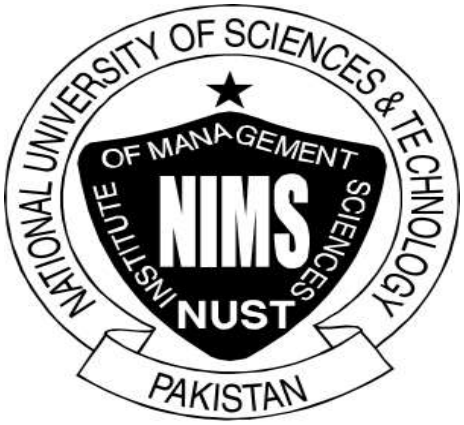

(NIMS)

NUST Institute of Management Sciences

MBA-2001

Final Research Thesis

Developing A Health Sector Strategy For Pakistan

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2001-NUST-MBA-140

Abstract

The health of the population in Pakistan has improved in the past three decades, but the pace of improvement has not been satisfactory. Today, Pakistan lags well behind the averages for low-income countries in key indicators, including infant and child mortality and the total fertility rate. Poor health status is in part explained by poverty, low levels of education (especially for women), low status of women in large segments of society, and inadequate sanitation and potable water facilities. But it is also related to serious deficiencies in health services, both public and private. There is a broad consensus in Pakistan that the health sector is in need of fundamental reform in order to achieve a better impact on the health status of the population. The present dissertation has been prepared as a contribution to the national -debate on health sector reform. The research focuses on three key broad areas of public policy in the health sector: the setting of priorities for the use of public revenues; management problems in the government health services and possible reforms; and weaknesses in private health services and suggestions for improving the beneficial effects of these services. Priorities among health services financed with public revenues should take account of what the private health sector is doing and could do in the short to medium term. Generally, government health services should seek to avoid "crowding out" private services, provided that the latter are supplied by providers with the requisite training. Such providers are not available in many rural areas of the country. The dissertation recommends that top priority should be given to health education, in such areas as nutrition, creating greater awareness of the health benefits of adequate birth spacing, and stressing the importance of immunization and other preventive interventions; control of communicable infectious diseases; and maternal and child health services including family planning, pre- and post-natal care, deliveries by trained personnel, and management of the sick child, especially for diarrhea, acute respiratory infections and malnutrition. Most of these top priority services could be delivered through first-level health care facilities linked to community-based health workers and backed by referral services in secondary hospitals at the Tehsil and District levels. The top priority services generally merit subsidization from public revenues. However, except for health education and certain types of communicable disease control interventions, the subsidy need not be equal to the cost of production. But the issue of what constitutes a suitable cost recovery policy in the health sector is a complex one. If charges were increased, there would be a risk of displacing poor patients towards untrained practitioners or self-care, and discrimination against women/girls in households' health care expenditure could increase. The latter effect would moreover tend to be more pronounced among poor households. Thus any new system of increased user charges would need to incorporate safeguards to protect the poor, and be piloted before its widespread application. Enhanced cost recovery would increase the resources available to the government health services, provided that steps are taken to ensure that revenues accrue to the collecting facilities and are truly incremental to their budgets. But there is also much scope for improving the efficiency of resource use and achieving a greater impact with existing resources. This could be achieved through reforms such as setting better priorities among types of inputs; undertaking periodic in-depth budget

reviews of both the development and the current budgets; deepening decentralization of management in the Provinces; establishing Health Boards at the district level; involving communities in supporting government health care providers and helping to increase their accountability; contracting out some services to NGOs and others in the private sector; and placing a greater emphasis on staff development. At the same time that a concerted effort is made within the government health sector to improve efficiency, responsiveness and impact, the public sector also needs to work with private health care providers and their representatives to effect a parallel improvement in private health services. The public policy goal should be to achieve an optimal division of labor between the public and private health sectors. Attention to private health services is crucial because surveys show that in Pakistan the great majority of the populations seek the care of private providers when they fall ill --in many cases providers with little or no medical training. The dissertation suggests several types of partnerships between the public and the private sectors in order to improve private services. Partnerships could aim at encouraging continuing education of private providers; empowering professional associations to manage a system of certification and licensing of providers; introducing a voluntary accreditation system for private clinics and hospitals; enhancing attention to preventive interventions; fostering consumer education in the health area; and facilitating the development of health insurance.

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CHAPTER 1: INTRODUCTION

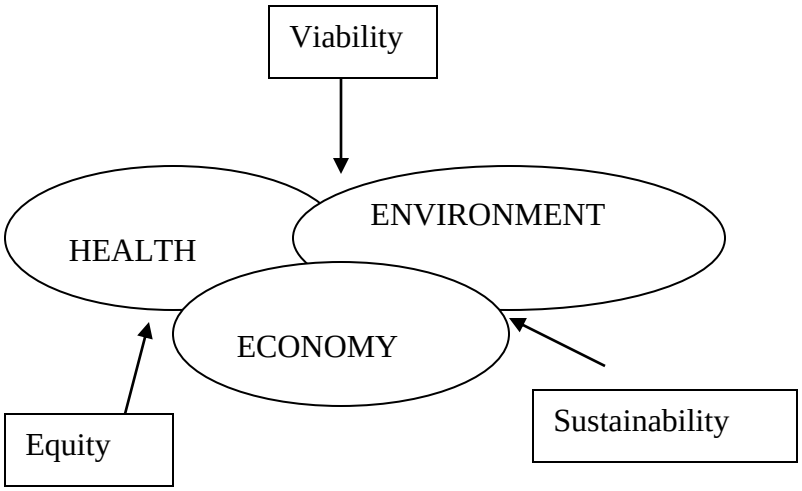
“If anything was made to be taken for granted, it is ‘culture’” (Gallagher and Subedi, 1995). Culture is the totality of socially transmitted behavior patterns, arts, beliefs, institutions and all other products of human work and thought. These patterns, traits and products considered as the expression of a particular period, class, community or population. It is nothing but the predominating attitudes and behavior that characterize the functioning of a group.

Health system is a set of cultural beliefs underlying health seeking and health promoting behavior. It is a system of institutional arrangements within which that behavior occurs. It is influenced by socio-economic, political and physical context of these beliefs and institutions. Institutional arrangements include family, community, health care services and other related sectors.

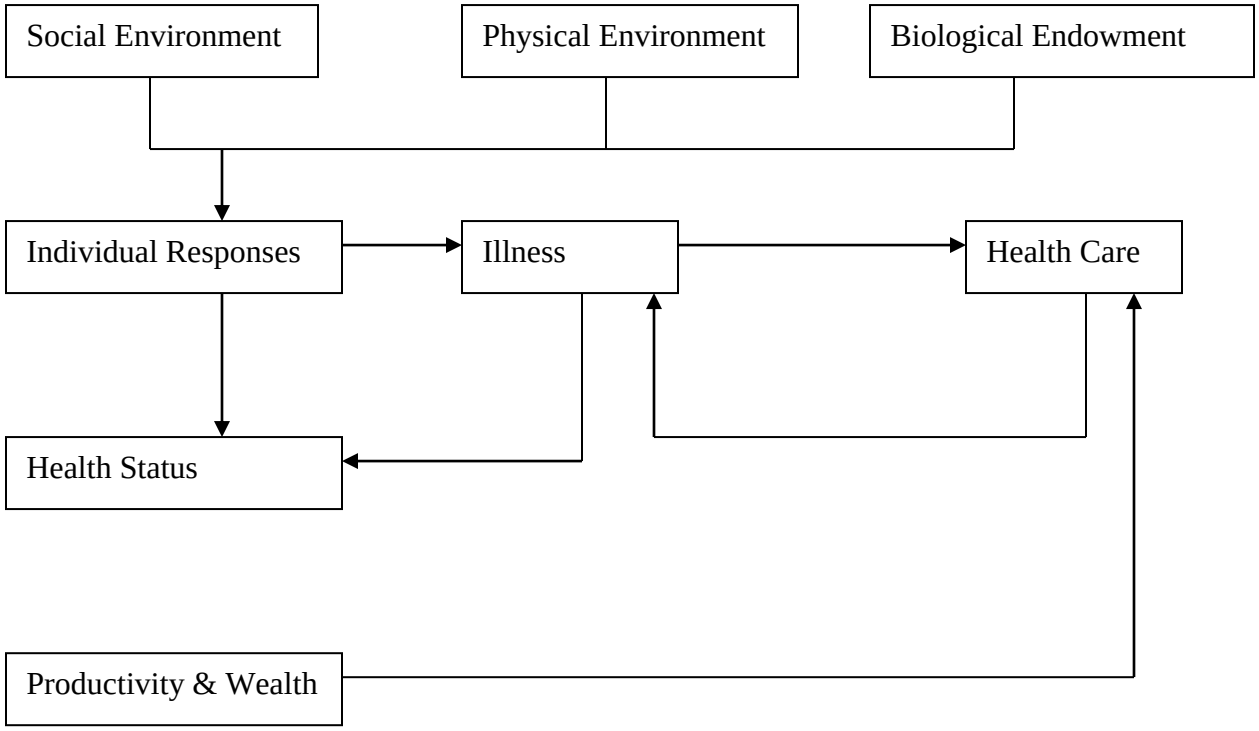
Health system would include:

- Cultural beliefs and practices
- Environmental conditions
- Nutrition
- Water supply
- Education
- Housing
- Status of women
- Social structure
- Economic/Political systems

Health is a full development of human potential, a fundamental right. It is freedom from unnecessary illness and premature death is a fundamental pre-requisite for development. Health and development are intricately interrelated. It is both a condition and a product of development. Health governance is the role of a healthy public policy. In order to have good health which is a realization and development of the human potential requires both an adequate economy and a viable environment.



1.1 Determinants of Health



Factors influencing health service utilization are socio demographic factors such as age/sex of child, family size/parity, education and occupation. Economic factors also affect in determining the choice of health service provider. Factors like possession of household items, type of residential house and other miscellaneous economic factor. Physical accessibility factor would also determine the choice of health service provider like availability of transport, physical distance of Health facility/Health Care provider and time taken to reach Health Facility/Health care provider. One also has to take into account the financial accessibility factors like fare spent for one round trip to Health facility/Health care provider and the total amount spent for treatment of last illness (excluding fare). In addition to this health service factors are also influenced by the

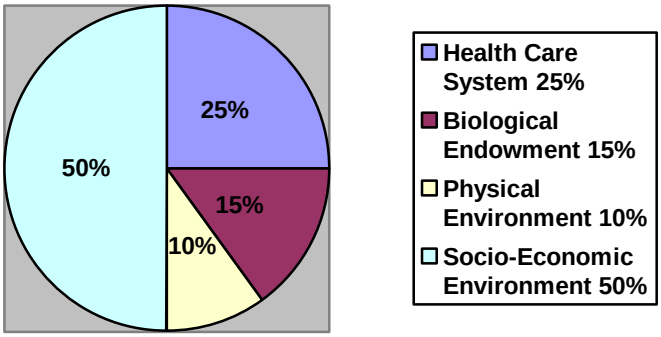
attitudes of health provider, satisfaction with the treatment, received medicines from Health Facility/Health Care Provider, and received prescription for medicines to be purchased from bazaar. Choice of a Health Care provider is also determined through Mother's autonomy for instance freedom to visit health facility alone, permission to spend money on health and decision power in emergency situation.

The choice of consumers is also determined by the knowledge of illness/wellness and of service available, prescriptions of services/service providers, Risk/symptoms assessment, cultural "prescriptions" and social pathways to care etc.

There are certain agents that are bringing about change in the health sector. These include changing disease patterns, advances in biomedical/clinical services, health sector reforms, global perspectives on health and health care, introduction of new specializations/ professions, information and communication revolution and globalization. Provision of Health care producing health focus on life style, environment, shifts focus from individuals to population, providing cost effective health care through evidence based decision policy and for allocation of resources to sector that contribute to health.

Income influences health as people in top income brackets are healthier than middle-income earners and middle-income earners are in turn healthier than people with low income. This means that the poorer people are the less healthy they are likely to be. Social status affects health by determining the degree of control people have over life circumstances. It affects their capacity to act and make choices for themselves and higher social position some how act as a shield against disease. Culture and ethnicity influence

how people link with health system, their access to health information and their life style choices. Dominant cultural values largely determine the social and economic environment of communities. The outcome of which is marginalization and lack of access to culturally appropriate health services. Gender also has a lasting impact on health. It is linked more to the roles, power and influence society gives to men and women than it is to their biological differences.



(Estimated Health Impact of Determinants of Health on Population Health Status: CIAR 1997)

The Government of Pakistan should focus on the entire range of individuals and collective factors taking into account the income and social status, education, employment and working conditions, social environment, physical environment, gender, culture, personal health and coping skills, healthy child development and health services. Health is determined by the complex interactions between individual characteristic, social and economic. Strategies to improve population health must address the entire range of factors that determine health. Important health gains can be achieved by focusing interventions on the health of the entire population /significant sub populations rather than individuals. Improving health is a shared responsibility that requires the

development of healthy public policies in areas outside the traditional health system. The health of the population is closely linked to the distribution of wealth across the population.

Health services move towards “broader resources” to support well-being. They should be designed in a manner that maintain and promote health, prevent diseases and restore health system functioning towards population health.

