Public Private Partnership in the Health Sector: Evidence From A Developing Country

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Abstract:

In the traditional sense, governments have predominantly funded social sectors. But in the face of limited financial resources and other constraints, governments have found it easier to formulate policies rather than to implement them. Thus the private sector has begun to play an increasingly important role both in the financing and in the provision of social services. However, neither sector can be relied upon completely to deliver comprehensive results independently. It seems apparent, therefore, that a public private mix of financing and provision will be the most sensible approach to achieve economic efficiency and equity in the provision of social services. Governance structures and degrees of progress towards governance goals vary widely and appear to be systematically related to the organisation, composition, location, and activity of each partnership.

This paper highlights how a successful partnership can be evolved in the presence of synergy between partners; strong leadership; shared objectives; success in coalition building; appropriate change in governance structure; a proper legal framework; and building in of safeguards and outside patronage. It examines successful interventions of the public private partnership in the health sector between a private medical college in Abbottabad and a public hospital in Mansehra, both within the province of NWFP, Pakistan. This paper has seven sections: An overview; The Partners; The Process of Building a Partnership; The Model of the Partnership; Workings of the Partnership; Evaluation of the Partnership and finally, some conclusions.

Section I: An Overview

1.1. Introduction

The aim of the government and the private sector in providing this public good is based on two entirely different perspectives; for the private

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sector, the fundamental concern is whether the delivery of service will make money; for the government, one of many considerations is whether it will save money through private sector participation. Moreover, the government must consider public values and address macroeconomic issues beyond the price of the service in the public and private sectors. A more cost effective and efficient service delivery in the public health care system can be achieved by reallocating budget expenditure (see Pasha, *et. al,* 1996).

Pakistan has many examples of inefficient nationalised institutions and it is now apparent that state interventions by edict in the affairs of citizens may harm rather than help. Prime steps would be taken for operationalising un-utilised or under utilised health facilities through NGOs in Public-Private cooperation (National Health Policy, 2001). Given that social sector expenditure of GDP is constant, then the rate of growth of public sector expenditure on the same will automatically slow down. However, it is found that 2/3 and 3/4 of total expenditure is obtained from private sources, which is the largest contribution in the health sector (see Sayeed & Ismail, 1996).

1.2. Private Sector Participation Methods

A good partnership takes shape when the objective of each partner is on imposing quality, efficiency and accountability in the services provided. The common understanding concerns finance, funding etc. and the detailed listing and study of all the benefits to each party. The contract highlights the governance structure so that both the parties exercise their rights to an extent and if a conflict arises, then the contract should signify the matter. Of key significance is the transparency and accountability of the contract. The competitive bidding approach is supported and intern productivity improvement best services at least possible cost are ensured (Stubbs & Clarke, 1996).

Whenever the universality, equity, efficiency and accountability in the delivery of the services increases, a partnership is successful. One case study involves how the model and working of the partnership contributes to the attainment of these objectives; Contracting, Concession, Franchise, Build Own Operate & Transfer (BOOT), Build Own & Operate (BOO), and Partnership (Public and Private).

Inputs, outputs or impacts are the three indicators for a quantitative measure of success. Benchmark data will be necessary in relative services prior to the formation of the partnership. This analysis will also impact the judgment concerning the degree of success of the partnership. Thus, a

common observation is that factors such as scope of synergy, quality of leadership, external support, success in coalition building, flexible and responsive governance structure, high level of transparency and accountability, presence of proper legal and regulatory framework etc. are indicative of the qualitative achievement of the partnership.

Given the financial constraints to the expansion of medical colleges in Pakistan, which have very high start up costs due to the need for expensive equipment and access to a hospital for clinical teaching, a real opportunity exists for a public-private partnership between a private medical college and a government hospital.

This case study examines the benefits from and functioning of such a partnership between the Frontier Medical College in Abbottabad and the District Headquarters Hospital in Mansehra. This is a unique case study due to the significance of scale in terms of the flow of funds between the partners and because of the ability of the partnership reaching a stage where it could be evaluated.

Section II: The Partners

2.1. Private Sector

The private sector partner in the Frontier Medical College (FMC) is located in Abbottabad, a divisional headquarter in the province of NWFP, with a population of 120,000 people. Recently, a public sector medical college, the Ayub Medical College has been set up in Abbottabad. This is a large teaching hospital complex with a capacity of 1000 beds.

The Frontier Medical College was established in 1996 in response to the need for more seats in medical colleges in Pakistan as a whole and within the province of NWFP. The College is fairly well endowed. It has about 50 acres of land, and is housed in a four-storey building with about 50,000 square feet of constructed area. It has a highly qualified and relatively well-paid faculty of 10 Professors, 2 Associate Professors, 5 Assistant Professors and 12 Lecturers. It is well equipped with the latest practical equipment and has a good range of educational models. The requirement for a teaching hospital is met through the partnership with the government District Headquarters hospital in Mansehra, which is in the adjoining district to Abbottabad. Facilities on campus include four lecture halls, four basic sciences labs, six demonstration rooms, three research labs, two seminar rooms, two dissection halls, two rooms to house the deceased, an auditorium with the capacity of seating 500 people, a museum, a

computer lab, medical treatment facility and hostels for students. The total capital cost is estimated at Rs.65 million (US $ 1.3 million).

