Special Section 1
Making Health Services Work for the Poor in Pakistan: Rahim Yar Khan Primary Healthcare Pilot Project*

1.1 Pakistan's Health Status

The health status of Pakistan is characterized by a high population growth rate, high incidence of low birth-weight babies and maternal mortality. The severity of health poverty is closely reflected in the country's poor health indicators. In 2002, infant mortality rate is 82 per thousand live births; life expectancy is 63 years. Although country's health indicators improved over time but its pace has been very slowed (see **Table 1**). Maternal mortality rate is also high at 350-435 per hundred thousands births, largely because 78 percent of births take place at home, under the care of traditional birth attendants. The proportion of low birth weight babies was 25 percent; child mortality rate is 95 per thousand and proportion of under 5 malnourished children is 39; about 10 million children under five years are malnourished resulting in 61 percent being stunted, 39 percent being under weight and 9 percent being wasted. The country's health indicators depict a dismal picture when compared with other countries at the same level of development.

Table 1.1: Pakistan's Health Indicators

	1990	2001	2003
Infant mortality rate (per 1000 live births)	108	84	82*
Life expectancy at birth	58	63	63
Maternal mortality rate (per 100 thousand live births)	-	350-550	350-435
Expenditure on health (as% of GNP)	0.8	0.7	0.7

Source: Economic Surveys,*PIHS 2001-02

The country's health indicators are poorer than the low-income countries such as India, Bangladesh, China and Sri Lanka. The poor outcome in health sector is mainly due to the ineffective delivery of services as well as the low spending on the health sector in Pakistan, which remained very low relative to other developing countries. In addition, even this low level of spending on health sector declined from 0.8% of GNP in FY90 to 0.7 percent of GNP in FY02. Not only the spending on health sector is low but also its allocation within the sector is directed to the areas that do not benefit the poor. Clearly, high priority was given to

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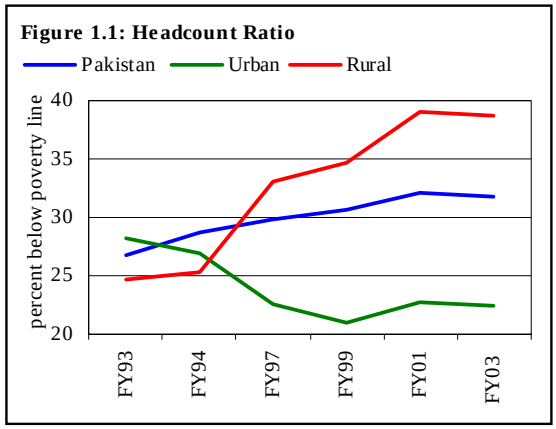
hospitals, medical colleges and curative services in urban areas, while primary healthcare and rural health service have been ignored which has led to a high rural-urban disparity in health care resulting in rapidly increasing poverty level in rural areas during the last decade (see **Figure 1.1**).



Poverty is thus both a consequence and a cause of ill health. Illness pushes people into poverty through lost wages, high spending for disastrous illnesses and repeated treatment for other illnesses. Due to inadequate nutrition and hence lowered immunity, poor are more susceptible to disease pushing them deeper into poverty. A recent health survey[1] shows that 55 percent of the poor and 65 percent of the extremely poor were ill in Pakistan. The poor quality of most government medical facilities and the lack of access by the poor forced them to go to private medical practitioners or quacks. Of the poor, on average, 54 percent go to private medical practitioners, 13.3 percent to government hospitals, 8.0 percent to government dispensaries and 5.6 percent to homeopaths, hakims and others. Ironically, a large number of private allopathic medical practitioners are poorly trained and have inadequate diagnostic facilities. As a result, the poor suffer a protracted illness and get locked into a high cost source of medical treatment. Since wages are commonly low, particularly in rural areas, unskilled labor, subsistence farmers and small holders are often forced to sell their meager assets and eventually borrow money to finance the treatment of the loved ones. Thus, the prevailing primary healthcare system in Pakistan pushes a vulnerable household into poverty and the poor households deeper into poverty. This is one of the explanations of a rapid rise in rural poverty during the 1990s (see **Figure 1).**

1.2 The State of the Health Sector

The major issue in primary healthcare system is the lack of capacity in district health offices in terms of human and financial resources that restrain their ability to provide primary and secondary health services to local population. Shortage of

[1] National Human Development Report Survey 2003.

equipment and staff at Basic Health Units/Rural Health Centres, particularly lady doctors, nurses, lady health workers, laboratory equipment, and drugs continue to affect the health system badly. Although doctors are paid on contract at a salary of Rs.12,000/- per month but they avoid to work in BHUs as they have no incentive to work in rural areas at such a low remuneration. Similarly, health personnel get paid their salaries but absenteeism is rampant particularly in BHUs. This reflects collusion between the health personnel and the district health offices at the expense of the rural poor. The BHUs are designed for primary healthcare in rural areas. The country has 5,308 Basic Health Units and most of them are non-functional because of absenteeism by doctors and health personnel. The corruption and collusions between paramedical staff and district health offices is also reflected by the fact that government medicines are sold in private market while spurious medicines are supplied to the poor patients making their life more miserable. There might be several reasons. Briefly, the primary healthcare system has fallen a victim to corruption and political influences. It is in this background that Government of Punjab has launched a pilot project in district Rahim Yar Khan in April 2003 in three phases to restructure the primary healthcare system through reorganization of BHUs in rural area.

