

# **Report of the Health System Review Mission – Pakistan**

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## **Acronyms**

BHU	Basic Health Unit
CHM	Community Based Health Management
COME	Community Oriented Medical Education
CPD	Continuous Professional Development
CPSP	College of Physicians & Surgeons Pakistan
DCO	District Coordination Officer
DFID	Department for International Development
DG	Director General
DOH	Department of Health
DTPS	District Team Problem Solving
EDO	Executive District Officer
GAVI/HSS	GAVI Health System Strengthening
GOP	Government of Pakistan
HDI	Human Development Index
HMIS	Health Management Information System
HRH	Human Resources for Health
HSA	Health Services Academy
IMF	International Monetary Fund
LHW	Lady Health Worker
MTBF	Medium Term Budgetary Framework
MOH	Ministry of Health
NHIRC	National Health Information Resource Center
NHPU	National Health Policy Unit
NWFP	North West Frontier Province
PC-1	Planning Commission-1
PIMS	Pakistan Institute of Medical Sciences
PM&DC	Pakistan Medical and Dental Council
PMRC	Pakistan Medical and Research Council
PRSP	Poverty Reduction Strategy Paper

## **Key Messages**

### **A. Challenges to the development of health system in Pakistan**

- There is a need to develop a clear vision for the health sector that addresses the major health problems relying on a well performing health system and is congruent with the GOP's Vision 2030;
- The institutional capacity of the federal MOH and the provincial DOH to undertake essential public health functions needs to be developed for improving the overall governance of the health system;
- The federal MOH should demonstrate greater leadership in developing a unified vision for health and in aligning its development partners to effectively contribute towards its achievement;
- There is a lack of clear long-term vision for human resource development, which is necessary to address the imbalances in health workforce in the public and private health sector;
- Health care financing in Pakistan is inadequate and inequitable and there is a general lack of information and understanding among policymakers in this key health system function;
- Public sector allocation to health at the primary, secondary and tertiary levels is not based on an assessments of costs and benefits in terms of potential health gains;
- There is inconclusive evidence on the impact of devolution on the access, efficiency, equity and quality of health services in the districts and there is the need to better define the role of the governments at the federal, provincial and district levels;
- The role of non-state sector and the communities in the delivery of health services needs to be reviewed and new innovations and interventions in public private partnerships tested out before scaling them up;
- The quality of care is not high on the health policy agenda of the federal MOH and the provincial DOH and a system of accreditation of health facilities does not exist;
- The health information system is fragmented. Each vertical program has more or less its own information system and none covers the private health sector. There is no organized system of disease surveillance and there is limited capacity to use information for decisions. The overall capacity to undertake health policy and systems research is deficient.

### **B. New thinking and initiatives by the Government of Pakistan**

- There is increasing awareness about the need to invest more in the formation of social capital through increased public spending on health and education benefiting from the sustained economic growth in the country;

- Equity and social protection are high on the political agenda as reflected in the poverty reduction strategy and safety nets;
- New reforms are being considered to improve governance particularly in the public sector;
- The government is preparing a Vision 2030 document that provides for a long term vision and strategy for national development and health is included in this initiative;
- New reforms are being implemented at provincial and district levels aimed at increasing access to primary health care and at improving public private partnership for health development;
- There is greater interest among development partners to align with MOH's agenda using health system strengthening as a platform.

### **C. Priority areas for support to Health System Development**

- Clear evidence based vision for health development as part of a comprehensive socioeconomic agenda;
- A well financed and equitable health system that progressively reduces out of pocket payment for those who cannot afford, secures financial risk protection and protects the poor from catastrophic health expenditures;
- A better managed and regulated public private mix that harnesses the private health sector to help achieve public health goals;
- A balanced, skilled, well distributed and motivated health workforce that is planned, produced to meet the needs of the public and the private sector and works in an environment that gives them incentives to address the health problems of the population ;
- Improved access to a well defined package of quality health services that tackles the major burden of disease, is well understood by the population, and targets the health needs of the poor, remote and the vulnerable segments of the population;
- A well functioning district health system aligned to the devolution process where the health managers have the necessary skills and capacities to engage communities to plan and deliver health services;
- A health information system that provides valid, reliable and disaggregated information on important health determinants, programs and system functions for informed decisions and is backed up by an effective disease surveillance system in the country.

### **D. Strategic directions for health development:**

- The development of a clear and comprehensive vision and strategy for health development based on the principle of universal coverage and supported by strong evidence to fill the knowledge gaps in key areas such as health care financing, the role of the non state sector and how to incentivize improvements in health services delivery;

- Institutional strengthening of the federal MOH, provincial DOH and district health offices on improved governance, standard setting, regulation, strategic planning and management;
- National commitment to increase public spending on health from 0.5 % to 2 % of GDP and to reduce out of pocket spending from 70 % to 60% over five years in order to reach the WHO target of 5 % GDP expenditure on health and of Commission on Macroeconomics and Health to secure universal coverage to an essential package of health services;
- Assessment of social protection through analysis of household data on health expenditure, utilization and catastrophic health expenditure;
- Feasibility studies to improve financial risk protection through prepayment schemes including community based health insurance;
- Design of vision for human resource development including policy, long term strategic thinking, management and evaluation;
- Strengthening of nursing leadership and increased production of nurses, midwives and community midwives to dramatically increase the proportion of deliveries by skilled birth attendants;
- Supporting MOH' s initiatives aimed at improving access to PHC by testing new innovations and approaches and then scaling them up;
- Strengthening decentralization by investing in capacity building, especially at provincial and district levels in planning, management, physical, personnel and financial, monitoring and evaluation, and the use of economic tools such as costing and cost analysis;
- Promotion of a culture of quality assurance and improvement in service delivery at all levels of care.

#### **E. Coordination and policy dialogue:**

- The MOH will involve its development partners, including WHO, to realign their technical and financial assistance to the health reform agenda;
- The MOH while maintaining its leadership role shall invite other stakeholders to participate in the policy debate on health development;
- WHO will contribute to the national policy dialogue and will assist the MOH to coordinate the input of various development partners.

# Report of the Health System Review Mission to Pakistan

WHO-UNICEF-WB-DFID  
February 19-28, 2007

## 1 Introduction, Objectives and Process

The health system in Pakistan is currently going through several reforms at the federal, provincial and district levels particularly to improve the delivery of health services to the population. These reforms are part of the overall development framework that endeavors to raise the importance given to the social sectors, particularly the health sector, in the country to address their poor performance despite a high level of economic growth in recent years. For these reforms to be successful, it is essential that these are based on clear evidence, are aligned to an overall vision for health development, and make a difference to the health of the population that is in greatest need for essential health services.

WHO fielded a mission to Pakistan from February 19-28, 2007 to initiate a policy dialogue with the Ministry of Health, Government of Pakistan and its development partners on key issues related to the development of the health system in the country. Partners from other development agencies who participated in the mission included UNICEF, the Department for International Development (DFID) and the World Bank. The objectives of the mission were to: (i) update knowledge and understanding on health system within the overall development context based on current evidence; (ii) review reforms undertaken by the government with the support of its development partners; and (iii) propose strategies to take forward the health system reform agenda and gain the commitment of the government. The terms of reference of the mission and its members are given in Annex 1.

The review process involved an in-depth desk review of development and health policy documents by the mission team. This was followed by a visit to Islamabad, the provinces of the Punjab and the North West Frontier Province and the district of Attock. During the mission, meetings were held with policymakers at the federal and provincial levels; senior managers in the Federal Ministry of Health and Provincial Departments of Health; District Government authorities and its health facility and outreach staff; heads of public sector institutions; development partners; and representatives of the civil society engaged in health and health related activities in Pakistan. Annex 2 provides a list of the individuals met and the institutions visited during the mission. The review did not include an assessment of the pharmaceutical sector, which will be undertaken separately. The findings of the mission were presented and discussed with the Federal Ministry of Health and its development partners in a wrap-up session.

