HEALTH SECTOR IN PAKISTAN

An Overview of the Health Sector: The Way Forward

November 2001
Health Sector in Pakistan

An Overview of the Health Sector: The Way Forward

Multi-donor Support Unit

Ministry of Health
Government of Pakistan

November 2001
Papers Prepared by the Multi-donor Support Unit for the Pakistan Human Development Forum

- Elementary Education in Pakistan: Current Status, Issues and Future Strategies
- Health Sector in Pakistan: An Overview of the Health Sector: The Way Forward
- Population Sector in Pakistan: Current Demographic Situation, Sectoral Issues, and the Way Forward
- Water Supply and Sanitation in Pakistan: Current Status, Issues and Future Strategies
- Governance in the Social Sectors in Pakistan: Analysis, Issues and Recommendations
Although Pakistan has made reasonable progress in improving the health status of its population during the last decade as reflected by an increase in immunization coverage and reduced infant mortality, we still have a long way to go. The fact that 9 out of every 100 new born child in our country dies before reaching her/his first birthday is a grim reminder of the long and tedious path we have to cover. With low literacy and primary enrolment levels, and lack of access to clean drinking water and adequate sanitation services, the task of improving health status of the people is even more difficult. Poor quality and coverage of services in the social sectors, and low economic growth during the last few years has led to rising poverty and impeded the development of the country. To reverse this trend, the Government of Pakistan has launched a series of reform programs – most important of which are the Poverty Reduction Programme and the Devolution of Power to grass-root levels through establishing Local Governments.

It has now been fully recognized that poverty cannot be reduced in the country without improving the health and education status of its people. The Ministry of Health has taken a lead in developing a Vision, Policy and Strategy to revamp the health services in Pakistan. The Ministry, over the last one year, has worked with its provincial counterparts in reviewing the existing policies and systems of health services. Based on this review, a comprehensive Health Policy was developed and announced by the Minister of Health in June 2001. This Paper is in continuation with that Policy and presents a Strategy for the development of Health sector in Pakistan over the next five years.

As spelled out in this document, the Government aims to provide quality health services that are accessible, efficient and equitable. This is to be done through Programmatic as well as Organizational and Management Reforms covering both the public and the private sectors. Unlike past, this reform program is outcome driven as we have laid very clear and tangible outcomes to be achieved by the year 2005. I hope, with the collaboration and cooperation of the provincial and district health departments and the Ministry of Population Welfare, we will be able to gradually transform the health services in Pakistan to better serve the needs of the people. I am confident that we will achieve the targets set for the next 5 years. We are cognizant that the key to success lies in implementation of the strategy. Regular monitoring will be conducted to ensure that the implementation is on the right course.

I would strongly urge our Development Partners to join hands with us in implementing the strategy. We value and welcome the technical as well as financial support provided by Development Partner agencies.

I am thankful to the provincial Health Departments and colleagues in the Ministry of Health in formulation of this paper. The Multi-Donor Support Unit provided invaluable technical assistance in facilitating the development of the Health Sector Overview.

