Review

The district health system: a challenge that remains

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SUMMARY The health care system in Pakistan has been confronted with problems of inequity, scarcity of resources, inefficient and untrained human resources, gender insensitivity and structural mismanagement. With the precarious health status of the people and poor indicators of health in the region, health care reforms were finally launched by the government in 2001. There are, however, numerous challenges and constraints in the system. The future health of the nation depends on this decentralization initiative. All our efforts should be concerted to support and facilitate the new system, which will mature into institutionalization of the health services at the district level. Most importantly, it will help in strengthening the primary health care services catering to the major fraction of the population. Besides political commitment, we ought to maintain attitudinal, behavioural and cultural conditions conducive to letting this system flourish.

Introduction

Health is a basic human right, and must be available and accessible to all in an affordable framework. To this end, an integrated approach to public health would combine preventive, promotive and curative health at all levels. Promoting good governance and fairness in the health sector through meaningful and consistent emphasis on prompt delivery, equitable and professional services, transparency and accountability must become a cardinal principle of the health sector, where social sector investment is perceived as a mathematical equation.

In many parts of the world, progress towards the goal of 'health for all by 2000' has been slow and in some cases unachievable. Whilst most developing countries formulated broad policies, strategies and plans with this goal in mind, the modus operandi has been weak and questionable. In recent years, reforms in Malaysia, the Philippines, South Korea, Spain, Tanzania and Uganda have had mixed results [*1,2*]. The objectives were common: improving 'allocative' and technical efficiency; innovating service delivery, improving quality, transparency and accountability; and achieving greater equity in the distribution of resources [*3*]. All these efforts may also be aimed at adding new resources, circumventing inefficient bureaucracies and assuring empowerment of the people [*4*].

This article is based on a thorough literature review, not only from the local journals but also from some international ones. A few publications of the United Nations Development Programme and the World Bank on the subject of decentralization were consulted to review best practices in

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various countries. Several types of decentralization case studies were included, and the official policy documents of the government of Pakistan were also referred to verify certain details.

Current situation in Pakistan

Healthy public policy covers policy decisions in any sector or at any level of government and is characterized by an explicit concern for health and accountability for health impact [5]. It is an established fact that most of the developing countries are not spending more than 2% of their gross national product (GNP) on health, resulting in poor coverage of public health services. The Government of Pakistan spends about 0.8% of GNP on health care, which is lower than some neighbouring countries such as Bangladesh (1.2%) and Sri Lanka (1.4%) [6]. In Pakistan, only 3.07% of the total annual budget is allocated for economic, social and community services, and 43 out of 100 Pakistan rupees are spent on debt servicing [7]. A further increase in the allocation for the health budget may not be possible for many years to come, therefore, alternative methods of health financing, including cost-sharing, have to be considered. In most of the developing countries of South Asia, out-of-pocket household expenditure on health is at times as much as 80% of medical expenditure [8]. For health expenditure in Pakistan, it is about US$ 17 per head per year, out of which $13 is out-of-pocket private expenditure [9]. Our country spends 80% of its meagre health budget on tertiary care services, which are utilized by only 15% of the population. In contrast, only 15% is spent on primary health care services, used by 80% of the population [10]. Quality of health care is questionable, with considerable expenditure on unnecessary and inappropriate (and sometimes unsafe) care. Despite Pakistan being an advocate of the Alma Ata Declaration and having a huge primary health care infrastructure (set up in the early 1970s, but having declined over the past 2 or 3 decades), there is still a dearth of trained human resources, inequity in financing of health care and a scarcity of reliable information. In this scenario, the devolved district health services are also presented with an opportunity to tackle the health-financing situation. It is obvious that there is willingness to pay for primary health care in the public sector services if users receive improved care. Districts would in this case be able to recover substantial costs and maintain their incomes.

