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**TECHNICAL ASSISTANCE TO PAKISTAN FOR
HEALTH SECTOR REFORM IN NORTH-WEST FRONTIER PROVINCE**

The attached Report is circulated for the information of the Board. The President approved the technical assistance on 29 December 1999.

For Inquiries: Mr. V. de Wit, Agriculture and Social Sectors Department (West)
(Ext. 5934)
Mr. B. Carrad, Programs Department (West)
(Ext. 6324)

ASIAN DEVELOPMENT BANK

TAR:PAK32056

TECHNICAL ASSISTANCE

TO THE

ISLAMIC REPUBLIC OF PAKISTAN

FOR

HEALTH SECTOR REFORM

IN

NORTH-WEST FRONTIER PROVINCE

December 1999

CURRENCY EQUIVALENTS

(as of 20 December 1999)

Currency Unit	–	Pakistan Rupee/s (PRe/PRs)
PRe1.00	=	\$0.0193
\$1.00	=	PRs51.9

Pakistan maintains a managed floating exchange rate under which the rates for the Pakistan rupee is fixed on a daily basis in terms of US dollars. For the purpose of calculations in this report, the rate of \$1.00=PRs50 is used.

ABBREVIATIONS

DHA	–	District health authority
DHO	–	District health officer
HSR	–	health sector reform
NWFP	–	North-West Frontier Province
PHD	–	Provincial Health Department
TA	–	technical assistance

NOTES

- (i) The fiscal year (FY) of the Government and its agencies ends on 30 June.
- (ii) In this report, "\$" refers to US dollars.

I. INTRODUCTION

1. Over the past 20 years, the Government of Pakistan has made major efforts to provide universal access to comprehensive primary health care. However, it is increasingly realizing that it is unable to finance and provide health care for all, that public and private services are often not reaching those most in need, and that services are not satisfactory. While this is a nationwide issue, the Government of North-West Frontier Province (NWFP), having legislative responsibility for health services in the province, has in the past 2-3 years initiated major health sector reforms (HSR) in the province.

2. The Bank's current country operational strategy for Pakistan gives high priority to human development, in particular of women and the poor. The Bank addressed HSR in Pakistan through a public-private partnership study in 1997.¹ During the Country Programming Mission in April 1999, the Government requested the Bank to provide assistance with HSR in NWFP. The 1999 Pakistan Country Assistance Plan includes advisory technical assistance (TA) in 1999, project preparatory TA in 2000, and a proposed loan in 2002 for this purpose. The TA Fact-Finding Mission visited Pakistan from 17 to 24 July 1999, and reached an understanding with the Government on the objectives, scope, cost estimates, financing plan, implementation arrangements, and consulting services for the TA.² The Mission held consultations with the Government ministries concerned, potential beneficiaries, nongovernment organizations, and funding agencies. The TA framework is in Appendix 1.

II. BACKGROUND AND RATIONALE

3. The overall impact of the public and private health system on the health status of the population of NWFP is unsatisfactory. NWFP's population of close to 20 million, including 2.5 million Afghans, is growing at 2.7 percent per annum. Due to the scarcity of arable land and employment opportunities, many families and men are forced to migrate in search of a living. The burden of disease reflects a transition pattern dominated by communicable diseases, complications of pregnancy and childbearing, and malnutrition. At the same time, there is an increasing demand for more costly health services for chronic health conditions and accidents associated with modern society. A 1996-1997 survey³ found a total fertility rate of more than six children per woman, and an infant mortality rate of 75 deaths per 1,000 live births in the first year of life (115 in the poorest quintile). The contraceptive prevalence rate was only 15 percent for any type of method, and only 45 percent of eligible children are fully immunized.

4. The Provincial Health Department (PHD) operates the public health system in NWFP, which includes 5 tertiary care hospitals, 21 district hospitals, 132 subdistrict hospitals, and 1,486 primary care facilities. The private sector includes 95 small hospitals and maternity homes; 79 specialist clinics; 1,557 general private practitioners; and numerous drugshops, traditional healers, and birth attendants. The network of public primary care facilities is relatively well spread out in rural areas, although few are in isolated locations. However, these services are highly underutilized, and many patients prefer the private sector (mostly informal in rural areas), tertiary care hospitals, or resort to self-treatment. About 70 percent of the services are provided by the private sector. Public as well as private services focus on curative care, with little attention to promotive and preventive care. The quality of both services is often poor, resulting in waste of Government and household resources and low impact. Total health expenditure is about \$12 per person per year, of which \$8 is out-of-pocket, although the poor spend much less.

