August 2025

Punjab's Evolving Health Sector

Insights & Reflections

SPHERE

Driving development through data

Contributors

This report, ***Punjab's Evolving Health Sector - Insights & Reflections***, has been developed to document the Government of Punjab's transformative journey in strengthening primary and secondary healthcare. It captures the authors' views on the strategic vision, operational innovations, and policy frameworks that underpin the province's health sector reforms.

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Recommended Citation

Majeed N, Maqsood A, Waheed F, Sadiq MAA, Dawood Z. (2025) *Punjab's Evolving Health Sector – Insights & Reflections*. SPHERE Consulting. https://doi.org/10.5281/zenodo.16887882

https://doi.org/10.5281/zenodo.16887882

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List of Abbreviations

ADP	Annual Development Programs
BHU	Basic Health Unit
CHI	Community Health Inspector
CIP	Central Induction Program
CoW	Clinic on Wheels
DHQ	District Headquarter
DGDC	Directorate General for Drug Control
DGHS	Directorate General of Health Services
DGPW	Directorate General of Population Welfare
EMR	Electronic Medical Record
EPI	Expanded Program on Immunization
HMIS	Hospital Management Information System
IRMNCHNP	Integrated Reproductive, Maternal, Newborn, Child Health & Nutrition Program
KPIs	Key Performance Indicators
LHW	Lady Health Worker
MNCHS	Maryam Nawaz Community Health Services
MNHC	Maryam Nawaz Health Clinics
MNH	Maryam Nawaz Hospitals
MSDS	Minimum Service Delivery Standards
NADRA	National Database and Registration Authority
NBP	National Bank of Pakistan
OPD	Outpatient Department
PHFMC	Punjab Health Facilities Management Company
PMU	Provincial Management Unit
PNC	Pakistan Nursing Council
PPIF	Punjab Population Innovation Fund
PPP	Public–Private Partnership
PWD	Population Welfare Department
RAS	Rural Ambulance Service
RHC	Rural Health Centre
THQ	Tehsil Headquarter
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund

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Introduction & Overview of Punjab's Health Reforms

Introduction

Over the past decade, Punjab government launched several initiatives to strengthen primary healthcare. In 2013, the Integrated Reproductive, Maternal, Newborn, and Child Health & Nutrition Program (IRMNCHNP) unified various maternal and child health programs (LHW Program, MNCH Program, nutrition, family planning) under one umbrella, significantly expanding community healthcare services across all 36 districts. This program managed a vast field force – including over 48,000 Lady Health Workers and 3,000 community midwives, at that time – and contributed to improved maternal and child health outcomes (higher immunization rates, more facility births). However, the LHW-based model still left coverage gaps in certain populations, especially urban slums and remote rural hamlets that LHWs did not reach. The current LHWs coverage has fallen to ~38,000 workers (2025).

A major reform, under the IRMNCHNP was the scale-up of round-the-clock functionality of Basic Health Units (BHUs) for provision of Basic Emergency Obstetric & Neonatal Care (BEmONC) along immunization and family planning services in evening shift. This was achieved through hiring of over 4,000 LHVs, and a similar number of support staff. The Program also successfully ran an outsourced security service for these round-the-clock BHUs. The Punjab's famous "Rural Ambulance Service (RAS)" was also a flagship initiative under the IRMNCH&N Program. With time, the Program became a hub of primary care reforms; including the technical wing for development and scale up of electronic medical records (EMR), the HMIS for Primary Care, and the Clinic on Wheels (CoWs) for urban slums and rural areas. However, the IRMNCH&N Program provincial management unit (PMU) was a development side funded program, funded by the provincial Annual Development Programs (ADP) budget.

In 2015, Punjab established the Punjab Health Facilities Management Company (PHFMC), a government-owned company tasked with managing hundreds of BHUs and rural health centers (RHCs) in select districts via contract staffing. PHFMC brought improvements in facility functionality – hiring doctors and nurses on fixed contracts to fill vacancies, reducing staff absenteeism, and introducing basic digital reporting – which kept the primary care facilities open more reliably. Yet, PHFMC's limited scope (about 14 districts) and lack of strong performance incentives meant that it did not dramatically increase service utilization or community trust. The experience showed that while contractual management can improve staffing, a more comprehensive, incentive-driven approach would be needed to truly revitalize primary healthcare. Another limitation in the PHFMC model was the lack of handing over of outreach services (e.g., LHWs, vaccinators, etc.) to the Company.

Against this backdrop, in late 2024 the Government embarked on an ambitious new health sector reforms to strengthen primary and secondary healthcare through innovation focusing on community-based services, outsourcing initiatives and public–private partnerships. Key programs include Maryam Nawaz Community Health Services (Community Health Inspectors), Maryam Nawaz Health Clinics, and Maryam Nawaz Hospitals. These programs have been introduced to drive innovation and public–private partnerships in service delivery. The overall aim is to bring healthcare closer to communities, improve quality of care, and increase efficiency and accountability in the health system. Since IRMNCHNP was an ADP funded program, the PMU had

to close down one day. Therefore, the transformation was done into a new PMU, that now looks after the IRMNCH&NP led initiatives like MNHCs & MNHs, CHIs, RAS, CoWs, etc.

