

Decentralization, health care and policy process in the Punjab, Pakistan in the 1990s

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SUMMARY

The Province of the Punjab underwent a number of attempts to decentralize the health sector in the 1990s. Among the most important were the decentralization of financial management within the district, the Sheikhpura PHC Pilot Project, the establishment of the District Health Authorities and District Health Management Teams, the creation of semi-autonomous hospitals and the programme of District Health Government (DHG). These usually received donor support and promotion, and emerged from within the provincial Department of Health, and more specifically the Secretariat and the internationally supported Second Family Health Project (FH2). Of particular significance was the DHG change, which involved a decentralization to the district, the appointment of powerful Chief Executives, the formation of District Management Committees and purchaser–provider separation. The paper reviews these proposals, focusing on the need to build on experiences and learning lessons from pilot projects, reform continuity, developing consultation and involvement and policy analysis. The latter indicates the importance of developing more in-depth policy analysis around the role of the central organization, the form of decentralization and the purchaser–provider separation. The paper concludes by underlining the need to ensure that political strategy and in-depth policy are appropriately coordinated in the policy process. Copyright © 2002 John Wiley & Sons, Ltd.

KEY WORDS: Pakistan; decentralization; policy process

Decentralization of the health care system is both a popular but problematic health sector reform in developing countries. On the one hand, there is concern over the lack of robust systems of policy formulation and implementation of health sector reforms together with the constraints ranging from political and bureaucratic resistance to the lack of managerial capacity at the district level. On the other, there is increasing anxiety that decentralization can have a negative impact on the development of progressive health policies. Concern ranges from the link between decentralization and inequity to the political manipulation of decentralization and the possibility of generating fragmentation and increased costs within the system.[†] In sum, despite high hopes the record of decentralization is not good. Yet there can be little doubt that decentralization is an important and necessary reform. Many

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[†]See the references indicated in Collins (1996).

of the major problems of bureaucracy, inflexibility, lack of community orientation and failure to develop an inter-sectoral approach to health are associated with a centralized system. There is clearly a need to improve the policy formulation and implementation of decentralization programmes. An important way forward is to learn both positive and negative lessons from policy experiences of decentralization. That is, by examining the process by which decentralization programmes are formulated and implemented, we should be in a situation to identify ways in which policy-making for decentralization and the substantive policies themselves may be improved. This aim of this paper[‡] is to contribute to that process by analysing attempts during the 1990s to decentralize the health care system in the Punjab, Pakistan with a view to identifying and discussing key features of the change process.

In the first part of this paper, the then existing public sector health care system in the Punjab will be described.[#] This is then followed by the reasons for and the initiatives taken in favour of decentralization during the 1990s. The analysis then moves onto identifying and discussing key lessons to be learned in the policy process of decentralization programmes in the province of Punjab. Particular attention will be placed on the need for developing policy analysis with respect to the DHG initiative. The paper finishes by stressing the need to develop the capacity for health policy analysis, formulation and implementation in the province.

Since conducting the work leading to this paper, a new system of devolution has been introduced in Pakistan. In the new set up, according to the Local Government Plan, 2000, promulgated on 14 August 2001,[¶] a department of an elected district government is responsible for health and population welfare in the district. The district assemblies have powers to levy taxes and exercise full authority over the resources. This paper will look at the attempts to decentralize prior to this devolution, but recognises that an understanding of this period should provide material that can be assessed by present-day policy makers. It should also be pointed out that the hospital semi-autonomy referred to in this paper has been introduced while the new devolved system builds on aspects of the changes discussed in the 1990s.

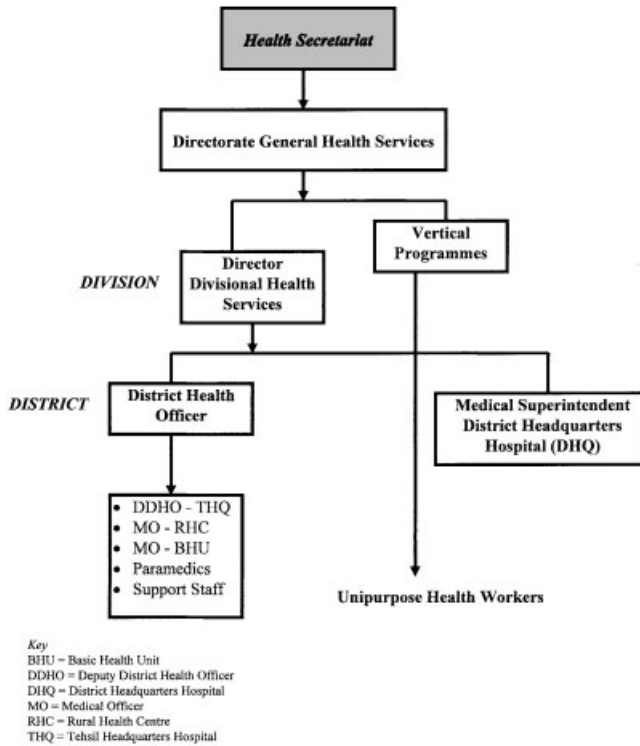
ORGANIZATION OF PUBLIC HEALTH SECTOR

Health is on the 'concurrent list' in Pakistan, and the Federal Government formulates the national health policies and helps the provinces in the implementation of

[‡]For two of the authors this paper is based on consultancy work on two projects. The Overseas Development Administration (ODA, now DFID)/Asian Development Bank Funded Project (ADB3) had, as its ODA funded component, the development of the strategic planning capacity at federal level and provincial level in Balochistan and North West Frontier Province. The Second Family Health Project (FH2) was a joint DFID (formerly ODA)/World Bank funded project in the provinces of Balochistan and the Punjab. The DFID component looked to strengthen management, planning, training and institutional development. Specific parts of this paper paraphrase/reproduce parts of the reports. Six consultancy visits were undertaken to Pakistan for periods ranging from 2–6 weeks. The views expressed in this paper are of the authors. The Department for International Development will not accept any responsibility for views expressed in this paper.

[#]The analysis will focus on the health care system under the Department of Health. It will not refer to health care provided by municipal corporations and related ministries.

[¶]Local Government Plan, 2000. *The Daily Dawn*, 14 August 2000.



Sources: Omar, M Consultancy Report presented to FH2, 26 Feb - 28th March, 1996 on District Health Management Strengthening Period.

Figure 1. Health services organization in Punjab, Pakistan

certain vertical programmes. The Provincial Departments of Health (DoH) had a tall organizational structure. The hierarchy was made up of various levels, these being provincial, divisional, district, tehsil or sub-tehsil, markaz, union council and local or village, as indicated in Figure 1. The provincial level has a further three relatively distinct elements—the Minister of Health, the Administrative Secretariat of Health Services and the Health Services Directorate.

