Proposals for the Formation of National Health Policy Council

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TABLE OF CONTENTS

Abbreviations and Acronyms	4
Executive Summary	6
A. Background	11
B. Examples of Policy Councils from other countries	13
C. Aims of the NHPC in Pakistan	17
D. Model and composition of the NHPC	19
Model 1	20
Model 2	23
Model 3	26
Model 4	34
E. Rules of business	37
Annex 1 – List of persons met	42
Annex 2 – Sample draft for inviting NGOs	44

ABBREVIATIONS & ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AKHSP	Aga Khan Health Services Pakistan
CBO	Community Based Organisation
CFHPC	Cape Fear Health Policy Council
CPNE	Council of Pakistan Newspapers Editors
CSR	Corporate Social Responsibility
DFID	Department for International Development
DOH	Department of Health
FPCCI	Federation of Chamber of Commerce and Industry
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HSRP	Health Sector Reform Programmeme
HSRU	Health Sector Reform Unit
HSSPU	Health Sector Strengthening and Policy Unit
M&E	Monitoring and Evaluation
MOF	Ministry of Finance
MOH	Ministry of Health
MOPW	Ministry of Population Welfare
NATPOW	National Trust for Population Welfare
NGO	Non Governmental Organisation
NICE	National Institute of Health and Clinical Excellence
NHPC	National Health Policy Council
NHS	National Health Service
NCSW	National Commission for Status of Women
ONA	Ohio Nurses Association
PAVHNA	Pakistan Voluntary Health and Nutrition Association
PHPC	Provincial Health Policy Council
PHSC	Provincial Health Strategic Committee
PIMA	Pakistan Islamic medical Association
PMA	Pakistan Medical Association
PMDC	Pakistan Medical & Dental Council
PMRC	Pakistan Medical & Research Council

PNAC	Pakistan National AIDS Consortium
PNC	Pakistan Nursing Council
PPHI	Peoples Primary Health initiative
PRHN	Pakistan Reproductive Health Network
SKMCH&RC	Shaukat Khanum Memorial Cancer Hospital & Research Center
TV	Television
UNICEF	The United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation
YDA	Young Doctors Association

Executive Summary

The National Health Policy 2010 has been prepared, which recognizes that delivery of health services is the responsibility of the provincial health department and the priority actions emanating from the policy objectives would be in concert with the needs and expectations of each province. The Federal Ministry of Health (MOH) will support and facilitate the provinces in implementing their strategies by providing the overall vision and the relevant financial and technical resources. To oversee and energize the implementation of this policy, it is envisioned to re-invigorate the National Health Policy Council (NHPC).

The National Health Policy 2010 states that there will be a line of accountability; however, the mechanism is not defined. To gain information on this aspect, examples of various health policy councils were studied and it was observed that each had their own mechanisms based on their aims and needs.

The MOH is working for establishing the NHPC, a body with representation from the public and non government sector for this purpose. The aim of NHPC will be to improve the health of the people of Pakistan through two key roles: (a) monitor implementation of the health policy and suggest feasible solutions to resolve the obstacles in implementation, including financial issues and constraints, and (b) help to improve the existing health policy on regular basis after reviewing critical issues related to public health, health care services and quality of care. Besides this, it will also have some additional functions described in the text, later.

To involve various stakeholders in the formation of the NHPC, deliberations were held at federal and provincial levels with the aim of constituting a viable productive body. This led to the emergence of distinctively different models with a range of functions, authority and compositions. These could be grouped under 4 models, as follows:

MODEL 1, Technical forum for discussion on health sector issues and suggesting resolutions – a think tank: Very few people advocated developing a forum (a think tank) of professionals equipped with technical expertise for reviewing the health sector in a composite way. Its functions should be: (a) to produce a “Country Health Report” every

5 year that should provide the situation analysis describing what is happening and what is not happening in the health sector, identify priority issues of the sector, and propose feasible policy options to overcome them, (b) in the interim period, analyse priority issues of the health sector, one by one, and present their solutions through brief but succinct guideline papers for MOH/DOH, and also (c) recommend and guide for appropriate distribution of funds, based on the identified needs.

Strengths of the model are that: (a) it will have a prime focus on improving the quality of health care and standardizing services not only in the public but also in the non government sector, and (b) leadership from the non government sector will guide the public sector to incorporate efficient business practices. Weakness of the model are that: (a) it does not have the focus on monitoring the implementation of the National Health Policy, which is the stated key aim for establishing the NHPC, and (b) the forum does not seem to have "teeth" to get things done.

MODEL 2, A monitoring body only overseeing the progress of policy implementation: This model proposes the formation of the NHPC for two key functions: (a) keeping decision makers and policy makers updated with progress in the health sector, and (b) playing effective role in securing budget according to policy needs. Membership of the NHPC is derived mainly from the MOH, DOH, Planning Commission, MOF and development partners with few members from other non government sector.

It proposes that staff members from HSSPU should visit the provinces to assist them in translating the Policy into operational plan with targets for implementation in the districts. Besides this, the provinces should also be trained in effectively monitoring those plans. However, a major pre-requisite is a well structured and functioning HSSPU at the federal level and HSRU/its equivalent at the provincial level.

The data generated at the district level would be reported to HSRU at the provincial headquarters every month for compilation. The provincial data for agreed indicators would then be forwarded to HSSPU every three months. HSSPU would aggregate the data from all provinces and special areas to produce the National data. This National data would be presented to the NHPC with a brief summary report, which would meet

every six months under the chairmanship of the Federal Health Minister to review the progress and make feasible recommendations.

Advantage of the Model is that it will provide close monitoring of the agreed indicators to ascertain progress in policy implementation. Disadvantages are: (a) it does not respond to the described aims of the Council, (b) the Council is mainly dominated by the members from the public sector, (c) the Council will have significant influence of donors/development partners, and (d) weak input from the other non government sector.

MODEL 3, A monitoring and advisory body working under MOH: This model has been favoured by the majority and has been considered most feasible. It also responds maximally to the missions/aims of the NHPC.