Another major development in the health sector is the integration of Population Welfare Department (PWD) with the Primary and Secondary Healthcare Department (PSHD). Following this long-awaited and much-needed merger, the Department is now renamed as Health and Population Department. This integration has been rolled out from the Provincial to District and facility level. There is now one Minister, and one Secretary of the merged Department. However, the Directorate General of Population Welfare (DGPW) has been retained, thereby the H&P Department now has three Directorates, i.e., the Directorate General of Health Services (DGHS), DGPW, and Directorate General for Drug Control (DGDC). The company, Punjab Population Innovation Fund (PPIF), also comes under the H&P Department. Thus, the Department now has two companies, i.e., PHFMC and PPIF.

Overview of Punjab's Recent Health Reforms

Punjab's health reforms are codified in an act, titled "**Punjab Primary and Secondary Healthcare Services Act 2025"**, which established new programs and structures for healthcare delivery. The reform package, named after the current Chief Minister, centers on the new initiatives, which restructure healthcare at community, primary, and secondary levels namely:

- **Maryam Nawaz Community Health Services (MNCHS)** – a new outreach program delivering basic healthcare *"from birth to end of life at home and in communities"* through a cadre of Community Health Inspectors. The **Community Health Inspectors (CHIs)** are an expanded community health workforce of Pakistan Nursing Council (PNC) *accredited healthcare professionals* who provide doorstep services and preventive care in each community.
- **Maryam Nawaz Health Clinics (MNHCs)** – upgraded primary healthcare facilities i.e. BHUs offering an essential package of health services. These clinics are managed under a novel outsourcing model with performance-based financing.
- **Maryam Nawaz Hospitals (MNHs)** – upgraded RHCs, providing specialty and inpatient services (e.g. pediatrics, obstetrics, minor surgery). These too, are being operated via performance-based contracts with specialist providers.

These components work in tandem to create a continuum of care: CHIs conduct community outreach and referrals, clinics handle primary care, and MNHs provide higher-level care, all under a unified reform vision. Table 1 summarizes the scope of each component:

Table 1: Key Components of Punjab's Health Reforms

Level	Program (Entity)	Services Provided	Management Model
Community	*Maryam Nawaz Community Health Services* (via **Community Health Inspectors**)	Household-level preventive care, health education, basic first contact services (from maternal/newborn advice to chronic disease follow-up). CHIs visit homes and communities according to assigned catchment areas.	**Contracted Hiring Model -** Government is hiring CHIs through third-party agencies on defined terms (including fee-for-service and specified responsibilities).
Primary Care	*Maryam Nawaz Health Clinics* **(upgraded BHUs)**	Outpatient consultations, immunizations, antenatal care, family planning, minor treatments, and referrals. Free essential medicines provided on-site. A large number of clinics operate 24/7 for deliveries and emergencies.	**Outsourced to Health Managers** – Each clinic is managed by a contracted medical practitioner ("health manager") under a performance-based contract. The manager has autonomy over clinic operations, staffing of allied personnel, and must meet service targets.
	Maryam Nawaz Hospitals **(new/upgraded RHCs)**	Comprehensive primary care, and addition of **basic** secondary care: pediatric, dental, gynecological, and general surgical services, diagnostics, inpatient care, and emergency services. Serves as referral hub for MNHCs/BHUs.	**Outsourced to Specialist Teams** – Hospitals are operated by contracted health managers (a team of specialists) on performance-based financing. The government defines eligibility and hires through open competition.
Secondary Care	*Tehsil and District Head Quarter Hospitals* ***(THQHs, DHQHs)***	Comprehensive care secondary care: pediatric, dental, gynecological, orthopedic, radiology, pathology, general surgical services, inpatient care, and emergency services. Serves as referral hub for all primary care facilities.	**Outsourcing - TBD**

Maryam Nawaz Community Health Services & Inspectors

Maryam Nawaz Community Health Services (MNCHS) is a flagship community outreach program. It aims to bring healthcare to the doorstep of the population, especially in rural and underserved areas. Under this program, Community Health Inspectors (CHIs) are being deployed across the province. CHIs are essentially a strengthened version of community health workers – *"accredited healthcare professionals"* tasked to provide basic preventive and curative services in the community. They conduct home visits, promote health education, identify illness early, and refer patients to facilities as needed.