The health system review in Pakistan does not present new information, most of which is already known to national policymakers. However, it does follow a new way of looking at public health problems in Pakistan using a 'health systems lens'. It is hoped that the *systems approach* advocated in this review shall complement the already well developed *programmatic approach* to tackling public health problems in Pakistan.

The team gratefully acknowledges the interest shown at all levels of the government and its partners during the mission and the effort undertaken by the MOH in organizing this visit. This report is one of the deliverables of the mission. This will be followed up with the development of several proposals for implementation for the strengthening of various health system components in Pakistan.

## 2 Health System Performance and Health Outcomes

Pakistan's health outcomes are poorer than desirable and are unlikely to meet many of the targets set out in the MDG health related goals unless the government undertakes several far reaching measures. Among these, measures to improve the performance of the health system are essential for the timely achievement of MDG health related goals. Table 1 provides selected indicators that provide an overview of the performance of the health system and achievements of health outcomes as basis for the analysis that follows.

**Table 1 Pakistan's Health Outcome and Health System Indicators**

Indicators	Years				
	1990	1996	2000	2002	2005
<b>Health Outcomes</b>					
• Life expectancy	59.1	62.5	63.0	63.6	64.0
• Infant mortality rate	96	86	85	82	77
• Under 5 mortality rate	138	120	118.2	117.6	111.2
• Maternal mortality ratio	550	300	450	350	350
• Population growth rate		2.7		2.1	1.9
• Children with low weight for age	40.1	30	30	30	
• Low birth weight	25	25	25	37	
• EPI coverage (Children 12-23 months, fully immunized – based on recall and record)		45	49	53	72
• Pregnant women attended by trained person		27	31	43	41
• Postnatal care		11		9	23
• Contraceptive prevalence	12	22	28	32	34
<b>Health System Performance</b>					
• National health policy documents	1990	1997		2001	
• Total health expenditure as percent of GDP		2.5	2.8	2.6	2.4
• Total health expenditure per capita (average exchange rate)		16	14	13	13
• Total government health expenditure per cap		X	X	X	X
• Private expenditure on health as % of total expenditure on health		67.4	67	65.3	72.3
• Physicians per 10,000 population		5.7	6.7	6.9	8
• Nurses and midwives per 10,000 population		3.4	4.2	4.6	3
• Hospital beds per 10,000 population		5.4	6.7	6.9	6.9
• PHC facilities per 10,000 population		1.2	0.8	0.9	0.9
• PHC facility utilization rate					

### **3 Current Issues and Initiatives**

#### **3.1 Social and economic determinants of health**

*Macroeconomic situation.* Pakistan's GNI per capita of approximately US\$ 700 is well in line with regional South Asia averages. It has grown substantially at more than 6% annually over the last five years. The poverty level in Pakistan increased from 26.1 percent in 1990/1 to 32.1 percent in 2000/01. Despite the impressive economic performance Pakistan has not been able to adequately reverse poverty, which according to the GoP, was estimated to be at 24% in 2004/05. These figures hide the gross distribution inequalities especially the level of poverty among the rural population. Beyond formal poverty there are however large number of households living just above the poverty line.

Due to stringent macroeconomic adjustments, better financial and budget management, remittance from abroad and sustained growth, the macroeconomic situation of the country has improved since the end of the 90s. Since 2004, Pakistan has not received IMF support under Poverty Reduction and Growth Facility that had previously supported the reforms. In the FY 2006-07, 22.5 % of Pakistan's budget was devoted to debt servicing but Pakistan is not among Highly Indebted Poor Countries. The improved level of foreign reserves along with the increased commitment of donor has increased the fiscal space for the provision of necessary social investments and for vital infrastructures. The increased fiscal space has led to some increase in overall expenditure on health but continues to be less than that projected in the Poverty Reduction Strategy Paper (PRSP).

*Social sectors.* The population growth is estimated at 2.4% per annum and poses a challenge to the government to create jobs and to provide health and education services. Pakistan ranks 134 in the 2006 UNDP HDI (Human Development Index) and most of its social and development indicators compare poorly with countries of similar level of economic development. According to the UNDP Development Report 2006, in the year 2004, 62% of males above 15 were literate and 32% of women could actually read and write. Literacy trends are however encouraging: literacy among women 15-24 of age has increased to 54.7%. Pakistan's expenditure on education decreased from 2.6% of GDP in 1991 to 2.0% in 2002, however, the government has renewed its commitment to increase it to 4% by 2012. UNDP estimates that in 2004 around 90% of the population had access to improved water sources and almost 60% had sustainable access to improved sanitation facilities. The latter is a substantial improvement from 37% in 1990.

*The Public Sector Response.* The GoP prepared the interim PRSP in 2001 to tackle the major developmental challenges outlined, followed by a full fledged poverty reduction strategy paper (PRSP 1) in 2003, and a new PRSP is currently under preparation. The PRSP 1 outlines the broad government framework and the strategies for poverty reduction based on four main strategic objectives: (a) accelerated economic growth within the limits of macroeconomic stability; (b) improved governance at all levels through civil service reform; (c) investments in human capital; and (d) the provision of services targeted in particular to the poor and the vulnerable.

Under the overall umbrella of PRSP the government in recent years has undertaken several initiatives to improve the social sector profile of the country. There is an active team of social sector experts in the Planning Commission lead by a seasoned bureaucrat that covers health, education, population and nutrition sectors along with experts in the area of poverty reduction, decentralization and good governance. The team is engaged in several initiatives that include the development of the annual public sector development program (PSDP); the preparation of three year medium term budgetary framework (MTBF) in which health and population have been the first to adopt this approach; and for ensuring the social sectors get their due importance in the Vision 2030 document being prepared by the Planning Commission. Much of the above are federally led initiatives and there seems to be disconnect in terms of a serious dialogue with the provinces on these matters. In addition, the chapter on health in the Vision 2030 document needs to be considerably strengthened to provide a clear vision for health that is congruent with and contributes to the overall vision for the overall socioeconomic development in the country.

### ***3.2 Health System Governance***

There is an increasing commitment to health development in Pakistan, which is also reflected in increased amount of resources allocated to the development budget for health at the federal and provincial levels. It was difficult to corroborate during the field visit, whether increased resources are reflected in improvements in per capita budgetary allocations to the districts. A new health policy is on the anvil in Pakistan and is expected to be announced in 2007. In addition, health is considered a priority in the Vision 2030 of the government for which work has been initiated in the Planning Commission.

Health system reforms are concurrently being undertaken in the two provinces visited by the mission. In NWFP, the reforms range from financing of the health sector, contracting out and improving the quality of health services, and developing a policy on human resource. The reform process is assisted by the World Bank with technical assistance from the German Agency for Technical Cooperation and DFID. In Punjab, the reform process is focusing on improving primary health care services by providing financial incentives and improving salaries of health professionals, creation of positions for midwives and lady health workers at BHU levels, provision of medicines and continuous professional development. There is however lack of harmonization among the provinces in the reform process and the federal government has so far not fulfilled its coordination function.

A national health policy unit was established in the federal MOH in 2004 with the technical assistance of WHO and financial support of DFID. The unit is in early phase of development. Its role within MOH organizational structure needs to be institutionalized and its capacity both in terms of human and financial resources needs to be strengthened for it to deliver on its mandated role of furnishing evidence for the much needed health policy and system reforms in the country. Despite the many constraints, the NHPU was able to constitute a National Health Policy Council, contribute to the health sector reform agenda for the Pakistan Development Forum 2006, and is now playing a more proactive role in the formulation of the new national health policy. In addition, its relationship with provincial DOHs and their health planning and reforms unit needs to be strengthened. The recruitment of staff in recent months provides some hope but there are concerns that the project might

expire on June 30, 2007 unless the new PC-1 of the NHPU is approved and funded by government or another development partner.

The process of development of the new national health policy has been led by the Pakistan Health Policy Forum, an NGO-led forum, which brings together the Government, development partners, and civil society through a consultative process with the provinces and other stakeholders. Based on discussion with the coordinator of the Forum, it seems that the new policy has followed a balanced approach to the importance of health systems and programs. It is critical that the NHPU MOH plays an increasing role in the formulation of the national health policy as this has indeed to be a government led process. There are indications that the Policy Unit and the Forum are collaborating and there will be a smooth 'handing over' of the policy document before it is finalized and announced by the federal MOH.

