

Encourage Public Pvt. Partnership For Improved Service Delivery



A Report on Third tranche action E.i &ii

- i) Authorize HMCs to Collect, Retain and Use User Charges
- ii) Majority of DGs Provide Financial Assistance to HMCs

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Policy Area: E. Encourage Public-Private Partnership For Improved Service Delivery

Background

The problem of financing health care in Sindh has been receiving increased attention. It is agreed fact that the resources devoted to health services are insufficient to provide free medical care to all segments of population considering the current economic problem. It is unrealistic however, to expect that the government's spending for health care will increase substantially over the next few years to the extent that it would cover all vulnerable groups. Ultimately some other alternatives will have also kept either under consideration or in operation that could be cost effective and affordable for the poor people living in rural areas and urban slums.

Preventive and curative health services can make a substantial difference to peoples' health, and health improvements can, in turn, provide poor households with the opportunity to escape from poverty. However, physical, cultural and financial barriers can reduce accessibility of health care, even where services exist. *User fees for such items as consultations, investigations, hospitalization and medication, prevalent in almost all low-income countries.*

Likewise in Sindh User fees have been collected and used to raise additional funds for government services. The Incharge of Hospitals at various levels of health facilities have been allowed to retain some proportion of the revenue raised to finance improvements of physical infrastructure; provide incentives to staff or purchase pharmaceuticals. Whereas, remaining amount was deposited in the government account as receipt. This practice is in vogue since last one decade or more. However, an attempt was made in early 90's to create hospital management committees to introduce most efficient and transparent utilization of funds for benefit of that particular facility and people using those services. Some how that initiative could not sustain but the collection and utilization of fees continued with local arrangement of hospital administration.

SDSSP Objectives

The overall goal of the DSSP is to improve people's education, health and access to water and sanitation, and thus help reduce poverty and gender imbalances. The Program has five principal policy outcomes: (i) further devolve social services to LGs, (ii) improve social sector financing and flow of funds, (iii) promote participation, linkages, and public accountability, (iv) rationalize services and set minimum standards, and (v) encourage public-private partnership.

This program aims to support financing, capacity building, partnership building and reforming of Sindh's devolved social services at the District level in Education and Health, and in Water Supply and Sanitation Sector at Town/Taluka Municipal Administration (TMAs) level. The total amount provided under this program is to be

disbursed in three years. Program support will comprise a conditional block grant support to LGs to undertake social sector development according to local priorities within the defined program scope.

Under SDSSP one of the key areas for improvement of health service delivery is the formation and strengthening of Health boards/health management committees (HMCs). It was conceived through policy matrix that establishment of independent, self-sufficient and accountable HMCs will ultimately improve the health service delivery. Further, through involvement of community in the service delivery mechanism it is assumed that their role will i) make them responsible for management; ii) involve them in the decision making process; and iii) ensure accountability through the society.

Third Tranche Action E.i

Under policy objective E Sindh has agreed to Encourage Public-Private Partnership (PPP) to Improve Service Delivery in social sector. As mentioned above PPP has various levels of understanding and operation with the basic founding objective to improve social service delivery.

The third tranche action E.i specifically provides that “Sindh shall have authorized health boards to collect, retain and use fees and user charges”.

Whereas, E. ii provides that Majority of DGs shall have provided financial assistance to health boards on a pilot basis

It is pertinent to point out that during the discussion with Review Mission on 2nd January 2006, it was agreed that the definition of Health Boards would be broadened and then would now be called as *Hospital Management Committees*.

The purpose of this report is to provide the update on above agreed tranche actions.

Steps

To achieve this objective various policy decisions were taken, that required involvement of Provincial Finance department, Health Department and District Government. Following major steps were taken to achieve the ultimate objective of this Tranche condition:

- 1) Devolution of User Charges
- 2) Policy decision on Establishment of HMCs.
- 3) Establishment of HMCs at district and Taluka hospitals.
- 4) Financial assistance to Hospital Management Committees by districts.
- 5) Authorization of HMCs to collect, retain and use user charges.

