Social Enterprise Development Centre

Policy Brief

PRIMARY HEALTHCARE SERVICE DELIVERY SYSTEM IN PUNJAB

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Executive Summary

Healthcare plays a vital role in sustaining human capital hence the healthcare delivery system in a country must be robust. Punjab still faces a high burden of disease and key health indicators show a poor performance. This is indicative of shortcomings in the service delivery mechanisms due to policy makers failing to cater to consumer demand leading to inefficient resource allocation, difficulty in accessing available facilities and poor conditions of those facilities. These weaknesses need to be addressed in order to counter the problems that have led to an underutilized primary level and an over-burdened tertiary level of healthcare services.

Current system and consumption patterns

Punjab's current population is estimated at 100 million. It continues to experience a high burden of disease yet simultaneously maintains a high population growth rate of 2.64 percent (Punjab Policy and Strategic Planning Unit (PSPU), 2012).

Punjab's under five mortality rate per 1000 live births is as high as 112 whereas the MDG target was to reduce by two thirds the mortality rate per 1000 live births. Similarly, the infant mortality rate at 77 and maternal mortality rate at 300 are also higher than the targets of reduction by two thirds and three quarters by 2015, respectively (Punjab Health Department, 2017; United Nations Development Program (UNDP), 2017).

Poor health indicators coupled up with a high population growth rate is a cause for concern as it mounts up pressure on existing resources.

Table.1 Leading causes of death

Cause of death	No. of deaths (thousands)
Respiratory Infections	104.5
Pre-term Birth Complication	77.4
Diarrheal diseases	63.7
Tuberculosis	4.6
Neonatal infections	41
Birth Trauma	52.3

(Source: WHO, 2012)

Punjab's health delivery system consists of 2,863 primary level facilities that include

2,454 basic health units (BHUs) and 291 rural health care centers (RHCs) (PSPU, 2012). A BHU serves up to 25,000 people with basic medical and surgical care, preventive services, maternal and child healthcare services. An RHC, with an additional facility of 10-20 inpatient beds, dental and ambulance services, serves a catchment population of up to 100,000 people (Punjab Health Department, 2012).

The existing ratios are such that there are around 1000 people per one bed/doctor/nurse (Ministry of Finance, 2016). The Eleventh Five Year Plan goes as far as stating that the basic medical facilities are non-existent in the primary tier (State Bank of Pakistan (SBP), 2016).

Only 1.98 percent of Punjab's rural population gets health consultations from BHUs/RHCs, 2.19 percent from a herbalist, 15 percent from a public hospital and 77.55 percent from a private hospital despite high out of pocket expenditures (Pakistan Bureau of Statistics (PBS), 2015).

Unmet targets, poor health indicators and changing consumption patterns indicate an inadequate current healthcare system.

Supply Side Problems

1) Budgetary Constraints

With the enactment of the 18th constitutional amendment, healthcare has been devolved to the provinces (SBP, 2016). During the past decade, Punjab's public healthcare expenditure has increased, reaching 0.6 percent of provincial GDP (PSPU, 2013) which is strikingly low compared to the minimum recommendation of 5 percent by the World Health Organization (SBP, 2016). The share of salaries in current expenditure on health increased from 55 percent to 63 percent and a very small part of it goes to the primary level (PSPU, 2013). Moreover, it compresses the non-salary part of the budget that includes procurement of infrastructure and supplies which the primary level lacks.

2) Geographical Accessibility

On average, a village in rural Punjab is located 8km away from the nearest BHU (PBS, 2015). Moreover, 20 percent of the rural population do not have a BHU within 10 km of the village, while 22 percent of them do not have an RHC within 10 km of the village (PBS, 2015). The distance is the most commonly provided reason by the rural households for not visiting a government facility (PBS, 2015).

3) Inadequate Infrastructure

The BHUs lack adequate infrastructural elements, be it general or medical. Free and Fair Election Network (2012) brought to the fore serious shortcomings in the infrastructure and facilities of the 70 BHUs monitored in Punjab. One-fifth of the BHUs monitored by FAFEN were found to be operating without specially trained staff to treat tuberculosis (TB) patients. Moreover, the BHUs lack trained staff for disease control programs such as the Control of Diarrheal Disease (CDD) and Malaria Control Programs (MCP). Other important positions such as those of birth attendants and sanitary workers were not fully occupied either.

Out of the 70 BHUs monitored, 12 were not in good condition; they did not have a boundary wall around the BHU, and were without a washroom (with running water). Additionally, 51 BHUs lacked mini laboratories and 66 BHUs did not have a generator for power backup, an absolute

necessity due to the prevalence of loadshedding (FAFEN 2012a). Moreover, maternity beds, labor rooms, sterilizers and stretchers were also missing. Residential quarters for the BHU staff, Lady Health Workers (LHWs) and doctors were also unavailable in a high number of BHUs (FAFEN, 2012a).

