Revisiting the three different tiers of the health system of Pakistan and their Implications for the achievement of MDGs by Pakistan

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Introduction

Pakistan healthcare system is passing through a complicated phase. It faces an increasing challenge for not making rapid enough progress to improve health outcomes and achieve Millennium Development Goals (MDGs) with an increasing population burden and gradually increasing double burden of diseases. There are a number of factors responsible for it, but weak governance and management challenges hold the key. These are further complicated by macroeconomic issues which limit the government's ability to enhance its investment in health; and an unstable security situation with a large burden of internally displaced populations needing redirecting scarce resources, and, finally, the political and administrative changes.

Government Organisation

Pakistan is a federation with three levels of government - federal, provincial and district. The capitol territory Islamabad, Federally Administered Tribal Areas (FATA) and the Federally Administered Northern Areas (FANA) come under the jurisdiction of the federal government. Whereas Azad Jammu and Kashmir (AJK) is an autonomous region with its own government. Subsequent to the partition from East Pakistan as Bangladesh in 1971, the federal and provincial governments were made responsible for the delivery of healthcare with implementation through the districts. The 1973 Constitution of Pakistan specifies the subjects that come under the responsibility of the federal and provincial governments, respectively. Constitutionally, the provision of health services is the provincial government's responsibility. The federal government's primary responsibilities are policy development and strategy delineating, monitoring and evaluation, health communication, advocacy and information, formulation of technical values and guidelines, and the prevention of communicable diseases. In other words, the federal government is a steward of the system rather than an implementer. The provincial governments' primary responsibility is health services, including planning, management and oversight, financing, implementation, medical education and training, monitoring and supervision, and regulation.

Management of responsibilities for healthcare is divided between the provinces and the federal government. This two-tier system continued until the Devolution Initiative (DI) in 2000. The Local Government Ordinance 2001 (LGO) created district governments (DG) as the third tier of government. The goal of the Devolution Initiative was to devolve administrative and financial powers at the local level to enhance local accountability and improve service delivery. It placed 13 sectors, including health, under the control of the district governments. In health, devolution did not change the role of the federal government, but rather the division of responsibilities between the provinces and the districts. The latter became responsible for the management, supervision, financing, and monitoring of primary and secondary facilities.

Till recently, all three levels of government used to play a role in the management and delivery of healthcare. The federal ministry's participation had grown beyond the role of over-sight as described in the constitution. In particular, it was involved in the funding and management of national programmes, but it also funded large hospitals and medical college construction at the provincial level. On the whole, the federal government was responsible for about a third of public expenditure on health. However, the government failed to take on all of its stewardship responsibilities. Similarly, provincial governments, whose function was more focussed on service delivery, including its organisation, monitoring and evaluation, did not fully adjust to the changed role. Their relationship with districts remained problematic, particularly in the smaller provinces where provincial governments still retained considerable influence on personnel management and on the use of development resources.

Under the three-level system, where districts are the third rank of government, the allotment of responsibilities across levels is blurred. In the DI, the responsibilities for managing different levels of service providers were mapped to different levels of government, and the

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distribution of responsibilities was planned to avoid replication. However, in practice, two shortcomings emerged. First, the milieu structure lacked lucidity; lines of accountability were confused. Second, the degree of autonomy in fact granted to and exercised by the districts to carry out their responsibilities remained quite limited.[1-5]

Devolution resulted in limited but positive impact on service delivery. Problems with service delivery run deep in Pakistan and harm devolution, so expectations about the force of devolution may have been overly optimistic. The evidence about the impact of devolution on performance is limited and mixed. Trends in health indicators and regional disparities were little impacted by it. Nevertheless, some small-scale studies showed that the availability of medicines and staff attendance may have improved. The Harvard study in 2007 manifested that in districts that had a greater capacity for decision-making, and greater responsibility of officials towards local authority, the coverage of maternal services was higher. While this did not establish causality, it showed that improvements can be achieved in a decentralised context.[4-7]

The federal government is responsible for a series of mainly preventive national programmes, the largest of which are the immunisation and the Lady Health Worker programmes. These were funded from the federal development budget, which represented more than 60 per cent of the total federal health budget (2005/06).