CHAPTER 2: HEALTH DELIVERY SYSTEM IN PAKISTAN

2.1 Government Health Services

The public (i.e., government) health delivery system is composed of four tiers: (i) outreach and community-based activities, which focus on immunization, sanitation, malaria control and maternal and child health and family planning; (ii) primary care facilities, mainly for outpatient care (iii) Tehsil (i.e., sub-district) and district headquarters hospitals for basic inpatient care and also outpatient care; and (iv) tertiary care hospitals located in the major cities for more specialized inpatient care. Primary care facilities are mostly managed by a Medical Officer, except for Maternity and Child Health Centers, which are managed by a Lady Health Visitor (LHV), and dispensaries, which are generally managed by dispensers.

Basic Health Units (BHUs) provide curative and preventive services for a catchment population of about 10,000-20,000 people, and are typically staffed by a Medical Officer, a LHV or Female Medical Technician, a Male Health Technician, a trained Midwife or unqualified midwife (dai), a dispenser, a sanitary inspector, a vaccinator and 2-3 non-technical staff (guard, sweeper, etc). *Rural Health Centers (RHCs)* provide more extensive outpatient services and some inpatient services, usually limited to short-term observation and treatment of patients who are not expected to require transfer to a higher-level facility. They serve catchment populations of about 25,000- 50,000 people, with about 30 staff including several doctors and a number of paramedical staff. They typically have 10-20 beds, x-ray facilities, laboratory, and minor surgery facilities. *Tehsil*

Headquarters Hospitals provide basic inpatient services as well as outpatient services. They serve a catchment population of about 100,000-300,000 people. They typically have 40- 50 beds and appropriate support services including x-ray, laboratory and surgery facilities. Its staff may include several specialists such as ear, nose and throat specialist, ophthalmologist, gynecologist, and a general surgeon. *District Headquarters Hospitals* serve catchment populations of about 1 to 2 million people and provide a range of specialist care in addition to basic hospital and outpatient services. They typically have about 80-100 beds. In NWFP and Balochistan, catchment populations and sizes of Tehsil and district headquarters hospitals are smaller.[1]

The District Health Officer (DHO) is responsible for all health services in his district. Managers of all Tehsil Headquarters Hospitals and first-level care facilities report to him. District Headquarters Hospitals are headed by Civil Surgeons, who, as well as DHOs, report to the Director General of Health at the provincial level. Tertiary care hospitals are directly under the provincial Secretary of Health.

2.2 Private Health Services

The private *health services* sector is dominated by more than 20,000 "clinics", the small, office-based practices of general practitioners. Other private sector facilities also tend to be small.

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[1] Pakistan Health Sector Study, World Bank, June 1993 page no :13. The figures quoted in this section are from the Census of Health Facilities conducted by the Federal Bureau of Statistics in 1988. Current numbers of private facilities are probably much larger than indicated here.

These include more than 300 maternal and child health centers (also known as maternity homes); about 350 dispensaries, which are outpatient primary health care facilities; and more than 450 small to medium-size diagnostic laboratories.

There are also more than 500 small and medium-size private hospitals with about 30 beds per hospital on average. They are equipped only for basic surgical, obstetric, and diagnostic procedures, and concentrate on low-risk care. In addition, there are a few large private hospitals, mainly run by NGOs and located in major cities[2].

Private health services are concentrated in urban areas. Only about 30 percent of all private health facilities (mostly clinics and dispensaries) are located in the rural areas, where about 70 percent of the population reside. Private urban hospitals are mostly concentrated in nine large cities[3]. These cities account for more than 75 percent of private sector hospital beds. The *quality of care* in large private hospitals ranges from reasonable to good. In smaller commercial hospitals, MCH centers, and clinics, however, the quality of service is often very poor. This poor quality is reflected for example in the use of outdated equipment, and in the severe shortage of nurses and paramedical staff and the use of untrained persons in their stead.

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[2] Pakistan Health Sector Study, World Bank, June 1993 page no :13. The figures quoted in this section are from the Census of Health Facilities conducted by the Federal Bureau of Statistics in 1988. Current numbers of private facilities are probably much larger than indicated here.

[3] Abbotabad, Faisalabad, Hyderabad, Karachi, Lahore, Multan, Peshawar, Quetta, and Rawalpindi/Islamabad.

Less than half of the doctors, nurses and paramedics working in the private sector are registered in the official registers of these professions; the rest either have no formal training or have failed to register (or allowed their registration to lapse). The private sector staff mix is highly skewed; about 40 percent of the technical work forces are doctors, but less than 10 percent are nurses.

2.3 NGOs

There has been no survey of NGOs working in the health sector in Pakistan. However, the predominant view appears to be that: (i) the number of NGOs operating in the health sector is small; (ii) most of them are very small in size, and (iii) they are heavily concentrated in urban areas. A notable exception to (iii) is the Aga Khan Health Services program, which has been successful in implementing its community-oriented primary health care model in two districts of the Northern Areas. As is the case with NGOs in general, many of the NGOs in the health sector are the product of a visionary and committed individual and lack a broad institutional base. There has been so far little government assistance to them.

CHAPTER 3: WEAKNESSES OF GOVERNMENT HEALTH SERVICES

The weaknesses of government health services can be described as the weaknesses of "Management System". The Government Health Services weakness includes:

- Insufficient focus on Prevention/Promotion
- Gender Imbalance
- Excessive centralization of Management
- Political Interference
- Lack of openness
- Weak human resource development
- Lack of integration
- Lack of healthy public policy

The problem areas that could be identified as a result are poverty, illiteracy, low status of women, inadequate sanitation and water supplies and poor quality of health services. Other major problems that have been identified are as follows:

3.1 Planning System

Planning is very centralized. It is concentrated in the planning agencies (Federal Planning Commission and provincial Planning and Development Departments), and the planning cells in the provincial DOHs. There have been recent efforts to begin district level planning with a few districts. Planning processes have thus far only dealt with the public

sector. Sometimes plans make reference to the private sector or NGOs, but there have been no significant coordination activities, joint services, or resource transfers among the various health sub-sectors.

The planning cells in the provincial DOHs have developed some staff capability over the last decade, but they are still small and only starting to have any influence on planning decisions. The planning function is also fragmented in the provincial DOHs. Planning cells are attached to the Secretary's office, but there are also planning staff among the Director General's staff. This is not intrinsically a problem, but most practice so far has been uncoordinated. Furthermore, many planning decisions that ought to have a technical basis are performed by people in the budget sections of the DOHs and Department of Finance.

An additional complication in the planning process is the lack of public health knowledge and orientation. The staff in each province with public health training and interest are very few. As a result, while few are even aware of it, the "medical model" tends to dominate many decisions in the government health services. (The private sector almost everywhere will operate by the "medical model", unless given strong incentives to behave otherwise). The "medical model" is characterized by an emphasis on curative health services, little concern with the overall pattern of allocation of resources, a desire to provide "state-of the-art" care, and the measurement of outcomes in terms of changes in the health status of individual patients. By contrast, the "public health model" emphasizes preventive interventions, obtaining maximum impact on the health status of communities for the resources available, the use of appropriate technology rather than "state-of-the-

art", and the measurement of outcomes in terms of changes in the health status of the population at large.

3.2 Implementation Systems

There is no unified system for service operations and practices. Some projects have developed procedure pro-forma for the project's specific needs. As part of the training for some cadres, standard practice procedures have been defined --e.g., for Lady Health Workers. However, since staffs are generally not trained jointly as working teams, there is no guarantee that other co-worker cadres will follow those same practices.

3.3 Personnel Systems

Procedures do exist; most of these are very similar government-wide and laid down by the Establishment Division. While there is some provincial variation in these procedures, it is not great. The procedures were designed largely to control personnel, and were framed to cover a much smaller number of centralized staff. Almost all the procedures deal with personnel actions, not personnel management. Because the system is several decades behind current needs, including little decentralization, it results in top managers typically spending a very large portion of their time on petty personnel actions. For this system (and most others), the formal system only provides a framework for the official paper generation, signing, and filing. The actual basis for decisions have little relationship to official criteria. Every personnel decision is largely person dependent –it depends on who wants a decision made, who is in a position to make the decision, and who else may be affected.

3.4 Drugs and Medical Supplies

There are some standardized procedures for requisition, supply, transport, inventory, and dispensing, but these are not integrated with each other. Dispensing practice is often based on types and quantities available. Supplies rarely match requisitions, and the situation is further aggravated by late deliveries, pilferage, and poor inventorying and storage practices. Moreover, as noted in the previous chapter, large savings could be obtained by emphasizing the use of generic drugs over branded drugs and shortening the Essential Drug Lists.

3.5 Financial Systems

Systems for accounting and audit follow the GOP standard with some provincial variations. One of the greatest weaknesses from a managerial perspective is that accounting is done by a single entry, cash accounting method, which has changed very little in 50 years. This system is suited for small operations in a single location. For systems the size of the government health services, a double entry, accrual method is necessary. Any financial management would be almost impossible now, as the official record of expenditures is not kept by the DOHs, but by the Auditor General's office. This office also re-categorizes expenditures according to different headings than those under the approved budget; therefore, relating the two is very difficult.

3.6 Monitoring and Evaluation

There is no systematic monitoring and evaluation of the performance of the health services. The introduction of the HMIS is a major improvement in terms of data availability, but it is not yet fully deployed and does not cover inpatient services.

Demographic and health surveys have given an indication of overall health status. There also have been ad hoc evaluation studies, usually done by international assistance organizations or independent authors. While these surveys and studies are useful, they do not represent an ongoing, internal system. Recent discussions of monitoring, and to a lesser extent evaluation, have lead to the notion that the solution to this managerial weakness will come from the creation of information systems (e.g., the HMIS) and/or monitoring units. This concept of compartmentalizing monitoring is a very risky strategy. Most of the monitoring functions should be part of the job of every manager. Managers are the real engines of monitoring as they make the monitoring decisions. An information system and a monitoring cell doing the preliminary analysis only provide the raw materials for the key process.

3.7 Governance

There are two broad categories of governance problems which affect the performance of government health services: (a) problems related to "rent seeking" behavior on the part of civil servants; and (b) interference by politicians in managers' decision-making.

3.8 Rent-Seeking Behavior

While some of them are difficult to document, it appears that various kinds of rent-seeking behavior are widespread among government health staff, which impair the functioning of health services. Examples (as reported by knowledgeable observers) include:

(i) Staff absenteeism:

Government health staff, especially medical officers, is often absent from their posts during normal duty hours. They are thus able to engage in private practice during this time, while at the same time collecting their government salary and other benefits. In many cases, staff theoretically posted to a rural health facility are actually "seconded" to other government facilities in urban areas and do not show up at their rural postings at all. In some cases staff reportedly make payments to their supervisors in order to be allowed to be absent from duty on a frequent or permanent basis. In other cases they are protected by powerful politicians who shield them from disciplinary action. A contributing factor to absenteeism is that the training of physicians is too clinically oriented, although some changes have been made to include more community/public health orientation. Also, many BHUs are located in out-of-the-way places with few amenities or basic services (such as schools), which makes medical officers reluctant to live on the premises. Originally, BHUs were intended to be staffed by para-medicals only. (One possible solution would be to concentrate medical officers at RHCs, which are usually located in or near small towns, and provide them with transport to visit BHUs in the surrounding area at certain pre-announced times).

(ii) Frequent transfers

Medical officers in government service compete for postings to health facilities located in the busier towns and trading centers, where they can have a profitable private clinic. They reportedly resort to making payments to those who have the power to effect transfers, and

this practice tends to increase the frequency of transfers of medical officers --thus weakening their ties to the communities they are supposed to serve.

(iii) Pilferage of supplies

In some health facilities, staff reportedly sell government-provided medicines and other supplies (which are in short supply to begin with) to private merchants or health care providers and pocket the proceeds.

3.9 Interference by politicians

Many of the government health managers interviewed for this report complained about widespread interference by politicians in various types of personnel management decisions, such as personnel recruitment, transfers, and disciplinary actions. Exercise of such influence is "political currency" which can be used to buy votes and political campaign work. Interference by politicians results in lower efficiency of the health services and is a major demoralizing factor for managers and staff.

One implication of political interference is that provincial health departments are very constrained in their ability to redeploy resources. Many health facilities are overstaffed for current utilization levels, but health managers find it nearly impossible to reduce the staff complements, or even to eliminate vacant posts. Attempts in this direction would encounter stiff resistance from the political level, even though they may make perfect sense from an efficiency point of view. With these constraints a manager has to be extremely creative and energetic in order to make any operation or activity effective.

3.10 Interactions With Other Segments of the Health Sector and Civil Society

Government health services are very closed to external influences. They have largely a one-way relationship with clients/patients. There is little meaningful interaction with communities, professional bodies, NGOs, and the private sector. The absence of meaningful interaction with these other segments of civil society weakens the impetus for meaningful reform.

3.11 Management Processes and Performance

Most managers do not have effective control of their resources. Control of resources and real management decision-making often rests far away from the delivery of services. This lack of local control makes implementation management extremely difficult.

Managers' effectiveness is also compromised by the fact that the Planning process still tends to be dominated by capital investment decisions rather than by a rational discussion of health services and their outcomes. There is no system to arrive at a consensus on service priorities, and to ensure that managers at all levels really focus on those services that are rated as top priorities. As there is no data-based assessment of managerial performance in the health system, it is only possible to make a general assessment of this performance. Given the encumbrances of the system and sub-systems, it is a credit to some individual managers who make an effort that any reasonable services are delivered. Managers trying to make services perform are often forced into a crisis management modality. Managers are often forced to operate programs and facilities with less than minimum basic resources. Proper planning would have created fewer programs or

facilities, which then could be adequately resourced. Good management in the government health system is person dependent, not system dependent. There is very little modern management practice, starting with time management. A considerable amount of most higher level managers' time is taken up with petty personnel issues, construction, drug procurement details, and foreign funded projects. The result is that managers have little time for more productive management functions, such as program/service planning, supportive supervision, information analysis, monitoring, or evaluation.

