

Restructuring Basic Health Units – mandatory safeguards

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Primary safeguards

A national strategy for making structural changes to the Primary Health Care System is desirable, but to be successful it must be coordinated with other measures

By Dr. Sania Nishtar

Recently, a national strategy has been approved for revamping the Primary Health Care System with structural changes envisaged at the District level based upon the results of a pilot experience in Punjab. The strategy aims to restructure the first tier of the health service delivery infrastructure – the Basic Health Units (BHUs).

By infrastructure standards, Pakistan has one of the largest health service delivery networks at a basic healthcare level. This comprises of 5301 BHUs, each with a catchment population of 10,000 to 20,000 and 552 Rural Health Centers (RHCs) – a step above the



Room for improvement: A BHU in the Frontier.

investment in infrastructure, staff and equipment in these sites.

Given these considerations, a strategy which aims to restructure BHUs is, in principle, desirable, given that BHUs in their present form are – put simply – underutilised and unsustainable. However, this strategy should pay careful attention to a number of steps that need to be taken in tandem in order to ensure its success and long term viability.

First, the potential within a pilot intervention to be up-scaled successfully depends on the overarching policy and procedural framework within which it is set. It is therefore important to develop a regulatory framework and a system of combined governance in the new contractual arrangements for ensuring balanced power

relationships, with careful attention to accountability and sustainability-related concerns. Once such parameters are in place, a core prerequisite to contracting out services is to develop operational frameworks. Selection criteria must be specified, procedures for recruitment must be articulated, guidelines on ethical and administrative matters should be developed and procedures for developing price negotiations and contracts should be laid down and made publicly available.

Secondly, within the context of contracting out, it has to be made sure that public funding is used to ensure that poor people who access health services are not disadvantaged or discriminated against, and conscious safeguards have to be built for this purpose. This

links in with the need to develop comprehensive Social Safety Nets, which scope beyond what is currently available through Zakaat and Bait-ul-Mal. Such frameworks must structurally safeguard the interests of the poor and develop waiver and exemption mechanisms for the poor in the event of a fee for service being introduced in health care facilities. Higher authorities should continue to have a role in order to ensure that the poorest have access to quality services.

Thirdly, 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; these have to be delivered by the state as public goods. In addition, BHUs also serve as training hubs for Lady Health Workers – Pakistan's field force of grass-roots level health care providers. Within this context, the mechanism of delivery of these essential public health services and the role that the government needs to play to deliver them, needs to be procedurally clarified in contracted-out arrangements. This highlights the need for a conscious and concerted effort to mainstream preventive, promotive and disease-control-related activities in these new contractual relationships.

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health-related public goods and priority services and its new operational role in these models. Such reforms should also assess the feasibility building incentives for promoting preventive practices in the communities these serve; measures such as distribution of iodized salt, free bed nets in malaria-affected rural areas and hand-dipped soaps can create added interest in preventive activities. Partnerships with NGOs can be rewarding and fruitful in this connection given the outreach

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advantage that they bring. Fourthly, restructuring must 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 mobilisation as part of the devolution initiative. Community Citizen Boards, Village Health Committees and

other grassroots level organisations – mandated as part of the district devolved system – can either play a role in the setting up of co-management boards, overseeing them or serving as one. Many measures can be taken to ensure transparency and garner greater community support for such initiatives; for example, user fees can be made public and prominently displayed. Targeted capacity-building in the area of financial management and control, account

keeping and management should be promoted in order to enhance the capacity of communities to serve this role. The feasibility of utilising village co-management structures for record keeping (as in the case of vital registration) and strengthening the referral systems also needs to be explored.

In the fifth place, decisions to revamp the primary health care infrastructure need to be locally suited. The model con-

tered on 'contracting out' appears to be suitable in some areas owing to the coexistent presence of NGOs with the ability to deliver in such arrangements. However in other provinces/districts, the feasibility of contracting out vis-a-vis other revamping options – transferring management to lower levels of government or maximising efficiency within the existing system – also need to be explored by determining whether the existing system can yield results if granted administrative and financial autonomy in addition, 'the recently established contracting arrangements should serve as empirical models from which useful lessons can be drawn with relevance for broader outcome-orientated arrangements.

