Policy Options For Financing
Health Services in Pakistan

VOLUME V
ORGANIZING AND FINANCING
RURAL HEALTH SERVICES

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POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN

A Compendium
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Volume I  Summary Report
by Marty Makinen

Volume II  Hospital Quality Assurance Through Standards and Accreditation
by Greg Becker

Volume III  Hospital Autonomy
by Stan Hildebrand and William Newbrander

Volume IV  Development of Private Health Insurance Based on Managed-Care Principles
by Zohair Ashir, Harris Berman, and Jon Kingsdale

Volume V  Organizing and Financing Rural Health Services
by Richard Yoder, Sikandar Lalani, and Marty Makinen

Afzal Siddiqui provided the legal analysis for the study and the component initiatives (Volumes 1-5).

Zohair Ashir studied the use of Muslim religious funds for financing health services for the indigent (Volumes 1, 3, and 5).
The purpose of this report is to explore an alternative approach to organizing and financing rural health services in Pakistan. The proposed model calls for the government to assign directly to rural communities the financial resources currently allocated to their local health facilities. The communities would then take responsibility for managing a contracting process whereby providers would compete to offer them a basic package of health services using existing government facilities and equipment. At the option of the community, additional services could be asked of the contractor in return for giving the provider the right to charge limited user fees. This report addresses the financing of different packages of services, including the provision of financial support for the needy; the development of a medical referral system; defining the contractual and oversight roles of the community; attracting providers to bid; and implementing, monitoring, and evaluating the proposed approach. Also included are a sample Request for Proposal and contract form that could be used in carrying out this alternative approach to the management of rural health services.
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ACRONYMS, ABBREVIATIONS, AND GLOSSARY

AI D U.S. Agency for International Development
(Washington, D.C.)

AKHS Aga Khan Health Services

AKU Aga Khan University

AKUH Aga Khan University Hospital

AKUHS Aga Khan University Health Services

Amir Head of a Muslim State

ARI Acute Respiratory Infection

Bait-ul-Mal Welfare funds established by the Amir

BHUs Basic Health Units

CCU Cardiac Care Unit

CDA Capital Development Authority

CDD Controlling Diarrheal Diseases

CHW Community Health Worker

CRHP Cost Recovery for Health Project, Cairo, Egypt

chowkidar Watchman

CV Curriculum Vitae

CZA Central Zakat Administration

CZC Central Zakat Council

DHO District Health Officer

DOH Department of Health (provincial level)

EPI Expanded Program of Immunization

ESSI Employee Social Security Insurance

Fatamid Foundation Blood Donor Agency

FGSH Federal Government Services Hospital

FJMC Fatimah Jinnah Medical Center

FMoH Federal Ministry of Health of Pakistan

FP Family planning

GDP Gross Domestic Product

GMO General Medical Officer

GNP Gross National Product

GOP Government of Pakistan

GP General Practitioner

Hakims Traditional health practitioners

HCFA Health Care Financing Administration, U.S. Government

HFS Health Financing and Sustainability Project

HMO Health Maintenance Organization

HPAC Healthcare Provider Accreditation Council

HPN Office of Health Population and Nutrition

HT Health Technician

ICT Islamabad Capital Territory

ICU Intensive Care Unit

IPA Independent Practice Association

ISL Islamabad

JCAHO Joint Commission for the Accreditation of Health Care Organization

JPMC Jinnah Postgraduate Medical Center

Katchi Abadis Squatter Settlements

KEMC King Edward Medical Center

KHI Karachi
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>LDC</td>
<td>Lower Division Clerk</td>
</tr>
<tr>
<td>LHV</td>
<td>Lady Health Visitor</td>
</tr>
<tr>
<td>Liaquat</td>
<td>Hospital (Karachi)</td>
</tr>
<tr>
<td>LZC</td>
<td>Local Zakat Council</td>
</tr>
<tr>
<td>Mali</td>
<td>Gardener</td>
</tr>
<tr>
<td>MCB</td>
<td>Muslim Commercial Bank</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>M.O.</td>
<td>Medical Officer</td>
</tr>
<tr>
<td>Mbhalla</td>
<td>Neighborhood</td>
</tr>
<tr>
<td>MSH</td>
<td>Management Sciences for Health</td>
</tr>
<tr>
<td>Mustaqeem</td>
<td>Needy People</td>
</tr>
<tr>
<td>Nai b/Qasid</td>
<td>Orderly/Housekeeper</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non-Governmental Organizations</td>
</tr>
<tr>
<td>NI CVD</td>
<td>National Institute of Cardiovascular Diseases</td>
</tr>
<tr>
<td>NJI</td>
<td>New Jubilee Insurance Company</td>
</tr>
<tr>
<td>NWFP</td>
<td>North West Frontier Province</td>
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<tr>
<td>ORT</td>
<td>Oral Rehydration Therapy</td>
</tr>
<tr>
<td>p.a.</td>
<td>per annum</td>
</tr>
<tr>
<td>PAHO</td>
<td>Pan American Health Organization</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Physician</td>
</tr>
<tr>
<td>parchi fee</td>
<td>Registration or door fee when using a health facility</td>
</tr>
<tr>
<td>PCSP</td>
<td>Pakistan Child Survival Project</td>
</tr>
<tr>
<td>PGM</td>
<td>Post Graduate Medical Institute, Lahore</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PIA</td>
<td>Pakistan International Airways</td>
</tr>
<tr>
<td>IMS</td>
<td>Pakistan Institute of Medical Sciences</td>
</tr>
<tr>
<td>PMDC</td>
<td>Pakistan Medical and Dental Council</td>
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<tr>
<td>PMRC</td>
<td>Pakistan Medical Research Council</td>
</tr>
<tr>
<td>PPGP</td>
<td>Pre-Paid Group Practice</td>
</tr>
<tr>
<td>PPO</td>
<td>Preferred Provider Organization</td>
</tr>
<tr>
<td>PZC</td>
<td>Provincial Zakat Council</td>
</tr>
<tr>
<td>RHC</td>
<td>Rural Health Center</td>
</tr>
<tr>
<td>Riba</td>
<td>Interest (or usury)</td>
</tr>
<tr>
<td>Rs.</td>
<td>Pakistani Rupees (approximately Rs. 25 = U.S. $ 1.00 in 1992)</td>
</tr>
<tr>
<td>SAP</td>
<td>Social Action Program</td>
</tr>
<tr>
<td>SES</td>
<td>Socio-economic status</td>
</tr>
<tr>
<td>SESSI</td>
<td>Sindh Province ESSI</td>
</tr>
<tr>
<td>Shariah</td>
<td>Islamic Laws</td>
</tr>
<tr>
<td>TA</td>
<td>Technical Assistance</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>Tehsil</td>
<td>Zone Within a District</td>
</tr>
<tr>
<td>Tehsil Hospitals</td>
<td>Hospitals Within a Zone</td>
</tr>
<tr>
<td>UI</td>
<td>The Urban Institute</td>
</tr>
<tr>
<td>USAID</td>
<td>U.S. Agency for International Development (Mission)</td>
</tr>
<tr>
<td>Ushr</td>
<td>Islamic levy on agricultural production given to the poor</td>
</tr>
<tr>
<td>VHW</td>
<td>Village Health Worker</td>
</tr>
<tr>
<td>Waqf</td>
<td>Property endowment to a religious or charitable purpose</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>Zakat</td>
<td>An obligatory Islamic religious donation for the indigent</td>
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AN OVERVIEW OF THE STUDY
"POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN"

INTRODUCTION

This is one volume in a set of five reporting on work performed between 1991 and 1993 by the Federal Ministry of Health (FMoH) of Pakistan with the assistance of USAID's Health Financing and Sustainability Project (HFS). The purpose of this study was to design four financial and organizational reform initiatives to improve the delivery of health services in Pakistan.

Volume I of this series summarizes the overall study and presents the recommendations made in each program area. Volumes II through V are technical reports that address the following issues:

- Assuring quality health services by establishing national standards for accrediting hospitals
- Granting autonomy to government hospitals
- Developing private health insurance based on managed care principles
- Providing new models for delivering health services in rural areas

OBJECTIVES OF THE REFORM

The FMoH’s new approaches to financing and organizing health services are intended to:

- Make more resources available to the health sector by increasing the share of the gross domestic product allocated to health.
- Increase efficiency in the use of resources by improving the cost-effectiveness of health spending.
- Ensure physical and financial access to basic health services for lower socio-economic status groups, both rural and urban.

GUIDING PRINCIPLES

The FMoH set out the following principles to guide the design of the four initiatives:

1. Those who have the resources must contribute to the cost of the health services they use, principally through
paying user fees, often facilitated through insurance mechanisms.

2. New methods must be developed to organize the way in which services are delivered, including offering incentives to service providers for efficiency, cost effectiveness, and quality.

3. Government allocations must target lower socio-economic status groups.

CHOOSING THE APPROACHES

In 1990, a broad-scope study of Pakistan’s health care system was conducted by the FMOH with assistance from the U.S. Department of Health and Human Services’ Health Care Financing Administration (HCFA). This study identified a list of areas in which organizational and financial reforms might be made.

In order to narrow down these areas and to design specific initiatives within them, USAID made available to the Government of Pakistan the technical services of its Health Financing and Sustainability (HFS) project. From 1991 to 1993, staff and consultants from the HFS Project gathered up-to-date information, consulting with government and private health service providers, provincial and federal health officials, employers in both the private and public sectors, insurers, and donor agencies such as the World Bank and UNICEF that are interested in health.

This information was synthesized and presented at a workshop organized by the FMOH in February 1992. Also presented were approaches to financing and organizational reform that had been identified in the 1990 HCFA study. After listening to commentary from workshop participants, the FMOH selected for further study the four areas identified at the start of this section. Partly, these were selected because it was felt that changes in one area would support changes in another. For example, granting autonomy to government hospitals (Volume III of this study) would free these institutions to work towards meeting nationally established standards of quality (the initiative described in Volume II). Hospitals would also benefit from the development of private, managed-care insurance plans (Volume IV). Such insurance plans would, in turn, use the information gained by independent assessments of hospital quality to choose facilities with which to associate. Furthermore, strengthened rural services (Volume V) would reduce the burden on government hospitals, and, as government hospitals improve, they would better serve as referral sites for rural services.

DESIGNING THE INITIATIVES

Following the 1992 workshop, the Federal Ministry of Health,
through the technical services of the HFS Project, pursued studies in each of the four selected areas. The study team was composed of seven national and nine external experts. Ultimately, three more workshops were held at which proposals in these areas were presented and feedback was obtained. The goal of this consultative approach was to gain the benefit of the wisdom and experience of all the important actors involved in Pakistan's health sector. This approach was also intended to build consensus concerning how to best address and implement reforms.

What follows is the technical report and the recommendations in the field of rural health services.
VOLUME V

ORGANIZING AND FINANCING
RURAL HEALTH SERVICES
EXECUTIVE SUMMARY
ORGANIZING AND FINANCING RURAL HEALTH SERVICES

PURPOSE

The purpose of the rural health component of this study is to develop an initiative to test an alternative organizational and financing approach to providing cost-effective health services to rural populations.

PROBLEMS

Typical problems associated with government-provided and financed rural services include the general "non-availability of 'free' health care;" absenteeism among health staff; hours that are short or inconvenient to consumers; an absence of essential drugs, medicines, and supplies; and insufficient funds. All of these factors contribute to poor health status indicators among rural populations.

DESCRIPTION OF THE INITIATIVE

Specific objectives within the overall initiative include: (a) developing alternatives for financing rural health services, (b) developing a workable referral system, (c) developing a strong community role in the health system, and (d) assessing the interest and role of potential contract providers in managing a set of health facilities. Although the initiative was developed for initial testing in Islamabad Capital Territory (ICT), the methods used for developing it can be applied to any area of Pakistan.

The initiative proposes developing, testing, revising, and replicating an alternative model of organization and financing of rural health services. The alternative recommended to be tested involves assigning current government operating allocations to rural communities for their use in competitively contracting, on a fixed-price basis, with private providers. The contract would require the providers to offer a basic package of services while operating government rural health facilities and equipment in the community. At the option of the community, additional services to the basic package may be asked of the contractor in return for the right to charge limited user fees. Zakat and other charities would help pay for the services used by the poorest, when fees are applied. Government, in addition to supplying the funds, facilities, and equipment, would act as a technical advisor to the community in the choice of services to ask for and in monitoring and evaluating provider performance.
METHODS

In the context of several broad working principles agreed on with the Federal Ministry of Health (FMOH), a variety of methods were used to develop the alternative approaches that follow, including interviews with a wide variety of health service consumers, government officials, and donors, as well as the conduct of numerous site visits.

RECOMMENDATIONS

Financing

To illustrate what the concept would mean in terms of the package of services communities could purchase, four model packages of services were developed and analyzed for the test site, ICT. The packages were analyzed for their implications concerning services available, costs, and user payments. The most basic package of services is that which is currently offered (in principle, although often not in fact) and paid for by government allocations. The three additional service packages proposed each offer the basic package plus supplementary services at additional cost. To obtain more than the basic package would require the community to agree to pay some user charges. The estimated average user charges required per visit vary according to the set of services contained in the optional packages; this charge ranges from Rs. 6 to Rs. 27 for Rural Health Center (RHC) services and from Rs. 4 to Rs. 15 for Basic Health Unit (BHU) services.

It is recommended that the contents of each of the service packages and the associated estimated user charges be explained to the communities involved in the test of the concept. Once the packages and their financial implications are understood, the community can specify which package, packages, or hybrid packages it wishes to include in its request for proposals (RFP) from potential providers.

Referral System

The referral system has been built around the principle that the foundation of any effective referral system is the availability and accessibility of high quality and affordable services at the primary level. The current locations of such services lend themselves to a natural referral structure for primary, secondary, and tertiary facilities which is presented in the main body of this report. Specific referral-related recommendations include:

- Differentiate among primary (BHU), secondary (RHC), and tertiary (hospital) levels of care and provide appropriate and affordable services at each level.
Institute progressively higher fee schedules at each level.

Create disincentives for "jumping the queue."

Provide referred patients with direct access to professional staff at the referral facility.

Install a formal communication system with standardized referral forms to ensure coordination among the different levels of care and facilities involved.

Community Role

Experience with substantial and successful community involvement in oversight and management of health services in Pakistan is limited to that of Aga Khan Health Services (AKHS) in the Northern Areas and Chitral. However, the experience of AKHS, as well as experienced in other countries, demonstrate that such involvement is possible and that it is an important component of many successful health service systems.

In the rural initiative communities are to be empowered to choose and oversee the performance of a private provider of their basic health services. The operating funds allocated by the government for the facilities serving the community, the facilities themselves, and their associated equipment will be assigned to the chosen provider for use in providing services. The services to be provided are to be those currently offered (theoretically) by the facilities under government management, subject to some negotiation with the community. The community may wish to negotiate the provision of supplemental services in return for the right of the provider to charge specified fees. The government, in addition to providing financial and tangible resources, will act as an advisor to the community in evaluating proposals from providers and in monitoring their performance of the agreed-upon services.

To help the communities in test areas (ICT or elsewhere) carry out their role under this initiative, the following steps are recommended:

- Develop a training program for communities in their role under this approach with the assistance of specialists in community development and the participation of community leaders from the test areas.

- Train the test communities in the concept of the initiative and on their role in carrying out the process. This would include training on:
  - selection of community representatives
definition of the basic package of services
- decisions regarding charging supplementary fees
- evaluation of proposals
- oversight of providers
- evaluation of performance
- decisions on renewal of contract

Conduct a conference to explain and seek feedback on the concept of this approach from interested providers, communities, and government units.

Work with the test communities to enter into cooperative agreements with providers for the test period.

Assist the test communities in choosing whether or not to ask for additional services and to permit fees to be charged; if fees are charged, help set up Zakat and other charity assistance to pay for the poorest.

Assist the test communities to monitor and evaluate provider performance and to decide whether to renew a contract or open it up for new bids.

Revise the community training program in light of lessons learned during the test period.

Assist the test communities with competitive bidding for subsequent contracts.