3.12 Human Resource Development

There is little human resource planning. What is done is only for a few cadres and short term --it is not comprehensive. There are too many doctors in relation to Para-medicals, and excessive numbers of non-technical support staff. The staff's gender composition is heavily biased towards males, in both total numbers and within management. Pre- and in-service training is generally of poor quality. Weaknesses in training pertain to both the relevance of the curricula to the needs of the job and the training process itself. Personnel actions are often compromised by political interference and other governance problems. There is little serious supervision, which contributes to high levels of absenteeism and poor overall performance.

3.13 Overstaffing

The numbers of posts for certain categories of staff would seem to be excessive. One category that needs scrutiny is that of general medical officers. While detailed information is not available, there is a widespread impression that the number of general

medical officers is excessive in relation to their workload in many public health facilities, especially in hospitals.

The argument is sometimes made that in Pakistan the medical schools are producing too many doctors relative to the country's "absorptive capacity", and that this in turn has led to overstaffing of government facilities with doctors. And it is true that medical lobbies have at times pressed the government to create unnecessary posts of medical officers under the pretext that there were supposedly many "unemployed doctors". The issue of what would be the optimal annual output of doctors at the present time in Pakistan is a complex one. It is possible that Pakistan is producing too many doctors. However, the main point we would like to stress in this report is that employment policy for doctors in the public sector should be decided without regard to the existence of unemployed (or more likely underemployed) doctors in the labor market. The government should only employ as many doctors as it needs, according to sound technical norms (and the same goes for any other category of staff). This policy should be clearly established.

Non-technical support staff also would seem to be deployed in excessive numbers in many government health facilities. A recent analysis of the situation in Northern Areas and AJK (conducted during preparation of the Northern Health Project) found that over 50 percent of the health department staff were in this category and they consumed 38 percent of the salary budget. While undoubtedly some of these chowkidars, sweepers, drivers, etc., are needed, it is most unlikely that they are needed in their present numbers[4].

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[4] Ministry of Health, Situation Analysis of Health Sector in Pakistan, Islamabad, December 1995 page no: 33

3.14 Badly Sited Facilities

There are reportedly several hundred rural health facilities (BHUs and dispensaries) which have been built but have not been made operational on account of poor siting. In many cases, poor siting has resulted from the practice of building facilities in donated land, instead of searching for and purchasing suitably located land. While these facilities are not currently imposing a fiscal cost, it is important that they should not be made operational as health facilities. The government should consider alternative uses for the facilities. It is also important that in the future every effort be made to avoid a repetition of these mistakes.

The above are some examples of low-productivity government expenditures in the health sector. It is likely that additional instances of such low-productivity expenditures could be uncovered by an in-depth analysis carried out by the Federal and provincial governments. This is likely to be especially so on the current budget side, since the annual process of current budget approval is largely mechanical. On the development side, there has been a bias towards construction of facilities without due regard to utilization prospects.

CHAPTER 4: CURRENT SCENARIO OF PAKISTANI HEALTH SECTOR

4.1 Health Care Policies and Development

National public health is a recent innovation in Pakistan. In pre-partition India, the British provided health care for government employees but rarely attended to the health needs of the population at large, except for establishing a few major hospitals, such as Mayo Hospital in Lahore, which has King Edward Medical College nearby. Improvements in health care have been hampered by scarce resources and are difficult to coordinate nationally because health care remains a provincial responsibility rather than a central government one. Until the early 1970s, local governing bodies were in charge of health services.

National health planning began with the Second Five-Year Plan (1960-65) and continued through the Eighth Five-Year Plan (1993- 98). Provision of health care for the rural populace has long been a stated priority, but efforts to provide such care continue to be hampered by administrative problems and difficulties in staffing rural clinics. In the early 1970s, a decentralized system was developed in which basic health units provided primary care for a surrounding population , rural health centers offered support and more comprehensive services to local units, and both the basic units and the health centers could refer patients to larger urban hospitals.

In the early 1990s, the orientation of the country's medical system, including medical education, favored the elite. There has been a marked boom in private clinics and

hospitals since the late 1980s and a corresponding, unfortunate deterioration in services provided by nationalized hospitals.

Medical schools have come under a great deal of criticism from women's groups for discriminating against females. In some cities, females seeking admission to medical school have even held demonstrations against separate gender quotas. Males can often gain admission to medical schools with lower test scores than females because the absolute number for males in the separate quotas is much greater than that for females. The quota exists despite the pressing need for more physicians available to treat women.

The government has embarked on a major health initiative with substantial donor assistance. It will provide help for staff development, particularly in training female paramedics, and will also strengthen the management and organization of provincial health departments.

In addition to public- and private sector biomedicine, there are indigenous forms of treatment. *Unani Tibb* (Arabic for Greek medicine), also called *Islami-Tibb*, is Galenic medicine re-systematized and augmented by Muslim scholars. Herbal treatments are used to balance bodily humors. Practitioners, *hakims*, are trained in medical colleges or learn the skill from family members who pass it down the generations. Some manufactured remedies are also available in certain pharmacies. Homeopathy, thought by some to be "poor man's Western medicine," is also taught and practiced in Pakistan. Several forms of religious healing are common too. Prophetic healing is based largely on the *hadith* of the Prophet pertaining to hygiene and moral and physical health, and simple treatments are used, such as honey, a few herbs, and prayer. Some religious conservatives argue that

reliance on anything but prayer suggests lack of faith, while others point out that the Prophet remarked that Allah had created medicines in order that humans should avail themselves of their benefits. Popular forms of religious healing, at least protection from malign influences, are common in most of the country. The use of *tawiz*, amulets containing Quranic verses, or the intervention of a *pir*, living or dead, is generally relied upon to direct the healing force of Allah's blessing to anyone confronted with uncertainty or distress.

4.2 Discrimination between Private and Public Sector Hospitals

The facility of tax-free import of medical equipment has been allowed to all except the private hospitals. Why this discrimination? Are the private hospitals not reducing the government's burden? Does the government want to discourage private hospitals, as a policy? Does the government want that private hospitals change their name and become trusts?

Treating private hospitals as hotels and other commercial organizations was enough discouragement and now they are being asked to pay customs duty on import of medical equipment. The matter needs reconsideration. The finance minister should call a meeting of the Private Hospitals Association and resolve the problems of a sinking sector. All private hospitals in Pakistan are not that strong or rich as the few in the main cities.

4.3 Unhygienic conditions in Govt-run hospitals

The lack of infection control has badly affected the efficiency of hospitals, particularly the public sector health facilities. The prevalence of certain bacteria, which is often

contracted by patients owing to lack of hygienic standards, has made the use of antibiotics highly cost-intensive, it has been learnt. The city's facilities – PIMS, FGSH, Capital Hospital, Holy Family, DHQ and RGH, and many others - are plagued by the problem of unhygienic atmosphere in and around these facilities. Particularly PIMS one of the city's largest health facility, with the condition of wards--medical, surgical, orthopedic, neurosurgery, etc-offers a repulsive sight to visitors, more so to the patients and their attendants. Lack of maintenance of hygienic standards is writ large on the benches, walls and floors of these wards and the patient may well fear that his condition will get worse by the time he leaves the hospital. Besides in sanitary conditions in the corridors and pathways are also no secrets. The Children Hospital in the middle of the hospital does not look like a part of it. It is a well-maintained unit, run and maintained by philanthropists but remains neat and tidy throughout day and night. All the medical and surgical wards in PIMS have been continuously suffering from lack of upkeep and maintenance. The toilets in the premises also present a repulsive sight. Such a situation prevails in almost all the government-run public sector facilities. Though some patients and their attendants could also be held responsible, lack of budgeting and monitoring on maintaining hygienic standards by hospital administrations are contributing to the prevalence of cross infections.

4.4 Cost of carelessness

A Colossal waste of scarce health resources as Government portrays, medical equipment worth over Rs 1 billion is lying in operational in many teaching hospitals in Punjab. Over

1,100 costly machines have been rendered useless in the absence of proper care and maintenance. Many of these are out of operation because of the non-availability of technicians and engineers as well as spare parts. Failure to install them or keep them fully functional shows a callous disregard for the needs of patients. As a result, many needy persons would either be deprived of the facility or forced to turn to expensive private hospitals and clinics for treatment. This defeats the purpose of providing affordable medical care in public hospitals and reflects poorly on the quality of their management. Ironically, while private clinics generally use cheaper Chinese and Korean machinery, most government hospitals rely on more costly European and Japanese equipment. Obviously, for sensitive medical equipment to run for a sufficiently long period of time, it is absolutely necessary that the technical know-how and supply of spares for their smooth running are ensured at all times. The governor's inspection team, which conducted a survey of the state of non-operational medical equipment, has suggested that the suppliers should be required to maintain machinery for a sufficiently long period of time. As an immediate solution, it has recommended that the suppliers of non-operational machinery should be asked to repair the equipment within a specified time limit, failing which they should be blacklisted and debarred from participating in future bidding. It is obvious that there are grave deficiencies in the system of purchase and repair of medical machinery. The governor's inspection team has observed that the hospitals were either not providing full specifications of the equipment or ordering it piecemeal. It is necessary to overhaul the system of equipment purchase and upkeep, ensuring proper use of funds and prompt repairs. Hospital managements must be held accountable for the smooth operation of the equipment at their disposal.

4.5 People without physicians

In Pakistan, the total allocation of funds for health is one per cent of our GDP, the lowest in the world. With a population of 140 million, the money spent for a sick person comes to Rs12 per year! Our eastern neighbor spends six per cent on health services, the USA 20 per cent and the UK 15 per cent of their GDP. Forty per cent of our population lives below the poverty line cannot afford private health care and has to depend entirely on public health services that are obviously quite inadequate. There is one specialist for every 25,000 patients in each of the special fields. It takes 15 years to make a specialist. The salary scale of a government-employed specialist is 1/10th of what they would earn in the UK or the USA, where they were initially trained at their own expense without any assistance from our government. These specialists are making a sacrifice by choosing to opt for a developing country on a meager salary. In the Punjab and the NWFP, the provincial governments are trying to pick the pockets of such doctors by depriving them of their private practice. In Sindh, 60 doctors were shot dead in the last year-and-a-half for unknown reasons. Neither the culprits were caught nor security is in sight for the future. So, it shouldn't come as a surprise that 20 specialists left the country last month. People are poor when the country's capital flies out, but people without physicians are as good as dead.

4.6 Fighting poverty and agents of change

Extreme poverty is the denial of human rights and is measured as the total absence of opportunities, accompanied by high levels of undernourishment, hunger, illiteracy, lack of education, physical and mental ailments, emotional and social instability, unhappiness, sorrow and hopelessness for the future. Poverty is also characterized by a chronic shortage of economic, social and political participation, relegating individuals to exclusion as social beings, preventing access to the benefits of economic and social development and thereby limiting their cultural development. By the end of 2003, there will be over two billion poor people in the world fighting for survival. The primary responsibility for finding solutions to poverty lies with countries themselves, but success will depend on the united efforts of government and civil society, and on strong and sustained support from the international community. For all stakeholders, the strategies chosen to reduce poverty must be comprehensive enough to address all of its many causes. For this reason, sustainable economic growth and social development are seen as the key elements in any framework for reducing poverty. Successful achievement of either element requires sound macroeconomic management and good governance. Together, these result in socially inclusive development. Reducing poverty and inequality is a humanitarian priority; it also promotes economic growth. Experience clearly demonstrates, though, that investments in areas such as education, microfinance, and health not only have an impact on poverty but also stimulate economic growth. **4.6.1 Growth**: The three-day meetings of Pakistan Development Forum (PDF), concluded in Islamabad on 14th May, 2003. Priority themes included continuity of economic reforms, poverty reduction and good governance. In the concluding session, the

PDF urged the government to carry forward the reform process robustly, with higher allocation of resources for poverty alleviation and development. A consensus also emerged that broad political ownership should be assured by presenting the draft Poverty Reduction Strategy Paper (PRSP) to Parliament in order to garner support for consistency in approach and implementation. Growth can reduce poverty by generating employment and incomes, and labor-intensive growth can reduce it even faster. Thus, policies that encourage labor-intensive growth are powerful pro-poor measures. Similarly, opportunities for self-employment by the poor must be promoted. Inflation and economic crises also have a severe impact on the poor. Consequently, sound macroeconomic management is essential for sustained reduction of poverty. The Three Year Poverty Reduction Programme (2001-04) Draft Document launched by the government in February 2001, is replete with lofty ideals but sorely lacking in terms of concrete measures and plans; once again the focus is more on meeting numerical targets. The three-year strategy emphasizes a great deal on the restoration of economic growth through investment with national savings, while providing greater access to social services and creating employment. The strategy calls for granting of proprietary rights to residents of urban "kutchi abadis" and the rural poor will be provided with access to credit through schemes such as the Khushhali Bank and the Zakat Rehabilitation Package, further supported with the redistribution of about 7,20,000 acres of resumed land and 21,88,635 acres of state land to women in particular. Social safety net in the strategy mainly focuses on zakat schemes, pension plans, and social security schemes. Reforms in governance are seen as an essential condition for the implementation of the devolution plan. The fact neglected by the policy makers is that any poverty reduction

strategy can only be successful if it recognizes the limitations confronting the society and works to eliminate them; and secondly, if it creates and makes use of the human and social capital required to avail economic opportunities. The strategy has its figures down accurately enough; however, it fails to accept the realities that surround the achievement of those figures, by not building in measures to counter expected hindrances. Once our state practitioners accept these realities, only then will such a document actually be workable enough to be seen through successfully. Market-driven growth processes typically benefit richer areas, where infrastructure and human capital are already reasonably well advanced. For poorer areas, public investment is generally necessary, especially in rural areas, which generally have excess labor.

