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Sindh Province Healthcare Financing

Analysis and Recommendations

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ACRONYMS

ANC	Ante-Natal Care
BHU	Basic Health Unit
CCT	Conditional Cash Transfer
DHIS	District Health Information System
DHO	District Health Organization
DOH	Department of Health
DPT	Diphtheria, Pertussis, Tetanus
EDO	Executive District Officer
EPHS	Essential Package of Health Services
HLSP	HLSP, Inc. Consulting Firm
HMIS	Health Management Information System
HR	Human Resources
HRH	Human Resources for Health
HSRU	Health Sector Reforms Unit
IMR	Infant Mortality Rate
LHV	Lady Health Volunteer
LIC	Lower Income Country
M&E	Monitoring & Evaluation
MCH	Maternal & Child Health
MDG	Millennium Development Goal
MSDP	Minimum Service Delivery Package
MO	Medical Officer
MOH	Ministry of Health
NCD	Non-communicable Disease
NGO	Non-Governmental Organization
OPD	Out-patient Department
PBC	Performance Based Contracting
PBF	Performance Based Financing
PHC	Primary Health Care
PKR	Pakistan Rupee
PNC	Post-Natal Care
PPHI	People's Primary Health Care Initiative
PRSP	Punjab Rural Service Provider
RBB	Results-based Budgeting
RBF	Results Based Financing
RHC	Rural Health Center
RMCH	Reproductive Maternal & Child Health
RSP	Rural Service Provider
SOP	Standard Operating Procedure
THE	Total Health Expenditure
TPE	Total Public Expenditure

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March 25 2014

I INTRODUCTION

In Pakistan's southernmost Sindh province, healthcare management and financing challenges have contributed to poor maternal and child health outcomes. In 2013, USAID's Health Systems Strengthening project, under the broader Maternal & Child Health Program (MCH), was launched to support innovative, cost-effective, integrated, quality programs and services to strengthen systems around reproductive, maternal, and child health services and to improve health outcomes.

This assessment was commissioned under the Health Systems Strengthening project, in order to analyze the international and local experience of health financing, and to recommend ways in which these experiences might be adapted to the Sindh health system context.

The objective of this assessment therefore, is to critically analyze the strengths, weaknesses and gaps in the Sindh health financing system and to assess whether and how innovative financing mechanisms could improve health systems performance in Sindh. These activities have led to the identification of feasible and high impact opportunities for USAID investment.

The first stage of the assessment, conducted in October 2013, was a literature review of key health system documentation from Pakistan and Sindh Province. Key topics for additional review of international literature were identified and included "contracting-out" of service delivery responsibilities to non-government entities, "contracting-in" or performance-based financing of service delivery responsibilities to government entities, and regulation of the private sector. The Literature Review was further informed by comments from JSI Pakistan and USAID before finalization.

In January 2014, the team conducted a two week visit to Pakistan that included a visit to Karachi to meet with key province-level stakeholders and to Lahore to learn from the Punjab experience. In Sindh Province, activities included meetings with and presentations to the Sindh Secretary of Health, the Health Sector Reform Unit (HSRU), USAID and their MCH partners (JHPIEGO, PSI, Marie Stopes), Benazir Income Support Program, World Bank, President's Primary Health Care Initiative, Heartfile, Pakistan Bait-ul Mal,and Zakat as well as site visits to Thatta District facilities and the District Health Officer (DHO). In

Lahore, the team met with the HSRU in Punjab, as well as the Contech Team to learn about the Sehat Sahulat Card Scheme.

Once the team synthesized information from interviews, they returned to Sindh to meet with the Sindh DOH Secretary, HSRU, JSI team, and USAID. These meetings gave the team an opportunity to vet recommendations with key stakeholders and receive feedback.

II BACKGROUND AND CONTEXT

Over the last two decades, improvement in Pakistan population health has been very slow (Bhutta 2013). Pakistan is not expected to meet its MDGs, and its health indicators are significantly lower than those of neighboring countries (Nishtar 2013). Health indicators demonstrate significant inequities between rural and urban populations, between upper and lower income quintiles, and between males and females.

The population relies heavily on a private health sector financed by out-of-pocket payments. Seventy-eight percent of the population pays out-of-pocket for health care. Private sector providers, who make up 70 percent of the health care providers in Sindh, mainly used for curative services (Nishtar 2013), are unregulated, and medical malpractice is a frequent concern in the media (Shiwani 2011). Providers in the private health system range from quacks lacking credentials to internationally accredited hospitals (Zaidi 2011); supply chains range from counterfeit drugs to strong philanthropy.

Less than four percent of Pakistan's general government expenditure is on health, which is less than half the mean amount spent by comparison countries (Nishtar 2013). Only 22 percent of the population has health costs covered through employers or social safety nets, and 70 percent of economic shocks to poor households are from catastrophic health expenditures (Nishtar 2013).

