Experience of devolution in district health system of Pakistan: Perspectives regarding needed reforms

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Abstract

Objective: To identify the strengths and weaknesses of the devolved district health system from the experiences of different stakeholders, and recommend direction for reforms in the existing system.

Methods: Using qualitative exploratory design, the study was conducted in 3 cities of the province of Sindh in Pakistan — Karachi, Khairpur and Larkana — from January to March 2010. Nine in-depth interviews were conducted with multiple stakeholders (District Coordination Officer, Executive District Officer, Medical Superintendent, Medical officers, Health system experts) of the district health system. Interviews included questions on autonomy in decision-making at the district level and the effectiveness of the devolved health system. Data transcripts were made from the recorded tapes and notes taken during the interviews. Thematic analysis was done and the data was classified into 3 broad themes of governance, financing and factors related to resources and service delivery.

Results: The main strengths identified included formation of District Health Management Team for wider inter-sectoral collaboration, creation of new posts at sub-district level for close monitoring and supervision, and greater financial autonomy to prioritise according to needs. The reported weaknesses included lack of team work, limited autonomy, lack of capacity, nepotism and poor accountability.

Conclusion: While devolution has been scrapped in most parts of the country, the findings of the study provide recommendations for the delegation of further powers at sub-district and union council level, enhanced capacity and increased transparency and accountability to make the system work.

Keywords: Devolution, District Health System, Health Reforms (JPMA 62: 28; 2012).

Introduction

Decentralization is referred to as the transfer of powers from the central government to lower levels in a political-administrative and territorial hierarchy.[1] Powers can be decentralised at multiple levels, including de-concentration (re-distribution of powers among different levels of central government), delegation (transfer of powers to semi-autonomous organisation) and devolution (transfer of powers to locally elected governments). Country reviews of decentralisation have given mixed effects in the developing world. A few countries have shown improvement in health indicators, while others have remained stagnant.[2,3]

Pakistan has a wide network of healthcare infrastructure, including 919 hospitals, 5334 Basic Health Units (BHUs) and Sub-Health Centres, 560 Rural Health Centres (RHCs), 4712 Dispensaries, 905 Maternal and Child Health (MCH) Centres and 288 Tuberculosis Centres.[4] The utilisation of this strong infrastructure has remained low over the years due to inadequate financing, lack of resources and structural mismanagement.[5] The country only spends 0.5-0.6% of its GDP on health.[6] Lack or absence of information at the district level has led to formation of national health policies based on political inference rather than evidence of the required need. Pakistan is listed as one of 57 countries with critical health workforce deficiency in the World Health Report 2006.[7] This deficiency is further compounded by the absence of a well-defined policy on human resource development, lack of formal in-service training, low numbers for certain categories of health professionals, migration of skilled workers and urban-rural misdistribution of workforce.[8] In order to address these problems, the government introduced a devolution plan in the year 2000 to reform all social sectors, including health.[9] Following this plan, administrative and financial powers were transferred to districts of all provinces through an ordinance in 2001. In this way a third tier of government was created and the 'District' was made the dominant level of decision making.

Devolution in the health sector was aimed at enhancing the financial and management authority at district level to improve service delivery and increase healthcare utilisation at grassroots level.[10] It was seen as an opportunity

to re-exert the agenda of providing primary healthcare to all and achieving the Millennium Development Goals 2015.[11] It also showed a way forward in integrating the vertical programmes, facilitating the inter-sectoral collaboration and fostering public-private partnership.[12] The concept of devolution promised to enhance the authority of identifying the health needs of the people leading to rational and evidence based policy making.