¹ TA 2576-PAK: *Public-Private Partnership in Health Study*, for \$450,000, approved on 31 May 1996.

² The TA first appeared in *ADB Business Opportunities* in June 1999.

³ Federal Bureau of Statistics. 1997. *Pakistan Integrated Household Survey*. 1996-1997. Government of Pakistan. Islamabad.

5. This situation prevails because of several factors. The low level of public awareness and social constraints affect the demand for services, especially for women. Public services may not be within reach of the poor and women, in particular, if there are additional charges for services, or if medicines need to be procured at market prices. Political and social constraints affect the staff working in rural areas, resulting in absenteeism, poor attitude, and poor performance. The general shortage of specialists, nurses, and paramedics mainly affects rural areas.

6. Much could be improved if resources were adequately distributed, and efficiently targeted and managed within the district. The core functionary responsible for managing the district health service is the district health officer (DHO). While many DHOs have been trained in public health, they are often less motivated to develop the district health system, and focus on promotive and preventive services given the challenges involved in dealing with the complexities of the Government system and the politicosocial environment. Government problems, including lack of transparency and accountability, also impact on the efficiency of the system. Due to the administrative risks involved in decision making, the DHOs are often reluctant to exercise authority or delegate responsibilities to other staff. A similar situation exists in the hospitals managed by the medical superintendents. Unless authority is decentralized to the district level, the DHO and his/her team or other authority will not be able to directly control resources to improve services, and be held accountable.

7. Several factors have stimulated a desire for HSR in NWFP, including a general dissatisfaction of stakeholders, serious fiscal constraints, dynamic leadership in PHD, and a highly supportive policy environment. As in other provinces, the people of NWFP are dissatisfied with the public health services because of poor quality of care and additional costs. Health care providers complain about low salaries, and lack of resources to provide appropriate services. The Government of NWFP is highly concerned about the inefficient use of limited public funds. It foresees major problems in financing largely subsidized public health services for a rapidly growing population, increasingly suffering from chronic diseases and demanding more expensive medical care.

8. In line with the National Health Policy, the Government of NWFP aims to develop a sustainable health system providing quality care in an efficient, equitable, and affordable manner. It is working to focus on its core responsibilities such as policy development, regulation, compensation for market failure, and ensuring health care for the poor, with less involvement in financing and the provision of curative services. In 1997 the Government of NWFP formed a task force chaired by a senior cabinet member to broaden stakeholder involvement and provide guidance to HSR. The task force reviewed existing structures and systems to plan an efficient and effective health system with access to quality care for all, particularly for women, children, and the poor.⁴

9. HSR can be broadly divided into (i) programmatic reforms, concerned with equity and allocative efficiency; and (ii) organizational and systemic reforms, concerned with institutional arrangements and factors determining technical efficiency.⁵ PHD initially focused on defining its programing priorities, and strengthening these with the assistance of the Social Action Program and projects. The overall priority is comprehensive primary health care, including first referral care, with special emphasis on maternal and child health and family planning services, nutrition promotion, health education, and the control of major communicable diseases such as tuberculosis. These interventions are most likely to benefit the poor, assuming they are reached. Maternal and child health and family planning have been the focus of several projects⁶ in Pakistan, and the Bank is planning further support with the Reproductive Health Project,⁷ to assist the Government in

⁴ The six workgroups of the task force focused on (i) health services delivery policies and strategies; (ii) health sector financing and private sector regulation; (iii) reproductive health; (iv) administration and management reforms; (v) human resource development; and (vi) community participation.

⁵ Frenk J. 1994. *Dimensions of Health Sector Reform*. Health Policy 27. Harvard University.

⁶ Including Loan 1671-PAK: *Women's Health Project*, for \$47 million, approved on 16 March 1999.

⁷ Expected to be approved on or about September 1999.

integrating health and population welfare services. Even with the National Health Policy, the adverse incentive system makes it difficult to focus on priorities outside of the vertical programs and projects. If programing priorities are to be sustained, the governance of the health system will need to be changed.

