Health sector reforms programme in Punjab: a primary healthcare initiative

Tahir Ali Javed and Shahid Amin

ABSTRACT – Punjab is the largest province of Pakistan with a population of over 85 million. Provision of equal access to primary healthcare is a mammoth task in this developing country with well known resource constraints. Punjab has a network of 2,748 primary healthcare (PHC) facilities spread over an area of 205,345 km^2. The Punjab government has initiated a two-year Health Sector Reforms Programme (HSRP) to make the primary healthcare network of 2,456 basic health units and 292 rural health centres fully operational. Benefits of the programme for medical staff include a substantial salary and an incentive package combined with improved working and living conditions, a pre-service orientation programme and regular in-service training, a supportive monitoring and supervisory mechanism, and periodic third party inspections. The strong political and administrative will to harness all available resources is the key to the success of the HSRP. All of the 35 district governments have signed terms of partnership with the provincial government to execute the programme. Preliminary reports show a rise in the recruitment of healthcare providers in remote rural facilities.

KEY WORDS: basic health unit, Health Sector Reforms Programme (HSRP), Millennium Development Goal (MDG), Pakistan, primary healthcare facilities, Punjab, Rahim Yar Khan model, rural health centre, terms of partnership

Introduction

The population of the province of Punjab is over 85 million spread over an area of 205,345 km^2.[1] The total fertility rate is 4.7 births per woman, and the infant mortality rate is 77 per thousand live births. The maternal mortality rate in Punjab is estimated to range from 300 to 533 per 100,000 live births, as only 32% of births involved skilled birth attendants.[2] Punjab has an elaborate pyramid-shaped system of healthcare (Fig 1). At the top of the pyramid are a relatively small number of large hospitals each with around 1,500–2,000 beds; at the next level is a network of district headquarter and Tehsil (an administrative sub-division of a district) headquarter hospitals. The base of the healthcare pyramid is made up of primary healthcare facilities and 'health houses' (a room in the lady health worker's residence used to display health education material).

There are 2,748 primary healthcare facilities spread across Punjab, but access to quality healthcare is still a dream for many. Although the reported maternal mortality rate in eleven districts of Punjab is lower than 200, against the national estimate of 533, much work is still needed to improve the health of the population of Punjab.[3]

It is particularly difficult to provide adequate primary healthcare for populations living in outlying rural areas. Young medical graduates seldom opt to work in a remote area where there is only a small social network, few civic amenities, limited opportunities for professional development and even fewer opportunities for education of children.[4,5] A lack of financial resources compound the problem. The total expenditure on health in Pakistan is estimated at $16 per capita, from which the total government health expenditure is $4 per capita. The Macroeconomic Commission of the World Health Organization recommends $34 per capita to provide essential health services.[6]

Pakistani national health policy prioritises both primary and secondary healthcare. The ninth national five-year development plan and the prospective plan for 2003–13 emphasise equity, efficiency and effectiveness as guiding principles for provision of services. The focus is on improving the quality of health service delivery rather than expanding the physical infrastructure.[7] The Punjab government accordingly allocates around 8 billion rupees to outreach, and primary and secondary healthcare facilities which are managed mainly by district government. The Health Sector Reforms

Tahir Ali Javed
MB BS MD MACP FCPS,
Minister for Health

Shahid Amin
MB BS DHA,
Deputy Secretary

Health Department,
Government of
Punjab, Pakistan

Clin Med
2007;7:19–22

INTERNATIONAL EXCHANGE

This new series aims to promote and exchange ideas in the development and delivery of healthcare internationally and to summarise the changes in the UK which would be of particular interest to the international reader. This series is a collaborative venture with the International Office of the Royal College of Physicians. The Editor is particularly grateful for the enthusiastic support of Professor Roger Williams and Tanya Barman.

Programme (HSRP) – a two-year government initiative to provide better and modern healthcare facilities in Punjab – will allocate additional resources of 5.5 billion rupees over the next two years to fully equip the 292 rural health centres and 2,456 basic health units in Punjab.