**Interest and Role of Potential Contractors**

Private providers have indicated some interest in contracting to operate government rural health facilities in the proposed arrangement. This interest, however, is tempered by concerns about the government meeting its obligations to provide the funding. Thus, in testing the approach, measures by government are needed to build provider confidence in its seriousness. In light of this, the following recommendations are made:

- Use, initially, a cooperative agreement-type arrangement in which the provider, community, and government together work out the specific terms and conditions of the contract, including the option (or mix of options) to be tested and jointly determine how performance is to be judged.

- Publish a solicitation of "expressions of interest" in major newspapers to solicit potential providers.

- Conduct a conference to explain and seek feedback on the concept of the approach from interested providers, communities, and government units involved in test sites.
Assure providers of full authority over personnel policies and procedures including hiring, discharging, and determining salary levels.

Implementation, Monitoring, and Evaluation

Recommendations related to implementing this initiative as well as to monitoring and evaluating contractor performance are:

- Contract initially on a cooperative agreement basis with private providers to manage a set of rural health facilities in rural ICT and, if there is interest, elsewhere.

- Formulate a competitively bid contract following the initial contract period, using lessons learned from the execution of the cooperative agreement.

- Use a fixed-price contract in which the government provides the provider chosen by the community with funds at least equal to the real (inflation-adjusted) amount currently budgeted for the subject facilities in return for a basic package of services that are roughly comparable to what now is offered (in principle) by government-operated facilities.

- Supplement, at the involved community's option, government funding of the contract with user fees and Zakat funds for the medically indigent in return for services additional to the basic package.

- Contract for management of a related group of facilities, such as an RHC with its associated BHUs, as opposed to a single facility.

- Exclude no party from submitting a bid, although the ideal provider would have sound business skills and a strong sense of being responsive to the public interest in health.

- Use more than one provider (if there is sufficient interest and capability) so that different arrangements can be tested and evaluated simultaneously.

- Provide training and technical assistance to communities involved in these tests to help them organize and play the expected role in choice and oversight of the provider.

- Monitor and evaluate the tests to draw lessons for modifications to the concept and for wider replication within Pakistan.
1.0. INTRODUCTION

1.1. Background

The Federal Ministry of Health (FMoH) recognizes that there is an imbalance in health status and health services availability between urban and rural areas. Rural health indicators are far worse than urban. The government health services system has been biased toward urban hospitals for years. The result is both inequitable and inefficient. The higher-income urban populations have benefitted more from government health spending. Less reduction in morbidity and mortality has been achieved than possible, given the resources allocated to health.

Recently, the FMoH and Departments of Health (DOHs) have taken steps to try to rectify these imbalances by making large investments in rural health. In terms of infrastructure, they have built an extensive network of Rural Health Centers (RHCs) and Basic Health Units (BHUs). These facilities have been assigned staff, including medical officers.

However, the increase in facilities has not been matched by an increase in availability of services. The staff assigned to RHCs and BHUs are frequently absent, and operating supplies, especially pharmaceuticals, often are unavailable.

One explanation for the absenteeism is that rural living conditions do not match urban, thus there has been little motivation for staff to take rural assignments. Health authorities have tried to address this issue by paying bonuses to medical officers assigned to rural posts and by building better housing for staff than is available in most rural areas. Unfortunately, this policy has had little effect on absenteeism, but has raised the bill for salaries.

The operating supplies budgeted for a health facility frequently do not even arrive at the intended facility. Whether the budget allocations for these supplies are adequate to meet needs remains an open question. The supplies that do reach the facilities clearly are inadequate to serve the rural populations.

Given this situation, the FMoH is looking for new approaches to help the DOHs to right the imbalances and to make the infrastructure investments pay off. The problems remain: high absenteeism and scarcity of operating supplies.

Thus, to address these issues one must look beyond the simple availability of facilities and budget allocations to the incentives and disincentives intentionally or unintentionally present in the current system. The suggestions made here attempt to put in place incentives for desired performance, in addition to generating sufficient resources to meet needs.
1.2. Rural Health and Primary Health Care in Pakistan

Within Pakistan, there are wide variations in income and substantial pockets of poverty. Life expectancy is 55 years; infant mortality is 104 per thousand; population growth is 3.1 percent with a total fertility rate of 5.7; maternal mortality is estimated to be 500 per 100,000 live births; more than half of all children under age five suffer from stunting and/or wasting. (World Bank Report No. 10391 - PAK, 1992).

According to a 1988 UNICEF study, Situation Analysis of Children and Women in Pakistan, the major causes of child deaths in Pakistan in 1986 were as follows:

<table>
<thead>
<tr>
<th>Cause</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrheal Disease</td>
<td>313,400</td>
<td>45</td>
</tr>
<tr>
<td>Neonatal Tetanus</td>
<td>109,500</td>
<td>16</td>
</tr>
<tr>
<td>Acute Respiratory Infection</td>
<td>80,000</td>
<td>12</td>
</tr>
<tr>
<td>Malaria</td>
<td>50,000</td>
<td>7</td>
</tr>
<tr>
<td>Measles</td>
<td>35,500</td>
<td>5</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>14,600</td>
<td>2</td>
</tr>
<tr>
<td>TB/Polio/Pertussis</td>
<td>12,200</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>74,600</td>
<td>11</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>689,300</td>
<td>100</td>
</tr>
</tbody>
</table>

Some 55 percent of the population in Pakistan has physical access to health facilities. The review of government-provided primary health services in Islamabad Capital Territory performed for this analysis indicated low quality of services; limited availability of drugs, laboratory tests, water and electricity; and uneven performance of the Zakat fund to help support health services for the indigent.

1.3. The Rural Health Care Study

The FMOH wants its rural health system to address the major sources of morbidity and mortality among vulnerable populations in a cost-effective and affordable way. Thus, the ministry is proposing an alternative approach which relies on private delivery of services; financing primarily coming from government allocations, with an option for some user fees; and on substantial
community participation in choosing services to be offered, in deciding which provider to engage, and in determining whether or not to charge fees.

The FMOH decided to design an initiative to test this alternative in the rural areas of Islamabad Capital Territory (ICT). Rural ICT consists primarily of the rural areas surrounding the city of Islamabad. It is a federally administered territory. The three Rural Health Centers (RHCs) and thirteen Basic Health Units (BHUs) serving ICT's 190,000 people are supervised by the District Health Office, which reports to the Chief Commissioner under the Ministry of Interior - not the FMOH. Administrative control of other health services which serve as referrals to the RHCs and BHUs fall under other authorities:

- Health services in the urban area of Islamabad are under the administrative control of the Capital Development Authority (CDA) in the Cabinet Division.
- Hospitals such as the Pakistan Institute of Medical Sciences (PIMS) and the Federal Government Services Hospital (FGSH) are under the administrative control of the Federal Ministry of Health, while Rawalpindi General Hospital falls under the administrative control of the provincial authorities.

The following sections lay out the design of an initiative to test an alternative approach to organizing and financing rural health services. The design is done to explore the alternative by trying it out in the government rural health facilities in ICT. The design includes: a statement of purpose and objectives (Section 2.0), a description of methods used to formulate the design (Section 3.0), a detailed description of the organization and financing of the initiative (Section 4.0), findings about the interest of providers (Section 5.0), recommendations about referrals (Section 6.0), recommendations concerning the role of the community (Section 7.0), a legal framework for implementing the rural initiative (Section 8.0), an implementation plan (Section 9.0), and a monitoring and evaluation plan (Section 10.0).
2.0. PURPOSE AND OBJECTIVES

The purpose of the rural health study is to develop for testing an alternative organizational and financing approach in providing health services to rural populations. The approach would be tested first in the ICT, and then, if successful, could be modified and extended to the provinces.

In the early stages of the study of this initiative, several working principles were identified by the FMOH that were used to guide the development of this alternative approach:

- Communities should be empowered to hire and oversee the performance of providers of rural health services.
- The means for community hiring and oversight would be to contract with a private provider for a specified set of services on a fixed-price basis.
- Current government operating allocations would be made available to communities to fund contracts with private providers for services offered within government facilities using government equipment.
- At the option of the community, the government allocation could be supplemented with user fees to fund the provision of services additional to the basic package.
- The solicitation of providers should be competitive among all organizations interested, whether commercial (for-profit) or voluntary (not-for-profit).
- Government should assist communities in evaluating the quality of services provided.
- The incentives embodied within the concept are to encourage overall performance and quality of care (the carrot of contract renewal) and to emphasize cost minimization as well as promotion of preventive services (the fixed-price is an incentive to minimize costs, including helping those covered to avoid illness).
- Zakat and other charitable funds could be made available to pay for the medically indigent where user charges are put in place.

Within the context of these working principles, specific objectives were identified for the development of an approach, including options and recommendations for the following:
Financing model: Develop alternatives for the delivery and financing of health services in ICT that are equitable, effective, and sustainable.

Providers' interest: Assess the interest and role of potential private providers to operate the health facilities under contract to the community.

Community participation: Develop an approach for communities to participate in the oversight and management of their health services.

Referral system: Develop a workable system for referring patients from one level of care to another.

Implementation: Recommend steps to test the design in ICT, or elsewhere, including monitoring and evaluation to prepare for wider replication.

Variants on the concept defined by the principles and systems proposed are developed within the context of preparing an initiative for testing in ICT.
3.0. METHODS

The methods used to accomplish the objectives for the rural initiative included the following:

- Review of relevant literature of experiences from both Pakistan and other countries;

- Discussions with a variety of interested parties and expert observers, including those representing:
  - Health providers from the ICT, CDA, and government hospitals;
  - Consumers in rural ICT from villages around rural health facilities;
  - Health policy makers from the FMOH;
  - Donor representatives such as those from USAID and the World Bank; and
  - Potential contract providers such as the Pakistan Institute for Medical Sciences (PIMS), the Federal Government Services Hospital (FGSH), and the Aga Khan Health Services (AKHS);

- Site visits to numerous health facilities including BHUs, RHCs, AKHS in Gilgit, and, briefly, two hospitals;

- Work by external and national consultants to develop the approach as well as model contracts, referral systems, and descriptions of community roles;

- Once the approach was developed, it was tested with the various interest groups, and modified accordingly;

- Preliminary observations were presented at an interim workshop held on November 21, 1992; and

- Detailed options and recommendations were presented at the final workshop held on February 16 - 17, 1993 and revisions were made accordingly.

These methods were carried out in the context of two trips to Pakistan by an external Rural Health Financing Specialist. The objectives of the first trip were to:

- Develop a framework for achieving the rural health financing objectives;
- Prepare Scopes of Work for the local consultants to do data collection and analysis and to prepare draft reports;
- Assess the type and quality of data available, particularly the cost recovery related data; and
- Begin the process of quantitative and qualitative data collection through meeting with Government of Pakistan (GOP) and USAID officials, health providers and consumers, and related individuals.

The objectives of the second trip were to make final the draft approach, test it out with the various interest groups, present the findings at the final workshop, and revise the recommendations, as appropriate.

Although all models and systems proposed are developed within the context of ICT, these same methods can be used for developing models and systems for other areas of Pakistan.

3.1. Frameworks for Assessing the Rural Health System

This section describes two frameworks for assessing the rural health system and developing the approach and recommendations for achieving the objectives described in Section 2. They are the organizational framework and the health system strategy framework.

3.1.1. The Organizational Framework

The organizational framework identifies the degree to which the structural aspects of the organization of the rural facilities (RHCs and BHUs) are public or private. This framework is derived from other HFS work done in Pakistan by William Newbrander and in the Philippines by Charles Stover. The components of the framework are:

- **Ownership**, which refers to who owns the physical assets;
- **Governance**, which refers to who has the authority for overall policy development, allocation of resources, and guidance of management of the facilities;
- **Management**, which refers to whoever implements policy and manages the facilities, including outpatient and inpatient services, administration, training, and allocation of resources;
- **Finances**, which refers to who pays for the operations of the facilities, including both operating and capital costs.
Each of these aspects has a range of forms it can take with varying degrees of autonomy from government, illustrating the multidimensional nature of public and private organization mixes. In matrix form, the range of options is shown in Exhibit 1. For example, ownership can range from the government to para-statals to non-profit organizations to for-profit organizations. Similarly, health services can be fully financed by the government (via taxes, etc.), by user fees, by insurance, or with any combination of these. The value of viewing the issue of public-private organizational mix this way is that it reduces the tendency to see private participation as an either/or choice, thus providing decision makers a broader array of options.

3.1.2. A Rural Health System Framework

The second framework, the rural health system, describes the type of health approach used. The system assumed here is primary health care (PHC) and involves emphasizing programs that address the major causes of morbidity and mortality. The primary health care systems can be understood in contrast to the "medical approach" which emphasizes treatment over prevention, hospitals over community-based health, and curative care over preventive care. It should be noted that although PHC emphasizes prevention, it includes a substantial amount of basic curative services. Effective implementation of a PHC system is expected to result in improving health status indicators of the broad majority of the population.

In contrast to the medical approach, primary health care emphasizes:

- Immunizations
- Promotion of proper nutrition
- Maternal and child health and family planning
- Local control of endemic diseases
- Provision of basic curative services
- Health education
- Provision of essential drugs and medicines
- The development of clean water supplies and basic sanitation

All but the last element (water and sanitation) are considered in the system being proposed in this initiative.

Primary health care also is characterized by:

- Equitable access to health services (geographic, financial and cultural);
- Coordination and integration of services; and,
- Decentralized management and community participation.
<table>
<thead>
<tr>
<th>Aspect</th>
<th>Range of Autonomy Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fully Public</td>
</tr>
<tr>
<td>1. Ownership</td>
<td>Government Corporation (Para-statal)</td>
</tr>
<tr>
<td>2. Governance</td>
<td>MOH (non-profit)</td>
</tr>
<tr>
<td>3. Management</td>
<td>Government employees</td>
</tr>
<tr>
<td>4. Financing</td>
<td>100% government with some user fees insurance</td>
</tr>
</tbody>
</table>
This section describes in detail the alternative approach designed for rural health care organization and financing in Pakistan. It covers general issues pertaining to the design, it specifies how services would be organized, and it shows how they would be financed.

4.1. General

On the basis of discussions held with the FMOH, there seems to be consensus among government officials on several basic parameters of the organization and financing approach to be tested. These parameters include (a) government funding of contracts with private providers to operate health facilities in a limited geographic area, (b) possible introduction of user fees, (c) retention and use of user fees at the collection point, (d) continuing government allocation of funds to the rural facilities at current levels.

Responses from the different interest groups to questions on these and other issues were mixed. Discussions with members of the community in ICT indicate a lack of confidence in the current health system: the hours are too short or inconvenient (no evening hours, for example); medical officers are often absent; and drugs, medicines, and supplies are typically unavailable. Health consumers are aware of the general "non-availability of free health care." In contrast, the so-called "quacks" are user friendly, have convenient hours, stock drugs and medicines on their shelves (even though the treatment provided may be inappropriate), offer 24-hour care, and are easily accessible. Given the popularity of the "quacks" (unlicensed, often untrained practitioners), it may be instructive to investigate the reasons for their popularity and, where appropriate, use some lessons from their experience in reforming the structure and functions of alternative models.

A major concern among health facility staff is with respect to job security issues. Several medical officers from the rural facilities stated that "no government doctor in Pakistan will work under a private provider." This kind of statement may be self-serving. Many (if not most) government doctors have private practices; many are employed by other private providers. Further, government service guarantees employment regardless of performance (indeed, regardless of even reporting for work). It is not surprising that many government servants would not want to give this up.

Affordability and not marginalizing the poor is another concern expressed by nearly everyone interviewed.

In general, it appears that, with some exceptions, there is a cautious willingness to test out alternative approaches so long as
the availability of quality services, in fact, improves, is affordable, and is carefully explained.

