4 HEALTH SYSTEM ORGANIZATION

4.1 Brief History of the Health Care System

Pakistan at the time of its independence in 1947 inherited a health care delivery system that was a legacy of colonial British period. This rudimentary system was in the shape of public health services and some curative services. It was essentially designed to prevent large scale epidemics and provide curative services for the population in large and medium sized towns, many of which were along the lines of communication or political or strategic consequences[8].

During initial phase (1947-1955), most important initial problem was the replenishment of staff. In addition to other programs, BCG vaccination campaign was launched with the support of UNICEF and two medical schools were opened in the West Pakistan. From 1955 onwards, developmental activities were affected in phases of five year and each phase was known as Five Year Plan. During 1st Five Year Plan (1955-1960) six new medical colleges, including one for women were opened in both wings. A nursing school was attached to each of these medical schools. Postgraduate institutions were established. A bureau was established to produce vaccines and sera. During 2nd five year plan (1960-1965), under the recommendations of a Medical Reform Commission, Rural Health Center scheme to cover 50000 population by each unit, two Health Technicians' Training Institutes were opened, family planning program, and a malaria eradication program were launched. 3rd five year plan (1965-1970) in addition to continuation of the aforementioned initiatives, witnessed launching of Tuberculosis Control Program and Small pox eradication programs. The major infrastructure of the public health care system was set up in the 1970s. Pakistan endorsed the "health for all by 2000" initiative which had been launched by the World Health Organization. Government launched an extensive infrastructure and policy building initiative. From the villages to the cities different levels of health care were started like the "Basic health units" for the villages. The Tehsil headquarter hospital represented secondary health care, and district hospitals and teaching and referral units represented tertiary care units. Along with this a significant public health campaign was launched for the first time, keeping in view local needs and WHO guidelines to meet the target. These were: An expanded program of immunization to eradicate the prevalent infectious diseases; Malaria control program; Tuberculosis control program; Family planning program; Diarrhea and pneumonia control programs; and many others. To monitor all these and to achieve further improvements and make sure the policy was being applied the national institute of health was created. During fourth five year plan (1970-1975), quota of medicines was substantially increased for major hospitals, a generic name drug system was introduced to bring down the prices of medicines, eight state-owned fair price drug shops were opened, six new medical colleges and three new nursing schools, and one public health school were opened. The fifth five-year plan (1978-1983) was scheduled for 1975-1980, but to cover the deficiencies and to make a more realistic plan, the slight shift was made. Under a process of a Country Health Program (CHP), that aimed at improving planning and management of health services. Under CHP it was recommended that rural health coverage be increased at least to 50%, in addition to others, striking the communicable diseases, combating malnutrition, food adulteration and industrial hygiene were highlighted. During Sixth five-year plan (1983-1988), government launched extensive rural development program that provided sound base for Health for all by the

year 2000. Seventh five year plan (1988-1993): Alma Ata declaration of 1978 remained the basis of all five years plan afterwards. During seventh five-year plan, new health facilities (Basic Health Units and Rural Health Centers) were established, a female medical technician school was established, and health facilities were provided with laboratory facilities. Health facilities were linked with semi-skilled, trained paramedics termed as community health workers. Third health project was launched aiming at improving MCH services. Second Family Health Project was started to improve the health of masses in general and that of women in particular. Minimization of drug abuse, establishment of national school health services and goiter control were other salient initiatives under this plan.

In Eighth five year plan (1993-1998), Health management information system (HMIS), Social action program (SAP), and Prime Minister Program for Family Planning and Primary Health Care were launched[9]. During Ninth five year plan (1998-2003) Decentralized Planning, levying user charges for financing, public private partnership and privatization of health facilities were the areas of programming. The strategy of the plan was to consider the gains already achieved in the previous plan and to improve the quality of service by creating a balance of promotive, preventive and curative services and removal of management weaknesses of the health system. [10]

In recent programs the government has aimed to bring about *Programmatic* and *Organizational and Management Reforms*. These are to foster alleviation of poverty agenda of government, under health sector reforms, devolution has acquired immediate importance and major impetus is on district health system. At federal level a policy analysis and reform unit is being established. The new Health Policy 2001 considers health sector investment as a part of government's Poverty Alleviation Plan. It gives more importance to primary and secondary health services as opposed to tertiary level health services in the past. Good governance is seen as a basis of health sector reform to achieve quality health care[11].

4.2 Public Health Care System

Organizational structure of public system

Under the Pakistani constitution, health is primarily the responsibility of provincial governments, except in the federally administered territories. The Federal Government is however, responsible or planning and formulating national health policies, although the responsibility for implementation rests largely with the provincial governments. The federal Ministry of Health is responsible for the implementation of some vertical programs on AIDS and malaria, and extended program of immunization.

Health care provision in Pakistan comprises private and public services. The private sector serves nearly 70% of the population, is primarily a fee for service system and covers the range of health care provision from trained allopathic physicians to faith healers operating in the informal private sector. Neither private, nor non government sectors work within a regulatory framework and very little information is available regarding the extent of human, physical, and financial resources involved. [12]

The public sector comprises more than 10,000 health facilities ranging from Basic Health Units (BHUs) to tertiary referral canters. At present a BHU covers around 10,000 people whereas the larger Rural Health Centers (RHCs) cover around 30000-450000 people. In Pakistan, Primary Health Care (PHC) units comprise both BHUs and RHCs. The Tehsil Headquarters Hospital covers the population at sub district level whereas the District Headquarters Hospital serves a district as its name suggests. Currently there are 22

tertiary care facilities in Pakistan, which are mostly teaching institutions located in the major cities. [13]