10. With the guidance of the task force, the Government of NWFP has pursued a number of reforms over the past two years. Initially these focused on resource development—making personnel available in rural areas, decentralizing drugs supply, increasing the nonsalary budget for operational expenditures, and increasing cost recovery. While there are indications that these have led to improved services, the impact of this resource mobilization in terms of utilization and quality of health services is uncertain, as it has not been assessed systematically. The Government of NWFP, highly concerned about the overutilization of tertiary care hospitals, also developed a plan for strengthening referral services in smaller hospitals and increasing fees in tertiary care facilities; this resulted in a considerable redistribution of services.

11. The Government of NWFP has realized that it is difficult to implement so many reforms with limited capacity, and that there is a need to phase reforms and broaden stakeholder involvement. The Government of NWFP is rightly giving priority to the development of hospital autonomy and district health authorities (DHAs) to overcome the chronic governance constraints in the public health system. The Provincial Cabinet has passed an ordinance to make four tertiary care hospitals autonomous, and is preparing another ordinance to establish DHAs in four pilot districts. Rules of business are being prepared. Each hospital and DHA will be provided with a global budget as grant in aid. A package of services, prices, and conditions needs to be developed, including a mechanism to provide affordable services for the poor. Legislation has already been passed allowing hospitals to retain revenues for their use.

12. Once these governance reforms are in place and are successful in setting up basic management structures and services, further reforms will be pursued, such as contracting out services, community involvement, and enforcement of private sector licensing and quality control. Within this decentralized governance structure, there will be more scope for public-private partnership, and pursuing the option of a full purchaser-provider split. The Government has some positive experiences in contracting out services, but the administrative capacity of the Government to contract out services (and regulate the private sector) still needs to be built up.

13. While HSR is pushed forward with vision and commitment, the reform process is heavily concentrated in PHD, which has limited capacity for planning, implementing, and monitoring HSR. It is mainly managed by public health specialists with limited background in HSR. For this reason, a special HSR unit is proposed in PHD. Second, there is inadequate involvement of stakeholders apart from those in the subgroups of the task force, and sharing and consultations will need to be broadened. Third, the planning process for reform has been ad hoc and is not well documented and monitored. This process will need to be strengthened to reduce the errors and risks of reform efforts. Fourth, to improve the implementation of HSR, it will be necessary to adjust the structure of PHD, and provide guidelines and training for program directors and district managers. Fifth, while realizing that there can be no blueprint for HSR, a strategic plan and road map to guide future HSR efforts is necessary.

14. Funding agencies have focused on vertical disease control programs, building primary care facilities, and human resource development.⁸ Less attention was given to the operationalization of primary health care facilities and first referral hospitals. Under the Family Health Project of the World Bank and the Department for International Development, efforts were made to strengthen district health management, but without the necessary authority at district level little has changed. The Bank's Women's Health Project has a setup whereby the DHO and his/her team will be able to plan

⁸ Loan 1200-PAK: *Health Care Development Project*, for \$60 million, approved on 1 December 1992, and expected to close in December 1999. The project is doing well in NWFP.

and develop priority services for women. The proposed HSR for decentralized governance would give even more authority to the DHO and his/her team, but also more control over the DHO at the district level. The government of Punjab is currently focusing on a similar reform agenda with the assistance of World Bank and the Department for International Development. The Ministry of Health proposes to establish a national forum for exchanging experiences in HSR.

III. THE TECHNICAL ASSISTANCE

A. Objectives

15. The purpose of the TA is to assist the Government of NWFP to strengthen its efforts in HSR to improve health sector performance in the province, with the ultimate goal of improving the health status of its people and achieving sustainable health sector development over the next decade. The TA will assist PHD to (i) strengthen institutional capacity in HSR, (ii) conduct sector analysis and assess progress in HSR, (iii) assist the task force to develop a medium-term strategic plan for HSR, and (iv) develop detailed plans for hospital autonomy and the DHAs.

B. Scope

16. The TA will assist in strengthening the institutional capacity of PHD for HSR. An HSR unit will be established in PHD's Planning Cell, a plan will be prepared to restructure PHD to support HSR implementation, directors and managers at provincial and district levels will be trained to implement HSR, and access to the Internet and other information will be improved and local study tours provided.

17. A selective HSR analysis will be conducted focusing on organizational reforms. Programing priority setting has already been done under the Social Action Program, and a brief services performance analysis will be done to provide benchmarks to identify trends and targets. Several studies are proposed for this phase, including basic documentation of the reform process and outcomes; an institutional analysis for capacity building in HSR; stakeholder analysis; a study of legal issues in decentralized governance; personnel and financial management studies; utilization and cost analysis of health services; and a household perception, utilization, and expenditure study.