Health sector investment in Pakistan is part of the government's Poverty Alleviation Plan,[7] and health sector development targets are fixed by the Millennium Development Goals (MDGs) agreed by the international community. The current status of these targets is given in Table 1. The HSRP is designed to help the government meet its obligations towards its people and the world community.

One basic health unit is situated in every Union Council (the smallest administrative division located within the Tehsil) covering an approximate population of 15,000–25,000. Basic health units provide mother and child health services, offering antenatal, perinatal and postnatal care, child growth monitoring, education about health and nutrition, sanitation and control of communicable diseases, family planning, immunisation, and treatment of common ailments. The units also provide services directed by government initiatives such as control of diarrhoeal diseases, acute respiratory tract infections and tuberculosis (TB), and assist patients with day-to-day management of long-term illnesses such as diabetes and hypertension.

Rural health centres are situated in larger towns within a rural area and are less than 10 to 15 km from the nearest basic health unit. They are the first referral point for local patients and provide treatment for uncomplicated illnesses. They have X-ray and basic laboratory diagnosis facilities, and an operating theatre, and a dentist and a female doctor are available.

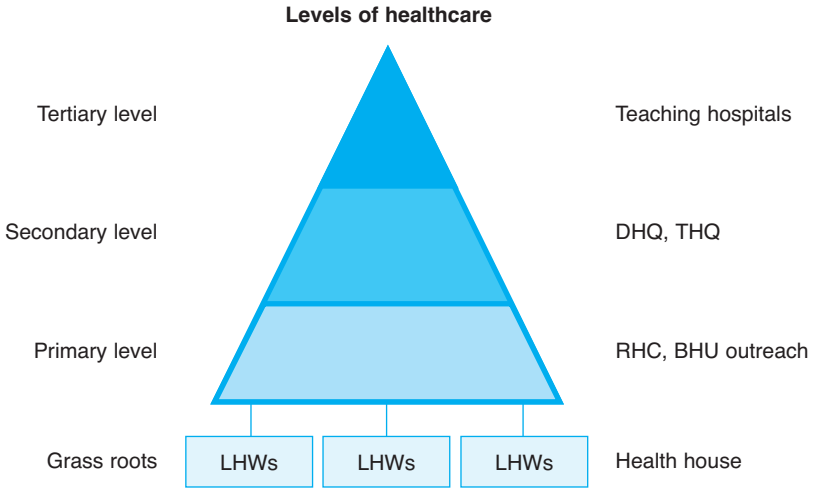

Fig 1. Punjab healthcare pyramid. Tertiary level = 15 mega hospitals attached to eight medical colleges, one medical university, one postgraduate medical institute, and seven specialty-based hospitals. Secondary level = 35 district headquarter hospitals (DHQs) and 65 Tehsil level hospitals (THQs). Primary level = 292 rural health centres (RHCs) and 2,456 basic health units (BHUs). Grass roots = one room of the lady health worker's (LHWs) residence designated as a health house for the local community.

Background

Pakistan has lagged behind its neighbours and many other low income countries in terms of health development and indicators. There are an estimated 400,000 infant deaths and 16,500 maternal deaths annually, and Pakistan has the sixth largest burden of TB in the world.[6] There is an urgent need to bring about major changes and to do whatever is possible with limited resources to achieve health targets.

A network of primary healthcare facilities was established in the early 1980s, and today there is either a basic health unit or rural health centre within 5–10 km in most districts. Use of these primary healthcare facilities over the past 25 years has, however, been suboptimal because of factors such as unavailability of medical staff (due to poor salary and lack of incentives to work in rural areas), poor supply of medicines and equipment, poor physical infrastructure, and poor location of basic health units.

The government has introduced a number of initiatives over recent years to try to address these problems. A computerised health management information system was launched in 1994.[8] This system generates around 18 monthly reports which are consolidated into an end-of-year report, and is the main source of information about primary healthcare functions such as mother and child healthcare, immunisation, malaria control, and an inventory of essential medicines. However, although the information is fed back to all levels within the district and province, there is little evidence that it is being used to its full potential to inform decisions at any level.