Less than 30 % of the population uses the facilities of the PHC units and some studies indicate that, on average, each person visits a PHC facility less than once a year.[14] The reasons for their underutilization, as identified by both the managers and consumers, are the realtive lack of health care professionals and specially women, high rates of absenteeism, poor quality of services and inconvinient location of PHC Units.[15] In addition, The Pakistan Army, railways, departments of local government and autonomous organisations provide healthcare to their employees, who form a significant portaion of the population. [16]Planning for health care in Pakistan comprises a formal planning, which resolves around the production of 5-15 year long term plans, short-term plans (ADP) and annual recurrent budgets. [17]The Federal Ministry of Planning and Development, popularly known as Planning Commission, is primarily responsible for long term and strategic planning, and the Ministry of Health and Provincial Health Departments design their plans in line with the overall policies of the Planning Commission. Developing appropriate plans that can be implimented requires information on health status in conjunction with other social development indicators. 'Needs assesment' for healrth care programmes in Pakistan is usually based on the size of the population in an area.[18] The specific needs of that area are often not taken into account directly, nor are issues such as access to services and disease pattern.[19]

Whereas the private sector is primarily a fee-for-service system., the public health sector at present generates a negligible amount of resources through token user charges. [20]The main source of financing of the public sector is the government. Capital investment in the public sector is financed through Annual Development Plans (ADPs) that also include external funding derivred from foreign aid (overseas funding) from both bilateral and multilateral organisations. Federal government substaentially fiannces provincial development buidgets, but the provinces make independent reagrding allocation of funds over various sectors. The provincial non evelopment budgets are funded from provincial government revenues, although the Federal Government covers existing deficits through non obligatory grants. Although public sector expenditure on health has remained less than 1% of GNP for a long time, per capita health expenditures have increased enormously in last decades. [21] The total percentage of GNP spent on the health in Pakistan ranges between 3 and 4 percent, with 2-3 percent of GNP spent on private health care.

Key organizational changes over last 5 years in the public system, and consequences

Up until the recent devolution initiative the health sector was not subject to major organizational and management reforms. There were some isolated attempts at reforms but most did not represent large-scale changes to the model of provincially centralized, in house provision of services using regular civil service employees. In recent years Punjab and NWFP have been experimenting with organizational reforms including contract employment of doctors and other cadres in an effort to achieve greater control over staffing. There have also been various initiatives to fund NGOs to deliver health and family welfare services – the most successful being the private public partnerships under the Northern Health Project. Punjab has led the way in granting a greater managerial and financial autonomy to its tertiary hospitals – accompanied by a strong drive to improve governance in these hospitals. Preliminary assessments of Punjab's experiment suggest that gains have been made in terms of efficiency and governance. NWFP has introduced reforms to improve personnel recruitment and deployment, pilot programs for

rationalizing health care services, tertiary government hospitals with greater managerial and financial autonomy and has undertaken some experiments with public/private partnerships.

Planned organizational reforms

Given in Decentralization and health sector reforms sections

4.3 Private Health Care System

Modern, for-profit

The private sector in Pakistan is varied with no defined structure and weak regulation exists in this sector. However the situation of the private sector hereby described.

Health infrastructure:

The private sector health infrastructure is not well organized. There is a wide range of disparity in health care provision in the private ranging from Hi-tech regular hospitals with all necessary provisions to a general store providing health care (although not authorized). A brief description of various types of health facilities is as follows.

- **Regular hospitals:** There are few regular hospitals in the private sector, which are fully equipped with necessary staff, supplies & equipment, transportation and skilled staff, and can be compared to any teaching hospital of the public sector. Such hospitals are generally private company type i.e. the economic support to these hospitals for establishment came from the investment of many members who entered in the hospital business and these are registered under company's ordinance. The running costs are offset against monthly income of hospitals as they charge fee to patients visiting hospitals. Being business concerns and lacking an overall structure there is no central depository of information about these hospitals and as most of the hospitals are under private ownership financial and business records are also not available. The anecdotal information about the conditions of these hospitals leads to the conclusions that the majority of the hospitals in the private sector are under staffed, lack drugs & supplies, lack adequate transportation facilities for patients (ambulance service), lack qualified staff and lack modern equipment. Under these conditions the service provision by the private sector cannot be relied upon but in spite of that about 80% of the population is seeking services from private sector as public is unaware of the quality and standard of the services which are being provided to them by the private sector.
- **Nursing homes/centers:** Nursing homes/centers are small structures compared to the private regular hospitals. These structures are usually established partnership basis where two or more people have pooled their resources. There are some good nursing homes/ centers with all necessary provision and skilled staff providing quality services to the public. Nursing homes/centers are mostly acting as maternity homes and generally are not well versed in providing most of the Primary health care services and even not equipped for newborn care. There are the cases where services at nursing homes are being provided by non-qualified and semi-qualified personnel adding to the increased risk of maternal deaths. Also these nursing homes are not fully equipped with supplies and equipment.

- **Clinics:** Clinics are generally owned by a single person who is sole-proprietor of this health care providing structure, but there are also some clinics, which exists on partnership basis. The clinics are of various types, some are day clinics, some are part time clinics, and some remain open 24hours. There are also wide variations in the quality of the services being provided at these clinics. There are some very good clinics being run by specialists, well-equipped and providing quality services but these are in limited numbers and are mostly situated in the metropolitan areas where people are well aware of the quality of the health services. But the condition of the most of the clinics is pathetic due to weak regulatory system and most of the structures lying in this category are not providing to the public the required services. There are clinics bearing the name of qualified person but most of the times not having the person around. Instead the semi-qualified or non-qualified staff runs the clinic. These clinics generally lack supplies and equipment.
- **Informal structures:** The health care services are also being provided by informal structures in Pakistan. Informal structures actually don't act primarily as health care provider and even are not legally authorized for this, but even then this practice exists. For example a (*karyana* store or) General Store is providing medicines for minor diseases, without telling the patients the side effects. Mostly they are having over the counter drugs like Aspirin, Paracetamol, but some also have stronger painkillers and antibiotics.