18. An HSR strategic plan will be prepared that will include the goals, objectives, process, progress, and activities in HSR. Consensus building will be done through workshops, consultations, etc. Outlines will be prepared for further studies, including a human resource development plan for NWFP, a provincial health accounts study, and a private sector regulation and insurance study.

19. The major focus of the TA is to assist PHD in developing detailed plans for hospital autonomy and the DHAs. This component will focus on key governance issues including (i) regulations, guidelines, and standards for the conduct of business; (ii) service mix to be provided; (iii) pricing guidelines, and cross-subsidy arrangements for the poor; (iv) procurement; (v) personnel management; (vi) financial management; and (vii) monitoring and auditing. The integration of services, contracting out of services, involving beneficiaries as decision makers, and introducing a health insurance card system or other forms of risk pooling will be considered in a later phase.

C. Cost Estimates and Financing Plan

20. The TA is estimated to cost \$625,000 equivalent, comprising \$350,000 in foreign exchange cost and the equivalent of \$275,000 in local currency cost. The entire foreign exchange component and the equivalent of \$150,000 of the local currency cost, totaling \$500,000, will be financed by the Bank on a grant basis from the Bank-funded TA program. The Bank will finance consulting services, studies, workshops, equipment, and administrative support. The Government will contribute

\$125,000 equivalent in kind for counterpart staff, office accommodation and utilities, data collection and workshops. Details of the cost estimates and financing plan are in Appendix 2.

D. Implementation Arrangements

21. PHD will be the Executing Agency for the TA. A steering committee, chaired by the provincial Secretary Health, NWFP, will be established to guide TA implementation, and to ensure the continuity of the government's participation in the TA. The committee will include representatives of PHD; the Provincial Planning, Environment, and Development Department; nongovernment organization and private sector representatives; and the team leader. A core HSR unit will be established in the planning cell of PHD, with an Internet facility, to which the consultants and full-time counterparts will be attached. PHD has confirmed that this unit will be available on commencement of the study, and that it will nominate counterparts in public health, health systems management, statistics, and computer programming to work with the consultants. PHD will facilitate the interaction of consultants with stakeholders. The consultants will help to develop policies and plans for HSR, and implement, monitor, and document prioritized HSR. They will also assist the unit in exchanging experiences and ideas with other HSR teams (including in Punjab), and in organizing workshops.

22. The TA will require 33 person-months of consulting services including 13 person-months of international consulting for an HSR/human resource development expert/team leader (7 person-months), and a health economist (6 person-months); and 20 person-months of domestic consulting services, including a public health management specialist/co-team leader (8 person-months), a financial management specialist (4 person-months), a sociologist/medical anthropologist (4 person-months), and a legal expert (4 person-months). The consultants will be engaged in accordance with the Bank's *Guidelines on the Use of Consultants* and other arrangements satisfactory to the Bank for the engagement of domestic consultants. The consultants will be engaged from a firm using the Bank's simplified technical proposal procedure. The terms of reference are in Appendix 3. Equipment, including a computer, printer, and photocopy machine, will be procured for the TA in accordance with the Bank's *Guidelines for Procurement*, to be handed over to the executing agency on TA completion.

23. The TA will be implemented over a period of eight months; it is expected to start in November 1999 and close in June 2000. The study design will ensure consultation with a wide range of stakeholders, including beneficiaries, nongovernment organizations, public and private sector providers, health managers, policymakers, technical institutions, and funding agencies. Within four weeks of the start of the study, an inception meeting will be organized with the participation of the steering committee. The team leader will present the draft inception report, which will provide an action plan and arrangements for TA implementation. The consultants will submit a midterm report within four months, and a strategic plan and detailed plans for the proposed decentralization within eight months.

IV. THE PRESIDENT'S DECISION

24. The President, acting under the authority delegated by the Board, has approved the provision of technical assistance, on a grant basis, to the Government of the Islamic Republic of Pakistan, in an amount not exceeding the equivalent of \$500,000 for the purpose of Health Sector Reform in North-West Frontier Province, and hereby reports such action to the Board.