Another important initiative is the establishment of a high level National Commission for Government Reform, which has a sub-committee on health. The committee is considering several reform initiatives in health that focus on good governance to improve the quality of essential health services. These reforms are essential and needed to bring rapid improvements in health services at the point of delivery. At the same time there is a need to review and reform the organization and functioning of the federal MOH, provincial DOH and district health offices to address some of the underlying governance issues that are responsible for the poor health services in the public and the private sector. In this regard essential functions such as institutional mechanisms for strategic health planning, regulation and standard setting, health information and its use, and disease surveillance need to be strengthened at all level of the public health sector.

Several bilateral donors led by the DFID and USAID and multilateral development agencies are active in the health sector in Pakistan. There is a forum of donors in which all big and small international health development agencies discuss health issues. However, there is a gap in their shared understanding of the health system issues in Pakistan and there is a lack of collective dialogue with the federal and provincial governments on these issues. In recent years there have been increasing opportunities for a dialogue between the government and its development partners, however, it needs to be better informed by evidence and be well coordinated. The government has established a policy coordinating committee with its development partners, which can play an active role in evolving a unified response to health system development in the country. WHO can play a catalytic role in helping the government to make this committee more active in accordance with the Paris agenda on aid effectiveness, as well as, in increasing its technical capacity to engage in a dialogue on health system development.

### ***3.3 Human Resource Development***

There is a lack of clear long-term vision for human resource development and the federal MOH or provincial DOH do not have a unit, responsible for such an important health system function. The imbalances in health workforce in terms of cadre, gender and distribution are well known in Pakistan (Annex 3). The public sector continues to heavily invest its scarce resources in the development of medical colleges and universities rather than investing in improving quality and quantity of nursing institutions, public health schools and technicians training institutions. Although there is a growing interest to address the identified shortcomings in human

resources including scarcity of nurses, midwives, skilled birth attendants, dentists and pharmacists; future scenarios for tackling the maldistribution of health professionals and the imbalances in skill mix across the country have not been developed.

A new national program for the training of community midwives, with considerable resources set aside for it, has recently been launched to tackle the shortages of personnel in this cadre. It is expected that the first batch of community midwives will be ready by XXXX. In addition, there have been recent attempts to establish new community midwifery schools and new nursing schools in some districts and provinces. Some academic institutions are also providing post graduate training in nursing in order to mitigate the crisis in nursing generated by limited production and external brain drain.

In the context of health system development, there is a serious shortage of qualified health system specialists such as health and human resource planners, health economists, health information experts and health system and hospital managers. The capacity to train such expertise is limited to non-existent in the country, and there are very few competitive positions to recruit them in the federal MOH, provincial DOH and district health offices.

Pre-service training of health professionals follows traditional methods and there is a mismatch between educational objectives, which focus on hospital based care, instead of addressing the needs of the communities for promotive, preventive curative and rehabilitative services. Some attempts to introduce innovative approaches including COME (community oriented medical education) in medical schools have not been successful for a variety of institutional and professional reasons such as the lack of involvement of the PM&DC from the beginning, weak department of public health in medical schools and poor commitment of government and heads of medical institutions .

The regulatory systems are either weak (for licensing) or non existent (accreditation). The Pakistan Medical and Dental Council (PM&DC) is responsible for registration, licensing and evaluation of the medical and dental practitioners, curriculum review, evaluation and approval of educational institutions in these two categories, and many other regulatory activities. Although the membership of the Council is broad covering most professions and including 52 members from almost all stakeholders, its coordination capacity to streamline the new policies and practices and to provide valid evidence on different aspects of human resources production seems to be weak. PM&DC has recently been through a period of turmoil and its independent role has been questioned by the Ministry of Health. How well the PM&DC fulfills its roles and functions in the new situation is uncertain.

There is a lack of organized continuous professional development (CPD) and there is no obligation for the health professionals to update their competencies. The attempts made by PM&DC have not materialized yet. The institutions for health professions education (medical and nursing schools) lack public health and community orientation in their programs. Graduates, unlike lady health workers, are not well prepared to practice in a PHC environment while these needs are most important. A network of 4 provincial and over 60 district health development centers was established in the 1990s under the Family Health Projects to develop programs for in

service training of staff. These centers have not been properly institutionalized beyond their project life and seem to fizzle out gradually.

Regulation of private practitioners and different traditional categories of medical practice such as homeopathic doctors and *Yunani Hakims* is non-existent. Data on various categories of professionals are scarce and fragmented. Such situation is affected by the fact that registration is not updated and in some cases professionals are practising without being registered.

Pakistan is nevertheless endowed with important training and research institutions and highly qualified professionals who can contribute in the design and implementation of a well articulated policy and strategies for human resource development.

### **3.4 Health Care Financing**

Estimates by WHO and other international development agencies show that the health system in Pakistan is clearly under funded. Total spending on health as a share of GDP is about 2.4 %, total MOH expenditure is 2.6 % of total government budget and 70 % of total spending is coming from out of pocket. The latter is the main reason behind the high level of payment at the point of service delivery at private facilities or user fee charged at public facilities, both of which are now well known to put unnecessary burden on the poor and promote inequity. According to an analysis carried out by the World Bank and the NHPU using data from Household and Income Expenditure Survey of Federal Bureau of Statistics, private expenditure is increasing in real terms over time but remains low by international standards. Like the case in many other countries, households in the lowest income groups tend to spend out of pocket mostly on medicines. Financial barriers, such as the high cost of health care in the absence of risk pooling<sup>1</sup>, explain the forgoing of health care by the lowest income quintiles.

Commendable efforts were made during the past five to six years to increase MOH budget though the share of GDP remains low (0.51 % which falls below the target set by the poverty reduction strategy of 0.92 %). According to calculations by Department for International Development (DFID) using GoP published figures, during the fiscal year 2005/06, the nominal increase of MOH's budget of 5.3 % was offset by inflation resulting in a decrease in real terms. Contribution of development partners in federal MOH's developmental budget was around 10-14 % in 2003/04 and 2004/05 and has now decreased to 4.1 %. However these figures do not capture increased investment by major donors to the health sector (DFID and USAID) through federal budget support, and by increased development partner investment at provincial level. The downward trend could be explained by this and by the increasing fiscal space made available at federal level.

Resources generated by government through budgetary and other means, seem to be mainly allocated to hospital facilities at the expense of primary health care and preventive services. Also there are concerns over the utilization of resources allocated to some federal and provincial public health programs or to public facilities in general. Such situation may be linked to weaknesses in financial planning and management at both provincial and district levels, which result in the lack of

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<sup>1</sup> Explain risk pooling

understanding of the total resources available, the flow mechanisms, and the speed with which they flow thereby hampering implementation. In recent years, however, the major national programs managed by the federal government have had large increase in budgets and at the same time have shown improved utilization pattern indicating improvement in their absorptive capacity.

Decision makers at federal and provincial levels seem to be aware about the need to mobilize more resources for health, particularly through public funding. Efforts are also being made to improve social protection for which a new national strategy is being developed the emphasis of which is on conditional cash transfers to poor household in exchange for actions that modifies their behavior to seek more social services including health. The overall understanding among public health professionals in the area of social protection in health is limited and the evidence insufficient. Studies to determine the feasibility of social protection interventions such as the development of prepayment schemes in the formal and informal sectors of the economy and to test the effectiveness of conditional cash transfer are essential for informing policy before any decision to scale up is taken.

### **3.5 Organization and Management**

Health is by constitution a provincial matter and service delivery is mainly the responsibility of provincial government while the federal government is in charge of policy development and broad strategic directions, monitoring and evaluation, inter-provincial and external coordination and certain essential functions such as international health regulation.