4.6.2 Social development: Economic growth can effectively reduce poverty only when accompanied by a comprehensive programme for social development. Just as some targeting of economic development is necessary to reach bypassed areas, so social development must be targeted. Therefore, Pakistan needs to have a comprehensive national poverty reduction strategy that provides for (i) adequate budgetary allocations for human capital, (ii) targeting of basic social services to the poor, (iii) removal of gender discrimination, (iv) an effective population policy, and (v) social protection

4.6.3 Human capital development: Human capital is the primary asset of the poor, and its development is of fundamental importance in the war against poverty. Every person must have access to basic education, primary health care, and other essential services. Without such access, the poor, and their children, will have little opportunity to improve their economic status or even to participate fully in society. It is also necessary to ensure that the relevance, quality, and quantity of education provided is designed to effectively

increase participation, both in the workforce and in society at large.

4.6.4 Population policy: The correlation between family size and self-perpetuating poverty is generally strong, especially in rural areas. Pakistan sees the need to reduce population growth to a rate where all children can be assured adequate investment in their future. To do this, a major effort is needed to enhance the quality of women's lives by giving highest priority to (i) ensuring universal education for girls, (ii) providing accessible reproductive health services, and (iii) increasing economic opportunities.

4.6.5 Gender and development: In many societies, women suffer disproportionately from the burden of poverty and are systematically excluded from access to essential assets. Improving the status of women thus addresses a priority area of poverty and provides important socioeconomic returns through reduced health and welfare costs and lower fertility and maternal and infant mortality rates. Giving women voice and promoting their full participation makes an important contribution to the overall development of society. Poverty reduction programmes involving microfinance, water and sanitation, and environmental restoration consistently demonstrate the substantial benefits from ensuring the full participation of women.

4.6.6 Social protection: Every society has people who are vulnerable because of age, illness, disability, and shocks from natural disasters, economic crises, or civil conflict. Social protection comprises a family of programmes designed to assist individuals, households, and communities to better manage risks and ensure economic security. Such programmes include Zakat fund allocation, old age pensions; unemployment and disability insurance; and social safety nets to cushion the adverse impacts of disasters, economic crises, or civil strife. Also included are policies to improve labor mobility and

the enforcement of labor standards

4.6.7 Good governance: The quality of governance is critical to poverty reduction. Good governance facilitates participatory, pro-poor policies as well as sound macroeconomic management. It ensures the transparent use of public funds, encourages growth of the private sector, promotes effective delivery of public services, and helps to establish the rule of law. A sound macroeconomic framework is needed to encourage efficient and productive domestic investment and to keep inflation low to protect real incomes of the poor. Good public expenditure management is necessary for fiscal discipline, economic growth, and equity. The latter is achieved through an effective, progressive tax system and adequate allocations for basic education, primary health care, and other public services. Effective regulation and supervision of the financial sector is needed to protect depositors, enhance competition, increase efficiency, and expand availability of financial resources for all members of society. Since effective and efficient delivery of basic services by the public sector matters most to the poor, weak governance hurts them disproportionately. Unfortunately, the country is faced with a similarly ugly situation in some social sectors, which demands radical changes. There are hospitals without doctors and schools without teachers. Where the necessary labor force happens to be available, it is not performing properly. Universities are no more breeding grounds for excellence. Funds for poverty alleviation do not reach the targeted groups. Public sector inefficiency, corruption, and waste leave insufficient resources to support the requisite level and quality of public services and targeted antipoverty programmes. However, denial of basic services to the poor is not just a matter of lack of investment. Often, it is the result of (i) institutional structures that lack accountability, (ii) domination by local elites, (iii)

widespread corruption, (iv) culturally determined inequality, and (v) lack of participation by the poor. Where such problems exist, systemic changes are needed to move from poor governance to government accountable to the poor. Such changes are difficult to bring about, since existing arrangements that exclude the poor reflect prevailing economic and power inequalities. Yet unless these issues of inequality are tackled, it will be difficult to raise living standards of the poor. In my view, there would always be a serious risk of performance deficit until and unless agents of change with the necessary vision and approach are introduced and properly authorized to create a conducive environment in the related fields. They must have the courage to confront the vested interests, take on the entrenched labor unions and refuse favors to the political heavyweights.

4.7 Quacks at work

A large number of quack doctors and dentists are massively contributing to the spread of Hepatitis B and C among the people. This observation was made by noted hepatologist, Prof Sarwar Jehan Zuberi, at a week-long course of the Pakistan Society of Physicians (Dawn March 17, 2001). The use of un-sterilized instruments for IV Injections, IM Injections, tooth extraction and other dental procedures by the quack doctors and dentists, who are operating their mobile clinics on the roadsides, should be taken note of by the authorities. Similarly the procedures of carrying out ECG require technicians to shave different people's chest. They use the same razor and blades and do not take proper precautionarymeasures.

The Ministry of Health is required to take immediate steps to prevent general public from such diseases, by removing the quack doctors and dentists from the roadsides. Similarly,

the technicians should also be trained by providing them proper literature, to protect people from diseases. There is an urgent need to create awareness in the general public for seeking medical advice from the government recognized hospitals, rather than going to quack doctors for treatment. PTV should also discharge its national responsibility by organizing programmes and inviting relevant doctors, who should speak on the issue.

4.8 Draining health

Did you remember why grandma's tub of water never filled up, and she failed to take a bath? Maybe not, so I had better retell the parable. The old lady sees a tubful of water with the taps on as she starts to undress. Being old she takes a while to get ready to slide in. By then, sadly, there is no water left. You can't keep the tub full if water is draining out faster than the inflow. Imagine the tub of water to signify the health of the country. The taps are controlled by a company that claims to be working for the country's well being. After all, it is pumping in the water, and surely that's good. What it doesn't tell grandma is that it also controls the drain, which is much bigger than the size of the taps. Poor grandma only sees the luxuriant flow of water coming in, and is puzzled. Now, what would you say if a tobacco company started building cardiac centers and cancer hospitals? For a start, you may want to pinch yourself to make sure you weren't hallucinating. Things are not as bizarre as this, I assure you, but we are getting close to it. A famous Pakistan tobacco giant linked to BAT, a huge international tobacco enterprise, has since 1988 set up medical clinics in the NWFP. A local Nazim said in praise of this company "such assistance to the ailing humanity would always be remembered," not realizing that much of what ails this poor province is its reliance on tobacco growing and

the consumption of its products. The company that provides jobs, and now health clinics, also brings death and ill-health - that's the drain that is rarely visible. The government fails to see the drain too. It is happy collecting high taxes from such tobacco companies, not realizing that expenditure in hospitals on (preventable) cardiac problems and cancers far exceeds the tax revenue. Our government needs to give up its tobacco habit for grandma to get a proper bath.

CHAPTER 5: RECOMMENDATIONS & CONCLUSION

5.1 Improving the Level of Skills of Private Health Personnel

A first type of intervention for improving the quality of private health care would be improving the level of skills of private health personnel. This, in turn, could be accomplished by improving pre-service training of health personnel and by improving continuing education. Pre-service training, for both those who end up working in the private sector as well as the public sector, is mostly carried out in government institutions, although some private training institutions also exist. There is consensus in Pakistan that pre-service training has many weaknesses; for example, the education of doctors tends to emphasize the treatment of complicated illnesses rather than the more common health problems most of them will have to deal with in practice. Also, nursing and other paramedical training should have a much higher priority than has been the case, as a long-term strategy to reduce the cost of health services. A detailed analysis of the problems in pre-service training of health personnel exceeds the scope of this note. However, this is clearly an area in need of further work and greater government attention, in close consultation with the private sector. Improving pre-service training is important for the future quality of services; however, it would not address the shortcomings of the current stock of health workers. For the latter, a greater effort is needed in terms of *continuing education.* The most promising channel for such an effort are the professional associations. Most of these associations have already launched their own continuing education programs for their members, funded from dues or direct user charges for the seminars and other educational programs they offer. These efforts should be encouraged by the government. One form of government support could be the inclusion of continuing

education activities by professional associations in future foreign-aided projects, which could be a suitable vehicle for technology transfer in this area. Another form of support could be for the government to link (via legislation) the successful completion of continuing education courses to the revalidation of the licenses of private practitioners.

5.2 Licensing Health Care Practitioners

The government could pass legislation enabling the professional associations to manage the licensing of health care practitioners. This activity could then be linked to continuing education. For example, the Pakistan Society of Family Physicians could be empowered to: (a) establish the requirements that would have to be met for someone to be licensed as a family physician; (b) run continuing education programs whose successful completion would be required to continue to hold a license to practice; and (c) take steps to sanction those who continue to practice without a valid license. Sanctions could take the form of fines or other measures enforced through the courts, or (more realistically, in view of the weaknesses of the justice system) by making the names of infractors readily available to the public. General practitioners in good standing (i.e., with a recognized degree, and having taken and passed the required continuing education courses) would be "certified" as such by the association, and this information would also be readily available to the public.

5.3 Introducing Independent Accreditation of Health Facilities

A third possible avenue to improving the quality of private health care would be the introduction of a mechanism for the independent accreditation of private clinics and hospitals.6 To this effect, an independent accreditation entity would have to be

established. Safeguards would be needed to ensure the integrity of the process; for example, the accreditation entity could include representation from major foreign hospitals or universities.

Accreditation, if credible, could be a powerful force for improving quality of care. Private hospitals and clinics would be asked to submit voluntarily to the accreditation process. Since they compete against each other, they would have an incentive to get accreditation. This would be especially so once the public (and insurers, once the insurance industry is better developed) became familiar with the system. Competitive pressures towards accreditation would also extend to government hospitals if they had to depend to a significant extent on selling their services for their financing.

Since accreditation would be voluntary, it is likely that no new legislation would be needed to put it into effect. The public sector could assist the process of establishing accreditation by working with interested parties in the private sector to organize the accreditation process. Some technical assistance may be needed to define accreditation procedures. Also, since there would be some costs involved, it would be necessary to determine how the accreditation work would be financed.

5.4 Enhancing Attention to Preventive Care

It is generally acknowledged in Pakistan that private health care providers do not pay sufficient attention to preventive care. This is in part because of a curative bias in medical education, and in part because private demand for preventive services is weak among the bulk of the population.

Addressing the first cause should be part of efforts to improve both pre-service and continuing education of health care providers. Addressing weak private demand is a longer-term proposition. Improvement of the general level of education of the population, and especially of women, is one key factor. A more pointed intervention would be public campaigns of health education highlighting the importance of preventive services. The combination of these interventions would lead over time to stronger private demand for preventive health services. In the meantime, preventive services should be aggressively promoted by the public health services.

5.5 Improving Consumer Protection

The task of improving consumer protection in the health area can be divided, for the sake of discussion, into two subtasks: (i) improving consumer protection from malpractice and fraud committed by health care providers who have completed the relevant professional training; and (ii) protecting consumers from malpractice and fraud committed by untrained practitioners.

5.6 Trained Health Care Providers

Consumer protection would improve with implementation of the above suggestions concerning licensing and accreditation. These tools for consumer protection would to a large extent rely on market forces to exert their influence. Consumers already have recourse to the courts in case of fraud and malpractice, although the consensus in Pakistan seems to be that the courts cannot be relied upon to resolve such cases in a fair and efficient manner.

The public sector also operates some regulatory entities in the health sector. For example, the provincial Departments of Health employ drug inspectors to inspect pharmacies and take samples of medicines which are tested in provincial drug testing laboratories. Cases of violation of existing rules for selling of pharmaceuticals are referred to the Drug Quality Control Board in each province. These boards are composed of experts from the medical and pharmaceutical fields and chaired by the Secretary of Health. The boards may prosecute the violators or take administrative action, such as issue a warning or cancel or suspend licenses. By all accounts, however, public sector regulatory mechanisms are not doing a good job. This is in part due to inadequate resources allocated to the task; the presence of corruption was also mentioned in many of the interviews with the private sector as an important factor.

5.7 Untrained Health Care Providers

The most promising strategy for improving consumer protection vis-a-vis untrained health care providers would seem to be public campaigns to educate consumers. The public sector should take the lead in this respect, but the professional associations could also assist in this effort. It would be unrealistic to expect, however, that public attitudes about untrained providers would change overnight. Improvement of the general level of education of the population would also help consumers to make more informed choices about different types of health care providers.

5.8 Fostering the Development of the Insurance Industry

Availability of health insurance has been very limited so far. The major system is that of the Employee Social Security Institutions (ESSIs), which provide health insurance

coverage to lower-income employees in the private sector. The ESSIs are quasi-public, operate under government ordinances, and are managed as autonomous organizations at the provincial level. They are funded entirely by a contribution from employers equal to seven percent of salary. Government regulations require that establishments with more than 10 employees register for ESSI coverage any worker earning less than Rs. 3,000 per month (about US$75). More than 500,000 employees (mostly urban) are registered. The ESSIs run their own network of health facilities and also pay for some types of care in private and public facilities[5].