What is a Basic Health Unit in Rural Area?

The Basic Health Unit (BHU) is a medical facility situated in rural Union Council. A BHU comprises of land donated by the locals on which there is an office building, residence for the doctor and residences of the staff. The sanctioned staff of a BHU comprises of i) a Medical Officer; ii) Medical Assistant or Medical Technician; iii) Lady Health Visitor; iv) Sanitary Inspector; v) Dispenser; vi) Mid Wife; vii) Naib Qasid; viii) Chowkidar and ix) Sanitary Worker. Basic Health Unit is designed for primary health-care, which comprises of the following functions: a) Treatment & medication of rural population; b) Health education; c) Running of vaccination programmes; d) Provision of basic health & antenatal care for women and children; and e) Implementation of national programmes related to diseases like polio etc.

The BHUs fall under the administrative control of the Executive District Officer (Health). The provision of salaries, medicine and equipment to the BHUs is done by the EDO (Health) from the budget provided by the District Government. The overall administrative control and financial management of the BHUs is the responsibility of the EDO (Health). Monitoring and supervision of the BHUs is also his responsibility. Majority of the doctors who work in the BHUs are not regular government employees but are contractual appointees. Their contracts allow them a salary of Rs. 12,000/- per month, which makes it mandatory for them to reside at a BHU and allow them to conduct private practice in the evening.

1.3 The Structure of the Primary Healthcare Model

The vision[2] is to reorganize the primary healthcare services for the rural poor within the existing resources through restructuring of existing infrastructure and providing incentives to the doctors so as to use their optimum services. The model envisages a non-political small and professional project management focusing on primary healthcare. It also envisages a new direction and discipline for the para medical staff. The mission is to serve the poor to improve their health conditions by restructuring the existing primary healthcare services that save them from private practitioners and quacks. The objective is to let the poor know that the state lives and cares for them. Salient features of the model is as follows:

- All BHUs in a district are organized in the form of clusters ensuring that the distance within a cluster is manageable and should not be more than 15-20 Kms. A cluster is comprised of three BHUs. The doctor is the administrative head of a cluster rather than a single BHU.

- With a lesser number of doctors being employed under a new contract, their salary is enhanced from Rs.12,000 to Rs.30,000 per month so as to give them incentive to live at the focal BHU. The doctor is not allowed to conduct any private practice and to ensure that no staff member indulges in such a practice within a BHU. Paramedical staff is also given a reward on their best performance.

- The mobility of the doctor is ensured. Doctors are allowed to get an interest free loan of Rs100,000 to buy a vehicle. The doctor covers all BHUs according to a timetable.

- The doctor is responsible for the overall discipline, records and betterment of his cluster. The doctor resides at the focal BHU and is also responsible for looking after emergencies even after office timings. The focal point is chosen on the basis of better residential facilities for the doctor along with availability of electricity and water.

- A Project Management Unit (PMU) is established in the district led by a Project Director and support staff. The PMU is responsible for the maintenance of stock and budget, which have been handed over by the

[2] The model was envisaged by Mr. Jahangir Khan Tareen, Advisor to the Chief Minister, Government of Punjab who adopted three Basic Health Units in collaboration with NRPS in the vicinity of Lodhran. The success of the model made Mr. Tareen thinks of launching a pilot project on a larger scale in Rahim Yar Khan.

District Government. Under no circumstances it is permissible to use the funds from the District Government for the PMU. The PMU expenditure will be minimum and remained within a limit of 5 percent of total BHUs budget in RY Khan, which is incurred from the funds provided by the PRSP.

- The PMU has taken over the overall administration of the BHUs from the district government. The PMU is also responsible for support as well as guidance to the doctors.

- A monitoring system independent of the district health office is the essence of the project. The PMU is responsible for monitoring, supervision as well as the collection of data. The Project Director visits at least 60 or more BHUs in a month. The Assistant Project Director also makes a similar number of visits to BHUs. During a visit the doctor and the staff are motivated, the patients are asked about the working of the BHU, all records and stocks are inspected.

- Community mobilization and health education is an integral component of the project. To provide health education, all doctors focus on this activity on the second Monday, Tuesday and Wednesday of each month. They talk to groups of patients, women & children giving them health tips. They visit schools to talk to children on the 3rd Thursday, Friday and Saturday of every month.

1.4 The Launching of the Project

The District Government Rahim Yar Khan comprised of four tehsils with a total population of 3.5 millions out of which 2.9 millions are rural population. The break up of BHUs and the number of doctors working there till April 2003 is given in **Table 1.2**.

