

Rahim Yar Khan' health initiative – revisited

Dr. Sania Nishtar

Perhaps no other health policy intervention in recent times has been the substrate of a greater controversy compared with restructuring the mode of primary health care service delivery in Rahim Yar Khan (RYK) as part of which the management of Basic Health Units, in twelve districts of the country, was handed over to the Punjab Rural Support Program in Punjab, beginning 2003.

True that an overview of health policy and regulation in Pakistan can highlight many sore spots; the generic drug scheme of 1973, partial deregulation of prices of drugs in 1993, the institutional based private practice fiasco in NWFP in 2002 and the more recent PMDC scuffle are examples of contentious policy issues. However what makes the RYK initiative unique is the length of time for which the controversy prevailed, the utter discord in professional opinion on envisaged merits and demerits, the lack of consensus over how the initiative needs to be contextualized in the overall context of health reforms within the country, lack of full ownership of the State's health machinery and most importantly, lack of clarity on steps ahead. This article attempts to bring clarity of some of these issues and proposes a way forward.

A few clarifications before that, though, just to emphasize the importance of consensus building and institutional buy-in in strategic planning. It is often said that a strong political will is critical to fostering change. True that political will is a sine qua non of directional change – but perhaps not the only! And the RYK example just helps to reiterate the point. Called the Chief Minister's program in Punjab and currently in all the four Provinces as the President's initiative, the RYK initiative was backed by strong political support at the highest level and in all fairness, through well-intentioned bold decision-making. However despite that, the initiative has fallen prey to turf battles and implementation challenges only to show that in addition to political will, the consensus of stakeholders, institutional buy-in and directional clarity are, and should be the key ingredient of structuring new initiatives. Within this context, a number of questions, which have emerged since the launching of this program with respect to the *institutional, structural, service delivery and public health* imperatives are flagged hereunder and a viewpoint articulated on how to address them.

Was there a need to restructure the primary health care system in Pakistan?

The answer to this is an emphatic 'yes', albeit with several careful considerations. Primary health care, in layman's terms, consists of both the public health programs and infrastructure for delivery of basic health services. The former in Pakistan consists of several federally led public health programs with implementation arms in the provinces and the districts whereas the latter consists of 5301 BHUs and 533 RHC – which by infrastructure standards is one of the most elaborate in the developing countries. However, functionally, factors such as staff absenteeism, infrequent availability of essential medicines, poor attitude of staff, inadequate quality of care and other issues such as difficult geographic access have led to an unacceptable level of underutilization and

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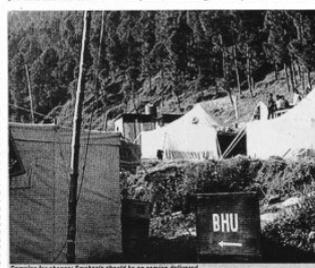
Basic considerations

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performance. Radical measures to reform the system were therefore not just needed but also timely. However it must be recognized that there were various options for restructuring BHUs which could have been considered. Contracting out management – the model opted for in RYK – is certainly one whereas the other options include transferring management to lower levels of government – either to the District Government (already introduced through the Devolution Initiative) or even to Tehsil Municipal Administration or Union Councils or maximizing efficiency within the existing system by decentralizing and granting greater financial and administrative controls to in charges of the health facilities, EDOs, and/or contracting in skilled managers at market salary to manage the system from within. In hindsight therefore, the RYK initiative should have been cited within an explicit macro policy environment which offered options for restructuring, which respective provinces and districts could choose from based on what seemed locally viable.

What should be the objective of restructuring Basic Health Units?

The ultimate objective of ‘restructuring BHUs’ should not be to ‘restructure management’ but to ‘reconfigure the mode of primary health care delivery’ with the understanding that *improving management* is a first step towards *improving health outcomes* within communities. Within this context, the RYK initiative has clearly shown management level success in terms of increased utilization of BHUs as is evidenced by high patient turnover, increased availability of drugs and better financial management; the initiative has also ensured increased field outreach to clients in 12 districts, primed schools to the concept of health promotion and most importantly addressed the issue of staff absenteeism by giving health care providers including women Medical Officers appropriate incentives to serve on station even in the remote areas. *The merit of this approach is not under question here.* However what is up for debate are two points: one relating to the question of whether the same results are possible if administrative and fiscal control is given to the government’s systems or using other options and the other relating to the potential that this model has to lead to sustained improvements in health outcomes vis-à-vis other envisaged models. And the answer to this can only be provided by evaluation to determine what gives the best value for money and is most equitable. The model centered on ‘contracting management’ may appear suitable in some areas owing to the concomitant presence of NGOs with the ability to deliver in such arrangements whereas other districts may choose to have other revamping options based on local adjustments.

What are the imperatives for institutionalizing the RYK model?