Human resources:

The human resource condition is not very different from infrastructure. At various health facilities various type and various grades of health care providers are available. A brief description of various kinds of services providers and the kind and quality of services provided by them is as follows.

- **Allopathic service providers:**

  Allopathic service providers are divided into three categories;

  1. Qualified: Qualified service providers include MBBS and Specialists. They are mostly providing services at private hospitals, medical centers/nursing homes and at their clinics. They are not allowed for dispensing at their clinics but this practice is very common in Pakistan.

  2. Semi-qualified: The semi qualified health care providers include LHVs, LHWs, etc. They are having some training and diploma as recognition. They are trained for specific purposes and have their limitations with respect to health care service provision. But it has been observed that they are mostly performing the functions of qualified doctors without enough knowledge.

  3. Non-qualified: Non-qualified service providers include dispensers, ward boys, peons (who have worked at some hospital or any other health care facility), or any other person having some experience of working with qualified health care provider. These persons may be dangerous and need to be controlled on serious basis as the quality of the services provided by them is not up to mark and they are performing illegal function that cannot be relied upon. The pharmacists lying in category A (whole selling) and B (wholesale + retail) providing consultancy and dispensing are also non-qualified persons.

- **Non-Allopathic service providers:**

  Non-Allopathic service providers include **Homeopaths** are those who have either got homeopath degree from some regular institution or have done correspondence

courses or there are some who are practicing without any proper qualification. **Hakims** are officially registered but they are assumed to be non-qualified, and not much research has been done in this field. ***Pehlwans*** are taken as non-qualified. Historically they were known to perform functions of orthopedists but now-a-days their knowledge about this field is quite crude. **Acupuncturists and Chinese medicine treatment providers** are also treating various diseases but not much information is available on them.[22]

Private health services consist of over 20,000 general practitioners clinics, 340 dispensaries, 300 small MCH centers or maternity homes, 450 laboratories, and 500 small to medium private hospitals[23]. The quality of care and services are generally poor, though there are some reputable urban facilities. Most of these private facilities are in larger cities[24]. There is great urban-rural misdistributions and imbalance in number of doctors and nurses and female health workers. There are 5.3 doctors to 1.8 nurses and 1.6 midwives per 10,000 populations.

In general, there is a shortage of health personnel with an acute shortage of nurses, midwives and female paramedical staff in the rural areas. In October 2002, according to Pakistan Medical and Dental council, of the 116,347 MBBS doctors and specialists registered with the council 36,930 or 32% are females[25].

In the for-profit private sector, several thousands registered medical practitioners; hakeems and homeopaths are also potential partners to the government program. The effective involvement of this group could have a substantial impact as over 80% of the population seeks curative care from the private practitioners. Though the government recognizes the importance of potential partnerships with the private sector, there is no well-defined strategy to harness that potential.

Both the government of Pakistan and the developmental agencies have always emphasized on the importance of regulation of private sector. Regulation of private sector falls in he domain of the federal level, Ministry of health and its provincial counter parts. The widely unregulated private medical practices have resulted into several illegal and unethical outcomes. Overcharging the patient, unnecessary prescription of drugs, advising clinical tests without indications are some examples found in literature with regards to the prevailing scenarios. There are a number of reasons for the delay in an effective regulation of private practice. The state, the community and the individuals –all have contributed to this. The political instability is one of the major reasons.[26]

Modern, not-for-profit

There are about 1800 local NGOs currently providing various health care services including, family planning and some of them have the potential to work in areas of safe motherhood. The government in coordination with development partners supports NGOs to become self-dependent, autonomous and financially sustainable, and various policies and strategies have been adopted to strengthen their organizational resources. These includes human resource development in management and financial areas; support to smaller NGOs and CBOs through umbrella NGO for providing training in maternal and child health and family planning, organizational management capabilities, and fund raising; and provision of equipment such as computers and vehicles.

NGOs are seen as major actors in development sector; the many success stories of Pakistani NGOs especially in the development sector, is significant. However a large number still remain poorly organized and require continuous support to exist. The small scale NGOs often look to the established ones for help in initiating their program. They seek the help of government departments for patronage. Of the well-established NGOs in Pakistan, some of whom go back between 20 to 40 years, have documented track

records, established and professional staff and have developed reputations with hard work and efficiency. For example Family Planning Association of Pakistan (FPAP) and Pakistan Voluntary Health and Nutrition Association (PAVHNA) have all these features. Given the poor state of NGOs/Government relations in Pakistan at present, it will be particularly important to promote enhanced cooperation between the two sectors.

In general government role has not been restrictive, although not overwhelmingly supportive for proliferation of NGOs. However the government's policy on NGOs has evolved rapidly in the past 10-15 years. It not only accepted that bilateral funds could be given to NGOs, but has undertaken loans from funding agencies and given them to NGOs as grants. This indicates change at policy planning level, which has been motivated by donor agencies.