According to the Health Facility Assessment–Punjab Provincial Report (2012), medical equipment and medicines are not topped up. A lot of BHUs did not even have as much as 25 percent of the drugs and vaccines (PSPU, 2012).

The Health Facility Assessment notes that even where the availability of infrastructure is not a problem, the healthcare professionals are unavailable which disrupts the service delivery. Due to weak monitoring, absenteeism exacerbates the problem. Furthermore, staff job descriptions and the protocols of service were poorly followed up at the majority of the health facilities (PSPU, 2012).

Current Approach and Critique

1) **Annual Development Program (ADP) 2016-2017**

The ADP states the bifurcation of the healthcare system into primary, secondary and tertiary healthcare as Specialized Healthcare and Medical Education (SH&ME) aimed at decreasing the load on tertiary level. The main focus is to upgrade already existing tertiary facilities to increase service reach and enhance the quality of healthcare provided in the future. Moreover, the Research and Development component of the program will also focus on establishing Research Labs, Information Systems and Nuclear Medicine Centers in urban hospitals (Punjab Planning and Development Department (PnD), 2017). Earlier Development Programs there have placed special focus on BHUs and RHCs and suggested consolidation of existing health facilities instead of creating new infrastructure. Moreover, despite being high, the resource allocation was need based (PnD, 2013). The current Development Program, be it the upgradation or building of facilities or research and development, completely shifts the focus on to tertiary level. To have no mention of the primary care in addition to its marginalization due to the new SH&ME translates into overlooking a major chunk of the population. If the RHCs and BHUs are made fully functional in terms of personnel, infrastructure and supplies, people would have no reason to go all the way to private hospitals and the problem of underutilization of the primary tier would be solved simultaneously.

2) **Programs run through BHUs:**

- **Expanded Program on Immunization (EPI)**

EPI is a world-wide program being carried out with the help of WHO and UNICEF to reduce child mortality by preventing vaccine-preventable diseases. The percentage of children aged 12-23 months that have been fully immunized is 68 percent (PBS, 2015). Measuring immunization presents its challenges because parents often do not have the children's immunization cards with information on vaccinations received. The alternative is to ask parents but this involves the risk of parents not being able to remember vaccinations and also confusing different types of vaccines or other injections with vaccinations (PBS, 2015).

- **Family Planning and Primary Health Care (FP&PHC)**

The FP & PHC program added 8,300 more LHWs against the target of 10,000 for the year 2016-2017 to its already recruited lot of more than 100,000 LHWs. Among their services are counselling regarding birth spacing and diet supplementation, improved sanitation, larger vaccination coverage, antenatal and postnatal coverage of the pregnant women. LHW program can be helpful for pregnant females, but the limited expertise of LHWs through short training cannot replace that a professionally trained nurse (Akram and Khan, 2007). However, antenatal care such as monitoring pregnancy and mitigating the risk of morbidity for the mother can only be provided by a skilled attendant. Due to the dearth of female gynecologists in health centers, this facility is not available to many women. Only 6 percent rural cases for prenatal and 3 percent for postnatal consultations were dealt with by a LHW (PBS, 2015).

Recommendations

Resources should be carefully managed by the provinces and distributed between urban and rural areas proportionally so the health status of the people is improved. Additionally, a higher proportion of the budget should be allocated to upgrade existing facilities by acquiring medical infrastructure.

Specialized trainings should be organized for doctors, nurses, lady health workers, health technicians and dispensers in order to enhance their performance and increase the coverage of their services.

Despite the emphasis on medical colleges and the number of doctors available, very few people are willing to extend their services to rural areas, hence the dearth and absenteeism. More incentives should be created for them in order to attract them to local areas e.g. provision for residential facility, and performance based bonuses etc. This would help fill up the sanctioned posts and reduce the doctor/nurse to population ratio.

It is important to monitor infrastructure, human resources, drugs, supplies and equipment. The last health facility assessment that took place was in 2013. Regular assessments of the healthcare facilities should be carried out to keep track of their performance and condition.

It is very important to involve the consumers in the reform process as they are the biggest stakeholders in order to make the program sustainable. Performance evaluations could be received from patients towards the end of their visit to record their feedback. Monthly performance review meetings should be held, spearheaded by health officials and attended by both officials and consumers.

In order to improve physical access, a transportation scheme could be set up that would allow people to commute easily from different stops near their houses to the BHUs.

Use of technology should be extended to healthcare professionals such as training them to provide health information, follow up reminders, and any health-related referrals and assistance via text messages. This is a cost-effective way to target remote villages (Punjani et al., 2014).

Biometric devices could be used to monitor check-ins and check-outs of the staff in addition to already existing penalties to curb absenteeism.

A good referral system must be established in order to reduce the burden on the tertiary level. Only cases requiring specialized care should be referred to a specialist, not those that could not be dealt with due to a shortage of supplies.

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