Healthcare systems in Pakistan. The role of federal and provincial governments in healthcare. The district health system, in the context of devolution.

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After attending this interactive lecture, students of 3rd year MBBS will be able

- Define health system.
- Compare & explain health systems in developing & developed countries with named examples.
- To describe introduction of Health system in Pakistan
- To explain the role of federal and provincial governments in healthcare
- Briefly explain all the different institutions that deliver healthcare in Pakistan.
- Understand the District healthcare system in the context of devolution

- A **“system”** can be understood as an arrangement of parts and their interconnections that come together for a purpose .
- **Health systems-** combination of resources, organization, financing, and management that culminates in the delivery of health services to the population.
- All activities whose primary purpose is to promote, restore and maintain health.

The world Health organization describes the healthcare system as comprising six building blocks

1. **Service delivery,**
2. **Health workforce,**
3. **Information,**
4. **Medical products,**
5. **Vaccines and technologies;**
6. **Financing, leadership, and governance**

Categories of Health systems

If mechanisms to finance healthcare are taken as a yardstick, contemporary health systems fall into 3 broad categories.

1. Welfare Models: Financed predominantly through public sources of health financing, which include revenues and/or pooling through payroll taxes or social security contributions. Examples include health systems of high income countries of western Europe, the Gulf Cooperation Council countries, and Canada.

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Categories of Health Systems

2. The 2nd category, of which the USA is the prototype, is characterized predominantly by a market system of pooling and provision.
3. Majority of the low- & middle-income countries including Pakistan fall within the rubric of the 3rd category, where publicly financed government health delivery coexists with privately financed market delivery in a Mixed Health System.

Pakistan: a snap shot

- Location: South Asia
- Population: 170 million
- 65% rural population
- 36.9% below the age of 15 years
- 29% population below poverty line
- Off track in meeting MDGs
- GDP per capita: 1000 US$
- Low ranking on HDI

Pakistan and its Healthcare Systems

- Out of 75 years of its existence, Pakistan has been under military rule for 31 years.
- Economic growth has been dependent on the level of international support, as opposed to democracy vs. military rule. Growth in the 1960s & 80s can be attributed to strong US support; the latter in the wake of the Afghan war.
- In the 1990s, ending of the Afghan war and Pakistan's declaration of its nuclear capability led to plummeting of growth due to decline in development assistance.

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- During 2001-07, debt rescheduling, and increase in foreign assistance and remittances subsequent to Pakistan's post-9/11 support to the 'war on terror' has been a strong factor leading to economic growth.
- However, growth could not be sustained.
- Despite these variations. There has been very little change in public sector allocations for health as a percent of GDP (gross domestic product) over the last 69 years.

- Pakistan is a federating system with authority shared between the federal government and its four provinces; 12.82% of the country's territory is semi-autonomous and is under federal control.
- Institutionally, the ministry of health is responsible for policy-making, coordination, and technical support. However, its role in providing services, both curative as well as preventive, has taken it away from its core normative functions.
- The provincial mandate is to deliver health. In 2001, political & administrative authority was devolved to Pakistan's 135 districts. Since then, decentralization of the govt. has fallen prey to jurisdictional disputes at several administrative and political levels.