Pakistan has an underfunded and underperforming public health system compared to other countries in the region. The volume of services provided per capita is very low (Martinez 2011). The public health sector faces serious governance challenges, including rampant informal fees, dual practice, and practitioner absenteeism (Transparency International 2011). Public facilities routinely lack essential drugs, staff, supplies, and basic equipment; their providers are unmotivated and facilities and equipment are poorly maintained (Martinez 2011). Patient satisfaction and confidence is low in the public sector, which is widely seen as corrupt.

Compared to other countries in the region, public preventive services are underutilized and consumers report their quality to be unsatisfactory (Nishtar 2013). In fact, 70 percent of the population does not regularly seek publicly-provided preventive care, preferring to wait until they are in need of curative care, which they seek from private sector providers. (Nishtar 2013). Outreach services to increase demand for public preventive services are limited, and ANC care uptake is particularly low.

Sindh Province faces the dual challenge of housing both a very urban and a very rural demography. Karachi, the province's capital, has a robust private healthcare sector, but also suffers from a significant non-communicable disease (NCD) burden, including Polio. Rural areas in Sindh suffer from under-nutrition, remoteness, and weak public health infrastructure. The Sindh public health system has lower utilization than other provinces (22% vs. 29 percent). In Sindh, due to poor access in rural areas, the infant mortality rate (IMR) is higher than the national average (81 vs. 78) and has not improved in the last

decade. The neonatal mortality rate has increased (from 44 to 53) in the same period. Sindh maternal mortality is higher than the national average (314 vs. 276) (Zaidi 2011).

In an effort to achieve the MDGs while facing an underperforming primary health care system, the President's Office launched the President's Primary Health Initiative (PPHI) in 2006. Under PPHI, management of 80 percent of Basic Health Units (the basic primary care unit in Pakistan) was contracted out to an NGO, the Rural Support Program (RSP). In 2011, a third party evaluation of PPHI was broadly positive, noting increased use of services, improved medication availability, better community engagement, and significantly improved physician attendance (Martinez 2011).

This positive experience of contracting out the management of service delivery laid the pathway for expanded contracting out and for many reform recommendations in the Sindh Health Sector Strategy, discussed in the next section.

III SUMMARY OF THE LITERATURE REVIEW

The following section summarizes the October 2013 literature review. The purpose of that review was to synthesize the various strategic purchasing approaches that have been applied in developing countries, and to document Pakistan's experience with some of these approaches, in order to provide background and context for the present field study and its recommendations. A summary of that literature review is provided here for reference only. For a more comprehensive look at the strategic purchasing landscape both globally and in Pakistan, please refer to the full literature review (Fitch 2013).

INTERNATIONAL TRENDS IN STRATEGIC PURCHASING

Contracting out to NGOs

Globally, contracting out management and service delivery to NGOs has had success in increasing primary health care services. Loevinsohn (2008) reported significant improvement in quality and utilization at equal or lower costs compared to baseline in a range of countries (Cambodia, Bangladesh, Bolivia, Afghanistan, Rwanda, Costa Rica, Guatemala, Haiti and Pakistan). The improvements were sustained up to nine years and were delivered on a large scale to many millions of people. Other contracting-out experiences (India, Madagascar, South Africa, Senegal) additionally confirm significant improvements in the quantity and quality of care compared to the previous services (Liu 2008, Loevinsohn 2008, Cristia 2008, Mills 1998).

The success of contracting out is attributed to varied causes (Loevinsohn 2008):

- Greater focus on measurable results
- Greater flexibility of private sector to avoid red tape and political interference
- Greater managerial authority and accountability needed to address absenteeism, kick-backs, and drug thefts
- Competition to improve performance
- Refocuses government on stewardship and oversight rather than service delivery

Successful contract performance was noted to depend on the contracting agent's provision of clear technical performance requirements and having effective contract management systems.

Contracting out to the private sector

Contracting out to the private sector has had less success in low and middle income countries. Key factors inhibiting success include weak ability of governments to regulate, license and/or accredit the private sector. Underfunded governments have difficulty managing contracts with diverse providers and assuring performance. Governance challenges also have shown to limit the accountability of contractees. These factors have often undermined public health services, since private providers tend to focus on profitable curative care than on preventive services.

Top-down regulation of the private sector is challenging for low and middle income countries (Smith A 2001, Tangcharoensathier 2008, Kumaranayake 1998). Registering and enforcing quality standards among public providers requires high levels of private sector management capacity. In systems where private providers are required to register, limited success has been achieved, as most providers see little value in subjecting themselves to government regulation. Even when private sector providers do register, the public sector often lacks the needed capacity to consistently enforce regulatory standards through rational systems of penalties and sanctions. These challenges stem from both governance complexities as well as lack of technical capacity. Recent efforts to increase private sector regulation have shown similar results in Sindh as well.