Several private insurance firms sell indemnity-type, third-party health insurance coverage. Authorization to start such insurance schemes is required from the Commissioner of Insurance. Most existing packages cover hospitalization services, particularly surgical procedures and related diagnostic services. They offer certain coverage up to a stipulated limit for various types of medical interventions. This type of insurance is mostly purchased by private firms for their employees; typically, before buying insurance, the firms were contracting directly with various health care providers. Indemnity insurance products now in the market benefit mainly the better-off. Present premiums generally range between Rs. 3,000-4,000 per enrolled person per year (US$75-100), with premiums varying according to age and gender and health care consumption history[6].

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[5] April 22, 1998 Health, Nutrition and Population Unit South Asia Region, page no: 61

[6] April 22, 1998 Health, Nutrition and Population Unit South Asia Region, page no: 62

Development of the health insurance industry would be an important boost for the private health sector in Pakistan. One possibility would be to expand the ESSI system, by for example allowing self-employed persons to enroll voluntarily. Another possibility worth considering would be for the provincial governments to sponsor a pilot project with the private sector to develop health-maintenance organizations (HMOs). In this model of health insurance, households which become members of an HMO pay a set fee per month and are entitled to free services within a defined "package" at the designated facilities owned and operated by the HMO. In other words, the HMO is both insurer and provider of services. Likely clients for HMOs may include employees of private firms not covered by the ESSI system (i.e., employees in firms with less than 10 employees, or employees in firms with more than 10 employees who earn more than the ESSI limit of Rs. 3,000 per month). Since many private firms (and parastatals) already have some form of health care benefit for their workers, these employers may be willing to pay all or part of the HMO fee. Self-employed workers with steady incomes may also be a market for HMOs. The direct benefits from development of the health insurance industry would accrue mostly to better off-households. However, poorer households could also benefit indirectly. This is because such development would enable a greater proportion of the population to purchase a broad range of health services privately, including care for catastrophic illnesses or injuries. Since fewer people would then resort to government health providers, development of the health insurance industry should release government revenues which could be applied to improving health services for poorer households with no access to health insurance. An important caveat is that, for the full savings in

government revenues to materialize as more people make use of private providers, the government must be ready to downsize its own capacity for providing health services. This would mean the closing of certain facilities and reductions in personnel. As the health insurance industry develops, it will be important for the government to build up its capability to regulate the industry. Hence this is another suitable area for public action complementary to private sector development. Support for capacity building in this area may be a suitable component for future foreign-aided projects, as there would be a substantial element of technology transfer involved.

5.9 Contracting With Private Entities for the Delivery of Government-Financed Health Services

Another type of public/private sector partnership that deserves attention is the contracting of private providers to deliver government financed health services. It was recommended that the Government expand its efforts to provide incentives for the creation and expansion of health NGOs. It was further suggested that special emphasis should be given to assisting the development of NGOs operated and staffed by women and focusing on maternal and child health care. But public/private partnerships of this type need not be restricted to NGOs. The possibility of establishing partnerships between government and non-NGO private health care providers should also be explored.

One model that merits consideration would be the contracting by government (provincial Departments of Health) with a professional association of private physicians --such as the Pakistan Society of Family Physicians—to provide a basic package of primary health services (with a strong focus on health education and other preventive interventions) to an identified population, on a prepaid capitation basis. It is recommended that the

provincial governments consider starting pilot projects to this effect, possibly targeted to urban slum populations. The contracts would have to ensure that a suitable number of the providing physicians are women (so as to be able to interact effectively with women patients and their young children), and that the physicians are complemented by an adequate cadre of nurses/midwives and back-up diagnostic facilities. Suitable performance criteria should be provided for in the contracts, together with arrangements for independent monitoring of compliance with contractual obligations, including ensuring acceptable quality standards. It would also be important to ensure that the communities benefiting from the scheme are actively involved in its governance. Other possible partners the government may consider include private "maternity homes" (which are found in most district headquarters and really serve rural women), and private health care organizations built around ethnic/religious groups (e.g., Parsis, Ismaelis etc.).

A number of suggestions has been made to address the weaknesses of the private health sector and facilitate its development. Each of these suggestions involves the formation of some sort of partnership between the public and the private sectors. To summarize, following initiatives have been be considered:

(a) Active encouragement by the public sector of the continuing education work being carried out by various professional associations of health care providers.

(b) Empowerment of professional associations to manage a system of licensing/certification for health care practitioners.

(c) Introduction of a voluntary accreditation system for private clinics and hospitals.

(d) Enhancement of attention to preventive care in private health care transactions through measures operating on both the supply side (correcting the curative bias of medical education) and the demand side (better informing the public about the benefits of preventive care).

(e) Public campaigns to educate consumers about the dangers of seeking help from untrained health care providers, and to help consumers to identify various categories of providers.

(f) Initiatives to foster the development of the health insurance industry, including allowing the self-employed to enroll in the ESSI system, a pilot project to develop health-maintenance organizations, and capacity-building work to strengthen the government's regulatory capabilities in health insurance.

(g) A pilot project for provincial governments to contract with an association of private physicians for the provision of basic health services to a targeted urban slum population on a prepaid capitation basis. Other modalities could be developed for contracting with other private sector partners such as maternity homes and health services built around religious/ethnic groups.

Domestic actions alone are insufficient for Public Health in globalizing world. Health achievements are critical to international development goals. Global risks for includes:

- Exclusion from global markets
- Private ownership of knowledge
- Migration of health professionals
- Cross border transmission of disease
- Environmental degradation
- Conflict

Implications of globalization and remedial measures example increased international aid to cover the rising costs due to costs of internationally mobile medical services-migration tiered pricing to ensure low cost prices for essential medicines for poor countries. New market incentives are being created to spur more investment in research and development of new drugs and vaccines for malaria, HIV/AIDS, and TB, and better diagnostic tests for these diseases. New resources are being raised to increase access to existing drugs and vaccines and provide more effective treatments to combat polio, measles, diarrhea and respiratory diseases. International partnerships between the public and private sector have launched campaigns, including Roll Back Malaria, the International AIDS Vaccine Initiative, and the Global Alliance for Vaccines Initiative, and Stop TB. Knowledge, technology and best practices for affordable and effective prevention and treatments are being shared more widely, and new research is under way to fill gaps in our knowledge.

New global health rules are being developed to control cross-border or global health risks: improved global disease surveillance through strengthened International Health Regulations; a Framework Convention on Tobacco Control to restrain the marketing and illegal smuggling of tobacco; collaboration with the World Trade Organization to ensure public health is protected and promoted in multilateral trade rules. All these global opportunities of health would lead to:

- Inclusion/Connection
- New market incentives for Research & Development
- New resources for effective interventions
- Knowledge dissemination
- New rules to control cross border risks

Public health crisis in Pakistan are because of poverty, debt, inequalities, high growth of population, double burden of disease, weak public health infra structure and weak public sector reforms. WHO's response to public health and globalization is to provide strategic directions, priority for the disease of the poor, and support for the national health system by forming partnerships and relationships with other countries in order to share resources, rules and optimism. In this respect WHO has formed a Globalization, Trade and Health program which is more of a policy, research and training program to develop knowledge and skills, to promote policy coherence and contribute to global public goods for health, global health funds and international rules for health.

Globalization and health policy measures would provide:

- Equitable and sustainable growth
- Openness…gradual, sequenced and paced
- Produce global public goods
- Increase transfer of financial and technical resources
- Result into strong national health policies, institutions, regulations and programmes
- Engage across sectors and borders

The developed countries can offer training of health care managers with a clear focus on quality standards; an accreditation system; cost control strategies; managed health care; and health insurance. Academic linkages with existing reputed Institutions for Medical Professionals to interact with their counterparts in the developed countries. are need. Also telemedicine could be practiced for second opinion on difficult cases. Sharing of information in the areas of advanced technologies would be helpful. India could benefit from information on the regulation Physician payment System and the physician's practices. Research support in the area of health care management is needed, as newer models need to be developed, tested & implemented. India would also benefit from training of health care managers in the area of implementation of newer and more efficient models on health care delivery, and software packages for keeping medical records.

BIBLIOGRAPHY

- National Diabetic Centre. Annual Report (1999).
- Cichon M (1989). Health Insurance in Fiji: Recent Developments and Future Options. World Bank
- Wong HJ (1992). Health Financing in Fiji. The role and potential
- McFarland DA (1993). Health Insurance in Fiji. Technical Note No. 20. Health
- Ffriancmr: *an_sl81fii1mmy1'ffirSi"rlblC:C['*
- Campbell DR (1994). Analysis of alternatives for cost recovery for the Ministry of Health's Health Planning Unit. Asian Development Bank Staff Consultancy.
- Campbell DR (1995). A plan for the phased introduction of cost recovery in the health sector of Fiji including the options for revenue retention, Vol (i) and (ii). Asian Development Bank Staff Consultancy.
- Tuqa S (1996). Health financing - Ministry of Health policies and plans.
- Catford J, White L, Richardson Jet al (1997). Health Insurance for Developing Countries
- Reserve Bank of Fiji. Insurance Annual Report (1999).
- Park and Park, Health Care System Textbook of Preventive and Social Medicine.
- Medical Council of India, Background Papers & Proceedings of WHO/Government of India Medical Council of India Workshop for Determination of Minimum Standards for Registration of Nursing Homes and Hospitals. August 18-19. 1999. New Delhi.
- Cornelius PK., 1995. Cash Benefit and Property Alleviation in an Economy in Transition: The case of Lithuania.
- Vivian, J. 1994. Social Safety nets and Adjustment in Developing Countries. (United Nations Research Institute for Social Development) Geneva, Switzerland
- Ministry of Health - Republic of Indonesia; 1998. Standard operational Procedures Social Safety Nets in Health. Revision Edition - Jakarta
- Triono Soendoro; 1999 - The Strategic Measures of Social Safety Nets in Health. *Medic Journal. Jakarta*
- Fetter, R. B. (1981). Testing and Evaluation of a Case Payment Reimbursement System. Final Report to Social Security Administration. Health Care Financing Administration contract no. 600-75-0180. New Haven: Health Systems Management Group, School of Organization and Management, Yale University
- Stem, R. S. and Epstein, A. M. (1985). "Institutional Responses to Prospective Payment Based on Diagnosis Related Groups: Implications for Cost, Quality, and Access," *New England Journal of Medicine,* 312, 621-7
- DesHarnais, S., Kobrinski, E., Chesney, (1987). "The Early Effects of the Prospective Payment System on Inpatient Utilization and the Quality of Care. *Inquiry,page no: 24, 7*4.
- Dranove, D. (1987), "Rate Setting by Diagnosis Related Groups and Hospital Specialization. *RandJ. Of Economics,* 417,
- Autumn Feder, J., Hadley, J. and Zuckerman, S. (1987). How did Medicare's Prospective Payment System Affect Hospitals?" *New England Journal. Of*

Medicine, 317, 867

- Guterman, S., Eggers, P. W., Riley, G. et al. (1988). "The First Three Years of Medicare's Prospective Payment: An overview," *Health Care Financing Review,* 9, 67
- Freiman, M. P., Ellis, R. P. and McGuire, T. G. (1989). "Provider Response to Medicare's PPS: Reduction in Length of Stay for Psychiatric Patients Treated in Scatter Beds," *Inquiry,* 26, 192
- Lave, J. R. (1989). "The Effect of the Medicare Prospective Payment System," *Annual Review of Public Health,* 10, 141
- Fetter, R. B., ed. (1991). DRGs: Design. Development. and Applications. Ann Arbor: Health Administration Press Coulan, R. F. and Gaumer, G. L. (1991). "Medicare's Prospective Payment System: Actual Appraisal," *Health Care Financing Review,* 12, 45
- Normand, C. and Weber, A. (1994). Social Insurance: A Guidebook for Planning. World Health Organization
- Ellis, R. P. and McGuire, T. G. (1986). "Provider Behavior Under Prospective Reimbursement: Cost Sharing and Supply," *Journal of Health Economics,* 5, 129

Committee of Medical Security Reform (1994). Reform Policy on Issues of Medical Security. Final Report to the Ministry of Health and Welfare. Seoul: Committee of Medical Security Reform

- Bureau of Census, Philippine Health Statistics. 1997.
- Income and Employment Statistics Office, Annual Poverty Indicators Survey. National Statistics Office, 1998.
- Department of Health, Annual Report. 1999.
- Department of Health, National Objectives for Health. 2000.
- Ministry of Health, Annual Health Bulletin 1998.
- NSACP, Review Report 1998.
- Minutes of the National Health Development Committee Meetings.
- Bureau of Health Policy and Planning, Ministry of Public Health, Health In Thailand. 1995-1996. The Veteran Press. Bangkok, 1997.
- Sriratanaban, J., Supapong, S., Kamolratanakul, Pet , "Situational Analysis of the Health Insurance Market and Exploration of Related Educational Needs in the Era of Health Care Reform in Thailand: Public and Private Perspectives," *Journal of the Medical Association of Thailand* (in press).
- Supachutikul, A., Situation Analysis on Health Insurance and Future Development, Thailand Health Research Institute, National Health Foundation, Bangkok, 1996.
- Surasiengsung, S., Private Health Insurance in Thailand, (in Thai) Chulalongkorn University, Bangkok, 1998
- Tangcharoensathien, Documents Presented At the Technical Advisory Group

Meeting for the Health Financing and Management Student Project. ADB No.2997-THA. Ministry of Public Health. Thailand, October 19-21, 1998.