Each level in the health system hierarchy contributes to the provision of health care and its governance. Special institutions, tertiary hospitals, medical colleges and special development projects are under the direct authority of the Health Secretariat. At each erstwhile divisional headquarters, there is a 350 bed Divisional Headquarters Hospital. At the district and tehsil levels there is a 125 bed District Headquarters Hospital (DHQ) and a 40–60 bed Tehsil Headquarters Hospital (THQ) respectively. For each markaz, a 20 bed Rural Health Centre (RHC) serves a cluster of 6–8 union councils, and at every union council headquarters, there is a Basic Health Unit (BHU). The villages, hamlets and scattered rural populations are all covered by the outreach services and static health houses. The latter have been set up by the Lady Health Workers (LHWs) of the National (Formerly Prime Minister’s) Programme for Family Planning and Primary Health Care.

For the governance and administration of the health care delivery network, there exist supervisory and controlling officers relating to their respective level. The Minister for Health is in charge of the health department, responsible for matters concerning the policy of the department and conducting the business of the department in the Provincial Assembly. The Secretariat constitutes the administrative department for health services. The Director General of Health Services (DGHS) is at the apex of the line Health Department (known as the Directorate General), regarded as the operational head of the department, to supervise health services in the periphery. A Director Health Services (DHS) headed the (former) divisional health management and was responsible for the supervision of the secondary care, district and tehsil headquarters hospitals through their respective medical superintendents, and primary health care through the District Health Officers (DHOs).[§] Similarly, the district health management is headed by the DHO who is responsible for supervising a primary health care network. In each district, there are Deputy District Health Officers (DDHOs) to support the DHO in his/her supervision of PHC in their respective tehsils.

Each governance or administrative level in the health system hierarchy exercises a certain amount of control over the resources of the Department of Health. The extent of this control, which varies from one tier to the other, is determined by the Finance Department in matters pertaining to the receipts and utilization of financial resources. Similarly, the Services and General Administration Department lays down the principles and codes of conduct for regulation, maintaining the efficiency and discipline and other human resources management issues. In addition, there is a plethora of other functions, which do not fall in the ambit of either administrative or financial functions. These may be called the 'legal' functions that are performed at different levels in the hierarchy of the health care delivery network and are governed under certain enactments that have been promulgated through the legislature.

THE PUSH FOR DECENTRALIZATION

There can be little doubt that the policy of decentralization has been, in principle, based on a sound concern for the damaging effects of an over-centralized administrative system. The organizational structure of the health care system in the 1990s was unwieldy and unnecessarily tall, there being eight supervisory levels. This resulted in a frustratingly long chain of command and delays in decision making. Several vertical programmes and structures further complicated the system. The nursing, blood transfusion services, EPI, sanitation and communicable disease control all operated vertically in the institutions while the 'in-charges' had no or little control over them. The centralized and top-down system of accountability and control had failed to ensure adequate resource management at the sub-provincial levels, leading to lack of discipline and efficiency through absenteeism, stock-out days for medicine and other consumables, and under utilization of health facilities (Project Management Team, 1994a). The political and other external influences further marred the system. This inculcated amongst the incumbents a sense of

[§]Re-designated as Executive District Health Officer in the new set-up.

Table 1. Initiatives for the decentralization of health care in the Punjab

Date	Initiative
1990	Delegation of financial authority to DDHOs (officers in charge at the Tehsil level)
1993-4	Sheikhupura PHC pilot project
1996	District Health Management Teams (DHMTs) established in 16 of 34 districts
1997	District Health Authorities (DHAs) established in Jhelum (July 1997) and Multan (March 1998)
1998	Semi-autonomous hospitals established in the tertiary sector
1998	District Health Government (DHG) developed, approved by the Chief Minister in November 1998. Since then, recruitment and training of district level Chief Executives and rules for DHG

Adapted from: Concept Paper: District Health Government, Department of Health, Government of Punjab.

insecurity and instability in their positions. Intersectoral collaboration was limited as vertical hierarchies failed to develop the necessary horizontal links, in addition to setting the organizational constraints to community participation.

Given the issues and problems persistently faced in the health care system, it was not strange to find decentralization being considered a remedy to recurrent problems. During the 1990s there were repeated but diverse attempts to promote the decentralization of the health care system in the Punjab, and these are identified in Table 1. Among these was the decentralization of financial management within the district, the Sheikhupura PHC Pilot Project, the establishment of the District Health Authorities and District Health Management Teams, the creation of semi-autonomous hospitals and later, the programme of District Health Government. Although generalizations can fail to capture the complexities of the policy process, the overall agenda for decentralization had been clearly influenced by the World Bank. Indeed, the World Bank conditions as part of the FH2 agreement were: the integration of vertical programmes, incentives to female paramedics and decentralization. The initiatives to promote decentralization had been taken forward by officers within the Secretariat and FH2.^{||}

Decentralizing financial management

Three attempts were made to decentralize financial management responsibilities within the district structure, although two of these measures have since been withdrawn. Conferring the powers of 'Drawing and Disbursing Officer' (DDO) to any officer in the Punjab enables her/him to have access to retrieval and utilization of resources earmarked by the exchequer for a particular accounting unit. DDOs are recognized as belonging to a hierarchy of categories which defines their financial authority, posing certain limits over the use of resources as prescribed under financial rules. The need was felt within the Secretariat to decentralize DDO powers and a number of initiatives emerged around 1990.

^{||}With the exception of the decentralization of financial powers in 1990 which was before the setting up of FH2. The FH2 office operated as a staff agency within the Secretariat office of the Health Department and was a component project of the Social Action Programme.

1. In a district, the District Health Officer is DDO in respect of all primary health facilities, i.e. RHCs, BHUs, MCH Centres and Dispensaries. The Deputy District Health Officer (DDHO) has been responsible for supervising PHC activities in the revenue limits of a tehsil without any authority over the district resources. Since districts in the Punjab are quite big with an average population of over 2 million having 50–60 PHC facilities, it was considered important to declare tehsils as accounting units and the DDHO in charge to act as DDOs in category III. For expenditure beyond the financial powers, the DDHO had to seek the approval of the DHO or through him/her, the Director of Health Services at the divisional level.[†] This change meant that the powers of the DHO as DDO were limited, although the office did retain all administrative powers over staff in the district, including the DDHO. Similarly, legal powers vested in the DHO under legislation continued to rest with that office. Interestingly, the staff who formerly dealt with financial matters for the DHO at the district level were not transferred to the tehsils, but continued to work at the district level, leaving the DDHOs to run their business with the help of one senior clerk only. This experiment in district decentralization was abandoned and the financial powers delegated to DDHO were withdrawn and conferred back to the DHO. This was largely a result of the audit which observed misappropriation and embezzlements in the government account.
2. At every constituent tehsil headquarters in the health district, there is an office of the Deputy District Health Officer (DDHO). A team of tehsil supervisory officers and support staff including a senior clerk assists him/her. In order to facilitate the smooth functioning of the tehsil health office, DDO powers were conferred on the DDHO in respect of the funds released for tehsil pay and allowances and operational contingent expenditure. In contrast and for the PHC facilities in the tehsils, the DHO was recognized as the DDO. Once again the change process was halted, with DDHO powers withdrawn through a circular. The latter gave no reason for the change. As a result the DDHO was obliged to look towards the DHO for petty expenditure, such as stationery.
3. The Rural Health Centres, one at each Markaz, i.e. a cluster of 6–8 union councils, are 8–20 bed small rural hospitals where diagnostic and operation theatre facilities are available. This serves as a first level referral care facility for the Basic Health Units (BHUs) located one at each constituent union council headquarters. These health units have an outpatient department and two beds are available for emergency and obstetric care. The RHC, in addition to pay and allowances, received an annual budget for commodities and services. Hitherto the budget was authorized by the DHO. From financial year 1999–97 a change in the financial management was introduced; the Senior Medical Officer In charge was made DDO in respect of the budget released for the RHC.[‡]

