Political Economy of Primary Healthcare Provision in Pakistan

1. Introduction

The state provision and delivery of social services in Pakistan is in crisis. Their coverage is inadequate and quality pathetic. Three out of four Pakistanis obtain their health services from the private sector/civil society, not from the government (Ismail, 2000). An overview of country's performance in social sector shows that though the country invested more than Rs.160.00 billion during 1993-97 under the Social Action Programme (SPDC, n.d.), it still ranks very low amongst the nations of the world. A comparison within South Asia is given in Table 1 below:

Table 1: Matrix of Social Indicators

Country	GDP Per Capita US$ (2004)[a]	Life Expectancy at Birth (2004)[a]	Infant Mortality Rate per 1000 Year 2003[b]	Mortality Rate under 5 per 1000 Year 2003	Annual Population . Growth Rate Year 2003[a]
Pakistan	623	63.4	74	98	1.9*
India	640	63.6	63	87	1.5
Sri Lanka	1033	74.3	13	15	1.3
Bangladesh	406	63.3	46	69	1.7
Nepal	252	62.1	61	82	2.2
Bhutan	751	63.4	70	85	2.6

Source: UNDP (2006)[a]
World Bank (2005[b] & 2006)
*Population growth for Pakistan is estimated at 1.9 percent for mid year 2005

This low performance is primarily because the commitment and investment in healthcare have been generally poor in Pakistan. It has even declined as a percentage of GDP from 0.58 in 1999-2000 to 0.51 in 2005-06 (GOP, 2006). Even within this low expenditure ratios, priority has been accorded to hospitals, medical colleges and curative services in the urban areas, while primary healthcare and rural health services have been ignored (SBP, 2004).

There are two schools of thought in Pakistan to tackle this critical problem. The first, *neo*-liberal school, believes that simply "rolling back the state" is a panacea for all ills. Rolling back the state is considered synonymous with the policies of liberalisation, deregulation and privatisation and is denoted by the notions encompassed in the philosophy of "New Public Management". The *neo*-liberal school maintains that the private sector is inherently superior to the public sector. Therefore, the contention that the state should role back and the private sector should take over.

The second, we may call the managerialist school of thought, agrees to the extent that the existing model of service delivery in Pakistan is seriously flawed and has failed to deliver. However, it contends that it is neither the lack of funds nor the absence of good policies but lack of will, vision and management that has led to this failure. Every one has shown a

marked disinterest and apathy in improving public policy and implementation processes. As a consequence, the policy has failed to keep pace with changing circumstances, and the end product delivered to the users has been extremely poor.

Another contention of the managerialists is that emphasis of the government has always been on *hardware,* i.e. buildings, equipment etc., while *software* i.e. human resource and management structures/system have been ignored. This management failure can be rectified by a systemic improvement that outflanks the present archaic system suffering from the malaise of managerial stasis. This can be done by evolving innovative models of social service delivery, and through the transfer of existing state infrastructure to a new and improvised management system that exists outside the present bureaucratic set up. Simultaneously, an effort should be made to develop the state machinery into an efficient and effective apparatus. This will ensure a very basic and deep reform of the existing institutions. This paper examines the notions and contentions of the managerialist school of thought by focusing on a case study for providing primary healthcare service in the rural areas of Pakistan.

The rest of the paper is structured as follows. Introduction is followed by a section providing a brief description of the healthcare delivery, its management structure and governance issues facing Pakistan. The third section discusses the case study of Lodhran/Rahim Yar Khan (RYK) model Primary Healthcare Delivery, while the penultimate section analyses the role of interest groups and political alignments in Primary Healthcare reform. Conclusion sums up the discussion and also suggests future course of action.

2. Healthcare System in Pakistan

2.1. Delivery of Healthcare in Pakistan

Delivery of healthcare in Pakistan is a mix of public and private providers. Federal, provincial and local governments provide tertiary care as well as operate an extensive infrastructure of First-Line Health Facilities (FLHFs) in the rural and urban areas. According to GOP (2006), 946 hospitals provide tertiary medical coverage in the public health sector, whereas the FLHFs consist of 552 Rural Health Centers (RHCs), 5,290 Basic Health Units (BHUs) and 4,554 dispensaries. The BHUs were established during the late 1970s and early 1980s at rural Union Council[1] level and provide services for a catchment population of about 10,000-20,000 people. They are typically staffed by a Medical Officer (MO) and six paramedical staff, and include an emergency operation theatre, a ward with 2 beds and residences for doctor and other staff. Government of Pakistan has invested at least Rs.32.00

1 Smallest administrative unit in District Government.

billion on BHUs starting from the late 1970s. Rural Health Centres (RHCs) provide more extensive outpatient and limited inpatient services, which include short term observation and treatment of those patients not expected to require transfer to a higher-level health facility. They serve a catchment population of about 25,000-50,000 people and have a staff of about 30 including several doctors and paramedic staff. They typically have 10-20 beds, X-ray facilities, laboratory, and minor surgery facilities.

