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Working paper of the health subcommittee

National Commission for Government Reforms

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Abstract

The National Commission for Government Reforms (NCGR) in Pakistan has been mandated with the task of developing strategic recommendations for improving governance and the functioning of the various tiers of the government. Within this scope, recommendations of the health subcommittee have been framed within the guiding principles of the reform as well as the values and objectives of the new health policy, which is currently in the final draft shape on its way to being institutionalized. Recommendations focus on the broader structural aspects of the envisaged health sector reconfiguration, within the ambit of reengineering of civil services and the way the government works and the interface between the federal, provincial and district governments; they also focus on the role of government agencies outside of the health sector. Recommendations are aimed at enabling the state to modernize public financing and provision of health services in order to make them efficient, effective, responsive and accountable so that they can provide the bulk of care either through their own infrastructure or by leveraging the infrastructure of the private sector. In the area of Governance, recommendations call for creating a **special Health Management Cadre** and the need to **leverage technology to promote transparency in governance and administration**. With respect to promoting alternative modes of service delivery, it is recommended that an **institutional mechanism/regulatory authority** should be created in order to establish a legal, policy and operational framework for fostering public-private partnerships. The creation of **District Health Boards** with multidisciplinary membership has also been recommended to serve an oversight bodies to plan, guide, oversee and coordinate the delivery of health within the district in line with local needs, albeit within the national health policy framework. In addition, **hiring of healthcare staff on a facility-specific contractual basis** has also been supported. A **social welfare intersectoral coordination committee** has been proposed to maximize operational linkages of the health sector with social welfare so as to institutionalize cash transfers for waiver and exemption systems in health facilities. In addition, it has been proposed that the scope of the National Population Commission be broadened to the **National Population-Health Commission** so as to institutionally integrate the delivery of population and health services in Pakistan and mainstream population planning and the delivery of its services into health policy and planning.

Background

The recommendations of the health subcommittee have been scoped within the broader ***mission*** and ***mandate*** of the National Commission for Government Reforms (NCGR), which is to improve governance and the functioning of the various tiers of the government in order to improve the delivery of basic services to the ordinary citizens of the country. They have further been framed within the guiding principles of the reform as envisaged in the NCGR's scope of work.[1]

The process of ***reform*** as it involves the ***health*** sector and the ***government*** can be extrapolated to any function of the health system and rightly so given that health is a social right enshrined in the Constitution of 1973 of the Islamic Republic of Pakistan, and a fundamental responsibility of the government. Hence it could be argued that *any* of the *various* aspects of health reform are relevant for highlighting at this forum. However in this document, the focus of recommendations is on structural issues, within the ambit of reengineering of civil services and the way the government works and the interface between the federal, provincial and district governments

The health perspective

A recent publication has collated *Health Statistics* in Pakistan since 1947 reporting them as a set of indicators, tracking health outcomes and health systems'-level processes and outputs since the country's inception.[2] *In a nutshell the report shows that although there have been significant improvements in health status, particularly with reference to improvements in some health outcomes and most intermediate health outcomes, the health status of the people of Pakistan generally remains poor.* Improvements have been seen in key maternal and child health indicators, some of the nutrition-related indicators and vaccine preventable diseases. However, improvements have to be contextualized to the issues inherent of the measurement of these indicators, the relativity of benchmarks against which data are pitched and the regional disparities that the averages tend to hide. Here it is important to note that Pakistan's key maternal and child indicators lag behind in comparison with averages for low income countries and in relation to international targets. In addition, averages also fail to show disparities, particularly with reference to differences in the performance of provinces and districts, across genders and the urban and rural areas.[3] In this document, tracking of trends was not possible for some indicators due to paucity of data and in these cases a snap shot of the health status was presented; data show that despite improvements in infectious disease control, Pakistan still harbors a significant burden of infectious diseases; this is compounded by the increase in the burden of non-communicable diseases with the epidemiological transition now underway

[1] National Commission for Government Reforms. Reforming the Government Services – a concept paper. Dated July 8, 2006.

[2] Nishtar S. Health Indicators of Pakistan: Gateway Paper 11. Heartfile in collaboration with the Federal Bureau of Statistics and the Ministry of Health: Islamabad; 2007.

[3] Government of Pakistan. Multiple Indicators Cluster Surveys. Statistics Division and UNICEF; 2002-2005.

and a number of emerging (e.g. SARS, Avian Flu) and re-emerging infections (e.g. Dengue fever).