Public health activities are carried out through ten (the 11<sup>th</sup> program on breast cancer screening is being developed) national priority health programs (Annex 4) which are implemented through an extensive network of primary health care facilities, outreach and community based services. Although federally led over the years there has been a gradual decentralization of the programs from federal to provincial and in some cases to the district level. These programs are often not well meshed with the components of the health systems at various levels leading to duplication of effort and possible inefficiencies, allocative as well as technical. For instance most programs have their own information system, many have separate logistics and procurement systems, and some have their own out reach workers.

#### **3.5.1 Decentralization of health services under the Devolution Plan**

The Local Government Ordinances promulgated in 2001 to devolve power and responsibilities to the Local Governments was silent on the roles of provincial governments. In the post devolution scenario, this has led to disagreements between Provincial Health Departments, Executive District Officers (EDOs) Health and their District Coordination Officers (DCOs). The June 2005 Amendment to the Local Government Ordinances establishes a separate district civil service cadre and provides stronger provincial powers to set aside the decisions of District, *Tehsil* and Union *Nazims*, and discretionary powers to suspend them from service.

There is some evidence to the mixed success of devolution. On the one hand it seems to have increased accountability towards citizen both for politicians and for health staff delivering services, while on the other, patronage has still a role in the appointment of staff and that there is room for the exercise of private interests at the

expense of the public in the organization and delivery of services. In addition, the transition from provincial to district management has raised some concerns about how to better define the new roles and responsibilities especially of the offices of the directorate general at the provincial level. EDOs Health have faced problems in forging good working relationships with the District Nazims, District Coordination Officers (DCOs), and EDOs Finance, although the overall picture is mixed. Many EDOs feel disempowered to make decisions and feel that they have not been given effective administrative authority over staffing issues, financial management or planning and budgeting.

The health profile has not risen in the majority of district development budgets. Many *Nazim's* have been primarily concerned with highly visible and short-term interventions that will ensure re-election. Road building and other physical infrastructure has therefore received higher priority than healthcare. However, in Punjab at least, health budgets have not suffered, and there is some evidence to suggest that drug budgets have increased if only by relatively small amounts

It is clear that in order to better implement devolution efforts should be made to improve managerial and planning skills at both district and provincial levels through capacity development and provision of technical expertise when needed. It is also critical that changing roles and responsibilities at three levels due to devolution be recognized. This would also need appropriate structural, technical and managerial restructuring of three levels in line with newly defined roles.

### ***3.5.2 Management problems of district health services***

Several management constraints influence access, efficiency, quality and distributional aspects of health services. Poor skills of staff, limited career opportunities, promotion unlinked to performance, unwillingness of staff especially physicians to serve in remote area and low staff morale are some of the important human resource management issues. Female health workers face particular constraints in certain areas due to lack of personal security, less opportunities for appointment to mid and senior level positions, and a serious imbalance such as a 7:1 ratio of male to female medical officers in the field.

Institutional and systemic factors include inadequate professional support from managers to front line workers often due to lack of operational funds, poor incentive system, poor adherence to post descriptions, inadequate job security, weak referral support and feedback, and non-conducive working environment due to non-availability of supplies and material and absence of basic utilities in health facilities. Despite constraints isolated examples of excellence have been seen in a few rural health facilities where a strong public service ethic has been fostered among the staff.

There is an urgent need to improve facility management at various levels of health care delivery. Hospital management through physicians without appropriate skills and knowledge needs to be revisited. This calls for investment in hospital management training both short and long term. Recently post-graduate training in this field was introduced by the College of Physicians and Surgeons. Some efforts are being made to improve the quality of service delivery in the bigger public hospitals driven by the desire to compete with private providers and to eventually attract medical tourists rather than to provide high quality care to its users.

Provincial health departments have embarked on a large scale programs to scale up service delivery through various measures including renovation of facilities, incentives to health workforce, availability of medicines, strengthening of preventive programs and improving outreach reproductive health services through creation of community midwives.

In Punjab, the health sector reform program is focussing on improving access to primary health care by improving access to first level care facilities. Such improvement has been made possible through financial incentives to attract and retain staff and through provision of medicines. The above reforms are in early stage of implementation and it is too early to assess their affect on service delivery however, the existing approach is input oriented without attempting to address key management issues the system faces.

Some initiatives are aimed at expanding service delivery through partnership with private providers and NGOs as part of contracting out arrangements. The various contracting out models of service delivery need to be evaluated and compared, as is being done in NWFP, with parallel initiatives to improve existing public provision, for example, through empowering Executive District Officer in Health (EDO(H)) before a decision is made about their nation or province wide adoption. There is a concern about the premature scaling up of these initiatives without sufficient evidence of their effect on access, efficiency, equity and quality of health services and their impact on health outcomes. In addition, their being led under the New Initiatives scheme of the Ministry of Industries without the active engagement of the MOH and the provincial DOH raises additional concerns about their sustainability.

Interest is also being expressed on quality assurance and improvement of service delivery, though there are limited initiatives in this respect apart from some isolated quality assurance efforts in tertiary care institutions. A quality policy is absent as are the quality standards for all levels of health care. A related issue is the absence of thinking on the establishment of a hospital and health facility accreditation program in the country.

The new initiative supported by GAVI called the GAVI health system strengthening [GAVI/HSS] window is being introduced to improve the EPI coverage. This window had been thought of in response to the stagnation of EPI coverage around 80% in many countries and at 72% in Pakistan. The EPI coverage is less than 60% in 54 of the 134 districts. This phenomenon had been related to the structural weaknesses of the health system in general and health care delivery in particular, especially at the district and sub district levels, as well as, to demand side and security barriers to service delivery. The first proposal prepared by the MOH to secure funding was not accepted by the GAVI secretariat. Preparations are underway for the submission of proposal during the second round, the deadline for which is in May 2007. WHO and other agencies are providing technical assistance during this round.

In its effort to promote medical tourism as well as to provide tertiary care services to the local population, the MOH is planning the establishment of medical towers in its two largest federal hospitals in Islamabad and Karachi. It is unclear whether the government has undertaken a feasibility study, in terms of the likely market, Pakistan's comparative advantage if any, and costs and benefits, before deciding to invest into such a high investment – with potentially high opportunity costs in

setting-up and running. There is limited understanding among policymakers of the pros and cons of promoting medical tourism in the country. There is good evidence from the work done globally and in the Eastern Mediterranean Region that promotion of medical tourism runs the risk of brain drain of providers from the public to the private sector, a tiered health care delivery system – one for the affluent and the other for the poor, and promotes inequity if the generated resources are not earmarked to protect the poor.

### **3.6 Health Information Support**

The health information system is fragmented. The Health Management Information System was established in the early 1990s with the support of the USAID and provides information on public sector first level care facilities. In addition, each vertical program has more or less its own information system. The LHW information system is community based, records births and deaths, covers well over 50% of the country's population and has the potential to provide reliable estimates of maternal and infant mortality. The major public sector hospitals of the country also provide information to the MOH on hospital mortality on an annual basis, with each hospital having its own information system. Overall there is a problem of high error rates in reports as well as over reporting through many of these information systems. None of the health information system covers the private health sector nor is there an organized system of disease surveillance in the country to detect and abort epidemics in the districts without delay. The Disease Early Warning System (DEWS) and the polio surveillance provide a useful basis for developing a disease surveillance systems and then integrating within the wider health information system.

Several population based surveys are conducted from time to time that include the Pakistan Integrated Household Survey, Demographic and Health Survey, Household Income and Expenditure Survey and others that provide information on health status, utilization and limited information on household expenditure on health. The National Health Survey of Pakistan was undertaken by the PMRC in the mid 1990s and has not been repeated since. These surveys are helpful but need better co-ordination and standardization of methodology in order to establish robust trend data that complement facility-based HMIS. Household level health expenditure surveys or inclusion of a health module in the Household Income and Expenditure Survey are two options to acquire data that would inform policies on health care financing.

The health information function and the capacity to use information in the federal MOH are weak. A National Health Resource Information Center (NHIRC) was established at a cost of Rs. 180.0 million in 2003/04, which has yet to be fully operational. It lacks adequate manpower that can provide leadership with knowledge and skills for information collection, aggregation, analysis and use to influence decision making. The HMIS, NHIRC and Department of Statistics are all working in isolation in the MOH. The HMIS produces a feedback report annually, while the department of biostatistics contributes to the Annual DGs Report.