Incentive-based regulation improves the quality of private sector service provision (Lagomarsino 2009). In developing country contexts, incentivizing performance shows promise over top-down regulation in ensuring quality healthcare provision. Incentivizing performance means providing work opportunities or payment contingent upon achieving certain conditions. Such conditions could include registering as a provider, completing accreditation or quality assessments, agreeing to provide priority services, and/or agreeing to report on service delivery per government requirements. Work opportunities could be licensing facilities to provide services or allowing approved providers to provide certain services. The literature shows that incentive-based regulation is also a major undertaking, and requires robust systems to support the necessary registration, quality assurance and routine reporting of the private sector. These activities are easier to administer when providers are voluntarily participating than when providers are forced to participate. Globally, LMICs have had greater success with incentives to improve quality than with top-down regulation, penalties, and sanctions.

Performance-based Financing

The literature on Performance-based Financing is vast and shows mixed results. Overall, the review showed that PBF has the potential to improve public health sector performance/service delivery in a wide range of contexts when effectively implemented. That said, implementation of PBF has many of its own challenges that limit its successful implementation. These challenges include:

- Effective operationalization of three independent functions: Regulator, Purchaser
- and Provider
- Establishing credible verification procedures
- Making informal private practice in public settings transparent and formal
- Addressing covert HR issues, such as upstream payments for hiring, absenteeism, unsanctioned transfers of staff, and appropriate staffing levels
- Assuring actual provider incentives are conditioned to actual performance

SINDH'S EXPERIENCE WITH STRATEGIC PURCHASING

Sindh Health Strategy

Following the national devolution reforms, the Sindh DOH responded to their new leadership responsibilities by exploring innovative approaches to strengthen the performance of the health system. The DOH engaged in a collaborative strategic planning process with health sector stakeholders to identify critical needs and innovative approaches to fill these needs. The resulting Strategy laid the ground for significant health system reform.

The key priorities of the Strategy are:

- Strengthening and expanding public district health systems to extend priority (maternal/child health, primary care) services to women, rural populations, and poor households;
- Increasing accountability through stronger M&E systems, contracting, regulation, and performance-based financing;
- Engaging the private sector to achieve provincial health system objectives through both top-down regulation and incentivizing accreditation, higher quality care, and provision of priority services.

A broad range of financing approaches, including vouchers, health equity funds, and contracting, are proposed in the Strategy to address health systems bottlenecks. The Strategy does not however, prioritize approaches; nor does it rationalize how these approaches would fit together under a coherent health financing framework.

Contracting out to the private sector

Contracting out the management of public health service delivery to NGOs resulted in many improvements in service delivery. When RSP/PPHI was contracted to manage public health service delivery at basic health units (BHUs) in Sindh province, the quantity and quality of services available to the population increased. (Martinez 2011) Most of the improvement occurred in remote facilities. Improvements of note include reduced stocks-outs of drugs and other supplies, staff satisfaction with management, record keeping, and patient satisfaction with services (Zaidi 2013). Under the contracting-out arrangement, RSP was able to exert greater management authority. Using this authority, RSP filled vacant positions by directly hiring new physicians on temporary contracts, re-structured physician's responsibilities with resulting salary increases, and strictly forbade dual practice, informal fees, and absenteeism. The quality and timeliness of monitoring and evaluation reports improved. Overall, the RSP/PPHI experiment demonstrated that allowing for greater management autonomy and flexibility has potential to directly contribute to improved service provision quality in Pakistan.

Contracting out is not a panacea: despite consistent improvements under contracting out, systemic health issues still inhibit Sindh's potential to improve public health. Chronic, low public investment constrains both access to and quality of primary and preventive care. Cost-effective outreach and mid-level (female) providers needed to service the population are not recruited nor are functioning. Service provision is dominated by physicians who focus more on profitable curative care, even in public settings. Management does not prioritize primary or preventive care. Out-of-pocket costs are high by regional standards, with transport costs being a major barrier to the use of primary care (Zaidi 2013). Consumer trust, particularly by women and children who are the main users of public primary care services, remains low. Consequently, the primary care system remains weak by regional standards. ANC utilization rates remain well below those of neighboring countries. Essential MCH utilization is low and reproductive health

utilization is "simply abysmal" (Martinez 2011). Many of these challenges require systems reforms that contracting out alone cannot accomplish.