GNP

Gross national product

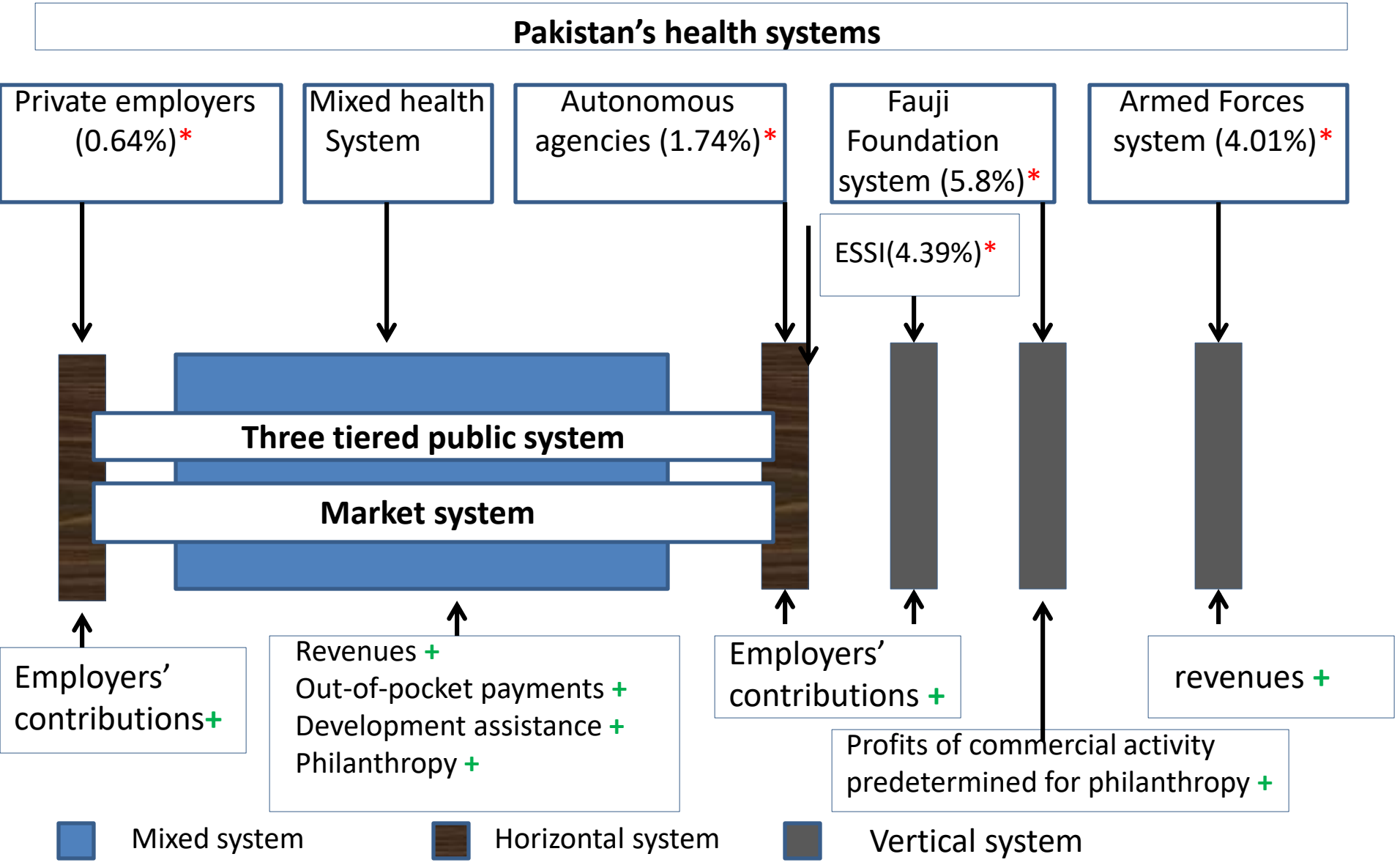
An estimated value of the total worth of production and services, by citizens of a country, on its land or on foreign land, calculated over the course of one year.

GDP

Gross domestic product

An estimated value of the total worth of a country's production and services, within its boundary, by its nationals and foreigners, calculated over the course of one year.

A stylized representation of healthcare delivery systems operating in Pakistan



* %age denotes proportion of the population covered by each system

\+ Sources of financing

1. **AFHS:** financed through tax revenues. Provides health coverage to 6.29 million servicemen and their dependents.
2. **FFS:** Funds generated by commercially viable non-profit conglomerates sustain a vertically integrated social protection system through which a range of social services including health are delivered to 9.1 m ex-military servicemen and their dependants. Both has their own independent workforce, infrastructure, service delivery & governance arrangements.
3. **ESSI,** a vertically-integrated health insurance system for the labour workforce in private industrial and commercial establishments with more than 10 employees under a stipulated salary scale. This is part of the Directorate of Labour and is, as such, totally outside of the purview of the departments of health. Financed through compulsory social security contributions made by employers and provides coverage to more than 6.8 m individuals.