Ejaz Rahim
Secretary
Ministry of Health
Government of Pakistan
TABLE OF CONTENTS

FOREWORD .................................................................................................................. 2
PREFACE ..................................................................................................................... 3
SYNOPSIS ...................................................................................................................... 5
EXECUTIVE SUMMARY ............................................................................................... 6
AN OVERVIEW OF THE HEALTH SECTOR: THE WAY FORWARD ................................................. 10
I. Investing in the Health Sector ....................................................................................... 10
II. Contextual Background ............................................................................................. 10
III. Burden of Disease ..................................................................................................... 13
IV. Challenges to Further Progress ............................................................................... 14
Vision for the Health Sector .......................................................................................... 14
Current Strategies in Health .......................................................................................... 14
V. Programmatic Reforms and Organizational & Management (O&M) Reforms: An Analytical Framework ................................................................................................................................. 15
Programmatic Reforms .................................................................................................. 15
Expanded Program of Immunization .............................................................................. 15
National Tuberculosis Control Program ......................................................................... 17
National HIV/AIDS Prevention and Control Program (NAPCP) ...................................... 18
National Malaria Control Program ................................................................................ 21
Reproductive and Child Health (RCH) ........................................................................... 21
National Program for Family Planning and Primary Health Care (NPFP&PHC) ................. 22
Health Education & Promotion ..................................................................................... 27
Nutrition Program ......................................................................................................... 28
Organizational and Management (O&M) Reforms ......................................................... 30
Decentralization to the District Level .............................................................................. 30
Contract Employment .................................................................................................... 30
Tertiary Hospital Autonomy ............................................................................................ 30
Improving Governance .................................................................................................. 31
VI. Major Weaknesses in Health Services ...................................................................... 31
Proposed Strategies in Health ........................................................................................ 32
VII. Immediate and Short-term Strategies ...................................................................... 32
A. Devolution of Power and Responsibility and Implications for Health Sector ................. 33
B. Strengthening District Health System (DHS) ................................................................ 34
Steps to Improve Service Delivery in the Districts ........................................................... 36
C. Improving Governance in Health ............................................................................. 37
D. Policy Analysis and Reform Unit in Ministry of Health .............................................. 37
E. Merger of Population Welfare and Health Programs ................................................ 38
VIII. Medium-Term Strategy ........................................................................................ 38
A. Health Sector Allocation and Expenditure ................................................................... 39
B. Explore Alternate Means of Financing Health Care .................................................... 39
C. Human Resource Imbalance in Health Sector .............................................................. 40
D. Autonomy to Teaching/Tertiary Hospitals .................................................................. 41
E. Public/Private Partnerships: Outsourcing Government-Financed Health Services ........... 41
F. Public/Private Partnerships: Public Initiatives to Improve the Quality of Private Health Services ................................................................................................................................. 42
IX. Response of the Ministry of Health .......................................................................... 43
X. Ten Specific Areas of Reforms ................................................................................... 43
An Overview of the Health Sector: The Way Forward

even a significant proportion of what the Federal Government spends is for procurement of inputs that are transferred to the provincial Departments of Health as grants-in-kind. Under the recent Local Governments Ordinance, the delivery of health services would be the responsibility of districts. It would, however, require substantial capacity development of these governments before they can be entrusted with full responsibility for the planning, financing and delivery of these services. The major exceptions are the Population Welfare Program and the National Program for Family Planning and Primary Health Care. Despite announcement by the government, the former has yet to be defederalized or merged with the latter. The Federal Ministry of Health however continues to play an important leadership role and provides valuable technical assistance to the provincial Departments of Health.

The vision for the health sector is to improve the health status of the population by reduction in the overall burden of disease through primary health care approach that envisions provision of quality health services that are accessible, efficient and equitable. This will be achieved through promotive, preventive and essential curative health programs that address the priority health problems of the country, along with the institution of organizational and management reforms that set the stage for their effective implementation.

There has been a clear thrust in recent years on the part of the government’s health services to give a higher priority to Programmatic reforms, and do more in the areas of communicable disease control, and reproductive and child health. This thrust has been encouraged by donors in the context of the Social Action Programme Projects (SAPPs), as well as the several development partner assisted “investment projects” that have complemented the SAPPs. The priority programs include Expanded Program of Immunization, National Tuberculosis Control Program, National HIV/AIDS Prevention and Control Program, National Malaria Control Program, Reproductive and Child Health. The latter includes several initiatives such as NPFPPHC, Asian Development Bank (ADB) financed Women’s Health Project, and the recent UNFPA assistance on safe motherhood, quality of care and information systems. Main Achievements of these priority programs are improved EPI coverage - up to 70% in Punjab, significant progress in Polio eradication, increased TT II Coverage - 50%, expansion of DOTS Strategy to cover 15% population in one year, annual parasite index for malaria less than 0.1/1,000 population, Contraceptive prevalence rate of 30%, delivery by trained personnel up to 45% in LHW areas, and averting thus far the HIV/AIDS epidemic.

Until the government announced its devolution plan, there had been a long period of time during which the government health services were not subjected to any major O&M reforms. Under the SAPPs’ reform agenda, the provincial Departments of Health had committed to achieve a greater decentralization of administrative and financial powers from the provincial level to the district level. In recent years, Punjab and NWFP have experimented with contracting of doctors and other cadres in an effort to achieve better service delivery with a greater degree of control over staff and greater flexibility in staffing. Punjab, under the previous government, led the way in granting a greater degree of managerial and financial autonomy to its tertiary hospitals. Improving governance is a cross-sectoral issue; however, it is the cornerstone for effective health sector reforms and for the improvement of health services. Four governance issues were identified as priority under the SAP - staff absenteeism, recruitment, procurement and site selection. Success with tackling governance issues has been limited, as the “therapy”
was more “symptomatic” instead of addressing the root causes of the problems. These initiatives were superseded by the more far-reaching devolution initiative of the government.