The Pakistan Medical Research Council (PMRC) recognizes the overall lack of capacity to undertake health policy and systems research in the country and its own shortcomings in this area. There has not been an organized effort to develop and institutionalize health system research since the World Bank financed Second Family Health Project, which was completed in 2003. Current allocations to support health

systems research are minimal and the PMRC has not been able to connect with international health research alliances to mobilize additional resources. The whole area of institutional capacity for health policy and systems research needs to be revisited to develop indigenous capacity for research that influences policies and programs on priority public health issues in the country.

#### **4 Challenges to Health System Development in Pakistan**

The foregoing analysis highlights several challenges to the development of health system in Pakistan. Addressing these challenges is essential for improving the health outcomes, aggregate and distributional, and in enhancing the contribution of health, to socioeconomic development in the country. The following challenges require the government's attention:

- There is a need to develop a clear vision for the health sector in Pakistan that offers a balanced approach to tackling the major burden of disease and the underlying determinants through a well performing health system and is congruent with the GOP's Vision 2030;
- The MOH is the principal steward of the health system at the federal level and the Departments of Health at the provincial level. Institutional strengthening and enhancing their capacity to undertake policy analysis, strategic planning, regulation and standard setting, disease surveillance, and monitoring and evaluation are essential for improving the governance of the health system;
- The federal MOH should demonstrate greater leadership in developing a unified vision for health and in aligning its development partners to in contributing to its achievement;
- There is a lack of clear long-term vision for human resource development, which is necessary to address the imbalances in health workforce with appropriate skills; and improved motivation, retention and productivity;
- Health care financing in Pakistan is inadequate and inequitable. Public sector spending on health in Pakistan is 0.51% instead of the targeted 0.92% of the GDP, health spending in the private sector is estimated to be 70% of the total health spending and almost all of it is out of pocket. There is a general lack of information in the area of health care financing;
- Public sector allocation in health is not based on careful feasibility studies, benefit-cost analysis and rate of return for the investments made in terms of health gains. There is thus a variance in the investments made at the tertiary, primary and secondary level and their potentials health benefits.
- There is inconclusive evidence on the impact of devolution on the access, efficiency, equity and quality of health services in the districts. There is a need to better define the role of the governments at the federal, provincial and district levels; improve the planning and management capacity of the health workforce in districts; and improve monitoring and evaluation of health services;
- There is a need to revisit the role of the civil society and NGOs, for-profit private sector and the community in the delivery of health services and to test out new innovations and interventions in public private partnerships, contractual as well as non-contractual, before scaling them up;
- Quality of care is not high on the health policy agenda, the federal MOH and the provincial DOH do not have quality assurance departments, a quality policy is

absent and so are quality standards for all levels of care, and a system of accreditation of health facilities does not exist;

- The health information system is fragmented. Each vertical program has more or less its own information system. None of the health information systems covers the private health sector nor is there an organized system of disease surveillance to detect and abort epidemics without delay. The capacity to use information in the federal MOH, provincial DOH and district health offices is weak. The overall capacity to undertake health policy and systems research is deficient and there has been no organized effort in recent years to develop and institutionalize health system research.

## **5 Priority areas for support to Health System Development**

The mission members propose the following priority areas be considered by the government in its current and future initiatives for the strengthening of health systems that would positively influence the priority public health programs and health services adopted by the GOP to achieve national targets and global commitments such as the MDGs. These priority areas have been expressed in terms of the following strategic objectives:

- Clear evidence based vision for health development as part of a comprehensive socioeconomic agenda;
- A well financed and equitable health system that progressively reduces out of pocket payments for those who cannot afford them, secures financial risk protection and protects the poor from catastrophic health expenditures;
- A better managed and regulated public private mix that harnesses the private health sector to help achieve public health goals;
- A balanced, skilled, well distributed and motivated health workforce that is planned, produced and work in an environment that gives them incentives to address the health needs of the population through the public and the private health sector;
- Improved access to a well defined package of quality health services that tackles the major burden of disease, is well understood by the population, and targets the health needs of the poor, remote and the vulnerable segments of the population;
- A well functioning district health system aligned to the devolution process where the health managers have the necessary skills and capacities to engage communities to plan and deliver health services;
- A health information system that provides valid, reliable and disaggregated information on important health determinants, programs and system functions for informed decisions and backed up by an effective disease surveillance system in the country.

## **6 Strategic pillars to support Health System Development**

### ***6.1 Generating more evidence***

The development of a clear and comprehensive vision and strategy for health development needs to be supported by strong evidence. Indeed there is a clear need to fill the knowledge gaps in some areas including health care financing, the role of the non state sector in service provision and how to incentivize improvements in health services delivery.

A household utilization and expenditure survey can be implemented either separately or as part of the routine household income and expenditure surveys carried out by the federal bureau of statistics. WHO can help in developing the questionnaire, in training surveyors and in analyzing the findings. Household data shall be used to measure equity in financing through measuring the catastrophic ill health expenditure using the WHO fairness of financial contribution analysis. A national health account analysis should be carried out in order to capture the financial flows in the health system from the various sources being households, government, social security and development partners.

Feasibility studies to improve social protection through pre payment schemes and conditional cash transfers in order to help policy makers refine social protection policies for health.

Data on costing and cost analysis should be collected and assessed in order to identify areas for improvement and to promote economic tools and thinking in health system management.

A particular interest should be paid to improving the vital registration through the establishment of sample vital registration system as has been done in India and China or making use of the network of the lady health workers whose responsibility includes recording all births and deaths in their community. The improvement of vital registration together with good morbidity and mortality data captured in public and private facilities will be useful for further burden of disease analysis.

Evidence should also be generated through small scale health system and service research focusing on the following themes:

- assessment of the impact of devolution on health services
- assess the performance of hospitals given autonomy
- assessment of contracting out of health services
- integration of vertical programs including population
- equity through analysis of social determinants: gender, poverty, illiteracy, environment, and others factors
- role of the private sector in service provision

In order to generate more evidence it is critical that:

- The Federal and provincial Governments as well as stakeholders (including donors) focus their attention on improving service delivery and identify policy issues/factors affecting it in light of current reforms; This will enable to inform and feed the policy dialogue health system on the basis of the country realities;
- A substantial dialogue aimed at critically reviewing experiences in services delivery at all levels is required (federal provincial governments and services supported by health development partners). This will enable to build a common understanding of what works and what does not and what are the policy implications of experiences gathered.

## **6.2 Strategies for Health System Strengthening**

### **6.2.1 Governance and Institutional strengthening**

Good governance and stewardship can influence all aspects of the health system, which can only be achieved through well functioning institutions in health. The following strategic directions are proposed:

- The federal Ministry of Health should lead the process of formulation of the new evidence-based national health policy with wide participation and consensus. The active involvement of the Pakistan Health Policy Forum, a civil society, is indeed a positive step, however the MOH should play a more proactive role particularly through the National Health Policy Unit;
- The sub-committee of the National Commission for Government Reform is playing a critical role in proposing measures to improve the governance and overall performance of the health system. Its recommendations, which shall be considered by the highest decision making level in the country, should be directed at taking urgent measures that provide a 'quick fix' to improve the delivery of health services, as well as, proposing a longer term institutional reforms that:
  - develop the capacity for policy analysis and strategic thinking in the federal ministry and provincial departments of health through overall strengthening of the directorate generals of health, health policy and health sector reform units, health planning and monitoring units; and health information units for informed management decisions and disease surveillance;
  - promote transparency and accountability in terms of resources allocated and spent on health and their distribution across provinces and districts; deployment of staff in health facilities, programs and various management positions; and the development of mechanisms to monitor the responsiveness of the health services that determine particularly the level of satisfaction of its users.
  - improve the synergy between the bureaucrats and technocrats working at all levels of the health system and promotion of values in their thinking such as universal access and equity as embedded in the Primary Health Care and Health for All approach.
- The continuation and institutionalization of the NHPU within the MOH is strongly supported. The new PC-1 should provide for measures to retain high quality staff, allow a degree of independence for objective analysis of national policies and programs, provide for the required leadership that is necessary for establishing such a unit, and propose institutional mechanisms that link the outputs of the NHPU to program planning in the MOH. The NHPU should take up among others such priority areas for research and analysis as developing a balanced and skilled workforce, adequate and fair health care financing and organization and management reforms in health.
- The standard setting and regulatory function in the federal MOH and provincial health departments is weak and needs to be strengthened to have more leverage over the private health sector. This requires legislation to establish a national

health regulatory authority that leads the process of health sector regulation, harmonizes the work being undertaken by the provinces and engages with the medical and paramedical associations in the development and enforcement of these regulations.