1. Two other health systems in the country can be described as being horizontally aligned. These include health services delivered by Pakistan's autonomous quasi-state organizations and Pakistan's corporate/commercial entities.
2. Together, they provide health coverage to an estimated 3.73 m employees and their dependents or 2.38% of the population. Both these systems finance health either by pooling for risk through insurance or by reimbursing providers for services rendered. Other than a few autonomous agencies, which have their own service delivery infrastructure, most access private providers for services.
3. The 3 vertical and 2 horizontal health systems almost fully cover 26.01m or 16.59% of Pakistan's population for healthcare costs.

- The Mixed Health System is characterized by roles played by public and private providers. This system provides healthcare coverage to 15.22m employees of the government and members of the judiciary and legislature with general revenues as a means of financing.
- With this, the total no. of individuals covered for health stands at 26.62% of the country's population.
- The remaining 73.38% of the population seeks care by making out-of-pocket expenditures at the point of care in the Mixed Health System where the public and the market systems run in parallel.
- Notwithstanding frequent blurring of the line b/w the two- employees of the public system engage in dual practice as a conventional norm – the relative proportion of care delivered in the market system is predominant.

Access to healthcare services in the Mixed Health System

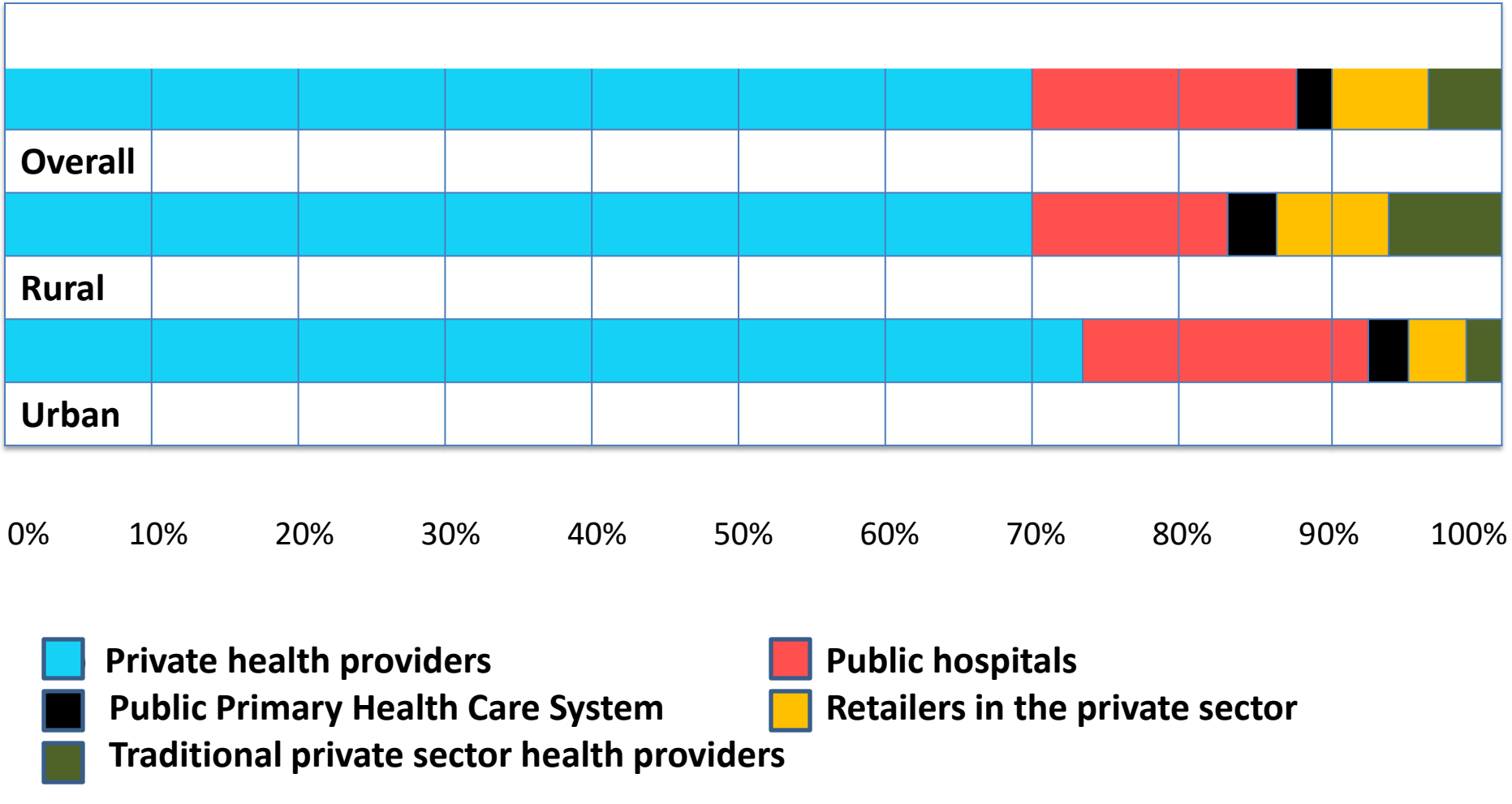
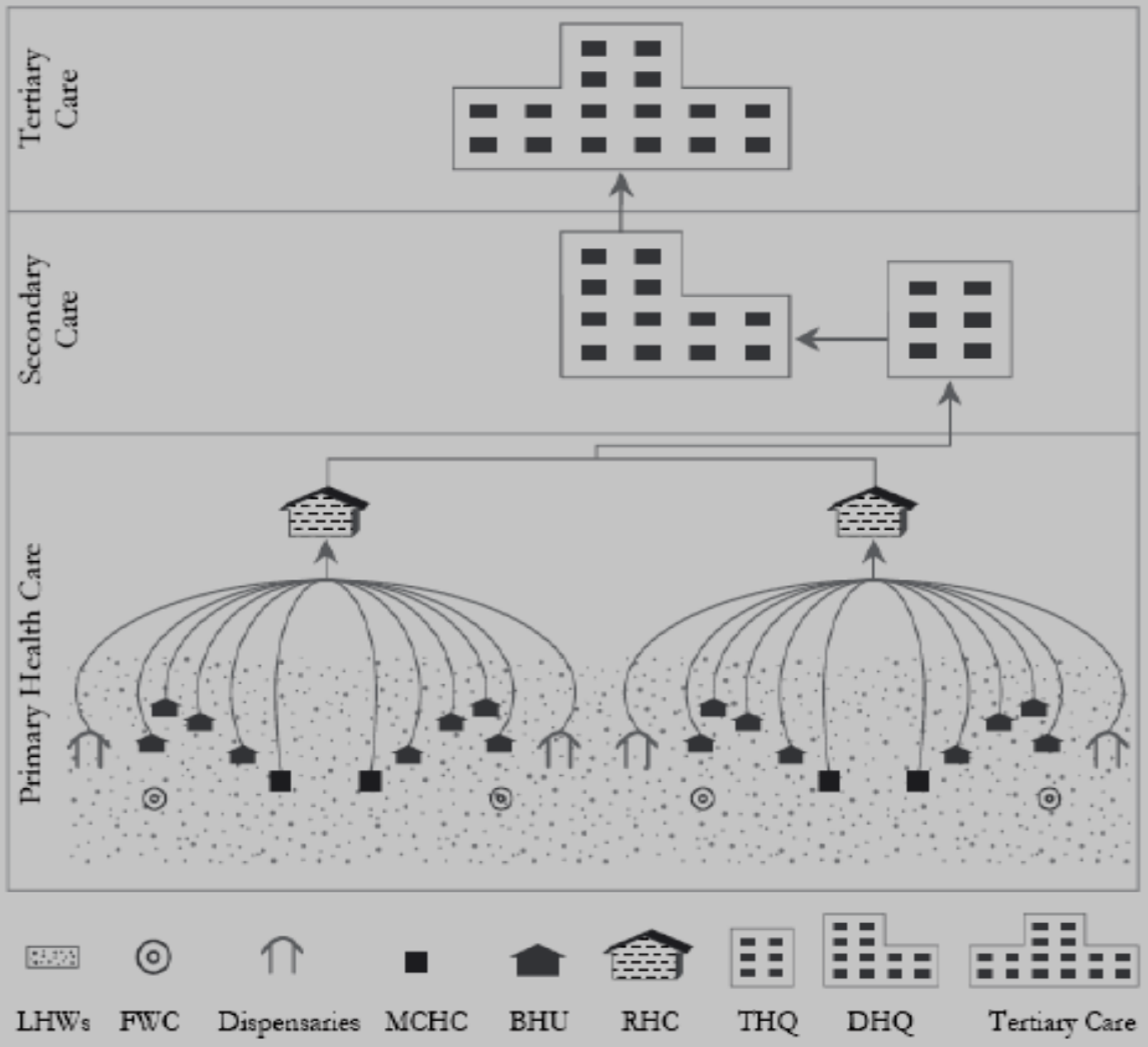