**Major weaknesses** that exist with respect to health services are: (i) office of the Executive District Officer Health (formerly District Health Officer) lacks capacity in terms of human and financial resource management as well as the authority and resources to effectively plan, deliver and supervise health services; (ii) BHUs / RHCs are generally ill equipped, under-staffed or under utilized; (iii) shortcomings exist in the District/Tehsil level hospitals, in emergency care services, and maintenance/repair of medical equipment; (iv) lack of a functioning referral system is major reason for poor handling of obstetric and other emergencies in rural areas; (v) family planning services are currently being provided as a vertical program; (vi) gender imbalance exists as the health staff and managers are predominantly male; (vii) non-salary components of primary health care programs are not adequately provided for in the provincial budgets; (viii) experience with autonomy of tertiary hospitals has been mixed and a clear picture in terms of improved services or enhanced revenue generation has not emerged; (ix) political interference has been frequent in the past, in personnel decisions such as recruitment, transfers and disciplinary actions; (x) private practice of public sector physicians and specialists is a universal malaise; (xi) private sector, the biggest provider of medical services, is unregulated and lacks government support; and (xii) poor regulations, commercialization and falling standards of medical graduates characterize the medical education sector.

There are several short- and medium-term strategies to improve the performance of the health sector. Although not a short-term strategy *per se*, the **devolution initiative** has acquired immediate importance, as it is potentially the most important O&M reform to come around in many years. This initiative implies a shift of responsibility for health services, from provincial governments to the newly created district governments. However, a number of critical features of devolution have yet to be finalized - financial and administrative arrangements, and the degree of oversight exercised and technical support provided by the provincial Departments of Health.

The Multi-donor Support Unit (MSU) has taken the **District Health System strengthening initiative in support of Devolution Plan of the government.** The focus of this initiative has been on strengthening management systems in the districts. An important intervention is the establishment of District Health Management Team, which is lead by the Executive District Officer Health and comprises all major stakeholders in the district. There is, however, a need to institutionalize DHS strengthening by the provinces through strengthening of the network of Provincial and District Health Development Centers to provide technical support for capacity development in districts; Health Directorates should provide the technical oversight for effective implementation of priority programs; upgradation of THQ/DHQ Hospitals; and measuring performance between and within districts over time.

The Ministry of Health has developed a PC-1 for the establishment of a **Policy Analysis and Reform Unit (PARU).** The total cost of the PC-1 for the first two years is Rs40.0 million. The objectives of the Unit are to enhance the capacity of the Ministry of Health for policy research and analysis in health sector; facilitate the overall process and content of policy development and implementation in the health sector; fulfill the information needs for “Health Sector Reforms”; and promote and coordinate need based research.
National Tuberculosis Control Program

16. Pakistan has the sixth largest burden of tuberculosis in the world, but until recently there was no concerted effort to deploy an effective control program. WHO has estimated the TB incidence to be 177 per 100,000 population. A successful start has been made in the last few years by initiating the phased introduction of the DOTS approach as recommended by the WHO. Federal and all provincial PC-1s for TB Control stand approved at a total cost of Rs.465 million (Table 4). The percentage of population covered at present is about 15 percent.