Online References

- http://www.pitt.edu/~super1/lecture/lec9261/index.htm
- http://www.pitt.edu/~super1/lecture/lec9331/index.htm
- http://www.pitt.edu/~super1/lecture/lec9321/index.htm
- http://www.pitt.edu/~super1/lecture/lec9491/index.htm
- http://www.phaef.org/HEinPak.htm

Acknowledgement

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ANNEXURE

ANNEX "A": Health Facilities In Pakistan

In Pakistan, health care is being providing to the public through a vast infrastructure of health facilities consisting of hospitals, dispensaries, basic health units and maternity child health centers with adequate number of doctors, dentists, nurses, lady health visitors and midwives. At present there are about 97,945 hospitals beds in the country, which give a population bed ratio at 1490 persons per bed. The number of available dentists is 4622 and that of nurses is 40114 and 5845 qualified health visitors. There is only one doctor for 1516 persons, one dentist for 31579 persons. There is about 907 hospitals and 4625 dispensaries in the country. The number of Basic Health Units (Bus) is 5230 while the number of Rural Health Centers (Rocs) is 541.Since the majority of doctors and hospitals are located in cities and towns, the rural population has much lower standard of health facilities. Some statistics pertaining to health facilities are reported in Table.

Health Manpower	Upto 2001-02
Registered doctors	96,248
Registered dentists	4,622
Registered nurses	40,114
Population per Doctor	1516
Population per Dentist	31579
Population per Nurse	3639

* Source Ministry of Health

HEALTH EXPENDITURE

Fiscal Years	Public Sector Expenditure (Federal Plus Provincial)			Change (%)	As%of GNP
	Development Expenditure	Current Expenditure	Total Expenditure		
1995-96	5741	10614	16355	35.3	0.8
1996-97	6485	11857	18342	12.2	0.8
1997-98	6077	13587	19664	7.2	0.7
1998-99	5492	15316	20808	5.8	0.7
1999-00	5887	16190	22077	6.1	0.7
2000-01	5944	18337	24281	10.0	0.7
2001-02	6688	19717	25405	4.6	0.7

NATIONAL MEDICAL AND HEALTH ESTABLISHMENT

(Calender year basis)

Calender Years	Hospitals	Dispensaries	BHU's SubHealth Centers	Maternity & Child Health Centers	Rural Health Centers	TB Centers	Total Beds	Population Per Bed
1990	756	3795	4213	1050	459	210	72997	1480
1991	776	3993	4414	1057	465	219	75805	1461
1992	778	4095	4526	1055	470	228	76938	1476
1993	799	4206	4663	849	485	233	80047	1455
1994	822	4280	1902	853	496	242	84883	1406
1995	827	4253	4986	859	498	260	85454	1426
1996	858	4513	5143	853	505	262	88454	1417
1997	865	4523	5121	853	513	262	89929	1428
1998	872	4551	5455	852	514	263	90659	1450
1999	879	4583	5785	855	530	264	92174	1492
2000	876	4635	5717	856	531	274	93907	1495
2001 p	907	4625	5230	879	541	272	97945	1490

- The decrease in MCH since 1993 on ward as against previous years is due to exclusion/separation of Family Welfare Centers from MCH structure in NWFP.
- Provisional data in respect of Punjab Province.

* Source Ministry of Health

REGISTERED MEDICAL AND PARAMEDICAL PERSONNELS AND EXPENDITURE ON HEALTH

(Calendar Year Basis)

Calendar Years	Registered Doctors	Registered Dentists	Registered Nurses	Registered Midwives	Registered Lady Health Visitors	Population Per			Expenditure(M	
						Doctors	Dentists	Nurse	Develop	N
1990	51883	2077	16948	15009	3106	2082	52017	6374	2741.00	4
1991	55572	2193	18150	16299	3463	1993	50519	6104	2402.00	6
1992	60042	2279	19389	17678	3796	1892	49850	5859	2152.31	7
1993	63003	2401	20245	18641	3920	1848	48508	5753	2875.00	7
1994	66196	2589	21419	19759	4107	1803	46114	5574	3589.73	8
1995	69691	2751	22299	20910	4185	1755	44478	5487	5741.07	1
1996	74229	2938	24776	21660	4407	1689	42675	5060	6485.40	1
1997	78470	3159	28661	21840	4589	1636	40652	4480	6076.60	1
1998	82682	3444	32938	22103	4959	1590	38185	3992	5491.81	1
1999	87105	3867	35979	22401	5299	1590	38185	3822	5887.00	1
2000	91823	4175	37623	22528 p	5619 p	1529	33629	3732	5944.00	1
2001	96248	4622	40114 p	22714 p	5845 p	1516	31579	3639	6688.00	1

- Expenditure figures are for respective financial year 2001-02.
- Registered with Pakistan Medical & Dental Council and Pakistan Nursing Council.
- Provisional

* Source Ministry of Health

DOCTOR CLINIC FEE IN VARIOUS CITIES

Ending November	Faisalabad	Gujranwala	Hyderabad	Islamabad	Karachi	Lahore	Peshawar	Quetta	Rawal Pindi	Sukkur	Average
1990	51.67	32.50	50.00	26.88	26.54	30.00	22.50	57.00	25.83	35.00	35.79
1991	42.00	32.50	50.00	27.50	27.09	24.64	22.50	60.00	26.67	40.00	35.29
1992	31.67	32.50	66.67	27.50	26.49	24.64	22.50	52.50	29.17	75.00	38.86
1993	32.54	43.75	80.0	27.50	28.85	27.14	27.50	52.50	19.17	75.00	42.40
1994	32.50	40.00	65.00	27.50	31.00	24.64	30.00	82.50	19.17	70.00	43.23
1995	37.50	40.00	65.71	27.50	32.24	30.00	30.00	90.00	30.00	75.00	45.79
1996	30.00	40.00	53.00	32.50	31.88	27.86	30.00	80.00	30.00	5.00	41.02
1997	35.00	40.00	46.25	32.50	31.88	27.86	30.00	80.00	30.83	60.00	41.43
1998	35.00	40.00	33.75	33.44	31.60	33.21	30.00	107.50	30.00	30.00	40.45
1999	35.00	40.00	33.75	33.44	32.17	33.93	30.00	107.50	31.25	30.00	40.45
2000	40.00	40.00	33.75	33.13	32.40	38.93	30.00	107.50	32.95	30.00	41.86
2001	40.00	40.00	33.75	33.13	33.00	41.96	43.33	107.50	33.75	30.00	43.64

Reference: http://www.phaef.org/HEinPak.htm

ANNEX B: GLOBAL PERSPECTIVE

With an emphasis on managed care, the integration of providers, capitation of payments, a focus on health and wellness, and community health improvement, the fundamental assumptions underlying the delivery model are the integration for the financing and care delivery functions into large managed care networks responsible for a defined population and 0perating within fixed resources.
Future trends putting pressure on the health care system include:

- The increasing number of the uninsured;
- Government regulations ranging from privacy and confidentiality to patient and worker safety;
- Quality control and patient safety issues. The public's eroding confidence in the health care system;
- New cost-increasing technology;
- Consumer empowerment and shared decision-making through the use of new information technologies;
- Increasing costs that are making it more difficult for consumers to pay for their care, for providers to be able to deliver high quality, affordable care, and for government programs to remain viable/solvent into the future;
- The introduction of complementary and alternative medicine into the traditional allopathic health care environment; and
- Workforce issues that threaten the ability of hospitals and health systems to make good on their commitment to society to provide health care.

These are some of the issues that are faced by the developing countries. Study of the health sector reforms of India, China and Bangladesh can act as case studies for us in making us understand the similarity of the problems with our country. These problems are further supplemented with the solutions, which could also be beneficial to our country in similar scenarios.

Bangladesh

The arsenic contamination of ground water problem is a recent problem that is impossible for a developing country like Bangladesh to mitigate through its own resources. The Government of Bangladesh has already mobilized its own resources for this program. Some development partners have offered to support the government initiatives, but these are too little to combat this problem. It is not a question of what counties are affected, but rather one of the suffering of mankind, and thus all parties should come forward to address this problem.

Collection of information, development of national strategic plan and conduction of activities to the reduction of arsenic pollution health problems have been incorporated in the operational plan of Environmental & Occupational Health including Arsenic Pollution Program for the year 1999-2000 under HPSP.

Major activities include the development of a National Strategic plan, piloting of awareness and education on arsenic pollution (with development of IEC materials); preparation, development, and production of training module for diagnosis, treatment of Arsenicosis cases; development of an Effective Reporting System (ERS) for Arsenicosis; case detection of clinical arsenicosis for early diagnosis, palliative treatment and management of arsenicosis patients.

Continuing Education of Physicians and other Health Personnel in Detection (clinical diagnosis) and Management of Arsenicosis. As arsenicosis is a very new public health problem in out country, physicians and public health personnel have little medical knowledge to identify the arsenicosis cases. As a result arsenicosis cases remain unidentified and the magnitude of the problem is yet to be defined. The preventive measure of arsenic toxicity is primarily lies with the Early Diagnosis of the cases and detection of arsenic in water. In this situation it is needed to develop knowledge and skill of the physicians & other public health personnel so that they can identify/diagnose the cases in the initial stage and take necessary steps for prevention. A total of 6000 doctors and 60000 paramedics will be orientated on arsencosis case detection and its management.

REPUBLIC OF CHINA

HEAL TH POLICY AND HEALTH CARE MANAGEMENT IN TAIWAN

Taiwan, The Republic of China, is a democratic state with a population of23,000,000. For a long time, Taiwan had only one dominant political party, the Kuomingtung, but after 1987, when martial law was abolished, many other political parties were established. Then in March of 2000, the main opposition party (The Democratic Progressive Party) won the presidential election. While under the control of the KMT, the central government was predominant in making health care policies. As a result, the national health insurance system was established in 1995. In this system, more than 95 percent of the population was insured. Therefore, accessibility to medical care was adequate. Even after the new party took over, the central government (Department of Health) is still dominant in making health care policies. There are two kinds of medical providers in Taiwan, public and private; therefore, the medical industry is not only controlled by the private sector. Although the government is dominant in making these health care policies, the health care providers and representatives still have the opportunity to influence these policies.

During the last 5 years, medical expenses have continued to rise; but under political pressure it is difficult to adjust the premium; therefore, currently the most important issue in health care is to search for more sources of funds and decrease expenses. Medical providers must try hard to comply with the requirements of the government in controlling medical costs. Another important issue is there are many different points of view on how to reform the insurance system, which make it difficult to reach a consensus. Because of rising medical expenses, a deficit has now appeared, and the government has started to use reserve funds to support the insurance system. According to the National Insurance

Law, the government is authorized to adjust the insurance premium to increase funding; however, due to political pressure and other factors, it is difficult to make these adjustments. Consequently, the central government has to consider other measures. For short term, some measures include not covering non-prescription drugs, requiring a fixed rate for co-payment for outpatient visits, reasonably limiting patient volume, implementing a referral system, reducing payment for outpatient visits, and requiring approval by the National Health Insurance Bureau prior to ordering high-tech or expensive treatments for patients. In the long run, the measures are focused on reform of the payment system, such as adopting a global budget system, or implementing HMO.

Although the whole medical industry has gotten used to responding to the policy changes of the government, different levels of hospitals have different abilities to respond. In general, large hospitals and primary clinics are more capable of dealing with these changes; however, medium-sized hospitals will have to modify themselves a lot to accommodate. In the long run, because the government has reduced subsidiaries for public hospitals, public hospitals are compelled to put more efforts toward cost control. Teaching hospitals, which also bear the missions of teaching and research, will have to work hard to balance teaching, research and clinical service, while private hospitals will struggle between cost control and medical quality.

On cost control, the government should consider the diversity of hospitals. They have to take different measures toward the teaching hospitals, which bear multiple missions, and are not profit driven. It is hoped that the forerunners can offer their suggestions on how to balance teaching, research and clinical service at a university hospital.

The third important issue is the future of the national insurance system. The current one is characterized by mandatory social insurance. The high coverage rate increases accessibility for people, but different people have different understanding and expectations toward the system. Some people expect it to be a comprehensive social welfare. In their opinion, the current items covered are not satisfactory, and they expect a larger coverage. However, they refuse to pay more premium or tax. Some other people think it may be easier for individual citizens to share the risk. They recommend reducing the benefits (only cover the expense of hospitalization and not include outpatient costs), increasing co-payment, and establishing medical saving accounts. A few people are more radical and propose to make huge changes on the existing structure of the insurance system.

Health reform should consider the accessibility of medical resources, and maintain a social insurance system. Under this premise, the reform should be focused on managing the hospitals more efficiently and still maintaining high quality care from all aspects. In other words, incremental reform is preferred. It is unwise to switch the responsibility to the individual citizens. We have to teach both medical providers and the citizens the appropriate concepts to work together to enhance medical efficiency and effectiveness. Although there are differences between Taiwan and the United States and the US does not have a national health plan, perhaps the United States' experience in establishing health care systems in different states can be a good reference for Taiwan.

India

The rapid rise in incidence and prevalence of cancer has led to a situation where the existing infrastructure is grossly inadequate to cater to the needs of millions of cancer patients all over the country. Because of this, the disease is often diagnosed late, leading to poor cure rates. Further, the availability of palliative care facilities is almost negligible and patients often suffer from extreme agony of cancer pain without access to oral morphine, hospice care and home care services.