Key features of CHIs and the community services program include:

- **Broad Service Mandate:** CHIs cover maternal, newborn, and child health, nutrition, family planning, and general health monitoring from birth through old age. They will ensure continuity of care by following up with patients in their homes.
- **Designation & Coverage:** The Health & Population Department will designate the catchment area and service package for CHIs. For example, a CHI might be responsible for a certain number of households or a village, ensuring no community is left behind.
- **Hiring Model:** CHIs are being hired via contracting various organizations, in the form of geographical lots. These third-party service organizations have been selected through a formal outsourced contracting agreement, as strategic purchasing. The arrangement is such that the government sets the terms, including any "fee for services" structure and responsibilities.
- **Terms of Service:** The government has determined CHI qualifications (mid-level health workers such as lady health visitors or nurses, duly licensed by the PNC), remuneration, and tasks. CHIs will be accountable to the Health & Population Department and must fulfill any additional tasks notified (e.g. participating in immunization campaigns or disease surveillance).
- **Integration:** CHIs will serve as the link between the community and facilities. They will feed information (e.g., pregnancies, outbreaks, childbirth, maternal and neonatal deaths) into the system and guide patients to MNHCs or MNHs when needed, contributing to the new digital health data system.

Rationale

Prior to this reform, Punjab relied on Lady Health Workers (LHWs) for community health, but coverage gaps remained (especially in urban slums and rural pockets). The MNCHS with CHIs is intended to fill these gaps and strengthen community-based care, bringing Punjab closer to universal health coverage by ensuring every Union Council has proactive health outreach.

It formally institutionalizes community health services as they are being funded through the recurrent budget rather than a development scheme; and incorporate modern elements like e-health (each CHI is expected to use electronic medical records via a tablet, feeding into central data).

Maryam Nawaz Health Clinics (Outsourced BHUs)

Maryam Nawaz Health Clinics (MNHCs) refer to the primary healthcare facilities that deliver essential medical services at the local level. These MNHCs are existing BHUs that have been upgraded using government funds and revamped by the Communication & Works Department (C&W). Their services are now being improved through a public-private partnership model. Initially, the Punjab government opted to outsource management of underperforming BHUs to improve their performance, branding them as MNHCs. However, now, all the BHUs have been outsourced.

An MNHC provides the standard package of primary care – outpatient consultations for common illnesses, maternal and child health services (antenatal/postnatal care and normal deliveries in 24/7 clinics), immunizations, nutrition services, family planning, treatment of minor injuries and ailments, and basic diagnostics. All services are free of charge to patients, with medicines dispensed at the clinic. Each clinic typically serves the population of one Union Council (ranging from 25,000 to 50,000 people).

Operational Model

What differentiates MNH Clinics is their management model

a) Each clinic is operated by a contracted Health Manager, usually a young qualified MBBS doctor selected through a competitive process. This manager is responsible for running the clinic – providing clinical care, managing support staff (dispensers, LHVs, vaccinators, etc.), and ensuring supplies.

b) The contract is a performance-based agreement between the Department and the health manager. The government sets performance benchmarks (e.g. a minimum number of outpatient visits per month, immunization coverage targets, maternal care targets, family planning services, nutrition component, etc.) and quality standards. The manager's compensation is tied to achieving these indicators.

c) Each clinic manager receives a fixed monthly budget (ceiling ~Rs. 893,000 for a 24/7 BHU) to cover all operating costs including salaries of staff and medicines. This is significantly lower than the historical government expenditure per facility and therefore expected to create cost-efficiency. In return, they are expected to raise patient utilization significantly (the initial target was ~1,970 patients per month per clinic, up from an average of 1,265). Performance beyond benchmarks does not yield extra payment at the moment but capitation may be introduced in future.

d) The private manager has flexibility in managing human resources (within guidelines) – for example, hiring additional staff or reorganizing clinic hours to better serve the community. However, they must provide mandated services and maintain standards. To ensure accountability, the department has put in place a robust monitoring system, including EMR based reporting and surprise inspections. In fact, 97% of the outsourced clinics are actively reporting service data through the EMR system, enabling real-time oversight by a central Command & Control Center.

e) Contracts are for a fixed term (one year, renewable based on performance). Poor performers can face termination. Anyone whose contract was terminated for poor performance is barred from reapplying in the next cycle. This clause serves as a deterrent against negligence.

f) Many clinics had existing government staff. The reform accounts for transitioning regular staff out of outsourced clinics. This includes reassigning them to other vacancies, mobile health units (Clinics-on-Wheels), or absorbing them in secondary care hospitals as needed. New clinic managers hire their own teams (often from local private sector), bringing in fresh talent. Moreover, existing staff

Phase-Wise Rollout of Maryam Nawaz Health Clinics

This outsourcing of BHUs under the MNHC initiative began with 150 clinics in the initial phase, funded from the recurrent budget. The provincial cabinet approved this in October 2024. By early January 2025, a transparent selection process had been completed: 150 healthcare professionals were selected out of 3,052 applicants and signed contracts to manage these clinics. These included 100 normal (daytime) BHUs and 50 round-the-clock BHUs distributed across all 36 districts.