17. Under the Global Drug Facility additional anti-TB drugs have been provided for 75,000 patients with a buffer stock for additional 75,000 for a period of two years. The Program targets are to have 100 percent population coverage under the DOTS strategy by the year 2005 (Table 5), to achieve a case detection rate of 70 percent and cure rate of sputum positive cases of 85.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Duration (months)</th>
<th>Up to</th>
<th>Cost (million Rs.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal</td>
<td>48 months</td>
<td>July 2004</td>
<td>66.7</td>
</tr>
<tr>
<td>Punjab*</td>
<td>24 months</td>
<td>July 2002</td>
<td>19.7</td>
</tr>
<tr>
<td>Sindh</td>
<td>48 months</td>
<td>July 2003</td>
<td>95.0</td>
</tr>
<tr>
<td>NWFP</td>
<td>60 months</td>
<td>July 2005</td>
<td>62.8</td>
</tr>
<tr>
<td>Balochistan</td>
<td>36 months</td>
<td>July 2002</td>
<td>99.7</td>
</tr>
<tr>
<td>AJK</td>
<td>60 months</td>
<td>Jan 2006</td>
<td>83.7</td>
</tr>
<tr>
<td>N Areas</td>
<td>48 months</td>
<td>Jan 2003</td>
<td>47.0</td>
</tr>
</tbody>
</table>

* Rs. 50 million annually allocated in recurrent budget for anti-TB drugs for DOTS

<table>
<thead>
<tr>
<th>Area</th>
<th>20000/01</th>
<th>2001/02</th>
<th>2002/03</th>
<th>2003/04</th>
<th>2004/05</th>
</tr>
</thead>
<tbody>
<tr>
<td>AJK &amp; NA</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Balochistan</td>
<td>11</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>NWFP</td>
<td>10</td>
<td>14</td>
<td>18</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>Punjab</td>
<td>5</td>
<td>12</td>
<td>18</td>
<td>26</td>
<td>34</td>
</tr>
<tr>
<td>Sindh</td>
<td>5</td>
<td>13</td>
<td>21</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>40</td>
<td>71</td>
<td>89</td>
<td>101</td>
<td>111</td>
</tr>
</tbody>
</table>

18. A key strategy for DOTS expansion is to strengthen Public Private Partnerships, which is being developed with DFID assistance. A Strategic Framework Study with the involvement of private practitioners and NGOs in TB DOTS has been completed and policy/operational issues have been identified by a core group. The framework provides the following strategic guidelines:
Strategic Framework
- NTP/PTP take up a leading role in enabling EDOs to operationalize PPP in TB Control
- Phases of operationalization - MOUs, action plans, capacity building, implementation
- Type and scale of potential PPP respond to district/facility level circumstances initially in geographically manageable areas
- PPPs should be evaluated for - use of social marketing / contracting / regulatory framework for NGOs

20. The following priority areas require additional inputs:
- Additional Technical staff
- Hardware
- Central Drug Bank
- Strengthening of referral Laboratory Network
- Information Resource Center
- Public Private Partnership
- Research and Training Institute

21. The estimated cost for strengthening the network of laboratories in the provinces and at the federal level is Rs.57 million. The estimated resource requirement for achieving 100 percent DOTS Coverage by 2005 is Rs.1,128 million.

<table>
<thead>
<tr>
<th>Total Resources Required</th>
<th>Rs. 2008 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available Government Resources</td>
<td>Rs.970 million</td>
</tr>
<tr>
<td>Development Partner Inputs</td>
<td>Rs.100 million</td>
</tr>
<tr>
<td><strong>Financing Gap</strong></td>
<td><strong>Rs.1128 million</strong></td>
</tr>
</tbody>
</table>

National HIV/AIDS Prevention and Control Program (NAPCP)

22. The number of officially reported HIV infections was 1,603 and AIDS cases 210 as of June 2001 based on data from the 47 surveillance centers (Fig 1), but there is a likelihood that the actual number of cases is much higher. Pakistan is a low prevalence but a high-risk country for an HIV/AIDS epidemic, as many of the conditions for its spread exist in the country. The experience of other countries such as India shows that prevalence of HIV infection can suddenly take off and increase manifold in a short period of time.
National Malaria Control Program

28. Pakistan has not had a major epidemic of malaria over the last two decades, however there are pockets of high endemicity in the rural areas of Sindh and Punjab. **Total Malaria Cases reported in government facilities during the year 2000 is 111,000.** *Falciparum* malaria, which is responsible for death due to malaria has registered an increase in Sindh (57%). Overall burden of *Falciparum* malaria in Pakistan is 33 percent of all malaria. Malaria accounts for 1.5% of all mortality reported in public sector hospitals. Resistance of malarial parasite to drugs has shown an increase in recent years – studies on pattern of drug resistance have become essential.

