

Review Article

The Healthcare Reforms Process

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Abstract

All stakeholders agree on the need for reform of the healthcare system in Pakistan. This article describes the process of healthcare reform in the Khyber Pakhtunkhwa province of Pakistan from 2013-2018, the numerous challenges this process faced, and continues to face, from a variety of vested interests, including those involved in planning and delivery of healthcare, the judicial system, and from politicians. Progress achieved thus far, and plans for the future, are also discussed. These reforms are to be the basis of a similar process of overhaul of healthcare in the Punjab, and so it is of vital importance that the process be understood, and that a serious effort be made to explain this to as wide an audience as possible. While reform may be implemented in a variety of ways, the struggles of the past five years have shown how working together can ultimately lead to improved healthcare provision for the entire country.

Introduction

The healthcare system in Pakistan is complex, made up as it is of government run systems (both federal and provincial) alongside a significant private sector. Previous attempts at reform within this have usually been both unwelcome and unsuccessful. These include attempts in the Punjab to make medical institutions more autonomous as well as an attempt to establish 'institution-based practice' in the KPK. The Healthcare Reforms Act in 2013 in KPK attempted to restructure government teaching hospitals and to make these institutions more independent, but implementation, against a backdrop of professional and political resistance, coupled with misplaced judicial activism, has been a long and arduous process that has continued to the time of writing. The whole undertaking has served as a lesson in attempting to bring about change in the healthcare service, while also serving to emphasise the criticality of having the right individuals implementing change, and the need to persevere through political pressure and adverse circumstances. Similar reforms are planned to be implemented in the Punjab, with additional focus on primary and secondary healthcare, so as to further improve the value of the change brought about.

Earlier Reforms

Earlier reforms and attempts at decentralisation were carried out in the 1990's in the Punjab. Government medical institutions were made autonomous, but their budgets and financial plans were still controlled by the health and finance ministries, effectively limiting the reforms from having any significant impact. In the early 2000's, consultant physicians at teaching hospitals within the Khyber Pakhtunkhwa province were compelled to commence institution-based private practice. This ultimately led to mass resignations and an exodus of senior physicians, many of whom went on to join the private sector. Paradoxically, growth and strengthening of the private healthcare sector was an unintended consequence of this misguided reform process. From 2013 to 2018, during the first Pakistan Tehreek-e-Insaf provincial government in the KPK, healthcare reforms were attempted again, through the Medical Teaching Institutions Reform Act of 2015. Thus began a long and arduous process of resistance, implementation, amendment and re-implementation, with the government, medical teaching institutions and individuals associated therewith all embroiled in seemingly never-ending legal battles in the courts of the KPK.

The Healthcare Reforms Act In Khyber Pakhtunkhwa

This act was intended to enhance performance, effectiveness and efficiency in the major government teaching institutions, and their affiliated teaching hospitals, in the KPK, and thereby ultimately provide quality healthcare services to the population. Initially four major institutions were granted autonomy and changes were made to their administrative structure. The four institutions were:

- 1) Khyber Medical Teaching Hospital and Complex in Peshawar
- 2) Lady Reading Teaching Hospital in Peshawar
- 3) Hayatabad Medical Hospital and Complex in Peshawar
- 4) Ayub Medical College and Teaching Hospital Complex in Abbotabad

For each institution, a board of governors was established to run the institution. This board ensured that the institutions' objectives were fulfilled, the government's minimum service delivery standards were met and that organisational performance was monitored. They oversaw the formulation of institutional regulations, by-laws, the mission statement and strategic plan, policy making and processes for staff appointment. The boards also approved the budget and the annual financial plan, and provided governance oversight of all major transactions, new programmes and services. The board had the power to form executive and other committees for these purposes; for example, for recruitment or for finance.

A dean was appointed for each medical school, together with a hospital director (HD), taking over the role of the medical superintendent, and a nursing director taking over the role of the nursing superintendent. The dean, following a further amendment to the Act in 2018, is now also the chief executive of the institution, thus ensuring a unified chain of command. A new position, that of a 'medical director', was introduced to supervise the clinical aspects of administration. The medical director's role was, and remains, to oversee the provision of clinical excellence and ensured that quality standards were maintained, ensuring timely and appropriate management of all patients and the best possible clinical outcomes. The medical director was also responsible for assessing and auditing existing clinical programmes and for developing new ones. Finally, the medical director develops the annual clinical budget for presentation to the Dean and thence to the board, ensuring particularly that medical staff input is sought and incorporated into all major medical equipment requests.

The hospital director's role, on the other hand, is to focus on the everyday running of the hospital and the non-clinical and administrative functions of the institution, including building maintenance, utilities, security, housekeeping, CSSD, laundry, dietary services, information systems and so forth. The HD ensures board targets are met, policies are implemented, and that the facility runs optimally. The hospital director prepares the annual budget for the Hospital to present to the Dean and to the board.