Figure 7. Configuration of Pakistan's public healthcare system



- **BHU** – A medical facility situated in the smallest administrative unit of govt.(UC) with an average catchment population of 10-25,000.
- **RHC** – an upgraded PHC facility located at the sub-district administrative unit at the junction of 4 or 5 UCs; the population served ranges from 20,000-500,000.
- **FLCFs** (1st level care facilities)comprise BHUs & RHCs, MCHCs, TB centers & Civil dispensaries.
- **MCHC** of the department of Health.
- **FWC** – family planning facility of the Ministry of Population Welfare.
- **LHW**: village-based female community health worker.
- **THQ**: secondary level hospital.
- **DHQ**: secondary level hospital.

•The physical infrastructure of PHC comprises FLCFs. Over 12,000 FLCFs are meant to deliver basic clinical services in the country.
•BHUs are also meant to deliver outreach services and serve as the implementation arm of the national public health programs.
•However more than 30% of FLCFs are currently non-functional.
•In addition, more than 90,000 LHWs provide preventive, maternal and child health, & related family planning services to 55% of population at the grass roots level.
•FP services are also provided through 2740 FWCs of the Ministry of Population Welfare.
•Secondary care includes THQs & DHQs, whereas tertiary care comprises teaching hospitals.
•There are 965 public hospitals in Pakistan.

Source: Choked pipes by Dr. Sania Nishtar

BHU

- BHUs are generally staffed with one doctor, one dispenser (pharmacist), and a male technician who aids in registering patients & handing out medicines
- In some facilities there is also a lady health visitor (LHV) who sees female patients. LHVs generally have minimal maternal health care training—they are trained to provide antenatal care, aid in deliveries, provide post-natal care, and occasionally provide contraception.

BHU

- located at a Union Council and serves a catchment population of up to 25,000.
- Services provided are promotive, preventive, curative and referral. Outreach/community based services
- BHU provides all PHC services along with integral services that include basic medical and surgical care.
- MCH services. BHU provides first level referral to patients referred by LHWs. BHU refers patients to higher level facilities as and when necessary.
- The BHU also provides clinical, logistical and managerial support to the LHWs. It also serves as a focal point, where community and the public sector health functionaries may come together to resolve issues concerning health.

RHC

- The RHCs have 10-20 inpatients beds and each serves a catchment population of up to 500,000 people.
- provides promotive, preventive, curative, diagnostics and referral services along with inpatient services.
- The RHC also provides clinical, logistical and managerial support to the BHUs, LHWs, MCH Centers, and Dispensaries that fall within its geographical limits.
- RHC also provides medico-legal, basic surgical, dental and ambulance services.

