

Session 6

Health Care for the Poor in Asia

- ▶ Health Care for the Poor in India with Special Reference to Punjab State

B.S. GHUMAN and AKSHAT MEHTA

- ▶ Health Care for the Poor and the Millennium Development Goals: A Case Study of Pakistan

SARFRAZ H. KHAWAJA

- ▶ Opportunities and Challenges in Local Governance of Public Health

VICTORIA A. BAUTISTA

- ▶ Building the Public Health Emergency Management System of the People's Republic of China

MENGZHONG ZHANG



NAPSIPAG



Health Care for the Poor in India with Special Reference to Punjab State

B. S. Ghuman¹

Akshat Mehta²

Introduction

The economic and social development of a country depends on the quality of its human resources, and the quality of human resources, in turn, depends on the quality of education and health services. Health, like education, is a “merit good,” which, if left to individuals, is generally under-consumed. This is so especially among the poor who have meager resources. Merit goods also have benefits that are not confined to the individuals who pay for it; the society at large also benefits. Health care being a merit good, private markets may restrict access. In India, the provision of health care is marred by class inequalities, the denial of opportunities to disadvantaged groups, low accessibility to the lower classes of society, and rampant corruption. The same trend is noticeable in Punjab (Government of Punjab 2004). Government must either provide health-care services or regulate their provision by the private sector to ensure equitable access particularly for the poor (Walsh 1997).

At present, there are three health-care policy initiatives for the poor: (i) exemption from the user fee in government hospitals; (ii) free treatment in private super-specialty hospitals (within a defined proportion of total patients); and (iii) health insurance.

This paper examines health care for the poor in India, particularly in the state of Punjab.

Methodology

The study used both primary and secondary data. The secondary data came from various government and private sector reports. The primary data were collected with the help of a structured questionnaire with five sections: general information about the respondents, awareness of the yellow card (an entitlement card for groups below the poverty line), use of the yellow card at government and private hospitals, level of satisfaction with health-care services,

¹ Professor and Chairperson, Department of Public Administration, Panjab University, Chandigarh, India.

² Research Fellow, Department of Public Administration, Panjab University, Chandigarh, India.

and health insurance. The questionnaire was pretested before it was finalized. Copies of the final questionnaire were given to 100 respondents, mainly residents of Mundi Kharar village in the Kharar development block of Ropar district in Punjab state. All the respondents belonged to the scheduled caste, the lowest class of society. In Punjab, as in the rest of the country, most of the poor belong to the scheduled caste. Data were also collected through observation, to supplement the information obtained through the questionnaire. The data were analyzed through simple techniques like percentages and averages.

Resource Allocation to Health Sector and Inequity in Health Services

The Indian economy has been growing at a rate of 5% since the mid-1980s, barring a few years of economic crisis. The benefits of economic growth, however, have not percolated to the social sector. The health sector—a major part of the social sector—instead of gaining has suffered on account of the allocation of funds during the period of high growth. Public expenditure on health was 3.12% of total government expenditure during the first year of economic liberalization (1992–1993) and declined to 2.99% in 2003–2004 (see Table 1). The combined expenditure on health as a percentage of gross domestic product (GDP) follows the same trend, according to Table 1: from 1.01% in 1992–1993, it went down to 0.99% in 2003–2004.

Table 1: Public Expenditures on Health, Disaggregated

Year	% of Total Government Expenditure			% of GDP		
	States	Center	Total	States	Center	Total
1992–1993	4.96	1.31	3.12	0.79	0.22	1.01
1993–1994	5.16	1.49	3.28	0.81	0.25	1.05
1994–1995	4.85	1.62	3.26	0.77	0.25	1.01
1995–1996	4.98	1.78	3.39	0.75	0.26	1.00
1996–1997	4.85	1.50	3.21	0.72	0.21	0.93
1997–1998	4.94	1.55	3.32	0.74	0.21	0.95
1998–1999	4.98	1.58	3.33	0.76	0.23	0.99
1999–2000	4.80	1.75	3.34	0.78	0.26	1.04
2000–2001	4.65	1.87	3.33	0.77	0.28	1.05
2001–2002	4.41	1.99	3.25	0.73	0.30	1.03
2002–2003	4.27	1.67	3.06	0.77	0.26	1.03
2003–2004	4.12	1.69	2.99	0.73	0.26	0.99

Source: National Accounts Statistics, 2004, Table SI.1, pages 196–197, cited in Planning Commission, 2005.

NAPSIPAG

Not only has public investment in health been declining, public health benefits have been accruing mainly to those who are better off. Marginalized and socially disadvantaged people have been hit hard (Government of India 2002). By one estimate, the infant mortality rate is 2.5 times higher among the poorest 20% of the society than among the richest 20% (Deogaonkar 2004). Mahal et al. (2002) also found bias in favor of the rich in public policy. According to them, the poorest 20% of the population receive only about 10% of the total net public subsidy. The richest 20%, on the other hand, get around 30% of the subsidy (Planning Commission 2005). The mushrooming of private sector hospitals has further widened the gap between urban and rural areas and between the classes of society. *The Hindu* in its editorial on 5 April 2005 stated:

International studies have shown nearly 80 percent of patients in India resorting to private caregivers for major and minor ailments—despite the existence of a public health system of a sort. Such patronage and steadily increasing demand have resulted in a significant expansion of private hospital bed capacity, although this is concentrated largely in urban India and remains unaffordable to the overwhelming majority of the people. The strong growth of private healthcare has understandably led to the demand for a system of oversight in the interests of equity, credibility, and professional accountability.

The case of Punjab state is not much different. Punjab state is one of the richest states of the Indian Union. Its growth rate (around 5%) was the highest among Indian states for about 30 years, although it has started to decelerate recently. Yet, despite being the richest state in economic development, Punjab lags behind in social development, particularly in health. According to the *Human Development Report 2004* prepared by the Punjab government, public investment in health in Punjab is very low. The lack of investment has affected primary health care the most and is pushing people, particularly the poor, toward expensive and unregulated private sector providers (Government of Punjab 2004). The state budget allocates meager resources to both the primary and secondary health-care sectors. Table 2 shows that the state allocates only around 4% of total expenditure to health. The total expenditure on medical and public health is only 0.79% of the net state domestic product, which is below the average expenditure of 0.99% nationwide.

Table 2: Punjab Government Expenditure on Medical and Public Health

(Rs10 million)

Item	Year	
	2003–2004 (Actual)	2004–2005 (Revised)
Total Expenditure	15,701.92	19,220.07
Expenditure on Medical and Public Health	556.70	704.77
Net State Domestic Product (NSDP)	69,840.82	–
Expenditure on Medical and Public Health as % of Total Expenditure	3.54	3.66
Expenditure on Medical and Public Health as % of NSDP	0.79	–

– = not available

Source: Punjab State Budget for 2005–2006. www.punjabgovt.nic.in.

Exemption from User Fee in Government Hospitals

Since the start of economic liberalization, privatization, and globalization in the 1990s, the Punjab government has introduced two drastic reforms in health policy. First, it set up the Punjab Health Systems Corporation (PHSC) in October 1995, under the World Bank-sponsored State Health Systems Development Project II, and transferred more than 150 health-care institutions run by the government to PHSC. To mobilize more resources, the hospitals no longer provide free services and instead charge all patients a user fee, barring a few categories of patients including people below the poverty line.

The second policy decision is the significant opening up of health-care services to the private corporate sector. Private sector hospitals have been getting land and facilities at subsidized rates and are expected in return to provide free treatment to yellow card holders (people below the poverty line)—up to 10% of outpatients and 5% of inpatients. Each year these hospitals are required to provide the details of their yellow card holder patients to the Punjab Urban Development Authority (PUDA), the organization that allotted land to these hospitals at subsidized rates.

In government hospitals, under the new policy, the poor are exempt from user charges, as stated earlier. However, the outcome is far from the rhetoric.

Primary data show that only a negligible proportion of people below the poverty line avail themselves of exemptions from user charges at government hospitals. According to Table 3, the yellow card holders treated free of cost make up only 0.4% of the patients treated in the outpatient department of the Kharar civil hospital in Punjab in 2002–2003, and the proportion further

NAPSIPAG

Table 3: Treatment of Patients in the Outpatient Department of Civil Hospital Kharar, Ropar District, Punjab

Time Period	Yellow Card Holders Treated	Total Patients Treated	% of Yellow Card Holders to Total Patients Treated
Sept 2002–Sept 2003	321	80,109	0.4
Sept 2003–Sept 2004	18	78,107	0.02
Sept 2004–Sept 2005	7	79,553	0.008

Source: Health Management Information System, Civil Hospital, Kharar, Punjab.

declined to a negligible 0.008% in 2004–2005. In the district hospital of Ropar, of the 148,300 patients in 2004–2005, only four were yellow card holders.

According to the field survey, two main factors—ignorance among the poor about the free treatment, and the complex and cumbersome procedure for getting and renewing the yellow cards—are constraining the access of the poor to public health-care services.

Around 58% of the survey respondents were yellow card holders at some point. Seventy-five percent of the respondents were not aware that a yellow card holder is exempted from user fees at government hospitals. As many as 43% of the respondents faced renewal problems and 32% said that they had encountered procedural problems while obtaining the yellow card. The overwhelming majority of the respondents, 84%, were illiterate. As a result, 37% of the respondents were not aware of the procedure for getting a yellow card and 31% did not apply to get one. While applying for a yellow card, 77% respondents had loan benefits in mind and only 7% were aware of the health benefits.

Of those who were aware of the user-fee benefits of the yellow card in government hospitals, only 8% used this facility. X-rays, medicines, and treatment were made available to them at concessional rates or free of charge. But even with the benefits, the out-of-pocket expenses were quite high, at around Rs500 per case on average.

Getting health-care benefits with the yellow cards is not easy. About 10% of the respondents found it difficult to get yellow-card benefits at government hospitals. The hospital staff were uncooperative and insensitive. The waiting list was long, so the card holders had to visit repeatedly to get the benefits. Others were told to pay for the services instead.

Lack of adequate health services from the government compels the poor to depend mainly on their own resources for health care. On average, poor households spend Rs428 per month on health care, or about 25% of their

NAPSIPAG

mean household income (Rs1,730). Among poor families the elderly suffer most from the lack of resources for health care. All survey respondents said that old people had to make a sacrifice because of low income. Children, followed by young people, get preference in health-care expenditure. Interestingly enough, among the poor there is no gender bias in getting medical treatment for family members.

In the absence of adequate opportunities from the government for health care, the poor in Punjab depend largely on the unorganized private sector (Gupta 2002). About 90% of the respondents preferred private hospitals because they get proper attention and immediate relief, and so they save time. Time saving is the major consideration, as the opportunity cost in the form of lost wages is high. But the private sector in Punjab is dominated by quacks. Eighty-nine percent of the respondents use the services of quacks, traditionally known as *dais*, for childbirth. Only when the *dais* cannot handle a case or complications develop are the patients taken to the government hospitals. *Dais* are preferred because their services are cheaper and more accessible. According to a recent report, three children died while two other children and one man were taken seriously ill within minutes of taking medicines given by quacks in Ludhiana. Such cases are not uncommon in Punjab (*Hindustan Times* 2005b).