[†]The DHO is a category II officer while the DHS (at the Divisional level) was a DDO category I officer. For re-appropriation of funds from one head of expenditure to the other, the DHS had authority in the districts.

[‡]Recognized as a new accounting unit under 'Delegation of Power Rules 1990', s/he was placed in category III.

The move to decentralize financial powers was, not surprisingly, opposed by the DHOs. A particular problem experienced in these measures was the lack of preparation among DDHOs to take on these financial powers, some of whom occupied their position in an *ad hoc* capacity. At the time, a number of audit concerns were raised over the DDHO use of these powers.

The Sheikhpura PHC pilot project

This was a management intervention study with decentralization and community participation as its major components. Specifically the pilot project aimed to (Project Management Team, 1993):

1. reorganize and decentralize decision-making responsibility within the project area, giving greater authority to the district and sub-district or tehsil level officials for management of government health services with a view to providing improved health services to the rural population; and
2. establish and test a system of health committees at several sub-district levels to promote increased community involvement in planning, managing and staffing local facilities.

Two major elements of the first objective were: integration of the existing and vertically organized monopurpose-programmes, and decentralization of administration and financial powers from the DHO to DDHOs. A salient feature of the second objective was the identification and training of voluntary village health workers and traditional birth attendants, who would catalyse community organizations. An incremental approach was adopted towards management change, the development of training materials, the identification and training of animators (village health and traditional birth attendants), the organization of communities and constitution of health committees, staffing selected facilities with auxiliaries, and ultimately management of primary health facilities by health committees.

The project was a pilot to the larger World Bank/DFID/KfW[¶] funded Second Family Health Project with the objective to replicate the results on a wider scale. The project, however, tended to lack an organizational basis within FH2 and did not manage to develop a strong sense of ownership among the general medical cadre working in the Directorate and at the decentralized level. Particular concerns were around policies of decentralization and community participation expressed in the pilot. Baseline and evaluation studies were conducted which indicated a varying degree of success in its different interventions (Project Management Team, 1994b). However, the qualitative assessment of the project, as envisaged, has not been done leaving many questions unanswered. Interest in the pilot project tended to subside as an alternative programme, the Prime Minister's Programme for Family Planning and Primary Health Care, made some advances in the area of community participation. The project did, however, have some impact on the decentralization process in terms of the DHA change (see below).

[¶]KfW, German Kreditanstalt für Wiederaufbau.

Contract appointments of medical officers

This measure, which emerged from within the Secretariat, was taken to reduce the authority of the Centralized Public Service Commission over human resource management and allow the divisional level a greater say over the management of contract staff. According to the conditions laid down in the Civil Servant Act, 1974, the gazetted officers in the basic pay scale 17 were appointed on a regular basis by the Administrative Secretary. The selection and recruitment was, however, carried out by the Public Service Commission. For contract appointments, the rules were relaxed and a committee at divisional level, headed by the divisional DHS, undertook all formalities for recruitment and selection. The list of the successful candidates was then forwarded to the Administrative Secretary who passed the appointment orders. These employees are classified as contracted staff and, as such, are not government servants eligible for promotion, pension and other recognized benefits. Similarly, in case of absence from duty or any other misconduct by the incumbent amounting to his/her dismissal from service, this was done upon recommendations by the divisional DHS. In this manner, the DHS at divisional level had assumed powers for hire and fire with a view to increasing control over, for example, absentee staff. Although this intervention appeared to have had an impact in reducing absenteeism, the measure met with criticism from the Pakistan Medical Association. It was feared that if the Public Service Commission was not in control of the selection of doctors, then the hierarchical system of medicine based on promotion between grades within the province would be weakened. Contract employees are for limited terms with renewal required.[§]

Establishment of District Health Authorities and District Health Management teams

The establishment of a system of District Health Authorities was a part of the Federal Government's agenda to decentralize administration of the public sector departments: it was firmly inscribed on the National Agenda and constituted a central point of the National Health Policy[¶] that was announced in late November, 1997 (Government of Pakistan, 1997). Similarly, at the provincial level, increasing decentralization of authority to districts figured as one of the two top priority policy areas in the Punjab Social Action Programme Project-II (SAPP2), the other being the provision of preventive health services to the people. The DHAs in Punjab were established by Executive Order in two districts: Jhelum in July, 1997 and Multan in March, 1998.

DHAs were formally conceived as a joint forum of the 'people' together with the public sector Health Department and other allied Departments. This was in order to involve the end users in the management of health services and evolve a district

[§]After the promulgation of Local Government Plan, 2000 on 14 August 2001 the functions and responsibilities hitherto performed by the District Health Service at division has been transferred to the Executive District Health Officer in the district. The latter, in the devolved set up, undertakes the contract appointments.

[¶]The National Health Policy laid down the establishment of District Health Authorities (DHAs), District Health Management Teams (DHMTs), and Community Based Organizations (CBOs) as vehicles for decentralization.

health system, which meets their needs. Its membership was drawn from government departments and sections of society. The extent to which this was part of an effective community participation strategy is, however, open to doubt given the definition of user representatives as 'community notables'. The District Health Officer, who was in charge of the district health system, was the Executive Secretary of the DHA.

The proposal to set up DHMTs follows on from the Sheikhpura Project and formed part of the National Health Policy document of November 1997. It was developed as a reform within FH2 and supported by the emerging Provincial and District Health Development Centres.[#] The teams, which were established in 16 of 34 districts, were seen as an executive arm of the DHA, being comprised of the incumbents from the public sector health department. Its mandate was to translate the policies of the DHA into actions and carry out the day to day management functions. The DHO, being the chairperson of this body, was to act as a link between the DHA and the DHMT.

Although DHAs were established in the two districts noted above, plans to set them up in two more districts, Sargodha and Gujranwala, though initially agreed were never completed. Critical observations were expressed regarding the authority of the two bodies (DHA and DHMT) as they were created under an Executive Order but not delegated powers, similar to those granted to the autonomous hospitals under new legislation (Khan, 1998 unpublished,[§] and see below). The DHA reform were eventually abandoned in favour of the District Health Government reform (see below).