However, health indicators in the country have shown slow progress over the past few years and it is unlikely that Pakistan will achieve health-related MDGs within the deadline. According to statistics of Pakistan Demographic and Health Survey 2006-07, contraceptive prevalence rate ((32% to 30%) and total fertility rate (3.9% to 4.1%) remained stagnant from 2003-06.[13] Progress on courts of child and maternal mortality has been dissatisfactory. The infant mortality rate has remained stagnant from 77/1000 in 2001 to 75/1000 in 2007 while maternal mortality has shown slow progress from 350/100000 in 2001 to 275/100000 in 2007.[14]

The introduction of devolution reforms lead to changes in roles of different stakeholders from top to bottom, thus re-distributing the power at various levels. These stakeholders include representatives from Ministry of Health, Secretariat, District Health Managers (Executive District Officers), Managers at sub-district level and Healthcare workers. Since the elected government took power in 2008, many structural changes have taken place and most of the provinces have reverted to commissionerate system that existed before devolution. A new health policy has been drafted and the federal ministry of health has been abolished under the 18th amendment to devolve further powers to the provinces.[15,16] In view of these changes, an inquiry into the experience of the devolved district health system provides us an opportunity to learn about the reforms required to make the system work.

The study aimed to identify the strengths and weaknesses of the devolved system from the experiences of different stakeholders, and recommend direction for reforms in the existing system to achieve better outcomes.

Methods

This was a qualitative inquiry with a descriptive exploratory study design. The purpose was to explore the ideas and perceptions of the stakeholders about the strengths and weaknesses of the system. Nine in-depth interviews were conducted from multiple stakeholders at different levels in 3 cities - Karachi, Khairpur and Larkana - of Sindh to learn about their experiences. The stakeholders in the hierarchy (Figure) included a Health Secretariat representative, a District Coordination Officer (DCO), 2 Executive District Officers (one urban and one rural), 2 medical superintendents at sub-district level and 3 medical officers working at BHU level for at least 10 years.

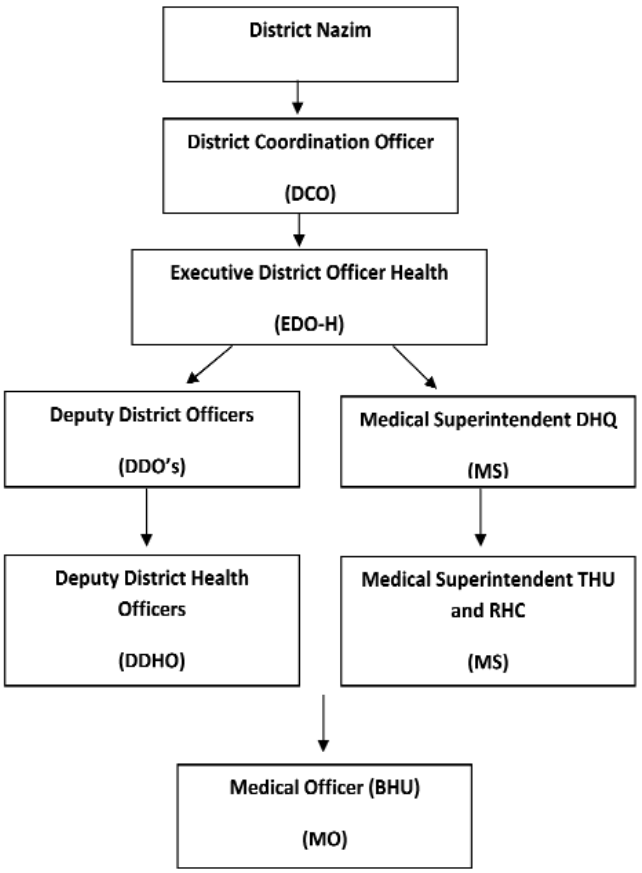

Figure: Schematic diagram of Hierarchy from District to Union council in District Health System.

Interviews based on open-ended questions were conducted by trained health research professionals. Interviews included questions on autonomy in administrative decision making at district level and effectiveness of the devolved health system. Respondents were asked what difference they felt regarding the shift of responsibility in the system, what change did the new system bring and what were the strengths and weaknesses of the system. Participants were allowed to express their views in response to questions and were further questioned whenever necessary.

The stakeholders were approached for an appointment to undertake the interviews via formal letter and telephone. Transport facilities were arranged by the Residency Programme of the Community Health Sciences Department of Aga Khan University. Informed written and verbal consent was obtained from the participants. Privacy was maintained during the interviews and the identity of the

participants has been kept confidential.