Lack of coordination between the DOH and PPHI hindered district-level management and facility-level service delivery and needed DOH reforms. As the decision to contract with PPHI was made by the President and not the DOH, contract management responsibility, as well as the responsibility to improve primary care and preventive services, remained primarily with the President's office and not with the DOH. Poor coordination between the DoH and RSP caused service delivery tensions between PPHI and supporting district facilities. When contracted facilities referred patients to non-contracted facilities, for example, the receiving facilities did not want to accept the patients. The DHO did not support, with staff, equipment and/or drugs, PPHI facilities. Coordinating services across contracted and non-contracted facilities was difficult, at times resulting in provider vacancies. PPHI facilities and district-managed facilities operated separately, rather than providing a continuum of care.

IV FINDINGS FROM IN-COUNTRY ANALYSIS

POLICY DIRECTIONS OF DOH

Overall, DOH wants to improve business as usual. The DOH has actively embraced the opportunities for innovation through devolution and is progressively working to define how it will structure regulation, provision, and management of services under such a structure. The DOH has been active in moving forward health reform with the Sindh Health Strategy. It has submitted a new bill to establish a Health Care Commission to regulate quality of all health care establishments. The DOH has expanded contracting out, as evidenced by the Secretary's recent enthusiasm regarding contracting-out and a recent public tender for management contracts of other service delivery entities. These factors represent a significant opportunity to support Sindh in taking bold steps to improve health services.

DOH leadership is favorable to well-managed contracting out. According to PPHI, there has recently been a five year renewal of the PPHI contract. Moreover, the DOH recently launched a solicitation for Expressions of Interest (EOIs) to manage services at additional select Rural Health Centers RHCs, mid-level hospitals (THQs), District Headquarter Hospitals (DHQs) and other hospitals. In addition to contracting out management of facilities, the solicitation requested EOIs for management of diagnostic and other services in hospitals, hospital trauma services, ambulance services and nurse/midwives and paramedic training.

The end of federal support for PPHI increases pressure on the DOH to define if and how it will engage in contracting out of health services management. In January 2014, the Federal Government terminated the Federal Support Unit, which provided some 700 million rupees of support for the national PPHI program. If provinces are interested in maintaining PPHI, then they must now finance the entirety of the program from their own provincial budgets. This policy is consistent with ongoing devolution of health responsibilities to the provinces. The Secretary and his department's initiative to allocate budget for PPHI will be a strong indicator of their commitment to contracting out.

DOH Contract Management Capacity

The DOH does not have authority to manage contracts. This is due to the structure of contract management in Pakistan. Federal contracts, such as PPHI, are managed at the

Federal level on behalf of the province, while provincial contracts are overseen by the DOF. Thus, the DOH does not have the mandate to oversee contractor performance, deny/approve payment, provide technical direction, and perform other essential contract management tasks. At the same time, DOF does not have the technical capacity in health sector management to oversee the performance of health contracts, nor have they established any coordination systems with DOH to fill this gap. For instance, DOF does not review M&E reports, review HR information, or evaluate quality of service delivery. Thus, the general perception is that contractors are poorly regulated and not adequately held accountable for performance.

DOH has the capacity to oversee the technical, but not yet the legal or financial, aspects of contractee performance. The basic elements for DOH to oversee the technical aspects of contractee performance are in place, as the traditional role of the DOH has always been to oversee and manage the technical performance of service delivery. Thus, with some support and reorientation, it appears that the DOH possesses the skills, tools, and systems to assume this role. However, since the DOH has not historically played a role in oversight of contractor performance, they do not have the knowledge, systems or tools to oversee the legal and financial aspects of contract management.

Despite devolution, integration of federally-supported vertical programs has been limited. The DOH, districts and facilities, recognizes the need to integrate parallel vertical programs at the provincial, district and service delivery levels. Because these vertical programs are federally managed, health facility managers and providers are unable to integrate the parallel vertical health programs (family planning, MCH, primary care, malaria/TB) and the Essential Health Service Package within primary care. The multiple vertical programs each have different and duplicative support structures, such as M&E and supervision. PPHI has attempted to take on some of these vertical health program responsibilities as part of their primary care, but not on a grand scale or in a systematic way. The HSRU recognizes and appreciates the challenges due to the lack of integration.

Management of Primary Care and Preventive Services

Volume and quality of preventive services remains low. Within Sindh, and even at public RHCs in rural areas, there is greater emphasis on curative than preventive services. There are fewer staff, less equipment, lower drug supplies, and less investment in public primary care and preventive services. Preventive care receives disproportionately less public investment than curative care, which is reflected by the inadequate levels of preventive activities such as mass education campaigns, community targeted education campaigns, and individual patient education.

Monitoring and evaluation of the quantity and quality of services delivered at primary care facilities is limited. Confirming recent reports from JSI, M&E registers appear incompletely filled out, particularly with patient-level data, but also diagnosis and treatment data. In one basic health unit (BHU), patient addresses only included the name of the village or were left blank. Without patient contact information, it is impossible to follow up with patients or independently validate data quality. The incompleteness of registers strongly suggests that Executive District Officers EDOs do not use service data to monitor the performance of district BHUs and their managers.