The number of doctors registered in Pakistan stands at approximately 80,000, of which over 10,000 are working abroad. Those working out of 70,000 serve a population approaching 138 million i.e., the ratio of one doctor per about 2000 population. In contrast the doctor to population ratio recommended for developing countries by WHO is one doctor per 1000 population. Therefore, at this standard, the requirement of doctors in Pakistan is about 140,000. Another 70,000 doctors are required to fulfil the missing needs. Given this acute shortage, it is not surprising that medical education continues to command a premium status.

Teaching started in FMC in 1996. The annual intake of students is 50 both nationally in Pakistan and from abroad as well. The course of studies for the MBBS is five academic years, each of a nine month duration. The total hours of subjects are 4825. There are five parts to the professional examination, held once each year. There is a special entry test with a weightage of 40% for admission. Currently, the total enrollment in the college is 200 students. FMC is recognised by PMDC and is affiliated to the University of Peshawar.

FMC is a self-financing institution with funding from a Trust registered as the Al-Jamil Trust. A twelve member Board of Governors administers the college. The members include senior federal and provincial government officials, representatives from the private sector, elected representatives and leading members from the medical profession. The Chief Minister of NWFP is the Chairman and the Principal of the college acts as the Secretary of the Board.

The founding Principal of the college is Professor A. J. Khan. He is the former Principal of the Bolan Medical College, Quetta, Balochistan and the founding Principal of Ayub Medical College, Abbottabad; both are public institutions. He has served as Director General of Health within the Government, and has acted as President of the PMDC. He is also the recipient of the highest civil award of Pakistan for public service. The Dean acts as the head of academics at the college. Academic matters of the college are decided by an academic council consisting of heads of departments and professors.

Tuition fees are relatively high at FMC at Rs.195,000 (US $ 3750) per academic session lasting one year. For foreign nationals, currently there are 29 enrolled, the annual fees are $ 10,000. In addition there is an admission fee of Rs.30,000, initial caution money of Rs.30,000 and other miscellaneous fees of Rs.10,000 annually. The hostel accommodation fee is Rs.30,000 per academic

session. Despite these relatively high fees, FMC received 430 applications for 50 seats last year. Its potential weakness is that the relatively high level of fees excludes access to meritorious but relatively poor students.

2.2. Public Sector

In essence, the partnership of FMC is legally with the government of NWFP, which owns the District Headquarters Hospital in Mansehra, the effective partner. Mansehra is the neighbouring district of Abbottabad (the hospital is located about ten miles away from the college on an excellent road). The town of Mansehra where the hospital is located has a population of 52,000, while the district as a whole has a population of 1.1 million. The hospital not only serves this population but also the populations in the adjoining districts of Batagram, Shangla, Buner and Kohistan (with a combined population of 1.7 million).

Mansehra is a pre-dominantly rural district with rainfed agriculture essentially on hill slopes. The principal crops are wheat, maize and rice. Production and yield levels are relatively low. Household incomes in the region have been substantially enhanced by the inflow of home remittances from migrants in the large cities of Pakistan and the Middle East. Consequently, consumption standards are relatively high, in particular for permanent housing structures and a high demand for services such as health, education, water supply, etc.

The government hospital in Mansehra was established initially as a Tehsil (Sub-District) level hospital in 1972. In 1976 it was declared a district headquarter hospital. A tehsil hospital usually has about 100 beds and seven specialities, with medical personnel who are mostly diploma holders; a district hospital has upto 250 beds, fully qualified doctors and a three times larger budget. In 1998 when the partnership with FMC was officially formed, the hospital had 100 beds and was handling over 100,000 OPD patients annually. In addition, about 8000 patients are admitted to the hospital annually and almost 4000 are operated upon.

The executive head of the hospital is the Medical Superintendant, a senior middle level government official. All essential departments required for the clinical training of under graduate medical students including medicine, surgery, gynae, obstetrics, opthamology, otolaryngology, pediatrics, orthopedics, dentistry, radiology and clinical pathology exist in the hospital. The total component of doctors and senior staff is 30.The students of FMC have been using this hospital for their clinical training since the commencement of their first clinical class at the beginning of 1999.

Overall, the strengths of the public sector partner consist primarily in its ability to make available at least a minimum package of medical services to all, including the poor, at a relatively low cost. However, weaknesses include over centralisation of decision making (in the provincial health department), shortages in non-salary inputs, which retard efficiency in the delivery of services, and limited access to funds for the upgrading and expansion of facilities. The staff is also poorly remunerated resulting in a lack of incentive for improving their performance.