Private Super-specialty Hospitals and the Poor

As mentioned earlier, the second policy decision was to open up health-care services in a major way to the private sector.

Unfortunately, the benefits of this policy decision have not percolated down to the poor. In one very prestigious private hospital, not a single poor patient received free treatment, against the targets of 10% for outpatients and 5% for inpatients. The PUDA so far has not received the required list of poor patients from any of the private hospitals in the state. The elite orientation of management, lack of awareness among the poor about free treatment in private hospitals, and ineffective regulatory mechanisms are the major hindrances to free treatment for the poor in private hospitals.

The field survey revealed that 99% of the respondents had not even heard about the user-fee benefits of yellow card holders at private super-specialty hospitals. Not only were the respondents unaware of any such facility but they simply could not imagine that the private sector, motivated solely by profit, could offer services for free. Only 1% of the respondents had approached a private sector super-specialty hospital. They said that the staff were nonsupportive because of their profit orientation and added that such hospitals do not pay attention to poor patients.

NAPSIPAG

But it is not only in Punjab where the poor have not gotten free treatment at the super-speciality private hospitals. Two public interest litigations (PILs) have been filed in Delhi High Court and in Bombay High Court against corporate hospitals for not providing free treatment to the poor. According to the PIL in Delhi High Court, the Delhi Development Authority provided land at concessional rates to 12 private hospitals, yet none of these hospitals provides free treatment to the deserving poor; but then nor do the 70 others in Bombay that have been similarly favored (Thomas 2005, *The Tribune* 1999). On the other hand, there have been reported cases of the nonpoor being classed as poor and given free treatment (*The Tribune* 1999). A recent study by the Planning Commission also says that the bulk of private health-care units in India are run by doctors and doctor-entrepreneurs and are unregulated in terms of adequacy of facility or competence, standards of quality, and accountability. Also, as a follow-up to the National Health Policy 2002, private hospitals were given concessional lands, customs exemption, and liberal tax benefits against a commitment to reserve beds for poor patients for free treatment. Unfortunately, as no procedure to monitor this exists and the disclosure systems are far from transparent, redress of patient grievances is poor (Neogi 2005). Adenwalla (2005), while making similar observations, noted: "The administrators in most private sector hospitals and medical colleges are essentially businessmen. They have reduced medical care to the level of an industry. The poor man, unless he is willing to incur enormous debts, is unceremoniously elbowed out of these institutions" (also see Praveenlal et al. 2005). The Prime Minister of India, while inaugurating a private sector multi-specialty hospital in Punjab recently, reiterated the Government's view that the benefits of these institutions must reach the poor (*Hindustan Times* 2005a).

Health Insurance and the Poor

Health insurance is another means of improving the access of the poor to health-care services, as was also underlined by the Prime Minister of India (*Hindustan Times* 2005a). In India, public sector insurance companies, nongovernment organizations (NGOs), and community-based organizations offer a host of insurance schemes for the poor. Two prominent schemes introduced by public insurance companies are *Jan Arogya* (an insurance policy designed for the poor with a view to protect them from high costs of hospitalization) and the Universal Health Insurance Scheme. The NGOs have around 26 insurance schemes for the poor. But all these schemes have not achieved their objective of helping the poor when they fall sick. For example, Bennett, Creese, and Monasch (1998), while reviewing the community-based insurance schemes, expressed the view that most of the schemes are poorly

NAPSIPAG

designed and mismanaged, and fail to reach the poorest of the poor. Their membership is not widely spread over the poor population, and these schemes also need extensive financial support (World Health Organization 2004). In Punjab, health insurance for the poor is in a grim situation. The insurance companies have not launched any comprehensive awareness and marketing strategies for the schemes, and thus the poor fail to take advantage. For example, the field survey showed that none of the respondents had even heard of health insurance policies for the poor, as nobody had told them; illiteracy also restricted their access to the policies. Though most of the respondents showed keen interest in the scheme, they did not know which agency to contact or what to do.

Conclusion and Policy Implications

In India, the social sector in general and the health sector in particular have been the loser on account of poor resource allocation during the post-liberalization and globalization phase. In the first year of liberalization (1992–1993), the combined expenditure of the central and state governments on health was 1.01% of gross domestic product. This declined to 0.99% in 2003–2004. A similar trend was noticeable in Punjab state. The meager allocations to the health sector have affected the poorer members of society more.

Punjab health policy has undergone two major reforms in the post-liberalization phase. First, the government set up the Punjab Health Systems Corporation (PHSC) in October 1995, under the World Bank-sponsored State Health Systems Development Project II, and transferred more than 150 health-care institutions run by the government to PHSC. To raise resources, the earlier practice of free services was discarded; instead the user fee was applied to all patients except for a few categories, including people below the poverty line. The second major reform was the opening up of health-care services to the private sector. Under this policy, private sector hospitals get land and facilities at subsidized rates from the government in return for free treatment for yellow card holders.

The data gathered from both secondary and primary sources suggest that the promised free treatment for the poor has not materialized. Two main factors—lack of awareness of the benefit among the poor and the bureaucratic procedures involved in getting and renewing the yellow cards—are holding back the poor from access to free health-care services.

Without adequate access to government hospitals, the poor depend mainly on the unorganized private sector for health care, a sector unfortunately dominated by untrained doctors or quacks. The poor, as a result, have to spend around one fourth of their income on health care.

NAPSIPAG

The benefits of super-specialty hospitals have not reached the poor at all. Factors such as the elite orientation of management, the lack of awareness among the poor about free treatment, and ineffective regulatory mechanisms are the major stumbling blocks.

The government and NGOs have announced many health insurance policies for the poor. Here the outcome is again unsatisfactory. Poor design and management of the policies, narrow coverage, and inadequacy of funds explain the unsatisfactory progress of insurance policies for the poor.

On the basis of this analysis, the study suggests the following ways of improving the access of the poor to health-care services in India in general and in Punjab in particular.

First, the national and state governments should allocate more resources to health care and achieve the target of 6% set by the National Health Policy 2002. Further, within the health sector, allocations for primary health care should progressively increase, as the poor are the major beneficiaries of primary health care services.

Second, the government and NGOs should launch a campaign to make the poor more aware of the exemption from user charges in government hospitals and super-specialty private hospitals. The government should make it mandatory for both public and private hospitals to prominently display on their premises information on the exemption.

Third, the procedure for getting and renewing the yellow card should be simplified and made more transparent and time-bound. In the light of decentralization initiatives (the 73rd and 74th constitutional amendments) to empower rural and urban locally elected bodies, the authority to issue yellow cards should be transferred to local governments.

Fourth, the government should make it mandatory for super-specialty hospitals to meet their targets for poor patients. The hospitals should regularly submit data regarding poor patients served to PUDA, and if they fail to do that, they should be heavily penalized.

Fifth, the poor should be widely informed through locally elected bodies and civil society organizations about the health insurance plans for them. The participation of the poor in the design, management, and implementation of such plans should be solicited.

Sixth, to make the delivery of health-care services pro-poor, a more vigilant, transparent, and regulatory regime is all the more necessary. Information about the regulatory authorities, particularly the nodal officer's name and phone number, should be displayed prominently in each hospital, so that the poor patients can easily contact the officer if the hospital refuses to serve them.

References

- Adenwalla, H. S. 2005. Unhealthy Practices in Patient Care. *The Hindu*. 6 November.
- Bennett, S., A. Creese, and R. Monasch. 1998. *Health Insurance Schemes for People outside Formal Sector Employment*. Geneva: World Health Organization.
- Deogaonkar, Milind. 2004. Socio-economic Inequality and Its Effect on Healthcare Delivery in India: Inequality and Healthcare. *Electronic Journal of Sociology*. <http://www.sociology.org/content/vol8.11/deogaonkar.html> (accessed on November 2005).
- EPOS Health Consultants. 2004. State Health Systems Development Project II: Punjab.
- Government of India. 2002. National Health Policy 2002.
- . 2005. National Rural Health Mission (2005–2012).
- Government of Punjab. 2004. *Human Development Report 2004*. New Delhi.
- Gupta, I., and A. Datta. 2003. Inequities in Health and Health Care in India: Can the Poor Hope for a Respite? Institute of Economic Growth, Delhi University.
- Gupta, Vineeta. 2002. Punjab Government Commission for Closure of World Bank–Funded Health Care Project. *PUCL Bulletin*, September.
- Hindustan Times*. 2005. At Apollo, PM Speaks for Punjab's Poor. 24 September.
- . 2005. Quack's Medicine Kills 3. 21 September.
- Mahal, Ajay, Janmejay Singh, Vikram Lamba, Anil Gumber, and V. Selvaraju. 2002. Who Benefits from Public Health Spending in India. National Council for Applied Economic Research, New Delhi.
- Mohanty, Bijoyini. 2004. Governance of Healthcare in Structural Adjustment Era in an Indian State: Orissa. *The Indian Journal of Public Administration* 50(1, January–March): 214–222.
- Multinational Monitor*. 2000. Unhealthy Policies from the World Bank. Vol. 21. 6 June.
- Neogi, Saikat. 2005. Medicine, Miracles and Ethics. *Hindustan Times*, 17 October.
- People's Union for Civil Liberties (PUCL). 2000. WB Funded Punjab Health System Corporation Makes Public Health Costlier. *PUCL Bulletin*.

- Planning Commission. 2002. *Punjab Development Report*.
- _____. 2002. *Tenth Five-Year Plan (2002–07), Volume II*.
- _____. 2005. Mid-Term Appraisal of the Tenth Plan (2002–07).
- Praveenlal, K., N. R. Arun Kishore, K.S. Shaji, and B.K. Ajitha. 2005. Healthcare and User Charges: Study of Thrissur Medical College Hospital. *Economic and Political Weekly* 40(7, February): 15-617.
- Punjab Health Systems Corporation. 2004. *Annual Report 2003–2004*.
- Thomas, Shibu. 2005. No Free Treatment for Poor at Charity Hospitals in City. *Mid-day*, 24 February.
- The Hindu*. 2005. Creating Healthy Hospitals. 5 April.
- The Tribune*. 1999. Free Treatment of Poor. 5 February.
- Walsh, Kieron. 1997. *Public Services and Market Mechanism: Competition, Contracting and the New Management*. Hampshire, England: Macmillan.
- World Health Organization. 2004. Health Insurance in India: Current Scenario. *Regional Overview of Social Health Insurance in South-East Asia*. New Delhi, July.

Health Care for the Poor and the Millennium Development Goals: A Case Study of Pakistan

Sarfraz H. Khawaja¹

Introduction

The development of the social sector of Pakistan in general, and the health sector in particular, has lagged behind and has not gotten the priority it deserves. As a result, the country's Human Development Index is abysmal. The *2004 Human Development Report* of the United Nations Development Programme places Pakistan with nine others at the lowest level of development.