4.2. Organization of Health Services

4.2.1. Findings

At the present time, in terms of the autonomy framework presented in Exhibit 1, the rural ICT facilities are fully public. The physical assets are fully owned by government, policies are established and implemented by government employees with operating and capital costs financed by government, although a small share of revenue (1 percent) is generated through user fees. By testing alternative organizational and financing models, the objective of the government is to find a way to make more effective and less costly the health system while still maintaining overall responsibility for improving the health status of the population. This means that government is willing to experiment with forms of organization other than fully public. Such a form of organization should put in place incentives for desired performance.

Exhibit 1 outlined the range of options for ownership, governance, management, and financing of health systems. Which option, or mix of options, is optimal? The immediate answer is that it depends on a number of variables. However, it is agreed by all concerned that the current "fully public" arrangement has not performed well and that alternatives are to be developed.

Analysis of the four aspects of organizational mix suggests that changes in governance, management and, perhaps, financing, could improve performance by changing incentives. The entities given charge of each aspect should be motivated to use that charge for desired performance.

Ownership. The fourth aspect, ownership of the facilities by government, seems to have little effect on performance, although the government often performs less maintenance on assets it owns than do private owners. No change is, therefore, proposed in the ownership of rural health facilities.

Governance. The direction (governance) of a particular rural health facility or set of facilities involves (at least) three sets of interests. Government is interested since its assets and financing are being used. Government also has a role to play in providing technical support to the community in terms of knowledge and analytical capacity regarding what and how medical services are provided. Government also often is interested in issues regarding equity of access (physical, financial, and cultural) to the services offered among population groups. The community served is interested in seeing that the services provided meet its priority needs and in assuring that the resources put at its disposal (or
generated by it) are used properly and efficiently. Finally, service providers have an interest in participating in setting the direction under which they work. Thus, some form of mixed governance, where all three parties might be represented but the community would have the dominant role, would seem appropriate.

Management. Management receives its overall direction from the governing entity. Responsibility for operational management would seem to be best placed in the hands of the providers as long as they are responsive to the governing entity. This could be accomplished by having the governing entity control the employment, rewards, and discipline of the providers. Government management of facilities is done through service providers (government medical officers). However, government servants are virtually guaranteed employment and the ability of government to reward and discipline on the basis of performance is weak. Hence, some form of provider-managers being hired, fired, rewarded, and disciplined by the governing entity would seem to offer possibilities for improving performance.

Financing. Financing provides the resources needed to operate and maintain facilities (eventually, financing also is needed to replace facilities and equipment). Government uses its power to tax and borrow to generate financial resources, some of which it allocates to health services. It does so to try and ensure that basic health services are available to the population. In the current, fully public arrangement, these financial resources have been badly used, mostly for reasons of governance and management. Therefore, there would seem to be no reason to change from government as the basic source of financing. However, the financing from government is limited. It cannot meet all conceivable needs, even if other changes in organization achieve efficiency in the use of available resources. Thus, the populations served may wish to supplement government financing through charging some kind of user payments to allow more services to be offered.

4.2.2. Options and Recommendations

In sum, the performance of rural health services has been unsatisfactory under government ownership, governance, management, and financing. An alternative model is proposed based on continued government ownership and basic financing, but also based on community-dominated governance, including government and provider participation, or having provider management responsible to the governing entity, or having optional supplemental financing through user charges. Any provider representation on a governing board would be on an ex officio basis. Clearly, the provider representation would be excluded from participation in the choice of the provider. This model would put parties interested in the performance of the system in key positions of authority and would also put incentives in place for performance by others.
The proposed organizational mix would result in gains and losses and in changes in authority and privileges for each interested party (see Exhibit 2). Government would maintain its key role in providing resources and advice and would be more likely to achieve its objectives of providing access to all basic, cost-effective services. Communities would gain much more influence over what and how services are provided and over the proper and efficient use of funds allocated for their health services. Providers would lose the guarantee of employment regardless of performance, but would gain the power to be rewarded for good performance, the flexibility of management under the direction of the governing entity, and the availability of complementary resources (e.g., drugs, supplies) needed in their work.
EXHIBIT 2
GAINS AND LOSSES OF INTERESTED PARTIES WITH ALTERNATIVE MODEL OF
ORGANIZATION OF RURAL SERVICES

<table>
<thead>
<tr>
<th>Interested Parties</th>
<th>Gains</th>
<th>Losses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>▶ Performance of System</td>
<td>▶ Some Governance</td>
</tr>
<tr>
<td>Community</td>
<td>▶ Role in Governance</td>
<td>▶ No-charge Services (at its option)</td>
</tr>
<tr>
<td></td>
<td>▶ Priority Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▶ Proper Use of Funds</td>
<td></td>
</tr>
<tr>
<td>Providers</td>
<td>▶ Ability to Earn Rewards</td>
<td>▶ Guaranteed Employment</td>
</tr>
<tr>
<td></td>
<td>▶ Management Flexibility</td>
<td>▶ Weak Discipline</td>
</tr>
<tr>
<td></td>
<td>▶ Complementary Resources</td>
<td></td>
</tr>
</tbody>
</table>

One way to test the proposed approach to reorganization is to create a community-dominated, mixed-membership governing entity which would then contract with an organization or group of individuals outside the public sector to operate the rural health system in a geographically limited area. The basic funding for the contract would be the current government operating allocation for the subject facilities. The ideal provider would be one that has sound business skills and a strong sense of the "public interest" in health. Ideally, several variants on the model would be tested simultaneously. It is proposed that such an initiative be tested first in rural ICT.

4.3. Financing

This section examines the adequacy of current government operating allocations to meet the costs of a basic package of health services delivered to the rural population of ICT through its RHCs and BHUs. It does so using the following process: analyzing allocations of operating funds to the facilities, their patient loads, and unit costs of services. This information then is integrated to establish to what extent expected government allocations would cover service needs. Following this analysis,
alternative financing options and services packages are presented and analyzed, including supplementing government allocations through user payments to allow additional services to be provided. The latter is proposed to be done at the option of the community concerned.

4.3.1. Recurrent Expenditure by Facility and Program

Exhibit 3 shows recurrent expenditure by type of facility in ICT based on expected costs for the fiscal year 1992-93. Expenditures are broken out by four program areas (RHCs, BHUs, mobile dispensaries, Expanded Program of Immunization [EPI]/Controlling Diarrheal Diseases [CDD]/Malaria control, and seven line items such as personnel, drugs, and transport. Management expenditures are those incurred to operate the District Health Office. They have been allocated over the four program areas. Except for personnel expenditures which have been estimated on the basis of the government's 1993-93 pending personnel budget net of increment, all other expenditures have been allocated from the "new item statement," "additional new item statement," and "budget order" for the year 1993-93.

As is often the case, the two largest expenditure categories are personnel (79 percent of the expected total costs) and drugs and medicines (18 percent of the expected total). However, when divided by total patient attendance, the Rs. 1.2 million drug budget amounts to Rs. 7.2 per patient attendance. This is considerably less than, for example, the Rs. 15 per patient of the Aga Khan Health Service in the Northern Areas and Chitral or that of other developing countries, which also is around Rs. 15."

* Personal communication with Stephen Rasmussen, General Manager, Northern Areas and Chitral, Aga Khan Health Service, 5 February 1993.

** Personal communication with Abdelmajid Tibouti, Senior Advisor, Bamako Initiative. UNICEF: New York, 10 February 1992.
EXHIBIT 3
Recurrent Expected Expenditure by Facility for the Year 1992-93

<table>
<thead>
<tr>
<th>EXPENDITURES</th>
<th>N=3 RHC</th>
<th>N=13 BHU</th>
<th>MGMT.</th>
<th>MOBILE DISPENSARY</th>
<th>EPI, CDD HYGIENE &amp; MALARIA CONTROL</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>CURRENT/NON-DEVELOPMENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel/Establishment</td>
<td>1,558</td>
<td>2,586</td>
<td>367</td>
<td>163</td>
<td>486</td>
<td>5,160</td>
</tr>
<tr>
<td>Drugs/Medicines</td>
<td>256</td>
<td>806</td>
<td>0</td>
<td>60</td>
<td>66</td>
<td>1,188</td>
</tr>
<tr>
<td>Supplies</td>
<td>11</td>
<td>16</td>
<td>35</td>
<td>0</td>
<td>0</td>
<td>62</td>
</tr>
<tr>
<td>Repair &amp; Maintenance</td>
<td>16</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>26</td>
</tr>
<tr>
<td>Transport</td>
<td>18</td>
<td>0</td>
<td>12</td>
<td>12</td>
<td>0</td>
<td>42</td>
</tr>
<tr>
<td>Utilities</td>
<td>17</td>
<td>0</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>28</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>33</td>
<td>0</td>
<td>0</td>
<td>33</td>
</tr>
<tr>
<td>Allocation of management costs</td>
<td>100</td>
<td>314</td>
<td>(463)</td>
<td>23</td>
<td>26</td>
<td>0</td>
</tr>
<tr>
<td>GRAND TOTAL</td>
<td>1,976</td>
<td>3,722</td>
<td>0</td>
<td>263</td>
<td>578</td>
<td>6,539</td>
</tr>
</tbody>
</table>

NOTES:
+ Personnel cost for sanctioned positions in the year 1992-93 has been estimated on the basis of average salaries for the required position taken from the pending personnel budget for the year 1992-93 net of increments.
+ Budgeted drugs & medicine cost plus pending bills has been allocated to cost centers on the basis of their respective patient attendance.
+ Management and other operating costs are allocated to RHCs and BHUs proportional to utilization.
4.3.2. Patient Load

Exhibit 4 projects the number of outpatient visits for 1993-94 for the three RHCs, 13 BHUs, the Mobile Dispensary program and the EPI/CDD/Hygiene/Malaria Control program. These projections are calculated on the basis of actual outpatient attendance in the year 1991-92, plus 20 percent. The 20 percent is added because of population increase (including in-migration) plus a growth in utilization in response to improved quality of services. While the RHCs all have inpatient facilities (10-20 beds per facility), no current inpatient use is recorded. The RHCs see an average of 55 outpatients per day while the BHUs see an average of 40 outpatients per day (assuming 260 workdays per year). Exhibit 4 includes data for the ICT Mobile Dispensary program. This program reportedly is weak and probably contributes little to the health of the rural population. It constitutes only 4 percent of operating costs.

EXHIBIT 4
Summary of Actual and Forecast Patient Attendance for the Year 1993-94
Based on Actual Attendance in 1991-92

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RHCs</td>
<td>35,614</td>
<td>7,123</td>
<td>42,737</td>
</tr>
<tr>
<td>BHUs</td>
<td>111,917</td>
<td>22,383</td>
<td>134,300</td>
</tr>
<tr>
<td>Mobile Dispensaries</td>
<td>8,267</td>
<td>1,653</td>
<td>9,920</td>
</tr>
<tr>
<td>EPI, CDD, Hygiene &amp; Malaria Control</td>
<td>9,157</td>
<td>1,831</td>
<td>10,988</td>
</tr>
<tr>
<td>TOTAL</td>
<td>164,955</td>
<td>32,990</td>
<td>197,945</td>
</tr>
<tr>
<td>Attendance/capita**</td>
<td>0.87</td>
<td>0.17</td>
<td>1.01</td>
</tr>
</tbody>
</table>

* Increase in volume expected because of population growth (2.7%) and greater attendance because of improved quality (17.3%).

4.3.3. Unit Costs

The data in Exhibit 5 show outpatient unit costs for 1992-93 in the ICT. Average cost per RHC outpatient treated is Rs. 55.5 while for the BHUs it is Rs. 33.2. This is higher than the results of a 1988 study which found an average cost (adjusted to 1993 rupees) per outpatient treated of Rs. 26 at Manga RHC in Lahore District in 1986/87 and Rs. 23 at Maraka BHU in 1986 (GOP. A Health Financing and Expenditure Study. April 1988). However, outpatient costs in the ICT are less than, for example, in Haiti, where outpatient costs ranged from the equivalent of Rs. 62 to Rs. 103 in 1988 (Wong, 1988). Personnel account for a large share of costs: 79 percent at RHCs, 70 percent at BHUs, and 74 percent of costs for all outpatient services.
# EXHIBIT 5

## ICT Outpatient Unit and Total Costs

<table>
<thead>
<tr>
<th>Facility Type or Service</th>
<th>Annual Attendance</th>
<th>Cost per Attendance (Rs.)</th>
<th>Avg Cost per Facility Type or Service (Rs. 000)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Personnel</td>
<td>Drugs/Med</td>
</tr>
<tr>
<td>RHCs (3)</td>
<td>11,871</td>
<td>43.7</td>
<td>7.2</td>
</tr>
<tr>
<td>BHUs (13)</td>
<td>8,609</td>
<td>23.1</td>
<td>7.2</td>
</tr>
<tr>
<td>Mobile Dispensary</td>
<td>8,267</td>
<td>19.7</td>
<td>7.3</td>
</tr>
<tr>
<td>EPI, CDD, Hygiene, &amp; Malaria</td>
<td>9,157</td>
<td>53.1</td>
<td>7.2</td>
</tr>
<tr>
<td>Total</td>
<td>164,955</td>
<td>29.1</td>
<td>7.2</td>
</tr>
</tbody>
</table>

Per cent of Total

<table>
<thead>
<tr>
<th></th>
<th>Personnel</th>
<th>Drugs/Med</th>
<th>Admin</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>73.5</td>
<td>18.2</td>
<td>8.6</td>
<td>100.0</td>
</tr>
</tbody>
</table>
4.3.4. Current Sources and Size of Revenues

The data in Exhibit 6 show the current sources and volumes of revenue for the ICT health programs along with expected costs. Total revenues are approximately Rs. 5.4 million. They come from three sources: (a) Rs. 5.3 million from the government budget, (b) Rs. 101,000 from user fees, (c) Rs. 50,000 from Zakat funds. It is the Rs. 5.3 million which the government would provide to the community (i.e., community-dominated governing board) for use in a contract(s). For 1993-1994 the government operating allocation is expected to rise to accommodate inflation and the filling of vacant personnel posts. With these adjustments, the amount available for rural ICT community contracts is expected to rise to Rs. 6.3 million (see section 4.3.6).

The user fee revenues are from a Rs. 1 per patient "parchi fee" (registration or door fee) that was introduced in 1988. Revenues from this fee are remitted to the District Health Office. There have been no observable or reported benefits at the facility level as a result of this fee. This is not unexpected in that these revenues are less than 2 percent of the total resources available.

Zakat funds are one of four major types of religious or Muslim charity funds, with the others being Ushr, Wafq Property, and Bait ul Mal. Currently, of the Rs. 90 million Zakat Funds collected in 1991-92, 3.5 percent, or Rs. 2.6 billion, are used for health-related services throughout Pakistan. Within the ICT, the Zakat fund, which is intended to be used by the indigent, has averaged Rs. 50,000 from 1986 to 1991.
EXHIBIT 6

<table>
<thead>
<tr>
<th>ICT Sources and Volumes of Revenues (1992-1993) (Rs. 000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Type or Service</td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
<tr>
<td>RHCs (3)</td>
</tr>
<tr>
<td>BHUs (13)</td>
</tr>
<tr>
<td><strong>Total RHCs and BHUs</strong></td>
</tr>
<tr>
<td>Mobile Dispensaries</td>
</tr>
<tr>
<td>EPI, CDD, * Hygiene, &amp; Malaria</td>
</tr>
<tr>
<td><strong>TOTAL ALL Facilities and Services</strong></td>
</tr>
</tbody>
</table>

* See acronyms list

4.3.5. Options for Health Services to be Offered and Associated Personnel Requirements

Exhibit 7 outlines four illustrative packages of services that could be purchased by ICT communities. The most basic package (option A) is current practice. Each other option (B to D) specifies additional services that could be offered and the corresponding personnel. As more services and personnel are provided, costs rise. This is discussed below along with its implications for user fees.

The sequence used for developing these options should be noted. The first step was to identify the major causes of morbidity and mortality. The second step was to define the services to be offered at the BHUs and RHCs to address the identified major causes. Once these services were defined, personnel required to provide these services were identified. The combination of services and personnel is the basis for preparing cost and revenue estimates. The options presented are indicative of the combinations of services which could be offered at ICT’s rural facilities. Other options could be defined as appropriate.