The proposed membership has equal number of members from the government and non government sectors (11 from each). The government members are drawn from MOH, DOH, Planning Commission, MOF, MOPW and Standing Committee on Health in National Assembly. The non government sector includes representative of PMA, CSOs, and NGOS; representative from three professional bodies working for women's health, child health, and infection control; representative from Committee on Corporate Social Responsibility, Federation of Chamber of Commerce and Industry (FPCCI) to represent private sector hospitals; representative of Council of Pakistan Newspaper Editors; few civil society leaders; and a representative of Donors/Development Partners.

Advantages of the Model are: (a) it responds to the defined aims of the Council, (b) has a good mix of member equally from the government and non government sectors, (c) proposed membership is well thought and well defined, and (d) it supports the MOH. Disadvantages are that senior public sector officers may not feel comfortable in working with so many high powered non government members.

MODEL 4, An autonomous regulatory body with powers to direct MOH: Advocates of this model would like the NHPC to be a body with powers equivalent to Public Accounts Committee of the National Assembly for enabling it to direct or restraint the MOH for/from certain actions.

The membership from the government sector is very similar to the model 3, with two exceptions. Non government sector membership includes representatives of PMA, two representatives from professional societies working for women's health and child health, PMDC, Academia, TV, radio, Council of Islamic ideology, Hakims, Homeopaths, minorities; a retired judge from Supreme Court or High Courts. It was advocated that the Council should be chaired by the Judge to make it an independent and non partisan body.

Advantages of the Model are: (a) it will be a regulatory body with powers to direct rather than only recommend, (b) it has a stronger representation of the non-government sector, which will maintain the pressure on the government to deliver. Disadvantages are: (a) it is confrontational model rather than facilitative, and (b) does not have a good mix of non-government members.

Rules of Business:

- It is proposed that NHPC should be a regulatory body with "teeth" and be given the status of a statutory body through parliament.

- Proposed membership is 20-22 members. Inclusion of any donor agency/development partner representative in the Council has been opposed

- The members from the public sector will represent specific positions; hence, the issue of duration of membership does not arise. The duration of membership of individual's representing non government sector was proposed to be 3 years.

- The HSSPU in Islamabad will be the Secretariat for the Council. It should be strengthened to make it functional in monitoring the policy implementation. Also, HSRUs in provinces should also be strengthened to play their role in monitoring the Policy implementation.

- Funding for functioning of the Council and its subcommittees should come from the government (such as Cabinet Division), but not from the MOH. No funding should be accepted from donors/development partners, to maintain its authority.

- The NHPC should meet twice in a year, March and October, to allow time for appropriate budgetary actions.

- The HSSPU should finalize the agenda of the NHPC meetings in consultation with the HSRUs in the provinces.

- Provincial Health Strategic Councils (PHSC) should be established in the provinces and Special Areas. If they are established, then HSRUs in the provinces and special areas will report to the PHSCs.

- The NHPC will have functional links with the other existing governance bodies and Councils in the health sector, such as PMDC, PNC, PMRC, Committee on Drugs, Tibb Council, Homeopathic Council, College of Physicians and Surgeons Pakistan; and also with policy level committees, e.g. Health System Strengthening Committee and Steering Committees. The links will be either through the representation of the MOH in these bodies (e.g. Federal DG Health is a member of the Executive Council of PMDC), or these bodies functions under the Federal Secretary of Health or the DG Health,

- The NHPC should report annually to the Social Sector Committee of the Cabinet.

- The NPHC should have the authority to; (a) form technical committees to look into specific areas, (b) call experts for making presentations on specific topics or for seeking guidance, and (c) direct the HSSPU for subcontracting out required research.

The 18th Amendment has created a new scenario, where the role and authority of the MOH is not yet very clear. Therefore, it was strongly recommended that formation of the NHPC should be delayed till the federal and provincial roles in the health sector are clarified.

A. BACKGROUND

The National Health Policy 2010 has been finalized and will be launched soon after the approval of the cabinet. The draft presents 7 policy objectives to reform and strengthen critical aspects of its health system and thus enable it to:

- Provide and deliver a package of quality basic essential health services
- Staff its facilities with competent and committed health care providers and managers
- Generate reliable and validated health information to manage and evaluate health services
- Adopt appropriate medical technologies to deliver efficient and high quality services
- Finance the costs of providing basic health care to all Pakistanis
- Reform the health administration to make it accountable to the public and deliver results
- Develop inter-sectoral linkages to address the social determinants of health

The Policy recognizes that delivery of health services is the responsibility of the provincial health department and the priority actions emanating from the policy objectives would be in concert with the needs and expectations of each province. The Federal Ministry of Health (MOH) will support and facilitate the provinces in implementing their strategies by providing the overall vision and the relevant financial and technical resources to ensure that essential health services are accessible to all citizens. It is expected that as the enhanced awards of the National Finance Commission work their way into the health system, the fiscal space afforded will allow the deployment of the commitments outlined in the Policy.

It is noted with concern that several national health policies were announced in the past but their translation into actions was far below than optimal. To oversee and energize the implementation of this policy, it is envisioned to re-invigorate the National Health Policy Council (NHPC).

A National Health Policy Council was notified in August 2005, which met thrice and then became dormant. The revived NHPC would have a broader mandate and wider representation, including from the civil society and others outside the government. It will either be notified or constituted as a statutory body through appropriate legal process, as deemed necessary.

B. EXAMPLES OF POLICY COUNCILS

Net search was done to study examples of various health policy councils and learn about their functions and memberships. The relevant examples were from UK or USA and none were from the developing countries. It emerged that the councils or their equivalents in UK and in different states of USA were formed for specific functions, which were well defined in scope. Some examples are being given below.

NICE (National Institute of Health and Clinical Excellence) was established in 1999 to ensure that everyone has equal access to medical treatments and high quality care from the NHS (National Health Service) of United Kingdom. NICE is recognized as a leader in setting standards for high quality healthcare and producer of clinical guidance. They also produce public health recommendations on how to help improve people's health and prevent disease. These are aimed not just at the NHS but also for local authorities and all those who have mandate for improving people's health in the public, private, community and voluntary sectors.