Autonomous medical institutions

The delegation of semi-autonomous authority to tertiary hospitals is a well recognized element of health sector reform in a number of countries (McPake, 1996; Collins *et al.*, 1999; Collins and Green, 1999). The application of this reform to the Punjab was supported by the World Bank and from within the Secretariat and particularly FH2. Under 'The Punjab Medical and Health Institutions Ordinance' promulgated on 23 May 1998 and subsequently enacted by the legislature, certain teaching hospitals with their attached medical colleges have been given a semi-autonomous status (Government of the Punjab, 1998a). An Institution Management Committee has been established to govern the institution. Headed by a Chief Executive (CE), who is a contract employee, the body is composed of members from both the public and private sectors. It receives the usual institutional budget as grant-in-aid upon which it has full authority for appropriation into various heads of expenditure and utilization. Similarly, the Institution Management Committee has administrative authority over all categories of its employees. This has the power to hire and

[#]These centres were created under FH2 during 1995–6 with the function of in-service training and management development.

[§]Khan ZF. 1998. District Health Government—A viewpoint (of the Chairman District Health Authority, Multan) unpublished.

fire those recruited on contract and surrender any permanent government employee to the Health Department.

In the first wave five institutions—Jinnah Hospital Lahore, Punjab Institute of Cardiology Lahore, Shaikh Zayid Hospital Rahim Yar Khan, Holy Family Hospital Rawalpindi and Bahawal Victoria Hospital Bahawalpur—were made autonomous. In the second wave six teaching hospitals with their attached medical colleges—Nishtar Hospital Multan, Services Hospital Lahore, Allied Hospital Faisalabad, DHQ Hospital Faisalabad, Rawalpindi General Hospital Rawalpindi and DHQ Hospital Rawalpindi—were granted autonomy.

Among the difficulties faced in implementing the legislation was that of the position of the Chief Executive. The law was not developed through the definition of legal rules, leaving something of an ambiguous managerial and legal framework. This allowed the CEs to develop their own authority in relation to the Medical Superintendent (who used to be recognized as the head and might well have a higher cadre grade to the CE) and the Principals of the Medical College (who are in a different cadre). These constituted, in the eyes of the protagonists, critical problems over positions within and between cadres. The Pakistan Medical Association had also been critical of this situation. The legal basis upon which the CE's authority rests have also been questioned.[†] Finally, legal rules have been framed and promulgated in January 2002—three and half years after the first batch of hospitals was made autonomous in July 1997.

District Health Government (DHG)

The Punjab Medical and Health Institutions Ordinance promulgated in May 1998 made no mention of the DHAs, but allowed the government to establish other health institutions. Indeed, the legislation on hospitals, together with its subsequent implementation, provided something of a model upon which the idea of District Health Government was developed. The experience of the semi-autonomous hospitals was perceived within, for example, the Secretariat and FH2, as positive, particularly in relation to the authority exercised by the CE. In this respect, the DHG reform looked to reproduce this authority at the health district level.

The DHG policy was based on the 'Concept Paper' produced by the Government of the Punjab and, for reasons of accuracy, will be quoted heavily in this paper (Government of the Punjab, 1998b). Support for the DHG reform came from a proactive Chief Minister and a Secretary of Health, the reform being approved by the Chief Minister (Punjab) in November 1998. Following this, recruitment and training of district level Chief Executives took place and some rules for DHG were passed. The features of the overall change are shown below, the basic structure of which is set out in Figure 2.

Reform of the overall structure of the Department of Health

The separation between the Secretariat and the Directorate within the Department of Health was to be retained, although the functional and organizational form of the

[†]Dawn (Pakistan based newspaper), 20 January 2000.

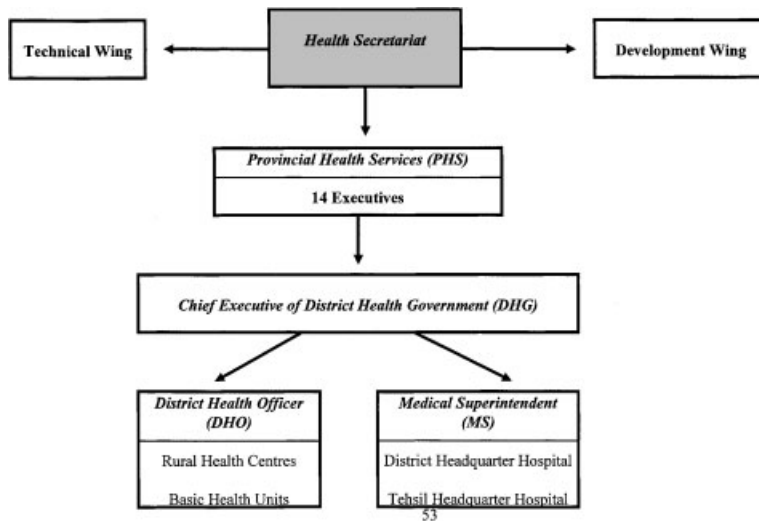


Figure 2. Proposed organizational structure of District Health Government (DHG) Punjab, Pakistan

separation was given precision and revised. The Secretariat was to be referred to as the Provincial Health Secretariat (PHSec) and would be ‘... responsible for the whole network of Health Care Delivery System in Punjab’ (p. 24—all page numbers refer to the Concept Paper). The Secretary to the Government of the Punjab was to be at the head and support was to be provided by a new organizational division between Technical and Development wings. The major functions of the PHSec would be: ‘Developing policy and setting priorities; on-going monitoring and built-in evaluation; organizing Third Party Evaluation as and when required; regular review by Technical and Development Committees; quality assurance’ (p. 24).

The Directorate was to be renamed as Provincial Health Service (PHS), headed by the Director General-PHS and run through 14 PHS Executives. The delivery of health care was to be entrusted to the districts that would be organized by a District Health Government which ‘... shall be responsible for promotive, preventive, diagnostic and curative activities in its respective district’ (p. 16).

The DHG was set to have the following powers and cover these areas:

1. Implementation: ‘To implement the policy directions and priorities of the DOH GOPb (...) and “To deliver *Package of Health Services* as set out in the Purchaser–provider Contract (...) including both the preventive and curative aspects especially in the following priority areas as set out by the GOPb DOH:‡ Health Education, Immunization, Communicable Disease Control (...), Integrated Management of Child Illness (...), Reproductive Health, Environmental Health (...), Chronic disease surveillance, prevention, cure and rehabilitation” (p. 16)’

‡Government of the Punjab, Department of Health.

2. Human Resource Management: 'Hiring and firing powers for all the health staff; To repatriate any regular officer/official working in the district, to the DOH; To make any contract appointment within the district health system at any level' (p. 16).
3. Logistics: 'To purchase drugs and other materials required by health facilities; (...), To make arrangements of repair of vehicles, equipment and other materials as and when required' (p. 16).
4. Coordination: 'To ensure inter-departmental and intra-departmental coordination and cooperation' (p. 16).

