# HEALTH SYSTEMS GOVERNANCE AFTER DEVOLUTION

Critical health indicators from Pakistan such as the rates of maternal (276/ 100,000 live births) and child (78 per 1000 live births) mortality are among 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[1] or around Rupees 450 (USD 4.5) per capita. These modest allocations are further compromised by poor planning, mismanagement of funds and inefficient implementation. These led to underperformance at public facilities, forcing people to turn to the private sector for healthcare, rendering the very large network of government clinics and hospitals underutilized and costly. Consequently, key health indicators languished in the decade of 2000-10. A crucial element of these management problems was central planning by the Federal Ministry of Health which was considered to be too far from service delivery sites and therefore not in tune with implementation issues. This was supposedly addressed by the 18th amendment to the constitution that devolved health to provinces. This brief assesses the brief 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 that the Federal Government discharged. 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 – the provinces receive a block grant called the National Finance Award (NFC) from which they must allocate to health and other sectors. The experiences 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 conducting some tasks such as procurements or planning on their own and learning necessary rules and procedures for the first time, there are some "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.

## Governance Issues Requiring Reforms

- Nearly all programming is based on inputs (and some outputs), with little regard to health outcomes, therefore programs ultimately don't respond to the needs of target beneficiaries
- Despite the recent devolution, the overall planning, human resource management and fund allocation remain 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 usually 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.
- The current monitoring systems hardly ever 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.
- Funding for health is limited which further diminishes the productivity of health facilities and staff. Some provinces have a low priority for health and population and therefore have allocated low levels of funding to these.

## SALIENT POINTS AND RECOMMENDATIONS

- **Decentralization** of Planning to Districts along with Autonomy for Financial and Personnel Decisions
- Incorporation of Systematic Evaluations including the use of existing program data into the overall **Monitoring and Evaluation** process
- Prioritization of which 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

- Corruption in the public health system is pervasive and has increased over time[2]. It deeply undermines health outcomes and health sector performance.
- Human Resource issues of non-merit based recruitment, deployment and promotion breeds inefficiencies, resentments and lack of morale.
- Government programs are often managed by career bureaucrats who move from program to program without gaining subject expertise. They are aided in each program by subject specialists who are usually restricted to middle management. 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.
- Procurement of personnel and services is based on an opaque system that while following some semblance of rules does not allow oversight.
- 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[3].

## Suggested Reforms

- Further devolution of planning, fund allocation and human resource management to district governments
- 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.
- Clearly define needs and prioritize/ allocate funds to reflect these needs. Programs should be monitored in terms of their ability to meet these needs.
- Make use of electronic media 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.
- Manage human resources - 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.
- 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.
- 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.
- 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.

## Stepping Forward

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. Specific recommendations for reform are presented. Better governance systems need to be developed to improve health service outcomes with the key role of the government in health delivery rethought. To achieve better health outcomes, Provincial Departments of Health should redefine their roles from being actively engaged in budgeting and day to day management to facilitating quality control and overall monitoring of the public health system.

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

2 Transparency International, Pakistan Report 2012.

3 Ahmed S, Khan AA and Khan A. Prioritized Targeting or Mile Wide, Inch Thin: Time to Strategize Public Sector Health Investments. Dec 2011, Pak J Pub Health 1(1) 59-60.

4 Misra V and Ramasankar P. Improving Health Services through Community Score Cards. August 2007. Social Accountability Series, Note No.1, World Bank.

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