Systems and processes to incentivize, monitor, and effectively manage preventive services can be improved. Assuring the quality and uptake of preventive services requires interested consumers, motivated and trained providers, and effective systems (HR, referral, supervision, information, logistics, and maintenance). However, many of these systems in Sindh province appear to be absent or poorly functioning.

Active performance management of physicians and other providers appears limited. Due to the large number of unfilled positions, many physicians have been re-posted to new locations, distant from their designated manager/supervisor. Facility managers may have little ability to motivate or sanction public commission staff that they do not directly supervise. Within facilities, use of clinical protocols is limited, and clinical supervision appears to be infrequent. At the district level, there does not appear to be any system of incentives or performance management to ensure the availability of essential drugs at BHUs. Effective recruitment and retention systems are needed to assure women providers to provide preventive care to women. Clinical care systems are particularly important for non-physician providers who deliver preventive services.

Accountability mechanisms to ensure quality of care are limited in the public sector. Formal accountability/regulatory mechanisms such as licensing and accreditation of facilities, consumer feedback/patient complaint procedures, patient bill of rights, and independent monitoring & evaluation appear to not be functioning. Furthermore, line managerial authority and responsibility for quality primary care services appears weak. Instead, large numbers of staff are voluntarily reassigned, services are organized according to their bureaucratic structure rather than consumer benefit, and service data do not correspond to health systems management needs.

The DOH's initiative to create a commission to license and accredit both the public and private sectors is promising. This initiative will be a major undertaking, for which many essential steps are needed. For instance, while physicians are registered with the Pakistan Medical Association (PMA), there are no laws to date requiring registration of un-credentialed providers. There are no formal complaint procedures for unsafe practices or ways for the government to protect the health of the population from known or unknown dangerous providers or practices. There is no database of providers. Though the ideas are still nascent, DOH has commented that once private providers are accredited, the DOH may consider contracting them to provide priority essential health services.

Health Financing Mechanisms

Competing, non-prioritized health financing strategies are under consideration. There is recognition of the need to strengthen health financing to improve service delivery. Health financing goals brought up by stakeholders during this assessment process include:

- Reducing financial barriers to health services
- Reducing rural/urban inequities
- Preventing catastrophic expenses
- Increasing efficiency of health expenditures
- Increasing accountability of health providers
- Raising revenues for health care
- Increasing quantity and quality of priority health services

While these are all important goals, there does not appear to be sufficient consideration as to the order in which each of these priorities should be tackled. Moreover, a variety of mechanisms have been proposed by the Sindh Health Strategy as well as the Health Financing Task Force, including health insurance, equity funds, pay-for-performance, contracting of management, vouchers, and others. It is unclear how these all fit together within a coherent health financing framework. In addition, many of these mechanisms had redundant purposes when discussed with DOH and other partners. That said, the stakeholders involved in this assessment generally agreed that the various financing objectives need to be prioritized in order to design effective financing interventions.

Public funding for health is significantly lower than in neighboring countries, but increasing public health spending does not appear to be a high priority. Increasing the percentage of provincial spending allocated to health was not identified as a priority, outside of the Sindh Health Strategy. Moreover, some stakeholders commented that several districts have reallocated health funds to non-health sectors. Low levels of budget allocation and execution were identified as key factors debilitating the health sector.

Although several revenue pooling mechanisms exist, they are not organized to provide coherent population coverage or strategic purchasing. Zakat, Bait-ul Mal, hospital funds, and other charitable giving mechanisms provide very limited coverage to the poor in certain cases. These funds each have different revenue sources and program objectives. Each follows different application and approval processes. There is neither coordination of benefits nor adaption of each program's target population to coherently cover the most vulnerable or poor. Interviews with stakeholders suggested that these mechanisms have governance challenges. Thus, in their current form, these funds provide little scalable pooling opportunity.

Many new strategic purchasing interventions are proposed in the Sindh Health Strategy, but they would be fragmented if implemented as outlined. Several interventions have been proposed to accomplish many of the health financing objectives that stakeholders discussed. These include equity fund expansion, social health insurance, pay-for-performance, contracting-out, contracting-in, vouchers, and community health insurance. Each of these interventions is complex and requires significant investment of political capital, human resources, and finance to develop. Moreover, an overall health financing framework has not been developed to hold together the various health financing interventions, thus risking the creation of redundant or duplicative mechanisms.