Decentralization to smaller management units

The idea behind the reform was that since the Department of Health had grown to an almost unmanageable size, the need to divide it into small management units (SMU) became necessary. The district with its entire public sector health care delivery network would constitute an SMU. This SMU could then further be divided into smaller SMUs, like DHQ hospital, RHC and perhaps even BHU. This was to be undertaken through a decentralization to the district level with '... full administrative and financial autonomy' (p. 13). The 'MS and DHO will have financial and administrative authority to work in their respective management units which will be DHQ/THQ in case of MSs and RHC/BHUs in case of DHO, with annual allocated budgets' (p. 15).

Purchaser-provider separation and contracting

The DoH was to become a purchaser of health care from the Provider, which was to be the 'District Management Committee (DMC) through the Chief Executive (CE)' (p. 14). These contracts were to be '... according to the priorities set by the Government' (p. 14).[‡] A second level of contracts was then to be established at the district level. They were to take the form of performance linked contracts whereby the DHG was to be the purchaser and the MS DHQ and the DHO the providers. These contracts heralded in a break with the system of tenured staff: 'CE will have fire and hire authority based on performance indicators agreed between the parties' (p. 17).

Resource allocation

The Department of Health was to allocate the annual budget amounting to approximately 100 million rupees as a grant in aid to each DHG that would have full authority over its utilization.

Revised internal district structure

District Health Government. The selection of the members of the DHG was to be recommended by the Secretary (DoH) and have to be approved by the Chief Minister. The proposed membership of the DHG was: CE (Chairperson), DHO (Secretary), and members: District heads of the Population Welfare, Social Welfare

[‡]It is understood that these are the same contracts referred to on p. 17 of the Concept Paper whereby 'The Health Department shall enter into a Performance Linked Contract (PLC) with the Chief Executive'.

Departments, Medical Superintendent (MS) DHQ Hospital, representative of the local Pakistan Medical Association, two notables of the society, Chairpersons of the Municipal Corporation and District Council and an NGO representative. 'Each member of the DHG shall have one vote and the decisions will be made with the consent of the majority' (p. 18).

The Chief Executive. The 'CE will be given complete administrative and financial authority and autonomy' (p. 17) '... will be accountable to the District Management Committee (...) and provincial health service executives' (p. 18). The CE was '... proposed to head the District Health Government (DHG) and shall be selected based on annual contracts initially' (p. 17). They '... shall be qualified health managers/professionals and shall be hired on the market driven salary package and his performance will be monitored by the PHS according to the purchaser-provider contract between the DOH and DHG' (p. 14). It was stated in the 'Concept paper' that they would be selected through a procedure that would 'be transparent and merit based' and the selected incumbent would have 'proven ability and track record' (p. 18). The CE '... will be responsible to deliver the health services package through the management structure available at the district level' (p. 17). The DHO and the MS DHQ would report to the CE, '... who shall act as a controlling body at the district level and will have full administrative authority' (p. 15).

Monitoring and accountability

The document identified two types of monitoring: 'in-built departmental monitoring' and 'third party periodic monitoring'. The former was 'routine reporting', to be '... consolidated by the Monitoring and Evaluation Cell of DHG and shall be shared with DHG managers and transmitted to Provincial Health Directorate (proposed PHS Executives)' (p. 19). This indicated a monitoring process covering service utilization, quality assurance, management and financial management and outreach services. Reporting parameters, responsibilities and frequencies of reporting and consolidation were also indicated. Third party, 'neutral' monitoring was proposed through, for example, private institutions and teaching public health institutions. The importance of benchmark information was emphasized and the system of monitoring together with the form of performance related contracts were to form part of the relations of accountability in the new system. Central control, however, was not to be far away: 'Punjab Provincial Assembly or the Chief Minister can make adjustments in the DHG, if working of DHG is found to be below the acceptable levels' (p. 21).

Later developments

At first sight, the prospects for implementing DHG in the Punjab looked good. It had crucial support from key decision-makers in the provincial government, it had clear legal backing and a project for change was formally elaborated. The CEs to head ten districts were selected following a long process that involved, inter alia, interviews with the Chief Minister. A month long induction course was designed and training of selected CEs was carried out. The Punjab Medical and Health Institutions Act, 1998 required the framing of rules for the establishment of DHGs and for the CEs to

exercise powers. These rules were framed and promulgated. Having said this, other areas of change were not implemented. With the Army taking over power and the political government having been suspended in October 1999, the process for establishing the District Health Governments was halted. As pointed out above, the Local Government Plan, 2000 was promulgated in August 2001, bringing a new system of elected district government to the country. The district assemblies were made responsible for the health and population welfare in the district, given powers to levy taxes and exercise authority over the resources. Contrary to the previous efforts, this intervention uses a cross-sectoral approach and the decentralization process has been underway in all public service departments. The reform means that the district is a basic unit of governance and administration. Within a district, there are three tiers: from below these are Union Council, Tehsil and District. The structure and functions of the existing divisional tier ceased to exist in August 2001, although it is being suggested to raise the status of the erstwhile divisions to the provinces.⁴ The District Health Officer, who was re-designated as Executive District Health Officer, is responsible for Public Health, Child and Women Health and Population Welfare. The Medical Superintendent(s) of hospitals (DHQ and THQ) function under this office. While this suggests a devolutionary model of decentralization, there is the other possibility that a government figure—such as a District Commissioner (now called District Coordinating officer)—emerges as an important district authority. How this would affect the position of the recently selected and trained CEs is yet to be seen.

POLICY PROCESS AND DECENTRALIZATION

There is both interest in and a need to understand and develop the policy process around the formulation and implementation of health sector reform (Walt, 1994; Walt and Gilson, 1994; Reich, 1995). The quality of the change very much depends on the quality of the policy process leading up to that change. Also, given the poor record of implementation in many countries, there is a need to understand how this can be improved. Ministries of Health, or their equivalent, are not renowned, however, for their strategic policy-making and policy implementation capacity. They tend to lack the skills, systems and structures to allow them to take on the strategic change role. Neither do they possess the authority within the government to promote change, being often one of the weaker ministries or departments within the governmental structure.

A review of the attempts to promote decentralization in the Punjab, as indicated above, suggests critical points for the development of policy processes: the need to build on experiences and learning lessons from pilot projects, reform continuity, developing consultation and involvement, and policy analysis.