- The provinces are at different stages of development of the health sector reform process. These reforms, while essential in their own right, need to be evidence based, well advocated with the concerned stakeholders, and harmonized and aligned to the national vision for health development in the country. In this respect the development partners have to play an important role in maintaining harmony across all the provinces.
- Enhancing accountability through health system performance assessment of provinces and districts and sharing the information with stakeholders through MOH website or through media is essential for improving the governance of the health system. The NHPU should undertake such analysis using various national surveys such as the Pakistan Living Standard and Measurement Survey (PLSMS) and Multiple Indicator Cluster Survey (MICS).

### ***6.2.2 Directions for health care financing***

The improvement of knowledge base on health care financing through household survey on expenditure and utilization and the implementation of the national health account analysis will allow the development of policy options for sustainable and equitable health care financing. Scenarios will be developed according to the political commitment and macroeconomic environment of the country.

The policy document will highlight ways and means of bridging the gap in financing through increased government spending on health and other contributions. Resource mobilization should also involve community participation through existing solidarity schemes including Zakat and Biet-ul- Mal.

Equity in health care financing should be the main objective of any health care financing policy. Efforts should be made to improve equity through any form of prepayment scheme building on existing tax-based financing and employed based social security insurance schemes in the provinces and private health insurance. A particular interest should be paid to protecting the rural population and informal sector through piloting of community based health insurance. Such scheme could start first in areas where community based initiatives are advanced including the WHO supported basic development needs sites.

Strengthening financial management skills at provincial and district levels with particular focus on health facility managers will improve the absorptive capacity of public institutions. Focus will be on financial management and program budgeting and on costing and cost analysis at the facility level. The development of costing will also help in improving cost containment and internal efficiency of the system.

Support should also be provided by WHO and other partners to use economic tools such as cost effectiveness analysis in health management. The use of CHOICE software developed by WHO could help in priority setting by focusing on cost effective interventions and programs.

### **6.2.3 Human resource development**

- Develop a clear policy and strategies for human resource development according to the longer term stated health development vision for Pakistan and to the more pressing requirements of improving health service delivery in the country;
- Mapping of health care providers and institutions through a national human resources for health (HRH) observatory, which should bring together all stake holders involved in human resource development;
- Developing a new function of strategic planning in human resource development at federal and provincial levels. Such new unit should also deal with standard setting and regulatory functions;
- Establish positions in the federal MOH and provincial DOH of health system specialists such as health and human resource planners, health economists, health information experts and health system managers, which are attractive enough to recruit qualified and experienced persons. In addition, tackle their shortage in the short term through external fellowships and in the longer term through the development of accredited training programs in the country.
- Review the performance of the four provincial and over 60 district health development centers established across the country under the Family Health Project and revamp this network for establishing an in-service training program for the health workforce in areas that support health system development such as leadership and management, health planning, monitoring and supervision and health system performance assessment.
- Production of the necessary motivated workforce with special reference to nursing and midwifery (community). A nursing directorate should be established in the MOH in order to strengthen leadership and to address the nursing crisis;
- The role of the PM&DC, CPSP and other institutions should be reviewed in view of new developments and planned reforms;
- Reorienting the production of health workforce towards more focus on public health and community needs through problem based training;
- Strengthening partner institutions such as Health Services Academy (HSA), schools of public health, academia and professional institutions in order to provide the necessary support to the various reforms aimed at increasing access to health services and at improving health system performance;
- Supporting initiatives aimed at improving the distribution and retention of workforce (financial incentives, career development etc.) and generalizing them after objective assessment.

### **6.2.4 Service provision**

#### **6.2.4.1 Increased access to PHC through consolidation of the government led initiatives**

Develop and cost an essential package of health services for ensuring improved accessibility and utilization of services in PHC facilities and tehsil hospitals. The essential package should ensure a strong promotive and preventive component in addition to the curative services offered at these facilities.

Enhance community based PHC services through expansion of the number and the ranges of services offered by LHWs to cover the entire rural population and those residing in urban slums. In addition, ensure that the cadre of community midwives

being developed are properly deployed and monitored to rapidly increase the proportion of deliveries by skilled birth attendants.

Strengthen the district and sub district level organizational and managerial capacities, through GAVI/HSS initiative through increased collaboration between the PHC Directorate and EPI at all levels and through engagement of the partners and communities.

It is unlikely that the 'business as usual' shall bring about the needed changes in the management system. Innovations and novel approaches would be required to bring about the necessary improvement, some of which are suggested here for the consideration of the federal MOH and provincial DOH:

- Select and appoint the 'right people' to manage – Instead of the usual seniority based appointments to key managerial positions, appointments and selection of managers should be through internal advertisement and selection made on competitive basis based on skills and competency;
- Recruit skilled manager from the private sector on management pay scale (MPS). This option is already available under the new policy directive by the federal government;
- Carefully monitor and evaluate the option contracting out of health and hospital services and expand it based on sound evidence (See 6.4.2.3)

#### *6.2.4.2 Promote culture of quality assurance at all levels of care*

Develop a policy on quality assurance and establish units in the federal MOH and provincial DOH to promote the quality of health services at all levels of care. This would need setting standards of care, training staff in standards of care, setting up system to measure quality, and to assess if quality standards are being adhered to on a regular basis. Eventually this would lead to the development of a system of accreditation of health facilities in the public and the private sector and tackle the serious issue of lack of patient safety in hospitals and health centers.

#### *6.2.4.3 Assessment of contracting out of essential health services before scaling up*

Avoid premature scaling up of contracting out initiatives in the country unless there is evidence that it provides greater values for resources than direct provision of services in terms of access, efficiency, equity and quality. The contracting process should be well established in terms of: 1) a well defined package of promotive, preventive and curative services; 2) a well functioning regulatory mechanism with working monitoring and evaluation system; 3) pre determined performance indicators; 4) community empowerment for ensuring public accountability.

Mainstream contracting out initiatives as part of the function of provincial DOH and develop capacities to successfully implement all elements of the contractual arrangement including design, award, regulation, monitoring and evaluation. Should the government wish to pursue contracting out of health services, capacities should be developed and contract management units established in the federal MOH and the provincial DOH and eventually at the district level.

#### **6.2.4.4 Strengthen the organization and management of health care delivery**

Clarify the renewed roles and responsibilities of the federal, province, the district and the sub-district levels of health care in the post devolution period based on wide consultations from all levels.

Strengthen the capacities of the provincial and district managers through an organized program based on training needs assessment and provide an environment that enables them to use their newly acquired skills and competencies in an efficient manner.

Develop capacities of the managers in district health planning based on the widely used Community Health Management approach (District Team Problem Solving) developed and implemented through technical assistance of WHO in several countries.

Develop and implement, based on sound evidence, *functional* integration of priority public health programs at the district and sub-district levels to improve the overall efficiency of the health care delivery system. This would entail interventions that involve creating a cadre of multipurpose health workers; and integrating monitoring and supervision system, health information system and support systems such as drug and vaccine supply, transport, and logistics.

Improve the performance of staff working in the districts by providing a package of monetary and non-monetary incentives that include a better salary package, career structure, training opportunities and improved living conditions in remote areas, learning from the ongoing small scale initiatives.