Encouraged by the progress of the initial roll-out, the Chief Minister instructed scaling up the initiative. Plans were drawn to expand the model to 982 BHUs. This expansion targets all BHUs being revamped under parallel development schemes (581 in South Punjab and 552 in North/Central Punjab in Phase I). A detailed PC-1 (project document) for outsourcing of 982 clinics at a total cost of Rs. 9.798 billion was then approved. In the third phase, all the remaining BHUs have been outsourced on a similar pattern, through recurrent budget.

Insight

The outsourcing initiative is inspired by global best practices. Punjab's planners referenced the UK's NHS Quality and Outcomes Framework (which incentivizes GPs for performance), Sweden's competitive primary care system, and Spain's Alzira model of public-private partnership. These models demonstrated that linking funding to health outcomes can drive improvements in quality and efficiency. Punjab's adaptation localizes this concept by engaging young doctors to run public facilities on a performance contract.

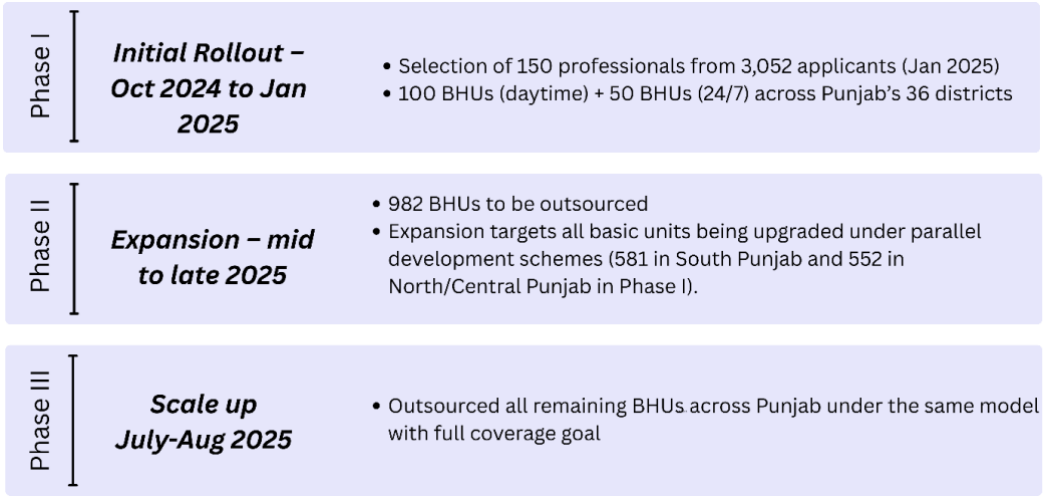


Figure 1: Phase-wise rollout of MNHCs

Maryam Nawaz Hospitals

At the next tier of primary care, MNHs have been established to complement the clinics. In the first phase, eighty RHCs have been converted to MNHs. In practical terms, these are comparable to upgraded RHCs or small Tehsil hospitals, providing services that BHUs cannot, thereby reinforcing the referral system.

A typical MNH offers a broader range of care, including specialty outpatient clinics (e.g. pediatrics, internal medicine), basic surgical facilities (for procedures like C-sections or appendectomies), emergency care, dental care, and advanced diagnostics (X-rays, ultrasounds, lab services). It is equipped and staffed to handle cases referred up from the clinics (complicated deliveries, higher-level treatment of illnesses, etc.) as well as direct walk-in patients in its vicinity.

Management Model

These hospitals also follow a complete outsourcing model on performance-based financing, similar in philosophy to the clinics:

a) Hospitals are entrusted to a consortium of specialist doctors through open bidding. The eligibility criteria demands higher qualifications (specializations in relevant fields) and proven experience, given the complexity of running a hospital.
b) Contracts include detailed terms such as scope of services to be provided (which specialties must be covered), responsibilities (including managing all clinical and non-clinical staff, maintenance of equipment, and drug supply), financial terms (a larger fixed budget or case-based payments), and KPIs to achieve.
c) The performance metrics for hospitals will cover not only patient volume but also quality indicators like surgical success rates, patient satisfaction, referral response times, etc. The government through its Directorate will monitor these via reports and digital tools, similar to the clinic oversight.
d) This model incorporates digital data recording, thereby allowing that after robust digitization of health data, capitation payments could be introduced for clinics, and by extension hospitals, meaning the contractors might be paid per capita for the population they serve. This would incentivize them to keep their catchment population healthy (preventing diseases) since they would handle all needed care within a fixed per person payment.

MNHs were conceptualized to ensure that improvements at the primary level do not falter due to weak secondary care. By outsourcing these mid-tier hospitals as well, the province aims to create a seamless, efficient network: CHIs refer patients to clinics; clinics handle most primary cases and refer upwards; MNH Hospitals manage referred cases and emergencies, and all levels operate under aligned performance goals and accountability.

While the hospital component, including for THQHs and DHQHs, is nascent, it represents the next phase of reforms. The legal framework is in place for outsourcing hospitals (The Punjab Primary and Secondary Healthcare Services Act 2025, promulgated from 1st July, 2025.

