Politics of health reform – Part 2

Dr. Sania Nishtar

It is said that "in order to judge the character of a nation, look no further than its health system". This yardstick unfortunately doesn't project a positive image of Pakistan's national character as the country fares poorly with respect to all the three measures of health systems performance assessment—equity in health outcomes, fairness in financing and responsiveness of the system.

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Part II

Governance

Dr Sania Nishtar

"In order to judge the character of a nation, look no further than its health system." This yardstick doesn't project a positive image of Pakistan, with respect to all the three measures of the performance assessment of the health system—equity in health outcomes, fairness in financing and responsiveness of the system.

But even more serious than the poor health status of the country's population are the wide inequities prevailing across income groups, rural or urban status of living and across genders. A recent analysis by the writer has shown statistically significant differences in health outcomes across quintiles of income measured in the Pakistan Demographic Health Survey database.

Three vertical "health systems" with mutually exclusive service delivery infrastructures, human resource, governance arrangements, and public or publicly-mandated private means of financing exist in their own right. These include health systems of the armed forces, the Fauji Foundation, and the Employees Social Security Institute. Collectively, these cover 14.20 per cent of the country's population. The predominant health "system" in the country can be described as being "mixed." Here, out-of-pocket payments and market provision of services predominate as a means of financing and providing services, alongside publicly financed government health delivery.

Two horizontal "health systems" provide health coverage to an additional 2.38 per cent of the population through this mixed system. These are the health systems of quasi-autonomous agencies of the government and the corporate sector. They use insurance or reimbursements as a means of financing but access the public or private sectors for service provision. Revenues fund healthcare for 15.22 million public-sector employees. In addition, 500,000 poor individuals are covered under safety nets. It can therefore be inferred that quality issues notwithstanding, 26.62 per cent of the population of the country is covered for healthcare costs, while 73.38 per cent is not, and makes some level of out-of-pocket payments to access healthcare. Recent health financing analyses show that out of the total amount of GDP spent on health (2.90 per cent), 1.16 per cent is contributed by the public sector whereas 1.73 per cent is contributed by the private sector. Predominance of out-of-pocket payments and private financing—regressive means of financing health—show that Pakistan fares poorly with regard to "fairness in financing," the second parameter of performance assessment.

A cursory examination of data from the Pakistan Social and Living Standards Measurement Survey of the Federal Bureau of Statistics shows poor performance with reference to the third domain, responsiveness. More than 70 per cent of service provision in health is by the private sector, but the state doesn't harness its capacity to deliver health-related public goods.

The poor performance of Pakistan's health system is in stark contrast with what Pakistan has stated in its successive policy frameworks and planning instruments. The design of Pakistan's three-tiered public infrastructure, a response to the international Alma Ata Declaration, has encouraged the mistaken notion that the state is pursing the goal of Health for All. The nature and magnitude of fundamental distortions in Pakistan's health system, therefore, make health reforms a strategic imperative.

A number of systemic changes are needed in the mechanisms of financing, delivering and governing healthcare, and in the means of providing inputs into the system (human resource, medicines and products), in order to meet the objective of Health for All. Healthcare is strongly influenced by the broader systems constraints within the sphere of political economy: without debt limitation, fiscal responsibility and measures to broaden the tax base, there won't be fiscal space available to allocate monies to the health sector.

There can be many entry points into health reform; change in financing arrangements is one of them. The objective should be to move towards public sources of financing (revenues and/or pooling) as opposed to private means of financing predominant in Pakistan. Here, Pakistan has to incrementally make indigenously relevant changes. Gradual increase in revenues is important, but more important is the reorganisation of existing financing. This can be achieved through action outside of the health sector and legislation to make it binding on employers to pool for employees through payroll taxes or employers' contributions for the formally employed sector. For those in the informally employed sector, there are options to broaden the base of social protection by augmenting existing waiver and cash transfer systems. Reform of the state's current arrangements (Zakat and Bait-ul-Mal) is critical in this space.

Management re-engineering of public-service delivery can be another entry point into health reform. It is envisaged that, with adequate re-sourcing and management re-engineering on private-sector management principles, workforce can be retained in the public sector, availability of medicines, supplies and infrastructure can be improved, and public facilities can be better managed. Similarly, market harnessing regulatory approaches to broaden the first point of contact in primary health care can be another entry point of health reform in Pakistan's setting. This approach can also enable purchase of services in order to achieve equitable access to care.

In most reform plans, institutional reform of state agencies mandated in a health role is needed to varying extents in order to enhance their normative and oversight capacity to implement and sustain reform. Institutional separation of policy-making, implementation and regulatory functions is usually a feature of such reorganisation. Most reform plans need to be supplemented with other changes, as has been observed in the case of the recent US health reform plan. Notable amongst these are the use of technology in order to assist with securing the distribution chain, making procurements transparent, optimising time and connectivity in health information systems, and bridging gaps in training, continuing education, and information dissemination

One must also not lose sight of the context in which support for implementation of health reforms has to be mobilised. With the budget sessions starting, experts are arguing for the need to curtail fiscal deficit as a priority and cautioning against an expansionary fiscal policy. Such a course will have fiscal implications for the social sectors. However, it is precisely in such a fiscally-constrained environment that the question of improving returns on spending needs to be prioritised in order to address constraints imposed by poorly-functioning public systems.

In this context, a recently released plan offers a roadmap to the reform of Pakistan's health sector in a phased manner. In addition to synchronised changes at the policy, legislative and institutional level, the plan draws attention to a number of structural factors within and outside the healthcare system, and lays emphasis on reform of governance and social welfare as an important adjunct to reform within the healthcare system. The reform roadmap is relevant to current efforts aimed at achieving development goals in today's macro-economically constrained environment and meeting broader development objectives in the context of Pakistan's geo-strategic challenges.