TECHNICAL ASSISTANCE FRAMEWORK

Design Summary	Indicator/Target	Instrument	Risks/Assumptions
<p>A. Goal Improve the health status of the population in North-West Frontier Province (NWFP), in particular women, children, and the poor.</p>	<p>In four hospitals: case fatality rate is reduced</p> <p>In four pilot districts: infant mortality and birth rates are reduced</p>	<p>Hospital records</p> <p>Survey with controls</p>	<p>Impact subject to level of reform. Impact follows technical assistance (TA)</p> <p>Surveys are done later under a project</p>
<p>B. Objective Strengthen the efforts of the government of NWFP in health sector reform (HSR) to improve the performance of public (and later also private) health services in NWFP in terms of quality of care, efficiency, equity, consumer satisfaction, sustainability, and ownership.</p>	<p>Utilization of health services by target groups</p> <p>Quality of several routine procedures</p> <p>Consumer perceptions and participation</p> <p>Financial performance</p>	<p>Monitoring system and survey</p> <p>Facility survey</p> <p>Exit interview</p> <p>Financial analysis</p>	<p>Government remains committed to HSR</p> <p>Health system environment does not deteriorate financially or otherwise</p>
<p>C. Components</p> <p>1. Improve institutional capacity for HSR:</p> <p>1.1 Help establish an adequately staffed HSR unit in the Planning Cell of PHD, and improve/maintain staff capacity.</p> <p>1.2 Develop a mechanism to broaden stakeholder consultation in planning HSR.</p> <p>1.3 Conduct an institutional analysis to identify internal and external constraints in proceeding with HSR, prepare a plan to address these, and help implement and monitor adjustments.</p> <p>1.4 Plan and implement training of directors and managers in HSR.</p>	<p>Staff capacity maintained</p> <p>Stakeholder consultation takes place regularly and recommendations are incorporated</p> <p>Institutional analysis report received; plans for adjustment of PHD proceed as planned</p> <p>Staff performance improved</p>	<p>HSR monitoring report</p> <p>HSR monitoring report</p> <p>HSR monitoring report</p> <p>HSR monitoring report</p>	<p>Senior staff can be retained subject to motivation, contracts, or incentives.</p> <p>PHD does not involve other departments, nongovernment organizations, or private sector representatives. Government of NWFP supports restructuring of PHD with minor financial consequences.</p> <p>Staff can apply what they have gained.</p>

(Reference in text: page 1, para. 2)

<p>2. Conduct sector analysis and assess HSR progress:</p> <p>2.1 Document HSR progress and establish simple tracking systems.</p> <p>2.2 Conduct stakeholder analysis (political mapping).</p> <p>2.3 Conduct general analysis of sources and spending of health sector funds.</p> <p>2.4 Conduct household and exit surveys on service utilization, perceptions, user charges, willingness to pay, and affordability.</p> <p>2.5 Conduct assessment of resources, utilization, and quality of services for benchmarking.</p>	<p>Progress in HSR documented and monitored with monthly HSR report All major stakeholders are involved</p> <p>Study provides reasonably reliable estimates of major indicators used Survey conducted in 3,000 households in 4 districts each</p> <p>Study completed in 20 facilities in each district and in 4 hospitals</p>	<p>HSR monitoring report Stakeholder analysis report</p> <p>Analysis report Survey report of good quality and report is available</p> <p>Study report</p>	<p>Basic reports and documents available.</p> <p>Will rely heavily on available data Adequate funds available for survey</p> <p>Data available</p>
<p>2.6 Conduct cost analysis to establish unit costs.</p> <p>2.7 Prepare financing and expenditure plans for district health authorities (DHAs) and autonomous hospitals, with budgets, financing options, and service delivery packages.</p> <p>2.8 Conduct a personnel management study for decentralized governance.</p> <p>2.9 Conduct a financial management study for decentralized governance.</p> <p>2.10 Conduct a study of legal issues for decentralizing governance.</p>	<p>Study completed in 4-8 facilities at each level. Government plan approved</p> <p>Study completed</p> <p>Study completed</p> <p>Study completed</p>	<p>Study report</p> <p>Study report</p> <p>Study report</p> <p>Study report</p>	<p>Data available</p> <p>Adequate information is available.</p> <p>Strategies can be agreed to by the Government</p> <p>Regulations are unambiguous.</p> <p>Legal issues can be overcome.</p>