The first amendment in the healthcare reforms act removed all civil servants from the board, leaving behind health professionals, members of the public, lawyers and businessmen. These varying perspectives, together with the inevitable learning curve, resulted in boards taking some time to settle in and to establish their authority, and in some misplaced and erroneous decision-making, early on. The second amendment was mainly procedural.

The Shaukat Khanum healthcare system generously donated its electronic health information system, completely free of charge, to all four institutions, and also provided free implementation and training in its use. This allowed for streamlining of registration, electronic prescribing and real-time access to laboratory results. A terminal was placed in each ward to give staff access to patients' laboratory test results. A patient bed management system was also set up.

There was significant incredulity and resistance in response to the formulation of the governing boards and gradually the discontented parties coalesced in their opposition to the reforms process; this included doctors, nurses, faculty and paramedical staff. There was also disagreement as to the role of the boards, which were clearly intended, by the Act, to be governing, and not managing, boards. The institutions in question had previously had much more managerial support and guidance from the government. Indeed, the level of such control had been so stifling as to completely snuff out any initiative or impetus for change in these institutions. Not surprisingly, even within the governing boards, some felt that they ought to play a greater part in direct management. Finally, even some employees found themselves nostalgic about the system prior to the reforms.

Political interference in the reforms process began almost immediately after the Act was initially passed. Some politicians saw the gift of patronage being wrested from their grasp. While a few went so far as to attempt to sit in on board meetings, many others tried repeatedly to apply pressure to appoint specific people for many varied roles within the institution. It was only continued and sustained resistance by some within each board, supported fully by

senior political leadership, which prevented these individuals from over-running the nascent boards completely. Similar influences affected the process of promotions, with much of the opposition being guided and aided by the civil bureaucracy, which had, until now, been heavily involved in running these institutions, and who were extremely hesitant to disengage and to give up the untrammelled power they had until now enjoyed. A major clash with the government occurred over an empty and unfinished maternal and child health building in Abbottabad. This building had been built 3 years prior to the constitution of the board, and left unfinished when a provincial inspection team had declared it to be mired in corruption and commenced a series of ineffectual and inconclusive enquiries into various aspects of its construction and commissioning. Quite amazingly, the provincial government attempted to shift responsibility for investigating and adjudicating upon this matter to the new Board of Governors, when whatever corruption which had or had not occurred had happened long before the current reforms process began, and well before the Board came into being. Despite threats of arrest and termination, the Board of Governors decided that they would not succumb to this pressure and went ahead with the commissioning of the building, which finally opened to patients in 2018.

Courts

Soon after the Healthcare Reform Act was passed, the courts in the KPK began issuing stay orders, initially against the act itself and subsequently against the formation and convening of the board of governors as well against individual decisions by the boards. This led to stagnation in the reforms process and thoughts of ending the reforms process in 2014. However, in 2015, all cases against these medical teaching institutions were finally clubbed together, and were heard, and dismissed, by the Chief Justice of the Peshawar High Court.

With the formation of an interim government in KPK, prior to the 2018 elections, all the boards of governors were summarily dissolved, and inquiries were commenced into all the changes brought about thus far. Some attempts were also made to undo reforms in certain areas, however this was short-lived and eventually new boards, with many of the original members being reinstated, were formed in September 2018, a sign that the reforms were here to stay.

Following on from this, the civil courts and the Peshawar High Court began issuing stay orders once again; the latest being against acting deans and acting directors appointing departmental chairs, for example.

Lessons

The lessons learnt during the whole process included the importance of bringing the right people (those committed to the reforms) on board especially for the roles of the directors within the hospital. While perseverance was obviously key, throughout this process, the importance of starting low-cost and high-impact initiatives, which are obviously appealing to consumers (and to politicians!) was another lesson learnt early on.

Plans For Reform In Punjab

In the Punjab, a similar Medical Teaching Institution Act will allow medical schools and their affiliated hospitals to function autonomously, with one-line budgets, allowing them to spend according to their priorities and requirements. The process will allow faculty to retain their accrued benefits and to opt in or out of becoming institutional employees. Alongside this, primary and secondary healthcare reforms will set targets, monitor implementation and ensure appropriate referrals to tertiary healthcare. district health authorities will have individual CEO's, to whom a medical director, hospital director and nursing director will report. Between three and five district health authorities will report to a single regional health authority with a total of nine RHA's envisaged. Efforts to pass such legislation are currently underway, and are proving harder to bring to fruition than was originally thought!

Conclusion

The healthcare reforms process in the Khyber Pakhtunkhwa province demonstrates sincerity and determination to bring about change for the better. While the reforms themselves could have arguably been different or improved upon, they showed how working together can ultimately lead to improved healthcare provision for the entire country.

Reference

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