Realising the limitations of rigid governmental structure and the inflexibility of rules and regulations, in the late 1990s the Punjab government set up initiatives to decentralise authority and to recruit nearly 2,000 health professionals. Doctors on facility-specific contracts were offered a special pay package to work in remote areas and were given on-the-job training.[9] The

Table 1. Current status and the targets of health sector development in Pakistan.

Target	2005–06	By 2015*
IMR	77	40
Under-five mortality mate	100	52
MMR	300	140
% age of births attended by SBA	48	90
% age of fully immunised children (12 to 23 months)	78	90

IMR = infant mortality rate; MMR = maternal mortality rate; SBA = skilled birth attendants.
**Pakistan Millennium Development Goals Report, 2005*. Islamabad: Planning Commission, 2005. www.un.org.pk/undp/publication/PMDGR05.pdf

impetus was not sustained, however, and the salary package lost its value due to devaluation. The situation remains unchanged due to continued absenteeism and lack of continuity of the reforms package.

The devolution of authority to the district level in August 2001 was another major policy reform. Local administrative and management structures replaced the traditional centrally controlled system. However, district governments had their own problems with budgetary limitations, developmental priorities in other sectors, political interferences, and limited management expertise. Thus, devolved authority did not lead to an increase in use of primary healthcare facilities to a level with any impact on major health indicators.

Key problem: poor use of primary healthcare facilities

The basic challenge was to increase the use of existing primary healthcare units and the referral network of secondary healthcare. A significant reduction in infant and maternal mortality was to be expected if primary healthcare became available to every mother and child. National information system data showed that numbers using the facilities did rise from 18 patients per day per facility in 1998 to 29 per day per facility in 2000.[10] However, the number of patients coming to the centres requiring treatment remained much higher than the number of people using the facilities for preventative services, which was only 10–20% of the target population.

Other interventions: Rahim Yar Khan experience

In 2003, a non-governmental organisation called the Punjab Rural Support Program (PRSP) presented a management model termed the 'Rahim Yar Khan' model. In this model, control of all the basic health units in the Rahim Yar Khan district was transferred to the local PRSP body which pooled all health resources and deployed them according to local priorities. The scheme operated on private finance, without following governmental procedures. The model is operational in 12 districts of Punjab and there are claims of marked improvement in use of treatment facilities. However, many question the long-term sustainability of the programme. The PRSP approach means that a doctor works in three basic health units during the week on a rotation; therefore two out of three facilities have to rely on a paramedic service for most of the week. Further, there is evidence that because clinical service delivery is the main focus, preventive and out-reach services are ignored under this strategy.

Health Sector Reforms Programme

Early in 2006, the Punjab government responded with the Health Sector Reforms Programme – a novel and aggressive approach to address the deficiencies in totality. Over two years 5.5 billion rupees will be invested in improvements to all basic health units and rural health centres in Punjab.[11]

Major features of HSRP

(a) Provision of facilities:
- equipment according to the revised minimum standard:
  - ambulance
  - X-ray facilities
  - dental unit
  - ECG machine
  - hot air oven
  - autoclave
  - ultrasound machine
  - operation table, general surgery and obstetric instruments sets, air conditioner for the operation theatre
  - fetal heart detector
  - computer
  - school van for employees' children.
- civil works:
  - approach road
  - boundary wall
  - repair of main building and residences
  - water supply, sewerage, electrification, and telephone facilities.

(b) availability of staff:
- substantial incentive package in addition to the basic salary (approximately 15,000 rupees per month)
- HSRP allowance of 12,000 rupees per month
- non-practice allowance of 2,500 rupees per month
- additional 5,000 rupees per month for hard to reach areas in the remotest districts
- annual increment of 3,000 rupees per month on satisfactory performance
- 25 additional marks awarded by the Punjab Public Service Commission towards selection for a permanent government job for doctors who complete two years contractual rural service
- preference for selection to postgraduate training courses at teaching hospitals upon completion of two years rural service
- furnished accommodation for doctors in rural health centres, creating a respectable communal living space rather than isolating doctors in the various units
- free school-run facility for children of health facility staff
- facility for purchase of motorcycles for doctors posted at basic health units
- permission to undertake private practice at the facility after hours.