The provision of healthcare by the private sector is dominated by more than 20,000 small office-based clinics of general practitioners. Other private sector facilities include around 300 maternal and child health centers (also known as maternity homes); about 350 dispensaries and more than 450 small to medium-sized diagnostic laboratories. There are also approximately 500 small and medium-sized private hospitals. The role of non-government organizations is quite modest in the provision of primary health care.

2.2. Governance Structure of Healthcare Provision in Pakistan

In the health sector, public sector organizations in Pakistan have evolved into complex matrix structures. The health department is headed by a Secretary, who is invariably an administrative cadre civil servant, and is assisted by a multi-hierarchical bureaucratic establishment of civil servants. The secretariat is expected to act as a public policy instrument under the guidance of publicly elected representatives and work as an arm of the government to provide strategic guidance and direction. Under the secretariat, there is the office of Director General, Health who is usually from the medical profession, and is again assisted by a hierarchy of officers. The office of Director General is expected to provide support to the secretariat in the operational matters of health service. However, with the passage of time, the public policy and operational functions have got mixed up. Both the offices of Secretary and Director General (Health) supersede each other's functions and create a confused, static and directionless office. This ultimately harms the provision of healthcare to the end user.

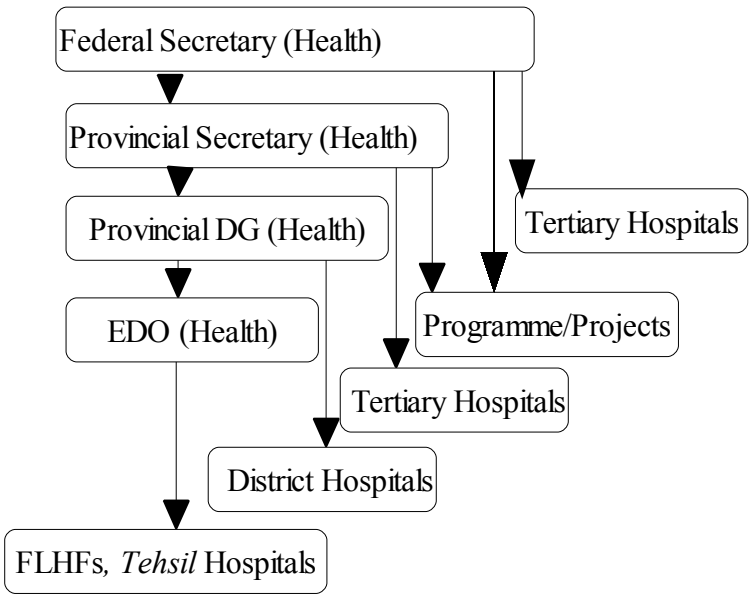
At the district level, Executive District Officer, Health (EDO/H) is responsible for most of the health services in his district. Managers of all *tehsil*[2] headquarter hospitals and First-Level Health Facilities report to him. However, district headquarter hospitals report directly to the Director General, Health at the provincial level. With some rare exceptions, tertiary care hospitals are also directly under the provincial government and report to the Secretary health. This is notwithstanding the critical role played by Finance and Services & General Administration Departments in the allocation of financial resources and imposing a regulatory framework for human resource management. According to Collins *et al (*2002), the

2 A second tier administrative unit after district.

organizational structure of the health system in the 1990s was over-centralized, unwieldy and unnecessarily tall, there being eight supervisory levels. This resulted in a frustratingly long chain of command and delays in decision making. The situation is not much different today.