<p>3. Prepare a medium-term strategic plan for HSR.</p> <p>3.1 Reach agreement on the terms of reference and process of developing a strategic plan for HSR.</p> <p>3.2 Share studies to work toward consensus.</p> <p>3.3 Prepare a strategic plan for HSR for the next five years. Include policy issues, phasing, studies, capacity building, and indicative inputs, using a participatory approach.</p> <p>3.4 Prepare a plan to link decentralized governance with communities, including risk-pooling schemes.</p> <p>3.5 Prepare a plan for contracting out services and public-private partnerships.</p> <p>3.6 Prepare a plan for improving the quality of private and public health services, using consumer mobilization, accreditation, a health council for monitoring and enforcement, a private sector data base; and self-regulated quality assurance for private providers.</p> <p>3.7 Plan a study for provincial human resource development, refer to staff mix, skills, standards, recruitment, sanctions, incentives, continuing education, accreditation and registration, and notification of standards and guidelines.</p>	<p>Terms of Reference</p> <p>Government plan approved</p> <p>Progress in planning</p> <p>Stakeholder involvement</p> <p>Progress in planning</p> <p>Communities consulted</p> <p>Progress in planning</p> <p>Participation of private sector</p> <p>Progress in planning</p> <p>Areas covered</p>	<p>Health management information system report</p> <p>HSR monitoring report</p> <p>HSR monitoring report</p> <p>HSR monitoring report</p> <p>Plan approved</p> <p>Plan approved</p> <p>Plan approved</p>	<p>Task force and funding agencies approve report</p> <p>Consensus can be achieved</p> <p>Task force and funding agencies</p> <p>Communities can be motivated and united</p> <p>Limited government commitment and capacity, and funding constraints. Private practitioners have vested interests, and key representatives will need to help to get others involved, to be considered funding agencies.</p>
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<p>4. Initiate decentralized governance in four tertiary hospitals and four district health authorities.</p> <p>4.1 Notify establishment of district health authorities (DHAs) and autonomous hospitals under the act.</p> <p>4.2 Prepare and notify rules of business.</p> <p>4.3 Prepare and notify a plan for redeployment of staff in the DHAs and autonomous hospitals, and help implement and monitor it.</p> <p>4.4 Introduce cost recovery and its local use. Monitor cross-subsidies for the poor.</p> <p>4.5 Revise and implement new financial management systems.</p>	<p>Act notified and approved</p> <p>Rules of business notified and approved Plan notified and approved Staff redeployed</p> <p>Plan notified and approved System introduced and monitored Plan approved by Government System introduced and monitored</p>	<p>Gazette</p> <p>Gazette</p> <p>Gazette</p> <p>HSR report</p> <p>Gazette</p> <p>HSR report Ministry of Finance letter HSR report</p>	<p>Government is willing.</p> <p>Government and public agree.</p> <p>People are willing and able to pay.</p> <p>Government agrees</p>
<p>D. Input</p> <p>For component 1: Capacity building: Consulting services, training, tours to Punjab, etc, Internet, national workshops.</p> <p>For component 2: Situation analysis: Consulting services, field visits, surveys, studies, provincial workshops.</p> <p>For component 3: Strategic plan: consulting services, provincial workshops.</p> <p>For component 4: Decentralization: Consulting services, training, field visits.</p>	<p>4.0 person-months (led by team leader)</p> <p>10.5 person-months, (led by economist) stakeholder study, user study, household survey</p> <p>5.0 person-months (led by team leader)</p> <p>13.5 person-months (led by public health expert)</p>		

COST ESTIMATES AND FINANCING PLAN
(\$'000)

Item	Foreign Exchange	Local Currency	Total Cost
A. Bank Financing			
1. Consultants			
a. Remuneration and Per Diem			
i. International Consultants	250	0	250
ii. Domestic Consultants	0	100	100
b. International and Local Travel	20	5	25
c. Reports and Communications ^a	5	5	10
2. Equipment ^b	10	0	10
3. Workshops	10	5	15
4. Studies	5	10	15
5. Miscellaneous Administration and Support Costs	0	5	5
6. Representative for Contract Negotiations	5	0	5
7. Contingencies	45	20	65
Subtotal (A)	350	150	500
B. Government Financing			
1. Office Accommodation and Transport	0	30	30
2. Remuneration and Per Diem of Counterpart Staff	0	70	70
3. Others	0	25	25
Subtotal (B)	0	125	125
Total	350	275	625

^a Includes international telephone and rental transport.

^b Includes a computer, printer, and photocopier.

Source: Staff estimates.