The need of the hour is developments of cancer care facilities in all geographical areas of India, so that people have access to the appropriate services at a place, which is accessible to them, and they can avail of the services offered. However, the establishment of these centers requires tremendous financial inputs due to the costly infrastructure required.

The availability of adequately trained doctors in the field of cancer care is also limited and the trained personnel are concentrated in a few major cities for several reasons. Establishment of palliative care services is another important area where major initiative from the government and the community is required, because palliative care services have to be offered as a compassionate and humanitarian service, without recovery of input costs in most cases.

STEPS TAKEN BY THE GOVERNMENT TO FIGHT CANCER

The Government of India has taken some important steps in this direction. One of the major initiatives taken by the government in this direction is the "National Cancer Control Program". The program was launched in 1975-76. Over the quarter century that it has been in existence, there have been some significant achievements but it can be said that the work has only begun. The policy of the program was revised in 1984-85 with the following objectives:

- Primary prevention of cancer by health education regarding tobacco consumption and for genital health in prevention of cervical cancer. These approaches target squamous cancer of the upper aerodigestive tract (tobacco-smokeless and smoking) and cancer of the uterine cervix. The third common cancer, breast cancer, is not amenable to primary prevention.
- Secondary prevention i.e. early diagnosis and detection (cancer of the cervix, breast cancer and oropharyngeal cancers) by screening methods and patient education on self examination methods.
- Strengthening of existing therapeutic services.
- Palliative care in terminal cases.

STRATEGIES IDENTIFIED IN EIGHTH FIVE-YEAR PLAN

- District cancer control programs for early detection of breast, cervical and oral

cancers, through rural health workers. For this purpose, a financial assistance of Rs.5.5 million is provided over 5 years to the selected districts. Only 40 (out of more than 500) districts have been covered till now.

- Development and dissemination of health education materials about hazards of tobacco, stress on genital hygiene, breast self -examination and oral self examination.
- Assistance to voluntary organizations for working on cancer awareness, prevention and early detection activities. Grant-in aid of Rs.5 lakh has been given to 27 organizations in the last 5 years.
- Procurement, supply and distribution of pain killers, especially oral morphine at regional cancer centers and some of the teaching medical colleges.
- Development of oncology wings in medical colleges and hospitals by providing financial assistance. An assistance of Rs.15 million is provided to the selected centers, in two installments and 29 medical colleges have received such assistance. Assistance for regional research and treatment centers. There are now 12 recognized regional cancer centers in India, while the number of states in India is 25 and some of the states are very large in terms of land area and population.
- Assistance for the purchase of Cobalt therapy units. For this purpose, the government is providing a one-time grant of Rs.l 0 million. Thirty-three medical colleges and hospitals have received this support.

The program has identified and helped 12 regional cancer centers which function as tertiary care centers in management of cancer. Eight of the 12 regional centers are receiving Rs.7.5 million per year, as grant-in-aid from the government, as part of the program. It is easy to notice that the number of regional centers is grossly inadequate for a country like India. Further the amount of Rs.7.5 million is a negligible, when we consider the cost of cancer treatment. It can neither support research or treatment of cancer patients.

The steps taken by the government to fight cancer include the launching of the national cancer control program in 1975-1976, and Revision of the Policy of the Program in 1984-1985 with the Following Objectives:

- Primary Prevention
- Secondary Prevention
- Strengthening of Existing Cancer Treatment Services
- Palliative Care
- Financial Assistance for Various Programs Identified with Cancer Control Health Education
- Assistance to NGOs for Cancer Awareness, Prevention and early detection Development of Oncology Wings in Medical Collages and Hospitals Assistance to Regional Cancer Care Centers
- Assistance for Purchase of Cobalt Therapy Units.

STEPS TAKEN BY THE PRIVATE SECTOR TO FIGHT CANCER

The government effort is supplemented by private effort, as enlightened members of the society recognize the problem and pool-in community effort and resources to develop cancer care facilities. Private sector has not come forward in a big way for establishing cancer care facilities. The main reason being, a cancer center is a capital intensive project and the returns are not expected for long periods of time. Majority of the private involvement is through charitable, non-governmental organizations, which have tried to raise funds from various sources. A number of such cancer centers have now come up and are doing service to cancer patients. In fact two major cancer centers in the country, now designated regional cancer centers, started as NGO run hospitals. These hospitals are, Tata Memorial Hospital, Mumbai and the Cancer Institute, Adyar, Chennai. From humble beginnings, they have grown with time and are pillars of cancer care in the country.

Dharamshila Cancer Hospital and Research center, established by the Dharamshila Cancer Foundation. From conception to commissioning, the center took four years to come up and has been functional for more than six years. The center is an integrated cancer hospital with Departments of Radiation Oncology, Medical Oncology, Surgical Oncology, Gynae-oncology, Pathology, Radio-diagnosis and Imaging. We also have a pain clinic with availability of oral morphine for pain relief.

Steps taken by the private sector to fight cancer in India include:

- Establishing the Indian Cancer Society, with branches throughout the country;
- Registering NGO's to run cancer hospitals;
- Mobilizing funding from the community in both the public and private sectors;
- Commissioning and administering state-of-the-art cancer centers, with trained oncologists, nurses, technicians and other paramedical staff;
- Disseminating information that cancer is curable if detected early and treated promptly;
- Educating the community about risks of getting cancer, means of cancer prevention and early detection;
- Cancer research; and bringing the fruits of years of research to the community.

INDIA (2)

NEED FOR REGULATING HEALTH CARE DELIVERY BY THE PRIVATE SECTOR IN INDIA

EXISTING SCENARIO

India has a National Health Policy, but it does not have a National Health Service. The health care service delivery in India is divided mainly into two sectors: the public sector and the private sector. Let me provide a brief overview of the status of the public sector, which is a three-tier system.

The Central Government is responsible for Policy making, Planning, Guiding, Assisting, Evaluating and Co-ordination of the work done by the State Government. At the Center we have The Ministry of Health & Family Welfare, The Directorate General of Health Services, and The Central Council of Health & Family Welfare.

Health Care is the primarily the responsibility of States, whose organizational structure is as follows: (1) State Ministry of Health Minister; Deputy Minister; Health Secretary. (2) Directorate of Health Services. (3) Directorate of Medical Education.

The principal united of administration is the District. There are 466 districts in India, which are further subdivided into the following: (I) Sub - divisions. (2) *Tehsi/s (Taluks)* (Indian administrative districts). (3) Community Development Blocks. (4) Municipalities & Corporations. (5) Villages. (6) Panchayats (elected village councils).

In India, 70 percent of the population lives in villages and only 30 percent in the urban areas. However, nearly 66 percent of the health care facilities are concentrated in urban areas while only 34 percent are located in rural areas.

At the grass-root level in the village the people who are involved in the delivery of the primary health care are the village health guides, traditional dais, and anganwadi workers: Above these people are the Health Workers. The work of Health Workers is being supervised by the Health Assistants.

Growth of the Private Sector

All the above are non-medically trained personnel and hence the people have little faith or confidence in them. Therefore, the public-sector health care service delivery system has lost its popularity and the people have turned to the private sector in search of alternative solutions to their health care needs.

The private sector can be divided into the for-profit sector and the not-for-profit sector. The not-for-profit health sector, which is very small, includes various health services provided by NGO's (Non-Governmental Organizations, Charitable Institutions, Missions, Trusts, etc.).

The for profit health sector is constituted by the General Practitioners, Specialists, Super Specialists, Consultants, Nurses and Paramedics, Licentiates, Registered, Rural Medical Practitioners (RMP's) and a variety of unqualified persons. Then there is an 'informal' sectol which consists of practitioners not having any formal qualifications, like the *tantriks,* faith healers, *bhagats, hakims,* vaidyas and priests who also provide health care.

In India the private provision of health care is an important constituent of the health care delivery system and its role has considerably increased over time. At present about, 50 percent of hospital beds are in the private (both profit and nor profit) sector. This sector employs 70percent of qualified doctors. Most of the newly qualifiee doctors prefer either

to work in private hospitals or start their own practice. They prefer tc practice in urban and semi-urban areas. Thus, medical specialist with higher qualification in urban areas is more than the demand which had resulted in various problems. There is a growing dissatisfaction with services offered by this sector and increase in complaint againsl the care provided by the Medical profession. These have attracted the attention of the consumer movement in the country. All these have necessitated the 'state' to playa role in regulating this sector. Private Medical practice has now been brought under the Consumer Protection Act (COPRA) 1986.

On the other hand as the public sector financing is not adequate to provide the health care services with increasing population, the health care services through private sector need to be regulated in the interest of the consumers of the services. One of the essential components of health sector refonns and health financing is a balanced mix of public and private sector health services.

Utilization studies have shown that health care services provided by this sector are used not only by the affluent classes; a large number of people from middle & low socio-economic groups also use them and have exhibited their preference for approaching private doctors for their health problems. The share of the private health care sector in the GDP is estimated to be about 5 percent.

India's Crucial Problem

This laissez faire growth of the private sector has raised a number of concerns. The role of the medical associations and medical councils has been very minimal in regulating this sector; Undesirable practices have grown considerably, affecting the quality of care. As far as introduction of legislation is concerned, there are only a few examples of regulations promulgated by the state governments e.g. The Nursing Home Acts of Delhi and Bombay, Tamil Nadu Private Clinical Establishments Act 1997.

As a result of the growth of this, sector the prevalence of certain practices, such as fee shifting, over prescription of medicines and drugs, inadequate sterilization procedures and employing untrained personnel has increased.

This has led to a great number of Nursing Homes with high utilization but has also led to a series of questionable practices and to questionable quality of care. Hence the need for an Act at the National level to regulate the functioning of private hospitals, keeping the human rights angle in mind. This Act would ensure registration of private hospitals with minimum facilities for different forms of treatment and monitoring to ensure that facilities and services created are maintained at desired level.

There are a great number of private and voluntary hospitals and nursing homes in the country and while several of them are well run, it is often alleged that some of them are running without qualified doctors, staff, adequate equipment and infrastructure. Further, many of these private nursing homes/hospitals are established and run in residential areas and thereby dump hazardous hospital wastes in residential areas.

The majority of hospitals operating in this country consist of those having bed strength of 10 - 15 or even less. The services provided by the hospitals are varied. Some provide service in anyone of the Specialties like Maternity, Eye, Pediatrics, Cardiac Care etc, while many of them provide services in more than one specialty. In addition to very small private hospitals having bed strength of 5 - 20 beds, there are corporate hospitals which have come up in the 80s with larger bed strength. These bigger hospitals and nursing homes, particularly those functioning in cities, cater only to the rich class of people and the cost of treatment in these hospitals is beyond the reach of common man. Commercialization has also taken place as several large business houses, in addition to their regular business, have diversified into the field of medicine.

STEPS TAKEN BY GOVERNMENT TO ADDRESS THE NEEDS

To regulate the ftmctioning of private hospitals, some State Governments have enacted legislation to provide for registration and inspection of nursing homes. Some examples are Delhi Nursing Homes Registration Act, 1953, Bombay nursing Homes Registration Act 1949 (amended in 1959) and Tamil Nadu Private Clinical Establishment Act 1977. It is Wlderstood that some other States like Andhra Pradesh, Karnataka and Uttar Pradesh are in the process of making the similar legislation.

Though legislation has existed in some of the States as pointed out above, it has been noticed that they have not been implemented in the right spirit and proportion and there has been haphazard growth of such private nursing homes and hospitals even in those States and even the regulatory functions prescribed in the legislation are not being carried out by the authorities concerned.

The Calcutta High Court, in response to a petition filed regarding the conditions of the private hospitals and nursing homes, appointed the Speaker of West Bengal Legislative Assembly in 1985, to prepare a report. This report showed that nursing homes lack floor space, ventilation, lighting, water, bath room facilities and qualified doctors and nursing staff.

In 1991, the Bombay High court issued an Order to the Municipal Corporation, to set up a permanent Committee to oversee and supervise the implementation of the Bombay Nursing Home Registration Act 1949 and make further recommendations. The Committee examined the quality of care provided in terms of physical standards, human power, sanitary conditions, equipment etc. of private hospitals and nursing homes in the city of Bombay. Both the above findings revealed that the standards in these hospitals and nursing homes were of poor quality, the majority of them were located in residential premises and many of them were congested, lacked adequate space, passages were congested, entrance narrow and crowded and there was inadequate space for movement of trolley or stretcher. Many of them did not have operation theater and labor rooms. Many of them were ill equipped and did not even have resuscitation sets in the labor rooms for new born babies, ambulance service, blood, oxygen cylinders etc. The staffs employed were mostly well qualified. Round the clock service by doctors was not

provided by many hospitals. Majority of nursing homes utilized the services of visiting consultants and most of them employ well qualified nurses. Sanitary conditions left a lot to be desired. They did not have continuous supply of water. With regard to waste disposal, they did not have incineration arrangements for disposal of hazardous hospital wastes.

In this background world, the need for formulating minimum standards for establishment of Nursing homes, etc. by the Central Government, which could be adopted by all the States where there are Regulatory Acts, these are either out-dated, inadequate or not being implemented. Further, the Acts mainly concerned themselves with registration of private hospitals/nursing homes and they have not described in clear terms the minimum standards to be maintained with regard to space, facilities, staff employed, sanitary conditions, equipment and other supportive services. It was noted a few years back, that only 1/3 of the private nursing homes were registered under the Bombay Nursing Home Registration Act.