The federal government also funded and ran a number of tertiary hospitals throughout Pakistan. Provinces and districts are mainly accountable for delivering curative services, funded through their recurrent budget .To a lesser extent, provinces also funded from their development budget other federally initiated national programmes, such as those related to tuberculosis, hepatitis etc. The sharing out of responsibilities between the provinces and the districts altered over time and across provinces. In all provinces, salaries, which constituted the bulk of recurrent costs for service delivery, were managed at the district levels, while the provinces retained most of the development budget. This division of financing left little room for districts to make things happen.[1-3]

Health Scenario

The Pakistan Demographic Survey (2003 and 2005),[8] and the Pakistan Health and Demographic Survey (2006/07) showed that the country had not been on track to achieve most MDGs related to health, nutrition and population.

A brief glimpse of MDGs and Pakistan.[9]

Goal-1: Poverty alleviation and fighting hunger:

The poverty head count ratio at Pakistan's national poverty line is 22.3% (World Development Indicators [WDI]-2011),[10] and 75.37% children are employed in agriculture. Also, in 2010, the country faced floods that killed over 1700 people and displaced another 20 million. In addition, there was the loss of infrastructure, livestock, agriculture, and housing worth billions of dollars. The estimated reconstruction cost was Rs578 billion. However, the two smallest shares of allocations were Rs4 billion for health sector reconstruction and Rs2 billion for disaster risk management.[11] Furthermore, during the last 10 years, Pakistan's economy has incurred enormous indirect and direct costs of the 'war on terror', amounting to Rs5037 billion ($67·93 billion).[12] Conflict in the country has coincided with a plummeting of the ratio of investment to gross domestic product (GDP) from 22·5% in 2006-07 to 13·4% in 2010-11, with grave consequences for jobs.[3] The challenge lies with increasing productive capacity, which, in turn, relies on peace in the region to attract investment.[12] Total health expenditure is a mere 2.6% of GDP. And only 0.86% of GDP is the public health expenditure.[10] Most (75%) of the health expenditure is out of pocket (OOP).[11] This scenario together with a lack of social protection mechanism puts large number families at risk of poverty because of illness. As Grant (2005) wrote: "Ill-health can be a catalyst for poverty spirals and in turn poverty can create and perpetuate poor health status".[13]

Slow progress towards health and nutrition related MDGs:

Pakistan is not performing well in improving health and nutrition outcomes or services, especially for the poor. The present rate of improvement is much lower than for its South Asian neighbours.

It needs to significantly improve its performance in these areas, otherwise poor health and nutrition outcomes would remain an obstacle to economic growth, especially during times of macroeconomic challenges, political and security-related instability and external shocks with a disproportionately negative impact on the poor.[8-10]

Linking MDGs 1, 4 and 5: Pakistan has made minimal progress in improving nutritional outcomes of children and mothers over the last two decades. For reliability with clinical screening, prevalence-based data are frequently reported with a cut-off value, often <-2 and >+2 2-scores. The rationale for this is the stastical definition of the central 95% of Pakistan suffers from high rates of childhood malnutrition with 38% of children under-5

being underweight (<-2SD weight for age) and 12.3% severely underweight (<-3 SD) and 37% of children being stunted (<-2SD height for age) and 18% severely stunted (<-3SD). Thirteen per cent of Pakistani children under-5 are wasted (<-3 SD weight for height) and 3% suffer from severe acute malnutrition (<-3 SD). One in four children (26%) is born with low birth-weight (less than 2.5kg). In addition, micronutrient deficiencies are widespread with high rates of iron-deficiency anaemia, zinc, iodine folic acid and vitamin A deficiencies having a particularly damaging impact on the survival, growth, development and productivity of pre-school children and pregnant women. Half (51%) of children under-5, years and 2 in every 5 (39%) pregnant women suffer from anaemia. Malnutrition is also prevalent among women of reproductive age with 13.6% being underweight, and 2.5% severely thin.[14-17]

Goal-2: Achieving primary education. The primary school enrolment has remained below 60% in 2008-09.[14] Although the literacy rate has shown marginal improvement, yet it remains far below of the MDG target.

Goal-3: Promoting gender equality and women empowerment. Even though the share of women's seats in parliament are substantially higher in Pakistan, women's share in non-agriculture and wage employment is far below the target of MDG 2015.