Devolution Of User Charges

During interaction with district governments at different levels it was noted that even after devolution the user fees collected at various health facilities is retained at two levels a) Part of the user fees collected was deposited in the account of provincial government and b) remaining amount was retained by hospital administration.

Under SDSSP, this matter was taken up with Finance Department that user charges should be devolved from province to districts in line with the spirit of SLGO. In this regard instructions were issued to relevant Provincial Line Departments allowing them to devolve user fees (Annex-I). Accordingly, Health department conveyed the direction to all districts (Annex-II), and finance department notified the devolution of user charges from Provincial Account I to Account IV (Annex-III).

Establishment of HMCs

It must be acknowledged that Health Department had already provided administrative as well financial autonomy to all teaching hospitals by establishing health boards. Under SDSSP policy reform initiative the scope of hospital autonomy was further broadened at District and Taluka Hospital level by establishing the Hospital Management Committees. Accordingly guidelines were prepared and disseminated to districts covering 1) Criteria of membership and 2) Terms of Reference of Committees etc. (Annex-IV).

Formation of Committees at Health facilities

This was one of the gigantic exercises undertaken at district level and Local support units of SDSSP have all the credit to undertake this whole exercise. Despite of the commitment and motivation 100% result is yet to be achieved, however, the level of compliance is encouraging and except three districts, others have not only constituted HMCs but also opened bank accounts and majority have provided reasonable financial assistance. According to the detailed information out of 23 districts 20 districts have constituted HMCs making 87% compliance level. Furthermore, total 65 HMCs are constituted at DHQ and THQ level, of which 19 are at DHQ level and 46 at THQ level.

Detailed summary of these committees, their account numbers and balance available is placed at (Annex-V). The supporting documents of the notifications are also placed at (Annex-VI).

Providing Financial Assistance to Districts

As mentioned above this initiative is still in primitive phase of formulation of HMCs their full activation and support will obviously require due course and time. Nevertheless, the commitment of district governments is evident that 14 districts have provided financial assistance to HMCs. In absolute terms out of 65 HMCs formulated so far 28 HMCs are supported.

Besides this, all districts have also allocated some amount from the 15% SDSSP grant available for CBOs the details are shown below whereas; documentary evidence is available at (Annex-3&4 of report on E.ii).

CBO FUNDS ALLOCATION BY DGs											
S. No.	District	2005-06				2006-07				Letter Ref. No	Date
		Total	15% for CBOs	HMCs	% of CBO funds	Total	25 % for CBOs	HMCs	% of CBO funds		
Amount in Rs.											
1	Badin	64,335,259	9,650,289	1,000,000	10%	71,825,122	17,956,281	1,000,000	6%	EDO/F&P/121/2006	June 17, 2006
2	Dadu	43,911,174	6,586,676	329,338	5%	44,029,724	11,007,431	5,503,715	50%	EDO/F&P/DDU/2006	June 10, 2006
3	Ghotki	53,757,059	8,063,559	4,640,000	58%	58,546,167	14,636,542		0%	415	June 21, 2006
4	Hyderabad	43,542,084	6,531,313	327,000	5%	41,037,765	10,259,441	769,000	7%	F-EDO (F&P)/2004/2295	June 19, 2006
5	Jacobabad	34,308,997	5,146,350	3,808,299	74%	33,572,047	8,393,012	6,210,829	74%	498	June 13, 2006
6	Jamshoro	32,504,116	4,875,617	-	0%	32,276,998	8,069,250		0%	EDO (F&P)/836/2006	June 15, 2006
7	Karachi	224,449,086	33,667,363	1,625,206	5%	229,004,200	57,251,050	3,227,700	6%	EDO (F&P) CDGK/-/2005	June 23, 2006
8	Kashmore	33,048,915	4,957,337	2,900,000	58%	32,273,781	8,068,445	4,000,000	50%		June 22, 2006
9	Khairpur	67,175,383	10,076,307	6,146,000	61%	72,606,312	18,151,578	10,890,000	60%	EDO (F&P)/khp/636/2006	June 13, 2006
10	Larkana	36,963,290	5,544,494	-	0%	35,218,563	8,804,641	-	0%	SDSS-6/2006/2	June 24, 2006
11	Matiali	23,016,013	3,452,402	345,240	10%	19,889,692	4,972,423	845,312	17%	EDO (F&P)/M/(66)/2005/409/2005	June 15, 2006
12	Mirpurkhas	39,185,253	5,877,788	2,900,000	49%	39,068,138	9,767,034	4,800,000	49%	EDO/F&P/M/620/2006	June 15, 2006
13	Naushehro Feroze	46,683,743	7,002,561	2,002,561	29%	47,941,001	11,985,250	1,985,250	17%	EDO (F&P)/NF/476/2006	June 15, 2006
14	Nawabshah	53,735,823	8,060,373	4,594,413	57%	57,765,366	14,441,342	8,231,565	57%	EDO/F&P/NWS/748/2006	May 3, 2006
15	Sanghar	61,596,490	9,239,474	7,200,000	78%	65,648,454	16,412,114		0%	EDO/F&P/SGR/475/2005	May 31, 2006
16	Shahdadkot	35,132,855	5,269,928	5,269,928	100%	33,332,661	8,333,165	8,333,165	100%	SDSS-6/2006/2	June 8, 2006