Two people were assigned to conduct each interview; one was responsible for conducting the interview and the other did the note taking. Interviews were recorded wherever it was allowed by the respondents.

Data transcripts were made from the recorded tapes and notes taken during the interviews. Thematic analysis was done and the data was classified into 3 broad themes of governance, financing and factors related to resources and service delivery. Anchors related to each theme were separately listed down. Content was independently analysed by two researchers and then compared and adjusted.

Results

The trickledown effect of the devolved system was supposed to improve resources and service delivery by enhanced responsiveness and improved performance of primary healthcare units, increased gate-keeping and formation of local committees having representatives of the community.

Table-1: List of reported Governance, Finance and Service related strengths and weaknesses of the devolved system.

Strengths
Governance:
◆ Trained Nazims and district managers
◆ Formation of DHMT for inter-sectoral collaboration
◆ Creation of new posts at sub-district level for monitoring at grassroots level
Financing:
◆ Retention of taxes by district
◆ Autonomy for need-based allocation
Resources and Services
◆ Outsourcing leading to regularity, punctuality and service delivery
◆ Procurement of drugs at district level
Weaknesses
Governance:
◆ Lack of administrative capacity
◆ Lack of administrative accountability
◆ Selection on personal and political choices
◆ Lack of power delegation at sub-district level
◆ Lack of practical planning at local level
◆ Lack of focus on preventive side
◆ Lack of evidence-based policy making
◆ Duplication of power between provincial and district governments
◆ Limited authority on vertical programmes
◆ Bureaucratic resistance
Financing:
◆ Allocations are not need-based
◆ Late release of funds
◆ Underpaid healthcare workers
◆ Extra burden of non-development funds
Resources and services:
◆ Lack of capable and trained healthcare staff and doctors
◆ Lack of laboratory facilities
◆ Lack of transport for emergency referrals
◆ Failure to deliver services practically
◆ Tertiary care excluded
◆ Non-functioning HMIS

DHMT: District Health Management Team; HMIS: Health Management Information System.

Table-2: Recommendations to improve the Devolved District Health System.

Recommendations:
◆ Selection of experienced, skilled and honest EDOs
◆ Devolution at sub-district level (powers of hiring and firing, community empowerment)
◆ Transfer of vertical programme management to district health system
◆ Capacity development of administrators and healthcare workers
◆ Increased accountability
◆ Improved HMIS application
◆ Improvement in contracting by empowering the existing system
◆ More investment in the overall health sector.

EDOs: Executive District Officers; HMIS: Health Management Information System.

All the respondents in the study supported the idea of devolution, but believed that most of the ideals of devolution were not translated into practical action. According to one of the EDO's, "Devolution never actually happened". One of the critics of the system from a rural town stressed that devolution is only suitable for metropolitan cities like Karachi where literacy is high and models of excellence are visible. Social system is not mature enough at grassroots level and, hence, there is no space for elected people in technical work. An official from Karachi further stressed that while there have been improvement in the development of the infrastructure in the big city, social sectors like health have remained neglected because the focus of the administrators has been on visible development. Respondents enumerated strengths and weaknesses of the system. Weaknesses outnumbered strengths according to respondents (Table-1).

On the basis of its findings, the study has put forward eight key recommendations (Table-2), but the study has a few limitations. The exercise involved only a few members of the health system and there may be many other viewpoints which it has not been able to capture. Study areas are quite different from one another which could affect the personal experience and hence the opinion of the respondents. However, selection of 3 different districts combines the urban and rural opinions.

Discussion

The essence of devolution include governance-related reforms that involved shifting administrative powers to the district level, creation of new posts for local supervision and monitoring, health planning at local level, enhanced inter-sectoral collaboration, support rational decision making and reduce top-down approach. Fiscal reforms include allocation of funds on grounds of

population and geographical size, disease burden, backwardness of the area, available infrastructure and previous performance of the specific sector.