Other Initiatives and Reforms

In addition to the above mentioned specific reform programs, Punjab's health reform encompasses broader initiatives:

Outreach Mobile Health Units

The Act mentions mobile units to serve hard-to-reach areas or urban slums lacking fixed facilities. These are essentially clinics-on-wheels that can be deployed flexibly. They too fall under the new framework and can be contracted out or managed by the department to extend services to uncovered populations. Currently, they are being managed by the Department, however, the day-to-day vehicle operations are outsourced to a vehicle rental company.

Tehsil & District Hospitals

The legislation allows the government to either directly run or outsource Tehsil Headquarter (THQ) Hospitals and District Headquarter (DHQ) Hospitals as well. It is expected that public-private management models will be implemented in these hospitals as well, to improve performance. This law, thus, enables PPP for secondary care.

Digital Health Systems

A significant reform aspect is the push for digitization and data-driven management. The new system mandates electronic medical records for patients and a Digital Referral System linking primary to secondary care. Each MNHC and Hospital is connected to a central system that tracks patient visits, diagnoses, and outcomes. This enables referrals to be made electronically and patients to carry a digital history, improving continuity of care. It also feeds into a centralized health data repository for monitoring and planning. A number of digital health systems reforms have been implemented in the health sector of Punjab over the last decade and a half; and now, the time has come to consolidate and unify these systems for better performance management and service delivery

Monitoring & Evaluation Directorate

To oversee all these outsourced services, a dedicated Directorate of Monitoring & Evaluation (M&E) with a Command & Control Center is being established in the Health and Population Department. This directorate uses integrated data – EMR reports, inventory data, and CCTV footage from facilities – to verify that services are delivered as contracted. The unit conducts routine and surprise inspections via monitoring teams, and their findings will directly inform contract management (including imposing penalties or deciding on renewals).

Legal and Policy Framework

The reforms are anchored in law to protect all parties. For example, the Act specifies that contracted personnel (CHIs, clinic managers, etc.) will not become civil servants and have no entitlement to permanent absorption, maintaining the flexibility of the model. It also provides indemnity to those acting in good faith under the law and an override clause making these provisions dominant over any conflicting laws. This strong legal framework reduces uncertainty for private partners and ensures the reforms can be implemented without legal hindrance.

Health Workforce Adjustments

Alongside outsourcing, Punjab is recruiting staff on special fixed-pay contracts for positions still managed by government (e.g. specialists for THQ/DHQ, nurses, paramedics). All new recruitments are on contract (non-civil service) to retain flexibility and performance focus. Special Selection Committees oversee these recruitments to ensure merit-based hiring of capable professionals.

Objectives & Rationale of the Reforms

Objectives and Rationale of the Reforms

Punjab's health reforms are driven by the need to address longstanding challenges in the public healthcare system. Insufficient human resources, staff absenteeism, frequent turnovers, and underutilization of facilities were common. BHUs often saw low patient turnouts despite substantial budgets, in part due to gaps in service quality and community trust. A number of interventions like round-the-clock BEmONC services, biometric attendance, monitoring mechanisms, etc. have helped improve the situation over the years. Now, the government's strategy introduced through the new initiatives aims to further:

Increase Access and Utilization

BRING HEALTHCARE CLOSER TO THE PEOPLE AND MAKE IT MORE ACCESSIBLE.

By placing CHIs in communities, sending out "clinic on wheels" to previously untouched areas, and upgrading clinics with better management, the reforms seek to raise service utilization. Indeed, the footfall per MNHC has already increased by ~55% under the phase-1 (from ~1,265 to ~1,970 patients monthly at normal BHUs), indicating previously unmet demand is now being served. Each clinic is now a lively hub, and outreach efforts by clinic managers (e.g. community visits, local announcements) further draw patients who earlier might not seek care. CHIs, once on board, will add further to this.

Improve Quality of Care

ENHANCE THE STANDARD OF SERVICES AT PRIMARY CARE FACILITIES.

Underperforming BHUs are being transformed – infrastructure has been refurbished, equipment provided (97% clinics now have functional basic equipment like autoclaves, oxygen cylinders, etc. after revamping), and outsourced staff are motivated by performance incentives. The quality of care is being assessed through patient feedback and third-party evaluations; early signs are positive, with over 95% of patients reporting that facilities are better run now than before. By holding managers accountable for results, the government expects more attentive healthcare delivery.

Encourage Innovation and Ownership

ENGAGE THE PRIVATE SECTOR'S EFFICIENCY MINDSET.

The reforms entrust young, entrepreneurial doctors with managing facilities, hoping they bring innovative solutions to longstanding problems. This not only creates self-employment opportunities for healthcare professionals, but also instills a sense of ownership. For instance, many clinic managers have introduced community outreach camps and customer service improvements on their own initiative to boost performance. SPHERE's assessment found the majority of managers took steps like community health talks, WhatsApp groups for patient follow-up, and feedback mechanisms to increase utilization.