Half a century down the road from independence, social and demographic indicators in Pakistan present a gloomy picture, despite advancement in the economic sector. The current effort of the government to decentralize the system of governance included the health sector, assigning responsibility for health to the newly-created local governments. The district governments, however, still lack the capacity and powers to cope with their new responsibilities.

There are a few questions which arise right away while considering the process of devolution. Are basic data on the characteristics of the population, level of health, major health problems and coverage of essential health care readily available in the district? Have district priorities been appraised? Have targets and objectives for health and health care been set? Does the district have a plan of action for important programmes such as health promotion, maternal and child health, school health, environmental sanitation, occupational health, control of diseases and curative services? Are there effective mechanisms to make communities and the public and pri-

vate health sectors work together? Are there adequate resources, logistics, organizational arrangements and incentives to ensure prompt implementation of programmes? Will activities be monitored regularly? Is there a mechanism for quality assurance? Will periodic evaluation be carried out? Many of these remain unanswered, even after the passage of 2 years.

Devolution of power in the health department

There has been an obvious political, social, economic, demographic and epidemiological need for health sector reform in Pakistan [*11*]. The ultimate goal of any health sector reform is to improve the aggregate health status of the people, whether through de-concentration, devolution or delegation [*12,13*]. It includes packaging of services; the structures and organization of service delivery; financing; and the consumer–provider relationship [*14*]. All these efforts are geared towards the empowerment of the people at grass roots level. The district will be the dominant level for decision-making in the health department. The quantity, quality and access of integrated health care delivery will be improved. This will promote good governance and human resource development for sustainable development. These steps should be the answer to challenges like high infant and maternal mortality rates, low prevalence of contraceptive use and a high population growth rate, along with scarce income and health resources.

The devolution plan in general as well as the health-related section can be analysed in 4 different respects: devolution (political power), decentralization (administrative authority), deconcentration (management functions) and diffusion (power–authority nexus) [*15,16*]. Therefore, the aim is to establish a set of activities that include improved access to and utilization of services; community involvement; local accountability [*17*]; integrated, comprehensive health care delivery; intersectoral collaboration; and a strong 'bottom-up' approach to planning, policy development and management. Hence, attaining equity, effectiveness and efficiency in the health sector should, in principle, lead to sustainability in the system.

Responsibilities/functions at the provincial and district level

The responsibility of the provincial government will cover policy-making and legislation for the province; drug control under the Drug Control Act; monitoring and regulatory functions of medical and allied institutions; health research and related health information gathering; interacting with donors and international agencies; personnel management; provincial procurements; and supervision and monitoring of health programmes [*18*].

Reproductive health and nutrition education; prevention and control of communicable and noncommunicable diseases; food and sanitation; health management information system; environmental and occupational health; hospital referral systems; ambulance services; and financial and personnel management will be the responsibility of the district government. The district government will also look after primary and secondary level health facilities.

Besides these, there will be a district health management team, which will comprise a district health officer, managers from other relevant departments, public and private sector health care providers and community representatives. The district

health management team will adopt a team approach, share and exchange views, and reduce the workload of the district health officer, optimizing the utilization of human resources and improving cooperation and collaboration between stakeholders [*19*]. It is expected that well-defined structures; meaningful partnerships; capacity-building at provincial, district, sub-district and community levels; detailed mapping of resources and services; and integrated approaches towards programme planning will emerge as desired outcomes. The district will get its budget share according to population size, socioeconomic development, health infrastructure, health needs and problems, and indicator-based performance evaluation. This will contribute to and maintain equitable allocation of health resources between different districts with different priorities.

Challenges and constraints

The new actors in the health system are looking for motivation and incentives for their new assignments. Defining their administrative roles and jurisdiction still remains a challenge. The distribution of financial power between provincial and district representatives is mandatory. The new political government of Pakistan is still in the early stages of dealing with this dilemma. Though this is the phase of transformative learning and transition, the jurisdiction of the Public Service Commission; medical colleges; tertiary hospitals; and federal initiatives like the programmes for AIDS, malaria, tuberculosis and lady health workers, and the Expanded Programme on Immunization need to be defined. The crucial step, however is building awareness in the general public.