Goal-4 and 5: Maternal and child health indicators have improved, but big challenges remain: The under-5 mortality rate has fallen by 24% since 1990, but there has been no change in the poorest income quintile since 1990. Maternal mortality seems to be declining, but women in Pakistan still run a 1 in 80 chance of dying of maternal causes during their reproductive life. The total fertility rate has declined from 5.8 children per woman in 1990 to 4.1 in 2005 with improving coverage during 2003/07 in antenatal care (35% to 61%), skilled attendance at birth (24% to 36%), and proportion of fully immunised children (53% to 76%). Despite these improvements there is still a lot to be done - about one-fourth of children are not immunised, two-thirds of women are delivering without skilled attendance, and there is a large unmet need for family planning.[8-10,14-16]

Goal-6: Combating HIV, Malaria and other diseases. Pakistan has shown progress in human immodeficiency virus (HIV) and tuberculosis (TB) programmes. However, more attention is needed in malaria programmes.

Goal-7: Ensure environmental sustainability. There are 8 indicators in the category and Pakistan is meeting only one target; that is the number of cars using the compressed natural gas (NCG) target. Otherwise, in all other areas Pakistan is lagging behind: access to safe drinking water, access to sanitation, forest covered land , land protected for conservation.

Goal-8: Develop a global partnership for development to foster cooperation at bilateral and multilateral level for attaining the MDGs. The Official Development Assistance as per agreement was to increase to 0.7 per cent of GDP, but the developed economies are merely providing a 0.25 per cent of GDP.

Understanding Pakistan

Politically, Pakistan is facing an increased emphasis on provincial autonomy and devolution of authority to the provinces from the federal governments. The unanimous passage of the 18th amendment to Pakistan's Constitution by parliament and its signature into law by the president is a major political and administrative development. The amendment envisages devolution of authority from the federal government to the provinces and eliminates the 'Concurrent List' in about 40 areas, including health, which now stands fully devolved to the provinces. The structure of the Pakistan healthcare mechanism, the 18th amendment and its impacts need to be understood properly to see the failure to meet MDGs in the relevant context and to make suggestions for political restructuring of the healthcare system.[18]

There are concerns about the ability of provincial governments to assume effective authority in these areas. In the health sector, the federal government which finances about one-third of health expenditure in Pakistan, the amendment envisages significant changes with limiting or almost eliminating federal government's stewardship functions and devolution of its functions to the provinces, including the management and financing of key national programmes. It remains unclear at present how and when the existing programmes will be devolved and whether the policy, oversight, regulatory, monitoring and evaluation functions of the ministry of health (MOH) will remain.

The quality of care in public facilities is low, resulting in low utilisation of public health facilities. In addition to spending more resources, Pakistan also needs to manage the sector better and spend efficiently. Because of the lack of a clear strategy, expenditures are volatile. There have been large expenditures on hospitals planned in the Public Sector Development Programme (PSDP) that seem at odds with efforts to address the MDGs and improve equity. Further, the public financing system is highly fragmented with various entities being responsible for funding limited components and activities of a

programme in the health system. Such fragmentation weakens accountability and contributes to the inefficiency of delivery. The government could better connect the private sector to achieve national health objectives. Much of the improvement in access to prenatal and obstetrical care is due to bigger access to and use of the private sector. Taking advantage of private-sector growth, even in rural areas, the government could develop alternatives to increase poor people's access to private providers. It could also consider buying services, such as institutional delivery, from the private sector. Management reforms are needed as much as additional resources. Political sponsorship, as well as limited administrative authority, undermines the ability of lower level managers to link rewards and punishment to performance. Consequently staff are unaccountable, barely supervised, and have diminutive incentive for performance.[9,10]

In the last two decades there has been a considerable boost in the numbers and size of National Health Programmes in Pakistan. All are under the purview of the federal MOH. As happened in many other countries, such programmes in Pakistan benefited significantly from the Global Health Initiative (GHI) and development partner finances.

Presently there is no alignment of provincial policies with the national policy. We can work on favourably alligning the priorities of the National Health Policy and federal financing. This could be outcome or result-based. Hence, provincial policies would also follow the same pattern.