Notwithstanding, the aforementioned, it must be noted that as a result of investments in the area of infectious disease control and maternal and child health, improvements are evident in the health sector at an intermediate outcome level. These include improvements in access to ante-natal and post-natal care and improvements at a process level in the key public health domains such as tuberculosis, malaria and HIV and AIDS.

A careful analysis of the available health systems' indicators and anecdotal evidence show that the observed intransigency of health outcomes can be attributable to a number health systems'-level challenges. This can be highlighted by *one* key feature of each of the four health systems functions – *governance, service delivery, health financing and health inputs.*

At a **service delivery** level, Pakistan has one of the largest public sector-owned service delivery infrastructure in the world at a primary health care level; however this remains underutilized and more than 50% of the care is provided by the private sector with out of pocket payments being the major contributor to financing healthcare within the country.

At a **health financing level,** although spending has increased recently, issues of fund utilization still prevail and alternative mechanisms of financing health – some of which have the potential to make financing patterns more equitable and efficient – have not been mainstreamed into the delivery of care. At an **input** level, the country's focus on producing more doctors has led to marked improvements in the doctor-to-population ratio; conversely, challenges relating to quality and capacity, and the effective and equitable deployment of health-related human resource still remain to be addressed. These issues are further exacerbated by poor regulation of the private sector. Also at the input level, lack of transparency in the pharmaceutical chain has a bearing on the performance of the health system and can reduce access to essential medicines, particularly for vulnerable groups. At **governance level**, policies and legislative and regulatory frameworks remain poorly implemented and administrative bottlenecks, decision-making delays and onerous financial and administrative procedures are known to undermine programme implementation. Furthermore, over the years, overlapping services have created ambiguities between federal and provincial roles and responsibilities and administrative authority particularly after the passage of the Local Government Act of 2002.

It is therefore evident that, improvements have occurred in a system where gaps abound and it is logical to assume that quantum leaps in health outcomes cannot be achieved if systems are not supportive to deliver programs. This realization has lent impetus to a system's strengthening approach within Pakistan through broad-based stakeholder efforts. The first step in this direction was the publication of the first health reform

agenda on the systems approach articulated in the Gateway Paper;[4] this was recognized as a blue print for a new national health policy in the country.[5]

Recommendations of the Steering Committee on Health are in line with the new health policy, which is currently in the final draft shape on its way to being institutionalized; the Steering Committee recommendations focus on the broader aspects of the envisaged health sector reconfiguration particularly where there is a role of government agencies outside of the health sector; this is on the premise that the NCGR would have the leverage to enable and lend impetus to such configuration.

The recommendations are grounded in a set of **values,** which are articulated in the new health policy; these include *social justice, fair financing, universal coverage, subsidiarity, inter-sectoral dependency, outcome orientation, gender mainstreaming, community involvement, quality management and technical efficiency.* Recommendations **focus** on *health systems strengthening* and *clearly defined priorities for investments*. In addition, there is a focus on creating a comprehensive social policy, within a social justice framework in view of the recent reshaping of the role of the state and the manner in which the government does business. Recommendations use health financing and alternative service delivery arrangements as a key tool in making the delivery of services more equitable and outcome-oriented; in particular, they focus on enhancing the capacity of the state to play a contemporaneously appropriate and effective stewardship, governance and regulatory role in the health sector.

Recommendations are also in concert with the **objective** of the new health policy, which is to *reduce mortality and morbidity and the disparities therein and to help attain a good standard of health for the entire population of Pakistan in order to promote health and enhance productivity*. **Operationally**, the recommendations would enable the state more broadly and the state-mandated agencies in particular to *pursue this policy objective by through modernization of public financing and provision of services in order to make them efficient, effective, responsive and accountable so that they can provide the bulk of care either through their own infrastructure or by leveraging the infrastructure of the private sector.*

Recommendations fall within the following areas:[6]

1. Governance

Improving governance in health and reconfiguring the stewardship role of the government is the single most important factor in improving health outcomes. This is so for two reasons; firstly, the bulk of health service delivery, especially *essential health services* must be provided by the state and secondly because the state also has the

[4] Nishtar S. The Gateway Paper: Health Systems in Pakistan – a way forward. Heartfile and Pakistan's health policy forum; 2006.
[5] Memorandum of Understanding. http://heartfile.org/policymou.htm.
[6] Minutes of the Meeting, February 19-20, 2007. No. 1 917)/2006-NCGR. Government of Pakistan; Dated March 12, 2007

responsibility to regulate the delivery of health services by the private sector. However, as opposed to this, it is widely established that there are many gaps in these areas. Administrative bottle-necks, decision making delays and onerous financial and administrative procedures are known to undermine program implementation and the effectiveness of the implementation of policies and lack of a regulatory framework limits the states ability to hold the private sector accountable. A number of capcity building and transparency promoting measures need to be taken to address these issues.