In countries where the administrative machinery has been decentralized to district level successfully, the development of the district health systems has been remarkable, despite an initial decrease in productivity, reluctance of the centre to share power and instability of the political framework [*20*]. Decentralization without delegation of appropriate financial and administrative powers does not work. There is also a need to ensure political commitment inside the district to create a fiscally and socially responsible management. The process requires trained health managers at district level, a team approach and planning support from the centre in the form of clear job descriptions, guidelines and advisory staff [*21*]. Devolution to the district level is imperative, and crucial if primary health care is to be improved. The advantages are a manageable size at district level, easily obtainable information and smooth communication between different stakeholders [*22*]. Moreover, decentralized programmes can be designed with a knowledge of the local culture and circumstances, thereby improving technical and allocative efficiency with appropriate local institutional capacity building [*23*].

District health managers need to be trained in areas like HIV/AIDS, control of diarrhoeal disease/acute respiratory infection, the Expanded Programme on Immunization, maternal and child health/family planning, health education, health management information system, nutrition, environment and sanitation, community mobilization, personnel and project management, etc. [*24*]. Information and data regarding population, health indicators, deployment of funds and coverage will be needed to appraise the district priorities and to set future objectives and targets. It will only then be possible to ascertain the

strengths and weaknesses of the existing district system, and take measures to improve it. The district health system has officially been with us for more than 2 years. The transformation of the fragmented and inefficient apartheid health system into a coherent health system capable of addressing the health needs of the vulnerable and marginalized population was, and still is, a massive challenge.

At the same time as adopting this new system, we cannot ignore ambitious targets like gender equality, empowerment of women, reduction in mortality rates for infants and children, reducing maternal mortality, improving primary health care and reproductive health services and poverty reduction. In order to meet such challenges, the decentralized system has to focus on equity, efficiency and good governance [*4,25*] and on developing tools to monitor and assess health system needs, especially in rural areas [*26,27*]. Today, about 67% of Pakistani people live in rural areas [*28*], but they have been completely neglected and disenfranchised in the decision-making processes that affect their daily lives. Lessons could be learned from the best practices of Brazil, Columbia, Morocco, South Africa and Chile [*29,30*].

Conclusion

With the transfer of administrative and financial powers to district authorities/local bodies, programmes relevant to the local needs and priorities will be facilitated [*21*], resources will be mobilized and greater community participation will be ensured [*30*]. There will be continuous monitoring and surveillance of continuity and quality of services, thus ensuring sustainability. This will create motivation, confidence and a sense of ownership. The strengthening of the first level care facility will bring an improvement in various health indices. The services and programmes could be designed on the concept "by the people, for the people, of the people" through more meaningful community participation, mobilization and empowerment. Of course, health system research should be part of every plan now. It will assist the newly-created district health system in defining clear goals and objectives, formulating strategies and providing quality services to the most underserved groups in the population. Only this approach can provide evidence-based services and address the needs of the community.

Decentralization has considerable promise. The empowerment of the decentralized bodies will lead to institutionalization of democracy, which is the key to progress. It will promote greater community participation, responsiveness of government institutions and increased flow of information between people and government [*31*]. This will not only make development programmes more flexible in catering to local needs, but also transparent and sustainable.

Health care is a right and not a privilege. Today, we are living in an epoch of urbanization, industrialization, demographic transition and globalization and their repercussions. Pakistan needs increased political freedom, economic facilities, social opportunities and transparency to break the vicious cycle of corruption and underdevelopment. This devolution plan, if granted full legitimacy, presents an opportunity to usher in a more democratic system of governance and effective and transparent health care delivery and management. For that to happen the citizens of Pakistan will need to participate proactively in the construction and functioning of the new institutions, and take advantage of the new environment for self-empowerment.

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