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Re-Imagining Public Private Partnerships for Better Health and Security

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Public private partnerships are embraced by successive Pakistani policymakers as a panacea for improving health delivery, but beyond the first headline shout, there is much to be done in moving from promising ventures to impactful ventures.

Success of public private partnerships lies in repositioning partnerships within Pakistan's efforts to meet the global Sustainable Development Goal Agenda of Universal Health Coverage (UHC) and global health security. UHC involves expanding affordable access to quality care with foremost attention to basic primary health care services. More recently with the pandemic outbreak causing major health and economic disruptions, there is a call for building disease detection, risk communication and community engagement within frontline care to build more 'health secure' nations.

Simply put there are two 'asks' to better configure public-private partnerships:

(a) Improve design of existing public private partnerships with NGOs that narrowly focus on revitalising government healthcare facilities, to deliver better on quality health services across a continuum of care, this has not conclusively happened so far.

(b) Expand to new partnerships with private commercial providers for primary health care and disease control, filling gaps in urban low-income areas where there is high concentration of credible private providers but absence of state funded primary care.

Promising Delivery but Falls Short of Impacts

PPPs have proliferated in Pakistan during district and then provincial devolution, driven by the impetus to improve functionality of poorly performing government health facilities in rural areas. Budget and administrative powers for facility management have been handed over to contracted NGOs, relying on private sector management expertise to get a reasonable modicum of service delivery and well-maintained health centres. The first set of small-scale PPPs were largely implemented in Khyber Pakhtunkhwa by district governments for few health facilities in crisis hit or hugely remote localities. Indicative data showed better staffing, medicines, supplies at health facilities contracted to NGOs but lack of performance audits. Next came the Lodhran example in Punjab of contracting Basic Health Units which escalated into the National Presidents Primary Health Care Initiative contracting more than 2000 BHUs across the country, contracting out both functional and dysfunctional BHUs for superior management. Third party evaluation showed both better equipped facilities and higher patient volumes compared to government managed facilities but little impact was seen beyond health facilities on population level service coverage.

While the National PPHI politically fizzled out after provincial devolution, the roll-out of

state funded public-private partnerships for primary care has continued visibly in Sindh for through 2 streams of work both of which target the improvement of government health facilities: contracting out Rural Health Centres and few secondary hospitals to NGOs and contracting out of Basic Health Units to a fit-for-purpose state-funded company called the Sindh PPHI. Systematic preparations are underway in KP for contracting-out dysfunctional health facilities in the newly merged districts. Our evaluation of Sindh's NGO contracting initiative, showed improvements that went beyond facility readiness and volumes as seen in the national PPHI initiative, to digital innovations, better staff knowledge, superior staff satisfaction, higher compliance with regulatory minimum service delivery standards. But on the downside, there were gaps in the continuum of care with essential services such as family planning, new-born care, child nutrition receiving less attention. Diagnostic services were only partially boosted, with private providers investing in more visible X-rays and ultrasounds imaging but overlooking low-cost laboratory testing required for routine disease management. And confinement of NGOs to facility control, without involvement in the health outreach programs, limited downstream community impacts. While the results from Sindh PPHI BHU contracting initiative have not been independently assessed, but due to design similarities it is likely to have at least similar results or likely better results given the facilitation received from the state apparatus for countering resistance to contracting. It is also likely to have the same design related short-coming, of limited community impact due to lack of control over community based outreach programs.

Quality Scores Across NGO Contracted and Government Managed PHC Facilities in Sindh

Quality Domains	Government (Non-Contracted Facilities)	Public Private Partnership (Contracted-out Facilities)
	Average % Score	Average % Score
Infrastructure & Staffing	41%	73%
Equipment	38%	75%
Drugs	51%	87%
Service delivery standards	8%	69%
Staff Knowledge & Satisfaction	59%	69%
Diagnostics	12%	39%
Record keeping	65%	83%
Service volume	37%	56%
Patient Satisfaction	63%	78%
Cumulative Score	41%	70%

Source: Zaidi S, Memon Z, et al. Agha Khan University, 2021.

The experiences show a promising glass half full - meaningful impact requires design improvement. within existing partnerships.

Quality Leadership and Overcoming Fragmented Delivery

Principles of successful designs include a defined service package, some level of target setting, independent performance monitoring and competitive tenders to get capable private providers from the market.

