HEALTH SYSTEMS GOVERNANCE CHALLENGES AND OPPORTUNITIES AFTER DEVOLUTION

Critical health indicators in Pakistan such as maternal (276/100,000 live births) and child (78 per 1000 live births) mortality are among some of the worst in the World. In part this is due to low health spending which is around 3.36% of the total GDP, of which more than 70% of the health expenditure is out of pocket.

The Government spends Rupees 82.5 billion (USD 825m) annually or around Rupees 450 USD 4.5) per capita. These modest allocations are further compromised by poor planning, mismanagement of funds, and inefficient implementation. This sets a downward cycle of underperformance at public facilities, with majority of the people seeking care in the private sector, and thereby rendering the very large network of government clinics and hospitals underutilized and costly.

During 2000-2010, key health indicators have mainly languished. A crucial element of these management problems was central planning by the Federal Ministry of Health which was considered to be far removed from service delivery sites and therefore not in tune with implementation issues. The 18th amendment supposedly aimed to address many of these issues and devolved health to the provinces. This brief assesses the initial experience of health following devolution and proposes suggestions to build on this opportunity.

The Pre-Devolution Scenario

Until recently, the overall planning and funding for health was done centrally by the Federal Ministry of Health which ran most (66% funding) of the prevention programs and a fifth (20%) of curative services (i.e. hospitals, clinics and other medical care facilities), and took up around a fifth of all administrative charges. The Provincial Health Departments, which managed health facilities, also exercised centralized control within their jurisdiction over allocations, human resource management and supplies. District Health Administrations which actually implement much of the preventive and curative services merely followed orders from the provincial governments.

The Post-Devolution Scenario

Since the Federal Ministry of Health was abolished (with some caveats) in July 2011 and its functions devolved to the provinces, the provinces have assumed planning and allocation responsibilities. While some of the preventive programs are still funded by the Federal Government – as their funding documents or PC-1s were already in place, they were allowed to run out their course (2014) – the provinces receive a block grant called the National Finance Award (NFC) from which they must allocate to health and other sectors.

The experience of Health and Population Welfare Departments has varied in different provinces. Some have allocated sufficient funds to them, while others have struggled. As the provincial authorities are conduct tasks such as procurements or planning on their own and learning necessary rules and procedures for the first time, there are some obvious “teething” problems. The main issue of lack of feedback from district level or point of service and the lack of involvement of beneficiaries or district authorities in decision making remains nearly unchanged even after devolution.

SALIENT POINTS AND RECOMMENDATIONS

- Decentralization to Districts of Planning and Allocation
- Incorporation of Systematic Evaluations into the overall Monitoring and Evaluation process
- Prioritization and assignment of services that the Government should provide, based on their maximum impact
- Increased Transparency and Control by Electronic publication of government processes including Recruitment, Promotions, Fund Flows and Procurement
- Citizen Participation using Citizen and Community Scorecards
- Managing Human Resources based on a system of merit

Governance Issues Requiring Reforms

- Input based Programming: Nearly all programming is based on inputs (and some outputs), with little connection to health outcomes, therefore programs ultimately don’t respond to the needs of target beneficiaries or deliver low results.
- Central Planning: Despite the recent devolution, the overall planning, human resource management and fund allocation remains centralized at the Provincial Government level. District authorities that actually implement health programs have little autonomy for decisions about their budgets, human resources or the nature of the services they would prioritize (based on feedback from local communities). In this regard:
  - The information flows within the health system are limited and still top down. Point of care and field implementers seldom get to have their concerns or suggestions heard by their managers.
  - Views, opinions and preferences of beneficiaries of programs or services are not used by the system to improve or alter services or programs.
  - There is little feedback to field level implementers about the nature or quality of their work.
- Weak Monitoring: The current monitoring systems rarely use systematic evaluations or analyze available data. The few evaluations that do occur seldom follow scientifically rigorous standards (and therefore produce unusable information) and their results are rarely used to modify ongoing programs or to guide future decisions or plans.
• **Tackling Corruption** in the public health system is pervasive and has increased over time. It deeply undermines health outcomes and health sector performance.

• **Merit Based System** - Human Resource issues of non-merit based recruitment, deployment and promotion breeds inefficiencies, resentments and lack of morale. Lack of subject expertise among senior managers leads to lack of objectivity in programs leading to lack of performance.

• **Political Interference** and Patronage limit any attempts at reform and add to the problems discussed above.

• **Prioritization Must** - Public sector programs form an important safety net for the poorest citizens. This safety net function is not fulfilled when the public sector health programs seek to provide all measures of services from vaccines to transplant. With limited resources, what actually happens is that no service is properly delivered to anyone.

**Going Forward Suggested Reforms**

The recent devolution of the Health Ministry is great opportunity for reforms to improve public sector performance. However, in order for any reforms to succeed, a departure from the past is needed.

• **Devolution of Decision Making** of planning, fund allocation and human resource management to district governments

• **Measuring Results not Fund Utilization** Develop and implement better mechanisms to measure performance of individuals and programs in terms of their ability to achieve actual outcomes (such as total number of women availing birthing or family planning services in the public sector) rather than simply reporting performance on funds used or persons hired.

• **Make use of electronic Reporting** for transparency of processes and electronic record keeping. For example, making procurement and bidding processes online will allow these processes to be monitored by the public and enhance accountability.

• **HR Reforms** - initiate the reform process by defining job descriptions and ensuring that employees understand these. Having explicit and measurable benchmarks to measure performance which in turn guide promotions based on merit as opposed to tenure will improve performance.

• **Specialization** is the hallmark of modern economic systems. Health programs should be managed by subject specialists with support from management experts with business experience.

• **Prioritize a Basic Set of Services** Departments of Health should prioritize those services that they absolutely must deliver and can cause the most impact with such as childhood immunization, safe births and family planning rather than maintain a huge and inefficient network of costly and underutilized hospitals and clinics.

• **Evidence based Advocacy** Public sector should improve their advocacy with Finance and Planning Departments, using tools such as cost effectiveness/cost utility analyses to make their case for increased funding for needed programs and by objectively demonstrating performance to ensure continued funding.

• **Community Oversight** Involve communities in oversight over local health facilities by using community scorecards^4^ and use the results of the scorecards to determine funding levels of facilities and to reward or promote personnel.

• **Contracting out** of Government services is being increasingly used to improve performance and reduce costs. This can be attempted for management of health facilities.

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1 National Health Accounts 2007-8. Pakistan Bureau of Statistics

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