The living standard of the poor has declined steadily over the years, while the gap between the rich and the poor has significantly widened. More than a third of the population lives below the poverty line. Overcrowding, improper ventilation, and poor sanitation make the poor vulnerable to various infectious diseases. Chilling stories of deaths due to slow starvation and malnutrition have become routine. According to the United Nations Population Fund, Pakistan's maternal mortality rate is 300–700 per 100,000 live births, partly because 80% of the 4.5 million births yearly occur at home. The Pakistan report (2003) of the United Nations Children's Education Fund suggests an infant mortality rate of 82 per 1,000 live births—the second highest in South Asia. A major reason for this poor performance is the Government's low spending on health. In 2004-2005, Pakistan spent only 0.6% of its gross development product (GDP) on the sector (Pakistan Economic Survey, 2005, Government of Pakistan, page 151).

This paper analyzes the issues facing the health sector of Pakistan and looks into the possibility of achieving the mid-decade Millennium Development Goals (MDGs) for the country by 2015.

Health-care Facilities in Pakistan

There is a Ministry of Health at the federal level and health departments at provincial levels. The Ministry of Health supervises the overall health delivery system of the country sets health sector policies and reforms. It also has a vast network of hospitals all over the country. However, the major responsibility for providing health services to the general public rests with the provincial health departments.

¹ Chief Instructor/Professor, Civil Services Academy, Walton, Lahore, Pakistan.

The public health delivery system has three tiers: (i) primary health-care facilities, comprising basic health units and rural health centers; (ii) secondary health-care facilities, made up of *tehsil* (subdistrict) and district headquarters hospitals; and (iii) tertiary health-care facilities (teaching hospitals).

Primary Health-care Facilities

Basic Health Units (BHUs). The BHU, with two labor beds and outdoor dispensing facilities, is the health-care facility provided at the level of the union council, the smallest administrative unit (population: 4,000–8,000). The Ministry of Health has made efforts to see that all union councils have at least one BHU each, providing basic curative, preventive, and supportive services. The BHU is staffed with a doctor, a male health technician, a female health technician, a lady health visitor, and other support staff. Every BHU also supervises the activities of 20 outreach lady health workers (LHWs). From 20 to 40 patients visit a BHU a day, on average.

Rural Health Centers (RHCs). The RHC is a better-equipped facility at the town committee level in the districts and has 20–30 beds. It provides inpatient and outpatient curative and preventive health services to a population of 20,000–40,000. The RHC is staffed with four to six male doctors and one or two lady doctors, plus technical and support staff, both male and female. Each RHC is a small colony consisting of the main building and residences for the medical officers and LHWs to ensure that they are available throughout the day.

Secondary Health-care Facilities

***Tehsil* Headquarters Hospitals (THQs).** Each THQ has 50–60 beds. The services the THQs provide differ from place to place.

District Headquarters Hospitals (DHQs). Each DHQ has 100 or more beds and provides secondary health-care services to a population of more than two million.

Tertiary Health-care Facilities (Teaching Hospitals)

At the highest level of the public health delivery system are these hospitals, situated in relatively larger cities. They offer extensive health facilities in several medical fields and are normally also attached to a medical college.

The present vision and strategy for the health sector of Pakistan is built on (i) the Health for All (HFA) principle; (ii) accessible, acceptable, and affordable service delivery; (iii) efficient, equitable, and effective health care; and (iv) preventive and promotive health care.

Shortcomings of the Health System

Through the network of primary health-care facilities, free treatment is provided to patients. But owing to inadequate laboratory equipment and medical staff, these government-owned health facilities and hospitals fail to provide adequate health care. Furthermore, most health practitioners are employed in public health facilities during the morning and practice privately in the evening. Most physicians in the basic health units are fresh graduates from the medical schools. (See Table 1 for a summary of health personnel numbers.) The allocation to the health sector is less than 1% of gross domestic product (GDP), but the distribution of financial resources is an even more serious problem, as can be seen from Table 2.

Efforts to contain infectious diseases are mostly in vain because of poor financial accountability, the scarcity of skilled manpower, inaccessibility, and other factors. Technical difficulties in the supply of medicines, such as the failure to maintain the cold chain in the case of the polio vaccine, are just as important. Polio cases are still found in the country despite the multiple mass campaigns. Pakistan has also been running a tuberculosis control program for the last decade and a half without achieving much.

Table 1: Health Personnel

Category	2002–2003	2003–2004	2004–2005
Registered doctors	101,635	108,062	113,206
Registered dentists	5,068	5,530	6,127
Registered nurses	44,520	46,331	48,446
Population per doctor	1,466	1,404	1,359
Population per dentist	29,402	27,414	25,107
Population per nurse	3,347	3,296	3,175

Source: Pakistan Economic Survey 2005; Government of Pakistan, page 150.

Table 2: Population Served and Share of Health Expenditure

Service	Population Served	Share of Expenditure
Primary health care	90%	15%
Secondary health care	9%	45%
Tertiary health care	1%	40%

Source: Ministry of Health.

State-run hospitals are tremendously overstretched and their standards are getting worse by the day. Primary health-care facilities are often without a doctor, so that patients are left to the care of paramedics or even peons. Insufficient funds and flagging management contribute in large measure to the failure of these facilities. The quality and delivery of services is likewise negligible at the secondary level of health care. At the tertiary level, care is well structured in the private sector but not accessible to more than 80% of the population. Tertiary care in the public sector is clogged. Lacking trust and confidence in primary and secondary level care, the masses move to the tertiary level if the facilities are accessible.

Despite the recent proliferation of medical colleges, there is still a shortage of doctors. There is at present a huge imbalance in the doctor-patient ratio. Doctors are reluctant to serve in remote areas because of insecurity and lack of professional growth. This, in turn, has bred quackery. According to one survey, 600,000 quacks are practicing illegally in the country.

The World Bank argues that poor health is largely a consequence of poverty, reflecting low income, poor sanitation, inadequate water supplies, and low level of education especially among women. But poor health in Pakistan is also indicative of major shortcomings in its health policy, and particularly denotes a failure to design and deliver the kind of health care that could be cost-effective, besides improving the health of most of the population. Health policies and program in Pakistan have often set ambitious health targets without adequate concern for the distributional aspect of health.

Policy Measures

To provide acceptable, accessible, and affordable health care, it is important to (i) promote the primary health care approach in the light of the global HFA strategy, (ii) improve the quality of health care in both rural and urban areas, (iii) encourage community and private sector involvement in health-care delivery, (iv) evolve and initiate a strong district health system, and (v) reduce or eliminate the use of narcotics and psychotropic drugs.

Short-term Policies

These will include the following:

- Reorganizing district health offices to make them more community-based and locally managed;
- Consolidating the primary health-care network in rural areas, achieving the functional integration of the vertical program, and making structural adjustments;

NAPSIPAG

- Promoting child spacing as a component of reproductive health services;
- Improving hospital administration and financial management;
- Establishing a properly regulated private health sector and protecting communities against quackery;
- Evolving a policy for making good-quality drugs available at affordable prices; and
- Reviving traditional medicine and the quality control center at the National Institute of Health (NIH).

Long-term Policies

In addition to continuing the above policy measures, the following steps will be taken over the long term:

- Streamlining the role of the federal and provincial governments to give more responsibility for health delivery implementation to provincial governments;
- Recovering the cost of services rendered and subsidizing services to the poor segment of vulnerable population through *zakat*;²
- Encouraging public-private partnership in health with nongovernment organizations (NGOs), local bodies, and the private sector;
- Improving services and making them more efficient through good governance;
- Making continued efforts to achieve self-sufficiency in vaccine and drug production;
- Eliminating malnutrition of all kinds among vulnerable groups; and
- Creating a drug-free society.

Improvements in Equity, Efficiency, and Effectiveness

At present, the provision of health services is inequitable and inadequate, inefficient, and ineffective. The long-term strategies will address the issue of equity by establishing primary health outlets in the public sector only for unserved and underserved populations and areas, involving NGOs, removing gender imbalance, and developing public-private partnerships in service delivery.

The long-term health sector strategies will address the issue of efficiency by improving the social environment and management capacity, controlling malpractice at all levels, enforcing accountability, decentralizing, recovering costs, maximizing the role of the private sector, reducing waste, and following a health sector reform agenda.

² It is incumbent on every Muslim to give 2.5% charity on amount of gold kept for more than a year.

The long-term health strategies will address the effectiveness issue by avoiding expansion, focusing on consolidation, linking primary health care with other components of the health sector, ensuring the availability of good-quality drugs at affordable prices, regulating the private sector, checking quackery, involving and empowering the community and NGOs/community-based organizations, and strengthening preventive and promotive health services through health and nutrition education.

Millennium Development Goals (MDGs)

The Millennium Summit 2000 convened by the United Nations is a landmark in the history of this global organization. Heads of 189 states and governments attended the summit and approved the MDGs. The MDGs are defined procedures for a dramatic reduction in poverty and marked improvements in the health of the poor. They constitute a development agenda—including quantitative goals, time-bound targets, and numerical indicators.

Pakistan is a signatory to the MDGs. Table 3 shows the targets for Pakistan.

Table 3: MDG Targets for Pakistan

Indicator	1990	Current	By 2015
Reduced child mortality			
Under-5 mortality rate (per 1,000 live births)	140	105	47
Infant mortality rate (per 1,000 live births)	120	82	40
Proportion of fully immunized children 12–23 months (%)	25	53	90
Improved maternal health			
Maternal mortality ratio (per 100,000 live births)	550	350	140
Births attended by skilled birth attendant (%)	–	24	90
Contraceptive prevalence (%)	12	30	90

– = data not available, MDGs = Millennium Development Goals.

Source: Progress on Agenda for Health Sector Reform, May 2003, Ministry of Health, Islamabad, Pakistan.

Strategies for Achieving the MDGs

The theme of Health Care for All (HFA)—providing services that are **accessible**, **acceptable**, and **affordable**—will be vigorously pursued over the long term. The service delivery mechanism will be made more **efficient**, **equitable**, and **effective**.

There will be a shift in policy from curative services to preventive, promotive, and primary health care.

Primary health care will be strengthened with necessary backup support in rural areas, where all the service outlets will be focal points for primary health care components and family planning services. In the urban areas, health centers will be established to cover the underserved population.

To address the issue of accessibility of health-care services to vulnerable sectors of the society, the Women Health Project, which is being implemented, will be replicated in the rest of the districts.

Medical staff at all levels will be trained and retrained through further support for the provincial and district human development centers established under health-care and family health projects.

Health sector reforms will deal with service cost recovery, subsidization for the poor segments of the target population, and regulation of the private sector.

Public-private partnerships will be instituted in the health sector through the privatization of unutilized and underutilized health facilities up to the secondary health-care level.

Autonomy will be given to teaching hospitals, and health boards and village health committees will be established.

The program of tuberculosis and malaria control—with the new strategies of directly observed treatment short course for tuberculosis and the Roll Back Malaria global partnership—will greatly help to deal with reemerging communicable diseases affecting mainly the reproductive age group.