Organizational learning and continuity

To a certain extent, a learning process may be detected in the attempts to decentralize in the 1990s. For example, the Sheikhapura project laid down some backing for

⁴NRB envisages 26 provinces, repeal of 13th Amendment. *The Daily Dawn*, 7 February 2002.

the DHA experience, and the lack of authority within the DHAs together with the development of the semi-autonomous hospitals led to the DHG reform. Nevertheless organizational learning is not a highlight of the reform process. Two important pilot projects have been undertaken in the Punjab—the Sheikhpura pilot and the pilot on DHAs established in two districts: Multan and Jhelum. Yet the evaluation of the Sheikhpura project was incomplete. In the case of the DHA pilots, before any proper structure of these new bodies had been developed and legalized for their legitimacy or powers essential for their operation were delegated, a new concept, The ‘District Health Government’ started taking shape. The pilots were abandoned before the DHAs were actually brought in place and able to develop a change process. During the pilot process, no arrangements were put in place whereby the DHA could have its own budget to run its business or had powers, which it could exercise to exert any control over the existing district health budget. The essential rules and regulations that were required for the delegation of financial, administrative and legal powers to the district were not framed. The routines and procedures required for the DHA and such structures to run their business were not established; and the government did not notify the ones suggested (Khan, 1998).

Neither was there significant continuity in the change process. While there were instances of continuity in, for example, the strengthening of the CEs position in both hospitals, organizational changes generally failed to build, in a progressive fashion, on previous changes. It is difficult to see the relationship between the earlier moves to decentralize financial authority within the district system and staff management authority of the divisional DHS with later policies of emphasizing the district level interventions through the DHA and DHG reforms. Neither is there any evident continuity between the DHA and DHG changes.

Another problem of continuity in the Punjab is that of staff turnover. Staff within the public sector health services, and particularly those within the District Management Group and the General Medical Cadre (GMC),^{||} suffer from constant turnover. In the latter case of the GMC, the reasons for this are a mixture of patronage and internal rivalry among staff for the preferred postings. The result is a lack of stability among staff and upon which skills development and organizational change can be developed.

Developing consultation and involvement

Consultation and involvement in the policy process is important for two basic reasons: firstly to improve the quality of change by incorporating the views and experience of health sector staff and users and secondly to develop a sense of ownership among the same. There was, however, limited consultation and involvement of these stakeholders in the policy process. The DHG concept developed by the top officials of the Department of Health was given the shape of a ‘Concept Paper’. Its tenets were later discussed in working groups and presented in a seminar chaired by the Chief Minister, Punjab. Virtually no changes were suggested since no amended edition of the DHG ‘Concept Paper’ was published. Ironically, however, almost at the

^{||}These are three cadres within the public service that include teaching cadre, specialist cadre and general medical cadre.

same time the Punjab Provincial Assembly was also discussing the Punjab Medical and Health Institutions Act, 1998.

Policy analysis

Given the deep implications of adopting decentralization and the costs involved in the process of change, it is essential that policy proposals possess both clarity and a strong basis in available evidence for them to go ahead. This is not fully apparent in the case of decentralization in the Punjab. The proposal in favour of DHG appeared to express this problem. The document (Concept Paper) proposed, for example, purchaser–provider separation, performance-linked contracts, user charges and new forms of staff contracting. Despite the international popularity of such changes they are definitely controversial and there is a strong body of evidence drawing attention to the problems such reforms can generate.

DISTRICT HEALTH GOVERNMENT AND POLICY ANALYSIS

In this section we shall analyse the DHG reform programme, as outlined above, paying attention to the research and understanding of the key issues in the reform programme and the appropriateness of the reform programme to the circumstances in the Punjab. The analysis will be conducted under three headings: central organization, decentralization, and purchaser–provider separation/contracting.

Central organization

Important structural changes, as outlined above, were proposed for the central DoH organization. It should be stressed that the emphasis of the Concept Paper on the central organization is to be welcomed. Decentralization does not mean a weakening of the centre but a change in its roles, structures, processes, staff and organizational values. This has been and will be one of the major challenges of reform in the Punjab. As decentralization progresses, the central MoH, in addition to maintaining and developing some of its operational roles, needs to adopt a more strategic, planning, resource allocation role, in addition to providing vital support and regulation of the strengthened decentralized units (Hogget, 1991; Collins, 1994).

In the Punjab, the DHG reform raised the issue of the divide between the Secretariat and Directorate branches of government within the Department of Health. The Secretariat was to be given a policy, monitoring, evaluation, review and quality assurance function. It is to be assumed that the broad policy priorities were to be defined by the Secretariat, converted into contractual[§] form by the Directorate and delivered through the DHGs with a series of additional contracts. The monitoring, evaluation and review of the contracts were to be conducted by the Secretariat, although the Directorate would make the contracts with the DHGs. The latter was given the delivery role. This raises three points:

[§]Although the contracts are were given the form of service level agreements.

- While some form of policy–delivery separation can make a lot of sense in such a large organization as the DoH, care has to be taken in ensuring the clear and effective linking of the two. For example, in order to set policies and priorities there needs to be a strong link between the Secretariat and the Districts through an informational and planning system. This was not developed in the Concept Paper. This does raise the critical issue of whether a precondition for the development of effective decentralization in the Punjab is that of a major rethink over the separation within the DoH of the Secretariat and the Directorate.
- The use of the term Provincial Health Service required further elaboration. The term tends to suggest a separate, semi-autonomous organizational structure with its own conditions of service for staff. Such a change would have very important implications for the service and would have to be examined in much more detail than presented in the Concept Paper.
- There was a need to think through the creation of 14 Provincial Health Services (PHS) Executives at the centre. They would have sat uneasily with the notion of DHG and the statement that ‘All decisions will be taking place at the district level without interference from any other quarter’ (p. 22). Yet the PHS Executives would ‘ensure the health care delivery in all the districts of Punjab’ (p. 14). This last point does suggest some concern over the issue of responsibility and clarifying organizational roles within the DoH. It is understood that the 14 Executives were seen as ‘specialists’ with a supportive role in implementing the district (action) plans.

Decentralization

The Concept Paper was clearly an attempt to promote decentralization. Research and experience suggest, however, that decentralization, if based on weak formulation and implementation can have quite negative consequences for the progressive development of the health care system. For this reason, there is a need to gain a clear and broadly agreed direction to decentralization policy and possess a clear policy as to how decentralization could be made effective. This observation is particularly relevant for the DHG system where five interrelated points would have had to be developed in the decentralization policy. These refer to the objectives of decentralization, the form of decentralization, the problems of decentralization, financing and resource allocation, and developing the conditions for effective decentralization.

Objectives of decentralization

These have to be formulated with a view to providing a coherent direction to the policy and also providing the basis for monitoring and evaluation. There are no universal objectives that apply to all decentralization programmes. Decentralization forms part of a broader process of health sector reform, which can be influenced by different objectives. For example, while the PHC approach has tended to see decentralization as being related to community participation, a redefinition of priorities and intersectoral collaboration, more market driven programmes of change have linked decentralization to limiting the role of the state and the introduction of alternative financing mechanisms, such as user fees.