Traditional

Pakistan's traditional unani and ayurvedic systems of medicine came to the United India via Arab physicians. However, the unani medicine currently practiced in Pakistan is vastly different from its Greek roots. Most Pakistanis rely on unani medicine, finding it efficacious, safe, and cost effective. The use of herbal medicines and homeopathy is also widespread. About 70% of the population, particularly in rural areas, use traditional and complementary/alternative medicine. Approximately 52,600 registered unani medical practitioners serve the nation through both the public and private sectors in urban and rural areas. About 360 *tibb* dispensaries and clinics provide free medication to the public under the control of the health departments of provincial governments. About 95 dispensaries have been established under provincial departments of Local Bodies and Rural Development. A separate Directorate of Hakims has also been established under the Federal Ministry of Population Welfare Program, and 16,000 diploma-holding unani physicians of traditional medicine have been involved in the National Population Welfare Program. About 40,000 homeopathic physicians are registered with the National Council for Homeopathy.

The traditional medicine has been accepted and integrated into the national health system in Pakistan. The Government has issued the Unani, Ayurvedic and Homeopathic Systems of Medicine Rules of 1965, which included implementing provisions on the registration of practitioners, elections to the boards, and recognition of teaching institutions. Under this Act, courses in homeopathy provided by recognized institutions must be four years in duration, culminating in a qualifying examination. The Board of Homeopathic Systems of Medicine was established in order to maintain adequate standards in recognized institutions and to make arrangements for the registration of duly qualified persons. The Ministry of Health, through the National Council for Tibb oversees the qualifications of practitioners. After successful completion of *tibb* qualifications, candidates are registered with the National Council for Tibb, allowing them to practice traditional medicine lawfully. Tibbia colleges, Pakistan's unani teaching institutions, are recognized by the Government and are under the direct control of the National Council for Tibb, Ministry of Health, which is responsible for maintaining standards of education in recognized teaching institutions, revising/modifying curricula and syllabuses, and holding annual examinations. Twenty-six colleges in the private sector and one college in the public sector offer four-year diploma courses in Pakistani traditional unani and ayurvedic systems of medicine that follow the prescribed curriculum and conditions laid down in the regulations[27].

Key changes in private sector organization

In the past two national health policies not much emphasis was given to the regulation of the private health sector. The national health policy of 2001 specifically focuses on introducing the regulatory mechanism for the private sector in health care. In its KEY AREA # 7, the policy states that;

"Introducing of required regulation in the private medical sector with a view to ensuring proper standards of equipment and services in hospitals, clinics and laboratories as well as private medical colleges and Tibb/Homeopathic teaching institutions".

Implementation Modalities:

- Draft laws/regulations on accreditation of private hospitals, clinics and laboratories have been circulated to all Provincial Governments and stakeholders. These will be finalized and submitted to the Federal Cabinet.
- A law to ensure that private medical colleges adhere to PMDC approved standards before they start admitting students have been circulated as above. This will be submitted to the Federal Cabinet after necessary processing.
- The existing law on Tibb and Homeopathy will be amended to recognize degree and postgraduate level courses in Traditional Medicine thus removing the existing lacuna on this account. The amendments will be submitted to the Federal Cabinet.
- Each Provincial Government will develop an appropriate framework for encouraging private-public cooperation in the health sector, especially for operationalizing un-utilized or under-utilized health facilities through NGOs, individual entrepreneurs or doctors' groups.
- In NWFP regulatory authority has been formed to regulate the private sector

Public/private interactions (Institutional)

Public Private Partnership (PPP) and Pakistan:

WHO has been implementing the PPP approach in the Tropical Disease Research Initiative, and Philanthropic Drug Donations and GFHR. These are examples of the global Public Private Partnerships working for health. In addition the PPP Model can be used for financing Health Services through social insurance schemes regulated by the Government, Infrastructure development of health facilities or Sub-contracting clinical services. A study done for Pakistan (ADB, by Arjumand Faisal) suggests methodologies for subcontracting of PHC facilities to the private sector. Efforts to implement these partnerships at the local level, however, face many challenges. For governments, the challenge is to find ways to fulfill their responsibility for ensuring that all citizens have access to basic services, while meeting the needs of private investors. This implies a new and often difficult transition for many governments, from provider and manager of basic services, to enabler and regulator. For private firms, the challenge is to be convinced that investing in any particular project offers more attractive returns than other available investment opportunities. Drawing that conclusion depends on the firm's comparison of the potential returns against the potential risks.

Partnerships between public/governmental entities, private/commercial entities, and civil society have a contribution to make in improving the health of the poor by combining the different skills and resources of various organizations in innovative ways. Public agencies clearly benefit from working in collaboration with the private sector in areas where the public sector lacks expertise and experience, e.g. in product development, production process development, manufacturing, marketing, and distribution. However,

there are areas, such as public health policy-making and regulatory approval, where the concept of partnership with for-profit enterprise is not appropriate.

Partnerships appear to be most justified where: traditional ways of working independently have a limited impact on a problem; the specific desired goals can be agreed by potential collaborators; there is relevant complementary expertise in both sectors; the long-term interests of each sector are fulfilled (i.e. there are benefits to all parties); and the contributions of expertise and resources are reasonably balanced.

There are five major concerns with regard to reliance on the private health sector to meet national health goals and objectives. Public policy needs to address each of these issues if governments are pursuing increased reliance on the private sector for health sector growth and development. These are:

1. Private provision of health services is driven by consumer willingness to pay, allocating resources on the basis of demand may not lead to allocative efficiency (e.g., expenditure on and consumption of ineffective medications as noted above).
2. Private provision is also driven by ability to pay, therefore inequalities in health service delivery may be exacerbated as poor areas and marginalized populations remain underserved as wealthy areas gain from expanding levels of service.
3. Health care suppliers may create excessive demand for their services (client agent problem).
4. Consumers often are unable to judge the quality of services rendered, so they may receive lower quality service than that for which they pay.
5. Demand for scarce human and physical resources by the private health sector may result in understaffing and other resource scarcities in the public sector.