Conclusion

The failure of successive national governments in Pakistan to develop a compact and comprehensive health policy is due to various factors. Other than the fragmented urban health services and problems related to public expenditure, these factors also include issues related to development projects like overlapping; gaps in planning and implementation; vertical program; dependency of provinces on the federal Government for funding, which delays the projects; planning problems; lack of regulation of the private sector; the issue of service accessibility; and poor community involvement.

The analytical review by Dr. Talib Lashari of different health policies in Pakistan leads to the conclusion that these initiatives were nothing more than Government's attempts to institutionalize and regularize the drafting of policies. Deploring the irrationality of decision making regarding health policy in Pakistan, Lashari (2004) writes: "This is due to three reasons: Health does not get priority in [the] overall decision-making process[;] health expenditures hardly differ from [the] previous budget; within the health sector, there is no proper use of minimal resources[;] and...decision making takes place in [an]

NAPSIPAG

isolated manner without including all stakeholders[,] i.e.[,] legislatures and civil society[,] etc.”

Lack of continuity of policies, lack of community participation, lack of government initiatives to bring the private health sector into the mainstream of health care, lack of good governance, and lack of the necessary skills and interest on the part of some stakeholders including public representatives and NGOs are some of the other negative factors.

The role of civil society organizations is very important in this regard. They can be very helpful to policy makers through their policy-related research and advocacy. Private sector resources can also be used to bring about a positive change in the health sector. But the private sector needs to be regulated so that the irrational use of drugs and other ills can be eliminated.

With the present low level of investment in the health sector, weak implementation, and poor accountability and monitoring, achieving the MDG targets within the given time frame would be an uphill task.

Recommendations

The first step, which urgently needs to be taken, is to change the traditional governmental perception of health. No development is possible without improving the health of a country. Development also depends on improvements in economic, political, and social conditions.

All these require better planning of human resources for health by (i) identifying shortages and surpluses of specific groups of health workers, (ii) defining the necessary core skills and competencies of categories of health personnel, (iii) identifying the training needs of health workers and using appropriate training methodologies, (iv) analyzing subsequent absorption and retention in the public and private sectors, and (v) instituting appropriate regulation.

Human resources are central to managing and delivering health services and to meeting the MDGs and other health targets. Given the diversity of health workers and their skills and experience, defining and classifying these human resources precisely can help policy makers and planners better appreciate the importance of health personnel. The development of human resources at all levels of health care must inevitably be a top priority. The medical education system should be allowed to develop in a decentralized manner. The development of local talent base should be undertaken as a top priority, and encouraged. It is a tedious and lengthy process, which cannot be cut short.

The level of investment in the health sector must increase: it should be no less than 2% of GDP to start with. Strategies must also be implemented well. The health system has to be based on needs and on primary health care,

NAPSIPAG

and balanced with an equitable distribution between curative and preventive approaches to health care. Research—both clinical and public health (health systems research)—is vital to the development of the health system and must be encouraged.

But the health system also cannot be developed in isolation. There has to be a long-term, integrated approach with the appropriate involvement of the education, administration, local government and rural development, community development, agriculture, livestock, public health engineering, and political sectors.

References

- Barker, C. 1996. *The Health Care Policy Process*. 1st ed. Thousand Oaks: Sage Publications.
- Government of Pakistan. Pakistan Economic Survey, 2004–05,
- Lashari, T. 2004. Pakistan's National Health Policy: Quest for a Vision. Health Policy Unit. Ministry of Health. September.
- United Nations Development Programme. 2004. *Human Development Report*.
- United Nations Population Fund. 2003. *Pakistan Population Assessment*.
- World Bank. 1998. *Pakistan towards a Health Sector Strategy*.
- . 2003. *Raising a Healthier Population in Pakistan*.

Opportunities and Challenges in the Local Governance of Public Health

Victoria A. Bautista¹

Introduction

Poverty is a persistent problem in the Philippines. While incidence has declined from 49.2% in 1985 to 39.5% in 2000, according to the National Statistical Coordination Board (cited in Reyes 2003, pages 10–11), the poor have increased in number over time, from 26.7 million in 1985 to 30.8 million in 2000. This increase can be attributed to the high population growth rate in the Philippines, which was 2.36 from 1995 to 2000 (Reyes 2003, page 5). There are also regional disparities in poverty. In some regions in Mindanao and the Visayas, more than 40% of the population is poor—in the Autonomous Region of Muslim Mindanao, where the proportion is highest, the poor make up 71.3% of the population—while in most regions in Luzon, except the Bicol region, the poor make up less than 40%.

The governance of public health should be of interest to Filipinos, especially the poor, who rely on this system for their needs. Public health services are generally cheaper, if not available for free. The reliance of the poor on public health facilities is borne out by studies on the use of these facilities, such as the ones done for the National Demographic Survey of 2003 and the Social Weather Station study for the World Bank in 2001 (cited in Olarte and Chua 2005).

Public health is normally concerned with “threats to the overall health of a community...[and] includes surveillance and control of infectious disease and promotion of healthy behaviors among members of the community” (www.answers.com/topic/public-health). Doctors, on the other hand, treat patients one-on-one for a specific disease or injury (www.answers.com/topic/public-health). Thus, public health involves not only the curative aspect of health for the entire community but also the promotion and prevention of diseases.

In this context, this paper discusses two key topics:

- What are the opportunities in public health governance in local government units (LGUs)?
- What still needs to be improved (challenges)?

¹ Vice-Chancellor for Academic Affairs, University of the Philippines Open University and Professor of the National College of Public Administration and Governance, University of the Philippines.

Opportunities

Devolution

Devolution is one of the opportunities in public health. For one thing, devolution gives local executives and implementers a direct hand in designing relevant projects and approaches according to the needs of their constituents. This mode of management veers away from the traditional way of having national planners and implementers design program and project packages for local government units, which may not suit the conditions in some localities.

Devolution also allows local executives and implementers to use resources that are indigenous to the locality, and to boost local capacities and energies in the process. Local knowledge, which has given rise to the application of some herbal medicines to treat ailments, could be harnessed to generate local enterprise and improve the local economy.

Then, of course, transferring decision making in health matters to local government enables the citizenry to see firsthand how decisions are made, to express their needs and concerns, and, more importantly, to be more actively involved in analysis, planning, implementation, and monitoring and evaluation. For participatory governance, development programs can be placed under the jurisdiction of local chief executives (LCEs), who have direct access to the people, instead of having decisions made chiefly by national decision makers and their regional counterparts.

The Local Government Code of 1991 made the maintenance of barangay health centers a key responsibility of the lowest level of the local government unit, the barangay. At the municipal level, the responsibility for health services includes the implementation of programs and projects in primary health care, maternal and child care, and control of communicable and non-communicable diseases, besides secondary and tertiary health-care services. Municipal health facilities also attend to the purchase of medicines, medical supplies, and equipment to carry out the services. Provincial health facilities provide health services in hospitals and tertiary health services.

These services are to be funded from the share of the local government unit in the proceeds of national taxes and other local revenues, and receive funding support from the national Government and its instrumentalities, and government-owned and -controlled corporations.

Volunteerism

One of the most significant contributions of advocacy for primary health care (PHC) is motivating community health volunteers. Barangay health workers (BHWs) have emerged as partners of government health workers

NAPSIPAG

since the early 1980s. They are in the frontline of the referral system chain, first-aid provision, community mobilization in public health projects, and the health information campaign. Even after devolution, we see vibrant volunteerism among BHWs. In fact, BHWs are active not only in public health but also in many community development projects. They gather information on local poverty indicators for the nationwide monitoring of the quality of such as in the communities. They take an active part as well in poverty programs like the Comprehensive and Integrated Delivery of Social Services (CIDSS), which was led by the Department of Social Welfare and Development (DSWD) until 2004, and the foreign-funded Kapit-Bisig Laban sa Kahirapan (“shared fight against poverty”)–CIDSS (KALAHI-CIDSS) project of the DSWD.

BHWs are also a very visible part of community-based health programs managed by nongovernment organizations (NGOs) as Plan International Philippines, which supports community-managed health programs, and World Vision, through its advocacy program against tuberculosis called Kusog Baga (“strong lungs”) Program.

The federations of BHWs around the country could be channels for social mobilization and advocacy.

The legacy of the Department of Health (DOH) in steering volunteerism in the community is still felt and seen today. If properly steered, the volunteers can be a significant force in public health advocacy and serve as key mobilizers in harnessing community participation in decision making.

Basic Needs Approach

The basic needs approach to assessing the quality of life, and even measuring poverty, is a comparative advantage for public health. It is a useful planning tool in determining which services should be prioritized, and which individuals and families should be given priority attention. Basic needs indicators have already been institutionalized in the Social Reform and Poverty Alleviation Act (Republic Act 8425) passed in December 1997. The indicators were advocated and implemented in national programs like the CIDSS.

The Local Poverty Reduction Action Agenda (LPRAA), drawn up by local government units at the prompting of the Department of the Interior and Local Government (DILG) applies a modified version of the basic needs indicators. The indicators have been reduced to 14 (with six of these related to health) from the original 33 indicators (the Minimum Basic Needs [MBN]). LGU advocacy of these indicators called the Core Local Poverty Indicators reinforces the local mandate for health embodied in the Local Government Code. These indicators set the parameters for allocating resources and for determining the progress made by different LGUs.

NAPSIPAG

An improvement in the new set of indicators is their focus on impact concerns rather than a combination of inputs, outputs, and impact (the concern of the set of 33 indicators). The 14 indicators also focus on individual household members and not on the household (the unit of analysis in the original set of indicators). The MBN and Core Local Poverty Indicators sets of indicators are compared in Appendix A.

However, both sets of indicators highlight the importance of enabling members of the community to identify the programs that respond to their needs, rather than providing them with packaged services.

Local Empowerment

An important feature of LPRAA is the recognition of people's organizations as participants in decision making. In the *Guidebook on Local Diagnosis and Planning* prepared by the DILG, the National Economic and Development Authority (NEDA), National Anti-Poverty Commission (NAPC), and United Nations Development Programme (UNDP), representatives of the basic sectors (farmers, fisherfolk, women, children, youth, senior citizens, persons with disabilities, indigenous peoples, informal labor, formal labor, urban poor, victims of calamities, cooperatives, and NGOs), mostly from the marginalized groups, are expected to be included in the Local Poverty Reduction Action Team (DILG, NEDA, NAPC, and UNDP 2002). In effect, this directive reinforces the participatory approach to health management consistent with PHC, a devolved responsibility under the 1991 Local Government Code. The advantage of planning with a poverty reduction focus is its holistic view of development, which the PHC approach underscores.

In addition, NGOs and people's organizations can participate in local planning, with their representatives composing at least one fourth of the planning bodies.

Role of LGUs in National and Foreign-funded Programs

Many national and foreign-funded programs or projects in health recognize the need to work in tandem with local government. The CIDSS and the KALAHI-CIDSS programs in poverty alleviation are national programs that engage the participation of local chief executives, who will ultimately have to commit their resources and people to these projects. In the case of the KALAHI-CDSS project, municipal officials chair inter-barangay forums to evaluate proposals for funding support from the World Bank, with counterpart funding from the local government unit. The inter-barangay forums also set the criteria for assigning priority to proposals from the different barangays.