The Concept Paper usefully linked decentralization to '... improving the health status of Punjab's population' (p. 12) and referred to the need for efficiency and effectiveness. Reference was made to 'health services at the doorsteps of the people' (p. 12) which may be understood as the need to provide improved access to health care through a greater community presence and orientation. The emphasis was certainly on efficiency as quicker decision-making (p. 21) and simpler procedures (p. 22) would be found. It should be said, however, that the Concept Paper did not stand out for its clarity in the definition of the objectives of decentralization.

The form of decentralization

International experience points to a wide range of organizational forms of decentralization. Not only are there the standard forms of deconcentration, devolution, delegation and managed markets, but each form allows for variations while country systems frequently combine different organizational forms. The emphasis in the Concept Paper pointed to Small Management Units (SMU), these being the district level while 'This SMU will be further divided into smaller management units at the DHQ/THQ level on the one hand and RHC/BHU level on the other' (p. 13).

When developing decentralization it is important to identify the form of decentralization and analyse the advantages and challenges of this form. Within the confines of the purchaser-provider contract, the Punjab system, as presented in the Concept Paper, would basically have been functional deconcentration with a line of management authority exercised from the centre: 'The District Health Government management shall be recommended by the DoH Secretary Health and approved by Chief Minister' (p. 18). We have also mentioned the overall responsibility of the DOH Secretariat.

Functional deconcentration has the advantage of allowing for a transfer of resources, responsibilities and authority while maintaining a coherent organizational structure for policy formulation and implementation. On the other hand, there are three specific problems well recognized of functional deconcentration. It is important that policy-makers are aware of these problems and develop policies to deal with them.

- Firstly, it is a relatively weak form of decentralization. Having said this, the decentralization credentials of the Concept Paper are, at first, hard to doubt. Yet there are several paradoxes. It informed that: 'All decisions will be taking place at the district level without interference from any other quarter' (p. 22). On the other hand, the members of the DHG were all central appointees. While we were informed that the Chief Executive would be accountable to the DHG, of which she/he is a member, it is difficult to see how the central hire and fire role would not be accompanied by central accountability. Concern may also be expressed over the creation of 14 PHS 'Executives' and the possible control they could have exercised over DHG. It would have been also useful to identify which sort of decisions would have been made at the district level. The Concept Paper, for example, said little about the district developing its own priority-setting process and programme development. It is well known that deconcentration does tend to be limited to administrative and not policy-making decentralization.

- Secondly, functional deconcentration is notoriously weak in developing intersectoral collaboration. The sectors of the governmental machinery have very few crosses over points with staff looking 'upwards' and not 'sideways'. We have already seen that decentralization was invoked in the name of improving the overall health status. The latter can only be achieved through a multisectoral approach, yet it is difficult to see how this was to be developed in the Punjab. It should also be noted that the Concept Paper (p. 26) referred to DHG 'observing' intersectoralism. The promotion of such an approach, however, did not appear to be a priority item in the Concept Paper.
- Thirdly, functional deconcentration is not renowned for establishing the basis for community participation. Authority is based on a top-down process and makes, at least on paper, little concession to bottom-up processes. This would appear to be an important issue given the community approach advocated in the name of decentralization in the Concept Paper. However and once again, community participation was not a priority feature of the Concept Paper (despite its recognition on p. 26). It would appear to have been limited to the central appointment of two society notables onto the DHG. This is not community participation.

The problems of decentralization

We have already noted that decentralization, if poorly formulated and implemented, can have quite substantial drawbacks. These range from a weakening of the public sector, a strategic weakening of the centre, inequity, political manipulation, and increased bureaucracy (Gonzalez-Block *et al.*, 1989; Kolehmainen-Aitken, 1992; Collins and Green, 1994; Collins, 1996). It is difficult to predict whether these problems will become evident in the Punjab—a lot will depend on subsequent policy developments. What is important at this stage is whether policy-makers are aware of the potential problems and have policies ready to avoid or deal with them. This was not always apparent in the Concept Paper.

- We have already seen that the Concept Paper justified decentralization as a tool for making quicker and simpler procedures, yet decentralization can lead to a duplication of bureaucratic costs. The latter may well be augmented by the transaction costs (see below) involved in the purchaser-provider separation and the contracting. The Concept Paper appeared to show great confidence in the largely structural changes that it proposed. Management change with a view to more efficiency, however, is a complex process involving changes in the relations between the district and the environment. It also involves changes within the district including the development of organizational structure, management systems, the capacity of human resources and the values pursued by the district. The integral character of this process of change was not always apparent in the Concept Paper.
- A further problem of decentralization is that it can be taken too far, weakening the centre, not allowing it to take on its key strategic, resource allocation, regulatory, support and selected operational functions. The Concept Paper is clear in that the DOH Secretariat would take on important functions, maintaining cohesion with the health care system. Having said this, there can be little doubt that this change

would have represented a major challenge for the centre in terms of developing the new structures, systems, staff and values appropriate to its new functions.

- Inequity can also be a problem of decentralization and will be referred to below.

Financing and resource allocation

According to the Concept Paper, the system of decentralization would continue to be financed through central grants, which would be allocated through the system of deconcentration. It is, however, a matter of concern that the planned resource allocation was to be Rs. 100 million as a grant-in-aid, the same sum to be transferred in the same amount to all districts. This failed to recognize the differences in population and relative needs of the districts. This rigid form of resource allocation was not translated into action. However, it does underline an issue that will be referred to again in the next section—the apparent absence in the Concept Paper of strengthening of the health planning system. The latter would allow for a decentralized interpretation of community needs and it would be linked to the resource allocation mechanisms. In the absence of such a provincial decentralized health planning system, it is to be suspected that inequity would have deepened. There is a further concern that has to be mentioned. The Concept Paper looked to develop alternative sources of health care financing in the form of user fees. It (p. 22) looks to develop this as a form of equity: ‘People who can afford shall be paying fees whereas the poor shall be subsidized by enhanced cost recovery. Mechanisms of cross subsidy shall protect the poor, (...) deserving poor will be given free treatment through Zakat funds’. There is a need to base such a policy on a thorough understanding of the potential difficulties surrounding user fees: restrictions on access, inequity, their transaction costs. According to the Concept Paper, the districts would generate additional funds through user fees and with the central funds would provide ‘health care for the poor and needy’. On the assumption that the districts would be able to generate additional funds (and this is by no means clear), then it would be the richer districts that would generate the additional funds and not necessarily the poorer ones. Decentralization can sow the seeds of health care inequity.

Developing conditions for effective decentralization

It is becoming increasingly clear that effective decentralization is more than the simple transfer of authority from centre to periphery but involves an across the board transformation in the public sector. Programmes of decentralization have to develop an agenda of complementary changes designed to implement and deepen the process of change. Key elements of this programme have already been mentioned in this paper and should include:

- defining the form of decentralization and the relations of authority;
- determining the levels to which decentralization is to be made;
- identifying and carrying out the synchronized transfer of authority, roles and resources;
- strengthening the capacity of the district to undertake its new roles;
- linking decentralization to community participation;
- linking decentralization to intersectoral coordination;

- fitting decentralized authority into the development of national health planning;
- making provisions to ensure the compatibility of decentralization with the principle of equity (see Collins, 1994).