The federal government manages 41 per cent of total public expenditure in health. A summary of public health expenditure by the federal government and four provinces for 2004/05 is a relevant document (Table). Provinces accounted for more than 35 per cent and districts, the remaining 24 per cent. On average in 2004/05, Rs 387 of public funds were spent on each person for health and population in Pakistan, or 2.5 per cent of the total public expenditure. The federal government spending amounted to about Rs160 per person. Budgetary inputs and financing came from the federal and provincial governments, as well as the donors, while districts funded salaries and operational expenditure. At the other end of the decentralisation spectrum, the lady health workers (LHW) programme ran as a national programme and recruitment of the LHWs was the only decision made at the district level. In most cases, programme interventions initiated under federal programmes were managed by stand-alone units rather than integrated service delivery. National programmes were conventional examples of a deficiency of clarity in responsibility. Such national programmes included outreach and community-based preventive programmes, such as the LHW and immunisation programmes, as well as other communicable disease control programmes and, more recently, the Maternal and Neonatal Child Health Programme. These programmes are initiated by the federal government, which provides technical guidance, strategic directions and, to a variable degree, funding. As a result of decentralisation, the management and financial responsibilities have been shared among various levels of government, but not uniformly. The immunisation programme is perhaps the most devolved programme but it still retains a centralised working system.[19-21]

Table-1: Expenditure (%) by different levels of government. (2004-2005).

	Share in Total Public Health Expenditure (%)	Share in Non-Federal Public Health Expenditure(%)	Share of Population(%)
Punjab	37	49	57
Sindh	16	30	24
NWFP	9	12	14
Baluchistan	7	9	5
Total	59	100	100
Federal	41		
Province	35		
District	24		
Total	100		

Source: National Health Accounts, 2005- 2006. Government of Pakistan.

The changes predict a limited role of the federal government; devolution of stewardship functions to the provinces; transfer of management of national programmes; management disease control and surveillance and also possible decrease in federal financing for health. This would need significant changes at the provincial level for effective management, including administrative reorganisation to manage stewardship functions; strengthening management structures presently responsible for implementation management functions of national programme; increasing financing for the national programmes and health to maintain at least same level of health expenditures for an increasing population and developing structures and systems for disease control and surveillance. All of the above have significant implications for MDGs — if the system is devolved as envisaged and provincial systems are not strengthened or reorganized - it is likely that Pakistan may slip further in the achievement of MDGs.[14,15,22-26]

There are anomalies in the 18th amendment - the main being it almost takes out federal stewardship functions, for instance disease control and surveillance are federal functions as the cross provincial and international boundaries. Pakistan is also signatory to international health regulations (IHR) which expect the state to report and take actions on epidemics. In a devolved systems, it is not clear who will be responsible for ensuring that Pakistan fulfills IHR requirements. The anomalies in 18th amendment like these need to be sorted out.[11]

Issues and Challenges

The MOH and the Department of Health (DOH) are facing problems in carrying out even their core stewardship functions. The current issues plaguing them have been identified mainly as lack of dedicated and capable officials; lack of in-service training for the staff that is available; lack of transparency in the system and performance assessment of officials; little or no resources applied to building capacity; and a need for development of a priority-based system in line with the national health policy.

Recommendations

Pakistan needs to work on the development of a merit-based system with adequate decision-making space and a transparent system for accountability to combat the problems underlying the inefficiency of the present organisational structure. This would assist in overseeing and managing the performance and the effectiveness of the provinces in tasks assigned to them. On an individual level this will not only enhance employee satisfaction, but also serve as an incentive to be dedicated and honest to their work. Also required is the pulling in of financial resources from the federal government to focus on improving provincial policies and align them with those at the national level. This will integrate and make the health infrastructure of the country more efficient. We also need implementation of an integrated budgetary process that would enable decisions about the capital budget to take into account its recurrent cost implications so that capital investments produce the desired results. The current un-integrated approach separates decisions on the capital budget from the recurrent budget leading to large-scale inefficient use of available resources. A holistic view which places respective priorities on resource allocation based on the need of the system is needed. A performance-based contracting system and increased autonomy is also suggested. All these measures would help achieve MDGs 1, 4 and 5. And, hence, indirectly by improving the health of mothers and children would facilitate MDGs 2 and 3.

Pakistan needs to remove anomalies of the 18th amendment with some key stewardship functions remaining with the federal government. Devolution should be planned over three to five years so that it may not jeopardise the achievement of MDGs. An assessment at the federal, provincial and district levels with a focus on functions and kind of organisation structures and staffing is imperative. We need the Essential Health Services Package at all the three levels of primary healthcare. The implementation of this across-the-board approach may cost a lot, and it would be helpful to look for alternative means of health financing.