The forums are composed of representatives from the national and local government units in social development, people's organizations, NGOs, and the basic sectors.

The foreign-funded project Family Health by and for Poor Settlers, funded by German technical cooperation (GTZ), on the other hand, mobilizes LGUs to help improve family health self-management activities and the use of family and reproductive health services by target groups; to organize and support community centers for family health; and to develop family health workers (DOH 2001a).

Working together with LGUs ensures transfer of technology and, hence, local ownership and program sustainability after the phaseout of the national and internal interventions.

Community-based Approach and Integrated Planning in National and Foreign-funded Projects

Many national and foreign-funded projects operating in different LGUs are committed to mobilizing communities to empower them, as well as to partnering with other civil society groups, especially NGOs. They also strive to take a multidimensional view to development, where health is often a concern.

For instance, UNDP, with P14 million in grants, supports the promotion of a multi-sectoral and community-based approach to HIV prevention in urban areas in the National Capital Region, Region IV, Cordillera Administrative Region, and Region VI (DOH 2001).

The Canadian International Agency for International Development (CIDA) has also extended a grant of P1.234 billion for community mobilization to reduce the incidence of tuberculosis in areas in four regions covered by the previous community-based program of World Vision (DOH Web site 2005).

A P49.882 billion grant from the Australian Agency for International Development supports the implementation and evaluation of self-sustaining community-based projects in malaria eradication. This entails mobilizing volunteers, setting up health insurance, conducting health education, and setting up surveillance systems (DOH Web site 2005).

Thus, of the 36 foreign-funded projects listed by DOH Bureau of International Health Cooperation in 2001 (DOH Web site 2005), 13 have community mobilization at the top of their agenda and, hence, conform to the PHC mandate.

Local Innovations Recognized by Award-giving Bodies

Award-giving bodies have recognized innovative approaches and strategies in governance in LGUs. An award specific to local health development is the *Sentrong Sigla* (“health center”) seal that the DOH gives to LGUs that meet health-care quality standards and comply with indicators pertinent to the physical and human resources available in their facility. The standards pertain to infrastructure and amenities, services, attitudes and behavior of health workers, human resources, equipment, medicines and supplies, health information system, and community intervention (Bautista, Legaspi, et al. 2002, page 32). These standards have been improved lately to incorporate not only input indicators but also process and outcome indicators. *Sentrong Sigla* LGUs receive monetary rewards by DOH for their use in their operations (interview with DOH technical staff, 6 June 2003).

The *Galing Pook* (“excellent place”) Foundation, started in 1993, is considered a pioneering program that recognizes innovation and excellence in local governance in the Philippines. From 1994 to 2004, *Galing Pook* annual awards went to 195 outstanding local governance programs, which are now models of effective local governance (*Galing Pook* Web site 2005). This award system is part of an international network of local governance award mechanisms in eight countries (Brazil, Chile, People’s Republic of China, Mexico, Peru, Philippines, South Africa, and United States) assisted by Ford Foundation (Rodriguez 2002). Innovations in governance with direct or indirect implications for health care are evident among the roster of winners. In 2002, 5 of the 10 awards went to the health sector, the highest number registered so far. The health awardees all subscribed to participatory governance, according to the PHC approach (*Galing Pook* Foundation 2002).

One of the recipients of a *Galing Pook* health award, a drive participated in by people’s organizations and other civil society groups, cleaned up the coastline of Bataan and helped prevent diseases. A constituent-responsive program in Bulacan, which applied the survey research method to get representative feedback from citizens on projects, led to the setting up of health insurance (*Medicare para sa Masa*) (“Medicare for the Masses”). Another initiative, this one started by the governor of Davao del Norte Province, used basic needs indicators, including health indicators, as tools in project planning and prioritization (*Galing Pook* Foundation 2002). Also a recent awardee was the inter-LGU-NGO partnership in health-care delivery in the province of Negros Oriental, where hospital boards capitalized on partnerships between stakeholders outside government to devise creative ways of addressing concerns in health-care delivery. Health zones were formed to devolve program

management further to the districts, a level of administration between the provinces and the municipalities.

All these award systems motivate LGUs to innovate in governance for local development.

International Commitments Reinforcing Health Priorities

Another opportunity is the commitment of global networks to prioritize health. For instance, the 20-20 agreement is a commitment that grew out of the World Summit for Social Development. It stipulates the allocation of 20% of government resources to so-called human priority expenditures to attain decent levels of human development. Official development assistance will allocate another 20%. The expenditures are mainly for PHC—reproductive health, basic nutrition, low-cost water supply, and sanitation. The others go to basic education, early child care, and basic social welfare.

The Millennium Development Goals (MDGs) reinforced the 20-20 initiative which were passed at a Special Session of the United Nations General Assembly in September 2000. Four out of the 10 goals pertain to health, with quantitative targets up to the year 2015 for use in assessing if the goals have been achieved. Corresponding programs of action to address each goal have been incorporated by the Philippines in its Medium-Term Development Plan. The four health-related goals are (United Nations 2000, Manasan 2002):

- Two-thirds reduction in child mortality (among children under 5 years old);
- Improvements in maternal health, as indicated by a three-fourths reduction in maternal mortality;
- Control of HIV/AIDS, malaria, and other diseases through the prevention or reversal of their spread; and
- Environmental sustainability, as indicated by a 50% reduction in the proportion of people without sustainable access to safe drinking water, and the integration of the principles of sustainable development into country policies and programs to reverse the loss of environmental resources.

The institutionalization of these goals in the Philippines steered the adoption of the Local Poverty Indicator Monitoring System by some LGUs to assess the extent of attainment of the MDGs. This was reported by DILG Assistant Secretary Austere Panadero (2005), citing the experience of Pasay City and the provinces of Camiguin, Marinduque, and Masbate.

Challenges

Role of Local Chief Executives (LCEs)

The most critical challenge in public health is obtaining the commitment of LCEs. While public health is a devolved responsibility, this is no assurance that the local executives fully understand the responsibility or will commit to it. Most problematic is local appreciation of the meaning of PHC, since the concept is not well defined even in the implementing rules and regulations of the Local Government Code. Hence, traditional curative health, and not health promotion and prevention (and even less the mobilization of communities and people in governance), is how these executives normally perceive their responsibility..

The most difficult challenge for public health workers is the 3-year term of local executives, since a change in political leadership could also mean a change in commitment and investments in health. Continuity of projects could be a problem, especially if the new executives are bent on making their mark through a change in administrative focus. Each change in administration necessitates advocacy and orientation for the new leaders.

The DILG and local universities can be allies in an orientation program in public health for new LCEs.

Career Path and Mobility for Public Health Workers

There is a need to assess how public health workers in LGUs can be motivated, as their career path is not clearly spelled out in the Magna Carta for Health Workers. This fact is considered a key problem by the national office (Bautista 2001, page 13). Unless innovative mechanisms for mobility are instituted in LGUs, not knowing how much professional growth is open to them could demoralize health workers.

Moreover, although the Magna Carta for Health Workers stipulates benefits and incentives for devolved health workers—including hazard pay, laundry allowance, holiday pay, and even remote allowance and medico-legal allowance (Olarate and Chua 2005)—many LGUs have reportedly failed to fully implement the provisions. Frustrated, the health workers either transfer to Manila or go abroad (Olarate and Chua 2005).

Need to Motivate and Orient BHWs

There is a need to continuously motivate BHWs to keep abreast of recent developments and challenges in health. Devolved health workers have a major role in harnessing, orienting, and motivating BHWs. But political intervention is possible, as local officials have the power to determine how much hazard

NAPSIPAG

and subsistence pay the BHWs can receive, in accordance with the BHW Benefits and Incentives Act (Republic Act 7883) of 15 February 1995. A recent study on the Directly Observed Treatment Short Course Strategy among tubercular patients noted that local chief executives had appointed political allies to replace well-trained and knowledgeable BHWs (Bautista and Gervacio 2003).

Need for Focused Targeting Technology in Health

In training programs of LCEs conducted by the National College of Public Administration and Governance of the University of the Philippines, health is often a dreaded service because, to them, it is a curative service that must be universally provided. Public health management should consider focused targeting technology, as this will enable health workers to determine who should receive priority attention. It is important to have a system that separates those who can afford the service from those who cannot, so that health services can benefit the most marginalized. Mechanisms for charging those who can afford to pay can be considered in public health systems to ensure that medicines, immunizations, and laboratory fees are not given to them for free.

The application of focused targeting technology hinges on the adoption of a set of indicators to assess the extent of deprivation. At the moment, only selected barangays that had been targeted in poverty alleviation programs have implemented the methodology as a national government priority, besides areas where LCEs took the initiative to adopt the system.

Advocacy of the indicators, as the basis for the LPRAA, has to be fast-tracked to cover more LGUs.

Having a reliable set of indicators could also be helpful in setting up a health insurance system, as was discussed recently at a National Conference for Community-based Monitoring Systems (Angelo King Institute for Economics and Business Studies of the De La Salle University 2005). Participants from the provinces shared the applicability of the indicators in targeting families and individuals that deserve priority attention.

The Challenge for Community Mobilization

The extent to which community mobilization is to be undertaken remains an issue. This devolved responsibility has been transferred to local health workers. The question is, who assumes this responsibility, and is mobilization to be continuous?

In a study on the impact of Plan International Philippines, an NGO that advocated community-managed health systems, its partner communities

NAPSIPAG

did better in mobilizing people's participation in governance after advocacy by the NGO's mobilizers (Bautista, Nicolas, et al. 2004). This assessment shows the importance of continuous advocacy to institutionalize the participatory approach.

Funds for Public Health

One of the nagging problems affecting the national Government is having to service government borrowings made to supplement revenue deficits. Debt service has major implications for the amount of money available for development projects and directly affects public health. The national budget for social development, including health, has declined from a high of 33.2% in 1999 to a low of 29.6% in 2003. Economic services also suffered a decline, from 24% to 20.2%. On the other hand, debt servicing increased from 18.3% to 27.8% in the same period (Briones 2002). By year 2006, the prognosis is even worse for social development, estimated to be P27.91% and economic services, 18.72% (Briones 1996: 2). This is because debt servicing has substantially increased to 32.28%.

Another issue is the extent of priority given to public health care. In a report on health spending by Simbulan (2001), it was learned that curative services got the major chunk of the national allocation for 1986–2000, as 20–73% of the budget went to hospital and regional operations, services, and maintenance. On the other hand, promotive and preventive health care got only 1.3–30% (Simbulan 2001, page 60).

Gañac and Amoranto (2001, page 23) disclosed that in 1999, 16.8% of the health-care expenditure of DOH went to public health, as against 67.54% for curative services. Also in 1999, in LGUs where basic health services were devolved, Gañac and Amoranto (2001) showed 47.39% going to public health while curative care got 26.35%. However, the average expenditure per public health facility was a measly P147,000 as against a whopping P1,720,000 per hospital.