29. A federal PC-i based on the Roll Back Malaria strategy of WHO has been approved at a total cost of Rs.253 million for the period 2001/06. The provincial Departments of Health have been advised to prepare PC-1s to complement the federal program. The provincial Departments of Health have prepared PC-1s to complement the federal program – Punjab Rs.155 million, NWFP Rs.35 million, Balochistan Rs.44 million, Sindh Rs.129 million, and AJK Rs.56 million. The priority need is to strengthen malaria microscopy in RHCs and BHUs of 40 high-risk districts for which Rs.141 million are required. The target is to reduce malaria morbidity (annual parasite incidence) by 50 percent over the next five years.

**Strengthen Network of Laboratories in PHC Facilities**

- Training of Mircroscopists Rs.24 million
- Equipment and Supplies Rs.85 million
- Strengthening of Reference Laboratories in provinces Rs.20 million
- Mapping of drug resistance Rs.8 million
- Trials on Combination Therapy Rs.4 million
- Resources Required Rs.141 million

Reproductive and Child Health (RCH)

30. Reproductive and Child Health is a complex area of health care interventions associated with human reproduction (ante-natal care, delivery care, post-natal care) and the health of children less than five years of age. Some of the major programs being implemented in health are in this area while others are in the pipeline.
National Program for Family Planning and Primary Health Care (NPFP&PHC)

31. National Program for Family Planning and Primary Health Care (NPFP&PHC) has recruited 58,000 Lady Health Workers whose major focus of work is provision of Reproductive and Child Health services at the doorstep of the community. The program is almost entirely funded by the Federal Ministry of Health (Fig 2). Since October 2001, 12,000 VBFPWs have been merged with LHWs. The Program coverage has now increased to 50 percent of the population mainly in rural areas and urban slums. Total allocation for the period 1994-2003 is Rs.9.1 billion of which utilization so far has been Rs.6.5 billion.

Fig 2: National Program for FP & PHC: Expenditure by Source of Funding

![Expenditure by Source of Funding](image)

33. A large-scale independent evaluation of the NPFP&PHC has recently been completed by the Oxford Policy Management Group of consultants and funded by the Department for International Development (DFID), UK in order to assess results on the ground. The final report of the evaluation is expected in the near future. The interim results have shown promising results. On the outcome side, the contraceptive prevalence rate (35% vs. 27%), TT coverage in pregnant women (54% vs. 35%), and delivery by trained personnel (45% vs. 37%) have shown significant improvement in the LHW areas as compared to the non-LHW areas (Fig 3). The incidence of infant deaths from diarrhea and the accompanying IMR has also declined during the last decade. However, the interim report does not comment on the Program’s contribution to reduction in infant mortality.
An Overview of the Health Sector: The Way Forward

Federal Component

- Support to NP FP and PHC: Rs. 942 million
- Neonatal Tetanus Campaign: Rs. 180 million
- HRD Nursing Education: Rs. 60 million
- Service Delivery at Federal level: Rs. 41 million
- Monitoring and Evaluation: Rs. 32 million
- Health Educ. & Social Mobilization: Rs. 26 million

39. At the provincial level the program will strengthen district health systems with a focus on the health of women and children and establish referral system for emergency obstetric care services in these districts. The project is in its second year of implementation. Some progress has been made in strengthening district health management system in the 20 districts with the assistance of the Multi-donor Support Unit.

Provincial Component

Objectives

- Increase access to priority reproductive health interventions
- Develop 20 women friendly districts delivering comprehensive health care at community, primary and referral levels – 8 Punjab, 4 Sindh, 4 NWFP, 4 Balochistan
- Build institutional and human resource capacity to support MCH, FP with special emphasis on women’s health

Key Outputs/Outcomes

- Basic and comprehensive emergency and obstetric care services in the districts are established
- Reduction in maternal and infant mortality along with increased contraceptive use