The earlier district led public-private partnerships and the national PPHI, transferred administrative responsibility but without a service package, targets, contract monitoring system. NGOs were directly selected rather than qualifying for contracts. Hence much was left to discretion of private partner in terms of what services to prioritise, which drugs to dispense and what staff mix to deploy. The recent initiative in Sindh, took a forward step of issuing contracts based on the Essential Package of Health Services and bring in NGO partners through competitive tenders. But the absence of target setting and complete reliance on private provider reporting has diluted government's stewardship on delivery.

Even if service packages, targets and independent performance monitoring is built in, vertical PC-1 driven health projects will continue to fragment quality controls. Private partners have an incomplete control over health facility services as budgets and authority for Nutrition, Family Planning, Maternal-Newborn Health, TB, HIV, Malaria, Hepatitis, Immunization remains verticalized. The proliferation of PC-1 supported health projects creates challenges of re-configuring resources and service delivery terms within private partner contracts. A paradigm shift is required within health sector of moving away from PC-1 supported individual health projects to a single integrated essential health service package, that is locked in with private partner contracts, and updates to contracts follow the updates to the package.

Another design weakness is the siloed working between health facilities and community health outreach programs. Administrative control for Lady Health Workers, community midwives and vaccinators lies with district health offices. Credible pilots are missing through which to test private partner capability to deliver outreach services, that can inform whether administrative control for outreach can be transferred in the more disadvantaged areas for effective delivery.

Payments and Financial Risks

Public-private partnerships in Health have followed a simplistic financing model involving a single line budgetary transfer of health facility operational budget and powers for flexible spending across funding lines.

On the positive side this payment model, consumes little administrative cost and by providing autonomy has been critical in bringing about speedy repairs, restoring staff strengths and equipping health facilities. At the same time, it opens up fiduciary risks for both the contracted NGOs and health departments. Annual disbursements are not linked to targets creating risk of under-delivery for the government. This is also a missed opportunity by government to push private partners towards output-based budgeting to get value for money. Capped budgets also create financial risks for contracted NGOs – increasing patient volume at functionalised PPP facilities has resulted in unanticipated consumption of medicines, cash flows issues and potential for replacing better quality medicines with cheaper quality medicines. Topping up budgetary transfers with few carefully selected performance-based targets can avoid budgetary squeeze and create incentives towards required services.

Getting the Architecture Right

Good practices for public-private partnerships, requires the setting up of a separate institutional structure for professionalised contract management and to warding off influences of those involved in direct service delivery. Post devolution, contract management structures have been established in at least two provinces - Public Private Partnership Node in Sindh's Health Department and the Health Foundation linked to KP's Health Department - to anchor contracting functions. While these are positive steps, the technical skills sets and supporting systems are thin, requiring niched assistance to deliver well. District PPPs are better run through

dedicated provincial structures. Establishment of provincial Health Care Commissions (HCCs) for regulating private and public health providers, presents valuable opportunity to link contract awards and renewals with quality-of-care pre-qualifications from HCCs - these opportunities are yet to be seized by health stakeholders.

Governance of public-private partnership also requires back-up legalisation for health sector's public-private partnerships. While this has been proactively introduced in recent years, it is framed within investment and infrastructure led frameworks, rather than considerations for accessible, affordable, and quality health services. The 'health lens' framing must be introduced to move from a narrow dysfunctional asset to creating population-based impact.

Finally, funding lines also impact on how well the partnership will be anchored. PC-1 funded public-private partnerships have not delivered well in the past, due to delayed take-offs, slow and uncertain financial releases leading to loss of private provider interest. When funded by foreign funding, it has further created complications of building in donor conditions into partner contracts. In contrast the diversion of recurrent funds to private providers has provided steady flows and allows for focusing attention on contract operation rather than worrying about funding pipeline.

Relational Working and Convergence of Interests

Probably the most critical part of the public-private partnership equation is the relationship between the public and private partners. Convergence of interests, some level of trust and policy champions have played an important role in persevering with public-private partnerships in Pakistan. Health partnerships have been driven by policy-makers urge to counter slow moving internal bureaucracies and invest in fast-paced uplift and functionalization of health facilities. These have also stemmed from low confidence in health department's technical capability to deliver. High support from planning departments, finance departments and political executives has so far provided the necessary backing to persevere with public-private partnerships. Private partners have come forward for funds, strategic alliances and expanding the development portfolio.

The weak link in the chain is the reporting relationship with health departments. The relationship is at best weak as public private partnership projects have been run as special initiatives with little coordination from the technical leadership. For example, the earlier national PPHI initiative reported to the Ministry of Industries, the new PPHI state-funded companies that reports to own company board not directly to health departments and NGO contracting where practiced by health departments have maintained a vertical reporting to top leaderships, to protect against from derailment by interest groups within health departments. Technical steering must be brought back firmly to health departments for quality standardization, service package and target setting to create health impact even if fund flow is separately maintained and protected.