The first eight services listed under "Basic Elements" represent the essentials of a primary health care strategy. The remaining
services are optional supplements to these essentials.

**Option A** shows the current situation (i.e., what services and personnel now are provided in the BHUs and RHCs by the government). Although RHCs are intended to be referral facilities for BHUs, in fact, services available at both types of facilities are nearly identical; these services are limited primarily to maternal and child health (MCH), family planning (FP), the expanded program of immunization (EPI), and some curative services.

**Option B**, termed "complete PHC," includes all the eight essential elements of primary health care. Beyond this, both the RHCs and BHUs have laboratory services, staff training, and community health. The RHCs are open eight hours per day, plus they are on call. Personnel available are matched to the services provided. The numbers in some categories of personnel rise and some fall as compared to the current situation. The BHUs are staffed by a Lady Health Visitor (LHV), a Health Technician (HT), and a "chowkidar" (watchman). The RHCs have two medical officers (M.O.s), one male and one female, two LHVs and two HTs (one each for on-call duty), along with support staff.

**Option C**, termed "PHC+," includes all services and personnel offered under Option B plus x-ray, inpatient, ambulance, and 24-hour services at the RHCs. The BHUs have no inpatient, no ambulance, and only eight-hour service plus "on call." The RHCs are staffed by two M.O.s, three LHVs and three HTs, an x-ray and laboratory technician, as well as additional support staff.

**Option D**, termed "PHC++," builds on Option C, provides the greatest number of services, and has the most personnel. In addition to all the primary health care services, the RHC has x-ray, dental, inpatient, and ambulance services. There are a greater number of laboratory tests available and a larger formulary of drugs and medicines. Personnel to provide these services are also the greatest in number. At the RHCs, there are two M.O.s, four LHVs, and four HTs (to handle the second and third shifts), along with a variety of other technical and support staff. Staffing at the BHU is similar to that of Option C.

In all the above options, staffing levels are indicative, not prescriptive. It is important that the contracted provider(s) have the option of making adjustments as appropriate.

**Additional Improvement**

There are some improvements recommended which fall outside of the package of services that could be purchased by communities using the government-operating allocations. These improvements would have to be paid for by government capital allocations. They are: running water, electricity, wireless communications, and residential facilities for medical staff.
### EXHIBIT 7
Options for Services, Personnel, and Infrastructure

<table>
<thead>
<tr>
<th>ITEM</th>
<th>Option A (Current)</th>
<th>Option B (Complete PHC)</th>
<th>Option C (PHC+)</th>
<th>Option D (PHC++)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RHC</td>
<td>BHU</td>
<td>RHC</td>
<td>BHU</td>
</tr>
<tr>
<td><strong>8 BASIC ELEMENTS (SERVICES) OF PRIMARY HEALTH CARE (PHC)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Education</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Nutrition Promotion</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Water &amp; Sanitation</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>MCH/FP**</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Endemic Disease Control (Malaria, TB, ARI, etc.)</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Basic Curative Services</td>
<td>some</td>
<td>some</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Immunizations (EPI)</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Essential Drugs &amp; Medicine</td>
<td>some</td>
<td>some</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td><strong>SERVICES ADDITIONAL TO THE ELEMENTS OF PHC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td>simple*</td>
</tr>
<tr>
<td>X-Ray</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Training (Staff)</td>
<td>some</td>
<td>some</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Community/Home (TBA/VHW)</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Dental</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Inpatient</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Ambulance</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>24-Hour Service</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>8-Hour Service + On Call</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PERSONNEL:</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Officer (m &amp; f)</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Lady Health Visitor (LHV)</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Health Technician (HT)</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Sweeper (part-time)</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Dental Technician</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>X-Ray Technician</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lab Technician</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TBA/CHW (volunteers)</td>
<td>?</td>
<td>?</td>
<td>45</td>
<td>130</td>
</tr>
<tr>
<td>Storekeeper</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>L.D.C.</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dispenser</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Driver</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Naib Qasid (orderly)</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Chowkidar (watchman)</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Mali (gardener)</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

* Primary health care
** Maternal and child health/family planning
† Blood and urine tests

(See main list for acronyms used in this chart.)
4.3.6. Costs of Alternative Service, Personnel, and Infrastructure Options

The total annual estimated costs associated with each of the four options for the ICT rural health facilities are summarized in Exhibit 8. As expected, Option D has the highest cost since it provides the largest number of services with more highly trained personnel, while Option A is the least costly. Options B, C, and D are 12, 44, and 57 percent more costly than Option A.

The following is a more-detailed explanation of how these costs are estimated, focusing on personnel and drugs.

**Personnel.** Personnel costs have been estimated on the basis of average salaries for each position as per the government's pending budget for 1992-93 net of increments. While comparative private sector salary data are not available, private salaries often are higher than those in the public sector. On the other hand, the productivity of private sector health workers may be much higher than that of public sector workers (see below), allowing the contracted provider to hire fewer workers to provide a comparable volume of services. Further, attracting personnel such as Medical Officers at relatively low salaries may not be difficult in light of their unemployment rates. Until practical experience with operating rural services shows otherwise, the best estimate is that the costs of personnel to provide comparable services to those now offered (in principle) is current personnel spending.

The current productivity of provider personnel (MOs, LHVs and HTs) is low. The 11 providers at RHCs saw an average of 4.2 patients per day in 1991-92. The 3 provider personnel per BHU saw an average of 11.0 patients per day. Option B is costed assuming that provider productivity can be approximately doubled at both types of facilities (to 8.3 and 20.0 patients per provider per day) while a complete PHC package is offered. Compared to Option B, lower productivity in terms of patients seen per provider is assumed for Options C and D, since extra technical personnel are added to offer additional services and to raise quality by improving diagnostic capabilities.

As quality is improved throughout the system serving the rural ICT population, shifts in utilization patterns should be expected. Improved services and a more-effective referral system (described below) will increase attendance at the BHU level and decrease it at the RHCs. In the longer term as the quality of care increases and people become aware of this, it is likely that total demand at both BHUs and RHCs will increase. To account for these changes, as well as for population growth (2.7 percent annually), the cost estimates assume that overall utilization will increase by 20 percent for all four options.
Drugs and Medicines. The second major expense at a health facility is the cost of drugs and medicines. It was noted in Section 4.3.1 that the government currently budgets Rs. 7.2 per patient attendance. For Options B, C, and D, estimates for drug and medicine expenditures have been increased to Rs. 15 per patient for the RHCs and Rs. 12 for the BHUs. These estimates are in line with drug expenditures of AKHS in the Northern areas and Chitral (which has considerably higher transport costs) as well as those of other developing countries.

Since procurement of drugs, medicines, and other supplies is to be the responsibility of the contract provider(s) operating the ICT facilities, they will be free to select their own suppliers. This could include government suppliers, private suppliers, joining up with other buyers to take advantage of economies of scale through bulk purchasing, or other cost-effective sources of supply. Given the proximity of the ICT to Islamabad, logistical problems should be minimal compared to those of provincial buyers.

4.3.7. Financing Options: Sources and Size of Revenues

In light of the service options outlined in Exhibit 7, and their associated costs, the question to be addressed is how to finance these options. Since the options B, C, and D cost more than current government operating allocations, if communities wish to have those services available, consideration will have to be given to using a combination of government operating allocations and user contributions. Both of these are discussed in turn.

4.3.7.1. Government Operating Allocation

As part of the process of experimenting to improve the performance of the health system, the government has stated that it will continue to make available operating funding at least equal to the same real amount (adjusted to keep up with inflation) currently budgeted for the rural ICT (i.e., Rs. 6.3 million). However, the government's allocation is sufficient only to pay for the cost of the services, personnel, and infrastructure currently available. As discussed above, simply changing the method by which providers are compensated without changing the amount of resources is expected to improve performance. This should arise from the change in incentives (see section 4.2.2). However, to be able to pay for any of the options that offer more services, other sources of revenue must be considered, specifically, user contributions.

4.3.7.2. User Contributions

The second possible source of financing revenue is user contributions. The community could agree (in its negotiations with the contract provider) to supplement the available government allocation with user contributions to obtain more or better services. User fees are employed here to illustrate the magnitude
of user contributions needed to supplement government allocations. User contributions could take any number of alternative forms such as local taxes or prepayment premiums. A precedent has been set for charging fees through the Rs.1 "parchi" (registration or door), fee.

Exhibit 9 shows an indicative schedule of user fees that could be charged to meet the costs additional to the government allocation needed to pay for each of the Options B, C, and D. The fee schedules are broken down by RHC and BHU as well as by the type of service provided. It should be noted that this is not a definitive fee schedule. Rather, it is an illustrative schedule that is expected to allow sufficient fee revenues to be generated to cover the additional costs of the options.

Factors considered in the fees proposed include: (a) patients' perceived ability and willingness to pay, (see section 4.3.7.3), (b) number and type of staff employed, and (c) cost of services provided.

The indicative fees are charged according to services provided. While this would be administratively more complex than charging a single flat fee per visit, the charges will reflect the costs of the services used. This is intended to help guide consumers in choosing the appropriate level and type of service for their illness and to reduce queue jumping. Thus, for options offering more services provided by more qualified staff, the fees are higher. Similarly, the fewer services available from less-qualified staff will be charged at a lower fee rate.

The fee schedules shown in Exhibit 9 and the estimates of the fees needed to cover the mix of services used by consumers are used in Exhibit 10 to show how revenues would be generated to meet the cost of the supplementary services. The average payments required per attendance also are shown. These range from Rs. 4 to Rs. 15 for BHU attendance and from Rs. 6 to Rs. 27 for RHC attendance. The lower average charges are for Option B, the higher for Option D.
### EXHIBIT 8
Estimated Annual Cost for Options A, B, C, & D (in Rs. '000)

<table>
<thead>
<tr>
<th>FACILITY</th>
<th>Option A (Current)</th>
<th>Option B (Complete PHC)</th>
<th>Option C (PHC+)</th>
<th>Option D (PHC++)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tarlai</td>
<td>805</td>
<td>741</td>
<td>1,049</td>
<td>1,209</td>
</tr>
<tr>
<td>Barakau</td>
<td>751</td>
<td>671</td>
<td>973</td>
<td>1,127</td>
</tr>
<tr>
<td>Sihala</td>
<td>419</td>
<td>678</td>
<td>947</td>
<td>1,068</td>
</tr>
<tr>
<td><strong>Sub-Total RHCs</strong></td>
<td><strong>1,975</strong></td>
<td><strong>2,090</strong></td>
<td><strong>2,969</strong></td>
<td><strong>3,404</strong></td>
</tr>
<tr>
<td>BHU</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sohan</td>
<td>282</td>
<td>308</td>
<td>384</td>
<td>408</td>
</tr>
<tr>
<td>Tumair</td>
<td>252</td>
<td>280</td>
<td>352</td>
<td>374</td>
</tr>
<tr>
<td>Jagiot</td>
<td>285</td>
<td>324</td>
<td>395</td>
<td>420</td>
</tr>
<tr>
<td>Sayydan</td>
<td>277</td>
<td>317</td>
<td>384</td>
<td>409</td>
</tr>
<tr>
<td>S.A.D.</td>
<td>266</td>
<td>294</td>
<td>368</td>
<td>392</td>
</tr>
<tr>
<td>Shahdara</td>
<td>241</td>
<td>248</td>
<td>320</td>
<td>343</td>
</tr>
<tr>
<td>Phulgran</td>
<td>313</td>
<td>358</td>
<td>434</td>
<td>461</td>
</tr>
<tr>
<td>Pind Begwal</td>
<td>275</td>
<td>306</td>
<td>377</td>
<td>403</td>
</tr>
<tr>
<td>Bhukkar</td>
<td>244</td>
<td>265</td>
<td>333</td>
<td>355</td>
</tr>
<tr>
<td>Gagri</td>
<td>293</td>
<td>337</td>
<td>408</td>
<td>434</td>
</tr>
<tr>
<td>Bhimber Trat</td>
<td>286</td>
<td>337</td>
<td>403</td>
<td>428</td>
</tr>
<tr>
<td>Rewat</td>
<td>429</td>
<td>566</td>
<td>635</td>
<td>669</td>
</tr>
<tr>
<td>Chirrah</td>
<td>278</td>
<td>345</td>
<td>411</td>
<td>434</td>
</tr>
<tr>
<td><strong>Sub-Total BHUs</strong></td>
<td><strong>3,721</strong></td>
<td><strong>4,287</strong></td>
<td><strong>5,206</strong></td>
<td><strong>5,529</strong></td>
</tr>
<tr>
<td><strong>Sub-Total RHCs &amp; BHUs</strong></td>
<td><strong>5,696</strong></td>
<td><strong>6,378</strong></td>
<td><strong>8,175</strong></td>
<td><strong>8,933</strong></td>
</tr>
<tr>
<td>EPI, CDD, HYGIENE &amp; MALARIA CONTROL</td>
<td>578</td>
<td>726</td>
<td>726</td>
<td>726</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>6,274</strong></td>
<td><strong>7,104</strong></td>
<td><strong>8,901</strong></td>
<td><strong>9,659</strong></td>
</tr>
</tbody>
</table>
## EXHIBIT 9
### Indicative Fee Schedule to Meet the Additional Costs of Various Options

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>Option B Complete PHC</th>
<th>Option C PHC+</th>
<th>Option D PHC++</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fees Recommended at RHC</td>
<td>Fees Recommended at BHU</td>
<td>Fees Recommended at RHC</td>
</tr>
<tr>
<td></td>
<td>Rupees</td>
<td>Rupees</td>
<td>Rupees</td>
</tr>
<tr>
<td>Consultation Only</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Medicines</td>
<td>3</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Injection (if prescribed)</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Antenatal exam (per visit)</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Postnatal exam (per visit)</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Delivery Package (a)</td>
<td>35</td>
<td>15</td>
<td>161</td>
</tr>
<tr>
<td>Minor Surgery (stitching &amp; dressing)</td>
<td>3</td>
<td>n.a.</td>
<td>13</td>
</tr>
<tr>
<td>Dressing of Wounds</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Lab test (per test)</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>X-ray (per X-ray)</td>
<td>n.a.</td>
<td>n.a.</td>
<td>13</td>
</tr>
<tr>
<td>Inpatient bed charges per day</td>
<td>n.a.</td>
<td>n.a.</td>
<td>27</td>
</tr>
<tr>
<td>Dental Services (b)</td>
<td>n.a.</td>
<td>n.a.</td>
<td>0</td>
</tr>
<tr>
<td>Vaccinations</td>
<td>Free</td>
<td>Free</td>
<td>Free</td>
</tr>
</tbody>
</table>

(a) Includes Delivery with 3 ante & postnatal exams + medicine 7x + 2 overnight stays.
(b) Services offered only at RHC under options C and D.
n.a. - Not applicable because the service is not offered.

## EXHIBIT 10
### Illustrative Estimates of Fees Needed to Cover the Costs of Various Options

35
<table>
<thead>
<tr>
<th>PAID SERVICES</th>
<th>Estimated Patient Volume</th>
<th>Option B (Complete PHC)</th>
<th>Option C (PHC+)</th>
<th>Option D (PHC++)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RHCs</td>
<td>BHUs</td>
<td>RHC</td>
<td>BHU</td>
</tr>
<tr>
<td>Consultation &amp; medicine</td>
<td>21,333</td>
<td>67,186</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Consultation, medicine &amp; injection</td>
<td>10,666</td>
<td>33,593</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Delivery with 3 ante &amp; postnatal exams + medicine 7 times + 2 overnight stays</td>
<td>853</td>
<td>2,688</td>
<td>35</td>
<td>15</td>
</tr>
<tr>
<td>Minor surgery (stitching &amp; dressing + medicines) (a)</td>
<td>853</td>
<td>2,688</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Consultation + lab tests + medicine</td>
<td>4,267</td>
<td>13,437</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Consultation + X-Ray + medicine (b)</td>
<td>8,852</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Consultation + lab test &amp; X-ray + medicine (b)</td>
<td>3,541</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dental (c)</td>
<td>1,770</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dressing of wounds + medicines</td>
<td>853</td>
<td>2,688</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Inpatient - Average 1 overnight stay + lab test &amp; X-ray + medicine 3x (b)</td>
<td>1,770</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>54,759</td>
<td>122,279</td>
<td>258</td>
<td>425</td>
</tr>
<tr>
<td>Total revenue RHCs+BHUs (Rs. 000):</td>
<td>683</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average charges per patient attendance (Rs):</td>
<td>21</td>
<td>11</td>
<td>27</td>
<td>15</td>
</tr>
</tbody>
</table>

(a) Not offered at BHUs under option B, so all patient volume assumed met at RHCs.
(b) Services offered only at RHCs under options C and D.
(c) Service offered only at RHCs under option D.