Ensure Financial Efficiency

DO MORE WITH EXISTING HEALTH EXPENDITURES.

A core objective was to reduce waste and redirect funds to where they have impact. By outsourcing, the department aims to reduce the average cost per patient encounter from about Rs.1,084 to Rs.453. This improvement (58% cost reduction) is expected to be achieved by rationalizing staff and operating costs under private management and eliminating inefficiencies. Overall (scaled to all BHUs), this translates to an annual saving of up to Rs. 6 billion for the government – funds that can be used to invest in further improvements or expansions of services. **However, this estimated cost reduction and efficiency will need a deeper analysis and assessment; at least a year after implementation of this new model.**

Increased Accountability and Transparency

Through performance-based contracts and the M&E systems, the reforms enforce accountability. There are clear consequences for non-performance (payments are tied to results, and contracts can be terminated). Moreover, the introduction of digital reporting (each clinic must submit service data via an app) means real-time transparency – any drop in service delivery is quickly evident to the H&P Department. This is a shift from the earlier system where facility performance was often opaque and not acted upon, as the Government was bound to pay the salaries on approved rates irrespective of performance.

Integrate Services and Continuum of Care

By structurally linking CHIs, Clinics, and Hospitals, the reforms aim for a continuum where patients smoothly navigate between levels of care. The digital referral system (currently being set up) will allow, for example, a CHI to refer a sick child to the clinic and that clinic to refer onwards to a hospital if needed, all while the patient's records are accessible at each point. This integrated approach reduces loss to follow-up and duplicative efforts, and is expected to improve health outcomes (e.g., timely management of high-risk pregnancies through appropriate referral).

Community Empowerment and Participation

The program's name itself - Community Empowerment through MNHCs - highlights engaging the local community. Each clinic is expected to form a community health committee (based on the existing health council model) and involve local leaders, thereby giving the public a stake in ensuring the clinic runs well. Communities are being empowered because the services are more responsive to their needs and they have channels to voice feedback (via the managers or district authorities). Local employment generation (hiring of support staff from the community by the clinic manager) also fosters community support.

Ultimately, the reforms are a step towards Universal Health Coverage (UHC) at the provincial level. They prioritize primary care as the foundation of the health system and leverage partnerships to overcome public sector constraints. The Statement of Objects and Reasons of the Act captures this, noting the aim to *"ensure universal access to quality healthcare"* and fulfill the state's obligation to provide adequate healthcare. By institutionalizing performance-driven practices and modern healthcare management, Punjab seeks to significantly uplift its health indicators in the coming years.

Implementation Status & Initial Impact of MNHCs

Implementation Status and Initial Impact of MNHCs – *An Assessment by SPHERE Consulting*

Though still in early stages, Punjab's health reforms have made swift progress in implementation and have yielded encouraging initial results. Recognizing the importance of independent evaluation, the department launched an interim-assessment of the MNHCs in mid-2025. This assessment was done by **SPHERE Consulting**, with financial support from UNICEF and technical oversight by Health & Population Department, Punjab. A detailed report of this assessment is available separately.

The aim of this assessment was to *"identify strengths, weaknesses, and gaps in service delivery at MNHCs and provide actionable recommendations"*. The assessment compared quality of care at MNH Clinics vs. traditional BHUs, client satisfaction, and health outcomes, thereby guiding any mid-course corrections. This shows the government's commitment to evidence-based improvements and not just expansion for its own sake.

A. Phase-1 Outcomes

The phase-1 MNHCs (150) have been operational under private management for several months. During this pilot, the Health Department closely tracked a range of performance metrics. According to official reports, and the assessment conducted by SPHERE Consulting, with support of UNICEF:

- **Patient Volume Jump:** As noted, patient visits increased to an average of ~1,970 per clinic per month, a jump of over 50% compared to baseline. Collectively, the 150 pilot clinics served hundreds of thousands of additional patient visits in the initial months, indicating improved community trust and service uptake. 100% of surveyed patients reported they received the medicines or treatment they came for, signifying that basic needs are being met reliably.
- **Maternal and Child Health Uptake:** Many of these clinics began conducting deliveries and providing round-the-clock maternal care (in the subset designated 24/7 BHUs). Where comparison data is available, improvements in antenatal care coverage and safe deliveries have been recorded. In one assessment of selected facilities, 96% of patients felt the clinic's performance on maternal/child services was "better now" than before outsourcing. Some clinics which previously referred all deliveries to hospitals are now retaining cases they can handle, easing burden on higher facilities.
- **Data Reporting and Transparency:** A remarkable outcome is nearly universal adoption of the EMR reporting system – 97% of MNH Clinics are regularly reporting data through the electronic system. This allows the department to have timely service delivery statistics (immunizations given, antenatal visits, etc.) and catch problems early. For example, any clinic reporting abnormally low figures triggers an inquiry. This data visibility is a vast improvement from the old paper-based reports that often came with delays.
- **Patient Satisfaction:** Third-party exit interviews, conducted by SPHERE, indicate a very high satisfaction rate. 98%+ of patients said the clinic now provides services free of cost without any informal charges (compared to occasional complaints earlier about staff shortages forcing patients to buy medicines outside). In terms of staff behavior, over 98% were satisfied

or very satisfied with how the clinic staff treated them – a significant cultural shift credited to the direct supervision by the private managers.