Some of these components were covered, in some respects, in the Concept Paper. Others, as already pointed out, required further policy analysis and elaboration.

Purchaser–provider separation and contracting

Purchaser–provider separation and contracting were key components of the Concept Paper. Although these two measures are often associated with ‘managed competition’, this would not appear to be the intention in the Punjab, at least in terms of organizational competition.[¶] There are, however, issues that make the nature of the contracting, as proposed by the Concept Paper, difficult to determine. In one sense, it was intra-organizational contracting between one purchaser (DoH) and the DHGs (DMC through the CE). On the other hand, they also appeared to be staff performance related contracts of employment involving the employer (DoH) and the CE. This mixing of purchaser/provider contracts with employment contracts would appear to occur whereby the DHG in turn fell into performance linked contracts with the providers—the MS DHQ and the DHO. Should this be the case then there were legal and administrative processes to determine and questions around the degree of transparency in the contracts.

The government sought to move forward in this area through the development of service level agreements. The specific interpretation of these agreements would appear to follow the definition presented by Nouri *et al.* (1998, p. 97) which sees them as identifying ‘... service specification to be provided at specific price, level at which service will be provided and mechanisms for charging for services, amending, dealing with disagreements and for terminating the agreement.’ Formats for the agreements were developed within government whereby the ‘Provider’ agreed to provide the health services to the public as outlined in a further document entitled ‘Exhibit-A’, while the ‘Purchaser’ agrees to provide the guidelines or templates as set out in a document ‘Exhibit-B’ for further development by the DMC as its rules of business. Lastly, a document ‘Exhibit-C’ set the indicators for use in ‘Third Party Evaluation’.

The introduction of purchaser–provider separation and contracts/agreements involves potentially complex problems. Whether the development of the system of service level agreements would have reproduced these problems remains to be seen. Contracting, for example, can introduce an element of formality and rigidity into the system and can lead to transaction costs that question the very objective of efficiency. It also separates policy-making from information gained in the very process of service delivery (Stewart, 1993). These problems should not be easily dismissed, but need to be considered in the process of policy analysis. This was not apparent in the Concept Paper. There are further issues for consideration.

[¶]One could infer from the Concept Paper that there was an intention to introduce elements of competition among staff in that they are to be bound by performance related contracts and would lose their employment if they do not perform.

- *Types of health care*—Flynn *et al.* (1996, p. 13) have argued the point (with reference to the UK) that ‘... *comparatively*, acute medical and surgical specialties are *relatively* easier to define, codify and calculate for contracting purposes than those elements of health services which are more continuous and comprise “care” rather than “cure”’. The draft service level agreements (Exhibit A) for the Punjab laid down a package of services including curative, preventive and promotive care to be organized by the provider. More reliance was, however, laid on monitoring by third party evaluators using indicators produced in a separate document (Exhibit C).
- *Planning and information requirements*—The use of contracts assumes that the information is readily available on the health and health care needs of the community together with the quantity and quality of health care required. The contracts also require a definition of ‘quality’ to allow for monitoring. This introduces the issue of who and how will the health and health care needs of the communities be determined and how they can be expressed in a contract. There are a number of considerations here. One would assume that a decentralized system of contracting should exist so that the purchaser is as near as possible to the community and will develop effective channels of community participation to ensure a community based focus to the determination of health needs. These would then be translated into contractual form. The system outlined in the Concept Paper, however, appeared to be a top-down system where the first purchaser is the DoH with a second purchaser then being the Chief Executive. The purchasers were organizationally distant from the communities they were supposed to determine the health needs of. It could be suggested that an effective system of planning and information could have been introduced to overcome this problem. However, there was no or little mention of this in the Concept Paper and it is difficult to see how such a system could be decentralized given the top-down nature of the contracting system.
- *Perverse incentives*—The introduction of a managed market system into the public sector can be associated with ‘perverse incentives’ (Harrison and Lachmann, 1996) such as ‘cost shifting’, ‘gaming’, ‘goal displacement’ and ‘adverse selection’. It is not inconceivable that some or all of these could have been developed into the system of contracting outlined for the Punjab.
- *Efficiency*—We have already seen that contracts are often justified on grounds of productive efficiency. Whether the system of contracts or service level agreements will encourage greater efficiency will depend on a number of issues, including the possible transaction costs. The definition given to efficiency and the impact on social objectives (equity) also has to be considered. We might also ask whether the emphasis on contracts and performance related criteria might lead, in the short term, to the use of temporary, part-time and less skilled staff. This could have well jeopardized the quality of care, the process of career development and the need for long term sustainability in the Punjab. Stewart (1993) has also raised the concern (see above) that contracts can separate the provider unit from the important experience of management learning. The latter comes with being the service provider (Stewart, 1993).
- *Management capacity*—A system of contracting will require new administrative and management structures, systems and skills within the DoH, including the

districts. Our understanding of the DOHs in Pakistan are that these were not present and would have had to be developed.

- *Responsiveness*—The health care system in Pakistan has tended to be politically, professionally and bureaucratically driven. It could be argued that a purchaser–provider separation could increase accountability and responsiveness in making more transparent and open the relations within the system. Staff and units would be held accountable for their performance within the system. It is noticeable, however, that the Concept Paper made little reference to community accountability.

CONCLUSIONS

This paper has focused on policy processes leading to health sector decentralization in the Punjab. While not wishing to pass judgement on the substantive policy of decentralization itself, the paper has raised concern over the policy process leading to the DHG reform. Four critical issues have been raised: the need to build on experiences and learning lessons from pilot projects; the importance of reform continuity in terms of substantive policies and staff stability; the need to develop consultation and involvement; and promoting the conduct of robust policy analysis. Yet decentralization is a complex and problematic process shrouded in a wave of popularity. There is a need to develop policy processes to ensure that the pernicious features of ineffective health sector decentralization do not spread. This paper has focused on three such key themes relevant to the case of the Punjab: the central organization of the DoH, the form of decentralization, and the purchaser–provider separation together with the form of contracting. Reference to these three items of the reform has served to emphasize the importance of policy analysis of health sector reform.

The analysis of the policy process leading to decentralization in the Punjab signals two key features. On the one hand, the introduction and implementation of reform is a political process operating in an unstable political environment. Effective policy implementation requires the capacity to understand and take decisions within this complex political environment. Alongside this political environment is the technical need for in-depth policy analysis in which the appropriateness of and the conditions for policy effectiveness are assessed. The development of health care decentralization in the Punjab signals the difficulty of ensuring that political strategy and in-depth policy analysed are effectively developed and synchronized in the process of change. The sustained and long term strengthening of the capacity for policy analysis in the Department of Health is a prerequisite for the formulation and implementation of effective health sector reform in the Punjab.

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