NICE tackles a wide range of issues. For example, topics covered by their guidance range from helping people to stop smoking and encouraging them to be more physically active through to the treatment of cancer, diabetes, musculoskeletal conditions and mental health problems. They also make recommendations on the use of a range of drugs. The recommendations are devised by independent committees.

Council on Health Care Economics and Policy in USA is an independent, non-partisan deliberative body of recognized experts to identify critical issues generated by health system change, analyse the economic impact of such changes, and disseminate findings to national policy makers, health services researchers, industry leaders, and the general public.

Although the principal focus of the Council is on economic issues, the Council also considers the implications of system changes for access to health care services and for quality of care. The Council strives to generate new ideas for improving both the financing and delivery of health care services.

The Council pursues its mission through the following specific objectives:

- Identify critical issues brought about by health system change
- Conduct original research and commission research from technical experts
- Create a forum for discussion of issues among Council members, health services researchers, representatives of Congress, Congressional staff, representatives of related governmental agencies, industry leaders, and members of the press
- Issue background papers, research findings, journal articles, press releases, and policy recommendations (as appropriate)
- Provide analytical leadership by formulating topical research agendas for the Robert Wood Johnson Foundation and/or other health services research organisations and government agencies
- Provide the Robert Wood Johnson Foundation with a flexible model that has the organisational capacity to address current health policy issues in a timely fashion, perform independent research and effectively disseminate findings.

The Cape Fear Health Policy Council (CFHPC) was formed in 2009 to provide a forum for the discussion and resolution of health policy issues in the region or elsewhere. Participants include representatives of Cape Fear Region non-profit organisations, health-care related social service departments and agencies, and the public. CFHPC seeks to inform and to improve networking and cooperation among participants with common health policy interests.

When participants express an interest in pursuing particular issues, follow up actions may include discussions at subsequent meetings, information dissemination, or a committee may be formed to continue the dialogue to an outcome. Where appropriate, contact with state or federal representatives is undertaken to seek solutions or further information.

The examples of issues dealt with are:

- Smoking Legislation, New Initiatives, and Cessation Efforts in the Region
- How North Carolina is Measuring Up in Children's Health
- Regional Air Pollution Standards and Issues
- Status of Stepping Strong Walking Programme
- Forthcoming Healthy Carolinians 2020 Initiatives – What to Expect and When

Texas Health Care Policy Council states that its mission is to research, analyse, and provide recommendations on ways to improve the quality, safety, efficiency, and effectiveness of the health care system in Texas, USA. The primary roles of the Council include:

- Researching and identifying approaches and solutions to address gaps, flaws, inefficiencies, or problems in the health care system and conduct research and analysis on ways to improve health care in Texas
- Ensuring the most effective collaboration among state agencies in the purchase of health care products and services
- Facilitating and promoting the use of technology in the health care system as a way to decrease administrative costs and to increase and improve the quality of health care
- Monitoring and identifying ways to ensure the health care workforce is large enough to serve the health care needs of the state
- Establishing and maintaining a clearinghouse of information to assist communities in assessing the needs of local health care systems; and
- Analysing other issues identified by the Governor.

Not later than December 31 of each even-numbered year, the Council submits a report of the Council's findings and recommendations to the Governor, Lieutenant Governor, and Speaker.

Ohio Nurses Health Policy Council consists of at least nine members and is deeply involved in both the legislative and political activities of Ohio Nurses Association (ONA). They make recommendations to the Board of Directors of ONA regarding the association's overall legislative platform. In addition, Council members review bills, participate in strategy development sessions, and can assist districts in developing their own legislative programmes. During election years members coordinate the candidate endorsement process and make recommendations about contributions from the Political Contributing Entity. Specifically, the Council does the following:

- Evaluate proposed federal, state and local legislation for its implication for nurses, nursing and health and make recommendations to the Board of Directors.
- Develop and institute a state legislative programmeme with the approval of the Board of Directors.
- Advise the Board of Directors, structural units and districts on legislative and political issues.
- Develop a grassroots political participation programmeme.
- Promote appointment of qualified nurses to key leadership positions in government, industry, state, health related foundations and consumer organisations.
- Oversee fund raising efforts for support of candidates for the state legislature.
- Implement the endorsement process in election years.
- Appoint the CEO as the treasurer biennially, who shall function in accordance with legal requirements for political contributing entities.

C. AIMS OF THE NATIONAL HEALTH POLICY COUNCIL IN PAKISTAN

The National Health Policy that has been put to the cabinet for approval states that there will be a line of accountability; however, the mechanism is not defined. The MOH is working for establishing the NHPC with the key aim of monitoring the progress of implementation of the National Health Policy. Discussions on defining the aims in detail for the Council have led to the following agreement, with few dissensions[1]:

The NHPC will be a body with representation from the public and non government sectors concerned with Ministry of Health's policy direction. The aim of the NHPC will be to improve health of the people of Pakistan through two key roles:

a. Monitor implementation of the health policy and suggest feasible solutions to resolve the obstacles in implementation, including financial issues and constraints.

b. Help to improve the existing health policy on regular basis after reviewing critical issues related to public health, health care services and quality of care.

Besides the above mentioned, it will also:

c. Recommend new legislation required to effectively implement the health policy

d. Review proposed legislations for their implication on health and make recommendations to the concerned ministries

[1] Very few people who participated in discussions thought that aims should not be monitoring but to be a think tank. Their view points are described in MODEL 1 presented later.

e. Endorse standards for quality of care in public and non government sectors and monitor the progress in their implementation

f. Support measures for engaging public, media and political parties in monitoring health policy implementation.

g. Identify other needs, including policy research and advise commissioning research on policy issues.