17	Shikarpur	47,768,763	7,165,315	2,000,000	28%	51,003,120	12,750,780	4,000,000	31%	F&P/SHP/ 732/2005- 06	June 15, 2006
18	Sukkur	46,647,382	6,997,107	9,329,476	133%	49,257,647	12,314,412	12,314,412	100%	EDO/F&P /842/2005	June 13, 2006
19	Tando Allahyar	22,332,916	3,349,937	3,349,937	100%	19,185,895	4,796,474	4,796,474	100%	291	June 8, 2006
20	Tando Muhamma d Khan	22,843,581	3,426,537	2,000,000	58%	19,712,034	4,928,009	2,900,000	59%	EDO/F&P /TMK/762 /2006	June 9, 2006
21	Tharparkar	58,179,340	8,726,901	4,200,000	48%	65,076,752	16,269,188	8,100,000	50%	EDO/F&P /452/2006	June 10, 2006
22	Thatta	68,605,466	10,290,820	-	0%	77,899,216	19,474,804		0%	461	June 12, 2006
23	Umerkot	34,038,813	5,105,822	-	0%	33,765,745	8,441,436		0%	DCO/F&P /UK/184	June 13, 2006
	Total	1,193,761,800	179,064,270	63,967,398	36%	1,229,936,400	307,484,100	87,907,421	29%		

Authorization of HMCs to collect, retain and use user charges

Utilization of user charges is function of respective district governments through HMCs as outlined in guidelines of Health Department. Therefore, after devolution of user charges to Account IV, it was essential to provide legal authorization to these HMCs to collect, retain and utilize funds in their respective accounts. Accordingly, Finance department Government of Sindh has issued such advise to all districts allowing all DCOs to further authorize HMCs to collect, retain and use user charges (Annex-VII).

Challenges

Undoubtedly, this initiative is a beginning towards autonomy of hospital management and encouraging the role of community in improving service delivery mechanism and accountability of public funds. However, there are certain areas where careful attention is required including sustainability of fund flow, proper accounting and auditing and capacity of committee members in managerial and financial skills.

Conclusion

Establishment of HMCs is very bold and commendable initiative towards autonomy of hospitals and acknowledging the role of community and elected representative in the affairs of planning and management of hospital affairs. This step conjoined with investment through SDSSP, is expected to improve the dilapidated condition of public hospitals and ensure availability of staff and logistics necessary for service delivery.