NOTE: Inpatient or overnight stay facility available at Options C and D only.
4.3.7.3. Analysis of Willingness and Ability to Pay

Are these fees affordable? Will the poor be excluded because of inability to pay? Or, if poor patients do choose to use and pay for these health services, would they make other basic-needs trade-offs such as forgoing food? These are difficult questions, but the following text summarizes indications about each. In addition, some other considerations are addressed.

Willingness to pay. Discussions with key community informants in rural ICT suggest that so long as quality services are provided (of particular concern is the availability of drugs), the population is willing to pay, although "how much" is unknown. (This is supported by a recent study in Cameroon. See Social Science and Medicine). These same informants state that the so-called "quacks" charge Rs. 50 to Rs. 100 for a consultation and Rs. 500 to Rs. 1,000 for a delivery. More generally, there is considerable evidence that consumers are already making significant out-of-pocket payments for health services, including both payments to private providers (quacks, private practitioners, pharmacies) as well as "under the table" charges paid to providers at public facilities (peon fees, gatekeeper fees, and bedpan-cleaning fees.). A 1986-87 household survey found that consumers were paying out-of-pocket up to 6 percent of their average monthly income for health care, and that low income households were paying more than 6 percent. (Health Sector in Pakistan, Final Report. April 1988).

Ability to pay. To examine the ability to pay the prices corresponding to Options B, C, and D, two scenarios are examined (see Exhibit 11). These scenarios help to analyze the effect of paying the prices on the resources of two households typical of the rural ICT population. The first is called a "lower income" household, which has an average per capita income of the lowest 40 percent of households in Pakistan. (World Bank Report No. 11127-PAK. 1992). This household type is expected to represent the bulk of the rural ICT population. The second household is called "very poor" and has a per capita income of one-fourth of the "lower income" households. It is intended to represent the lower extreme of the rural ICT population.

The scenarios examine the burden imposed on its income when the household makes more than three times the average use of ICT health facilities (3.0 visits per capita versus the current 0.9 visits per capita). The prices associated with one BHU visit and two RHC visits per capita under each of the options are compared with per capita income. This comparison shows that the burden on the "lower income" household is less than 2 percent of income for all options. For the "very poor" household, the burden surpasses 5 percent of income only for Option D (reaching 6.2 percent of income). (Household income is approximated by the household expenditure data reported in World Bank Report 11127-PAK. Five percent of income spent on health services is often used as a threshold of
affordability. Spending more than 5 percent of income is believed to begin to require cutbacks in spending on other basic needs, such as food, clothing, shelter, and education of children.) Thus, there may be a need to forgive at least some portion of payment for some very low income households at high levels of utilization of services when prices approach those estimated to be needed to pay for Option D's package of services.

In light of the foregoing, paying less than 2 percent of income for health services for the bulk of the rural ICT population seems reasonable assuming that quality services are, in fact, received and that "unofficial" payments discontinue.

EXHIBIT 11
Ability to Pay

<table>
<thead>
<tr>
<th>Household Type</th>
<th>Per Capita Income (Rs)</th>
<th>Percent of Income for Use of ICT Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Option B</td>
</tr>
<tr>
<td>Lower Income</td>
<td>4,420</td>
<td>0.4%</td>
</tr>
<tr>
<td>Very Poor</td>
<td>1,105</td>
<td>1.4%</td>
</tr>
<tr>
<td>Price of BHU + 2 RHC visits</td>
<td>16</td>
<td>53</td>
</tr>
</tbody>
</table>

Protecting the poor. In spite of this expectation of affordability for the majority of the population, there are likely to be people, such as very poor household members, who would find fees unaffordable. They then would be excluded from access to health services or they would face other basic-need tradeoffs. To handle such cases, two additional sources of revenue could be tapped: Zakat and other religious charities, and cross-subsidization.

4.3.7.4 Zakat and Other Religious Charities.

The Zakat fund already is used in rural ICT to help pay for drugs for the poor. However, those interviewed in the community perceived Zakat badly and the amount of Zakat funds currently allocated for health in rural ICT is probably inadequate to provide much help for the very poor. If a greater share of Zakat funds allocated for health were to reach rural ICT, or if more of Zakat's allocations went to health, it could play a more significant role in helping the poorest when fees are charged.

When interviewed, ICT community members and junior-level Zakat Fund administrators expressed considerable dissatisfaction with the Zakat fund. For example, many community members interviewed did not know of any cases where Zakat was used. Community members who did know of the Zakat fund felt the beneficiary selection process was politicized so that deserving people were not beneficiaries of the
fund while undeserving people were. This same feeling was expressed by some junior-level Zakat Fund administrators at the facility level. At the same time, several of the facilities visited in ICT had some "Zakat drugs" available on the shelves which were intended for use by Zakat-qualified patients.

Zakat's current spending of Rs. 50,000 in rural ICT represents about one-quarter of a rupee per capita. This is clearly inadequate to have an impact. However, rural ICT does not seem to receive its fair share of Zakat funds allocated to health. Rural ICT's share of the total Rs. 90 million of Zakat allocated to health would be Rs. 147,000 or Rs. 0.78 per capita. With such an amount of Zakat funds, exemptions from payment could be given, for example, to the lowest 10 percent of the income distribution for two attendances per year under Option B (one each to a BHU and a RHC) or to the lowest 5 percent for one BHU attendance per year under Option D. If, as the Central Zakat Administration has indicated is possible if requested by the FMOH, allocations of Zakat spending for health-related purposes can be increased from 3.5 percent to 6 percent of its total funds, more can be done. The lowest 13 percent could be exempted for two Option B attendances or 9 percent for one BHU attendance under Option D.

The figures cited above indicate that Zakat could play an important role in helping protect the interests of the poor if its administration in rural ICT could be improved to make it less politicized and better targeted to those in need.

**Cross-Subsidization.** An alternative to reliance on Zakat funding to help protect the financial access of the poor to services would be to charge higher fees to those able to pay higher prices. This would allow cross-subsidization. The extra revenues generated from the more able would make up for the exemptions given to the poor. An example of how this might be done is shown in Exhibit 12. It is assumed that 12 percent of the total patient load will be provided free services, with another 6 percent of patients paying 50 percent of the fee. Thus, the net fee remission covering people's inability to pay comes to 15 percent of the total fee income. The resulting fees appear to remain within the reach of most of the rural ICT population.
### EXHIBIT 12

**Illustrative Effects of Cross-Subsidies on Fees Charged Under the Various Options (in Rs.)**

<table>
<thead>
<tr>
<th></th>
<th>Option B</th>
<th></th>
<th>Option C</th>
<th></th>
<th>Option D</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RHC</td>
<td>BHU</td>
<td>RHC</td>
<td>BHU</td>
<td>RHC</td>
<td>BHU</td>
</tr>
<tr>
<td><strong>Average charge</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>per visit without</td>
<td>6</td>
<td>4</td>
<td>21</td>
<td>11</td>
<td>27</td>
<td>15</td>
</tr>
<tr>
<td>cross-subsidy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Average charge</strong></td>
<td>7</td>
<td>5</td>
<td>24</td>
<td>13</td>
<td>31</td>
<td>17</td>
</tr>
<tr>
<td>per visit with</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cross-subsidy*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Assuming 12 percent of patients are provided services at no charge, 6 percent are provided services at 50 percent charge, and the charges for the remaining 82 percent are increased to make up for the lost revenue.

**Fees guide utilization.** Fees have the potential to reduce unnecessary utilization and to encourage patients to use the most appropriate and cost-effective level of care. The latter is achieved by charging higher fees for higher levels of care, thus encouraging patients to seek the lowest and least-costly to provide the level of care that is appropriate for their illness.

**Fees elsewhere in the health system.** It is important that fees be introduced simultaneously at all facilities, including the hospitals available to the rural ICT population. To introduce fees only at the rural ICT facilities could have the effect of providing substantial numbers of people with further incentives to jump the queue by by-passing the rural facilities (even more than they currently do) to go directly to hospitals in Islamabad or Rawalpindi (Yoder, 1989).

### 4.3.7.5. Summary of Revenue Sources and Size

Exhibit 13 summarizes the sources and size of projected revenues of the three RHCs and 13 BHUs for each of the options.
EXHIBIT 13
SUMMARY OF SOURCES AND SIZE OF REVENUES BY
SERVICE OPTION (RS.000)

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>Option A (current)</th>
<th>Option B (complete PHC)</th>
<th>Option C (PHC+)</th>
<th>Option D (PHC++)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Govt Allocation</td>
<td>5,696</td>
<td>5,696</td>
<td>5,696</td>
<td>5,696</td>
</tr>
<tr>
<td>User Fees</td>
<td>0</td>
<td>682</td>
<td>2,479</td>
<td>3,237</td>
</tr>
<tr>
<td>Zakat*</td>
<td>0</td>
<td>(102)</td>
<td>(372)</td>
<td>(486)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>5,696</td>
<td>6,378</td>
<td>8,175</td>
<td>8,933</td>
</tr>
</tbody>
</table>

N.B. These budgets are for the operation of the 3 RHCs and 13 BHUs only.

* Ideally, Zakat would provide sufficient funds to allow total exemption for 12 percent of patients and 50 percent exemption for an additional 6 percent of patients. The user fee revenues shown do not count on realization of this ideal.

As can be seen from Exhibit 13, the government allocation remains constant for each of the options. User fees are the variable income source and increase from Option B to Option D. The amount of Zakat contribution that would allow total exemption for 12 percent of the population and partial exemption for 6 percent more also is shown. The user fee revenue shown includes enough to cover all estimated costs of the options without a Zakat contribution.

4.3.7.6. Summary

There are a variety of financing choices available to communities. They would choose, in negotiations with candidate contract providers, the combination of services and user contributions, if any, that best suits their needs and means. The price/service combinations presented here are indicative of how the communities’ choices are likely to look.
5.0. INTEREST AND ROLE OF POTENTIAL PROVIDERS

5.1. Findings

For the alternative approach to organization and financing for rural health services to work, there must be an interest by potential contract providers in playing the role indicated. This section describes the results of an inquiry into this interest.

In assessing the interest of potential contract providers, a variety of options were considered and organizations contacted. Contacts were made with government-related institutions such as Pakistan Institute for Medical Sciences (PIMS) and Federal Government Services Hospital (FGSH), with for-profit groups such as Shifa International, with not-for-profit non-governmental organizations (NGOs) such as the Aga Khan Health Services, as well as with private individuals who might have an interest in forming or linking with a legally recognized body to manage health facilities.

On the basis of such explorations, the extent of provider interest in operating rural health facilities appears limited. Some organizations were not at all interested while others wished to be kept informed as progress is made toward implementation of this initiative. Confidence that government would meet its obligations appears to be a major concern of potential contract providers.

However, it also appears that with appropriate incentives and contractual arrangements, providers will emerge. For example, there is reason to make further explorations with the Aga Khan Health Service. In addition, there has been some discussion of several individuals representing different skills and backgrounds coming together and perhaps linking themselves to an existing organization that has credibility in order to bid for a contract.

What seems important is not to close doors. Government should be open to considering NGOs, for-profit groups, hospitals, and groups of doctors and managers. Contrary to conventional wisdom, it is possible that a well-run and cost-effective for-profit group could provide high quality services at prices competitive to not-for-profit groups. In light of the experimental nature of this innovation, flexibility in determining clear terms of reference and in establishing sound monitoring and evaluation systems is important.

5.2. Recommendations

In light of the above-described discussions and findings, the following recommendations are made for government action:
Use a "cooperative agreement"-type arrangement where the provider, community, and government together work out the specific terms and conditions of the contract (a model contract is in Appendix 3).

Publish an "Expressions of Interest" notice in a variety of news media in order to ensure that it reaches the widest possible coverage of potential contract providers (see Appendix 1).

Offer to make advance payments to providers equal to semi-annual or quarterly projected expenditures, with some amount held back to ensure contract completion, as a confidence builder.

Conduct a conference to explain and seek feedback on the concept of the approach from interested providers, communities, and government units involved in the test sites.

Exclude no provider from submitting a bid, although the ideal provider type to operate under the contract is one which has sound business skills and a strong sense of the "public interest" nature of health.

Assure providers that they have full authority over personnel policies and procedures, including hiring, discharging, and determining salary levels.

Offer the following options to government employees currently posted in the ICT facilities:

- During the testing period, allow those who wish to try to be employed by the contract provider to go on a "leave of absence" without pay or other benefits.

- Following the first contract period, choose to:
  - Remain government servants and be transferred to another post.
  - Leave government to apply for a position with the contract provider.
  - Leave government service and seek other employment.
6.0. REFERRAL SYSTEM

This section examines the role of referral systems as a means of strengthening the efficiency and effectiveness of the rural health system. It presents findings on the current status of the referral system in the ICT, identifies the essential ingredients of a sound referral system, and then presents recommendations for developing a workable referral system.

6.1. Findings

A common occurrence in ICT is long queues of patients at hospitals such as Federal Government Services Hospital or Rawalpindi General Hospital, and no queues and few patients at the RHCs and BHUs. Although there are a variety of reasons for this, the main reason is that patients feel they can receive better care at the hospitals. Consequently, their staff and facilities often are overburdened while there is substantial underutilization at the RHCs and BHUs.

A referral system is designed to redress the imbalanced, and often inappropriate use of staff and services at the different levels of care. It can lead to better care, lower prices for patients, and lower costs for providers.

The foundation of an effective referral system is the availability of quality services at the primary level. At the present time, this is not the situation. Quality of care at the primary level is low. Referral systems are essentially non-existent in the ICT. While some facilities have referral forms, they are not used. There is currently no differentiation of services between the BHUs and the RHCs. The latter has implications for staffing patterns and support services and, consequently, budgets. Matters are complicated further in ICT since administrative control of health services falls under three different ministries or divisions (see section 1.3.).

Health service objectives could be better achieved if a workable referral system were developed and enforced. This would include coordination among the various institutions involved; disincentives for queue jumping (see Sections 4.3.7.2. and 4.3.7.3. for more on using the fee structure to impede queue jumping); differential fee structures at the primary, secondary, and tertiary levels; and provision of appropriate services at each level. As with the introduction of user fees, it is important that the introduction of a referral system be coordinated and that all relevant facilities be involved including Rawalpindi General Hospital outside ICT which, along with PIMS and FGSH, is among the referral hospitals for the rural ICT population.

6.2. Recommendations
A first step in developing a workable referral system is to differentiate among the services offered at the community level such as traditional birth attendants (TBAs) and community health workers (CHWs), and at primary (BHU), secondary (RHC), and tertiary (hospitals) levels. Since communities will be choosing the package of services to contract for, the government should help promote to them this kind of differentiation of services. In general, the following set of services is recommended (also shown in Exhibit 7):

> **Services offered at the community level:**

Through TBAs and CHWs health promotion and education, home delivery, basic medicines, nutrition education, oral rehydration therapy (ORT), and malaria prevention.

> **Services offered at the BHUs:**

Maternal and Child Health and Family Planning: vaccinations, nutrition education, endemic disease treatment such as ORT, essential drugs, basic curative services, and health education.

> **Services offered at the RHCs:**

All the above services offered at the BHU plus the following: an expanded drug supply, basic diagnostic services (x-ray and laboratory), minor surgery, basic dental services, and 24-hour indoor services.