- **Softer Indicators:** Managers have reported better staff punctuality and lower absenteeism. Many clinics extended hours or rearranged duty shifts to match patient flow (e.g. keeping clinics open in evenings if local need exists). Community feedback mechanisms, like suggestion boxes or periodic meetings, have been instituted in several locations by the proactive managers, as was the practice previously as well, and reflects compliance to the Minimum Service Delivery Standards (MSDS) laid down by the Punjab Health Care Commission.

B. Financial Efficiency

On the government side, initial financial analysis shows substantial cost savings. Each pilot clinic is operating within the agreed budget cap, and collectively the 150 clinics are delivering more services at a lower aggregate cost than when they were government-run. This efficiency validates the hypothesis that a performance-based contract can curtail wastage. However, it is also noted that managers' profit margins are modest and they must carefully manage resources to stay within the budget. Some managers have voiced that the fixed payment is tight especially when patient numbers rise beyond expectations – a consideration for future capitation adjustments.

C. Scale-Up Progress

As of mid-2025, the government had:

- Identified the next batch of BHUs to be outsourced (prioritizing those being upgraded under development programs).
- Prepared and submitted budgetary allocations for the expanded program (Rs. 1.357 billion were earmarked as a supplementary grant for FY 2024-25 to kick-start the scale-up).
- Formed selection committees and advertised for the new round of recruitments, learning from the pilot to further refine selection criteria if needed.
- Started to address human resource adjustments for the larger scale (placing existing regular staff elsewhere as needed, in consultation with the Finance Department). The expansion was planned in phases to ensure quality isn't compromised. Full province-wide coverage via MNHCs has been materialized, as of August 2025

D. Legislative Backing and Policy Continuity

With the enactment of the Punjab P&SHC Act 2025 in June, these reforms gained legal sanctity beyond an administrative initiative. This significantly mitigates the risk of policy reversal. The Act ensures that even if government leadership changes, the framework for performance-based health services remains in force (unless formally amended). The law empowers the department to make rules – draft rules for contracting processes, data management, etc., are reportedly under formulation to guide implementation details.

E. Monitoring Mechanisms in Action

The M&E Directorate established under the project has been active since 1st of July 2025. They verify monthly performance reports from each clinic, using a combination of EMR data audits, patient phone calls, and site visits. For instance, to discourage inflated reporting, random household surveys and phone verifications are being conducted. In the data audit, conducted by SPHERE as part of the assessment of MNHCs, discrepancies like a few false entries of delivered services were noted (e.g. instances where patient contact could not be verified and turned out to be non-existent). In cases where the directorate finds such instances, swift action is taken – warning letters and in a couple of cases withholding of payments for that period have been done. This demonstrates a *zero tolerance for fake and fabricated data* and strengthens the credibility of the performance data. It's an ongoing learning process; the assessment has also suggested systemic improvements such as better training for clinic data handlers and more rigorous checks on outlier data points to further improve accuracy.

F. Infrastructure and Supplies

The program also injected development funds to renovate facilities and equip them. Out of the pilot clinics, some still reported infrastructure issues (about 14% noted building repairs needed like fixing leaks or sanitation facilities). The government is addressing these via its development schemes in parallel. On supplies, the government's logistic system provides contraceptives and vaccines to the clinics. Most essential drugs and family planning commodities have been available (>95% availability reported for all key vaccines and contraceptives), although a few managers noted instances of stock-outs (for which they are supposed to procure from the market). These supply chain wrinkles are being sorted through better coordination with the provincial store and encouraging clinic managers to buy all items in the "essential medicine list" locally according to needs. However, it is important to note that the routine OPD medicine, medicines for antenatal care, and normal delivery services are the responsibility of the clinic managers and they have to ensure stock availability of essential items within the budget allocated to them for running the clinics.

G. Community Response

On the ground, the community reception appears positive. The rebranding under the prominent "Maryam Nawaz Health Clinic" name, along with visible upgrades (revamping, new paint, clean premises, etc.), has attracted public attention. While some skepticism existed initially (given past experiences with short-lived initiatives), the consistency of services over months is gradually building public confidence in the system. A notable difference in feedback about staff attitudes has been seen during the assessment.