D. MODEL AND COMPOSITION OF THE COUNCIL

Deliberations were held with several stakeholders to discuss the composition of the NHPC with the aim of constituting a viable productive body. This led to the emergence of distinctively different models with a range of functions, authority and composition. The main models for the NHPC that emerged during the discussions are presented below:

1. Technical forum for discussion on health sector issues and suggesting resolutions – a think tank

2. A monitoring body only overseeing the progress of policy implementation

3. A monitoring and advisory body working under MOH

4. An autonomous regulatory body with powers to direct MOH

In the Consultative Meeting on the draft proposals for NHPC held on 16 June in Islamabad, Model 3 and 1 were considered as options, with wider support for Model 3. Model 2 and 4 were not considered viable models.

MODEL 1

Forum for Discussion and Resolution of Policy Issues– Think Tank

Very few people advocated this model, although it has lots of merit for serious consideration. According to its advocates, this should be a forum (a think tank) of professionals equipped with technical expertise for reviewing the health sector in a composite way, identifying the priority issues facing the country and suggesting viable solutions. Its functions should be to:

- Produce a "Country Health Report" every 5 year that should provide the situation analysis describing what is happening and what is not happening in the health sector, identify priority issues of the sector, and propose feasible policy options to overcome them.

- In the interim period, analyse priority issues of the health sector, one by one, and present their solutions through brief but succinct guideline papers for MOH/DOH.

- Recommend and guide for appropriate distribution of funds, based on the identified needs.

Thus its main task will be identifying and highlighting issues – both technical and financial, describing them clearly, and providing guidance for resolving them. Its output papers and reports should have technical analysis of the issues and put forward options for their resolutions for government's consideration.

For example, the Council could address the issues of quality of care:

- Approve quality standards (managerial + clinical) for primary and secondary health care

- Give recommendations on new and existing medicines, treatment, clinical guidelines and interventional procedures

- Recommend quality and outcome framework for GP practices

Or provide guidelines on dealing with determinants of health

- Provide guidelines for increasing access to the public sector health services

- Analyse the factors affecting the health of the youth and recommend specific policy measures.

- Identify measures for improving people's health and preventing illness and disease at work places.

It was emphasized that **it should not be a monitoring body.**

This forum should have powers to create technical groups for looking at different issues.

This model is somewhat comparable to the functions of NICE in United Kingdom and Council on Health Care Economics and Policy in USA, as described earlier.

Membership:

It was suggested that experts, both from the public and non government sectors , should be invited to become members of this forum. These members should elect a Council of 15-20 individuals to lead the process. The Council should elect its Chairperson. This procedure for selection of the members and the Chair would help to make the forum an autonomous body.

Strengths of the model:

- It will be a think tank of technical experts from the public and non government sector, hence, will have a prime focus on improving the quality of health care and standardising services not only in the public but also in the non government sector.
- Leadership from the non government will guide the public sector to incorporate efficient business practices

Weakness of the model:

- Does not have the focus on monitoring the implementation of the National Health Policy, which is the stated key aim for establishing NHPC.
- This forum does not seem to have “teeth” to get things done. Many good recommendations are given in different reports but they are not implemented. It was feared that without any powers to “get things done” it will not be able to make any “dent” in the system.

MODEL 2

A monitoring body ONLY overseeing the progress of policy implementation

This model has been advocated by some public sector participants, especially by those who have played a role either in policy making or in monitoring of health programmes.

This model proposes the formation of the NHPC for two key functions:

- Keeping decision makers and policy makers updated with progress in the health sector
- Playing effective role in securing budget according to policy needs

It defines distinct roles for players in the health sector at different levels and describes the functioning of this model on the basis of described roles:

National Level	Formulation of Health Policy
Provincial Level	Translation of National Health Policy into Operational Plan
District Level	Implementation of Operational Plan to achieve health targets

It proposes that once the National Health Policy is announced, staff members from the Health System Strengthening and Policy Unit (HSSPU) should visit the provinces to assist them in translating the policy into operational plan with targets for implementation in the districts[2]. Besides this, the provinces should also be trained in effectively monitoring those plans. According to this proposal, a major pre-requisite is a well

[2] Not all provinces have agreed to receive help from HSSPU for developing plans. Punjab would like to follow its health policy, however, is willing to participate in NHPC provided its mandate is not very narrow and the province is not dictated to follow every bit of the NHP.

structured and functioning HSSPU at the federal level and the HSRU or its equivalent at the provincial level.

The monitoring by NHPC will be based on the data provided to the HSSPU. The data generated at the district level by different bodies would be reported to the Health Sector Reform Unit (HSRU) at the provincial headquarters every month for compilation and production of provincial data. The data for agreed indicators would then be forwarded to HSSPU every three months. HSSPU would aggregate the data from all provinces to produce the National data. This National data would be regularly reviewed at the HSSPU and presented to the NHPC with a brief summary report.

The NHPC would meet every six months under the chairmanship of the Federal Health Minister to review the progress and make feasible recommendations. Every year, the Health Minister would present the progress of the health sector to the cabinet and the parliament and seek their support in overcoming the identified barriers.

Membership	
Government	Non Government
Federal Minister of Health	Pakistan Medical Association
Secretary, Federal Ministry of Health	Civil Society Organisation
Director General, Federal Ministry of Health	Representative of NGO
Provincial Secretaries Health (5)	Representative from Private Medical University
Provincial Secretary Health AJK	DFID
Chief of HSSPU	USAID
Financial Advisor (FA Health) from Ministry of Finance	WHO
Member Social Sector, Ministry of Planning and Development	World Bank
Chairman, Standing Committee on Heath (National Assembly)	
Executive Director, Institute of Public	

Health, Lahore	

Advantage of the Model:

- Close monitoring of the agreed indicators to ascertain progress in policy implementation.

Disadvantage of the Model:

- Does not respond to the described aims of the Council
- The Council is mainly dominated by the members from the public sector, hence will lack the push brought about by strong civil society voices
- There is potential of significant influence of donors/development partners
- Very weak input from the other non government sector units.