Once the set of services to be offered is made final, staffing patterns along the lines shown in Exhibit 7 would be expected to be proposed by potential contract providers. The staffing pattern used is significant because appropriate staffing patterns can result not only in considerable cost savings but also in provision of better services and, consequently, in improvement in health status indicators.

Within the context of services offered at the primary and secondary levels and in light of the current physical plant infrastructure (which in most cases is adequate), the existing location and distribution of RHCs, BHUs, and hospitals lend themselves to a natural referral structure. This structure is shown in Exhibit 14.

It is recommended that, due to the easy accessibility of Rawalpindi General Hospital and the absence of an easily assessable RHC, BHU Sohan refer patients directly there. For similar reasons, it is recommended that BHU Shah Allah Ditta refer patients directly to PIMS or FGSH.
For the proposed referral structure to function properly, it is further recommended that:

- Quality services be available at the primary level.
- Running water and electricity be made available at all RHCs and water at the BHUs.
- Fee structures be differentiated, and made progressively higher, at each of the three levels of care.
PROPOSED REFERRAL STRUCTURE FOR ICT HEALTH FACILITIES

EXHIBIT 14

PIMS & FGSH

SIHALA

REWAT GAGRI
BOHKAR

JHANG SAIDAN
BHIMBER
CHIRAH
JAGIOT

PINDBEGWAL
TUMAIR
PHULGRAN
SHADRA

TARALAI KALAN

BKRKAHU

COMMUNITIES:
COMMUNITY HEALTH WORKERS
TRADITIONAL BIRTH ATTENDANTS

SHAH ALLAH
DITTA

SOHAN

REFFERAL HOSPITAL:
TERTIARY LEVEL

RAWALPINDI
GENERAL

RHC:
SECOND.
LEVEL

BHU:
PRIMARY
LEVEL
Patients who "jump the queue" and go directly to an RHC or a referral hospital should be penalized by paying, for example, a "by-pass charge" of an amount triple the normal fee. Further, as a disincentive for the provider to see the patient, two-thirds of this fee could be returned to the facility where the patient should have first gone with the remaining one-third staying at the facility providing the care. Rules for exceptions to this by-pass charge, such as life threatening situations, should be developed.

Funds be built into each facility budget (particularly for BHUs) to transport (for example, by public means or rental of private vehicles) legitimate cases to the next referral level rather than providing in-house ambulance services (which are very costly).

Provide referred patients direct access to the M.O. of the referral facility, rather than joining the queue of general outpatients.

Develop a formal communication system with standardized forms between levels of care to ensure continuity of care; this should include not only referrals up the system (from primary to secondary and tertiary) but also downward so that the attending health professionals will know what treatment was provided.
7.0. COMMUNITY ROLE

7.1. Findings

Currently, there is no community participation in rural ICT health facilities nor are there examples of community participation in the oversight and management of government health facilities elsewhere in Pakistan, although there are some Pakistani examples in the non-government sector. Consumers interviewed informally in rural ICT tended to be interested in playing a role in health facilities, although they are fully aware of the political hazards involved such as health committees being co-opted by local power structures. ICT health providers, on the other hand, are considerably more skeptical, mostly for reasons such as fear of losing some control. Many of the potential contract providers who were interviewed also were skeptical and would dislike having anyone else, particularly "lay people," telling them how to run their business.

The Aga Khan Health Service (AKHS) in the Northern Areas and Chitral appears to have demonstrated that community participation is not only possible, but also can be an important component of a successful health service system. Through their village organizations, women's organizations, and local and regional health boards, a sense of ownership in the health facilities has evolved. More importantly, and for a variety of reasons (some of which are the roles communities play) health status indicators have improved considerably (Le Sar, 1990). AKHS staff emphasize, however, echoing experience around the world, that the process of building up this institutional base at the community level is complex, time consuming, and has had many setbacks in addition to the successes.

A common critique of the AKHS is that its success results from the homogeneity of the population it serves. However, AKHS staff and reports indicate that some 40 percent of the population served are non-Ismaili. Further, there appear to be no differences between health status indicators of the Ismaili and non-Ismaili communities.

There are many roles which communities can fulfill in primary health care, including:

- Providing, recruiting, and/or supervising volunteer community health workers and trained traditional birth attendants.

- Mobilizing the community for immunization, health education, and other activities.

- Monitoring and evaluating health services.

- Providing land, and even buildings, for health facilities.
- Providing funding through such things as user fees and drug revolving funds.

- Doing the bookkeeping for, and monitoring the management of, funds raised by the community.

- Advising on community needs and priorities and on how funds raised by the community are to be spent.

- Participating in health planning activities.

- Identifying community members too poor to pay for health services.

- Participating in management and/or advisory boards.

These activities can serve to help identify and solve problems, hold providers accountable, increase utilization and participation in activities, facilitate trust and empathy, and develop a sense of ownership by the community.

7.2. Recommendations

For the primary health services management and financing approach being proposed here, it is recommended that the community play a key role. Communities are to be empowered to choose and oversee the performance of a private provider of their basic health services. The operating funds allocated by government for the facilities serving the community, the facilities themselves, and their associated equipment will be assigned to the chosen provider for use in delivering services. The services to be provided are to be those currently offered (theoretically) by the facilities under government management, subject to some negotiation with the community. The community may wish to negotiate the provision of supplemental services in return for the right of the provider to charge specified fees. Government, in addition to providing financial and tangible resources, will act as an advisor to the community in evaluating proposals from providers and in helping communities measure their performance of the agreed-upon services.

Because community participation in the provision of health services is relatively new in Pakistan, a considerable amount of education will need to be done, including education of the contract provider as well as of the communities and their representatives. Because of the complexity of developing effective community participation, it is essential that this process not be left to chance. Rather, an institution with demonstrated competence in working with communities should be engaged to help develop the community participation system and conduct training. Two organizations to consider in this regard are the National Rural Support Program and AKHS.
The following are specific recommendations for the government to take into consideration to help the communities in test areas (ICT or elsewhere) carry out their role under this initiative.

- Develop a training program for communities in their role under this approach with the assistance of specialists in community development and the participation of community leaders from the test areas.

- Train the test communities in the concept of the initiative and their role in the process:
  - Selection of community representatives
  - Definition of the basic package of services
  - Decision regarding charging supplementary fees
  - Evaluation of proposals
  - Oversight of providers
  - Evaluation of performance
  - Decision on renewal of contract

- Conduct a conference of interested providers, communities, and government units to explain and seek feedback on the concept.

- Work with the test communities to enter into cooperative agreements with providers for the test period.

- Assist the test communities in deciding whether or not to ask for additional services and in determining fees to be charged; if fees are charged, help set up Zakat and other charity assistance to pay in the place of the poorest.

- Assist the test communities in monitoring and evaluating provider performance and in deciding whether to renew the contract or to open it up for new bids.

- Revise the community training program in light of lessons learned from the test period.

- Assist the test communities with competitive bidding for subsequent contracts.

In addition to the above recommendations, the following general recommendations are made:

- If possible, test various options of community representation for the health initiative.

- Monitor and evaluate the tested community representation options to assess which elements are more conducive to success.

- Adopt the community participation concepts at the BHU and RHC levels and on the autonomous hospital boards recommended elsewhere in this report.
8.0. LEGAL FRAMEWORK FOR THE RURAL HEALTH INITIATIVE

8.1. Overview

The team carrying out the overall Health Financing and Sustainability study found that no law currently exists in Pakistan under which the initiatives in the four program areas can be implemented. It is therefore recommended that a single Health Policy Law be enacted as a comprehensive Central Statute to provide a permanent legal framework for these initiatives. Within this statute, the details of each initiative would be worked out. These details would include specific regulatory provisions, sanctions, administrative structures, and financing.

Having a comprehensive statute would remove the need for going back to the legislature on a regular basis. The proposed law would encompass all four of the health financing initiatives and would be applicable to the whole of Pakistan.

8.2. Sanctions

The Health Policy Law should identify reasonable sanctions that could be invoked to ensure that the various initiatives are implemented. The HFS team believes that these sanctions should be corrective and remedial rather than punitive.

This law also should mandate the creation of mechanisms that provide ways for grievances and complaints to be addressed. This would help the consumers of health services provided through the four initiatives not to feel helpless and in need of resorting to litigation.

Possible mechanisms could be a local-to-federal grievance structure and a system of ombudsmen to serve as advocates and adjudicators of issues.

8.2.1. Grievance Structure

A self-contained adjudicatory system could be established to handle grievances. One possible way of designing it would be to:

1. Have grievances against an individual brought to the notice of an authority at the divisional level.
2. Have grievances against a hospital also be brought before this divisional-level authority.
3. Create an appellate authority at the provincial level.
4. Establish a final adjudicatory authority at the central level.
8.2.2. **Ombudsman System**

An ombudsman system could be established to serve as an advocate for consumers and an arbiter of issues. Within this system, all except trivial matters would be dealt with at the local level by a tribunal made up of at least two members, one of whom would be a medical specialist. More serious matters would be dealt with through the ombudsman structure: Deputy Medical Ombudsmen would serve at local and regional levels, Provincial Medical Ombudsmen would serve at the provincial level, and a Central Medical Ombudsman would serve as a final arbitrator at the federal level.

**8.3. Laws Related to the Rural Health Initiative**

The law should allow the federal and provincial governments to permit community organizations to make contracts with private organizations of health providers for the operation of rural (and urban) ambulatory health facilities and equipment. (See appendices for sample Request for Proposal [RFP] and contract.)

**8.3.1. Community Organizations**

The law should identify the methods by which the community organizations' members would be selected and allow for government representation in these organizations. Such government representation would be kept to a minority in terms of voting strength.

**8.3.2. Operating Expenditures**

The community organizations would be permitted to use the operating expenditure allocations of the relevant governments to fund contracts with health services providers. At their option, the community organizations would be permitted to supplement the government funds by allowing providers to do such things as charge fees for services used or accept charitable donations. Government funds made available would be no less than the real (adjusted for inflation) value of the average operating allocation for the subject facility(ies) over the last five years.

**8.3.3. Services Offered**

The law would provide that government would be able to specify a minimum set of services to be offered under such contractual arrangements, but this should set be kept to an absolute minimum in order to grant the communities the greatest possible flexibility in using the resources to their advantage. The communities would be constrained to using government funds only for provision of health services. A definition of health services should be contained in the law.
8.3.4. Capital Replacement and Acquisition

The government should provide funds for all capital replacement and new capital acquisition by the facilities. (Capital is durable equipment and structures with a lifetime of three years or longer.) The community organization should request desired capital replacement and acquisition funds from the government.

8.3.5. Rights of Personnel

The proposed approach to organizing and managing rural health services necessitates that the contracted provider possess the power to engage, reward, discipline, and discharge personnel as do private-sector enterprises. However, the current personnel of the rural facilities are government servants, with all of the (different from private-sector employees') rights and privileges of that status. To allow the contracting providers the power to control personnel requires that some variant on the following be done: Offer current employees the choice of being transferred to other government jobs where they would maintain their government servant status, or applying for jobs with the contracting provider while changing their status to private-sector-type rights and privileges. The contracting provider could be asked to give priority to initial hiring of personnel already working at the facilities. The contracting provider would retain the right to treat such employees just as any others following initial hiring. This would allow contracting provider management to control its personnel and it would allow those who want to continue to work in the facilities while requiring that other jobs be found within government for personnel unwilling to convert their status.
9.0. IMPLEMENTATION PLAN

The following is an outline of the steps it would take to implement a test of the proposed model of rural health services organization and financing in rural ICT. The implementation of the test begins with assignment of responsibility for its oversight to a FMOH unit and continues through the evaluation of monitoring data to assess performance and make modifications in the policy (see Exhibit 16 which is a table summarizing the implementation plan).

The unit which would oversee the implementation of this plan would contain or would be able to hire on a consulting basis an economist, a public health physician, and a sociologist. This unit would assist with all aspects of the test, setting up needed administrative arrangements among the government units involved; negotiating with communities and potential contract providers; hiring needed consultants; conducting baseline, monitoring, and evaluation data collection; performing analysis of data and policy formulation; and disseminating results.

The first step to be taken by such a unit would be to follow all of the necessary protocols with the units of government currently involved with the operation of the ICT rural health system to gain their permission to go ahead with the planning and execution of the pilot tests. Exhibits 15 diagrams the relationships among the parties involved. This would include developing referral relationships with hospitals in Islamabad and Rawalpindi.
EXHIBIT 15
DIAGRAM OF RELATIONSHIPS AMONG PARTIES IN RURAL HEALTH MODEL

OVERSIGHT UNIT

MONITOR & EVALUATE
PROPOSE REVISIONS
DISSEMINATE

(ADVICE)

GOVT.

GOVT ALLOCATION (Rs)

> SELECT & NEGOTIATE
CONTACT

PROVIDER

TRAINING IN
PARTICIPATION

COMMUNITY

OPTIONAL USER
PAYMENTS

SERVICES
The first step of implementation is to inform and train the concerned communities in their roles and responsibilities within the approach. The community training would be assisted by an organization with experience in fostering community participation in social activities. The training should be interactive so that the community can suggest modifications to its expected role where the recommended approach appears difficult or unwieldy. This process would help shape the ultimate design of the community role, using that described above as a base. Concurrently, the oversight unit would prepare a draft of a cooperative agreement including the provider, the community, and the local government.

Once the communities have been organized and trained, they and the local government, with the help of the unit, would solicit interest from and would select among interested provider organizations as contract providers. The communities, the selected provider organization, and local government representatives, with the assistance of the oversight unit, would then negotiate the terms and conditions of a cooperative agreement for the operation of the facilities. The "cooperative agreement", used only during the initial testing phase, would permit the oversight unit, local government, and community special access to the books and records of the contract provider. In return, the oversight unit would make some financial guarantees (such as indemnification of financial losses) to the provider. This approach allows maximum learning from the tests (about costs, utilization, and service quality) while minimizing risks to both the community and provider. This process would include negotiating whether or not additional services would be provided, accompanied by financial contributions from the community (often fees) to supplement the government allocation of funds.

During the execution of the test, the unit would assist the community and provider to solve problems that might arise and would monitor performance. Near the end of the test, the unit would evaluate its performance, disseminate results, make modifications to the approach, and prepare for replication.