(Reference in text: page 4, para. 20)

OUTLINE TERMS OF REFERENCE

A. International Consultants (13 person-months)

1. Health Sector Reform Expert/Team Leader (7 person-months)

1. The team leader will be a public health or institutional development and management specialist with at least 10 years experience in public health sector development, health sector reform, and personnel management, preferably in the region. The team leader will have overall responsibility for the consulting inputs into the technical assistance (TA) and will help ensure that the TA outputs are of high quality and are completed in a timely manner. The team leader will be the principle liaison with the Provincial Health Department (PHD), North-West Frontier Province (NWFP), and other agencies. The consultant will have the following responsibilities:

- (i) Ensure regular guidance from PHD and the steering committee. Regularly consult the Provincial Planning, Environment and Development Department, and the Finance Department of NWFP; the Ministry of Health; and the Punjab Health Department. Remain in contact with the Bank's mission leader and consulting services to keep them informed of the status of the TA and to resolve technical and management issues.
- (ii) Organize, manage and monitor progress of TA implementation in coordination with PHD. Guide and supervise consultants and counterparts, and ensure that all consultants complete their respective terms of reference and submit concise reports on time, including annexes. Prepare terms of reference and negotiate subcontracts for studies. Prepare work plans, organize workshops, and monitor activities to be carried out.
- (iii) Advise PHD with setting up the health sector reform (HSR) unit to provide high quality and sustainable support for HSR over the next ten years.
- (iv) Study the organization and capacity of PHD and its environment; and propose and help implement PHD restructuring, capacity building, and the maintenance of strong commitment to reform.
- (v) Review and disseminate HSR experiences in the country and elsewhere.
- (vi) Document the reform process to-date and assess achievements; help setting up a system for documentation and monitoring of HSR. Monitor HSR inputs, processes, and outcomes; and disseminate the findings.
- (vii) Arrange training activities, workshops, and study tours for decision makers and senior managers to enhance their exposure to HSR.
- (viii) In partnership with the Executing Agency, team members, and other stakeholders, conceptualize the overall HSR and develop a strategic plan.

(Reference in text: page 5, para. 22)

2. Health Economist (6 person-months)

2. The consultant will be a health economist with at least 8 years experience in economic analysis of the public health sector in this region, including in health sector reform and national accounts. The health economist will have overall responsibility for assisting the team leader to plan and guide the situation analysis. The consultant will have the following responsibilities:

- (i) Conduct a household study to determine current use of health services; formal and informal charges; other major household expenditures; willingness to pay for different types of health care; affordability based on household income and size; and perceptions of public and private health services, cost recovery, and payment methods.
- (ii) Conduct an exit study of clients of targeted hospitals and health facilities to determine their socioeconomic status, reasons for consultation, referral, willingness to pay, and perceptions of the services. This will serve as a baseline to monitor the impact of decentralization on the use of these health facilities.
- (iii) Conduct a province-wide analysis of sources and uses of the provincial health accounts including the public and private sector, and, where possible, trends over the last ten years. For sources of funds, provide tables summarizing federal and provincial contributions, out-of-pocket contributions, and contributions from funding agencies, health insurance, employers, nongovernment organizations and others. For expenditures, provide tables showing expenditures by program, administrative category, level of care (community, primary, secondary and tertiary), and type of services offered (curative, preventive, promotive).
- (iv) Compare strategic options and prepare a detailed implementation plan for the financing of decentralized health services from various sources, including authority to use local payments. Develop plans for cross-subsidies for the poor, financing preventive and promotive services, paying for catastrophic illnesses through a health card or other system, and performance-based incentives.
- (v) Based on the national burden of disease and cost-effectiveness of interventions, identify the range of common services to be provided at the various levels in the public health system. Identify unit costs in coordination with the financial management expert, and propose interventions packages to be provided, with their cost and conditions.
- (vi) Develop a plan for contracting out health services, including an assessment of perceptions of nongovernment agencies and the private sector regarding public-private partnership.
- (vii) Carry out such tasks as the Bank or PHD may reasonably request within the scope of the TA and time.
- (viii) Provide a complete, concise and timely report on those areas assigned by the team leader.