(To be continued)

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As a preliminary step to gauging fairness in financing, the construct of Pakistan's health system should be brought to bear. This is highly complex in its own right with many institutional actors. Three vertical 'health systems' with mutually exclusive service delivery infrastructure, human resource, governance arrangements, and public/publicly-mandated private means of financing exist in their own right. These include health systems of the armed forces, Fauji Foundation, and the Employees Social Security Institute. Collectively, these cover 14.20% of the country's population. The predominant health 'system' in the country can be described as being 'mixed'. Here out-of-pocket payments and market provision of services predominate as a means of financing and providing services alongside publicly financed government health delivery.

Two horizontal 'health systems' provide health coverage to an additional 2.38% of the population through this mixed system. These are the health systems of quasi-autonomous agencies of the government and the corporate sector. They use insurance/reimbursements as a means of financing but access the public/private sectors for service provision. Revenues fund healthcare for 15.22 million public sector employees. In addition, 0.5 million poor individuals are covered under safety nets (10.04% of the population). It can therefore be inferred that quality issues notwithstanding, 26.62% of the population of the country is covered for health (care costs), whilst 73.38% is not and makes some level of out-of-pocket payments at the point of care to access health care. Recent health financing analyses show that out of the total amount of GDP spent on health (2.90%), 1.16% is contributed by the public sector whereas 1.73% is contributed by the private sector. Predominance of out-of-pocket payments and private financing—regressive means of financing health—show that Pakistan, fares poorly with regard to 'fairness in financing', the second parameter of performance assessment.

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of service provision in health is by the private sector, but the state doesn't harness their capacity to deliver health-related public goods. Quality of healthcare issues implicit in recent malpractice scandals and coverage challenges illustrated in closed public health facilities—both courtesy of the media—underscore the magnitude of other 'responsiveness' related challenges.

Poor performance of Pakistan's health system is in stark contrast with what Pakistan has stated in its successive policy frameworks and planning instruments. The design of Pakistan's three-tiered public infrastructure, a response to the international Alma Ata Declaration has ingrained the belief and a welcomed aspiration, but a mistaken notion that the state is pursing the goal of Health for All. However many on-ground realities refute this notion, as has already been illustrated. The nature and magnitude of fundamental distortions in Pakistan's health system, therefore, make health reform a strategic imperative.

A number of systemic changes are needed in the mechanisms of financing, delivering and governing healthcare and in the means of providing inputs into the system (human resource, medicines and products) in order to meet that objective. Before drawing attention to these it must be recognised that healthcare is strongly influenced by the broader systems constraints within the remit of the political economy. Without debt limitation, fiscal responsibility, measures to broaden the tax base, there wont be the fiscal space available to allocate monies to the health sector and without measures to improve overall effectiveness in governance, there will be impediments to bringing about change in health systems performance.

There can be many entry points into health reform; change in financing arrangements is one of them. The objective should be to move towards public sources of financing (revenues and/or pooling) as opposed to private means of financing, which are predominant in Pakistan. Here, Pakistan cannot adopt a cookie-cutter approach and has to incrementally make indigenously relevant changes. Gradual increase in revenues is important but more important is the reorganization of existing financing. This can be achieved by action outside of the health sector and by enacting legislation to make it binding on employers to pool for employees through payroll taxes or employers' contributions for the formally employed sector. For those in the informally employed sector, there are options to broaden the base of social protection by augmenting existing waiver and cash transfer systems. Reform of the state's current arrangements (Zakat and Bait-ul-Mal) is critical in this space.

Management re-engineering of public service delivery can be another entry point into health reform. It is envisaged that with adequate resourcing and management re-engineering on private sector management principles, workforce can be retained in the public sector, availability of medicines, supplies and infrastructure can be improved, and public facilities can be better managed. Similarly market harnessing regulatory approaches to broaden the first point of contact in primary health care, can be another entry point of health reform in Pakistan's setting. This approach can also enable purchase of services in order to achieve equitable access to care.

In most reform plans, institutional reform of state agencies mandated in a health role is needed to varying extents in order to enhance their normative and oversight capacity to implement and sustain reform. Institutional separation of policy-making, implementation, and regulatory functions is usually a feature of such reorganization. Most reform plans need to be supplemented with other changes as has been observed in the case of the recent US health reform plan. Notable amongst these are the use of technology in order to assist with securing the distribution chain, making procurements transparent, optimizing time and connectivity in health information systems, and bridging gaps in training, continuing education, and information dissemination

Whilst health reform is imperative, one must also not loose sight of the context in which support for its implementation has to be mobilized. Pakistan has many competing priorities. With budget sessions commencing, experts are arguing for the need to curtail fiscal deficit as a priority and are cautioning against an expansionary fiscal policy. Such a course will have fiscal implications for the social sectors. However, it is precisely in such a fiscally constrained environment that the question of improving returns on spending needs to be prioritized in order to address constraints imposed by poorly functioning public systems.

Within this context, a recently released plan offers a roadmap to reform Pakistan's health sector in a phased manner. In addition to synchronized changes at the policy, legislative, and institutional level, the plan draws attention to a number of structural factors, both within and outside of the healthcare system and lays emphasis on reform of governance and social welfare as an important adjunct to reform within the healthcare system. The reform roadmap is relevant to current efforts aimed at achieving development goals in today's macro-economically constrained environment and meeting broader development objectives in the context of Pakistan's prevailing geo-strategic challenges.

To be continued…

The data reflected in this comment is quoted from the author's recent book on health reform, Choked Pipes. Details can be accessed at http://sanianishtar.info/choked-pipes.html