MODEL 3

A monitoring and advisory body working under MOH

This model has been favoured by the majority and has been considered most feasible. It also responds maximally to the missions/aims of the NHPC presented earlier.

The proposed membership of this model is as follows:

Membership	
Government	Non Government
Secretary, Federal Ministry of Health	Pakistan Medical Association
Director General, Federal Ministry of Health	Representative of CSOs
Provincial Secretary Health (Balochistan)	Representative from a Professional Society Working for Women's Health
Provincial Secretary Health (Gilgit-Baltistan))	Representative from a Professional Society Working for Child Health
Provincial Secretaries Health (Khyber Pakhtoonkhwa)	Representative from a Professional Society Working for Infection Control
Provincial Secretary Health (Punjab)	Representative from Committee on Corporate Social Responsibility, Federation of Chamber of Commerce and Industry
Provincial Secretary Health (Sindh)	Representative of NGOs
Federal Secretary Ministry of Population Welfare	Representative of CPNE
Financial Advisor (FA Health) from Ministry of Finance	Civil Society Leader
Member Social Sector/Chief Health,	Civil Society Leader

Ministry of Planning and Development	
Chairman, Standing Committee on Heath (National Assembly)	Representative of Donors/Development Partners

Rationale for this Membership is given below:

Government Membership: A consensus existed for the proposed 11 members from the government sector. However, a few other members were also proposed by 1-2 persons, which were not considered feasible by others. These included:

- Representative of Ministry of Education
- Representative of Ministry of Agriculture
- Representative of Ministry of Law
- Representative of Ministry of Environment

It was suggested that these representatives could be included in sub committees formed for specific tasks (see sub-committees described later).

Non Government Membership: Several members were proposed to be in the Council for the suggested 11 seats. Out of these, 11 have been listed above based on the emerging consensus and their potential effectiveness. The rationale for their inclusion is given below.

Pakistan Medical Association (PMA):

Pakistan Medical Association is the professional body of the doctors established in 1948 and has played a role in reviewing past health policies and in suggesting policy reforms to the various governments. It has 104 district branches throughout the country and reaches the medical community through various means such as seminars, lectures, specific campaigns, the “Journal of Pakistan Medical Association”, monthly newspaper “Medical Gazette” which is circulated in all the branches, two six monthly journals “Journal of Medical Ethics” and “Journal of Medical Education”. These characteristics will be very useful in disseminating the national health policy and operational plans for its successful implementation, provided PMA is taken on board as a valuable stakeholder.

PMA was recommended for membership of the NHPC as it is considered a larger and more representative body of the medical community in comparison to other similar

organisations like PIMA (Pakistan Islamic Medical Association), YDA (Young Doctors Association), etc.

Civil Society Organisation:
Few leading civil society organisations (CSOs) have been identified that have significant contribution in delivery of low-cost quality health care and/or in development of human resource. Presence of CSOs in the Council would be enriching to benefit from their experience and success. The selection of one member from CSOs was considered important.

Some Examples of CSOs:
The Aga Khan Health Service, Pakistan (AKHSP) is a Not for Profit Public Company with annual spending of Rs. 844 million towards its programme objective. The organisation has gone through a process of gradual evolution and has accumulated extensive experience and developed a specific perspective towards developing health systems with full involvement of the communities. AKHSP's main strength in health is its vast community based network of more than 100 primary health care delivery outlets through out Pakistan, with 70% of these in the more disadvantaged areas in Northern Areas of Pakistan, NWFP and rural parts of Sindh and Punjab. AKHSP is considered to be a leader in area of maternal and child health promotion. The organisation through its capacity development programmes for trained birth attendant in Northern Pakistan has been able to remarkably reduce the deaths of women in the most under privileged communities.

Fatima Memorial System is a multidisciplinary, state-of-the-art non-profit organisation providing quality services in areas of social development, health care, education, research and community uplift in Lahore. These include 500 bed tertiary care general hospital, College of Medicine and Dentistry, College of Nursing, Institute of Allied Health Sciences, Centre for Postgraduate Training and Centre for Health Research, outreach community programme, formal and non formal schools, and upcoming College of Midwifery.

Shaukat Khanum Memorial Cancer Hospital & Reseach Centre is a state-of-the-art hospital located in providing comprehensive care free of cost to cancer patients. It is a

charitable institute funded predominantly from the donations of friends and well-wishers from around the country and across the world; and has spent over Rs. 6 billion in supporting the treatment of thousands of indigent cancer patients.

Representative from Professional Societies Working for Women's Health, Child Health and Infection Control:

The representation from these three professional bodies in the NHPC is considered important as the national health policy focuses on maternal and child health, and infectious diseases. Several leading obstetricians, paediatricians and infectious diseases experts from professional bodies have been involved in policy formulation, implementation and monitoring of various health programmes and have the experience, expertise and vision to be a valuable member in the NHPC. It was recommended that the executive committees of the relevant professional societies should be invited to nominate the most competent expert for the membership. A major consideration should be the willingness of the selected individual to give the required time.

Representative from Committee on Corporate Social Responsibility, Federation of Chamber of Commerce and Industry (FPCCI) to represent private sector hospitals.

FPCCI is the apex body of the private sector and private hospitals are associated with it in different ways. The Chamber has a standing committee that deals with Corporate Social Responsibility (CSR) in which health is the primary component. Mr. Sultan Chawla , President of FPCCI has shown keen interest and expressed willingness to nominate a visionary person in the NHPC to represent the private sector hospitals, who would also benefit the council by sharing the corporate sector practices. He gave example of the Indus Hospital, which is member of the FPCCI.

The Indus Hospital is a joint venture of the Ruffaydah Foundation and the Islamic Mission Hospital Trust in Karachi. It is a state of the art hospital and provides free of cost medical care to the poor and needy of not only Karachi but patients coming from far and wide. The tertiary care facilities at the Hospital are complemented by community outreach programmes focused on prevention and early detection of disease, encouraging community involvement and ownership.