Project Financing

<table>
<thead>
<tr>
<th>Executing Agency</th>
<th>Project Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal</td>
<td>US$ 15.8 million</td>
</tr>
<tr>
<td>Punjab</td>
<td>US$ 25.2 million</td>
</tr>
<tr>
<td>Sindh</td>
<td>US$ 12.5 million</td>
</tr>
<tr>
<td>NWFP</td>
<td>US$ 13.7 million</td>
</tr>
<tr>
<td>Balochistan</td>
<td>US$ 7.7 million</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>US$ 75.0 million</strong></td>
</tr>
</tbody>
</table>
40. The Asian Development Bank is assisting the Government in the preparation of a US$ 36 million Reproductive Health Project from improving RH services in 36 underserved districts of the country and to strengthen national and provincial RH management structures, develop human resource and expand RH services through NGOs and the private sector. The credit is expected to become effective from the fiscal year 2002/03. The proposed Project has the following components:

- **Improve Quality and Range of RH Services**
  - Training, supplies, equipment, monitoring and supervision
- **Improve access to RH Care for Underserved/Poor**
  - Train 4400 LHWs, 2000 midwives and upgrade 43 FLCFs and 34 DHQ / THQ Hospitals
- **Advocacy to Promote RH in specific target groups**
  - Media, politicians, local leaders politicians, local leaders
- **Strengthen RH Management Capacity**
  - Strengthen Provincial Health Directorates
- **Human Resource Development for RH**
  - Pre and in-service training of all cadres in RH
- **Support to NGOs and Private Sector**
  - Training of 2500 private providers, 4000 female paramedics, 8,000 druggists / shopkeepers paramedics

41. UNFPA assistance in its 6th Country Program for the period 2000/03 had set aside US$ 35 million of which almost 80 percent has been allocated to reproductive health in the areas of safe motherhood, quality of care and geographic and management information systems. During the remaining 30 months, the program expects to disburse up to US$ 19 million due to delays in program implementation. UNICEF also provides assistance to reproductive health activities through breastfeeding promotion, a safe motherhood project, and support to integrated management of childhood illness initiative. In addition to supporting IMCI, WHO also provides technical assistance through an integrated PHC Project and a Home Health Care Project.

42. In 1999, the Ministries of Health and Population and the respective provincial departments agreed on a Reproductive Health Package on the initiative of the Multi-donor Support Unit. Four areas have been identified under the package as priority. These include safe motherhood, family planning, infant health, sexually transmitted diseases and reproductive tract infections. There is, however, a large “unfinished agenda” concerning RCH:

(i) about 80 percent of all births take place at home, the bulk of them by unsupervised or inadequately trained personnel;

(ii) except for the WHP, there is no concerted program to improve obstetric emergency care in the other 100 or so districts, which is essential to reduce the incidence of maternal and peri-natal mortality;
A. Devolution of Power and Responsibility and Implications for Health Sector

Although not a short-term strategy per se, the devolution initiative has acquired immediate importance, as it is potentially the most important O&M reform to come around in many years. This initiative implies a shift of responsibility for health services, from the provincial governments to the newly created district governments. However, a number of critical features of devolution have yet to be finalized:

(i) Financial management arrangements (e.g., what parts of the budget will be managed by district governments, and what restrictions, if any, will be imposed on district governments in this regard);
(ii) Administrative arrangements (e.g., what personnel management powers will the district governments have over existing civil service staff, and will they be free to contract out services instead of hiring additional civil servants); and
(iii) The degree of oversight to be exercised, and technical support to be provided, by provincial Departments of Health vis-à-vis district-managed health services.

Devolution opens up a range of opportunities for improving health services, but there are also major risks. A lot would depend on the nature of the local governments emerging from the electoral process, that is, enlightened elected officials seeking to enhance the welfare of the majority vs. self-serving elected officials using public resources for their own benefit and the benefits of their own class, and the checks and balances built into the system.

At its best, devolution could:

(i) Improve accountability of government health staff to the public;
(ii) Improve efficiency in resource allocation within the health sector, because of better knowledge by local officials of local conditions (assuming local officials have significant control over resources and are well-meaning);
(iii) Open up experimentation leading to more effective services, for example, through contracting out services and other forms of partnerships with the private sector;
(iv) Bring better coordination with private health services.