Public Budgeting & Public Financial Management (PFM) of the health sector represent a complex challenge. A recent assessment of overall national Public Financial Management found significant weaknesses in Sindh's public financial management system. The assessment was focused on the overall financial management system and pointed to many of the weaknesses at non-health entities, including the DOF, the Controller General of Accounts (CGA) office, and other relevant entities. Nevertheless, interviews with DOH officials suggest that the weaknesses indicated in that report apply to DOH as well, that the overall system of PFM is still in development at the DOH level, and that this system requires support. Budget execution needs improvement; however there are many factors that are beyond DOH control, such as slow/delayed fund release and political issues. DOH has taken some effort to produce a needs-based medium-term budget framework (MTBF), but this has not resulted in budgetary change. Both DOF and DOH require increased skills and process improvements to institutionalize the MTBF process.

Donor-funded projects have used vouchers to increase the quantity and quality of services, but these are not designed for sustainability. Voucher programs run by PSI, Marie Stopes and Jhpiego, were designed to increase service delivery, generate public expectations, and demonstrate proof of concept. These programs were not designed to be sustainable. With that in mind, the voucher programs are not coordinated or coherently linked together. Given their small scale, this is not a major challenge that needs immediate attention, especially since the programs are intended to target different services and different provider segments. The DOH is not involved with the planning and oversight of these programs and does not want to be, as ongoing funding would be difficult.

Human Resources

DOH is actively moving to improve management capacity in the DOH, districts, and facilities. Until now, managers and administrators have been physicians, with no training in finance, management, HR, procurement/logistics, or other skills relevant to managing systems of service delivery. The DOH has endorsed the establishment of a new health management cadre, with formal training in management, to improve district and facility-level management of the health sector with the support of JSI. Currently, the actual grade of these managers is being determined. It is not clear how the transition from current physician managers to this new cadre will occur, but resistance to change should be anticipated.

The inability of the public sector to recruit health workers over the last decade has resulted in high vacancies for sanctioned posts that compromise the system's ability to deliver services. There are large numbers of vacant posts and shortages of health workers particularly in remote or hard-to-fill posts. Only 30 percent of female health workers are in rural areas, where they are most needed. Large numbers of physicians have been reposted, where they work away from direct supervision. Their previous positions, now vacant, may not be filled because the transfers have not been formalized. Such large numbers of transfers appear to be either short-term responses to bureaucratic inertia and/or the result of non-transparent hiring preferences. Regardless of the cause, the large number of vacant positions and transfers seems to signal poorly functioning HR procedures.

Hiring of temporarily contracted health workers and more active supervision has improved service delivery under PPHI. PPHI initially inherited all the civil service-posted physicians, but has replaced all civil service vacancies with directly contracted physicians. According to PPHI, hiring contracted staff allowed management to withhold pay for absenteeism, sanction poor performance, and sanction corrupt behavior (informal charges, private referrals, etc.), in ways that are not possible through the civil service. PPHI was even able to terminate the contracts (or have these physicians reassigned to non-PPHI sites) of absent civil service physicians through prolonged advocacy with the Department of Health and the Public Service Commission (PSC). Additionally, PPHI restructured physicians' job duties to cover a cluster of BHUs. This restructuring allowed salary increases of civil service physicians as well as directly contracted physicians.

Human resources needs have not been updated nor reassessed with recent reforms. While physician salaries have increased recently, the sanctioned cadre of providers continues to show chronic and large numbers of vacancies and limited performance. New staff recruiting is reported to be limited by procedural and political issues as much as by actual health worker shortages. Curative care continues to be the focus with physicians as the dominant cadre rather than more cost-effective mid-level providers.

V RECOMMENDATIONS FOR A SINDH HEALTH CARE FINANCING STRENGTHENING PLAN

The recommendations that follow are focused on practical, feasible, and high impact opportunities for USAID investment. The following criteria were used to prioritize recommendations:

- Address a pressing problem;

- Be politically feasible;
- Be in line with the Sindh Health Strategy;
- Be technically sound;
- Leverage existing systems;
- Be incremental with long-term vision.

The final lists of recommendations were presented to DOH and other stakeholders. The following figure graphically represents the development objective and key strategies recommended to achieve this objective. The development hypothesis underlying this results framework is that improved uptake of priority services fundamentally depends on 1) improved strategic purchasing by the Government of Sindh and 2) More efficient strategic planning, budgeting and financial management.

Development Objective: Increased uptake of priority services

Result 1: Improved strategic purchasing of priority services			**Result 2:** Improved strategic planning, budgeting, and financial management	
Strategy 1.1: Strengthen Contract Management Capacity in DOH	**Strategy 1.2:** Introduce/expand Results-based Financing	**Strategy 1.3:** Support innovative methods to finance human resources	**Strategy 2.1:** Prioritize and Rationalize Health Financing	**Strategy 2.2:** Improve public budgeting and financial management
Activity 1.1.1: Formally designate contracts management of health contracts to DOH	Activity 1.2.1: Support DOH to implement PBC of outsourced service delivery programs, such as PPHI.	Activity 1.3.1: Support the development of a human resources strategy	Activity 2.1.1: Develop a comprehensive health financing plan for Sindh	Activity 2.2.1: Conduct PFM assessment for the health sector.
Activity 1.1.2: Provide DOH training and capacity building in all aspects of contract management.	Activity 1.2.2: Introduce PBF with non-contracted health facilities delivering primary health care services.	Activity 1.3.2: Support the establishment of temporary health worker fund using temporary contracts	Activity 2.1.2: Conduct a pilot in two hospitals to coorindate Bait-ul-mal, Zakat, hospital funds, Heartfile and other equity funds sources.	Activity 2.2.2: Provide support to MTBF process
				Activity 2.2.3: Support implementation of routine resoure resource tracking

