was based on Acts and Ordinances passed and issued by Federal and Provincial governments, Gazette notifications, Books and journals etc.

4. Discussion

Health governance and healthcare delivery are the key areas of research all over the world. Good governance has a very positive impact on all healthcare indicators. All such international agencies and organizations are seriously working for improvement in global health governance through all concerned stakeholders. Pakistan is the fifth most populous country in the world with a population of around 242 million. According to the WHO Health Performance Report -2022, Pakistan is at number 122 against a total of 190 countries with a ranking of 154th in terms of quality healthcare and health accessibility. Since its independence in 1947, health governance in Pakistan could not resolve real health issues resulting in poor health governance, professional negligence, resources and budgetary constraints, health governance through nonprofessional's, lacking of accountability, transparency, efficiency, effectiveness, responsiveness and capability. Health governance, policy-making and execution of standard healthcare delivery are undermined by external and internal differences, administrative failures and political clashes between federal and provincial governments. Health was declared as the provincial subject in the light of the recommendations of the Bhore Commission – 1946 which were adopted by the then government and after independence by the Government of Pakistan with command and control of the health ministry through the federal government. The functions of the federal health ministry were delegated under the Rules of Business by the Government of Pakistan mainly: i) Policy planning and coordination; ii) close liaison with national and international donors; iii) HRM and HRD in the health sector; iv) education for medical and allied subjects; v) legislation for health; vi) issuance of licenses for approved drugs; vii) preventive programs for infectious and contagious diseases; viii) family planning; ix) execution of health-related programs to control the spread of TB, Malaria, tobacco, blindness, HIV, Hepatitis, and influenza; and x) EPI, National Nutritional Program. During the federally controlled health system from 1947 to 2010, the federal health ministry rarely could set the priority agenda in health resulting in poor policy-making, health governance and healthcare delivery in Pakistan. After the 18th amendment, the federal health ministry was restructured and named as Federal Ministry of National Health Services Regulations and Coordination with the mandate to look after i) the Drug Regulatory Authority of Pakistan; ii) the Directorate of Health Establishments; iii) Pakistan Institute of Medical Sciences; iv) National Institute of Health; v) Pharmacy Council of Pakistan; vi) Universal Service Fund; vii) National Health Emergency Preparedness Network; viii) National Trust for Population Welfare; ix) National Council of Homeopathy; x) Pakistan Medical Research Council; xi) Health Services Academy; xii) Pakistan College of Physicians and Surgeons; and xiii) National Institute of Population Studies. After the 18th amendment, the health sector was allocated to provinces with key functions: i) close coordination with the federal health ministry and other national and international health agencies, regulators and donors; ii) legislation, policy-making and execution of health programs in the provinces; iii) execution and monitoring of health governance and delivery within provinces through all public, private and other healthcare providers; iv) accreditation of medical education through provincial

institutions; and arrangement of necessary budget and resources through provincial budget and donor agencies.

Healthcare delivery is available to all citizens of Pakistan through healthcare institutions all over the country through preventive, promotive, curative and rehabilitative medical facilities. The employees and their dependent family members of federal, provincial governments and autonomous departments are entitled to medical treatment as per their entitlement. The non-affording patients are also entitled to free medical treatment through different government programs from designated hospitals. The affording patients are getting medical treatment from private hospitals against cash payment. As per the report published in the Economic Survey of Pakistan – 2021, the existing health facilities all over Pakistan include 1276 major hospitals, 5558 BHUs, 736 RHCs, 5802 primary level dispensaries, 780 MCHs and 416 TB centres with a total bed capacity was 146,053 in all hospitals. The number of health professionals includes 266,430 doctors, 30501 dentists, 121,245 nurses, 44693 Midwives, and 22,408 LHWs in all healthcare institutions of Pakistan. Despite huge infrastructure and resource availability, public sector hospitals are still the least priority of the public for medical treatment due to long queues, health professionals' attitude towards patient care, misuse of resources, unhygienic environment and harsh behaviour of staff. In the year 2020, 70% of patients availed medical treatment from private sector hospitals due to the reasons already mentioned. Major healthcare models being practiced in the world are Beveridge Model, Bismarck Model, National Health Insurance and medical treatment against cash payment. Beveridge Model is based on the concept of a National Healthcare System with free medical facilities to the public with payment through taxation introduced by Sir William Beveridge in 1942. Bismarck Model was introduced by Otto von Bismarck, German Chancellor during his tenure from 1871 to 1890 under which National Health Insurance System was implemented in Germany in 1881 with provision of medical facilities through health insurance companies from designated hospitals against mandatory deductions from employees' monthly salary. The mixture of Beveridge and Bismarck models is called National Health Insurance model under which the public are entitled to get medical treatment from designated hospitals with payment by the government to all concerned health insurance companies. The concept of the out-of-pocket medical expenditure model is based on private medical practice under which patients are getting medical treatment from their choice of doctors and hospitals against payment from their own pocket.

There has been a visible improvement in healthcare under the provincial government after the 18th Amendment. Provincial governments improved healthcare delivery through different means, especially through the Peoples' Primary Healthcare Initiative (PPHI), increase in budget and resource allocation, increase in health infrastructure, provision of health facilities to the public at their doorsteps like the establishment of cardiac, trauma and other specialized costly medical treatments on free through well-established healthcare institutions like NICVDs, GIMS etc, engaging other partners with the support of provincial government programs like INDUS, HANDS, AMAN Foundation, Green Star, Pathfinder etc., legislation in health through provincial legislative assemblies, health monitoring through Healthcare Commission.

7. Conclusion

The 18th Amendment in the 1973 constitution of Pakistan has a significant impact on the political and constitutional development of Pakistan. On 8th April 2010, the National Assembly of Pakistan passed the 18th amendment under which the powers of the President of Pakistan to dissolve the parliament were removed by empowering parliament and democracy again; renaming North West Frontier Province as Khyber Pakhtunkhwa; and administrative, financial and legislative autonomy to provinces including transfer of federal departments to provinces. The bill was passed by the Senate of Pakistan on 15th April 2010 and signed by the President of Pakistan on 19th April 2010. In the light of the 18th amendment, health becomes the provincial subject. Health governance in Pakistan needs further improvement so as to achieve quality healthcare services and better health outcomes. Such an approach to health governance requires evidence-based policies and, a sustainable governance structure in coordination and collaboration with national and international stakeholders. In order to address multiple challenges like budget and resource constraints, gaps in health infrastructure, varying social, political, ethnic and religious issues mixed with legal, legislative and administrative problems, Pakistan needs to prioritize health governance and healthcare delivery with a transparent, accountable, responsive, need-based efficient and effective system. Around 242 million population in Pakistan essentially require improvement in healthcare which positively impacts the socio-economic progress and development of Pakistan. A multi-pronged approach can improve the health sector with a special focus on primary health care, preventive healthcare measures, and focused and targeted health-related interventions. The policies must be aligned with evidence-based policy and decision-making, promotion of health and strategies for disease prevention. The collaboration of health ministry, public sector healthcare institutions, national and international health agencies and donors, private sector, philanthropists, spiritual healers, NGOs and civil society by involving communities and marginalized populations in policy and decision-making can positively impact health governance and healthcare delivery. The existing traditional bureaucratic model of governance needs to be replaced with any other governance model to ensure quality healthcare. The model of public-private partnership in healthcare as already being practised in collaboration with the Sindh Government and PPHI can also ensure improvement in healthcare delivery.

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