Representative of NGOs

Groupings of NGOs focusing on specific health issues exist, for example, PRHN, MUBARIZA, PNAC, NATPOW. Pakistan Voluntary Health and Nutrition Association (PAVHNA) appears to be the only umbrella body of 40 NGOs and CBOs in Sindh, Balochistan and Khyber Pakhtoonkhwa working in the development field in areas of reproductive health, safe motherhood, STIs, HIV and AIDS, gender and women empowerment. The Association is registered at Federal and Provincial levels, and in its 31 years of experience has demonstrated strength of building capacities of NGOs, working with diverse groups and in community mobilization.

Criteria with score should be developed and sent to the leading NGOs and the selection could be made after the scrutiny of the response. Suggested criteria could be:

a. Years of experience
b. Organisational structure
c. Management structure
d. M&E capacity
e. Financial management capacity
f. Number of projects implemented
g. Evidence of success.

A draft sample letter is attached as Annex 2.

Representative of Council of Pakistan Newspaper Editors (CPNE)

Media has played a prominent role in highlighting the political issues in Pakistan. In the recent past, they have gained credibility due to several successful interventions. It has been argued that this “power” be utilized to monitor the implementation of the National Health Policy with direction from the NHPC. It has been suggested to include a member from CPNE, to play the role responsibly. In contrast to this nomination, most participants advised not to seek nomination from Pakistan Broadcasters Association, which includes TV and radio broadcasters, as they often sensationalize the issues rather then taking objective approach.

Civil Society Leaders

Several participants stated that it is often an individual rather then the organisation that makes things happen. Therefore they advocated that the NHPC should include some

civil society leaders. These individuals may not belong to any of the category of the proposed organisations for membership, their organisation may not be selected to represent, or they may have retired after a successful tenure. Certain names were quoted as examples, including Shamsh Kassim Lakha, Shaheen Atique ur Rehman, Fakharuddin G. Ibrahim, Anita Ghulam Ali, Shahima Rehman, Asma Jehangir. It was suggested that the criteria for selection of these individuals should be:

(a) extremely well known in their field
(b) demonstrated vision in their approaches
(c) have proven track record of success
(d) are articulate
(e) have willingness and time to participate
(f) have background to interact with ministry or government departments, and
(g) are not suffering from chronic ill health.

Representative of Donors/Development Partners

Most participants have opposed the inclusion of the donors/development partners in the Council while a few advocated having representative from the leading ones, such as DFID, USAID, WHO, UNICEF and World Bank. An intermediary approach suggested is to have one "donor/development partner representative" in the Council.

Other members that were suggested but are not included in the above 11 are presented below:

- Pakistan Nursing Council
- College of Physicians and Surgeons
- Representative of Private Medical Education System
- Pakistan Broadcasting Association
- Pakistan Bar Council
- Consumer Protection Bodies
- Private Health Insurance Company
- Human Rights Commission of Pakistan
- Teachers' Association

Key reasons for their exclusion were any of the following:

- They have a role only in limited areas of health policy and they can be included in subcommittees as deemed necessary
- The organisation is not a unified body, not yet credible among its own peers, and several members are driving their own agenda.
- The organisation is weak.
- May not be relevant to meet the objectives.

Chairperson:

Public sector participants suggested that the Council should be chaired by the Federal Secretary or the Minister of Health, however, more were in favour of the Federal Secretary of Health. It was stated that getting implementation done is the responsibility of the bureaucracy, and not of the Minister.

Some participants from the non government sector were of the opinion that the Council should be chaired by a non government sector member, and the person may not even be from the health sector (even a retired judge of the Supreme or High Court was also suggested). However, others from the non government sector adopted a less aggressive approach and recommended that the Council should be chaired by the Federal Secretary of Health. They argued that selecting a non government Chairperson would result in confrontation with government from the beginning and would be a non-starter. They suggested making Co-Chair from the non government sector.

A few individuals suggested that the Council should elect its Chairman for a period of 3 years, who could either be from the non government or public sector.

Advantages of the Model:

- It responds to the defined aims of the Council
- Has a good mix of members equally from the government and the non government sectors
- Proposed membership is well thought and well defined
- It supports the MOH

Disadvantages of the Model:

- It was mentioned by a few government officials that the Secretaries of Health may not feel comfortable in working with so many high powered non government members.

MODEL 4

An Autonomous Regulatory Body with Powers to Direct MOH

This model has been advocated by a few people who would like the NHPC to be a body with powers equivalent to Public Accounts Committee of the National Assembly for enabling it to direct or restraint the MOH for/from certain actions. However, most participants thought this would create conflicts and ripples rather than facilitate implementation.

The proposed membership of this model is as follows:

Membership	
Government	Non Government
Secretary or Director General, Federal Ministry of Health	Pakistan Medical Association
Federal Secretary Ministry of Population Welfare	Representative from Professional Society Working for Women's Health
Financial Advisor (FA Health) from Ministry of Finance	Representative from Professional Society Working for Child Health
Projects Wing, Planning Commission	Retired Judge from Supreme Court or High Court
Chairman, Standing Committee on Health (National Assembly)	Representative of media – TV
Provincial Secretary Health (Balochistan)	Representative of media – radio
Provincial Secretary Health (Gilgit-Baltistan))	Academia
Provincial Secretaries Health (Khyber Pakhtoonkhwa)	Representative of Council of Islamic Ideology
Provincial Secretary Health (Punjab)	Representative of Hakims

Provincial Secretary Health (Sindh)	Representative of Homeopaths
	Representatives of Minorities
	PMDC
	Expert from Non government

This model proposes to include members from media (both TV and radio but not newspapers), Academia, PMDC, Council of Islamic Ideology, hikmat, and minorities, which were not recommended in the previous models. The rationale given for their membership is as follows:

Media:

Media, especially television, has been very active in highlighting the corruption, negligence, and poor performance in several areas that has an effect on the life of people. They have shown activism in mobilizing people against wrong doings of the various departments. This strength should be used for forcing the public and non government sectors related directly or indirectly with the health of the people to perform according to the prescribed standards and rules.

