SHORT COMMUNICATIONS

Prioritized Targeting or Mile Wide, Inch Thin: Time to Strategize Public Sector Health Investments

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The total health care expenditure in Pakistan is Rs 185 billion (USD 3.08 billion), of which the private sector spends Rs 121 million and public sector spends Rs 59.5 million (1). This spending which comes to around 2.2% of the GDP or around USD 19 per head annually is among the lowest in the region. The government's share of this whole is around 0.6-0.7% of the GDP (2) and has largely remained unchanged over the years due fiscal and political constraints.

Public and private sectors combine to provide a range of healthcare services in Pakistan. The public sector provides curative services from a large infrastructure of nearly 15,000 health facilities and around 100,000 lady health workers that provide outreach services at the doorstep, and is the near exclusive provider of preventive health services from its vertical health programs e.g. (MNCH, EPI, Tuberculosis etc.). The private sector while larger in scope provides almost exclusively curative services via many different types of private providers that include quack, hakims, homeopaths along with doctors and as can be expected, slightly favors a more urban and affluent clientele (Khan et al, under review).

Approximately 25% of the government's health budget on preventive programs (1) and accounts for nearly all preventive health investment, except around 5% of vaccination (3) and around 65% of family planning services (4) that are provided by the private sector. Thus, it appears that for many of the essential preventive services, the government is the only sole provider/ guarantor. On the other hand, the public sector contributes only a small fraction of curative health services. For example, only around 21% of all outpatient visits in 2008 happened in the public sector and that this contribution has hardly changed over the years (5,6). The one caveat is that the reliance on government services is somewhat higher in rural locations and among the poorest (Khan et al, under review).

The critical point is that the public sector is the near exclusive provider of preventive services and predominant provider of curative services to the poorest. For almost all the rest, its contribution to curative care is modest. Yet, many inefficiencies exist in public sector operations. Many public facilities remain underutilized and yet salaries and overheads must be paid in full, thus yielding inefficient use of healthcare resources. This was addressed by contracting out nearly half of the public sector first level facilities to an NGO and yet all the administrative personnel in these districts were retained, in addition to those the NGO employs, thus creating massive duplication of personnel and expenses.

Should public sector funds be prioritized where they do the most good, i.e. for preventive services and curative services for the poorest and in the most remote locations and work with the private sector on innovative models to cover the rest of the population such as vouchers or insurance that may be availed at private outlets, perhaps as an add on to one of its current schemes such as zakat or Benazir Income Support Program. It can also demand certain standards of quality of care at these facilities. innovative delivery models such as contracting out services (7) or some model of incentives can enhance healthcare access for the poor while reducing the demands on public sector budgets.

Regardless of particular choices, some sort of strategic prioritization is desperately needed. Even by diverting nearly 50-60% of its funds to curative care, the government currently captures less than 10-21% of these services (1). On the other hand coverage of essential preventive services languishes. For example, full coverage with the modest current repertoire of vaccines has never exceeded 70% (6). Only around 14% of all eligible women receive any family planning services and only a third of these do so from a public sector source (4). Indeed, the contraceptive prevalence rate has risen by 0.5% annually in the past 50 years (4,8) with a quarter of women expressing an unmet need for contraception and the government's contribution of services remaining nearly static (4,9). Some of these issues relate to ineffiencies but largely it's a funding issue. There is just so much that can be done with the current USD 6 per capita annual funding in the public sector (1), particularly when a portion of even these meager

resources are squandered due to inefficiencies.

Health has moved from simply managing ailments to providing health as a social good to being a social protection, justice and equity issue. While Pakistan continues to strive to meet these commitments to its people, it will have to take stock of what has been learned. A key lesson of the past 65 years is the meager improvement in virtually any health outcomes despite investments and the rather large infrastructure. The recent devolution of health to provinces presents a unique opportunity to re-address some of these reforms and providing some of these essential services. That said, none of these are any substitute for increasing funding for health to bring them at par with other poor countries in the region, but that will require doubling or tripling of health budgets and under the current political circumstances, this seems unlikely.

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