Medical practitioners have been brought under the Consumer Protection Act recently. But this Act, however, does not provide any regulatory function over the institutions in which the doctors are working. Since more than 70 percent of health care is provided by the private health sector, there is need for regulating the growth of this sector with regard to fulfillment of prescribed standards as majority of people at present have little or no control over the quality of services or pricing of the private nursing homes.

In India, the Indian Hospital Association may take steps to promote voluntary accreditation system. The Bureau of Indian Standards have laid down standards for hospitals up to 30 beds and are in the process of evolving standards for a 100 bedded hospital. The Medical Council of India has formulated standards for a medical college with 50, 100 and 150 admissions and the standards for attached teaching hospitals with 400, 500 and 750 beds.

It may be noted that the standards laid down by Bureau of Indian Standards are for relatively larger hospitals located in major urban areas. In the present scenario there is demand for quality health care services due to increasing consumer awareness and the rights of the middle class. This can be seen in the context of implementation of Consumer Protection Act for health care services with the failure to enact and implement the existing legislation, the opening of the insurance sector etc. There is need to examine a self regulation model. A survey was undertaken regarding the need for accreditation system among the health care providers in 1998 by CEHAT, Bombay. There was an over all consensus for accreditation system. However, certain doubts were expressed as to how this system would be made applicable for smaller nursing homes, whether they would be able to offer the cost for upgrading standards, etc. Majority of the Associations felt that the hospital owners and Government should playa leading role in the formative stages of setting up of such a system. Most of the Associations felt that the accreditation system should function as non profit organization. A strong opinion was articulated that the system should assess and assist hospitals in maintaining and upgrading standards which should ensure a continuous process of quality assurance.

Regarding the patients' redress system, some Associations felt that it would help to build confidence between doctor and patient and help in patient education, solve problems and misunderstanding between doctor and patient and would decrease litigations. Some Associations, however, felt that patient complaints fall outside the authority of the accreditation system. Most of the Associations felt that physical aspects like equipment, qualification and number of personnel employed/attached, type of treatment and follow up of care provided should be monitored though some of them felt that the type of treatment and follow up care provided cannot be monitored. Some Associations felt that standards should be laid down only for equipment and not for space. One Association felt that standards should differ according to the geographical location.

The Central Council of Health & Family Welfare at its meeting held in January 1997 made the following recommendations:

The Council after reviewing the functioning of private and voluntary hospitals in the country resolved that (1) states may enact laws to provide for registration of only those private hospitals which have minimum facilities for different forms of treatment; (2) monitoring mechanisms should be developed by the State to ensure that the facilities and services created in private and voluntary sector hospitals continue to be available and are maintained at the desired level; and (3) private hospitals in non-conforming areas which are posing health *hazards may* be considered for shifting to other areas.

PRESENT PROBLEMS

It was also noticed that the standards being of low quality, these nursing homes, hospitals were following irrational and unethical practices. They trend to perform unnecessary investigations/tests, consultations and surgeries, which in turn increased the cost of medical treatment. There are also complaints of over charging, irrational therapeutics etc. further, defunct equipment are used. Transparency in the investigation, treatment and management of patient care is not made available. Further the record keeping is also very poor.

Such dismal conditions of hospitals and nursing homes can be attributed to their being practically no monitoring and accountability to the people or any authority in most of the States. As regards the rating of hospitals/nursing homes, it was felt that ratings would help the patients realize whether the kind of treatment he/she needs is available or not in a particular institution. Also the patient would be able to choose where he/she wants to go for a particular kind of treatment.

As regards assessment of standards, some felt that it should be done by the participating hospitals followed by an external team. It was felt that consumer participation in this process could also be encouraged. One association was of the opinion that it should be only done through the process of self-evaluation. A majority of the opinions expressed in trends of the follow-up mechanism included providing recognition to those who met standards, assistance in: upgrading standards and taking punitive action. A majority of the

associations felt that the accreditation system should be an independent and autonomous body while one association was of the opinion that it should be supported by legislation.

SUGGESTED SOLUTIONS

Solutions to address the above problems are not easy; however the following recommendations can be made. First, enumerate the existing healthcare establishments in detail (number of beds, type of services, the equipment, the manpower, their qualifications, and the workload). Second, standardize the nomenclature or the terminology (Clinics, Nursing Homes, Hospitals, Day care centers, etc.). Third, enumerate the type of services offered by these healthcare establishments (Maternity, ICU, Surgical, Ophthalmic Care, Diagnostic, etc.). Fourth, establish Quality Standards in trends of space requirements (essential equipment, the minimum number of qualified professionals, semi-skilled personnel required, unskilled personnel, etc.). Fifth, existing healthcare establishments, which do not meet the quality standards, should be directed to upgrade their facilities, and sufficient time should be given for these healthcare establishments. In some cases, however, the government may have to give soft loans to some of the healthcare establishments in order to upgrade their facilities. Sixth, all new healthcare establishments should obtain a written permission from health authorities who should assess the need, the feasibility, depending upon the existing facilities in the locality, etc. Seventh, involve the private healthcare establishments in the implementation of the National Health Programs and also give some incentives to those private healthcare establishments who meet the targets.

In addition, the Director of Health should appoint a special committee to monitor the activities of private healthcare establishments. The Committee should be empowered to take punitive action, and the punishment should also be specified. The proper medical record system should be enforced. Registration of health care establishments should be mandatory and their renewal should be on the basis of their past performance.

All notifiable diseases should be brought to the notice of the health care authorities within the stipulated time frame. All professionals should obtain a valid license to practice medicine and this license should be renewed every 5 years based upon the work done and CME's attended. All Institutions should themselves seek voluntary accreditation. An accreditation committee should be formed which will grade the health care establishments. Finally, the physician payment system should be standardized.

Lessons to Be Learn’t:

Development of a National Strategic plan, piloting of awareness and education on pollution (with development of IEC materials); preparation, development, and production of training module for diagnosis, treatment of cases; development of an Effective Reporting System (ERS) for water pollution; case detection for early diagnosis, palliative treatment and management of patients.

Continuing Education of Physicians and other Health Personnel in Detection (clinical diagnosis) and Management of diseases. Develop knowledge and skill of the physicians & other public health personnel so that they can identify/diagnose the cases in the initial stage and take necessary steps for prevention.

Health reform should consider the accessibility of medical resources, and maintain a social insurance system. Under this premise, the reform should be focused on managing the hospitals more efficiently and still maintaining high quality care from all aspects. In other words, incremental reform is preferred. It is unwise to switch the responsibility to the individual citizens. We have to teach both medical providers and the citizens the appropriate concepts to work together to enhance medical efficiency and effectiveness.

Primary prevention of cancer by health education regarding tobacco consumption and for genital health in prevention of cervical cancer. These approaches target squamous cancer of the upper aerodigestive tract (tobacco-smokeless and smoking) and cancer of the uterine cervix. The third common cancer, breast cancer, is not amenable to primary prevention. Secondary prevention i.e. early diagnosis and detection (cancer of the cervix, breast cancer and oropharyngeal cancers) by screening methods and patient education on self-examination methods. Strengthening of existing therapeutic services. Palliative care in terminal cases.

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medicine and this license should be renewed every 5 years based upon the work done and CME's attended. All Institutions should themselves seek voluntary accreditation. An accreditation committee should be formed which will grade the health care establishments. Finally, the physician payment system should be standardized.

The Hospitals must provide medical service for the society at an affordable cost. Thus, a government subsidy is a must, unless the government manages to find a new form of medical subsidies stem for the low and middle class society. Second, the Hospital must provide a center to provide professional manpower for medical service. This automatically would further serve itself to serve the majority of poor and middle class society since these funds are difficult to obtain from customers. Third, after privatization the hospital must find a way to pay the staff. These social problems forced the management to lower its medical services fees so as not to create undue burden for those already experiencing hardships. Increasing demands for professionalism and to meet international standards. The Government should force the management to spend more resources on the training and salaries of its staff.

The Government should assure basic health care for pregnant women, infants, and children under - 5 years of age, and the aged, especially for those with low incomes. Assure adequate budgets for the access to basic health care for vulnerable groups in sub rural areas with low-income status. Assure nighttime emergency & essential health care by poor communities throughout Pakistan. Strengthen and improve the health insurance system. Promote disease prevention and health promotion programs more than costly curative care services. Improve efficient & effective health care and health programs. Improved the productivity of health care staff. Increase the supply of medicines/drugs as well as the use of generic medicines/drugs. Strengthen the private sectors.

Managed care has been a prominent feature in the United States healthcare system. In Pakistan however, the MCO is only starting to play its role in the middle to late 90s. Areas which Pakistan may learn from the U.S. include issues related to its effectiveness, advantages as well as its shortcomings. Collaboration and sharing of knowledge by both countries on the issue through seminars, meetings, and visits should be further intensified. Collaboration between hospitals, universities and institutions of higher learning in Pakistan and the United States in the area of training of medical as well as para-medical personnel should also be initiated, such as embarking on twinning degree programs, providing placement opportunities for students for hands-on experiences in various organizations, exchanging staff for a duration of time to expose them to different cultures and work ethics.

In conclusion, healthcare needs in Pakistan can be addressed by co-operation of the government and private sectors in Pakistan working closely hand in hand to ensure that the healthcare objectives of the country are achieved.

ANNEX C: PATIENT CARE

Role & Functions of Nurse

The role of a nurse should be a caregiver. Nurse should help clients regain health. Nurse should address holistic health care needs including emotional and social well-being. Nurse should help clients, families in setting goals, meeting these goals with minimum cost and energy. Nurse should act as a decision maker. Nurse use decision-making skills to provide effective care alone with family and other team members. Nurse should act as a protector and client advocate. Nurse should maintain safe environment by preventing injury. Nurse should take care of adverse effects of diagnostic and Rx measures. Nurse should protect local and human rights of her clients. Nurse should act as a Manager by coordinating with other health care members to manage total care of patients, manages own time, resources, delegates care responsibilities and supervises other care workers. Nurse should act as a rehabilitator by giving client returns to maximal normal health after accidents and disabling events, levels of functioning after illness is the responsibility of Nurses. Nurse should help them to adapt to changes in life after physical and emotional impairments. Nurse should act as a comforter by caring as a person, traditional and historic events of Nursing should continue in any new role. Nurse should comfort the client physically, emotionally (strength to recover). Nurse should act as a Researcher by investigating problems to improve nursing care status, should define and expand scope of nursing care. Nurse should also act as an Educator. Good communication with patient, clients, families other nurses and other health providers.

PATIENT RELATION PROGRAM

The Patient Relations Department should be established to ensure that patient care is delivered in a professional and courteous manner, respecting the dignity and rights of patients and staff. The department should manage the Patient Relations Program, which, should be designed to assist both staff and patients by providing a structured approach to resolving complaints, forwarding suggestions and routing compliments.

The Patient Relations Program concept should focuses on positive communications skills and behaviors, which could defuse potentially explosive situations and specific techniques that could positively enhance the patient/staff experience. The effectiveness of the program could be attained through the use of Patient Contact Representatives (PCR) which should be assigned to specific areas and can usually resolve most patient concerns as they occur. Patients could be referred initially to the respective PCR whenever feasible. When attempts to solve problems fail at the PCR level, the PCR seeks the assistance of their Leading Petty Officer/Leading Chief Petty Officer, Division Officer, or Department Head as appropriate.

The objectives of the Patient Relations Department should be to:

- Provide a convenient mechanism for patients and providers to register and resolve complaints.
- Monitor complaints and compliments; investigate and make recommendations on suspected problem areas.
- Train personnel to interact with the patient in a manner that will prevent adverse actions.
- Develop and improve customer relations' skills on and off the job that are essential to achieving excellent customer service.
- Act as a patient advocate.
- Consider suggestions for performance improvement concerning patient service issues.
- Define, prioritize, and study processes to improve effectiveness, efficiency, and patient satisfaction.
- Develop and publish metrics that provides feedback on patient service initiatives.

Mission

To strengthen, personalize and enhance the relationship between patients, their families, community and staff; and to assist the hospital staff in gaining awareness of patients' perceptions of the hospital experience.

Vision

Patient relations is a daily event; therefore, the vision of this department is to become the benchmark "First and Finest" in patient and customer relations at hospital; the preferred choice for quality, access, cost and personalization of customer relations.

Guiding Principles

- To have moral and ethical obligation to meet the expectation of those served.
- To provide interface and collaborate across all lines of communication in the effort to exceed the expectations of those served.
- To firmly and sincerely strive to do what is right for those served regardless of personal feeling and outside influence.
- To pledge and obligate to ensure that patient rights and responsibilities are upheld and that conflicts are promptly resolved.
- To be forthright and fair in all encounters.
- To respect and maintain the sacred trust of those served by only disclosing information to those that have a need to know.
- To endeavor to respond promptly to all encounters.

Strategic Goal

To have a virtuous Patient Relations Department that practices benevolence, compassion, intellectual honesty, humility, competence and suspension of self-interest. To this end the hospital would:

- Be accessible and visible to patients, their families, community and staff, and view caring as being just as important as curing.
- Firmly and sincerely strive to do what is right in ensuring patients' rights and dignity.
- Provide prompt responses to concerns, compliments and suggestions.
- Review and trend all patient satisfaction surveys and implement performance improvements when appropriate.
- Conduct hospital training to all staff and provide monthly in-services to Patient Contact Representatives.

Strive to recognize and reward staff members for their outstanding acts of caring and compassion.