The addition of donor funded federal and provincial vertically integrated projects[3] have further added complexity to an already complicated organisational structure. They run parallel to the existing administrative arrangements, and there is weak coordination and absence of proper organisational linkages with the existing health hierarchy (Collins *et al* 2002). The result is that the donor funded projects dealing with key preventive services, rather than becoming part of a routine job of a health professional, have been assigned to specific staff under the administrative control of various programmes/projects. This has introduced a certain degree of compartmentalization in the provision of healthcare. The administrative structure has been illustrated in Figure 1 below:

Figure 1: Governance Structure of Healthcare Provision in Pakistan



This complex administrative structure creates confusion about the relationship between principals and agents. Due to the multiplicity of principals and confusion about their roles, as well as the absence of functional linkages between different vertical and horizontal tiers, the administrative and organisational structures have become cumbersome and unmanageable.

A crucial issue relating to a dysfunctional organisational structure is bad governance in the health sector. There are various dimensions to this problem. The first is staff absenteeism: either the staff is absent during normal duty hours or in many cases, staff theoretically posted

3 e.g. National Programme for Family Planning & Primary Health Care, Women Health Project, National Nutrition Project, Reproductive Health Project, Expanded Programme of Immunization, and National Maternal and Child Health Programme 2005-2011 etc.

to a rural health facility are actually "seconded" to other government facilities in the urban areas. The second is interference by the politicians in health managers' decision-making, restricting their ability to redeploy resources and to use them in an efficient and optimal manner. The third relates to absence of any meaningful interaction with communities, professional bodies, private sector or civil society at large. This has weakened the impetus for meaningful reform. Fourthly,there is no systematic monitoring and evaluation of the performance of health services. Demographic and health surveys only serve as *ad hoc* evaluation studies, and are not essential component of an established and ongoing monitoring and evaluation system. The fifth problem relates to the procurement and supply of medicines and drugs. The standardized procedures developed by provincial governments have not been integrated. The result is that supplies rarely match requisitions, and the situation is further aggravated by late deliveries, pilferage, and poor inventorying and storage practices. The corruption and collusion between paramedic staff and district health authorities are evident from the fact that government medicines are sold in the private market and spurious drugs are supplied to the poor patients (SBP, 2004).

The result is under-utilization of different health facilities in the rural areas. BHUs are visited by on average 22 patients per day, while in the North West Frontier Province, an analysis undertaken by the Department of Health in 2005 showed that 75% of BHUs received less than 10 patients per day (World Bank, 2006). A recent survey indicates that only 2.2% of the people use the network of primary healthcare nationally and in Punjab, the utilisation ratio was only 0.7%, lowest amongst the four provinces (GOP, 2005b).

3. Reforming the Primary Healthcare System in Pakistan

There has been a general realization that the healthcare system in the country needs to be overhauled and rehashed. Collins *et al* (2002) refer to several earlier initiatives undertaken by the provincial government for reforming the healthcare system.

Table 2: Earlier Initiatives for Reform in the Health Sector

Date	Initiatives
1990	Delegation of financial authority to Deputy District Health Officers (officer in charge at *tehsil*[4] level).
1993-94	Sheikhupura PHC pilot project.
1996	District Health Management Teams (DHMTs) established in 16 out of 34 districts.
1997	District Health Authorities (DHAs) established in Jhelum (July 1997) and Multan (March 1980).
1998	Semi-autonomous hospitals established in the tertiary sector.
1998	District Health Government (DHG) developed, approved by the Chief Minister in November, 1998. Since then, recruitment and training of district level Chief Executives and rules for DHG.

Adapted from Concept Paper: District Health Government, Department of Health, Government of Punjab

4 An administrative unit above Union Councils and is normally a large town.

These initiatives and the overall reform agenda were clearly influenced by the World Bank conditionalities that emphasized the integration of vertical programmes, incentives to female paramedics and decentralization. However, they were introduced within the administrative and institutional context of health department. Some major departures can be seen, when administrative and financial powers were delegated to lower tiers to give them greater autonomy in the decision-making processes, but these could not be fully implemented due to opposition from pressure groups as well as lack of capacity and training to exercise authority at the the lower tiers. Some hospitals were also made autonomous and were headed by Chief Executives leading to a tussle between the CEOs and Medical Superintendent of hospitals or Principals of medical colleges. This created administrative problems. The scheme, though technically in place, has been abandoned for all practical purposes. The District Health Government scheme attempted to develop a relationship between purchasers and providers through transparent and well-defined contractual agreements. There was an attempt to create *internal market* on the pattern of National Health Service of the UK. However, the scheme could not take off first due to change of government and secondly, the introduction of District Government system in 2001 proved that to be a its death knell.