Membership from the newspapers was ruled out on the basis that the readership is very limited.

Academia

A representative from medical education, especially those who are actively involved in public health research, should be included, to guide for required research.

Pakistan Medical & Dental Council (PMDC)

Representation from PMDC will help to ensure that the curriculum of the medical colleges' responds to the National Health Policy and also that degree to the graduates and certification and accreditation are given in accordance to the aspiration of the National Health Policy.

Representative from Council of Islamic Ideology

It was argued that various misconceptions among the people obstruct the implementation of health and family planning programmes, especially for services

related with females. This needs to be overcome with concrete and specific policy guidelines. It was mentioned that assistance from learned *ulema* is required for the purpose. Examples of very positive experiences of interactions with *ulema* were narrated in the project "Extended Service Delivery" being implemented by MOPW. .

Representative of Hakims and Homeopaths

Hakims and Homeopaths are a recognized system of medical care services in Pakistan. They need to be given a boost as they are less costly and more affordable by the general public. Their representation is essential in the NHPC to give them a voice and promote these important but neglected methods of medical care.

Minorities

A few participants stated that minorities may have some specific religious issues and other concerns in health care that have never been highlighted. Therefore, a dynamic leader from their group should also be a member of the NHPC to draw attention to the issues of minorities.

Chairperson:

It was advocated that the Council should be chaired by a Judge to make it an independent and non partisan body. Concerns were expressed that if it is chaired by a representative of MOH, it will become a body similar to the Population Commission, which has not been effective in resolving the issues.

Advantages of the Model:

- It will be a regulatory body with powers to direct rather than only recommend.
- It has a stronger representation of the non-government sector, which will maintain the pressure on the government to deliver

Disadvantages of the Model:

- It is confrontational rather than facilitative and
- Does not have a good mix of non-government members

E. RULES OF BUSINESS

The Council will function with the participation of the federal and provincial governments, civil society organisations and other non government organisations.

Advisory or Regulatory Body:

Almost all individual recommended that NHPC should be a regulatory body with “teeth”, whichever model is accepted. It should be made a statutory body through parliament.

Many emphasized that it should be autonomous otherwise it will not be very effective. An example of National Commission on Status of Women (NCSW) was given, which takes decisions independently but the financial control is under Ministry of Women’s Development that hinders the Commission’s functioning substantially. While others disagreed with the proposed autonomous status, they contended that NHPC’s role is to discuss and resolve issues to facilitate implementation by the Ministry and Departments of Health, and not to “whip” them.

Secretariat of the Council:

The HSSPU in Islamabad has been designated as the Secretariat for the Council. A major pre-requisite for it to function effectively is to strengthen its structure and make it functional in monitoring the policy implementation. It also requires establishing infrastructure at the provincial level for monitoring implementation of Health Policy. The Health Sector Reform Unit (HSRU) or its equivalent unit (e.g. HSRP) should be made the responsible body for monitoring the implementation of the heath policy and provide the required data to the HSSPU.

The data generated at the district level by different bodies should be reported to the HSRU at the provincial headquarters every month for compilation and production of provincial data. The data for agreed indicators should be forwarded to the HSSPU every three months. The HSSPU should aggregate data from all provinces to produce the national data. This national data should be regularly reviewed at the HSSPU and

presented to the NHPC with a summary of the findings. The NHPC should review the progress and make feasible recommendations.

Number of Total Members:

Most participants suggested for keeping the membership up to 15 members, while some were willing to extend it up to 20-22 members. Their reasoning was that it is important to have membership from all relevant quarters rather than emphasizing for a smaller group.

Exclusion from Membership:

Most of the persons met have opposed the inclusion of any donor agency/development partner representative in the Council. Also several participants categorically emphasized that pharmaceutical industry has a clout; hence they should NOT be given the membership of the Council.

Duration of Membership:

The members from the public sector will represent a specific designation; hence, the issue of duration of membership does not arise. The duration of membership proposed for the non government sector individual's representing various categorized has ranged from 3 years to 7 years, with most favouring 3 years. However, those who advocated 5 to 7 years were of the opinion that policy effects are not visible in a short period, hence, longer terms be given to the members.

It was also suggested that on completion of the first term, only half of the members should be replaced to maintain continuity, as is done in the Senate.

Funding for the Council:

It was recommended that the funding for functioning of the Council and its subcommittees should come from the government, but not from the MOH. Most participants recommended that no funding should be accepted from donors/development partners, to maintain its authority. It was suggested to fund it through Cabinet Division, as Peoples Primary Health Initiative (PPHI) is being currently funded through this mechanism.

A few felt that donors could support the functioning under some umbrella arrangement like TRF.

Meeting and Time:

Most participants favoured holding meetings twice in a year. One meeting should be held in March or early April, which would allow time for appropriate budgetary actions. The second meeting should be held accordingly after six months in September or October.

However, the majority of the people met suggested that initially the meeting should be held quarterly at least for the first year to allow “gelling together” and to acquire a grip on the tasks.

A suggestion for holding a meeting through video conferencing was also floated to cut the costs and save time in travel, which could be utilized in prolonging the session of the Council.

Agenda for the Meetings:

Provinces have emphasized that HSSPU should finalize the agenda of the NHPC meetings in consultation with HSRUs or any other counterpart unit in the province.

Linkages with Provincial Health Strategic Councils

It has also been suggested to consider establishing Provincial Health Strategic Councils (PHSC) in the provinces and Special Areas. If they are established, then HSRUs in the provinces and special areas will report to the PHSC in their respective province/special area. PHSC will then forward the data to the HSSPU.

The provincial members in the NHPC will also be members of the PHSC, which will serve as the bridges between the NHPC and the PHSCs in the provinces and special areas.

Relationships with other Policy Level Councils and Committees in the Health Sector:

The NHPC will have functional links with the other existing governance bodies and Councils in the health sector, such as PMDC, PNC, PMRC, Committee on Drugs, Tibb Council, Homeopathic Council, College of Physicians and Surgeons Pakistan; and also with policy level committees, e.g. Health System Strengthening Committee and Steering Committees.