Health-care spending in 1999 was below 5% of gross national product (GNP), the standard set by the World Health Organization (WHO), with the Philippines spending 3.4% of GNP (Gañac and Amoranto 2001).

The current Secretary of Health believes that a budget of P86 billion (versus the present P10 billion) is needed to allow the Government to comply with the WHO recommendation (Crisostomo 2005).

Poor Appreciation of Health Insurance

Appreciation for health insurance to date is very low. That leaves the poor at the mercy of government health facilities. Per capita expenditure for

health in 1999 was P1,449, with P70 of that (or 0.5%) coming from social insurance and P549 (or 37.9%) from government. Private spending, to make up for the difference, amounted to P829, or 57.2% (NSCB 2001).

This pattern implies that the financial burden of health on individual families remains heavy, leaving access to care highly inequitable (NSCB 2001).

Preventable Diseases Still Prevalent

A raging public health concern is the burden of managing and controlling infectious diseases that can be prevented or avoided. The latest statistical data from the DOH on leading causes of morbidity for 2001 show that 8 out of 10 are preventable (diarrhea, bronchitis, pneumonia, influenza, tuberculosis, malaria, measles, and chicken pox) (DOH Web site 2005). The two other causes are hypertension and diseases of the heart. (See Appendix B.)

Two of the 10 causes of mortality in 1997 (pneumonia and tuberculosis) were preventable (DOH Web site 2005). The other eight causes were diseases of the heart, diseases of the vascular system, malignant neoplasms, accidents, chronic obstructive pulmonary diseases and allied conditions, certain conditions originating in the perinatal period, diabetes mellitus, and nephritis/nephritic syndrome/nephrosis) (DOH Web site 2005) (See Appendix B).

The fact that preventable disease still exist shows the need to invest more effort in promotive and preventive health care.

The health management burden is aggravated by the fact that annual population growth (2.36% in 1995–2000) is higher than in neighboring countries (Reyes 2003, citing National Statistics Office data). In 1997, the population growth rate was 1.9% in Bangladesh, 1.9% in the People's Republic of China, 1.6% in Indonesia, and 0.9% in the Republic of Korea (Government of the Philippines and United Nations Fund for Population 1999, page 10).

Then, of course, new global threats as bird flu have to be dealt with and are a further drain on local resources.

Conclusion

On the whole, these issues and challenges reflect expectations on the part of the national and local governments to improve the implementation of public health services.

More specifically, national and local health offices have a major role to play in continuous advocacy among local government officials to get them to commit to the delivery of health services, consistent with the needs and demands of the community, and the principles of the PHC approach. This means that advocacy must deal not only with health programs but also with the basic principles of participatory governance, which is what PHC is all

NAPSIPAG

about. There is therefore a need to orient a new breed of public health practitioners who will also excel in social mobilization, policy advocacy, and alliance building, apart from the technical dimension of health. This group can foster partnerships with civil society groups, the private sector, and LGUs in devising more urgent solutions to public health problems. Hence, these practitioners must have the skills to mobilize the community to participate in governance.

An information dissemination network that makes available constantly updated data on the technical aspects of diseases will help prevent outbreaks and facilitate public health service planning and implementation.

National and local health offices should also seize opportunities to use existing technologies for governance, such as local information systems, that could objectively and rationally define the needs of the community. The technology could be used for focused targeting of beneficiaries, apart from planning and monitoring and evaluation, to achieve global commitments such as the MDGs.

Furthermore, strengthening the capacities of LGUs to seek out new sources of revenues to supplement what they can generate apart and what the national government is able to transfer to them is another possible area of advocacy.

NGOs and multinational agencies have as much responsibility to consider the capabilities of the localities and recognize their role in the governance of development projects. In keeping with the spirit of PHC, they should involve people's organizations in local governance to ensure that programs and services are appreciated and sustained.

References

- Angelo King Institute School for Economic and Business Studies, De La Salle University. 2005. *The Evolving Roles of CBMS in the Philippines Amidst New Challenges: Compilation of Papers*. Presented at the Third National Conference on Community-Based Monitoring Systems, held at the Angelo King Institute, 28–30 September.
- Answers.Com. 2005. *Public Health Definition and Much More*. www.answers.com/topic/public-health (accessed on 15 October 2005).
- Bautista, Victoria. 2001. *Challenges to Sustaining Primary Health Care in the Philippines*. For the World Health Organization.
- Bautista, Victoria, and Juvy Lizette Gervacio. 2003. *Community Participation in World Vision Kusog Baga Program*. Quezon City: University of the Philippines–National College of Public Administration and Governance’s Center for Leadership, Citizenship and Democracy. Prepared in cooperation with World Vision.
- Bautista, Victoria, Eleanor Nicolas, et al. 2004. *Community-Managed Health Systems in Plan Partner Communities: An Assessment*. Quezon City: Center for Leadership, Citizenship and Democracy of the University of the Philippines National College of Public Administration and Governance. For Plan International Philippines, Department of Health and Philippine Council for Health Research and Development.
- Bautista, Victoria, Perla Legaspi, Eden V. Santiago, and Lilibeth J. Juan. 2002. *National and Local Government Roles in Public Health Under Devolution*. Quezon City: University of the Philippines Press.
- Briones, Leonor. 2002. *The 2003 Budget: Deficit in Funds or Deficit in Services*. Prepared for Social Watch Philippines. November.
- . 2006. *Financing the MDGs: May pera pa ba? Kung meron, kasya ba?* In *Moving Forward with the Millennium Development Goals: May Pera Pa Ba?* Quezon City: Social Watch Philippines, United Nations Development Program and U.P. National College of Public Administration and Governance.
- Crisostomo, Sheila. 2005. *Health Funding Way Below WHO Recommendation*. *The Philippine Star*. 4 October.
- Department of Health (DOH). 2001a. *List of Foreign-Funded Projects*. Bureau of International Health Cooperation, DOH.

- _____. 2001b. www.doh.gov.ph/nationa%20health%status.htm (accessed on 15 August 2003).
- _____. 2005. www.doh.gov/international-engagements (accessed on 15 October 2005).
- Department of the Interior and Local Government, National Economic and Development Authority, National Anti-Poverty Commission, and United Nations Development Programme. 2002. *Guidebook for Local Poverty Diagnosis and Planning*. December.
- Galing Pook Foundation. 2002. *A Tribute to Innovation and Excellence in Local Governance*. Pasig City: Galing Pook Foundation.
- _____. 2005. *Overview: Gawad Galing Pook 2005*. www.galing.pook.org (accessed on 15 October 2005).
- Gañac, Virginia, and Glenita Amoranto. 2001. The 1991–1999 Philippine National Health Accounts. Paper presented at the Health Research for Action National Forum held on 28–29 June 2001 at the Philippine General Hospital.
- Government of the Philippines and United Nations Population Fund. 1999. *Country Population Assessment*. Manila: GOP and UNFPA.
- Manasan, Rosario. 2002. *Philippine Country Study on Meeting the Millennium Development Goals*. Makati: United Nations Development Programme.
- National Statistical Coordination Board. 2001. The Country's Health Care Spending Continues to Remain Inadequate. Fact Sheet No. 8, Series of 2001.
- _____. 2002. www.nscb.gov.ph/secstat/d-vital.htm (accessed on 15 August 2005).
- Olarte, Avigail, and Yvonne Chua. 2005. Up to 70% of Local Health Funds Lost to Graft. *Malaya*. 2 May.
- Panadero, Austere. 2005. Localizing the Millennium Development Goals: CBS as a Tool for MDG Benchmarking and Poverty Diagnosis and Planning. Department of the Interior and Local Government.
- Republic of the Philippines. 1991. *Local Government Code of 1991*.
- Reyes, Celia. 2003. *The Poverty Fight: Has it Made an Impact*. Manila: Philippine Institute for Development Studies.

Rodriguez, Luz. 2002. Letter of Invitation to Screening Committee Members. Galing Pook Foundation.

Simbulan, Nymia Pimentel. 2001. The Impact of Structural Adjustment Programs (SAPs) on Health in the Philippines. *Public Policy* 5(2, July–December).

United Nations. 2000. Millennium Declaration. Adopted by the United Nations General Assembly on 5 September.

Appendix 1: Indicators on Basic Needs

Basic Needs	Minimum Basic Needs (MBN) Indicators	Core Local Poverty Indicators
SURVIVAL A. Food and Nutrition	1. Newborns with birth weight of at least 2.5 kg. 2. No severely and moderately underweight children under 5 years old 3. Pregnant and lactating mothers provided with iron and iodine supplements 4. Infants breastfed for at least 4 months	1. Malnutrition prevalence - Proportion of children 0–5 years old who are moderately and severely underweight
B. Health	5. Deliveries attended by trained personnel 6. Infants 0–1 year old fully immunized 7. Pregnant women given at least 2 doses of tetanus toxoid 8. Not more than 1 diarrhea episode per child below 5 9. No deaths in the family due to preventable causes 10. Couples with access to family planning 11. Couples practicing family planning in the last 6 months 12. Solo parent availing himself or herself of health services	2. Proportion of children aged 0–5 years old who died to the sum of children 0–5 years old 3. Proportion of women's deaths due to pregnancy-related causes
C. Water and Sanitation	13. Access to potable water (faucet/deep well within 250 meters) 14. Access to sanitary toilets	4. Proportion of households without access to safe water 5. Proportion of households without access to sanitary toilet facilities
D. Clothing	15. Family members with basic clothing (at least 3 sets of internal and external clothing)	6. Proportion of households who are squatters 7. Proportion of households who are living in makeshift housing
SECURITY A. Shelter B. Peace and Order/Public Safety	16. House owned, rented, or shared 17. Housing durable for at least 5 years 18. No family member victimized by crime against person 19. No family members victimized by crime against property 20. No family member displaced by natural disaster 21. No family member victimized by armed conflict	8. Proportion of households victimized by crime

continued on next page

Appendix 1: Indicators on Basic Needs (cont'd)

Basic Needs	Minimum Basic Needs (MBN) Indicators	Core Local Poverty Indicators
C. Income and Employment	22. Head of family employed 23. Other family members 15 years old and above employed 24. Families with income above subsistence threshold level	9. Poverty incidence -Proportion of households with income less than the poverty threshold 10. Subsistence incidence - Proportion of households with income less than the food threshold 11. Proportion of households eating three meals a day 12. Unemployment rate
ENABLING		
A. Basic Education and Literacy	25. Children aged 3–6 attending day care/ preschool 26. Children 6–12 years old in elementary school 27. Children 13–16 years old in high school 28. Family members 10 years old and above who are able to read and write and do simple calculation	13. Proportion of 6–12 children who are not in elementary school 14. Proportion of 13- to 16-year-olds who are not in secondary school
B. People's participation	29. Family members involved in at least 1 people's organization 30. Family members able to vote at elections	
C. Family Care/ Psychosocial Needs	31. Children 18 years old and below not engaged in hazardous occupation 32. No incidence of domestic violence 33. No child below 7 years old left unattended	

Appendix 2: Health Statistics

10 Leading Causes of Morbidity, 2001 (Rate per 100,000 population)

Causes	Rate
Diarrhea	1,085.0
Bronchitis/Bronchiolitis	891.7
Pneumonia	837.4
Influenza	641.5
Hypertension	408.7
Tuberculosis, respiratory	142.2
Diseases of the heart	60.4
Malaria	52.0
Measles	31.4
Chicken pox	31.3

10 Leading Causes of Mortality, 1999 (Rate per 100,000 population)

Causes	Rate
Diseases of the heart	78.4
Diseases of the vascular system	58.4
Malignant neoplasms	45.8
Pneumonia	44.0
Accidents	40.2
Tuberculosis, all forms	38.7
Chronic obstructive pulmonary diseases and allied conditions	20.3
Certain conditions originating in the perinatal period	17.1
Diabetes mellitus	13.0
Nephritis, nephrotic syndrome, and nephrosis	10.1

Source: Department of Health Website: www.doh.gov.ph/health-statistics. January 2005.