Recommendations

1.a It is recommended that a **Special Health Management Cadre** should be developed. Initially this should be developed at a provincial level so that all administrative and management posts are held by officers of the health management cadre. Ultimately, the feasibility of developing an all Pakistan administrative and management cadre, which sets common standards of accountability and performance, should be explored, given the strategic nature of the all Pakistan administrative and management cadre.[7] Within the structure of the new management cadre, reforms centered on good governance, accountability, factoring in of performance-based incentives and mainstreaming managerial audit should be institutionalized and safeguards should be built against political and external interference.

1.b The **use of technology to promote transparency in governance** and administration is also recommended. This includes establishing a system for National Health accounts, *electronic public expenditure tracking procedures and electronic equipment and supply inventories and a nation-wide database for matching staff and wage payments; these can* can track leakages from the *system and* can maintain up-to-date personal records and therefore can assist in eliminating abuses such as paying ghost workers.

3. In the area of drugs and supplies, it is recommended that **Drug Procurement Reforms** centered on electronic bidding should be introduced and phased-in for enhancing transparency.

2. Public-private interface

The government of Pakistan's current overarching policies focuses on privatization, liberalization and deregulation on the premise that the role of the government is to create an enabling policy environment. This leads to reconfiguration of the *public* and *private* roles and enables the public sector to leverage the strength of the private sector for fostering growth and development. However, these considerations also impact the discourse over public goods and the role played by governments in financing and providing social services – health and education, in particular. It is therefore plausible to explore different mixed arrangements for the delivery of public goods. This would not mean changing the role of the government but transforming it. In the new health policy therefore, the concept of the delivery of the essential health services hinges not only on

[7] Ejaz Rahim. Re: Reforming the government – a concept paper. Cab. Div UO No 1/1/2006-PS/CS, dated 10th July 2006. Government of Pakistan; Cabinet Division.

getting the government infrastructure to deliver these goods but also enabling the government to *finance* the delivery while leveraging the private sector to *provide* services. The role of the private sector becomes all the more important in view of the need for alternative service delivery arrangements to make Government-owned health facilities viable and sustainable in Pakistan's context.

It is well established that leveraging the potential of the private sector partners can significantly improve outcomes across a range of social services and can enable the State to share responsibility for getting programmes out to communities by relying on groups and organizations that have complementary mandates. These arrangements present a very powerful mechanism for leveraging the strengths of various partners; however caution needs to be exercised given that the idea is not to privatize public responsibilities; ethical, conflict of interest-related, methodological, accountability, sustainability and governance issues in such relationships merit careful attention.

Recommendations:

2. a It is **recommended that** an institutional mechanism/regulatory authority should be created in order to:

establish a legal, policy and operational framework for fostering public-private partnerships;
develop a regulatory framework to mainstream the role of the private sector into the delivery of healthcare and mainstream the services of bona fide NGOs into the national development process and foster public-not-for-profit relationships at an overarching level; and
assist with quality management, performance assessment, credentialing of doctors, continuing medical education and licensing and accreditation of service delivery facilities

The NCGR can assist with a normative role as there is a need to develop norms and standards which stipulate certain criteria in relation to the relevance of partnerships to the overall goal of development.[8] NCGR's overarching structural role can be important in this connection. To pilot test this approach, the NCGR has developed a set of tools to bring greater clarity, consistency and transparency in this area.[9]

[8] The Punjab Government has drafted a law – the Punjab Private Participation in Infrastructure Development Act – which lays down a statutory framework and procedures for formalizing the participation of the private sector in building infrastructure in the province. According to their website, the law will come into force after approval by the provincial cabinet and assembly. However, this law and the institutional mechanisms which it will create – the Punjab Infrastructure Regulatory Authority – are primarily relevant to building infrastructure and outlining contractual agreements on the basis of BOT, BOO and ROT – expressions that have been referred to in the Medium Term Development Framework. However, legislation on public-private relationships needs to be more overarching and applicable at a country level. The role of the recently created Infrastructure Project Development Facility under the auspices of the Ministry of Finance can be important in this regard as it can play an important role not just by providing timely and easy access for PPP implementing agencies but also preparing and managing PPP projects in the country in view of the aforementioned broader considerations.