Towards the end of the period of performance of the initial contract, the oversight unit would assist the communities and local government to prepare for the next contract, whether it be renewal of the first contract or competition among new provider organizations. Once sufficient testing has been done (one or more rounds of "cooperative agreements") to be satisfied that the approach performs well, when modified by lessons learned from the testing, broad-scale replication may go forward. This would be done using competitively bid contracts with providers, allowing them and the communities to be flexible in how they organize health services delivery. The competitively bid contracts would be awarded on a fixed-price-plus-community-option-for-supplementary-contribution basis. Possible renewal would act as the incentive for good performance by the providers.
<table>
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<tr>
<th>COURSE OF ACTION</th>
<th>OBJECTIVES</th>
<th>DURATION</th>
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<th>WHO/WHAT</th>
<th>BUDGET RESOURCES</th>
<th>COMMENTS</th>
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<tr>
<td>Manage, Monitor &amp; Evaluate Tests</td>
<td>CREATE &amp; STAFF OVERSIGHT UNITS</td>
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<td>1-1</td>
<td>FMOH</td>
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<td></td>
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<tr>
<td>Operate Oversight Units</td>
<td>OPERATE OVERSIGHT UNITS</td>
<td>INDEFINITE</td>
<td>1-ONWARD</td>
<td>FMOH</td>
<td>FMOH &amp; DONOR</td>
<td>FMOH FOR STAFF &amp; OPERATING COSTS; DONOR FOR CONSULTANTS</td>
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<td>Obtain Permission &amp; Cooperation From Government Units</td>
<td>OBTAIN PERMISSION &amp; COOPERATION FROM GOVERNMENT UNITS</td>
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<td>2-3</td>
<td>OVERSIGHT UNITS</td>
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<td>Develop Referral Relations</td>
<td>DEVELOP REFERRAL RELATIONS</td>
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<td>RELATIONS WITH HOSPITALS IN ISLAMABAD &amp; RAWALPINDI</td>
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<td>Prepare For Tests</td>
<td>CHOOSE COMMUNITY PARTICIPATION APPROACH</td>
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<td>OVERSIGHT UNITS, COMMUNITY LOCAL GOVERNMENT</td>
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*From start of initiative.*
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<thead>
<tr>
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<th>DURATION (MOS)*</th>
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<th>WHO/WHAT</th>
<th>BUDGET RESOURCES</th>
<th>COMMENTS</th>
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<td>TRAIN COMMUNITY IN PARTNERS ON APPROACH</td>
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<td>FMOH</td>
<td>HIRE TRAINERS FROM A GROUP LIKE AKHS</td>
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<td>SOLICIT &amp; SELECT PROVIDER</td>
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<td>7-8</td>
<td></td>
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<td>FMOH</td>
<td>ASSISTANCE FROM OVERSIGHT UNIT, FMOH FUNDING FOR ADVERTISING</td>
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<tr>
<td>PREPARE DRAFT COOPERATIVE AGREEMENT</td>
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<td>5</td>
<td></td>
<td>OVERSIGHT UNIT</td>
<td>FMOH</td>
<td>HIRE LEGAL CONSULTANT</td>
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<tr>
<td>COLLECT BASELINE DATA</td>
<td>3</td>
<td>6-8</td>
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<td>OVERSIGHT UNIT &amp; CONSULTANTS</td>
<td>FMOH &amp; DONOR</td>
<td>DONOR FUNDS FOR CONSULTANTS</td>
</tr>
<tr>
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<td>DELIVER SERVICES</td>
<td>12-24</td>
<td>9-21 OR 9-33</td>
<td>PROVIDER</td>
<td></td>
<td>LOCAL GOVERNMENT &amp; OPTIONAL USER FEES</td>
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*From start of initiative.
**EXHIBIT 16**

**RURAL HEALTH SUMMARY IMPLEMENTATION PLAN**
(Continued)

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<th>BUDGET RESOURCES</th>
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<td>MONITOR &amp; EVALUATE</td>
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<td>9-33</td>
<td>OVERSIGHT UNIT</td>
<td>FMOH &amp; DONOR</td>
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<td></td>
<td>DISSEMINATE LOCALLY</td>
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<td>FMOH</td>
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<tr>
<td></td>
<td>DISSEMINATE NATIONALLY</td>
<td>2-4</td>
<td>EVERY 6 MONTHS, BEGINNING WITH 15</td>
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<td>FMOH</td>
<td>DONOR FUNDS FOR CONSULTANTS</td>
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<td>REVISE POLICY</td>
<td>FORMULATE ALTERNATIVES</td>
<td>2-4</td>
<td>16-20 OR 28-32</td>
<td>OVERSIGHT UNIT</td>
<td>FMOH &amp; DONOR</td>
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*From start of initiative.*
<table>
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<tr>
<th>OBJECTIVES</th>
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<td>COMMUNITY &amp; LOCAL GOVERNMENT</td>
<td>LOCAL GOVERNMENT</td>
<td>ASSISTANCE FROM OVERSIGHT. GHT UNI T TO DRAW UP NON-COOPERATIVE AGREEMENT CONTRACT</td>
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</tbody>
</table>

*From start of initiative.*
10.0. MONITORING AND EVALUATION

The monitoring and evaluation of the rural initiative should measure how the test performs relative to goals and objectives. These goals and objectives have been set by the FMOH for both the overall health sector and for the health system serving the rural population. The tested approach should be monitored and evaluated to determine to what extent it addresses current problems without creating larger, new problems.

The FMOH’s overall vision for the sector calls for more resources to be allocated to health, improved cost-effectiveness, and targeting of government resources to the poor. It seeks a financially more sustainable system where the growth of the resource burden on government would be reduced. The principles enunciated to achieve the vision include requiring contributions in order to obtain payment for services from those who are able to pay; developing systems with incentives for efficiency, cost-effectiveness, and quality; and targeting resources to lower socio-economic status groups.

The FMOH would like the rural health services system to address the major sources of morbidity and mortality in the population in a cost-effective way. Further, this effort should be affordable. Problems with the system currently which inhibit achievement of the vision are staff absenteeism, short and inconvenient hours of operation of facilities, and the absence of essential drugs and supplies.

Objectives. The proposed monitoring and evaluation plan (summarized in Exhibit 17) reflects these goals, objectives, and principles. It sets out four categories of objectives:

- Addressing major morbidity and mortality sources
- Improving efficiency and cost-effectiveness
- Targeting of government resources
- Improving quality of service

These objectives encompass what is expected in the FMOH’s overall and specific vision statements, address the identified problems with the status quo, and support the principles set out to guide solutions. Overall, the objectives should be met in the context of a financially sustainable model of organization and management.

Measuring indicators of each of the objectives would permit analysts and decision makers to watch how well or how badly the approach is performing (monitoring) and to determine whether it should be modified, replicated, or abandoned (evaluation).
Major sources of morbidity and mortality. Service statistics need to be developed to indicate to what extent the approach addresses major sources of morbidity and mortality. Complementary epidemiological information would be needed to identify the sources. Monitoring of services used could be done quarterly, with annual evaluations.

Cost-effectiveness. If the services provided address the major sources of morbidity and mortality, then they meet the effectiveness side of cost-effectiveness. To monitor costs and efficiency, annual estimates of the unit costs of providing services should be compared with the costs of providing similar services using other organizational approaches such as the traditional direct government provision approach. It would be important to compare services similar in quality, so that the cost comparison is fair. The elements of quality that might be considered are the qualifications of personnel providing care (although some substitution of nurses or other paramedics for doctors may be done without affecting quality of care), the diagnostic procedures applied, and the drugs and supplies used. Lower cost-per-patient visits would indicate that the approach was achieving greater efficiency. A combination of lower costs per visit and visits which meet major morbidity and mortality causes would indicate cost-effectiveness.

Targeting of government resources. The scarce resources of government are supposed to be targeted to those in greatest need, while those who are able may be asked to contribute to meeting the cost of services. To judge how the rural initiative approach contributes to these objectives, two indicators may be monitored: the level of fees agreed to by participating communities, and how well the system works to waive those fees for those unable to pay. The proposed approach suggests that any fees charged to supplement government allocations (in order to pay for more services) be agreed to by the community board. That should ensure that they are affordable to the majority of the population. However, one way to check on this would be to conduct a baseline survey to find out how much families are spending on health services before the new approach is applied, then again later to see how their health expenditures change. The aim is to provide them with low-cost, higher-quality services than those currently available to them in either the private or the public sector. It is possible that some families may save money, while enjoying better care.

Protecting the poor. To ensure that the prices charged do not pose an insurmountable barrier to use of services or cause a hardship, systems to identify and reduce or waive payments by the poor are recommended. The services used by such people would have to be paid for either through cross subsidies or payments made by Islamic charities. Indicators of low socio-economic status (SES) could be used to monitor whether those benefiting from lower charges were those truly in need. Data on such indicators could be
Financially sustainable model. One objective of the approach is to find a financially sustainable model of delivering quality services. This would require that the contracting organization at least break even on its costs of providing services. Break-even-or-better financial performance would allow the provider to continue to be interested in such contracts. Financial losses would discourage further participation. Earning surpluses also would attract interest from other organizations. The entry of other organizations into the pool of possible contract providers would tend to compete away large surpluses. It is recommended, during initial testing of the approach, that a cooperative agreement type of arrangement be used. Under a cooperative agreement, the contracting organization would agree to keep its financial books open to government and to the community in exchange for greater flexibility in terms of what the provider is to deliver and in terms of its compensation. A one-time supplemental allocation of government funds could be needed for the latter, if costs were dramatically underestimated. This would allow the government and community to know more about what are the true costs of operating health services under such an arrangement. Quarterly financial reports would allow financial performance to be monitored, with an in-depth evaluation performed at the end of the year.

Quality services. The objective of improved quality of services relates closely to the problems identified with the status quo. The indicators of improved quality recommended are the presence of staff at the facility, the convenience and number of hours the facility operates, and the use and availability of a set of critical essential drugs and supplies. The first and last indicators could be monitored through quarterly unannounced visits to the facilities. The satisfaction of the population served with the hours of operation could be judged by an annual survey.

Relationship to MEDEX PHC indicators. The indicators recommended here parallel many of those suggested by MEDEX's primary health care planning and management manual (1983). MEDEX's indicators are designed to be used for the primary care system as a whole, while the indicators needed here are for the monitoring and evaluation of the test of the initiative. The above-recommended indicators of efficiency, cost effectiveness, and sustainability overlap with MEDEX's Measures of Financial Health. The indicators of targeting of government resources parallel MEDEX's patient costs indicators. MEDEX's output indicators are similar to those recommended for addressing morbidity and mortality causes. The recommended indicators of quality are similar to MEDEX's for primary health care training (staff presence) and performance standards (drug and supply availability).
Implementation of Monitoring and Evaluation. The unit within the FMOH assigned responsibility for oversight of the test also should be assigned the duty of monitoring and evaluation. The unit would either conduct it itself or hire consultants to perform the data collection and analysis tasks enumerated above. This unit would be responsible for sharing and disseminating the results of the analyses with the communities, providers, involved governments, and wider health-sector community. With input from all of the foregoing, the unit would make modifications to the approach before wider replication.
## ALTERNATIVE RURAL MODEL MONITORING AND EVALUATION PLAN

<table>
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<th>OBJECTIVES</th>
<th>MONITORING INDICATORS</th>
<th>EVALUATIONS</th>
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<td>ADDRESS MAJOR SERVICES PROVIDED</td>
<td>SERVICING PROVIDED</td>
<td>QUARTERLY MONITORING, ANNUAL EVALUATION OF SERVICE STATISTICS</td>
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<td>SOURCES OF MORBIDITY &amp; MORTALITY</td>
<td>GIVE EMPHASIS TO MAJOR MORBIDITY &amp; MORTALITY</td>
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</tr>
<tr>
<td>EFFICIENCY &amp; COST-EFFECTIVENESS</td>
<td>QUALITY-ADJUSTED COST PER VISIT</td>
<td>ANNUALLY COMPARE PER-CAPITA EXPENDITURES WITH PRE-CONTRACTING EXPENDITURES</td>
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<tr>
<td>TARGET GOVERNMENT RESOURCES</td>
<td>ANY FEES CHARGED ARE AFFORDABLE &amp; WERE AGREED TO BY THE COMMUNITY</td>
<td>QUARTERLY MONITORING OF SES OF THOSE WAIVED &amp; ANNUAL EVALUATION</td>
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<td>PROVIDE FINANCIAL PERFORMANCE</td>
<td>QUARTERLY MONITORING &amp; ANNUAL EVALUATION</td>
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<td>IMPROVE QUALITY</td>
<td>PRESENCE OF STAFF</td>
<td>QUARTERLY UNANNOUNCED VISITS</td>
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<td>CONVENIENCE &amp; NUMBER OF HOURS OF OPERATION</td>
<td>ANNUAL SURVEY OF PATIENTS</td>
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<tr>
<td></td>
<td>DRUGS &amp; SUPPLIES AVAILABLE &amp; USED</td>
<td>QUARTERLY UNANNOUNCED VISITS</td>
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*Compare costs of visits for a set of common illnesses where similar inputs were used in terms of personnel, diagnostics, drugs, and supplies.
APPENDICES
APPENDIX 1

INVITATION TO SUBMIT "EXPRESSIONS OF INTEREST"

The Federal Ministry of Health of the Government of Pakistan has developed alternative organizational and financing models for providing health services to people living in rural areas. Implementing some of these models will involve contracting with private individuals or organizations to manage Rural Health Centers and Basic Health Units under terms and conditions which are designed to improve people's access to health services. In addition to receiving a government subsidy, the provider who is contracted with will also be able to charge a user fee in order to cover operating costs. Mechanisms will be built into the model that will ensure access to the rural health facilities by low-income people. It is intended that this model will first be tested in the Islamabad Capital Territory, although consideration will also be given to testing it in other geographic areas. Based on lessons learned from this test, the model could then be modified and used in other parts of Pakistan.

Individuals, groups, companies, non-governmental organizations, and other entities interested in putting themselves forward as potential managers of Rural Health Centers and Basic Health Units are invited to submit in writing their Expression of Interest, including a brief statement of their organization's experience in the health care field. It is expected that a meeting will then be held with interested parties at which general operating information and financial data relating to the rural health models will be made available and issues/questions will be discussed.

Expressions of Interest should be submitted by (date) to the following address:

Director General
Health/Additional Secretary
Federal Ministry of Health
Government of Pakistan
Pakistan Secretariat, Block "C"
Islamabad
APPENDIX 2

SAMPLE REQUEST FOR PROPOSALS (RFP)

The following sample contains the major elements of a request for proposals. It is intended to be the beginning of a model that could be adapted for use by communities (assisted by their local government) wishing to receive proposals from private contractors interested in operating rural health facilities. When combined with the sample contract (Appendix 3), these models provide the base for implementing aspects of the rural health initiative described in this report.

ISSUED BY: The Community of __________________
Address: 
Telephone No.: 
Fax No.:

Assisted by:

The Government of __________________
Address: 
Telephone No.: 
Fax No.:

PURPOSE: The management of one or more Rural Health Centers (RHCs) and its (or their) dependent Basic Health Units (BHUs)

ISSUE DATE: ____________________________

DUE DATE: Responses to this RFP should be forwarded to the address of the community identified above. All responses must be delivered no later than ______________. Only completed responses meeting the criteria outlined in the Requirements section of this RFP will be honored.

Background

The community of ____________________ in collaboration with the Government of Pakistan, Ministry of ____________________ (or provincial Department of Health ____________________) wishes to procure the services of a local Pakistani health services provider organization to manage ______________ rural health facility(ies).
Description of Activities

The specific activities to be carried out under this contract are described in the attached Scope of Work.

Relationship of the Parties

The firm that is selected shall operate as an independent contractor. This firm shall be solely responsible for any and all claims, damages, or lawsuits arising out of the acts or omissions of the firm, its employees, servants, or agents. The firm shall be liable for compliance with all laws, regulations, ordinances, rules and orders as they may affect its employees and any third-party relationships.

Request for Proposals

The community of _____________ hereby invites your firm to submit a proposal for services outlined in the attached Scope of Work. Your submission should be received at the address noted above no later than ______ date ______.

Interviews and follow-up meetings may be scheduled with firms that are deemed (1) qualified to perform said services, and (2) competitive in terms of cost.

Requirements

Please furnish the following information as part of your proposal:

Technical Proposal

1. A description of your firm, including date of incorporation, principal services provided, and annual revenues.

2. A description of services similar to those required by this project which your firm has provided to other clients. Please furnish references from these clients, including: (a) contact person and title, (b) name of firm, (c) telephone number, (d) dates when services were performed. References provided will be contacted.

3. Other client references that may be contacted.

4. A description of your proposed approach to the assignment outlined in the Scope of Work section. This description should demonstrate an understanding of the technical, administrative, and managerial issues involved in carrying out this project.
5. A description of the Project Director who would head up this assignment, including both a curriculum vitae (CV) and a Biographical Data Sheet. Also include CVs for all individuals filling program leadership positions (no Biographical Data Sheet is necessary for these candidates).

6. If government employees (civil servants) are to be used in carrying out this assignment, please enclose with your proposal a signed form that certifies that, during their period of performance with this contract, these civil servants will not receive salaries from the Government of Pakistan.

7. A description of the additional resources (both personnel and materials) that are available to your firm which will be used to conduct this project's activities. For example, this description should include available staff, vehicles, data processing capabilities, etc.

**Cost Proposal**

8. An estimate of the cost of providing services for the project. This estimate is due on the same date as the technical proposal, but should be submitted in a separate package.

9. A list of personnel who will participate in this project and the estimated level of effort (number of working days) for each team member. For the Project Director position, please specify the percentage of time that person will devote to working on this assignment.

10. Please ensure that your cost proposal takes into account all phases of this project from designing the management approach, to training staff, to providing services, to maintaining data, to assuring quality of care, to writing final reports.