Building the Public Health Emergency Management System of the People's Republic of China

Mengzhong Zhang¹

Jianhua Zhang²

Introduction

Severe acute respiratory syndrome (SARS) is a new contagious disease that spread to 33 countries and regions from November 2002 to June 2003. In the People's Republic of China (PRC), cases of SARS were found in 24 provinces, autonomous regions, and municipalities. The 7-month SARS problem sparked public health issues and related economic, social, cultural, and psychological problems. The event also had a significant impact on PRC's politics, economy, and society, especially public health. It is thus important to analyze the impact of SARS, find out what problems remain, and examine the development and future directions of the public health emergency preparedness and response system in the PRC.

The history of mankind is a history of struggle with diseases that threaten survival and development. The shocks dealt by these diseases have often affected not only the body but also the mind and the spirit. For this reason, there have been more severe than those caused by wars, revolutions, and riots. The SARS outbreak in the spring of 2003 is a case in point.

The outbreak lasted for about 220 days—from 16 November 2002 (in Guangdong Province) until 24 June 2003, when the World Health Organization announced that it was lifting its warning against travel to the PRC. In that time, there were 8,430 cases of SARS. The PRC had 5,327 reported cases, including 349 deaths. SARS was reported to have caused a loss of \$50 billion in Southeast Asia and CNY151 billion (Ping 2005).

From the first to the last case, the Chinese Communist Party, the new administration, and local governments tried their best to deal with SARS and achieved temporary success. But the SARS crisis exposed weaknesses in the country's public health system. It showed that the PRC lacked the knowledge

¹ Assistant Professor, School of Humanities and Social Sciences, Nanyang Technological University, Singapore.

² Deputy Director, Public Health Bureau, Jiangxi Province, People's Republic of China.

and the capacity to respond to public health emergencies. Disease prevention and control was deficient; the flow of information about the disease was not smooth; laboratories had no quick-diagnosis system; monitoring and enforcement was inadequate; medical care did not fit the requirements; laws and regulations were incomplete; government functions were unclear; coordination was weak. Moreover, the public psyche had been severely damaged (Wu 2003).

The experience with SARS showed that the management of public health emergencies had to be strengthened to guarantee the security and safety of the country, social stability, and the interests of the public.

Now, 3 years after SARS, the PRC has built an emergency preparedness and response mechanism, as the Central Committee of Chinese Communist Party and the State Council planned, and with the help of relevant organizations and medical staff. The system covers the management of public health emergencies, disease prevention and control, medical care, and health maintenance and monitoring (Zhao 2003). The national Government and local governments have also restructured public expenditure to increase public health spending.

Yet much more needs to be done. Using Jiangxi Province as an example and data from surveys and focus group discussions, this paper looks at the present status of public health and disease prevention in the PRC, reveals the areas that still need to be addressed, and proposes policies to strengthen the system.

Public Health Emergency Preparedness and Response Systems

The United States (US)

The public health emergency preparedness and response system in the the United States (US) is one of the most advanced in the world. Through vertical (federal-state-local) coordination and horizontal collaboration among government organizations, the US has built a comprehensive and multilayered response network for public health emergencies. When a significant public health emergency occurs, a system-wide alert is raised, a suitable response is readied, and information is fed into the federal emergency program via the Centers for Disease Control and Prevention in Atlanta, Georgia. The President decides, depending on the nature and seriousness of the emergency, whether to declare a state of emergency and start the federal emergency program (Zhang 2003).

At present, the US Government is improving the following aspects of the response system (Liu and Hu 2003):

- **Preparedness planning and assessment.** Strengthening strategic leadership, management, assessment, and coordination capability; enhancing and maintaining the capacity of federal, state, and local government agencies to respond to public health emergencies; and ensuring coordinated operations.
- **Surveillance and epidemiology capacity.** Improving routine surveillance; strengthening epidemiology capacity; and creating the capacity to respond rapidly, identify the type of event, and immediately report its progress to guide decision making.
- **Laboratory network.** Building a nationwide network of laboratories at the federal, state, and local government levels; and strengthening research on hazardous biochemical materials.
- **Health-related information and communication technology.** Building an effective computer-based information network; strengthening communication between health workers and the public; and strengthening the security of information.
- **Dissemination of health and health risk information.** Helping state and local public health organizations to build an effective mechanism for exchanging information about public health risks, making them better able to communicate relevant information to the public. The work would include training service delivery personnel, certifying the primary spokesperson, printing pamphlets for public distribution, reporting information on time, and effectively interacting with mass media.
- **Education and training.** Training personnel for public health emergencies and communicating relevant information to the public through a variety of channels.

The PRC

The Government has prioritized to develop and improve the public health response system in view of the weaknesses revealed during the SARS outbreak. To effectively prevent and immediately control and do away with public health threats, ensure the health and safety of the public, maintain the normal social order, and build a lawful system of information, rapid response, vigorous management, and clear responsibility to cope with public health emergencies, the State Council, on 12 May 2003, passed a regulation governing the suitable response to public health emergencies. The regulation is based on the law on the prevention and treatment of contagious diseases and other relevant laws, as well as the experience with SARS in early 2003. While its passage was an

immediate outcome of the SARS event, the regulation applies to all public health emergencies in the PRC. The SARS incident made the country realize the importance and necessity of building a comprehensive response system for public health emergencies. It is looking to borrow from the experience of other countries with more advanced systems and to adapt the experience to the PRC context.

Research Questions and Methodology

This paper is mainly interested in two research questions related to the building of the public health emergency management system:

- What is the status of the system and what remaining issues need to be settled?
- What are the policy implications of the construction of the public health emergency management system?

The authors of this paper relied on empirical research (a case study) to deal with the foregoing issues. Survey questionnaires, focus group discussions, individual interviews, and a review of the experience of the PRC and other countries, particularly the US, were used. The respondents were drawn from among the officials and staff of provincial health organizations in Jiangxi and public health agencies in Nanchang and Ganzhou cities. Materials from other provinces were also referred to for a broader understanding of the issues.

The 150 survey questionnaires sent out to public health agencies at the provincial, prefecture, and county levels were all filled out and returned. The organizations surveyed included the Chinese Center for Disease Control and Prevention (CDC), hospitals, and health surveillance, administration, education, and other agencies. The questionnaires were distributed as follows: Jiangxi Provincial Health Bureau, 10; Jiangxi Provincial Medical University, 10; Jiangxi Provincial CDC, 15; Jiangxi Provincial Health Surveillance Institute, 15; Health Bureau of Nanchang City, 10; Health Bureau of Ganzhou City, 10; CDC of Ganzhou City, 30; The First People's Hospital of Ganzhou City, 30; and Health Surveillance Institute of Ganzhou, 20.

The survey questionnaires asked three open-ended questions:

- Is the provincial public health response system adequate or not? What are its main problems?
- What are the main issues to be considered in building the provincial public health response system?

- What do you recommend for the construction of the provincial public health response system?

Three separate focus group discussions were held among public health administrators, medical personnel of hospitals, and CDC and health surveillance staff to get a variety of views about the public health response system for Jiangxi Province, the problems that still have to be resolved, and recommended strategies and measures.

To get the views of different professional groups, three focus group discussions were conducted for the following:

- Eight public health administrators occupying positions higher than that of deputy section chief—four from the public health bureau of Ganzhou City, one from the Ganzhou Municipal Surveillance Institute, and three from the County Public Health Bureau—for more than 3 hours in the afternoon of 5 September 2005.
- Eleven frontline doctors, all with intermediate professional experience and qualifications—one from Public Health Bureau of Ganzhou City, four from Gannan Medical College Affiliated Hospital, four from the First People's Hospital of Ganzhou City, and two from Ganzhou Municipal Hospital—for 3½ hours in the morning of 6 September 2005.
- Eleven CDC and health surveillance staff members above the level of deputy section chief or with intermediate professional qualifications—one from the Public Health Bureau of Ganzhou City, six from the municipal CDC, and three from the Public Health Surveillance Institute—for 4 hours in the afternoon of 6 September 2005.

A bureau official of the Ministry of Public Health was also interviewed about his understanding of the current state of the public health response system in the PRC, its defects, and areas that need more attention.

In addition, secondary data were obtained from a research survey on the public health response system, carried out by the Ministry of Public Health in February 2005. Of the 76 respondents, 25 had bachelor's degrees, 31 had master's degrees, and 15 had doctoral degrees; five gave no details about their educational qualifications. The respondents comprised 24 administrative staff (31.6%), 51 professional personnel (67.1%), and one whose job position was unspecified.

The analysis and proposed policy recommendations in this paper were based on these primary and secondary data.

NAPSIPAG

Administrative Constraints on the Public Health Response System of the PRC

The PRC has a vast territory (9.6 million square kilometers) and a population of about 1.3 billion. Its economic and social development is still low, and public health emergencies are frequent.

The PRC has dealt with a number of such emergencies in the last 5 decades, among them, the cholera epidemic of Yang Jiang City in Guangdong Province in 1961 and the hepatitis A outbreak in Shanghai in 1988. Thus, the PRC has had some experience in preventing and treating contagious diseases. Nevertheless, the PRC tends to be tentative and to rely on compulsion in dealing with public health emergencies. This approach may be effective in the short run but is wasteful of resources. Agencies are created ad hoc and are dissolved after the crisis. Thus, the rich experience of handling the crisis is not summarized, systematized, and institutionalized, and the experience is not shared throughout the country.

The SARS epidemic in 2003 had a significant impact on the economic development, social stability, and foreign relations of the PRC. Among the main reasons for the spread of SARS in the early stage were the defects in the public health response system. The PRC lacked the capacity to cope with and manage the crisis.

Blind Faith in Economic Growth and Market Principles

The Government has often emphasized the country's focus on development. But development has been narrowly interpreted to mean economic growth. Other areas, public health among them, have had to give way to the pursuit of economic development (Ge 2005). There seems to be a consensus that development is the answer to a host of problems. The assumption is that as long as economic growth is maintained and the pie gets progressively bigger, other issues as public welfare can easily be solved. Indeed, if all social classes closed the fruits of economic growth, public welfare would improve. However, the fruits of economic growth are not equally shared. Therefore, regardless of how fast the economy grows, public welfare will not improve.