3. Social protection

The new service delivery arrangements being promoted through the new health policy, mainstream the role pf the private sector. Although this will enhance the capacity of the government for outreach, mainstream efficiency and avoid pilferage, at some point it will also introduce user charges in facilities. Introduction of the market mechanism into the delivery services, even if financed by the government, may in cases introduce costs and therefore access issues for the poor; and it is here specifically that social protection arrangements assume importance.

Social protection is generally regarded as a mechanism to address poverty and vulnerability by providing protection against uninsured hazards such as illness, unemployment and disasters, which push vulnerable households into poverty and the poor into persistent poverty. If equity funds are made part of social protection measures they enable exemption at the point of service and therefore mitigate the risk of exclusion based on access. Pakistan is fortunate to have developed a Social Protection Strategy; the short term recommendations of this Strategy are to *"extend existing cash transfer programmes to reach the poorest ten percent of households, and to introduce conditional cash transfer programs to achieve specific objectives".* Cash transfers are important because such funds can be used in waiver and exemption systems in health facilities where health services have been contracted out and where user charges have been introduced. However this would entail inter-ministerial coordination and support by the Ministry of Social Welfare to the Ministry of Health and the departments of health in terms of linking *Zakaat* funds from the Bait ul Mal to waiver systems in health care facilities.

Recommendations:

3. It is recommended that a health-**social welfare intersectoral coordination committee** should be constituted with representation from both ministries; this committee should be given the mandate to create/maximize operational linkages of the health sector with social welfare so as to institutionalize cash transfers for waiver and exemption systems in hospitals and other health facilities.

Over the long term, an integrated social protection system based on social insurance and covering the entire population should be the goal; this again is a wide social policy objective – one that has to be pursued together through inter-ministerial coordination. Social welfare is traditionally financed through insurance contributions. Here it is important to recognize that this has limited value in Pakistan's context for the following reasons: insurance contributions are usually levied on workers and employees; in Pakistan, where 40% of the workforce works in the agricultural and informal sectors, there are no structured mechanisms to ensure contributions from salaries dedicted at

[9] National Commission for Government Reform and Heartfile. BHU restructuring Guideline. Islamabad; 2007. In press

source. Therefore, if pooling is pursued as a long term financing objective, it can only be done so with the understanding that this will be done through the state's contributions in what could then be called a social equity fund; this could tap into philanthropic and community contributions. Institutional arrangements relevant to both the cases exist and can be used as an entry point; Pakistan Institute for Philanthropy in the case of the former and community linkages, both within the devolution initiative as well as the community networks of organizations such as the Trust for Voluntary Organization and the rural support programs, in case of the latter. The potential within these can be harnessed in building a larger resource base for financing health and other social services.

4. Integrated and synchronized delivery of population and health

Integrated and synchronized delivery of both, population as well as health services can significantly enhance the state's ability to achieve population and health outcomes. The NCGR has the leverage to address this issue, which involves two ministries as it has an overarching governance and structural mandate.

The population-health *strategic* and *operational* disconnect is deeply embedded in structural administrative and institutional issues within the country. A number of attempts have been made in 1970, later in 1980 and most recently in 2000 by the federal government, the Multi Donor Support Unit and later by the Asian Development Bank Reproductive Health Program, for integrating population and health. However, all these initiatives used mergers of ministries as an entry point to integrating population and health. However, on the other hand, many opportunities exist to create better linkages for improving outcomes through approaches that are less threatening and more acceptable to stakeholders on both sides. For example, the existing quasi-integration of population and health, at the Executive District Officer level, under administrative devolution can be further built upon; population welfare services can also be integrated for patients/clients in the newly evolving public-private partnership frameworks that the health sector is pursuing. In addition, family planning can be brought on the mainstream agenda of the Ministry of Health and integrated with programs such as the Lady Health Worker program.

NCGR can take a lead role in assessing the population and health institutional arrangements, which need to be integrated within the county to the extent possible and to a degree that will allow synergizing activities, leveraging strengths and enable maximizing of efforts and mitigating duplication. However, in order for this to be sustainable, the proposed strategy will have to be grounded in evidence and based on consensus of all stakeholders.