### **6.3 Mainstreaming policy dialogue on health system development**

The government at the federal, provincial and district levels has started taking vital preliminary actions to strengthen the health care delivery system. However much more needs to be done to address the systemic shortcomings taking into consideration the social, economic and cultural realities of the country. The reform agenda is articulated in the overall development program including the PRSP and commitment to MDGs.

The health system reforms are not just a set of technical interventions but have strong political underpinnings, as has been seen with the reform on decentralization in Pakistan. As in many other countries, these reforms face resistance from different stakeholders and vested interests. It is therefore important to do social marketing in order to reduce resistance and develop consensus prior to and during their implementation. Media, civil society organizations, parliamentarians, academia and professional associations have to be involved in the policy debate around health development. MOH should have a more proactive role in initiating and in managing the policy dialogue on the reform agenda including the design of an appropriate vision for health development.

As signatory of the Paris Declaration, Pakistan is receiving substantial development assistance through budgetary support which implies that donors are broadly aligned

with development priorities of the government and that they are engaged in a strategic policy dialogue with the government.

Unfortunately there is little evidence that the Paris agenda is applied in the health sector. Much more work on harmonization and alignment is required in Pakistan to improve the effectiveness of aid in the health sector.

Several MoH officials and development partners have acknowledged the urgent need to strengthen the health system and to reform it in order to make it more effective, more equitable and more sustainable.

Development partners in Pakistan should also coordinate, harmonize and align their input to support the national health development agenda using health system strengthening as a platform. Their input to the various public health programs and for improving service delivery requires a well functioning health system at various levels. A prerequisite for this is a national vision and strategic plan for health that goes beyond development projects, the onus of which is with the government.

WHO should play a more active role in coordinating the input of various donors and in aligning their contribution with MOH's reform agenda, through its technical cooperation and advocacy.

## **7 Next steps**

The mission report provides strategic direction in terms of *what* needs to be done to strengthen health system in Pakistan. It does not tackle the important question of *how* it will be done. This section briefly points to how these strategic directions can be made implementable in the coming months and suggests certain steps in that direction:

- Under the leadership of the MOH, the team entrusted with the task of developing the national health policy should carefully review this report and consider including the proposed strategic directions in the national document;
- The MOH may establish a high level task force with the active involvement of the provinces, and with the participation of stakeholders including the private health sector, civil society and the development partners to guide the strengthening of health systems in the country;
- The MOH and provincial DOH should prepare several concept papers and/or proposals on strengthening different aspects of the health system with WHO's and other development partners' assistance. The funding mechanisms will have to be thrashed out to ensure that the strengthened health system, which is meant to avoid fragmentation of programs, should not itself become an isolated vertical program.
- A health sector strategic plan with a strong health system strengthening component needs to be developed and financed through the recurring as well as development budget of the government. In the case of the development budget, it has to be agreed whether the project will be in the form of: (i) comprehensive PC-1 on health system strengthening; (ii) several small PC-1s on different aspects of health systems; or (iii) clearly defined health system strengthening components

as part of PC-1s for priority public health programs. It is important that the government commit resources upfront, only then will the donors be willing to support health system strengthening in Pakistan. The proposed areas around which such proposals need to be developed in the first round are:

- Strengthening the ministries of health and provincial health departments
  - Establishment of prepayment schemes for adequate and fair financing of the health system
  - Developing a strategic plan for human resource development
  - Integrating health information and surveillance system
  - Improving access and efficiency through a better functioning decentralized district health system
  - Improving quality of care in public and private health facilities
- The MOH should align the development partners who are keen to support health system strengthening in Pakistan to its vision through continuous dialogue so as to avoid duplication and minimize fragmentation of the support to health systems.
  - WHO country office, with appropriate backstopping by the regional office and headquarters, should provide the necessary technical assistance in the accomplishing the steps identified. This should be adequately funded in the biennial plan 2008/09 of WHO for country assistance to Pakistan.

## **Annex 1                      Terms of Reference**

The terms of reference of the *health system assessment review mission* are as follows:

- Review major health policy and system development documents developed by government, non-government and international development agencies;
- Meet senior representatives of the federal MOH, as well as, visit provinces and selected districts to discuss health system issues with functionaries at the various levels of the government;
- Organize meetings with key stakeholders in the public and non-state sectors to acquire a broader view point on health system issues in Pakistan;
- Appraise the performance of the health policy unit in the MOH, which was developed with the technical assistance of WHO and financial support from DFID and suggest measures for its improvement;
- Engage in policy dialogue with the health decision makers to advocate the importance of health system development for effective program implementation;

The mission members comprised the following team:

### **World Health Organization**

- Khalif Mahmud Bile, WHO Representative Pakistan
- Belgacem Sabri, Director, Division of Health System, WHO EMRO
- Sameen Siddiqi, Regional Adviser, Health Policy and Planning, WHO EMRO
- Paolo Piva, Scientist, Evidence and Information for Policy Cluster, WHO HQ
- Amr Mahgoub, Regional Adviser, Health Management Support, WHO EMRO
- Ali Hassanabadi, Regional Adviser, Education Development and Training
- Werner Buehler, PHC Medical Officer, WHO Country Office, Pakistan
- Asad Hafeez, WHO Consultant

### **Other Development Partners**

- Ibrahim Erziq, Health Adviser, UNICEF, Pakistan
- Jane Edmondson, Senior Health Advisor, DFID, Pakistan
- Inaamul Haq, Senior Health Specialist, World Bank, Islamabad

**Annex 2****List of Individuals Met**

<b>Name</b>	<b>Position</b>
<b>Federal Capital, Islamabad</b>	
Mr Nasir Ahmed Khan	Federal Minister for Health
Mr Syed Anwar Mahmood	Federal Secretary Health , Ministry of Health
Mr Ejaz Rahim	Member Social Sector, Planning Commission
Maj. Gen.(Retd.) Dr Shahida Mali	Director General Health, Ministry of Health
Prof. Shakila Zaman	Director, Health Services Academy
Mr Tariq Bajwa	Joint Secretary, Ministry of Industries and Special Initiatives
Maj Gen (Retd.) Dr Masood Anwe	Executive Director National Institute of Health
Mr Syed Najam Saeed,	General Manager, Civil Services Reform Unit, Establishment Division
Prof. Syed Fazle Hadi and senior s	Executive Director PIMS
Dr Mushtaq A Khan and research associates	Chief, National Health Policy Unit
Dr Huma Qureshi	Executive Director, Pakistan Medical Research Council
Mr Abdul Jalil	Deputy Financial Advisor, Ministry of Health
Dr Haroon Jehangir Khan	DDG( PHC) and Staff
Dr Hassan Sadiq	National TB Programme Manager
Dr Faisal Mansoor	Director, Malaria Control Programme
Dr Mubasher Ahmed	Chief Research Officer, Pakistan Medical Research Council
Dr Amjad Mehmood	Health Services Academy
Brig (Retd.) Perveen Aslam	Nursing Advisor
Mrs Nighat Durrani	Registrar, Pakistan Nursing Council
Begum Anwar	Director National Regularity Authority/NIH
Dr Samina Rahman	Deputy Secretary, Pakistan Medical & Dental Council
Dr Sania Nishtar	President <i>Heartfile</i>
Dr Syed Mursalin Ali	Technical Officer HMIS
Dr Safi Malik	DNC(SMT)
Dr Anjum Javed	ADG(PHC)
Dr Amir Attique	DNC(GF)
Dr Salma	JICA Consultant
Dr Ghulam Shabir	Technical Adviser(UNFPA)
Dr Kamran Siddiqui	Leeds University
Dr Ian Cameron	Leeds University Primary Care Trust
Ms Mary Skarie	Health Office Director USAID
<b>Punjab Province</b>	
Mr. Salman Siddique	Chief Secretary Punjab (in chair)
Mr. Raees Abbas Zaidi	Secretary-Health, Government of Punjab
Dr Syed Muhammad Awais,	Vice Chancellor, King Edward Medical University, Lahore
Mr. Muhammad Umer Masood	Staff Officer to Chief Secretary Punjab
Mr. Raees Abbas Zaidi	Secretary-Health, Government of Punjab (in chair)
Mr. Shumail Ahmed Khawaja	Special Secretary-Health, Government of Punjab
Dr. Muhammad Aslam Chaudhry	Director General Health Services
Mr. Jawad Rafique	Additional Secretary(Development),Health Department Punjab
Mr. Suhail Suqlain	Additional Secretary (Technical), Health Department Punjab
Dr. Muhammad Aslam Chaudhry	Director General Health Services (in chair)