One of the strengths of the system was the formation of District Health Management Team (DHMT) for wider inter-sectoral collaboration. One EDO said: "At least representatives from multiple sectors got together and sought cooperation of each other. We found it easier to organise immunisation campaigns with the support of all departments." However, the DHMT could not translate into a team that could support general betterment in a district. The main reason behind lack of cooperation has been conflict between district administration and beaureucracy.[17] Devolution curtailed powers of civil beaureucracy as a result of which local administrators had to face resistance in implementing development plans. Another feature of devolution was introduction of health planning at district level. EDOs expressed dissatisfaction with the transferred authority.

Reports generated at the district level are often based on an extremely unreliable Health Management Information System (HMIS) which has been a victim of scarcity of resources (in forms of skilled personnel and finances), contentious quality of data and lack of motivation and feedback among health managers.[18] Despite the fact that the powers of EDOs have increased and they can tailor their management needs by appointing, posting or firing anyone, districts have remained recipients of policies made at higher levels.[19] The role of district administration is still limited to looking after curative services. Vertical programmes are still federally administered and districts only have a coordination role.

Numerous questions were raised about transparency of appointing EDOs. An EDO said, "Under the law, EDO Health should have post-graduate degree in public health. But the criteria for their appointment have largely been political rather than academic. The performance of EDOs can be judged by the fact that no efforts have been made to create new sources of fund generation." This assessment is supported by a previous survey which reports that 80% of the managers received no professional in-service training during their service period.[20] A qualified health expert while sharing an experience of a workshop that he conducted with the EDOs, said: "Majority of the EDOs are not even capable of writing a PC-1[i] document."

The devolved system also aimed at creating new posts at sub-district level for close monitoring and supervision. Taluka Health Officers (THOs) and Deputy Taluka Health Officers for preventive and curative services were appointed in this regard. But unfortunately, many positions of deputy THOs remained unfilled. The reason specified for underutilisation of these posts was lack of support from administration and local committees. Powers were never delegated to the sub-district level. As such, the creation of new posts only put extra burden on the fiscal side.

While devolution did bring financial authority to the districts because taxes generated were retained locally, but the focus of district administrators, or Nazims, was on visible development. They were keener to finance local infrastructure rather than social sectors like health and education. Besides, there were also issues related to the disbursement of funds.

As a result of irregularities at the district level, the performance of first level healthcare facilities failed to show much improvement. Doctors and healthcare staff remained underpaid which demotivated them and affected their performance. The work environment has made these healthcare units dysfunctional and the utilisation of these units is less than 20%.[21]

Outsourcing of primary healthcare (PHC) services to non-governmental organisations (NGOs), in recent years has been tried with successful results in some countries.[22]

In 2003, the provincial government of Punjab and the district government of Rahim Yar Khan signed a memorandum of understanding (MOU) with a national NGO, the Punjab Rural Support Program (PRSP). It was given complete autonomy to manage 104 BHUs of the district. The evaluation of the project revealed that the arrangement showed improved utilisation and increased patient satisfaction.[23] The government of Sindh also initiated the People's Primary Healthcare Initiative (PPHI) in 2008 and the management of 526 BHUs in 17 districts were transferred to SRSO[ii]/PPHI. The review report of PPHI suggests that availability of doctors and healthcare staff has improved and non-functional BHUs have been made functional.[24] Such steps have increased expenditure on primary healthcare as compared to the past when majority of funds were consumed by secondary and tertiary care levels.[25] Doctors working under these reforms expressed improved regularity, punctuality and services in the BHUs, but administrators raised concerns that outsourcing has created a parallel system. They feared that PPHI was functioning at the cost of the district health system. Moreover, long-term sustainability of the process was questioned as there is a definite gap between the two setups.

Conclusion

The study findings suggest that the devolved healthcare system was never implemented in its true letter and spirit. While devolution has been scrapped in most parts of the country, many lessons could be learnt from the opinions of the stakeholders who worked in the system for

new policies to be implemented successfully.

i- PC-I is the basic form on which all projects/schemes are required to be drawn up for submission of project proposal to the Planning Commission of Pakistan.
ii- Sindh Rural Support Organisation.

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