Chief Minister's Initiative on Primary Health Care (CMIPHC) In Punjab - Third Party Evaluation

صحت زندگی

In past few years Pakistan has made improvements in its Primary Health Care (PHC) system but this has not been clearly reflected in the key health indicators which remain poor. With the aim to improve service delivery through efficient management in Punjab, district government of Rahim Yar Khan initiated a pilot project in Lodhran, through signing a Memorandum of Understanding (MoU) with the Punjab Rural Support Programme (PRSP). Following the experience of the pilot same model was extended to 11 more districts of Punjab as the Chief Minister's Initiative for Primary Health Care (CMIPHC) and it is currently being implemented in 14 districts of the Province.

To improve further the organisational and contractual arrangements between the Department of Health (DoH) Punjab and PRSP, the Government of Punjab, with facilitation from The Technical Resource Facility, commissioned independent Third Party Evaluation (TPE) of PRSP services related to maternal, neonatal and child health, family planning services, outpatient services and referral. The evaluation has demonstrated that it is cost effective in terms of services than conventional Basic Health Units (BHUs) but, there is a need to improve the management and service delivery while effectively utilizing the autonomous powers.

CMIPHC - Third Party Evalution

The key objective of the initiative was to reorganize and restructure the management of all the BHUs in the district with a central role given to community based support groups. TPE assessed the performance and value for money of the CMIPHC implemented in PRSP assigned districts by comparing with the non-PRSP districts of Punjab. A mixed methods research approach (Table 1) was used for comparing performance of the CMIPHC and non-CMIPHCdistricts. Four districts from each group were selected within which 64 BHUs were evaluated (8 BHUs from each district unsupervised and without continuing education and lack of functioning referral facilities.

Table 1: Research Methods for TPE

- Review of relevant reports and DHIS data
- Semi-structured interviews with key informants and focus group discussions with community leaders in the catchment areas of the BHUs
- Facility functionality survey of a sample of BHUs in both PRSP and non-PRSP districts.
- Exit interview survey of a sample of clients who accessed care at the BHUs included in the study.
- Community based household survey of a sample of families living in the catchment area of the BHUs included in the study
  Field based costing study of selected service lines

Results of Evaluation

a. Governance and Management

At Provincial level arrangements did not existed to govern or manage PRSP's operations in terms of setting strategic direction, agreeing performance standards, monitoring performance or reviewing the effectiveness of PRSP's provision of services at the BHUs. As a result strengthening of oversight of PRSP at Provincial level was proposed in both the DoH's Operational Plan 2012 to 2017 and new contract with PRSP. In non-PRSP districts DoH oversight of BHU performance was found to be limited to receipt of District Health Information System (DHIS) reports and monthly meetings.

At District level relationship between the EDOs (H) and PRSP was ill-defined. There was no obvious sense in which district governments exercise effective oversight of PRSP's management of the BHUs. There are no mutually agreed objectives, performance targets, requirements to report or arrangements for assessing the adequacy or effectiveness of the services provided by PRSP. By contrast EDO's in non-PRSP districts were able to manage BHU services directly and effectively

b. Service Packages

Both PRSP and non-PRSP BHUs offer the same range of health services mainly focusing on the curative ones. PRSP Medical Officers (Mos) use to conduct medical camps and also out-patient clinics in two or three BHUs on rotation. Lady Health Visitors (LHVs) was found to be an un-managed cadre in both systems. No evidence was of partnership working being developed with community midwives. PRSP has not made any great use of its freedoms to "re-organise and re-structure" to "allocate and re-allocate staff" and take initiatives or experiment with innovations which would include available 24/7 skilled delivery, ante-natal care, availability of laboratory investigations or the appointment or development of staff with specific skills. One non-PRSP district reported that ultrasound investigation is available in almost all its BHUs, yet this remains un-available in most PRSP BHUs. The staffing establishment in PRSP BHUs exactly mirrors that in non-PRSP BHUs.

c. Service Utilisation

Use of public and private facilities in both the PRSP and non-PRSP districts was same. 91.7% in the non-PRSP district reported the closeness of the facility to be a factor for utilizing that facility comparative to 88.2% in the PRSP districts.

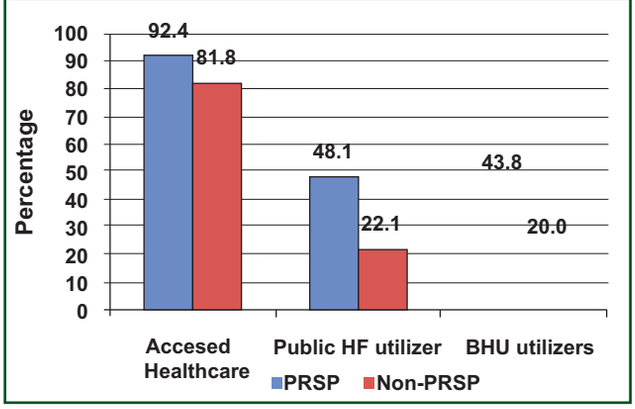
An analysis of the number of patients seen in the BHUs indicated that a significantly higher mean number of male patients visited non-PRSP BHUs than PRSP BHUs, and no significant difference in the mean number of total patients seen per BHU per month across PRSP and non-PRSP facilities (Table 2)

Table 2: Utilisation rate of BHUs (mean number/month)

S No.	Patient category	PRSP	Non – PRSP
1.	Male	384	498
2.	Female	424	479
3.	Total	807	943