RECOMMENDATION 1

Prioritize and Rationalize Health Financing

Develop a comprehensive health financing plan for Sindh. The health financing recommendations in the Sindh Health Strategy are a bold list of many mechanisms to improve equity, access, and coverage. However, it includes redundancies across mechanisms, and it is unclear how these mechanisms link together. A patchwork approach of many financing interventions would be very burdensome administratively, and would increase the fragmentation of all risk sharing and pooling efforts. Therefore, it is recommended that Sindh prepare a Health Financing Plan to articulate a long-term vision of how Sindh would finance the health system. Within this framework, the plan would prioritize health financing objectives and health financing interventions. The Sindh Health System Financing Plan will take into account available resources, population needs, and the feasibility of financing interventions in the context of the larger health system. The plan should include 1) the roles of both public and private health sectors, 2) mechanisms

for targeting vulnerable populations, 3) approaches to bridge the rural/urban inequities. In the process of preparing the plan, DOH and stakeholders should also evaluate the various strategic purchasing modalities (PBF, Contracting-out, PBC, Vouchers, equity fund) by assessing the technical merit, political support, institutional capacity, and governance requirements.

Conduct a pilot in two hospitals in Sindh to coordinate Bait-ul-mal, Zakat, hospital funds, Heartfile, and other equity fund sources. The different equity funds have very different objectives and implementation approaches, with varying strengths and weaknesses. In two supported facilities, we recommend piloting the coordination of these funds and to learn from their different approaches. This would entail coordinating patient application procedures, setting up standardized criteria for application, and harmonizing other key processes. This pilot could also leverage strengths of each mechanism. For example, Heartfile relies extensively on an automated database, while other programs are manual. A facility-level pilot to harmonize and coordinate the different equity funds would identify major problems that could arise if consolidation were done on a larger scale.

RECOMMENDATION 2

Strengthen Contract Management Capacity in DOH

Support the formal establishment of a DOH role in the management of health sector contracts. As Sindh Province moves forward with contracting in and contracting out in the health sector, it is increasingly critical for the DOH to play an active technical role in the management of those contracts. The DOH, at minimum, should have the responsibility for developing contract performance requirements, linking these to payment, and overseeing contractee technical performance. Since these tasks are not possible for non-technical departments such as DOF to oversee, the DOH must be involved to ensure contractor performance and accountability.

To operationalize this recommendation, an assessment should be carried out to clearly identify what role the DOH can feasibly assume in contracts management. This assessment should consider technical capacity of DOH to carry out the full range of contract management functions, including technical oversight, financial oversight, legal and regulatory compliance, and reporting. Key questions that should be examined include: 1) Does the DOH have the capacity to coordinate across units, such as HR, HMIS, EDO office, and others to provide sound technical oversight of contractee performance? 2) Can the district EDOs objectively review service delivery statistics and communicate performance issues to DOH? 3) Does DOH have the capacity to monitor spending of contractees using verified expenditure systems accepted by the CAG or Auditor General? 4) Can the DOH put in place patient grievance systems? 5) Is there political interest within the DOH to formally designate an office to be the focal point for contracts management, and provide this office with the appropriate authority/mandate to carry out its functions? The assessment should also examine the political feasibility for DOH to assume roles that are currently the responsibility of other departments.

Provide training and capacity building to DOH in contracts management. The DOH office designated to manage contracts should be provided training and capacity building in all aspects of contract management, including legal and financial aspects. With appropriate involvement of other sectors, these staff will need to understand usual contract management functions, such as the use of standard terms and conditions, tendering, payment approval/disapproval and best management practices to improve performance. Positive incentives, as well as sanctions, will need to be used effectively to improve

performance. Working with third party verifiers/purchasers will need to function well. Key actions to build the capacity of the contracts management office would be:

- Formal training in all aspects of contract management
- Review of existing procedures to write robust terms and conditions and tenders, to approve payments and to manage contractee performance.
- Ensure standardization of tendering & contract documents (bidding documents, clauses, etc.)
- Develop standard and transparent financial reporting systems linked to the accountant general and auditor general's office

As contract management responsibilities currently are located at the DOF, delegation of some contract responsibilities to the DOH may need to be negotiated and clarified. Shared, but well-defined, responsibility for oversight of contracts may reduce the risk of collusion and/or corruption. For example, DOH could be responsible to indicate to DOF whether contractor performance has been satisfactory prior to routine fund transfer.