In addition to the health regulations and safeguards that are the responsibility of government and have been mandated in all the countries discussed in this paper, formalized partnerships with the private sector provide additional opportunities for the government to take advantage of the benefits of the private sector while controlling the potential negative impacts.

Owing to the worldwide fame of the public private partnership and keeping in view the limited resources available in the health sector the ministry of Health has taken serious initiative in this respect. There is a plan to include the PPP aspect in the new National Health Policy as private sector in Pakistan is the major health care provider and both the sectors (public & private) has been working independently. Now MOH is strongly addressing the need of collaboration between the public and private sector with an aim to increase the health coverage to the vulnerable groups. Various researches, workshop have been planned to explore the possible PPP models and opportunities in Pakistan. The current project is also a part of this initiative and aimed at exploring the possibilities of PPP in providing integrated primary health care.

The Public Private mix approach be of two types (i) Internal (ii) External Internal PP means shift of the responsibility of health care e.g. diagnostic, catering cleaning ambulatory services private beds, and user fee, but external PPP is the indirect approach which shares burden of public health sector by implementing policies out side of the health facility and network e.g. Tax relief, Insurance schemes and legalizing private practices. All these policy ingredients have reasonable room in the Pakistan health network which can be implemented after though assessment.

Some of the examples of PPP initiatives in Pakistan are as follows:

- Rahim Yar Khan project where all the BHUs have been contracted out to Punjab Rural Support Program (PRSP), which is working by increasing the salaries of doctors and making them responsible to three BHUs under special contract. Better management and a functioning system of monitoring and supervision are improving the services.
- Public Private collaboration is going on for some hospitals of the NWFP province. This collaboration is mainly between private medical colleges and public secondary or tertiary hospitals to benefit from each other and better provision of services.
- The Enhanced HIV/AIDS control program is being implemented with a major proportion of Public Private Partnership component.
- Collaboration of LHW program with NGOs for improving supervision, training and referral system. Under the newly approved PC-1 of the LHWs' Program, Reproductive Health Project and Women Health Project funds have been specifically allocated for public-private partnership.
- Tuberculosis (DOTS implementation through NGOs). Some of the activities are being implemented under GFATM funds, whereas a PC-1 is underdevelopment for PPP interventions for better implementation of DOTs and to increase its coverage.
- Testing impregnated bed nets by Malaria Control Program in collaboration with NGO in NWFP.
- Iodized salt fortification and the piloting of floor fortification.
- Implementation of GFATM projects in Pakistan.

However most of the projects are pre-mature and at early stages of implementation and extensive evaluations are required for learning more about the experiences and outcomes[28].

Public/private interactions (Individual)

There is no formal documented officially accepted policy system for interaction between the public and private health care providers. Pakistan Medical Association is the recognized body, which provides a platform for interaction between government and private sector.

For curative care services, the interaction is mostly on personal level. The cases are referred and handled on personal interaction. Most of the public health care providers are also practicing in private clinics. The process is only institutionalized in the armed forces set up where the classified specialist is allowed to use the official premises for private practice. A small percentage of the fee goes to the organization. The practice timings are in the evening that is after the official timings of the organization.

In the civil set up there is no such facility of private practice within the organization. The private practice is carried out in private premises. There is no cost sharing or revenue implication between the hospital and the provider.

During last few years, provincial health department of NWFP placed a ban on private practice for the public sector. They allowed public sector consultants to practice privately in the same facility in the evening. Major share was to be of the doctor and the rest was for the organization. The doctors who were well established in their practice resigned from government sector. This caused a dearth of qualified and experienced doctors in the public sector. In the meantime the provincial health management changed and the new management withdrew this decision as the quality of services declined with the departure of senior doctors. No review or third party evaluation of this experiment was

ever conducted. In Punjab this process never gained a shape more than a thought as the doctors who practice have strong clouts and lobby.

Planned changes to private sector organization

The government is committed to regulate the private sector as evident in National Health Policy 2001 Key Area No.7, "to introduce required Regulation in the Private Medical Sector with a view to ensuring proper standards of equipment and services in hospitals, clinics and laboratories as well as private medical colleges and Tibb/Homeopathic teaching institutions". The implementation modalities would be:

- Draft laws/regulations on accreditation of private hospitals, clinics and laboratories have been circulated to all Provincial Governments and stakeholders. These will be finalized and submitted to the Federal Cabinet.
- A law to ensure that private medical colleges adhere to PMDC approved standards before they start admitting students has been circulated;
- The existing law on Tibb and Homeopathy will be amended to recognize degree and postgraduate level courses in Traditional Medicine
- Each Provincial Government will develop a framework for encouraging private-public cooperation in the health sector, especially for operationalizing un-utilized or under-utilized health facilities, individual entrepreneurs or doctors' groups.

In NWFP a regulatory authority for private sector has been established but they are in process of developing a strategy.

4.4 Overall Health Care System

Organization of health care structures

Function of Ministry of Health and Health departments (Federal and Provincial level)

Ministry of Health (MOH) at the Federal level has the major role to develop national policies and strategies for the entire population of the country, especially those who are under-served. It sets national goals and objectives for maternal health care. Under Pakistan constitution, health is primarily responsibility of the provincial government, except in the federally administrated areas. The federal government is therefore responsible for planning and formulating policies, although the responsibility for implementation largely lies with provincial governments.