A major challenge would be to ensure that local governments give priority to those types of services which are cost-effective and have the potential for effecting large improvements in the health status of the population, such as immunization, communicable disease control, maternal and child health, and family planning. Since local elite would already have access to most of these services, they may attempt to steer government expenditure towards higher-level services not available locally.
There is no generally accepted blueprint for how to decentralize health services to the district level. Some principles/guidelines have emerged from the experience of other countries, which includes the following:

(i) It is critical that “the center” — in this case the provincial governments have a functioning information system to be able to track the evolution of the reforms and results on the ground, and to take prompt corrective action. Aspects of quantity, composition and quality of services need to be tracked. Special attention should be paid to whether poor households are accessing a “fair share” of the services managed by district governments. In addition to maintaining the Health Management Information System, it would be important to carry out a round of baseline district surveys, to be repeated biennially thereafter;

(ii) In order to make intelligent use of the information gathered, the provincial level should create and staff a competent Policy, Monitoring and Evaluation Unit;

(iii) It is critical that the provincial levels have the capacity and resources to provide technical assistance to the local governments (e.g., in the preparation of annual operational plans, in budgeting, in quality control of key programs such as tuberculosis control);

(iv) There will be a great need for building management capacity at the district level and below. Each district should have a district and/or tehsil health management team(s). As a first step, selection/promotion of EDOs/DOHs/DDHOs should be made on competence instead of seniority and from officers with at least an MPH (Master of Public Health) or equivalent qualification;

(v) In order to ensure that local governments respect national priorities such as priority preventive programs, it may be necessary to earmark part of the resources transferred to local governments. The provincial level may also wish to retain some discretionary funds to provide incentives to the local governments to pursue certain priorities. It may be preferable to retain central control of procurement of most drugs and supplies, e.g., through the use of rate contracts;

(vi) To ensure financial soundness, the provincial level would have to impose a “hard budget constraint” on local governments, in respect of transfers from the provincial level. Local governments could be allowed to mobilize resources over and above transfers, e.g., through user charges, but in that case there would need to be an explicit monitoring of the effects of increased charges on poor households.

B. Strengthening District Health System (DHS)

The Multi-donor Support Unit (MSU) has taken the DHS strengthening initiative in support of Devolution Plan of the government. The focus of this initiative has been on strengthening management systems in the districts. The important activists related to systems development carried out in the district cover:
(iv) Introduction of a voluntary accreditation system for private clinics and hospitals;
(v) Enhancing attention to preventive care in private health care transactions through measures operating on both the supply side (correcting the curative bias of medical education) and the demand side (better informed public about the benefits of preventive care);
(vi) Public campaigns to educate consumers about the dangers of seeking help from untrained health care providers and of self-medication with over-the-counter drugs, and to help consumers identify various categories of providers.

IX. Response of the Ministry of Health

85. The Ministry of Health has responded to the challenges facing the health sector by announcing the New Health Policy 2001 in June 2001. The new policy has the following key features:

(i) Health sector investments are viewed as part of Government’s Poverty Alleviation Plan;
(ii) Priority attention is accorded to primary and secondary sectors of health to replace the earlier concentration on Tertiary Care; and
(iii) Good governance is seen as the basis of health sector reform to achieve quality health care.

86. A series of measures, programs and projects have been identified as the means for enhancing equity, efficiency and effectiveness in the health sector through focused interventions. The policy document offers a blueprint of planned improvements in the overall national health scenario that will require commensurate investments and interventions by the Provincial Governments for improving health infrastructure and healthcare services. The Federal Government will continue to play a supportive and coordinative role in key areas like communicable disease control programs.

X. Ten Specific Areas of Reforms

87. In order to concretize the reform process, ten specific areas have been identified. These are:

(i) Reducing widespread prevalence of communicable diseases;
(ii) Addressing inadequacies in primary/secondary health care services;
(iii) Removing professional/managerial deficiencies in the District Health System;
(iv) Promoting greater gender equity;
(v) Bridging basic nutrition gaps in the target-population;
(vi) Correcting urban bias in health sector;
(vii) Introducing required regulation in private medical sector;
(viii) Creating Mass Awareness in Public Health matters;
(ix) Effecting Improvements in the Drug Sector; and
(x) Capacity-building for Health Policy Monitoring.

88. There are certain areas that fall under the purview of the Ministry of Health while others are largely within the domain of the provincial Health Departments. The Ministry of Health has requested all the provinces to prepare a master plan for operationalizing each of the key areas identified under the new health policy, which shall be discussed in a forthcoming Inter-provincial meeting of the Health Ministers. Some of the key areas identified in the health policy would require additional support either through governments' own resources or development partner agencies.