Health facility utilisation among community survey participants for mother and child illness showed that a significantly higher proportion of mothers in PRSP districts utilise BHU for their illness than non-PRSP districts. (Figure 1)

Figure1: Use of government and BHU services



d. BHU Functionality

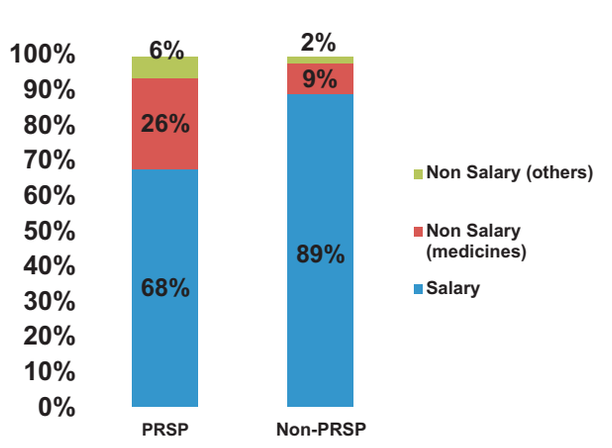
Better physical infrastructure, amenities and functioning essential equipment was found at PRSP BHUs. No significant difference was found in availability of essential medicines, vaccines and family planning supplies. Only 17 PRSP and 17 non-PRSP BHUs (out of the 64 units surveyed) had a functioning autoclave. Dissatisfaction was shared due to restricted services timings (8 am to 2 pm). PRSP BHUs scored better than non-PRSP in ensuring the availability of staff in key cadres and providing antenatal care services. Key interventions such as screening of high risk ante natal patients, referral of complicated cases, neonatal examination and ambulance services were available at more non-PRSP BHUs. Non-PRSP BHUs in general generated less satisfaction than PRSP BHUs. Neither of the two groups of facilities system performed outstandingly in all or most aspects of care

Value for Money (VfM) Analysis

Analysis of financial data revealed that average BHU spending by non-PRSP districts during the fiscal years (2010-2013) was 213 % more as compared to PRSP managed districts. The government run BHUs were spending more on non-medicine items as compared to PRSP which spent more on medicines (per capita). Management costs were 60% more in the government managed BHUs as compared to PRSP managed BHUs. The analysis also found that on average PRSP procurement prices were 9% lower as compared to that of the non-PRSP districts.

Efficiency analysis revealed that PRSP districts were able to spend more money on non-salary expenditures as compared to Non-PRSP districts (figure 2). On average during fiscal years 2010-13, 9% of the non-PRSP expenditure for BHUs was spent on non-salary components including medicines. In comparison during the same period PRSP spent 32% on non-salary component including medicines.

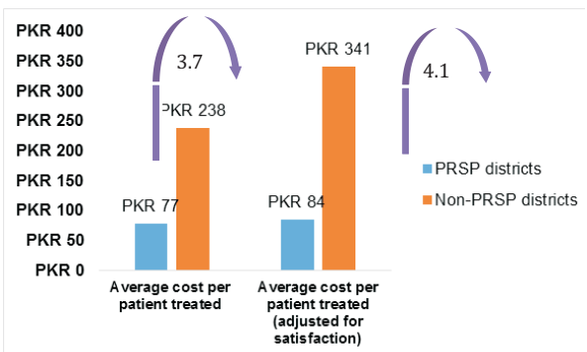
Figure2: Critical expenditure mix



Costing of key MNCH services showed that PRSP districts reported lower costs for most services. On average costs of providing these services were 24% lower in PRSP districts as compared to Non-PRSP districts. Patients accessing maternal services in Non-PRSP district paid 2.4 times more as compared to patients who accessed similar services in PRSP run districts

Cost of treating an average patient under PRSP model costs 3.6 times less as compared to the government run facilities (Figure 3). Similarly, out of pocket expenditure for accessing maternal care was 41% less in PRSP districts. Assessing efficiency, effectiveness and cost-effectiveness of both the management models, PRSP managed BHUs are providing better VfM as compared to the government managed BHUs, primarily due to lower management and procurement cost and efficient functioning of BHUs.

Figure 3: Per patient average treatment costs



Recommendations

It is clear that neither system is providing a flaw less primary healthcare system and it is not possible to conclude that one system is performing outstandingly better than the other. The vfm analysis indicates that the PRSP system is more efficient financially than the non-PRSP system. Considering the evaluation findings, the following are recommended

- New and revised contracts should be issued to PRSP; these should be time-bound, identify an essential health services package, specify financial allocations, identify good performance, and ensure integration with the district health system.

- Contracted-out services should be subject to a continuous process of independent **third party monitoring** to ensure improved performance of contractors who provide health services.

- Contracts should incorporate **Performance Based Financing** which will link the funding received by the contractor to results achieved and is known to be effective in improving contractors' performance in the delivery of health services.

- The DoH should review the mechanisms for **allocation of resources**, identify gaps and reduce delay

- The DoH should review its **existing staffing and other management** related allocations to identify lapses and reduce management costs at district level. The role of EDO (H) should be clearly defined in terms of managing the contracted out services in line with district health system.

The DoH along with PRSP has demonstrated a fairly successful model of contracting out of services. However, there is a need to re-visit and revise the contracting processes along with effective oversight and management of governance arrangement at Provincial and district levels. Both systems (contracted and government managed BHUs) need to improve overall management and services to provide consistent primary health care services.

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