A relatively recent attempt at reforming the primary healthcare was made through a private initiative in a small town, Lodhran, in the Punjab province. Realising that the government sponsored healthcare system did not have the capacity to cater for the needs of the people, an experiment was made in 1999 to re-engineer the business processes for primary healthcare. The reform initiative was undertaken in collaboration with a public sector NGO, National Rural Support Programme (NRSP), that managed and ran one cluster of three BHUs on behalf of the district administration. This experiment, though rudimentary and on a small scale, proved a success.

However, the introduction of District Government System provided a real opportunity and test for the Lodhran/RYK[5] model at the district level. Relative success of the programme in Lodhran convinced the provincial government to take over the initiative and launch the programme as Chief Minister's Initiative on Primary Healthcare (CMIPHC). District Rahim Yar Khan (RYK), whose district *nazim* (mayor) endorsed this programme and extended political and administrative support to it, was chosen as a pilot district for the project.

Under this initiative, one Provincial Support Unit (PSU) was established with grant-in-aid by the Punjab government to Punjab Rural Support Programme (PRSP), another public sector NGO established by the provincial government. The Terms of Partnership (TOP) Agreement

5 The pilot project was initiated in a small town Lodhran and was later replicated in district Rahim Yar Khan (RYK). That is why, it is called Lodhran/RYK model of primary healthcare.

was signed between PRSP and district government for a period of five years on April 15th 2003. On signing the agreement, 104 BHUs along with their allocated budgets were transferred to PRSP that was given complete administrative, functional and financial autonomy in the management of BHUs in the district. The MOU indicated that the District Government "shall relocate the staff as requested by PRSP in the best interest of the management arrangement." However, PRSP will manage within the existing health budget. It also had not administrative control over vaccinators or management of several federally and provincially sponsored Primary Healthcare or Family Planning development projects.

Under the CMIPHC initiative, BHUs have been consolidated in the form of clusters of two/three within a range of 15-20 KMs. However, keeping in view the peculiar circumstances of each situation, there are instances where no clustering has been done. This indicates that it is not clustering alone that is the special feature of this initiative. Rather flexibility and customised management solutions are its hallmark. There is one doctor posted for each cluster and covers all BHUs according to a timetable. He is paid Rs.30,000 per month in case of three BHUs and Rs.24,000 per month if he is supervising two BHUs. This package is significantly higher that Rs.12,000 salary offered by the provincial government. In addition to that, he is allowed an interest free loan of Rs.100,000 to buy a vehicle to ensure his mobility (SBP, 2004). He resides in the focal BHU which is decided on the basis of better residential facilities and is not allowed private practice during the period of his contract. He is the administrative head of BHUs cluster and is responsible for its overall discipline, management and maintenance of record.

PRSP has successfully addressed the problem of almost total absence of Female Medical Officers (FMOs) in the rural areas of Pakistan. Due to social reasons, women in Pakistan and especially in the rural areas are shy of consulting male doctors. Therefore, presence of female medical officers is crucial for improving the health of mother and child. However, due to insecurity, it is not possible for the FMOs to reside in rural areas to which they normally do not belong. It is also a taboo for them to ride motorbikes. Therefore, an out of box and innovative solution was found to the problem. The FMOs were not only offered a special package, but also also allowed to reside in the *tehsil* headquarter and visit 5 BHUs and one girls school in a week. She was paid a salary of Rs.37,000 per month. In addition to that, she was offered an interest free loan of Rs.150,000 for the purchase of a car. The FMO paid the salary of the driver and was responsible for the fuel and maintenance of vehicle. The result was there that by the mid 2005, eight female medical officers were working in Rahim Yar

Khan and visiting 40 BHUs every week. They provided gynaecological cover for the first time in the rural areas.

104 BHUs in district Rahim Yar Khan have been operated in 35 clusters and de-linked from the provincial and district health administration, except that salaries of the paramedic and support staff continue to be paid by the latter. The District Government transfers primary healthcare budgets to PRSP as a one-line transfer to ensure financial and management flexibility for operations. PRSP renders accounts of the operation to the District Government within a period of three months at the end of every financial year. After encouraging response in RYK, the project has been replicated in eleven more districts of the province at their request.