RECOMMENDATION 3

Introduce/Expand Results-based Financing

Support DOH to implement performance-based contracting of outsourced service delivery programs, such as PPHI. The DOH should be trained in performance contracting, as opposed to cost-based contracting. Once the DOH understands different contract structures, they can consider paying PPHI based upon the numbers and quality of clinical services actually offered at facilities at opposed to input-based reimbursement. Contracts can have performance-based payment requirements to varying degrees. The initial PPHI contract guaranteed payment regardless of technical performance. In contrast, in a completely performance-based contract, such as a procurement of goods, there may not be any payment unless 100 percent of the performance is completed. Many contracts link payments to achieving certain intermediate levels of performance. Having a good understanding of the range of contract structure options would allow DOH a more active role in performance management.

The DOH should be supported to assure that verification of contractee performance is objective and accurate. An independent third party may be the best option to minimize any appearance of collusion with facilities or districts. Currently, service data collected at facilities is neither complete nor verifiable enough to form the basis for objective and accurate performance verification.

The DOH should consider performance-based financing with non-contracted health facilities delivering primary health care services. Implementing performance-based financing of public service commission employees/providers working in public facilities has shown significant improvements in service delivery in a wide range of settings. In Sindh Province, public providers may already be incentivized and motivated by informal private practice. PBF of preventive services would similarly incentivize providers to offer these preventive services. If an additional goal is to increase accountability and to reduce informal practice, then tighter supervision of providers would also be needed. Public service regulations would need to be understood to identify possible bureaucratic obstacles to payment of incentives. A PBF pilot in a single district could address the logistical challenges of provider incentive payments (within the PSC), indicator selection, and performance verification prior to larger scale-up.

RECOMMENDATION 4

Support Innovative Methods to Finance Human Resources

Support the development of a human resources strategy. There are significant HRH challenges in Sindh Province limiting the quality and quantity of service delivery. There are large numbers of vacancies that have been unfilled for years. Some of these vacancies result from shortages of trained health workers; other vacancies result from market forces attracting health workers to private earning opportunities. Still others result from bureaucratic and/or political constraints. Given these longstanding and significant constraints, the DOH should consider a strategy on HRH that addresses the following: the health worker labor markets, financing mechanisms to improve health worker retention, motivation and performance, incentives to address rural shortages, chronically unfilled positions, and others. This strategy will build on the HRH analysis and data presentation completed by JSI.

Support the establishment of a temporary health worker fund using temporary contracts. A temporary health worker fund would allow urgent responses to health worker shortages, other than re-posting workers from their sanctioned posts to one far away. The legal ramifications of temporary contracts, particularly the obligation to regularize appointments within specified time periods, should be considered. Hiring temporary health workers could be outsourced, via a contract, to an independent agency that may bypass some bureaucratic constraints. Lastly, the performance of temporary contracted health workers should be actively managed and evaluated to inform national HR practices.

RECOMMENDATION 5

Improve Public Budgeting and Financial Management

Conduct public financial management assessment for the health sector. A multi-sector public financial management assessment showed various challenges, suggesting the need for a closer review of the DOH. While many public financial management (PFM) functions are managed by the DOF, clarity on the capacity of DOH to manage public finance is essential. This is especially true if DOH moves towards contracting of health services. Thus, a health-focused PFM assessment is recommended to understand the strengths, weaknesses, risks, and bottlenecks with the PFM system for health.

Provide support to MTBF process for health. The HSRU requested assistance in managing the MTBF process. The MTBF is an important channel towards developing strategic, needs-based budgeting. Thus, support in this area should be focused both on improving DOH capacity to develop a MTBF and supporting the DOF to interpret MTBF submissions for appropriate allocation. On the DOH side, technical assistance focus should be on capacity development to DOH officials for adequate planning and budgeting to MTBF categories. On the DOF side, providing them support to understand and interpret the health MTBF is recommended.

Support resource tracking for budget planning and execution. The focus of this recommendation is to support the development of routine systems for resource tracking, rather than one-off resource tracking exercises. Routine tracking of public resources will greatly improve the transparency of public expenditures. Specifically, this means tracking the source of financing, the intermediaries through which financing flows, and the ultimate beneficiaries. As Pakistan has conducted nationalhealth accounts exercises in the past, mapping public expenditures to NHA categories will also provide great insight into

the allocative efficiency of resource spending. Ultimately, these can be mapped to MTBF categories, thus improving the analytical base by which MTBF is created and evaluated.

ANNEX 1

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ANNEX 2

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