Ministry of Health consists of one division, the Health Division and following departments

- Central Drugs Laboratory, Defiance Housing Authority Karachi.
- College of Physicians surgeons of Pakistan, Karachi
- Drugs Controller, Abbasi Clinic & Hospital Karachi.
- Drugs Controller, Blue Area Islamabad.
- FGSH Islamabad.
- Jinnah Postgraduate Medical Centre, Karachi
- National Council for Homeopathy, Rawalpindi.
- National Council for Tibb, Islamabad.
- National Health MIS

- National Institute for Handicapped, Islamabad.
- National Institute of Cardiovascular, Karachi
- National Institute of Child Health, Karachi
- National Institute of Health, Islamabad
- Pak Medical & Research Council, Islamabad
- Pakistan Medical &Dental Council, Islamabad
- Pakistan Nursing Council (NIH) Islamabad.
- Pharmacy Council of Pakistan, Islamabad.
- PIMS Islamabad.

Ministry of Health:

Ministry of Health is headed by Minister of Health (currently there is also a Minister of State for Health). At bureaucracy level, Federal Secretary (Health) is in-charge who is assisted by Director General (Health), Chief (Health), two Joint Secretaries, one looks after finance and development and the other deals with administration. As per Rules of Business, functions of the Ministry of Health are:

- National Planning and Coordination in the field of health.
- Dealings and agreements with other countries and international organizations in the fields of health, drugs and medicines.
- International aspects of medical facilities and public health; International Health and medical facilities abroad.
- Scholarships / fellowships, training courses in health from International Health Agencies such as WHO and UNICEF.
- Medical, nursing, dental, pharmaceutical and allied subjects: -
  - Maintenance of educational standards.
  - Education abroad; and
  - Educational facilities for backward areas and for foreign nationals except the nomination of candidates from Federal Administered Tribal Areas for admission to Medical Colleges.
- Standardization and manufacture of biological and pharmaceutical products
- Vital Health Statistics.
- Medical and health services for Federal Government employees.
- National associations in medical and allied fields such as the Red Crescent Society and T.B Association.
- Coordinating medical arrangements and health delivery systems for the Afghan refugees.
  - (i) Legislation pertaining to drugs and medicines, including narcotics and psychotropic, but excluding functions assigned to the Pakistan Narcotics Control Board
  - (ii) Administration of Drugs Act.1976 and
  - (iii) Poison and dangerous drugs
- Prevention of the extension from one province to another of infectious and contagious diseases.
- Lunacy and mental deficiency.

- Administrative control of the Pakistan Medical Research Council,(PMRC),Islamabad.
- Administrative Control of the National Institute of Handicapped (NIHD), Islamabad.[29]

Departments of Health:

Political head of the Department of Health is the Health Minister. Secretary is the overall in-charge of the Department. Director General is the technical head who reports to the Secretary. Functions of different provincial health departments is given below:

1) Punjab Province:

The role and responsibilities of Health Department after devolution encompass the following major areas: -

- **Operational Strategy:** The federal government frames Policy and the implementation takes place mainly in the districts. The role of provincial government is to coordinate between the federal and district government to ensure implementation of countrywide policy by evolving non-operational strategies.
- **Regulatory:** The Health Department frames laws, rules and regulations to enforce policies of the Government in areas such as foodstuffs, blood safety, drugs, smoking etc.
- **Standard Setting:** The Health Department lays down standards for quality control of drugs, electro-medical equipment and quality of health care services. It also prescribes standards for medical education and training of doctors, nurses and paramedics.
- **Technical Support:** The Health Department provides technical support for capacity building of District Governments in administrative, financial and development areas. It provides necessary personnel and arranges for their appropriate training.
- **Resource Mobilization**: The Health Department seeks to fill resource gaps through budgetary and extra-budgetary resources. It explores new avenues such as public-private partnerships and seeks diversification of resources.

2) Sind Province:

- Policy development, legislation and monitoring the implementation
- Supervision and monitoring of provincial institutions and district performance and provide technical guidance.
- Coordination and regulation of Medical, Dental, Nursing & and Paramedical Education
- Recruitment, transfer, posting, promotion & disciplinary action of all cadres /grades for provincial institutions
- Recruitment, transfer, posting, promotion & disciplinary action from BPS 18& above for doctors and BPS 17 & above for other cadres of district.
- Planning and Development for all provincially managed institutions and macro level planning for the districts
- Policy dialogue /coordination with Federal /district Government and Donors
- Procurement of goods /services for provincially managed institutions, vehicles, electro -medical equipment, technical assistance and rate contract for medicines for districts.

- Constitution of Medical Boards for provincial employees, Standing & Special Medical Board (SBM) for all employees.
- Data analysis & feedback to MoH and Districts
- Budget allocation and control for provincial institutions only.
- Health and Nutrition Education activities.
- Undertake Health System Research
- Development of minimum standards of service delivery.
- Provision of technical support to the Districts in all respect.
- Resolve inter and intra districts conflicts.
- Annual monitoring of district performance against agreed indicators.

3) Balochistan Province:

- Provision of health services to the population of the province, including preventive and curative care through the set up of provincially administered hospitals/institutions.
- Management of Federally designed programs on immunization (EPI), Control of Diarrheal Diseases (CDD) Malaria Control Program, ARI Program, AIDS Control Program, Health Management Information System (HMIS), and National Program for Family Planning and Primary Health Care etc.
- Planning and Management for the Health system.
- Procurement of transport, specialized equipment.
- Development of new projects in consultation with District Governments
- Human Resource Development.
- Regulatory function.
- Procurement of drugs through medical store Depot (MSD) for provincial institutions.
- Issuing of drugs sale licenses

4) NWFP Province:

As per a document "Reforming the Health Sector in the NWFP" the following functions are assigned to Provincial Health Department:

- Make health policy for the province.
- Legislate on provincial health issues.
- Ensure drugs control under the Drugs Control Act.
- Carry out monitoring and regulatory functions of health/medical institutions, both in public and private sectors.
- Coordinate and regulate, medical, dental nursing and paramedical education.
- Conduct health research and related health information gathering (HMIS).
- Coordinate and interact with donors and international agencies.
- Carry out all aspects of personnel management of the present provincial cadres in health.
- Carry out all provincial procurements and M&R. Ensure functioning of the Medicine Coordination Cell (MCC).