THE MIXED HEALTH SYSTEMS SYNDROME

•Despite the existence of a complex Mixed Health System, Pakistan has failed to achieve **'health for All'.**

•The determinants of this failure are perceived to be rooted in the interplay of a *Triad of Determinants* – inadequate state funding, a burgeoning unregulated role of the private sector, and lack of transparency in governance.

•Chronic under-funding of the state's public health infrastructure is a major fault line. As a result, providers in the public system are seldom remunerated according to prevailing market trends.

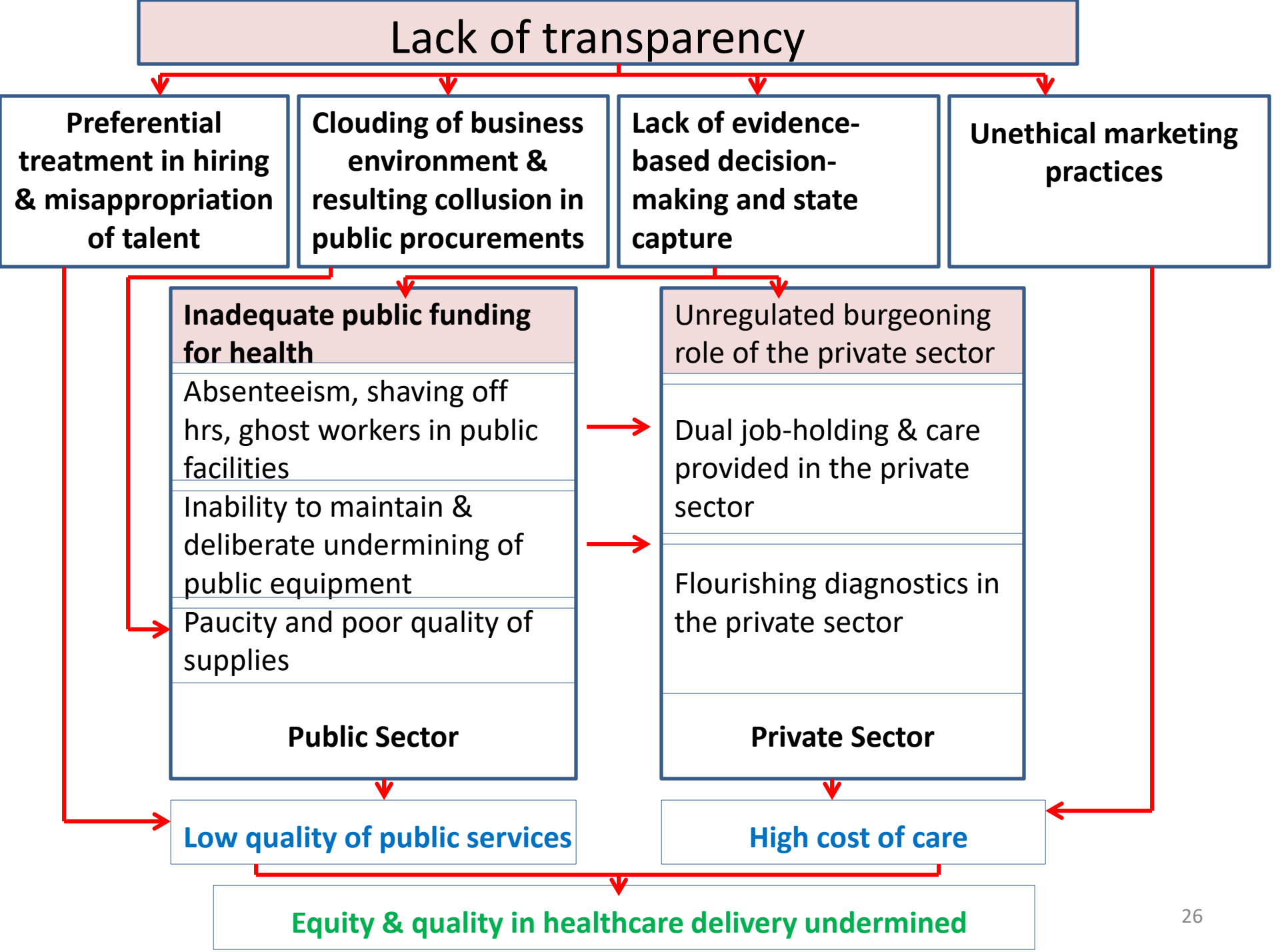
•Better incentives in the private system lead to dual job-holding, and in remote areas, where oversight cannot be maintained, absenteeism and the ghost worker phenomenon become commonplace.