The strategy to restructure basic health care units also brings to the forefront many questions of overarching relevance – questions that relate to mandates, prerogatives and responsibilities and queries that have to do with the federal-provincial relationships and prerogatives in policy making. Perhaps BHU restructuring can also be used as a test case to bring clarity to some of these overarching issues.

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Recently, a national strategy has been approved for revamping the 'Primary Health Care System' with structural changes envisaged at the District level based upon the results of a pilot experience in Punjab. The strategy aims to restructure the first tier of the health service delivery infrastructure – the Basic Health Units (BHUs).

By infrastructure standards, Pakistan has one of the largest health service delivery networks at a basic healthcare level. This comprises of 5301 BHUs, each with a catchment population of 10,000 to 20,000 and 552 Rural Health Centers (RHCs) – a step above the BHUs. However in reality only 70% of the BHUs are currently operating; their infrastructure is used by other sectors in many cases and a vast majority is underutilized with a recently reported average daily turnover of 20 to 30 patients a day. The low turn-over observed at these sites is attributable to low-quality inputs as is evidenced by staff absenteeism, infrequent availability of essential medicines, poor attitude of staff, and other issues such as geographic access and out of pocket payment for supposed free services. As a result, the average cost-per-admission and outdoor-contact incurred does not justify the present level of investment in infrastructure, staff and equipment in these sites.

Given these considerations, a strategy which aims to restructure BHUs is, in principle, desirable given that BHUs in their present form are – put simply – underutilized and unsustainable. However, this strategy should pay careful attention to a number of steps that need to be taken in tandem in order to ensure its success and long term viability.

Firstly, the potential within a pilot intervention to be up-scaled successfully depends on the overarching policy and procedural framework within which it is set. It is therefore important to develop a regulatory framework and a system of combined governance in the new contractual arrangements for ensuring balanced power relationships with careful attention to accountability and sustainability-related concerns. Once such parameters are in place, a core prerequisite to contracting out services is to develop operational frameworks. Selection criteria must be specified, procedures for recruitment must be articulated, guidelines on ethical and administrative matters should be developed and procedures for developing price negotiations and contracts should be laid down and made publicly available.

Secondly, within the context of contracting out, it has to be made sure that public funding is used to ensure that poor people who access health services are not disadvantaged or discriminated against and conscious safeguards

have to be built for this purpose. This links in with the need to develop comprehensive Social Safety Nets, which scope beyond what is currently available through *Zakaat* and *Bait-ul-Mal*. Such frameworks must structurally safeguard the interests of the poor and develop waiver and exemption mechanisms for the poor in the event of a fee for service being introduced in health care facilities. Higher authorities should continue to have a role in order to ensure that the poorest have access to quality services.

Thirdly, 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; *these have to be delivered by the State as public goods*. In addition, BHUs also serve as training hubs for Lady Health Workers – Pakistan’s field force of grass-roots level health care providers, which deliver priority health services at the grass roots levels. Within this context, the mechanisms of delivery of these essential public health services and the role that the Government needs to play to deliver them, needs to be procedurally clarified in contracted-out arrangements. This highlights the need for a conscious and concerted effort to mainstream preventive, promotive and disease-control-related activities in these new contractual relationships. The State must define mechanisms for the delivery of health-related public goods and priority services and its new operational role in these models. Such reforms should also assess the feasibility building incentives for promoting preventive practices in the communities these serve; measures such as distribution of iodized salt, free bed nets in malaria-affected rural areas and branded soaps can create added interest in preventive activities. Partnerships with NGOs can be rewarding and fruitful in this connection given the outreach advantage that they bring.

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In the **fifth** place, decisions to revamp the primary health care infrastructure need to be locally-suited. The model centered on ‘contracting out’ appears to be suitable in some areas owing to the concomitant presence of NGOs with the ability to deliver in such arrangements. However in other provinces/districts, the feasibility of contracting out vis-à-vis other revamping options – transferring management to lower levels of government or maximizing efficiency within the existing system – also need to be explored by determining whether the existing system can yield results if granted administrative and financial autonomy. In addition, the recently established contracting arrangements should serve as empirical models from which useful lessons can be drawn with relevance for broader outcome-orientated arrangements.

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