4. The Political Context of Healthcare Reform

Though the Lodhran/RYK model may not be unique in the world, it is a home grown model of Primary Healthcare reform. It was solely developed by Pakistanis and not promoted or financed by external agencies (World Bank, 2006). Its impact is also significant since it has been implemented on a large scale and provides primary healthcare services to more than 25 million people. This is an intriguing model for contracting in a setting where there already exists a large but poorly functioning public sector primary healthcare system. It outsources the healthcare management and facilities to an NGO, albeit a public sector one.

While the Local Government System made the District Health Government scheme superfluous, the Lodhran/RYK model could not have survived and flourished without a decentralized set up. The introduction of this model at district level was made possible, since primary healthcare was devolved from the provincial to district governments under the new dispensation. The district governments had the legal mandate to continue the system or change it at their discretion. However, the district *nazim* (mayor) was not the management wizard to slice through the "Gordian knot" of complex, inadequate and antiquated management structure supported by entrenched vested interest. In order to make devolution a real and sustainable success, the management systems at the district level needed to be radically overhauled with the aim of evolving innovative model(s) to be manned by adequately compensated and motivated staff. This effort was supplemented with simplified business processes. For this purpose, it was also important that the official government policy was linked to this model. Provincial bureaucracy and health professionals lobby were convinced to follow the new and simplified operating procedures, and elected public representatives at the district level believed that this new model would ultimately work for

their political advantage. It was the realignment of so many interests which could ensure the beginning and continuation of Lodhran/RYK model.

How good the initiative, it could not have succeeded without the support and sponsorship of some one at the helm of affairs. The chief coordinator of this initiative was then advisor to the Chief Minister, Punjab and was the one to design and run this programme in Lodhran on a pilot basis. He was able to approach and convince the Chief Minister to adopt the Initiative and launch it as the "Chief Minister's Initiative for Primary Healthcare" (CMIPHC). The Chief Minister had nothing to lose from the success of this management innovation, if the Initiative succeeded. In case of failure, he could always dissociate himself from it.

The provincial and district health offices and more crucially, the doctor's lobby would have opposed the very idea. However, their resistance was overcome when the initiative was launched in the name of the Chief Minister of the province. The doctors' lobby, dominated by bigwigs such as professors in medical colleges, were careful not to antagonise the Chief Minister. Secondly, the relatively small beginnings of the Initiative in a remote district in rural Punjab was not likely to hurt their vested interests. Its focus on primary rather than tertiary healthcare also kept its profile low. Thirdly, the provincial government was already recruiting doctors for these FLFHs on a contract basis. The transfer of these facilities to PRSP multiplied the doctors' salaries with almost similar terms and conditions.

As for the district government, Rahim Yar Khan was home constituency of the chief coordinator of the Initiative, and district *nazim* was closely related to him. Without whole-hearted support from the District Government, it would not have been possible to start the Initiative at district level.

Punjab Rural Support Programme (PRSP), a public sector NGO, was established by the Punjab government itself. Working like a private sector NGO gave PRSP the managerial flexibility necessary for implementing customized and out of box solutions, while being a public sector NGO provided a comfort and confidence level to the district and provincial governments to transfer to it the assets and budgets of BHUs.

Realising that the initiative cannot work without a close interaction, coordination and support of other government offices, PRSP hand-picked officers from the civil service and posted them on a handsome salary package to its Provincial and District Support Units. By adopting this strategy, PRSP ensured a continuous and sustained support of the provincial bureaucracy. Furthermore, by offering a salary package much better than the one these officers were enjoying in their regular postings, PRSP has made sure that they stay with it and work efficiently. Even the Chief Executive Officer of PRSP is a retired senior civil servant with

considerable clout within the Punjab government. Without him, the implementation of the initiative would have been doubtful.

The dynamics of interest groups interaction have been summed up in Table 3 below:

Table 3: Matrix showing Dynamics of Interest Groups Interaction

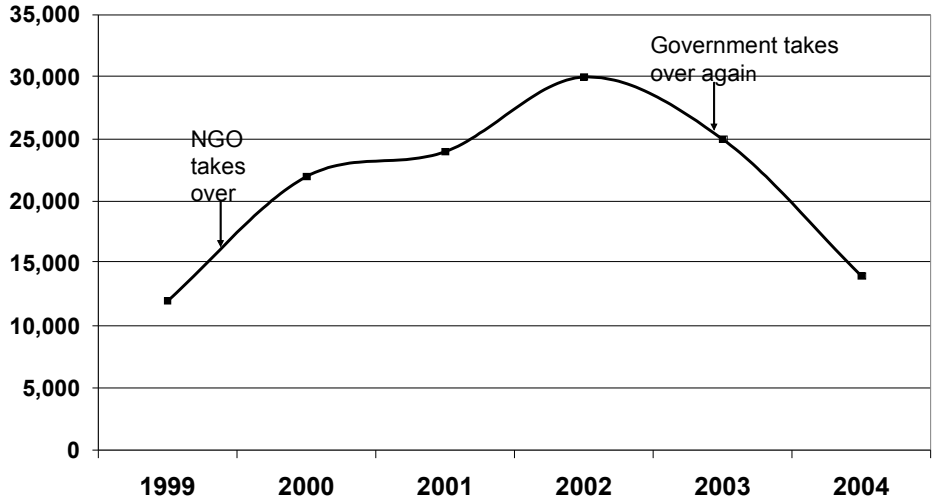
Problem	***Solution***
Official Government Policy is linked to this model.	(a) Chief Minister is convinced to launch this programme as his initiative.
Provincial bureaucracy is convinced to follow the changed operating rules.	(a) Model involves a *public sector* NGO; (b) The public sector NGO is headed by an ex-civil servant with wide clout in the bureaucracy; (c) The Provincial Support Unit is headed by a serving civil servant posted there through transfer; (d) District Support Units are manned by officers from bureaucracy, posted there through transfer.
District *nazim* is convinced to adopt and support this initiative.	(a) Rahim Yar Khan is the home constituency of chief coordinator of this initiative. (b) District *nazim* (mayor) is closely related to the chief coordinator.
Health professionals are convinced to follow the changed operating procedures.	(a) The Chief Minister supports the initiative and it is not *wise* to oppose him. (b) Doctors were on contract with a meagre salary package. This new contractual relationship is accompanied by a better package; (c) They work in a better management environment, with less hassle; (d) They have flexibility in managing their affairs at the BHU level.
Elected public representatives are convinced to support the new model.	(a) Since the existing system does not satisfy anyone, the new model, with potential to satisfy the needs of the poor and provide them political mileage, ultimately wins them over. (b) The Chief Minister supports the initiative and it is makes political sense to support him.

5. Conclusion

Lodhran/RYK model of Primary Healthcare is a home-grown effort that was conceived and developed in response to the pathetic conditions of basic healthcare in rural Punjab. It has been envisioned to re-engineer the primary healthcare services for the rural poor through the restructuring of existing infrastructure. It is unique in the sense that it outflanks the antiquated and regimented system to give the primary healthcare infrastructure an overhaul. However, the outflanking move should not ignore the state; rather it gives it a breathing space for improvement. In that sense, the managerialist model does not believe in privatising the provision of social sector services but favours a Keynesian welfare state that has a potent and benign role by making the provision of service delivery more efficient and sustainable in the long run. The idea is that PRSP should hand over the management of primary healthcare units back to the District Governments, after a rehashed and re-engineered Health Management

System is operational. If this is not done and the BHUs are returned to the same old health department, the results will be disastrous. This is evident from the case of district Lodhran, where the first beginnings of this model were made. After running the BHU cluster for nearly three years, District Government decided to terminate the contract with NRSP and run the BHUs on its own. What happened has been depicted in Figure 2 below.

Figure 2: District Lodhran: Continuity is Important



The figure shows that soon after taking over the BHUs by NRSP, number of visits to OPD went up and they remained high as long as the BHUs were being run by the public sector NGO. When the District Government took them back in 2003, the number of visits went down dramatically. Two conclusions can be drawn from it. Firstly, continuity is important. Secondly, the whole exercise of handing over BHUs to an NGO is futile, if it is to be returned to the same old corrupt and static bureaucratic system. This shows how important it is to revamp and re-engineer the government apparatus.

The experience of Lodhran also shows that the services of an NGOs are likely to be hired for an interim period and there is always a likelihood that the management contract is not renewed. It is, therefore, important that government should restructure and modernise its health management administration at district and provincial levels.

The successful implementation of the model shows that is possible to bring to life and vibrancy the provision of primary healthcare system in the rural areas. The main problem is the existing administrative apparatus and rigid and archaic government rules and regulations that govern the health service. The solution lies in finding customised solutions that focus at achieving programme objectives. Punjab Rural Support Programme provided the platform on which the edifice of a feasible and functioning Primary Healthcare delivery system was built. This can be further expanded to include whole of the country.

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