Table 1.2: BHUs and Doctors in Dist. Rahim Yar Khan

Tehsil	BHUs	Doctors
Rahim Yar Khan	30	18
Sadiqabad	24	7
Khanpur	22	11
Liaquatpur	28	4
Total	**104**	**40**

Out of these 40 doctors only 9 were residing in the BHUs and almost all of them used to conduct private practice. All the problems that have been enumerated as causes of the failure of the primary healthcare system in Pakistan existed in Rahim Yar Khan as well.

The project was launched under the Chief Minister's Initiative on Primary Healthcare. The District Government Rahim Yar Khan signed an agreement with the Punjab Rural Support Programme (PRSP) for outsourcing of the management of all Basic Health Units in Rahim Yar Khan to the PRSP for a period of five years from April 15th, 2003. The District Government has transferred to the PRSP the budgetary provision relating to unfilled posts, medicine, maintenance and repair of buildings and equipment, utilities, stores and office supplies for the relevant financial year. Total BHUs budget in Rahim Yar Khan district is Rs 72.1 million, of which non-salary budget is 41.6 percent in FY04. The financial provisions placed with the PRSP are in the form of a grant in aid. The PRSP renders accounts of the management operation to the District Government within a period of three months at the end of financial year.

1.5 Performance Evaluation of the Project

While reorganization of BHUs and the expenditure incurred on health services are essential elements to revive the primary healthcare system in rural areas, the real test lies in their impact upon the health of the poor. However, there is a lag between the expenditure incurred on health services and the final outcome on health indicators. Nevertheless, an attempt has been made to evaluate the performance of the project. To collect the data and information, a survey has been carried out in remote rural areas of district Rahim Yar Khan by the SBP in the first week of December 2003. Two questionnaires—one for the doctors and the other for the patients have been prepared to get information, data and feedback from the doctors as well as the patients about the use and improvement in primary healthcare service at BHUs. Questionnaires are designed to get information on socio economic attributes of patients so as to conduct meaningful analysis from the data. Almost all doctors (35) were asked to fill the questionnaire on 2nd December during a monthly review meeting at the PMU, Rahim Yar Khan, while 30 patients were interviewed during a two-day visit to 12 BHUs located in the vicinity of Rahim Yar Khan and Sadiqabad. The preliminary findings of the survey are summarized here:

- The education status of patients indicates that primary healthcare services are mainly used by illiterate (50%) followed by patients with primary (23%) and secondary education (17%), respectively.

- The occupational status of patients shows that they belong to the low paid jobs as 43 percent patients were Agricultural labourers, 23 percent were service workers, 17 percent were small farmers, 10 percent were carpenters and masons and 6 percent had their own small shops.

- The utilization of primary health care services has increased substantially , as OPD increased by about 200 percent since the launching of the project in April 2003. About 83 percent of those who visited for treatment before recent reorganization of BHUs responded that they now feel a significant improvement in health service in BHUs. On the other hand, 17 percent patient responded that treatment was already good.

- Distance of BHUs from the residence of the poor is an important indicator for utilization of health services. More than 70 percent patients responded that the distance of BHUs from their home was less than 3 Km, while 23 percent and 7 percent patients responded that their distance was between 4-5 Km and more than 6 Km respectively. The majority of the patients (60%) reported they walked to the BHUs, while 23 percent used bicycle and 17 percent used public transport. The average travel cost to reach BHUs was about Rs.7 per person. Almost all the patients responded that they would prefer to use a government health facility because of free provision of treatment and medicine.

- The absenteeism by doctors seems to have been overcome as about 96 percent patients said that they found a doctor in BHUs during working hours. About 93 percent of patients said that they are now satisfied with the health services provided in BHUs mainly because of good treatment, free medicines and good services. While majority of the patients complained about the non-availability of a midwife at BHUs, most of the patients responded that their children are provided free immunization facilities at BHUs. Majority of the patients responded that they do not find any political interference or corruption in BHUs.

- While almost all doctors responded that they have a complaint system in BHUs, majority of the patients said they do not know how to make a complaint about the services. About 91 percent of doctors responded that they are satisfied with the services provided at BHUs, while only 9 percent responded that they are not satisfied and the system needs further improvement. They were of the opinion that facilities like blood/urine examination, nebulizer and x-ray should be provided at BHUs. Majority of the doctors were satisfied with their salary package, as they do not find any need to do private medical practice.

The preliminary findings of Rahim Yar Khan pilot project suggest that the poor have started benefiting from the services. While there is a need for further improvement in BHUs, the experience demonstrates how one can make primary

healthcare services work for the poor by restructuring the system within existing resources. Upon the initial success of the project, the Government of Punjab is now replicating this project in few more districts. There are 5308 BHUs in the country. Most of them are non-functional mainly due to absenteeism, corruption and political influences. These BHUs can be made functional by replicating the experience of this project along with ensuring that the quality of project management unit is also strengthened.

Although emphasis has been on accelerating the economic growth rate for human development and poverty reduction but it is not enough. It also requires more effective use of existing resources to deliver the basic services to the poor. The rural poor who are about 39 percent below official poverty line or 40 million of total population badly need an improvement in health services, which would help them to get out of poverty and ensure healthy lives for their children.