The links will be either through the representation of the MOH in these bodies (e.g. Federal DG Health is a member of the Executive Council of PMDC), or these bodies functions under the Federal Secretary of Health or the DG Health, or they will be invited to attend the Council meetings for related issues.

Reporting:

The NHPC should report annually to the Social Sector Committee of the Cabinet.

Technical Committees:

The NPHC should have the authority to form technical committees to look into specific areas. For example, it could form a sub-committee to look into the status of health of the youth in Pakistan, to identify policy gaps that are detrimental to their health and make recommendations for policies that can lead to the improvement.

Inviting Experts:

The NHPC should also have the authority to call experts for making presentations on specific topics or for seeking guidance, as and when necessary.

Sub-Contracting:

The Council should have the authority to direct the HSSPU for subcontracting out required research.

Other Points for Consideration:

- The 18th Amendment has created a new scenario, where the role and authority of the MOH is not yet very clear. Therefore, formation of the NHPC should be delayed till the federal and provincial roles in health sector are clarified.

- In past, some new structures in the system created hurdles rather than facilitating processes. Therefore, it should be carefully planned that NHPC is a supportive and facilitative structure rather than an obstructive institution.

Annex – 1

List of Persons Met

Islamabad

1. Mr. Agha Nasir – Geo TV
2. Mr. Aijaz Gul – Geo TV
3. Dr. Arif Hussain – TRF
4. Dr. Asad Hafeez – HSSPU
5. Dr. Bashirul Haque – Public Health Expert
6. Dr. Fazle Hakim Mian– Chief Health, P&D
7. Dr. Inamul Haq – Senior Health Specialist, World Bank
8. Dr. Mushtaq Khan (Late) – Ex Chief NHPU
9. Ms. Nasreen Azhar – Member National Commission for Status of Women
10. Dr. Qaisar Pasha – AusAid
11. Dr. Raza Zaidi – DFID
12. Dr. Riaz Ahmad – Public Health Expert
13. Ms. Saadiya Razzaq – HSSPU
14. Dr. Shimail Daud – Director, Health Services Management, Maryam Hospital and Member Hospitals Association
15. Ms Stella Nazir, Advisor Nursing Council
16. Dr Syed Ozairul Ghani – Director ASK Development
17. Mr. Tahawwar Ahmed – Financial Advisor (Health), MOF
18. Dr. Tauseef Ahmad – Demographer and Sociologist
19. Ms. Zarina Kausar – CCM

Karachi

20. Dr. (Capt) Majid – Special Secretary Health, Sindh
21. Dr. Amer Raza – General Secretary, PMA Karachi
22. Ms. Afsheen Ahmed – President, PAVHNA
23. Ms. Fauzia Matloob – Manager Operations, PAVHNA
24. Dr. Farhat Abbas – Dean, Aga University Medical College

25. Dr. Fauziah Rabbani – Chairman, Department of Community Health Sciences, Aga University Medical College
26. Dr. Idrees Adhi – President PMA Karachi
27. Dr. Khalil Ahmed Mukaddam, VP PMA Karachi and Director HealthPak
28. Dr. Masood Hameed – Vice Chancellor, Dow University of Health Sciences
29. Dr. Mirza Ali Azhar – PMA Center and Member Amnesty International
30. Dr. Qazi Wasiq – PMA
31. Ms. Rehana Rashdi – Director Programmemes, PAVHNA
32. Dr. Rizwan Azami, Member Executive Council, CPSP
33. Ms. Rozina Mistry – Director Community Health, AKHSP
34. Dr. Salamat Kamal – VP PMA Karachi
35. Dr. Samrina Hashmi – Member Society of Obstetrician & Gynaecology + PMA
36. Dr. Shoaib - PMA
37. Mr. Stephen Hayes – CEO, AKHSP
38. Mr. Sultan Ahmed Chawla – President, Federation of Chamber of Commerce & Industry

Lahore

39. Mr. Abdullah Khan Sumbul – Special Secretary Health
40. Mr. Shahzad Chowdhary – Executive Director, Fatima Memorial System
41. Dr. Faisal Sultan – CEO, Shaukat Khanum Memorial Cancer Hospital & Research Center

Peshawar

42. Dr. Syed Sohail Altaf – Secretary Health
43. Dr. Shabina Raza – Chief, HSRU
44. Dr. Shaheen Afridi – Deputy Chief, HSRU

Annex 2 – Sample Draft

Call for Nominations for Membership of National Health Policy Council as Representative of NGOs

The National Health Policy Council has recently reached an agreement about its aims and structure. It will consist of 22 members (11 each from the government and non government sectors). One of the members will be a representative of the NGOs. The structure and responsibilities of the NHPC are outlined in the attachment.

The purpose of this notice is to solicit nominations for the NHPC from the NGOs to represent NGOs. One NGO will be selected as a member for an initial term of 3 years, with possibility of renewal for an additional 2 year term.

You are requested to provide the following information about your NGO:

- Number of years of experience
- Organisational structure
- Management structure
- M&E capacity
- Financial management capacity
- Number of projects implemented
- Evidence of success.

Besides this, also provide the following information about the person being nominated to represent in the NHPC:

- Name, title of the nominee
- Brief statement of his/her contribution in the field and skills offered to the NHPC
- Brief CV or biosketch
- Statement from the NGO Board that they are prepared to support the nominee for the NHPC work

In addition to the responsibilities outlined in the attachment, we anticipate that participant in the NHPC will be required to attend 2 face-to-face meetings each year and periodic teleconferences. Consequently, it is essential that the NGO include a statement that they will support that level of participation.

Please submit nominations to ……. no later than close of business on …….2010. It is anticipated that selections will be announced on or before …….2010. Please pass it on to other interested parties.

The member to represent NGOs in NHPC will be selected based on the commitment to follow issues, available time, technical expertise, and representation of the broad and diverse NGO spectrum and other criteria specified above.