Any new initiative emerges as a creation; if the idea comes forward from within the establishment, it gets institutionalized at inception. However if it is a product of thinking within the civil society or technocrats – which then acts as a catalyst for change – it may take a while for it to get implemented or to institutionalize. Within this context, PRSP as an NGO took the lead in the process and clearly they qualified to be the initial partners. However systems interventions carried out by civil society organizations must be institutionalized when taken to scale. And now that there are public statements to support the up-scaling of the pilot project, consensus of the professional and public health community and its citing within an explicit policy framework become an imperative. This exercise must also carefully bear in mind questions relating to mandates, prerogatives and responsibilities at the federal-provincial interface with reference to policy making. Within this context therefore, careful attention needs to be paid to the following considerations: **Firstly**, getting the main stakeholders i.e. Ministry of Health and provincial departments of health on board and signaling of a clear policy position from the Federal Ministry of Health on the available options for restructuring BHUs, albeit giving provinces flexibility to choose what they think is most locally viable. **Secondly**, analysis at the provincial and district level of what is most suited for their needs and works best based on outcomes and financial analysis. **Thirdly**, in the event of restructuring within the existing systems, linking in with mechanisms that have already been set up such as the National Commission for Government Reform. **Fourthly**, guidance for provinces and districts that choose to contract out services in the areas of competitive selection processes. In the **fifth** place the stipulation of a minimum package of services to be delivered through the contracted out facilities and their means of monitoring and evaluation. And **lastly**, a reconfiguration of the State’s institutional ability to regulate the delivery of services by the private sector, because in the new contracting out models, the state will be the regulator and financier of services but not the provider as opposed to the earlier situation where it was all three.

What are the structural imperatives in the event of adopting the contracting out arrangement for restructuring BHUs?

Work needs to be initialized on a number of macro-structural issues in order to institutionalize the contracting of BHUs. *Firstly*, frameworks for public-private partnerships need to be developed; *secondly*, capacity of provincial and district governments needs to be enhanced in order to manage service delivery contracts; *thirdly* in the event of a fee for service being introduced in the contracted out sites, a mechanism of social protection has to be mainstreamed to ensure that public funding offsets the risk to the poor through waiver and exemption mechanisms. *Fourthly*, another structural imperative is to integrate community co-management at a basic healthcare level. The concept of having a community-based body at the facility level to oversee management and quality issues is now realistically possible, given the focus on community development and mobilization as part of the devolution initiative. *Fifthly*, the referral chain of contracted out facilities, which will then be in the private sector with RHC/THQ in the public sector need to be defined and streamlined. And *lastly*, the institutional arrangements for handling the BHUs restructuring program will have to be defined. BHUs until recently were controlled by the District health departments; however we now see the emergence of a different lines of reporting to a high level institutional arrangement. The prerogatives of this with the State health machinery will have to be defined at the provincial level and the manner in which this will regulate the delivery of services through contracted out partners will have to be clarified.

What are the public health imperatives of contracting out BHUs?

The contracting out option of restructuring BHUs also underscores the need to define the mechanisms of the delivery of preventive public health services which the state presently delivers through these sites and which *must* be delivered as a public good. Notwithstanding major issues in their present form, BHUs and RHCs serve as community hubs for the delivery of preventive and promotive services such as vaccination and control of infectious diseases; in addition, BHUs also serve as hubs for Lady Health Workers including training, reporting etc. In facilities where management is contracted out the State must define mechanisms for the delivery of health-related public goods and priority services and its new operational role in these models and explore whether these programs can be part of the package for which the management organizations is responsible for.

In summary therefore, the RYK Model of contracting out basic health facilities offers one restructuring option for galvanizing the States primary health care infrastructure into action; contrary to popular belief, it does not involve privatization of facilities, franchising or the introduction of a fee for service. Notwithstanding its weaknesses, the model has its merits and the impetus that it provided to alternate service delivery arrangements needs to be appreciated. However given that there may be other options for enhancing the functioning of BHUs which gel with the administrative prowess of the devolution initiative, restructuring decisions should be based on what is locally guided by evidence. A system for restructuring BHUs must also have appropriate checks and balances for ensuring sustained improvements. Ideally there should be a role for *management* in these arrangements, which can be taken by the party to which work is contracted out; a role for *quality assurance and evaluation* which can be taken up by State agencies, who must have appropriate capacity for this purpose and a role for *community oversight*, which can be served through linkages with the devolution initiative.

The challenge at the policy level now is to articulate a clear policy position on these matters with stakeholder, institutional and professional buy in and with the active involvement of the Ministry of Health and the departments of health as per constitutional prerogatives. Within this entire paradigm, the contribution of the NGO in serving as a catalyst for change should be lauded. But now is the time for mainstreaming this through the State's institutional mechanisms – regardless of how weak they are – for it is ultimately the responsibility of the State to deliver health and it is only by strengthening their ability to do so that the civil society's unwritten mandate can be truly served.

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