<b>Name</b>	<b>Position</b>
Dr. Tanvir Ahmed	Project Coordinator-National Programme (PHC &FP)
Dr. Muhammad Afzal Shaheen	Director Health Services (EPI)
Dr. Zia-ur-Rehman	Director Health Services (CDC)
Dr. Abdul Qayyum	Director Health Services (P&D)
Dr. Shamsa Shafi	Director Health Services (MCH)
Dr. Drakhshan Badar	PTP Manager-Punjab TB Control Programme
Dr. Ali Razzaque	Project Director-Punjab AIDS Control Programme
Dr. Capt. Malik Javed Tariq	Director Health Services (BHS/HQ)
Dr. Mehmood Ahmed	Add. Director Health Services (Nutrition)
Dr. Muhammad Arshad Umani	Add. Director Health Services (Malaria Control Programme)
Mr. Shahid Pervaiz Khan	Add. Director Health Services (Health Edu/Hepatitis Control)
Dr. Muhammad Naeem	Add. Director Health Services (TB-DOTS)
Dr. Mubashir Ahmed Malik	Provincial Coordinator (HMIS)
Dr. Atique-ur-Rehman	Add. Director (Medical)
Mr. Muhammad Saleem Rana	Entomologist-DG Health Office

### **North West Frontier Province**

#### **District Attock**

Mr. Bashir Ahmed Farooqi	District Coordination Officer- District Attock
Dr. Mussarat Hussain Abdullah	Executive District Officer (Health), District Attock
Dr. Ibrar Hussain	District Officer (Health), Attock
Dr. Sultan Mehmood	Medical Superintendent-DHQ Hospital, Attock
Dr. Babar Ali	Dy. District Officer (Health), Attock
Dr. Muhammad Afzal Mirza	Director –DHDC, Attock
Ms. Samina Yousaf	Asst. District Coordinator – National Prog (PHC &FP)
Dr. Shahid Hafeez Khan	Medical Superintendent–THQ Hospital, Hassan Abdal Attock
Dr. Sultan Mehmood	Medical Superintendent, DHQ Attock
Dr. Capt. Nasir Jamal	Deputy Medical Superintendent, DHQ Attock
Dr. Wajahat Hussain	Surgeon, DHQ Attock
Dr. Nadeem Qureshi	Child Specialist, DHQ Attock
Dr. Tanvir Gillani	Eye Specialist, DHQ Attock
Dr. Riaz ahmed	Medical Specialist, DHQ Attock
Dr. Fayyaz	Pathologist, DHQ Attock
Dr. Shujaat Ali Khan	Senior Medical Officer, RHC Bahtar, district Attock
Dr. Gulnaz Farooq	Women Medical Officer, RHC Bahtar, district Attock
Dr. Sajjad Hafeez	Medical Officer, BHU Jhang, district Attock
Ms. Imtiaz Begum	Lady Health Visitor, BHU Jhang, district Attock
Ms. Zanoobia Mubarak	Lady Health Supervisor, BHU Jhang, district Attock
Ms. Zahida Begum's Health House	Lady Health Worker, BHU Jhang, district Attock
Dr. Shahid Hafeez Khan	Medical Superintendent
Dr. Liaqat Ali	Surgeon, THQ Hospital Hassan-Abdal, district Attock
Dr. Khalida Qureshi	WMO, THQ Hospital Hassan-Abdal, district Attock
Ms. Sajida	Staff Nurse, THQ Hospital Hassan-Abdal, district Attock

**Annex 3 Distribution of Health Workforce by Public and Private Sector**

Category	Total Number	Sector		
		Total Public	Total Private	Total Private not-for-profit
1. Physicians :	116298	46520	63963	5815
<i>Generalists :</i>	98757	34565	59254	4938
<i>Specialists :</i>	17541	14033	3157	351
2. Nurses :				
<i>Registered nurses</i>	48446	29068	14534	4844
3. Midwives :				
<i>Registered Midwives</i>	23318	8161	13991	1166
<i>Enrolled Midwives</i>				
<i>Traditional birth attendants (TBA)</i>				
4. Dentists :				
<i>Dentists :</i>	6452	2258	3871	323
<i>Dental technician :</i>	860	576	240	44
<i>Dental assistant :</i>	550	358	165	27
5. Pharmacists	8102	2836	5023	243
6. Physiotherapist	200 (20)*	40	128	32
7. Medical assistants	200	200	0	0
8. Clinical officers/ Dispensers	13000 (5662)*	10472	1896	632
9. Laboratory				
<i>Laboratory scientists</i>	1300 (451)*	826	346	128
<i>Laboratory technologist</i>	1700 (608)*	1086	447	167
<i>Laboratory assistants</i>	3000 (1015)*	1914	808	278
10. Radiographer	1200 (470)*	880	254	66
11. Environmental and Public Health Officers	106			
<i>Environmental and Public Health Officers Professionals</i>				
<i>Environmental and Public Health Officers Technicians</i>				
12. Other Technicians and Health Care Cadres				
13. Community Health Workers (LHWs)	83829			
14. Administrative and support staff				
<i>Skilled administrative staff</i>	42000 (15328)*	27322	10528	4150
<i>Other support staff</i>	107000 (39009)	69558	26726	10716

#### **Annex 4 Priority Public Health Programs in Pakistan**

1. National Programme for Family Planning and Primary Health Care
2. Expanded Programme of Immunization
3. National AIDS Control Programme
4. Malaria Control Programme
5. National TB Control Programme
6. Nutrition Programme
7. Women Health Project
8. Maternal, Neonatal and Child Health Project
9. Prime Minister's Programme for Prevention and Control of Hepatitis in Pakistan
10. National Programme for Prevention and Control of Blindness in Pakistan
11. Breast Cancer screening program (under preparation)

**WHO's Response (Not to be included in the final report)**

As part of the UN Reform – UN country team health inputs should be coordinated around one program on health development. WHO should play a leading role in streamlining the inputs of various partners using health system strengthening as a platform. The major strategic directions should be shared with all other partners in Pakistan.

The role of WHO in technical cooperation will be based on the country cooperation strategy using the biannual joint planning and programming exercise for implementation. Efforts should be made to improve WHO's support by partnering with the provinces in coordination with the federal ministry of health.

WHO should play an important role in advocacy by promoting investing in health development by the government of Pakistan and national and international development partners.

Technical support through the biannual exercise should cover some of the areas identified as priorities during the health system review exercises. These areas include the following:

- support to efforts aimed at generating better evidence for policy analysis and development including training on national health account methodology, training on measuring fairness of financial contribution and training on burden of disease analysis methodology.
- Support to institutional strengthening through capacity development of health policy unit members in some specific areas and the use of analytical tools for policy analysis and development including political mapping and stake holder analysis. Health system research methodology should also be promoted and some initiatives should be financially supported by WHO as part of the evidence generation.
- Capacity development in management and planning at provincial and district levels using the WHO tools including district team problem solving and community based health management ( DTSP/ CHM). Specific courses for executive managers from MOH and other concerned ministries including finance and planning should be designed and implemented in partnership with training and research institutions including the Health Service Academy and the Pakistan Research Institute.
- Partnership with academic institutions and professional associations in order to improve human resource development. Activities should include all aspects of human resource development including long term strategic thinking, production using innovative approaches, management and monitoring and evaluation. A particular interest should be paid to revamping the bold initiative promoted through WHO's support on community oriented medical education. Edward Medical College in Lahore could be considered as potential partner in this

respect. Partnership could also include some exposure to health systems by academic staff.

- Strengthening technical assistance in health system development at the country level both at Islamabad and at WHO country sub offices. There is a need to recruit national and international long term advisers in health system strengthening to help in implementing the various activities identified in the review report.