(c) improved service delivery:
- provide staff according to new minimum levels
- a school health and nutrition supervisor at all basic health units
- one additional midwife at basic health units
- four to six registered staff nurses at rural health centres
- anesthesia and operation theatre assistant, additional woman medical officer, midwife at rural health centres

- a computer and operator at every basic health unit and rural health centre
- induction and in-service training of health facility staff.

(d) regular monitoring and supervision of staff:

- regular monitoring and supervision of staff by district and provincial governments
- periodic evaluation of the programme against standard parameters based on main functions of the health facility
- comprehensive third-party evaluation of the programme at the end of second and third years of the programme.

Discussion

The HSRP will allocate medical resources for basic health units and regional health centres and provide additional staff. There are financial and career incentives too. A doctor in a city makes about 15,000 rupees per month, while a doctor working under the HSRP may make up to 30,000–35,000 rupees per month. Doctors selected to work at basic health units and rural health centres under the HSRP will have a one-week induction, and refresher training after one month.

Staff performance will be monitored regularly by district and provincial governments. Any staff reported to be absent or failing to meet performance standards in his or her duties will be given a warning. If performance does not improve after a second warning, the member of staff will be discharged.

Staff and equipment should be in place and ground works completed at all rural health centres by August 2007, and at all basic health units by August 2008. All 35 district governments have signed terms of partnership with the provincial government to commit to the programme and 1.2 billion rupees has already been released to the district governments to implement the programme.

As a result of recruitment rounds in April and May 2006, 85% of medical officer posts, 80% women medical officer posts and 70% of dental surgeon posts in the primary health facilities of Punjab have been filled, compared with a previous baseline of 70%, 44% and 41% respectively.[12] Interestingly, the greatest positive effect has been in the recruitment of dental surgeons and woman medical officers, who traditionally have been the most difficult to recruit in the rural areas. Almost 100% of vacancies have now been filled.

Conclusion

The task of providing primary healthcare to a population of more than 85 million in the province of Punjab has always been difficult due to the economic and sociocultural constraints common to all provinces and countries in the developing world. Many attempts to create an adequate healthcare system in the past followed a traditional management model, or trialled new initiatives such as contract appointments, decentralisation and devolution, but none proved successful to the level of expectations. All stakeholders, including doctors and, perhaps for the first time, the community, have been consulted in the design of the current HSRP, and lessons have been learned from the past. The result is a comprehensive package designed to meet Millennium Development Goals, and fulfil community needs.

The real impact of this initiative on the Millennium Development Goals and other primary healthcare indices will only become apparent following two to three years of implementation, and provided that the current political will and commitment is maintained.

References

1 Bureau of Statistics. *Punjab in figures, 2005.* Government of Punjab, Lahore.
2 Khan S. *District-based multiple indicators cluster survey.* Lahore: Government of Punjab and UNICEF, 2005:3–5.
3 Khan MN. *National maternal and child health policy and strategic framework (2005–2015).* Islamabad: Ministry of Health, 2005:5.
4 *Private health services for the poor: draft policy note.* India, March 2004. www.sasnet.lu.se/EASASpapers/11IsmailRadwan.pdf
5 Farooq U, Ghaffar A, Ahmed I *et al.* Doctor's perception about staying in or leaving rural health facilities in district Abbot Abad. *Journal of Ayub Medical College* 2004;16(2):4–6.
6 Khan MN. *Progress on agenda for health sector reforms.* Islamabad: Ministry of Health, 2004.
7 Kasi AM. *National health policy, 2001.* Islamabad: Ministry of Health, 2001.
8 Affi A. *Annual report health management information system.* Lahore: Department of Health, 1998.
9 Government of Punjab. *Training 2000, instruction manual for medical officers, women medical officers and lady health visitors.* Lahore: Department of Health, 1998.
10 Mursaleen. *Utilisation of public health facilities in Pakistan: assessed through national HMIS data.* Islamabad: Ministry of Health, 2002.
11 Javed TA. Presentation on Health Sector Reforms Programme. Punjab Cabinet presentation, 4 April 2006.
12 Saeed N. *First quarter (April–June 2006): progress of HSRP.* 30 June 2006.