

Devolving health

Dr. Sania Nishtar

Pakistan's Ministry of Health was abolished on the 30th of June and a number of federal health responsibilities were placed under the jurisdiction of seven other government ministries/divisions. The dynamics of this change and the questions emerging as a result thereof have been discussed in these columns on July 23. This comment presents an option for the way forward with regard to entrusting national/federal health responsibilities to appropriate institutions at the federal level. Most of these functions are linked to each other. Information, a key responsibility, has to be consolidated across streams, that in turn informs high level decisions related to national roles, in particular disease security, trade in health, federal fiscalism, external resource mobilization, each with a deep bearing on provincial and district level service delivery, health financing, human resource management and health governance.

Failure to retain national responsibilities and ensure their institutional linkages can have serious consequences. I have attempted to illustrate these by building five hypothetical scenarios.

Scenario 1, 2013: Pakistan becomes the last remaining reservoir of poliovirus transmission in the world and is jeopardizing worldwide efforts to eradicate a disease for the second time from this planet. Buffer stocks of vaccine have been depleted and the weaker provinces have not been able to put procurement systems in place. There is no concordance in national immunisation days across provinces and the number of newly reported cases is burgeoning.

Scenario 2, 2012: there is an outbreak of Avian influenza in Asia and cases have been detected in Pakistan. None of the provinces take responsibility. Health information is fragmented. Emergency preparedness is under Cabinet Division, which is fire fighting on many fronts. The Central Health Establishment, responsible for health-related border security is placed under the Division for Inter-provincial coordination, which is inundated with many post-devolution responsibilities. No one owns infectious disease surveillance, all elements of which have been "devolved" with devolution of national programmes. Pakistan is not compliant with International Health Regulations, 2005. If scenario 1 and 2 actually dawn, the country risks becoming a "global health pariah".

Scenario 3, 2012: after devolution of "regulatory responsibilities" a patient from Khyber Pakhtunkhwa and service provider from Punjab lock horns in litigation in a malpractice suit. Both provinces have different standards for quality and service regulation and dilemma arises about the standards courts are to apply.

Scenario 4, 2012: an acute shortage of nurses is precipitated in Punjab as a human resource placement firm in Balochistan starts exporting nurses to the gulf countries. In a country where trade—including cross border supply of services and migration of human resource—is guaranteed by the Constitution under Article 151, cross border movement of human resource cannot be controlled.

Scenario 5, 2012: Pakistan is criticized at a multilateral forum for setting a wrong precedent for other federating systems. Some of the major development partners decide to pull out support since they cannot be responsive to four "windows" instead of one and do not want to operate in an uncertain environment. Pakistan risks losing millions of needed "health dollars" from GAVI and the Global Fund. Word limit precludes me from painting other scenarios.

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Part - II

Governance

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Appropriately synchronised federal health structures can safeguard against such malfunctions. However, these must never encroach on provincial space in health but should strictly be confined to "national roles". The proposal of the Health Division under a relevant ministry still stands as the best option. However, since this is perceived as being against the spirit of devolution, the next-best option for the proposed national structure is being presented. This is outlined in an illustration accessible at <http://www.heartfile.org/pdf/devolutioninfinalreport.pdf>.

The option comprises many steps. First, a "health structure", which consolidates national responsibilities to the extent possible, should be delineated. The National Institute of Health's (NIH) mandate could be expanded so that it can assume that role. The idea of an Epidemiology Division, which was mooted previously by some experts is relevant in this regard. This division, as the centre-piece and hub for health information can become an important federal institution.

In the originally floated idea, the division had the mandate to deal with Integrated Disease Surveillance and Response (IDSR), its subset the Disease Early Warning System (DEWS), the Epidemic Investigation Cell (EIC) and the Field Epidemiology and Laboratory Training Program (FELTP), all critical for ensuring disease security. In the post-devolution situation, the mandate can be broadened so that it also assumes the broader responsibility for health information and engages in collating, consolidating and analysing information and relating it to the appropriate decision-making level. In this role it would then also be linked to the Federal Bureau of Statistics, which houses the National Health Accounts Cell and conducts the FHS and PSLM surveys, all relevant for health sector planning. In addition institutional linkages would also have to be established with the National Institute of Population Studies, the Pakistan Medical Research Council and the District Health Information System (DHIS) and where relevant, its precursor, the Health Management and Information System.

Devolution of national public health programmes is an opportunity to integrate silo surveillance systems, which can either be combined in the IDSR or the DHIS. For example, the EPI's case-based surveillance, its sentinel surveillance sites for Bacterial Meningitis and Rotavirus, and its Measles case-based surveillance, can be combined in the IDSR for notifiable diseases, or its subset, DEWS. Many aspects of routine EPI surveillance such as immunisation coverage, stock position and monthly reporting can be integrated with the DHIS, as can the management information components of all other programmes.

Secondly, a converging entity—for example, a board—for high-level policy relevant to national roles in areas related to disease security, trade in health, federal fiscalism, external resource mobilisation, and interprovincial coordination should be formed and can be entrusted with advisory, technical support and oversight functions. The converging entity should have an adequately resourced technical secretariat, which can be housed at an appropriate institutional structure. The board can have close linkages with the devolution unit in the Economic Affairs Division to which responsibility for donor linkages has been entrusted, the devolution unit in the Cabinet Division, where the government desires to place emergency preparedness, and the health unit in the Planning Commission.

The enclosed figure also shows how two other institutions will continue to report to a relevant ministry, the Pakistan Medical Research Council (PMRC) and the Health Services Academy. The proposed new Drug Regulatory Authority of Pakistan has been shown reporting to the Cabinet Division, since all autonomous regulatory agencies have the same reporting relationship. However, technical oversight would be necessary. It has also been proposed that attention be accorded to other human resource regulatory agencies, such as the PMRC, the Nursing Council, etc. at the same level.

In proposing this solution I have gone out of the way to accommodate sensitivities about the 18th Amendment—in particular notors relating to going against the spirit-of-devolution. The solution is recommended as a means of retaining what the government has already created and builds further on that. Creation of the epidemiology division at NIH and the policy board is envisaged to cement the current post-devolution fragmentation of health to the extent possible, given current constraints.

Decision-makers must consult themselves to resurrecting national roles in health. Without attention to these, the spirit enshrined within devolution, provincial empowerment for enhancing their capacity and ownership to deliver services can be seriously undermined.

Concluded

The writer is the founding president of

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Decision makers must commit themselves to resurrecting national roles in health. Without attention to these the spirit enshrined within devolution, provincial empowerment for enhancing their capacity and ownership to deliver services, can be seriously undermined.

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