- Plan, implement, supervise and monitor health programs transcending district jurisdiction.30

Functions of District health departments:

Given at Annex

Other Departments/ Public sector departments involved in Health care:

A number of public sector organizations are providing commendable health services to the population. A few of these have been described below;

- **Pakistan International Airlines Corporation:** Pakistan International Airlines Corporation is the national flag carrier of the country and has about 25000 employees of various categories. It provides medical cover to its employees, dependents and the passengers during the flight operation. PIAC medical wing consists mainly of curative facilities but certain degree of preventive services like immunization etc is also provided. Medical setups exist at Karachi, Lahore, Rawalpindi/Islamabad, Peshawar and Multan providing comprehensive medical coverage to around 130,000 employees and dependents.
- **Pakistan Railways:** Pakistan Railways is a large public sector organizations with about 200,000 employees and retired personal along with 600,000 dependents, whose medical treatment is the responsibility of the department. The Railways have a network of curative facilities spread all over the country having more than 1500 indoor beds.
- **Employees' social security benefit organization:** Employees social security benefit organization provides health cover to industrial workers and families allover the country. In Punjab alone it covers 544,800 workers and their 3228600 dependents. It has a network of 14 hospitals and other health facilities in the province and has about 1300 indoor beds. Mainly curative services are provided to the secured workers and their families.
- **Water and Power Development Authority (WAPDA):** WAPDA is a large organization spread allover Pakistan with large number of employees and dependents. The medical service division provides comprehensive medical coverage to all the employees and dependents according to rules in their own hospital network or supports the treatment in other hospitals. WAPDA has 11 hospitals (750 in beds in total) and 24 dispensaries. It has about 1200 employees in the medical division providing predominantly curative coverage to the organization.
- **Pakistan Bait-ul-Mal:** Pakistan Bait-ul-Mal comes under the jurisdiction of ministry of social welfare and special education and has a wide network in all the provinces and districts with its head office in Islamabad. It is running a number of projects in the health, education and social sectors, on behalf of the government of Pakistan, in partnership with various donors and organizations. "Tawana Pakistan" is a social sector project aiming at improving the nutritional status of the girl child in 29 high poverty districts of Pakistan. It also helps in improving school enrolment and retention of girls in the schools and is covering around half a million children in the targeted districts at primary level. Bait-ul-Mal provides individual financial assistance (IFA) to the poor, destitute women, orphans and disabled persons for medical treatment and rehabilitation.
- **Others:** A number of organizations in public sector are performing a commendable job in provision of healthcare at various segments. These include Pakistan

Telecommunication organization, Fauji Foundation, Armed Forces Institutions and others.[31]

Brief description of current overall structure

Ministry of Health (MOH) at the Federal level has the major role to develop national policies and strategies for the entire population of the country, especially those who are under-served. It sets national goals and objectives for maternal health care. Under Pakistan constitution, health is primarily responsibility of the provincial government, except in the federally administrated areas. The federal government is therefore responsible for planning and formulating policies, although the responsibility for implementation largely lies with provincial governments.

The program development and implementation, including those for maternal health, takes through the provincial Departments of Health (DOH), which have an extensive network of nearly 10,000 service outlets at various levels, including limited facilities for emergency obstetric care.

The Provincial Health Secretary translates the provincial health policy, exercises control over the budget and has direct control over the teaching hospitals and other special institutions. The provincial Director General Health Services (DGHS) is the chief executing officer responsible to ensure delivery of policies and plans related to primary and secondary health care delivery. At the provincial level, a team of Directors supports DGHS, including Director MCH or Reproductive Health. The DGHS supervises the work of Divisional Director Health Services (DDHS) who are posted at the divisional level. The Executive District Officer Health (EDO-H) is in charge of the district and is responsible for delivering promotive, preventive and curative services through the outreach workers and primary care facilities in the district.. Managers of all Tehsil Hospitals, RHCs and BHUs report to him. On paper, EDOHs have responsibility for all health matters in the district. Medical Superintendents are the chiefs at DHQ Hospitals, and they, as well as EDOHs, report to the Director General of Health through their respective Divisional Directors. Tertiary care Hospitals are directly under the provincial Secretary of Health.

In each province, the Department of health (DOH) provides safe motherhood related services through a *four-tier* system as part of the overall health delivery system. It consist of the following:

Community-based activities:

The maternal health, child health and family planning services are provided by the outreach workers that include LHWs, Female Health Technicians (FHTs) and TBAs. Each LHW has established a "Health House" in her home and also reaches the doorsteps of the people to serves as the first level of health services for the rural and peri-urban women and children. LHWs maintain records for all the households in their catchment areas and actively follow up each family every month, especially the defaulters for immunization or dropouts for family planning and to persuade families to adopt healthier life style.