Downstream power friction with district health offices also needs attention for day to day operational delivery. Power tussles have led to staff transfers at PPP facilities, siloed delivery of vertically managed preventive services, weak referrals between PPP facilities and district hospitals. It is possible to look for a win-win relationship between private partners and district health offices by joint credit-sharing on achievements, joint field monitoring and integration into district planning.

The Future : Integrating Commercial Private Providers for Essential Care and Diagnostics

So far there has been little attempt to forge partnerships with commercial private health providers for expanding affordable, accessible health care. National surveys show that more than 70 percent of outpatient health consultations take place at private providers, more than 90 percent of clinics are in the private sector, and more than 60 percent of registered laboratories are managed by the private sector. The costs of private provider encounter are borne by the patients and families, amounting to 58% of total health expenditure.

Private clinics and laboratories with licensed staff are amply seen in major and secondary cities, providing a reasonable starting point for partnerships. but are largely non-existent in remote disadvantaged areas where the so-called private sector comprises unlicensed providers or side clinics of government doctors. Pakistan's burgeoning cities, at the same time have a dearth of government run primary health centres, unlike rural areas which benefit from a well-planned primary health infrastructure, leaving primary care unfunded for the urban poor. For example, estimates from Karachi show that there is 1 government first level care facility to 65000 population – given that an urban primary care centre should cater to at least 25,000 persons then a two fold growth in public sector funded centres is required in the low income localities for affordable, accessible services. Rather than a time consuming, costly process of expanding government PHC health infrastructure and running duplicative clinics, harnessing existing licensed private provides can be the future partnership agenda. As a start, few impactful services such as low-cost frontline diagnostics of priority diseases, first-level treatment of priority diseases, basic mother-child preventive care and family planning, can be piggybacked onto existing private provider health clinics at incremental cost in major cities drawing in the available market and plugging the state funded primary care gap.

Establishment of national disease surveillance network is a fundamental step towards national health security and requires adequate laboratory capacity. The COVID-19 response showed that speedy disease detection and was only possible due to policy pressure on private laboratories for diagnosis and reporting of COVID cases – as per official estimates alongside 54 public sector laboratories at least 184 private laboratories were involved albeit charging market rates. Diagnostic referrals to private laboratories with state funding for the poor can be piggybacked on primary care partnership or initiated as standalone arrangements.

New partnerships would require spending more on primary care spending and basic diagnostics by the state. The public sector spends $15-17 per capita on health and most of this goes on teaching hospitals rather than downstream care. Reversing the historic imbalance of high tertiary spending will economically make sense, as investing in primary care will decongest the state run hospitals, providing routine services at lower costs and managing health issues earlier before complications set in results in increased life expectancy and quality of life.

Meaningful practical partnerships will also require careful attention to the monetary and non-monetary motivations of private providers. Our formative research points out that financial gain for commercial private providers such as neighbourhood general practitioners, polyclinics, maternity homes etc, is tied to patient revenues and not dependent on recourse to state funds, unlike NGOs who are dependent on grants. In-fact many private commercial providers are wary of entering into monetary arrangements with health departments, fearing unnecessary bureaucratization, uncertainty of payment release and compromised security of patient records. Confidentiality of patient records is a highly sensitive issue for both smaller clinics as well as larger hospitals, as comprised confidentiality can irreversibly damage patient volumes. COVID-19 handling showed that private laboratories served as the bedrock in diagnosing, reporting and referring cases, this was made possible on condition of protecting patient data. Private health facilities prefer third party payments or commodity support for supporting primary care and basic diagnostics. Training, accreditation, and positive branding are the pull factors, that enhance local standing and provide self-development as little is otherwise available.

So, it is time to have a strategy for public-private partnerships with a decisive positioning towards universal health care and better health security. Existing partnerships with NGOs or state-funded companies for functionalising public sector facilities require can work for remote rural areas where government is constrained to deliver but with more impactful design. New partnerships are needed with private neighbourhood providers to meet basic primary healthcare needs, priority disease screening and frontline disease management, supported by upstream diagnostic support to cover service gaps starting from Pakistan's low-income urban areas. Third party payments and quality regulation will be required.

There is no perfect implementation model of public-private arrangements as seen from experience of other countries – it's an evolving equation requiring persistence and innovation.

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