Recommendations:

It is proposed that the scope of the National Population Commission be broadened to the **National Population-Health Commission** so as to institutionally integrate the delivery of population and health services in Pakistan and mainstream population planning and the delivery of its services into health policy and planning

5. Structuring the inter-sectoral scope of health

It is widely recognized that factors, which determine health status range much broader than those that are within the realm of the health sector and that modern healthcare has less of an impact on population health outcomes than economic status, education, housing, nutrition, sanitation, population dynamics, human development and improvements at a governance level. As opposed to this, health is viewed in a *healthcare system* rather than a *health systems* context.

Most of the available information about Pakistan health systems refers to provision of and investment in health services curative more than preventive and palliative – directed at individuals and populations. This constitutes the healthcare system; however a health system is much broader; this underscores the need for health to be viewed in its inter-sectoral scope. It is well established that many factors which determine health status range much broader than those which are within the realm of the health sector. Health cannot be extricated from the political, economic, social and human development contexts. It is well established that liberalization of international trade, global infectious disease pandemics, natural disasters and humanitarian crises can be detrimental to health outcomes as can be changes in international cooperation and geopolitical situations which can have implications for the manner in which health is resourced in a country such as Pakistan. Globalization has brought in its wake many contemporary challenges. The technology boom and the speed and access to interconnectedness has created a huge opportunity for capacity building, streamlining quality and efficiency in the delivery of care and management, and knowledge sharing but on the other hand also the risks of spurring costs as a result of over-utilization especially in the unregulated private sector. Liberalization of trade under WTO in a globalized community brings its own access and affordability issues particularly in terms the affordability of newly discovered medicines and under GATS, the mainstreaming of the market mechanism in the delivery of care in a manner that is detrimental to the interests of the marginalized, is a potential threat. In a globalized world, pandemics are known to spread with relative ease as have the SARS and Avian flu epidemics shown and mass damage by biological weaponry and humanitarian crises as a result of conflict and acts of terrorism are known to have health implications.

In view of the aforementioned, the proposed reforms *within an inter-sectoral scope* entail developing alternative policy approaches to health within its inter-sectoral scope with careful attention to the social determinants of health and several contemporary considerations that influence health status – in other words, broadening the ‘healthcare system’ to a ‘health system’. This would necessitate redefining targets within the health sector in order to garner support from across various sectors and setting these targets within an explicit policy framework in order to foster inter-sectoral action. In addition this also warrants the creation of inter-sectoral agencies that concentrate on prevention and health promotion at multiple levels – legislative, ministerial and others as necessary; development of dedicated provincial agencies that implement such programmes and overarching policy and legislation for health promotion.

Areas 2-5 scope health outside of the traditional health care domain and need to be pursed as part of a comprehensive development agenda; the mandate for the latter has been devolved to the district level after the passage of the local Government Ordinance of 2001. Within this context, it is important to create a district level coordination mechanism to synergize the roles and contributions of all the actors in the health sector at the district level to common objectives and envisaged outcomes.

Recommendations:

It s recommended that District Health Boards should be created within each district. Membership of the Board should be interdisciplinary both from the public and private sectors; the EDO health should be the secretary of the board. Broadly, the Board should be mandated as an oversight body, to plan, guide, oversee and coordinate the delivery of health within the district in line with local needs, albeit within the national health policy framework. The following roles should be assigned to the board:

A) developing mutually agreed strategic workplans for the district with participatory consensus of all stakeholders in the health and development sectors
B) Providing a point of contact for stakeholders in the health and population sectors and other areas relevant to the intersectoral scope of health for coordinating plans and activities
C) Coordinating public and private roles for the delivery of healthcare based on locally relevant evidence
D) Providing oversight to decisions on contracting out services to the private sector at a basic healthcare level and contracting in private sector services for public sector secondary level hospitals, which fall within the jurisdiction of the districts.
E) Developing locally suited monitoring and evaluation plans and overseeing compliance to these
F) Reviewing and critically analyzing district level data from the health management and information systems for decision making
G) Liaising and negotiating with the Federal and provincial governments for resource allocations from development budgets
H) Providing a point of contact for international development partners for district health-related activities
I) Clarifying roles and responsibilities and developing an institutional consensus on federal, provincial and district roles and prerogatives and administrative authority should also be another area for concerted effort.
J) Authority to hire healthcare staff on a facility-specific contractual basis, determining remuneration for the staff and serving as a reporting line.