B. Domestic Consultants (20 person-months)

1. Public Health Management Consultant/Co-team Leader (8 person-months)

3. The consultant will be a public health management specialist with at least eight years experience working with public health development programs in the country. The consultant will have a public health degree from an accredited institution, extensive experience in health planning and management, and strong skills in team-building and communication. The consultant will have the following responsibilities:

- (i) As deputy team leader, assist the team leader to ensure that overall objectives of the TA are achieved and reports are submitted in time.
- (ii) Arrange for the counterparts and TA office in PHD. Prepare job descriptions, interview candidates, and hire staff for management support.
- (iii) Assist the team leader in developing an HSR strategy plan with a long-term vision for the province, and planning capacity building for HSR.
- (iv) Assist the team leader with the planning of the studies and conceptualization of hospital autonomy and district health authorities.
- (v) Conduct a study on the functioning of four tertiary hospitals and health facilities in four districts, to determine performance in terms of utilization and quality of care, and factors affecting these. This will serve as a baseline to monitor the impact of decentralization on the performance of these health facilities.
- (vi) Organize the inputs of team members and develop detailed work plans for setting up four autonomous hospitals and four district health authorities, and initiate implementation of these plans.
- (vii) Carry out such tasks as the Bank or PHD may reasonably request within the scope of the TA and time.
- (viii) Provide a complete, concise and timely report on those areas assigned by the team leader.

2. Sociologist/Medical Anthropologist (4 person-months)

4. The consultant will be a sociologist/medical anthropologist with at least eight years experience in the health sector, strong communication skills, and understanding of the social values and perspective of potential beneficiaries in NWFP. The consultant will be guided by the Bank's handbook on social analysis. The consultant will have the following responsibilities:

- (i) Review sociological and medical anthropological studies relevant to the situation in NWFP. Conduct a social analysis for the target populations covered by the four hospitals and four district health authorities. Prepare a summary report of

target populations, including their socioeconomic profiles, perceptions, health care behavior and coping mechanisms. Help to develop strategies that ensure that HSR has a positive impact on the poor, and plan implementation and monitoring of these strategies. Plan further social analysis as part of strategic planning for HSR to ensure that the poor and other vulnerable groups benefit from HSR.

- (ii) Conduct stakeholder analysis/political mapping of HSR. Develop strategies to improve stakeholder participation in planning, implementing, and monitoring HSR. Implement and monitor plans to improve group dynamics and decision-making processes for HSR.
- (iii) Develop strategies to enhance community involvement in the targeted districts.
- (iv) Carry out such tasks as the Bank or PHD may reasonably request within the scope of the TA and time.
- (v) Provide a complete, concise and timely report on those areas assigned by the team leader.

3. Financial Management Consultant (4 person-months)

5. The consultant will be a qualified accountant or economist with experience working in the private health sector for at least five years. The consultant will have responsibility for financial management analysis, cost analysis and the design of a financial management and pricing system for decentralized services. The consultant will have the following responsibilities:

- (i) Review the current issues of financial management including the procedures for preparation and revision of the annual budget, release of funds, and their disbursement within PHD at the provincial as well as peripheral level.
- (ii) Prepare a comprehensive situational analysis report on financial management in the health sector in the province, identify the constraints and bottlenecks, and make recommendations to overcome these within the decentralized health system.
- (iii) Carry out a detailed cost analysis with the help of surveyors in 4 tertiary care hospitals, and 4-8 facilities at each level in 4 districts. Identify fixed and variable costs, and break down variable costs by production and overhead costs by cost center. Establish unit costs based on various inputs from major cost factors. In collaboration with the health economist, propose packages and prices for the poor and non-poor, based on the studies of affordability for outpatient and inpatient care.
- (iv) Propose budgets and sources of funds for hospitals and district health authorities, based on various prices, volume and subsidy. Compare estimated budget requirements with current expenditures, analyze discrepancies, and adjustments as appropriate. Document the method used as a model for later use.

- (v) Carry out such tasks as the Bank or PHD may reasonably request within the scope of the TA and time.
- (vi) Provide a complete, concise and timely report on those areas assigned by the team leader.

4. Legal Consultant (4 person-months)

6. The consultant will be a legal expert with at least 15 years experience working in the field of corporate and public law. The consultant should have demonstrated experience working with the public sector and should have a sound understanding of the administrative and financial constraints that adversely affect the effective implementation of public sector programs in the country. The consultant will have the following responsibilities:

- (i) Develop the rules and regulations for the conduct of business of the autonomous hospitals and decentralized health authorities.
- (ii) Assess the feasibility of, and develop procedures for, contracting out services to the private sector within the decentralized set up.
- (iii) Carry out such tasks as the Bank or PHD may reasonably request within the scope of the TA and time.
- (iv) Provide a complete, concise and timely report on those areas assigned by the team leader.