On the other hand, the country has put too much trust in the market in many areas, including public health. Behind health sector and other reforms is the unproved assumption that the market can allocate resources more efficiently. In reality, this assumption could hardly be farther from the truth. In public health as in other areas of life, human behavior has externalities, information is asymmetric, and information asymmetry leads to market failure.

NAPSIPAG

In short, blind faith in economic growth has resulted in the failure of government to shoulder its responsibility, and blind belief in the market has resulted in unequal and inefficient allocation of health resources.

Inability of the Current System to Cope with the New Situation

Many countries have built emergency management systems. International organizations have also prepared crisis management plans for coping with epidemics, natural disasters, and wars that cost millions of lives (Qin 2003). In the US, the Federal Emergency Management Agency has a system of assessment, recovery, and management, and an innovative emergency response system (www.fema.gov/tabs_disaster.shtml). Believing that public health is part of national security and is as important as defense, financial stability, and information security, the US established and strengthened its public health response system. The electronic surveillance and reporting system has subsystems for different types of diseases. The objective is to detect signs of a disease outbreak early enough to prepare and respond adequately (Huang 2003). Communication is an essential part of these emergency systems.

In the PRC, the traditional way of handling an epidemic is to conceal it from the public. Without information from the Government, the public relies on rumors, and rumors feed confusion and panic.

To improve its image and earn the public trust, the Government must handle public health emergencies with greater openness and transparency. There must be open, timely, and smooth flow of information to the public. Public health, after all, is all about the public, and the public has the right to know.

Shortage of Public Health Resources

The shortage of public health resources and the policy of requiring the health sector to fend for itself have jeopardized and even paralyzed the public health defense system. Public finance is market economy finance in essence. As such, it should not intervene in areas where the market is effective but should play a role where the market cannot effectively solve the problems (Xia 2004). Public health cannot rely solely on the market economy to provide services. Thus, government intervention is necessary in arranging financing and promoting usage. Public finance should be central to public health.

Perceived Defects of the Public Health Response System in the PRC

The SARS emergency revealed the vulnerability and inefficiency of the public health response system in the PRC. At least six problems weigh down the system.

NAPSIPAG

First, the response management system is not equipped to respond. Health resources are vertically and horizontally segregated. Communication and coordination are not sound, and some local governments cannot manage on their own. Thus, it is hard to integrate resources effectively. In the face of public health emergencies, there is no mechanism for coordinating the participation of several organizations. Vertical management is unclear, as is the devolution of authority to local governments. Local governments do not feel quite responsible, in the belief that such emergencies are properly the domain of public health agencies. On the other hand, public health agencies are not sufficiently empowered to act (Li 2003).

Second, response plans are absent or ineffective. The agencies therefore have no clear duties and tasks, and management and operations are poorly coordinated. The surveillance warning system is not reliable; response equipment and facilities are far from adequate. Some places stay passive for some time. Thorough drills involving different agencies are rare. When public health emergencies as the SARS epidemic arise, public health organizations are unprepared and do not know what to do (An 2004).

Third, information reporting is not sound. Data on epidemics are not efficiently collected, analyzed, and reported. Governments and relevant agencies are slow to grasp emergencies. The PRC is not inferior to advanced countries in the number of hospitals. Beijing, for example, has 275 hospitals, including about 70 “triple AAA” hospitals. However, these 275 hospitals belong to eight different systems, including those of the Ministry of Public Health, the People’s Liberation Army, and the Medical Branch of Beijing University, and thus do not exchange information (http://industry.ccidnet.com/art/35/20040409/101608_1.html, accessed on 8 October 2005).

The vertical and horizontal segregation of hospitals and the lack of information exchange were to blame for the initially passive reaction to SARS in Beijing. Public health agencies could not get accurate information in time, and frontline medical staff could not receive relevant background materials as well as information on clinical behavior and means of prevention and cure.

Fourth, the capacity for responsive medical care is not adequate. Many medical organizations are not equipped for emergencies and the medical staff lack knowledge of emergency prevention and response techniques. The SARS episode also exposed the risk of contamination in hospitals. Internal contagion management in hospitals is the task of the contagion and defense section. But this section is usually the weakest. Moreover, brain drain has seriously depleted personnel resources in many places, especially in the old base of the revolution, minority regions, hinterlands, and poor areas. The age and specialty structure

of the current staff is unsatisfactory. With the current staff, the PRC will be hard put to meet the challenge of future public health emergencies.

Fifth, the disease prevention and control system is weak. Less than 1% of public health staff have master's degrees. In the US, about 10% to 20% of such staff have master's degrees in public health (MPH) or other relevant degrees, and 5% to 6% of those working in the public policy area have MPH degrees. At each level of disease prevention and control in the PRC, poorly qualified personnel and backward medical equipment are common. In addition, there is no clear division of labor, and efficiency suffers. The public health sector is in urgent need of an emergency response workforce armed with sound public health knowledge (Li 2003).

Sixth, the legal infrastructure for handling public health emergencies is deficient. During the SARS period, only the Contagious Disease Prevention and Remedy Law was available. Legalizing administrative authority for emergency management is a worldwide issue. While the Constitution regulates emergency status, administrative power in emergencies must be authorized by law. The public health emergency response regulations passed with urgency by the State Council in 2003 are far from complete. Detailed laws must be passed for coping with different types of emergencies (Yang 2005).

These problems, and others, have serious consequences. When public health emergencies happen, they cannot be effectively addressed and controlled in time. Thus, epidemics spread and persist. Not only do they threaten the health of the public, they also have significant impact on economic development and social stability (Gao 2004).

Policy Recommendations for Improving the Public Health Response System

In the global SARS crisis of 2003, the PRC was the hardest hit. The crisis severely tested the capacity of the Government to handle emergencies and exposed its inexperience in dealing with large-scale public health crises. It raised challenges and questions for the public health management system of the country in general. The PRC has no public health alert and treatment system. But a response mechanism for emergent public health emergencies has been initially set up (The 2003 Executive Order 376 of the State Council, Emergent Public Health Responsive Regulations).

The surveys of the Ministry of Public Health and the Public Health Bureau of Jiangxi Province indicate that the PRC has made a good start in establishing and improving its public health response system. Still, there are

problems. The crisis mind-set is not firmly ingrained in the public health agencies, which are not attuned to effectively addressing public health emergencies. Communication and education in public health emergencies are inadequate. The public does not know enough to protect itself and is therefore easily driven to panic. At the grassroots level, the CDC and medical institutions have weak capacity to prevent and deal with epidemics. Medical personnel are poorly qualified and do not have much opportunity to learn. They can hardly identify major epidemics. Funding for public health is far from enough. Because of the funding shortage, grassroots prevention is difficult or even impossible. The legal infrastructure has yet to be completed.

Coordination in emergencies is a significant problem. There is a lack of concerted effort between the public health sector and other departments. Many other areas—such as public finance, education and communication for emergency management, personnel training, public health response system in the rural areas, and the speed and sensitivity of the response—need to be strengthened.

From the Jiangxi survey, 89 of the 150 respondents (59.3%) considered the response system inadequate. Lack of funding is still a bottleneck, particularly for public health in the local areas. For lack of funds and attention, the necessary equipment cannot be purchased and training is inadequate. The respondents were concerned about the effectiveness of the response workforce, security of response supplies and equipment, preparedness, coordination between prevention and cure, and the legal framework.

The following principles are offered to guide improvements in the public health response system of the PRC:

- Establish a response system that is in harmony with the Chinese context and strengthen the system.
- Make prevention the priority.
- Build a strong response workforce to prevent, control, and cure diseases. Recruit and train more people, and equip them with the right techniques and materials.
- Constantly deepen awareness of crisis.
- Strengthen communication and education in public health events.
- Monitor public health activities according to the law and establish a responsibility system.

References

- An, Xuejun. 2004. Thinking Over the Problems of Public Health System from SARS Prevalence and Corresponding Counter Measures. *Chinese Public Health Management* (1): 10–11.
- Gao, Qiang. 2004. Report on Establishing and Improving the Responsive Mechanism of Emergent Public Health Events. Presented at the Eighth Session of the Tenth National People's Congress. 4 April. <http://sports1.people.com.cn/GB/shizheng/2428504.html> (accessed on 17 September 2005).
- Ge, Yanfeng. 2005. State Council Research Institute Claims That China's Medical Reform Is Basically a Failure. http://news.xinhuanet.com/cic/2005-07/29/content_3282394.htm (accessed on 29 July 2005).
- Government of the People's Republic of China (PRC). 2004. How many illness will come back? It is not a calm Spring of 2004. http://industry.ccidnet.com/art/35/20040409/101608_1.html (accessed on 8 October 2005).
- _____. 2005. China's Emergent Management Mechanism. http://www.gov.cn/yjgl/2005-09/23/content_69182.htm (accessed on 5 October 2005).
- Huang, Jianshi. 2003. American Experiences in Preventing and Curing SARS. 26 September 2003. <http://www.qshx.sdnu.edu.cn/shownews.asp?newsid=2182> (accessed on 11 September 2005).
- Li, Liming. 2003. Actually Strengthen the Construction of China's Public Health System. *Seeking Truth (Qiushi)*, No. 20: 43–45.
- Liu, Antian, and Chunlei Hu. 2003. Public Crisis Treatment: US Experience and Chinese Reality. 15 August. <http://economy.scol.com.cn/bxsh/20030507/20035785253.htm> (accessed on 17 October 2005).
- Ping, Chuan. 2005. *Emergency Management*. Beijing: Contemporary World Publishing.
- Qin, Dejun. 2003. Public Confidence in Government and Social Cohesion. 3 June. <http://www.pkusimba.com/sars/newsdetail.php?pid=270> (accessed on 14 September 2005).
- Wu, Yi. 2003. Strengthen the Construction of Public Health, Pioneering a New Stage of Public Health Work of Our Country. *Health Newspaper* (20 January). <http://www.100md.com/html/Dir/2003/08/21/6684.htm> (accessed on 20 October 2005).

- Xia, Yuanxiang. 2004. On Building Social Welfare Budget under Public Finance. 7 July. <http://down.qyjia.com/bylw/ShowArticle.asp?ArticleID=35864> (accessed on 18 September 2005).
- Yang, Haikun. 2005. Public Crisis and Legalize Emergent Administrative Power. <http://npc.people.com.cn/GB/14841/53042/3705771.html> (accessed on 19 September 2005).
- Zhang, Mengzhong. 2003. The Emergency Management System in the USA and Its Application in Preventing SARS. *Chinese Public Administration* No. 7: 55–59.
- Zhao, Shengyu. 2003. Our Country Will Build Up a Responding Mechanism of Emergent Public Events within Three Years. 30 October. <http://auto.beelink.com.cn/20031030/1450158.shtml> (accessed on 21 October 2005).

