

Politics of health reform – Part 3

Dr. Sania Nishtar

Pakistan is faced with many unprecedented challenges. Ongoing acts of terrorism, the executive-judiciary confrontation, threats of environmental disasters looming with the Hunza lake bursting at its seams and a storm whipping up in the Arabian sea, a relentless energy crisis, a tough balancing act in the forthcoming 2010-11 fiscal policy, and many others. With many pressing governance concerns at hand, health reform may appear low on the list of priorities. That notion is misplaced for three reasons. Firstly, health reform is usually an elective process or a course, which is adopted by choice. However, at times it is inadvertently forced on the system because of certain institutional changes that are made outside of it. Such changes in the functioning of the state have already been made in Pakistan and have altered the equation of responsibility in favor of the provinces vis-à-vis the federal government as far as health is concerned. The 18th Amendment to the constitution, the 2010 National Finance Commission (NFC) Award, ongoing reorganization of the devolution initiative are not just political-point-scoring decisions, they have a deep bearing on the executive's functioning and the manner in which governance has to be reorganized in response to changes in structural norms. The 18th Amendment abolished the Concurrent List under which health was a subject in the purview of both the provinces as well as the federal government. The Local Government Ordinance 2001 stands omitted from the Sixth Schedule of the Constitution and therefore provinces have the prerogative to restructure the local government system according to the mandate in Article 140-A. Under the 2010 NFC Award provinces also have additional fiscal resources to support plans. These institutional changes can be an entry point into health reform with respect to reorganizing the stewardship capacity of state agencies—Ministry of Health and departments of health—which is an important element of any reform measure.

Secondly, the federal government's budget 2010-11 is just around the corner. This time round under a new fiscal model—the Medium Term Budgetary Framework—indicative ceilings have been stipulated for ministries for a three year period. This is a time window during which handling of responsibilities from the federal to the provincial government as outlined by the 18th Amendment have to be completed. Since the budget is one of the key instruments through which fiscal allocations can signal the directions of change, clear directions must be agreed upon.

The third imperative for health reform stems from poor health status of the country's population and the need for measures that aim to improve returns on health spending by seeking to address constraints imposed by poorly functioning public systems. Understanding these challenges and the means of their mitigation assume great importance in Pakistan at a time when the need to deliver welfare to the people of the country has never been more dire, given the country's prevailing geopolitical challenges.

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Part III
Governance
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Health reform is not a short-term measure. Sustained political will, consistency of policy direction and the resolve and capacity to cascade multidimensional changes in a sequenced manner as tangible action into coordinated policies, laws, and institutional arrangements are the prerequisites for its implementation. There are many political and technical capacity constraints, which stand in the way of achieving this in today's systems of governance. That notwithstanding, the institutional changes, which have been forced on the health system should be used to reorganise stewardship capacity of state agencies. This would, in any case be a prerequisite to

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implement the reform process if and when the country's technical and political capacity constraints are overcome. The opportunity should also be seen in the context of other opportunities in the country that can be capitalised for improvements at the health systems' level. Of particular note in this connection is the space that exists to exercise leverage on the potential within public-private engagement to make pluralism in service delivery work for equity and quality. The promising prospects of harnessing the potential within the country's telecommunication boom to mainstream technology in health systems for gains at several levels, is another. While yet another Pakistan's extensive public sector institutions infrastructure, which can be reformed with regulatory interventions and payment and incentive systems. Stewardship agencies need to be reconfigured to reap these low-hanging fruits as a priority. There are changes needed to reconfigure stewardship capacity at all three levels—federal, provincial and district—in order to do that. At the federal level, the ministry of health has an important role to play even after measures, which have granted provinces more health-related autonomy. However, its core mandate after the 18th Amendment appears to centre around normative tasks, coordination, resource mobilisation, information and evidence, disease security, ensuring compliance with international health regulations, and streamlining trade in health and the aid effectiveness agenda. Many changes are required in its culture to align its functioning

with this mandate. Currently the ministry is swamped by management of a few tertiary care hospitals and running operational controls of the national public health programmes. Its functionalities are overwhelmed by administrative tasks, and managing its subordinate, attached, and allied or autonomous departments. As a result the space for normative and strategic work has been crowded out. Its planning infrastructure is weak and there is no institutional entity responsible for human resource planning; the potential of its functionalities remains largely un-harnessed. The ministry's capacity is also limited to ensure compliance with international health regulations and serve one of its core roles, which relates to the information-evidence-policy cycle. It is performing a mix of normative, regulatory and implementation tasks often with lack of needed separation. A revamped ministry needs to concentrate on its core mandate and develop its capacity in these areas. In the pre-18th Amendment and NFC 2010 era the ministry embarked upon the process of formulating a new national health policy with an operational flavour, which must now be revisited and its orientation changed to that that resonates with the new mandate of the ministry.

Provincial agencies—the departments of health—require a different set of competencies. They have to develop the capacity to plan, implement and oversee a reform process that upholds the focus of primary healthcare both with reference to the set of services to be delivered as well as the first point of contact with individuals. In order to achieve this they need to develop capacity to regulate service provision by non-state actors to whom services have been contracted out under programmes launched in the last decade and develop protocols for intra-organised national contracting of services from one level of the government (provincial) to another (the district).

At the third tier of government, the need for operational clarity vis-à-vis divisional and district roles is urgent since issues at this level under- mine service delivery. Districts additionally have to develop capacity to integrate national public health programmes with district accounting and accountability channels and hone designated roles for management, quality assurance, evaluation and inter-sectoral collaboration.

Health reform can have many entry points—changes in financing, service arrangements, payment and incentive systems, labour market interventions and social protection arrangements. However, for each, institutional capacity at the stewardship level is a prerequisite. There is an opportunity today to draw upon the external drivers to reconfigure systems of governance facilitate health reform. A critical opportunity will be lost if we fail to do so.

(Concluded)

The writer is the author of a recently published book on health reform, *Choked Pipes*. Email: sania@heartfile.org

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The opportunity should also be seen in the context of other opportunities in the country that can be capitalized for improvements at the health systems level. Of particular note in this connection is the space that exists to exercise leverage on the potential within public-private engagement to make pluralism in service delivery work for equity and quality. The promising prospects of harnessing the potential within the country's telecommunication boom to mainstream technology in health systems for gains at several levels, is another. While yet another is Pakistan's extensive public sector institutional infrastructure, which can be reformed with regulatory interventions and payment and incentive systems. Stewardship agencies need to be reconfigured to reap these low-hanging fruits as a priority. There are changes needed to reconfigure stewardship capacity at all three levels—federal, provincial and district—in order to do that.

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The author has recently published a book on health reform, titled Choked Pipes. <http://sanianishtar.info/choked-pipes.html>