11. Cost estimates should explicitly detail the following information:

   a. Personnel costs including salaries, allowances, fringe benefits, and overhead charges.

   b. Drugs, medicines, and supplies, including laboratory reagents, x-ray films, and spare parts (refer to Scope of Work, Section IV, concerning whether laboratory, x-ray, and other services are to be provided).

   c. Repair and maintenance costs.
d. Transportation (including ambulance services or rental, if specified in the Scope of Work).

e. Utilities charges (e.g., water and electricity), if applicable.

f. Management and administrative costs.

g. Other costs.

h. Fee charged.

Questions

All questions regarding this Request for Proposals should be directed to ________________.

SCOPE OF WORK

I. Background

The community of ________________, in collaboration with the government, is planning to contract for the operation of (number and name) Rural Health Center(s) and (number and name) Basic Health Unit(s) to private health services provider organizations.

The scope of work that follows is intended to specify the exact responsibilities that the contract provider will undertake while operating the above-specified rural health facility(ies).

II. Tasks and Activities

The following is a list of tasks to be undertaken by the winning provider under this assignment:

A. (Tasks would be identified that apply to the specific management and service provision responsibilities of a given health unit or units).

B.

C.

D.

E. Keep records on all services provided.

F. Provide appropriate equipment and materials to implement these activities including vehicles, computers, office
space, and other appropriate office machines.

G. Ensure proper accounting, control, and reporting procedures in accordance with GOP requirements.

III. Personnel

Personnel requirements for this assignment include:

1. Project Director: The project director must be available to work on this contract at least __% of his/her time. The individual filling this position has overall responsibility for the operation of the specified health facility(ies) including ultimate accountability for service delivery and quality. Additional responsibilities include organizing the training of other personnel, ensuring the availability of needed drugs, medicines, and supplies, the delivery of high quality services, and serving as a liaison between the winning organization, the community, and the government. Minimum requirements for this position are (a) previous experience managing a health facility, (b) previous management of working groups, and (c) "x" educational requirements or a minimum of "x" years' experience in this field.

2. Medical Services Staff: (Described here would be the medical, nursing, and technical skills needed to operate Rural Health Centers and Basic Health Units.)

3. Support Staff: (Fill in as appropriate.)

IV. Contractor Obligations

Contract:

The obligations of the contractor are as follows:

A "fixed price" contract will be set up in which the government gives the provider chosen by the community an amount at least equal to the inflation-adjusted amount currently budgeted for the specified facilities.

Fee Schedule:

At the option of the community, the fixed price may be supplemented by a fee schedule. If the community chooses this option, it should request the following information:

1. List of charges proposed for each service. The charges should be higher for similar services offered at the referral RHC(s) compared to the primary BHU(s). No charge should be proposed for preventive services.
2. Expected utilization of each service charged for.

3. Expected revenues generated by the charges both by service and overall.

4. Expected total costs and total revenues, including "fixed price," and the sum expected to be received from users.

Where user fees are included in the agreement, the provider will be responsible for collecting user fees and for making available to the monitoring and evaluation team related financial reports.

Keep the user fees that are collected.

Negotiate with the community the combination of Zakat and other charitable funds and cross-subsidization that will be used to pay fees for the medically indigent.

Services to Be Provided:

(Specific services would be identified here using Options A, B, C, and D in the Rural Chapter, Exhibit 7, as models).

Staff:

The provider will recruit, train, supervise, and evaluate an appropriate mix of personnel to provide the services at the specified facilities. The provider will have full authority over personnel policies and procedures.

Facilities:

The provider is responsible for routine maintenance of facilities and equipment.

The government is responsible for capital replacement and major repairs at the facility.

Monitoring and Evaluation:

The provider will be responsible, working in collaboration with the government and communities, for cooperating with an independent monitoring and evaluation unit.

Monitoring will be done on the basis of an agreed-on, limited set of indicators to measure: inputs, outputs, health status, and financial information.
Referral System

The provider will be responsible for developing and following a referral system. (Self-referrals and other conflict of interest practices are not acceptable.)

V. Government Obligations

The government of ____________ will be responsible for:

- Guaranteeing an allocation of Rs._______ to the provider selected by the community (the equivalent real amount allocated for operating costs in 1993-1994 for the specified facilities).
- Advancing the proportional amount of funds quarterly if the provider is in compliance with the terms and conditions of the contract.
- Retaining ownership of the physical plant.
- Retaining ownership of the existing furniture and equipment with the provider being responsible for greater-than-normal wear and tear.
- Providing for capital expenditures and major repairs.
- Establishing an independent monitoring and evaluation body.
- Permitting a leave of absence to those health staff that currently are in the government service who wish to work with the contracted provider for the first contract period without loss of servant status. These people will be under the full authority of the provider.
- Organizing (with technical assistance from an institution with demonstrated competence) community health committees.

VI. Other

Locations for testing the alternative rural health models will not be limited to the Islamabad Capital Territory, but will be open to other geographically limited areas.

Preference will be given to offering contracts for the management of a system rather than a single rural health facility.

A survey will be conducted that will develop a set of baseline data to measure changes that occur over the life of the contract.
Contracts will be let for one to two years.

VII. Deliverables

Services:

The services described herein are specific outputs to be offered by the provider and serve as measurements for this assignment. Each service area will be monitored on a regular basis. Payments under this contract will be based on the successful completion of each component service.

Timeline:

The time period covered by this contract is the (one or two year) period beginning __________ and ending ____________.

Supervisory Party:

The party(ies) responsible for overseeing the deliverables and the timeline of activities are the community of __________________ and the government of _____________.

Contract Amendments:

Any changes the winning provider may wish to make in its contract agreement once it has been finalized and signed (including a revision of the timeline and/or deliverables) can be made only with the approval of the designated representatives of the community of _______________ and government of ____________.
APPENDIX 3

MODEL CONTRACT BETWEEN
THE GOVERNMENT OF PAKISTAN AND PRIVATE PROVIDER

THIS DEED OF CONTRACT AGREEMENT is made the _____ day of _________, 1993 BETWEEN the President of Pakistan (hereinafter referred to as "the Federal Government") on the one part AND M/s (hereinafter referred to as "the Providers") on the other part as follows:

WHEREAS the Government of Pakistan has introduced a plan to provide general medical/health coverage to the people of Pakistan (hereinafter referred to as "Health Care");

AND WHEREAS the Providers have available with them requisite medical, para-medical and administrative personnel, medical care equipment, medical care medicines, units, and infrastructure (hereinafter referred to as "Health facilities");

AND WHEREAS the Government of Pakistan under the scheme of providing medical care, has introduced a system of providing health care to the people of the country under various schemes fully described in the Medical and Health Care Act, 1993;

AND WHEREAS the Government of Pakistan has agreed to award a contract for implementation of one such scheme known as: Providing health services at health facilities within the rural areas of the provinces of Pakistan;

AND WHEREAS the providers have available with them complete requisite health care equipment and infrastructure;

AND WHEREAS the providers have agreed to provide health care facilities in accordance with the aforesaid scheme at the Rural Health Center of (place) and Basic Health Units of (place);

NOW THEREFORE, THIS DEED WITNESSETH AS UNDER:

1. Definition:

1.1. All terms used in this contract shall have the same meaning as provided in the Medical Health Care Act of 1993.

1.2. In case of any inconsistency or difficulty in the definition under the Act and in terms of any terminology in this contract, the terminology as defined in the Act shall have precedence.
1.3. In case any term used herein is not defined in the Act and, if the term used is technical, then it shall have the same meaning as is understood technically in its field; and if the undefined term is not of technical nature then it shall have the ordinary dictionary meaning.

2. Duration of the contract:

2.1. This contract is valid for a minimum period of ____ years.

2.2. The contract, unless it has become terminable for reasons described below, shall be automatically renewed on the expiration of one year on a year-to-year basis for a maximum period of three years on conclusion of which the contract shall come to an end.

2.3. On termination of the agreement, the parties may agree to enter into a fresh agreement in accordance with the provisions of the Act.

2.4. The providers shall not have a right to seek extension of this contract after the expiration of the three-year period. However, a fresh agreement may be executed between the parties.

3. Health Facilities:

3.1. The Medical Unit at (place) is owned by the government and consists of land and buildings as described in Schedule "____." 

3.2. The existing Medical Unit is equipped with such equipment as is identified in Schedule "____." 

3.3. The providers have available the requisite qualified medical staff, para-medical staff, and administrative staff as specified in Schedule "____." 

3.4. The providers also have available the requisite equipment and medicines as specified in Schedule "____." 

3.5. The providers also have available the requisite infrastructure for effectively running the Medical Care Center as defined in Schedule "____." 

NOTE: All schedules annexed with this agreement are duly signed by the parties and form an integral part of this agreement.
4. Cost-sharing and Finances:

4.1. Estimated cost and expenses of operating a Medical Unit for the first year is Rs. ______.

4.2 The government has made available to the providers the existing Medical Unit along with the existing facilities and, for performance of this contract, the existing facilities are valued at Rs._____.

The land, buildings, equipment, and facilities provided by the government at the Medical Unit shall always remain property of the government, to be returned on conclusion of the contract.

4.3. The government has also agreed to make available to the providers subsidy of the value of Rs. _____ for one year duration, worked out on the present evaluation of the size of the unit and the expected average expenditure.

4.4. The government cash and kind subsidy shall be in the ratio of 50:50.

4.5. The government shall extend the cash and kind subsidy to the providers on a month-to-month basis. If the government delays the payment, the providers will be entitled to per diem compensation @ 0.5% of the amount due. If the government fails to make the payment, the providers may discontinue the services and would be entitled to claim their dues from the government and shall have lien on the government property in the provider's possession, to that extent.

4.6 The remaining expenses (i.e., Rs.____) for operating Medical Care Unit for one year shall be borne by the providers.

4.7. The providers have been authorized to charge the patients for the medical services provided.

4.8. The providers can charge the patients treated only at such rates as are previously agreed between the government, the providers, and consumer representatives which shall be prominently displayed at the Medical Care Center. Such list of rates shall also form part of this agreement.

5. Termination:

5.1. This contract is valid for such period/periods as are mentioned above.
5.2. The contract may not be terminated by either party except for reasons mentioned below.

5.3. If the government receives complaints of non-availability of facilities, unsatisfactory medical treatment, and gross negligence on the part of the providers in providing agreed-upon health services, then the government may call upon the providers to remove the deficiencies and/or to show cause as to why the contract may not be terminated. The complaint may also be referred to the Adjudicatory Body set up by the government under the (Medical and Health Care) Act.

5.4. If the providers fail to improve their performance despite shown-cause notice, the government may terminate the contract forthwith.

5.5. If the government receives serious complaints of professional negligence and misconduct from the patients and the providers are found to be guilty of gross negligence and misconduct, then the contract may be terminated forthwith in addition to any other liabilities to which providers may be attached.

5.6. The providers may terminate the contract any time by giving three months notice provided during the notice period the providers shall continue to provide medical facilities as per this Agreement.

6. Indemnities assurances:

6.1. The providers hereby agreed to indemnify and keep the government harmless of any claim of damages or liabilities arising out of negligence or misconduct of the providers.

6.2. Performance Bond shall be issued by any scheduled bank or registered insurance company for due performance of this contract.

6.3. The providers shall also provide the security bond for proper use and return of government property/equipment on conclusion of the contract subject to fair wear and tear. In case of abnormal wear and tear attributable to negligent and improper use, the contractor shall restore the damage to original condition.

6.4. The providers shall also provide guarantees either issued by a bank or acceptable guarantees for due performance of their obligations under this contract.
6.5. The government undertakes not to interfere with the due performance of the provisions of this contract by the providers.

7. Disputes - Claims:

7.1. All disputes, claims, and questions on matters arising from this agreement or touching or relating hereto shall be resolved in such manner as is provided in the Act. Providers hereby specifically agree to submit to the jurisdiction of the authorities designated in the Act for resolution of the disputes.

7.2. The venue of litigation shall be ________________.

8. Insurance:

8.1. The providers may enter into a separate agreement with any recognized insurance company for providing health care at the unit.

8.2. Any policy sold to a potential consumer shall be registered with the Government of Pakistan.

8.3. The provider shall not claim any extra compensation from the government for providing medical service to a consumer who has purchased health insurance policy from a recognized insurance company and whose medical expenses are to be borne by that company under the policy held by him or her.

9. Amendments of the agreement:

9.1. The parties may agree to amend terms and conditions of this contract provided that such amendments should not be in conflict with the provisions of the Act.

9.2. Until an amendment is brought about, the existing provisions shall remain valid.

9.3. Either party may notify in advance of its intent to seek amendment in the contract and shall specify the proposed amendments.

9.4. No amendment shall be incorporated unless it is found to be necessary for the implementation of the contract and is necessitated because of extraordinary circumstances.

9.5. The providers shall not refuse to be bound by the contract for the remaining period even if the amendments are not approved.
10. **Personnel**

10.1 The provider shall recruit and retain requisite technical (medical and para-medical staff) for the entire duration of the contract.

10.2 The provider shall recruit and maintain requisite administrative staff for the entire duration of the contract.

10.3 The provider shall prepare and implement his own policies for his personnel. However these policies shall not be in conflict with the laws governing employments.

10.4 The provider shall be responsible for maintaining discipline at the unit.

10.5 The provider shall be responsible for payment of all dues, wages, benefits payable to the employees and/or to any public department relating to service benefits.

11. **General obligations of the Provider.**

11.1 The provider shall not turn away any patient or consumer for the reason of his inability to pay the provider his medical treatment fees.

11.2 Specified preventive services shall be provided free of charge by the provider.

11.3 Zakat fees shall be used for medically indigent.

11.4 Self-referrals and other conflicts of interest are not permissible.

11.5 The contractor shall establish an independent monitoring and evaluation body in collaboration with the government.

Note: Agreed limited set of indicators measuring forming basis of monitoring and evaluation is set out in Schedule _____.

11.6 All monitoring costs shall be borne by the contractor. All evaluation costs shall be borne by the government.
11.7 The contractor will survey at his own expense to
develop a set of baseline data to determine such
changes that may be deemed necessary for the remaining
duration of the contract.

11.8 The contractor will enforce the use of a referral
system or some acceptable modifications thereof,
including any recommendations that may be considered
appropriate for purposes of the contract.

11.9 The contractor shall organize Health Committees to be
established at the medical unit for appropriate advice
or management.

12. General Obligations of the Government:

12.1 To guarantee subsidy to the contractor at a level and
rates specified in Schedule ____.

12.2 To make payment of the subsidy on a month-to-month
basis
in advance, but in cases of genuine need and subject to
furnishing of adequate security, the government may
make advance payment of a sum up to three months.

12.3 The government shall always retain ownership of the
property mentioned in Schedule ____.

12.4 The government shall ensure that the contract shall not
be terminated without reasonable excuse.

12.5 The government shall ensure that the contractor shall
have a right of vote in the governing body through the
nominee director of the provider.

12.6 The government shall pay costs of the evaluation of the
monitoring and evaluation body.

12.7 The government guarantees availability of a sum up to
Rs. ____ from the Zakat funds to be used only for
treatment of medically indigent.

12.8 The government agrees to pay a sum of Rs. _____ towards
capital expenditures each year during the currency of
this contract.

12.9 In case the provider employs any medical or para-
medical staff who is presently in government service,
the government will permit such civil servant leave
without pay to serve on secondment under the provider;
such civil servant shall retain his lien in government
service and will not lose his seniority and civil
servant benefits while in service of the contractor; this person shall remain under his discipline but not liable to disciplinary action affecting his government service.

13. Subletting.

13.1 The provider can sublet the contract or any part hereof.

13.2 Sublet shall have to be approved by the government.

13.3 The sublettee must possess same qualifications as are possessed by the provider.

13.4 The provider shall not be absolved of his liabilities notwithstanding consent of the government to the sublet.

IN WITNESS WHEREOF we, ______________, for and on behalf of the President of Pakistan and on behalf of M's ____________ the providers have hereunto signed at _________ the day, month, and year written above.

WITNESSES EXECUTANTS

1. 1.

2. 2.
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