Primary care facilities:

These include MCH Centers (MCHC), Basic Health Units (BHUs) and Rural Health Centers (RHCs). There is at least one primary health care center present in each of the Union Councils, which has a range of population from ten to twenty five thousand people. MCHCs and BHUs are to operate from 8 am to 3 pm, except Sundays, while RHCs are to provide 24-hour services. However, most of these facilities are operational for 3-5 hours on each working day. There are 1084 MCHCs32 in Pakistan, which are managed by LHVs

and provide basic antenatal care, normal delivery, post-natal and family planning services, and treatment of minor ailments to women and children.

BHUs have a staff of 10 people consisting of a male doctor, a LHV or a FHT, a Male Medical Technician or/and a dispenser, a trained or unqualified midwife (dai), a sanitary inspector, a vaccinator, and 2-3 support staff (guard, sweeper, gardener, etc.). They are required to offer first level curative, MCH, family planning and preventive services through doctors and paramedics. There are 5798 BHUs/SHCs in Pakistan.

RHCs provide more extensive outpatient services and some inpatient services, usually limited to short term observation and treatment of patients who are not expected to require transfer to a higher level facility. They serve catchment population of about 50,000 to 100,000 people, with about 30 staff including 2 male medical officers, 1 female medical officer, 1 dental surgeon and a number of paramedics. They typically have 10-20 beds, x-ray, laboratory and minor surgery facilities. These do not include delivery and emergency obstetric services. The country has 581 RHCs.

Referral level care facilities:

These include Tehsil Headquarters (THQ – sub district units) and District Headquarters (DHQ) Hospitals that are located at respective levels and offer first line referral services. Tehsil Headquarters Hospitals (THQH) serves a catchment population of about 100,000 to 300,000 people. They typically have 40-60 beds and appropriate support services including x-ray, laboratory and surgery facilities. The staff includes at least three specialists: an obstetrician & gynecologist, a pediatrician and a general surgeon.

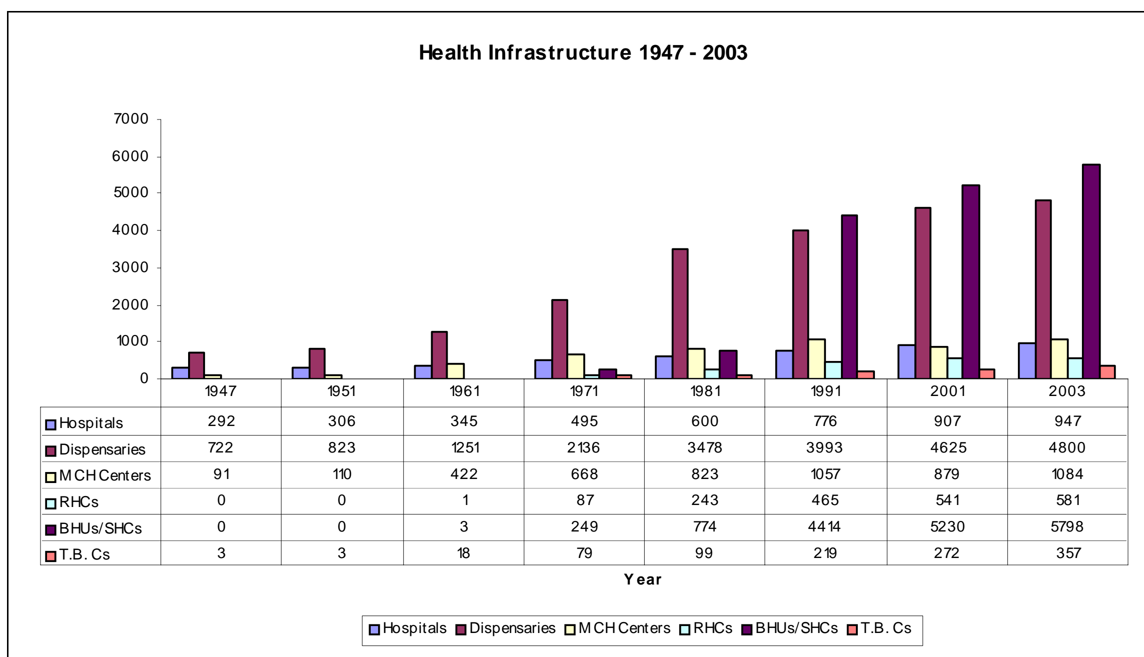
District Headquarters Hospitals (DHQH) serve catchment population of about 1 to 2 million people and typically have about 100-150 beds. There are at least 8 specialist including obstetrician and anesthetist. There are a total of 947 THQH and DHQH in Pakistan. The hospitals actually providing Comprehensive EmOC are very few.

Tertiary care facilities:

There are 29 teaching hospitals in Pakistan. They also provide sub-specialty care. These hospitals mainly provide curative services and to a limited extent some preventive services. Majority of the communities have access to a primary care facility within a radius of 5 kms. While access to government health facilities is generally good, the utilization levels are low. Several surveys have consistently shown that about 80 % of clients seek care from the private sector and only 20 % visits the government managed facilities for ambulatory care, which is indicative of considerable unutilized capacity in the system.

The details of the health system infrastructure and manpower in Pakistan are shown in the figure below:

Figure 1 Health establishment / facilities in Pakistan (since 1947)



	1947	1951	1961	1971	1981	1991	2001	2003
Hospitals	292	306	345	495	600	776	907	947
Dispensaries	722	823	1251	2136	3478	3993	4625	4800
MCH Centers	91	110	422	668	823	1057	879	1084
RHCs	0	0	1	87	243	465	541	581
BHUs/SHCs	0	0	3	249	774	4414	5230	5798
T.B. Cs	3	3	18	79	99	219	272	357

Source: Annual report of Director General Health: 2000-2001. Ministry of Health