Challenges and Lessons Learned

Challenges and Lessons Learned

Despite these gains, the implementation has highlighted some challenges:

Human Resource Constraints

With expansion, finding enough qualified and willing doctors to manage nearly 2,500 BHUs is a challenging task. The high interest (by 3,000 applicants) in the first phase is encouraging, but many were attracted by the novelty. Sustaining this workforce over the years, especially in remote areas, will require continued incentives (like the promise of CIP, Central Induction Program marks for post-graduate specialization for those who serve in clinics, which the government has offered) and support to the young managers.

Risks in Hiring of HR and Procurement of Medicines

A significant risk is being apprehended in hiring of paramedical staff, as the health managers have an incentive in low-grade staff; they save more from the one-line budget allocated to them. Therefore, there is a tendency to hire unqualified or untrained staff at lower wages – usually much less than the minimum wage benchmark notified by the Government. A similar tendency is observed in procurements – since the health manager has to procure all medicines within the one-line budget, they may opt to select sub-standard or counterfeit medicine.

The Department is cognizant of these risks, and is working towards development of mechanisms to minimize such instances; and to track and trace such incidents for immediate remedial actions.

Capacity Building Needs

Not all recruited doctors have prior experience managing a facility. The need for management training is evident – topics like inventory management, bookkeeping, human resource supervision, and even basic accounting/taxation for running the clinic were identified as gaps. 89% of the clinic managers said they have conducted or plan to conduct staff training to improve service delivery at their clinics, showing willingness, but many would benefit from formal training themselves. The department, possibly with partner support, will have to organize capacity building workshops to ensure these managers can also be good administrators.

Primary and Preventive Health

Analysis of data during the assessment has reflected a declining trend in immunization rates at the MNHCs. This has emerged as a significant concern, particularly regarding the number of children receiving essential immunization services i.e., the EPI vaccines. This downward trend not only threatens the hard-won progress in preventing childhood diseases but also highlights critical gaps in the current outreach and engagement strategies at the primary care level. Ensuring robust immunization coverage remains a cornerstone of preventive health, and any lapse can quickly reverse public health gains, exposing communities to the risk of vaccine-preventable outbreaks.

Addressing this challenge will require a renewed focus on both community mobilization and the integration of immunization services into routine clinic operations, as well as continuous monitoring to identify and rectify bottlenecks in the system. The reason for this decline appears

to be a lack of clarity on importance of EPI service provision through MNHCs, and lack of orientation of midwifes/LHVs appointed at MNHCs regarding EPI services.

Integration with Broader Health System

There is a learning curve in aligning the roles of district health administration with the new autonomous clinic managers. Some managers reported lack of support from the district health office in certain areas (e.g., family planning supplies provided only once and then stopped). Clear operational guidelines are needed to define how district health officers, who used to supervise BHU staff, now interact with contracted clinics. The District Health Authorities (DHAs) need to be actively involved, possibly focusing on contract monitoring rather than direct management. Emphasizing the role of DHAs in oversight was one recommendation emerging from the field.

Financial Processes

Although payments to contractors are currently underway, the first disbursements were delayed while financial procedures were being clarified. The first payment had to be done manually, after which an online transfer system through a designated bank (NBP) was established. There is also an evolving penalty framework; for instance, if a clinic falls significantly short of its target or if verification calls to patients reveal issues, a portion of the payment is withheld as a penalty. Conversely, if a clinic exceeds targets, currently there is no additional reward beyond goodwill. This has led some to question if the model should evolve to a more dynamic payment mechanism (like true performance bonuses or capitation). The "ambiguity on payment model" for the future is noted as something that needs clarity for contractors to plan ahead.

Data Integrity and Oversight

As mentioned, a few cases of data inflation were detected. This underscores the importance of strict oversight; otherwise, the performance-based payments could create perverse incentives. The Health & Population Department is investing in solutions like integrating NADRA ID verification for patients and increasing random spot-checks to ensure veracity of reported data. Maintaining trust in the data is critical, as it underpins the whole payment mechanism, as well as the integrity of overall health records of the public which are going to be used for future planning and evidence based decision making.

Sustainability Concerns

Some stakeholders have wondered about long-term sustainability – *will these young doctors stay on? What happens when their contract ends?* The government's stance is to continuously induct new talent if some exit (the opportunity is attractive to many fresh graduates). However, to ensure continuity, they might consider multi-year contract options for good performers. Additionally, since this is funded through the government's budget (consolidated fund), fiscal sustainability depends on political commitment to keep allocating resources. So far, the results have garnered cross-cutting support due to demonstrable improvements, but maintaining that support will require ongoing communication of results and perhaps institutionalizing these reforms within the regular budget framework (which the new Act helps to do).

Conclusion

In short, the initial phase of Punjab's health reforms shows promising improvements in healthcare delivery at the grassroots. Utilization is increased, costs per service is seemingly lowered down, and patient satisfaction high – indicating that outsourcing coupled with the upcoming community outreach model can revitalize primary healthcare. At the same time, careful attention must be paid to training, monitoring, and system integration to address the challenges that have emerged. These early lessons will inform the refinement of the model as it scales up.



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