References

1. Local Government Plan. National Reconstruction Bureau 2000, Ministry of Health, Islamabad. Government of Pakistan; 2001.
2. National Plan of Action for the Control of Micronutrient Malnutrition in Pakistan. Micronutrient Initiative and Nutrient Wing, Islamabad. Government of Pakistan; 2005.
3. Lee R, Mason A. Population aging, wealth, and economic growth: Demographic dividends and public policy. Background Paper for the World Economic and Social Survey, Department of Economic and Social Affairs. New York: United Nations; 2007.
4. Pakistan Demographic Survey (2004 and 2005), Federal Bureau of Statistics, Ministry of economic Affairs and Statistics, Government of Pakistan; 2005.
5. Pakistan Demographic and Health Survey (2006 and 2007), National Institute of Population Studies Islamabad, Pakistan Macro International Inc. Calverton, Maryland USA. Government of Pakistan; 2008.
6. National Tuberculosis Control Program. Ministry of Health. Government of Pakistan. (Online) 2010 (Cited 2011 Feb 20). Available from URL: www.ntp.gov.pk.
7. Poullier JP, Hernandez P, Kawabata K. Patterns of Global Health Expenditures: Results for 191 Countries. Health systems performance assessment: debates, methods and empiricism. Geneva, World Health Organization. 2003.
8. Pakistan Demographic Survey (2003 and 2005), Federal Bureau of Statistics, Ministry of economic Affairs and Statistics, Government of Pakistan; 2005.
9. Gill Z. Tracking the millennium development goals. Pakistan Demographic and Health Survey, TACMIL Health Project, USAID Pakistan; 2009.
10. World Development Indicators (WDI) data, The World Bank. (Online) 2012 (Cited 2010 Feb 20). Available from URL: http://data.worldbank.org/data-catalog/world-development-indicators.
11. Baley T, Couffinhal A, Haq I, Kazi S, Loevinsohn B. Pakistan sector report: delivering better health services to Pakistan's poor. Washington, DC: World Bank, 2010.
12. Pakistan Ministry of Finance. Economic survey of Pakistan 2010: flood impact assessment. Islamabad: Planning Commission, 2010.
13. Jalal S. Improving health: can Pakistan prioritise? Lancet 2012; 379: 410.
14. The Millennium Development Goals Report 2008, United Nations, New York; 2008.
15. Attaining the Millennium Development Goals in Pakistan: How Likely and What Will It Take to Reduce Infant Mortality, Child Malnutrition, Gender Disparities and to Increase School Enrollment and Completion? Report published for the South Asia Human Development Division (SASHD), World Bank; 2005.
16. Bossert TJ, Mitchell AD. Health sector decentralization and local decision-making: Decision space, institutional capacities and

accountability in Pakistan. Soc Sci Med 2011; 72: 39-48.
17. Bossert TJ, Mitchell A, Mian N, Janjua MA. District-level Decision Space Analysis in Pakistan: Relationships between decision space, capacities and accountability in five health functions with selected district performance measures. Pakistan Initiative for Mothers and Newborns; 2008.
18. Nishter S. National health Policy 2010. Heartfile. (Online) 2010. (Cited 2011 Jan 20). Available from URL: http://www.heartfile.org/pdf/73_National_Health_Policy_2010.pdf.
19. Charlton J, Cyan M, Hasnain Z, Manning N, Porter D, Sharif H. Devolution in Pakistan: An Assessment and Recommendation for Action . Asian Development Bank , Department for International Development and World Bank; 2004.
20. Evans and Khan. Review of the Policy Development, Budgeting and Financial Management in the Ministry of Health, Pakistan. Mid-Term Budgetary Framework (MBTF) Project, Technical Note 4, Price Waterhouse Coopers; 2003.
21. Economic Survey of Pakistan, 2006/07. Finance Division, Economic Advisor's Wing, Government of Pakistan, 2008.
22. Social Policy and Development Center, Social Development in Pakistan: Devolution and Human Development in Pakistan, Annual Review 2006-07, Karachi, Pakistan.
23. United Nation 2006 Department of Economic and Social Affairs, Population Division, World Population Prospects: 2006.
24. World Bank. Partnering With NGOs to Strengthen Management: An External Evaluation of the Chief Minister's Initiative on Primary Health Care in Rahim Yar Khan District, Punjab, South Asia Development Series, No. 13 Washington; 2006.
25. World Bank, South Asia Region, Pakistan: Towards A Health Sector Strategy, Report No. 16695-PAK, HNP Washington, DC; 1998.
26. Haq I. Project Information document concept stage. World Bank. Pakistan; 2010.