•Limited public resources also cannot sustain infrastructure of public facilities, as is evidenced by the state of dilapidation, most public facilities suffer from.

•In such an environment of under-provision and poor provision by the public sector, market mechanisms come into play to meet the ever-growing demand of burgeoning populations.

•The resulting out-of-pocket payments, coupled with rampant unethical provider behaviors – the latter because of gaps in regulation – undermine health systems performance.

•The situation is complicated further by rampant collusion in procurements, preferential treatment in staff deployment, and state capture by the elite.


Lack of transparency
Preferential treatment in hiring & misappropriation of talent
Clouding of business environment & resulting collusion in public procurements
Lack of evidence-based decision-making and state capture
Unethical marketing practices
Inadequate public funding for health
Absenteeism, shaving off hrs, ghost workers in public facilities
Inability to maintain & deliberate undermining of public equipment
Paucity and poor quality of supplies
Public Sector
Unregulated burgeoning role of the private sector
Dual job-holding & care provided in the private sector
Flourishing diagnostics in the private sector
Private Sector
Low quality of public services
High cost of care
Equity & quality in healthcare delivery undermined

The public-private mix is not, however, a guarantee of poor performance. Locally relevant public policy choices can be adopted to develop stewardship mechanisms, which influence the behavior of private providers in order to harness their outreach.

Devolution

- Devolution means decentralization of administrative and financial powers to the lower levels of govt to improve the responsiveness and quality of services, by bringing decision-makers and service departments closer, better informed and more accountable to the population they serve.
- It simplifies the management structures & enhance the efficient use of resources, ensuring equity in terms of improved access to & delivery of services for underserved, marginalized, vulnerable & remotely located population groups.

Speculative objectives of devolving the governance system from central to lower administrative level:

1. Restructure the bureaucratic set up and decentralize the administrative authority to the district level & below.
2. Re-orientate administrative systems to allow public participation in decision making.
3. Facilitate monitoring of govt. functionaries by the monitoring committees of the local councils.
4. Introduce performance incentive systems to reward efficient officials.

5. Eliminate delays in decision-making and disposal of business through enhanced administrative & financial authority of district and Tehsil/Town level officers.
6. Improve administrative & financial management practices in the district and management controls over operational units.
7. Redress grievances of people against maladministration through the office of local govt. functionaries.
8. Enable proactive elements of society to participate in community work and development related activities.

Devolution in Pakistan's Health System: The 2001 Devolution

On 14th August, 2001, local govts. Were formed at 3 levels: District, Tehsil/Town & Union Council. The new system brought about changes in the administrative & financial structures. An attempt was made to create a unified administrative structure at the district level to ensure adequate provision of services closer to people. The new system endeavored to create an enabling environment in which people can start participating in community welfare and be the masters of their own destiny

Structure of district administration

- The district govt. comprised of a *Zila Nazim* (district Mayor) and a district administration.
- *Zila Nazim* is an elected official & executive head of the district govt.
- He is assisted by the district admn. Headed by a DCO, who is a BS-20 civil servant.
- Each district dept. is headed by the EDO, like EDO Health (previously known as DHO).

- EDO Health has several portfolios namely public health, population welfare and district hospitals.
- The Deputy District Officer is in-charge of a sub-office at Tehsil level and looks after health entities and programs at tehsil/town level.
- Furthermore, at Union Council level, the Union *Nazim* heads the Union Municipal administration, and with the assistance of *Naib* Union *Nazim*, looks after the administrative matters of health of the villages within the union council jurisdiction.

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