Section III: The Process of Building a Partnership

3.1 Impediments

The process of building a partnership between the public and private sector is rendered difficult by the general climate of mistrust and lack of confidence that prevails between the two parties. On the one hand, the government sees the private sector as being motivated primarily by profit maximisation considerations and therefore, fundamentally in conflict with the objective of increasing the outreach of health services to essentially poor unserved populations at a relatively low cost. On the other hand, the private sector sees the government as being restricted by bureaucratic red tape, which tends to slow down decisions and retard innovation. Perhaps, even more importantly, government functionaries are seen as being notoriously prone to corruption in their dealings with the private sector, which raises transaction costs and frequently distorts the allocation of resources.

The evolution of the partnership between FMC and the government of NWFP has a long and chequered history. Initially, the FMC had proposed to the provincial government that it might be the recipient of land sold in Mansehra at relatively low costs in order to establish a teaching hospital. But the local landowner demanded a high price, well above the prevailing market rate, and hence, this idea had to be abandoned.

Thereafter, the FMC made a bid for using the large 600 beds at DHH, Abbottabad to serve as its teaching hospital. This was a logical choice as it was located close to the college campus and had all the facilities necessary for the effective clinical training of students. But there was no clear cut response from the authorities because the future of this hospital was uncertain. Abbottabad city already had a substantial presence of government (including military) and private hospitals. The commissioning of the 1000 bed hospital in Ayub Medical College raised the number of hospital beds in the city to over 2500.This implied considerable excess capacity, in the presence of which there was a strong case for closing down the DHH.

The third option presented by FMC was to establish a partnership with DHH, Mansehra, which was not as well endowed with the proper facilities as the DHH, Abbottabad. The college initially offered capitation fees of Rs 10,000 per student, which had to be raised to Rs 50,000 during the negotiations. The FMC agreed to the escalation on the condition that most of this money would be used to upgrade the facilities at DHH, Mansehra, and thereby improve the quality of clinical teaching there.

The principal of FMC has made the significant observation that frequent changes in the provincial governments (1996, 1997 and 1999) and in the posting of government officials have created hurdles in the evolution of the partnership. Given the uncertainty, FMC insisted on a legal agreement being signed with the government of NWFP initially for a period of three years specifying the terms and conditions of the partnership. Also, given the delays, FMC started teaching on its own in 1996 in a small, temporary structure.

Other impediments to the development of a partnership lie in the divergent interests of the various stakeholders. In the case of Mansehra, the staff members of the DHH were initially opposed to the idea because of the fear that it might affect the terms of their service, impose additional workload on them in providing inputs of clinical teaching to the students as well as interfere with the discharge of their normal duties relating to the treatment of patients.

The community at large in Mansehra was also apprehensive of the impending partnership between FMC and DHH as this appeared to be the first step towards the ultimate privatisation of the latter facility. It was feared that user charges would be raised drastically making the facility out of reach for the poorer segments of the population in Mansehra district. These concerns had to be allayed by a number of meetings by the Medical Superintendant of DHH with notables of the area.

3.2. Role of Leadership

Perhaps a critical element in the eventual formation of the partnership was the leadership role played by Prof. A. J. Khan[1], founding Principal of FMC. Despite the many impediments, Prof. Khan pursued with determination and zeal his goal of establishing a private medical college in

[1] Prof Khan's significant advantage was that he had held several key government positions and had been the Principal of two major public colleges. He not only had contacts with the highest level functionaries within the government of NWFP but he was also widely respected in the health department of the province and in PMDC.

Abbottabad. Not only did he donate his own land to the college but he mobilised funds for the establishment of the college by establishing a trust.

Given that he was from the district of Mansehra, there was a general trust of the people in his desire to do something positive for the district. In addition, the formation of a trust and the appointment of a strong Board of Governors with the Chief Minister as the Chairman removed any residual mistrust that may have existed in the minds of officials about the motivations of FMC. Furthermore, the partnership was strengthened at the operational level by the unwavering understanding and cooperation developed between the Principal, FMC, and the Medical Superintendant, DHH, Mansehra.

Section IV: The Model of the Partnership

4.1. Objectives of the Partners

As explicitly stated in the legal agreement between the partners (the government of NWFP and the FMC) the basic objective of the NWFP government (and its health department) is to upgrade and improve health care facilities at the DHH, Mansehra, while the FMC is desirous of obtaining teaching facilities for its medical students at this hospital.

4.2. Inputs by Partners

The DHH, Mansehra will provide for and make facilities available for teaching purposes for the students of the college. In return, the FMC will make payment of capitation fees as given below:

- Capitation fee of Rs.50,000 per student per year for three classes over three years (from January 1, 1999 to December 31, 2001) totaling Rs.15 million as follows:

Year 1	50 Students	1 Class	Fee Rs.2.5 million
Year 2	100 Students	2 Classes	Fee Rs.5.0 million
Year 3	150 Students	3 Classes	Fee Rs.7.5 million
Total	300 Students		Fee Rs.15.0 million

- The capitation fee as indicated above shall be paid in two installments. A sum of Rs.8 million as part of the first installment of the capitation fee shall be paid immediately upon signing of the agreement. The remaining amount of Rs.7 million shall be paid within 18 months of signing this agreement.

Therefore, the model of the partnership is essentially based on financing by the private sector and provision of services by the public sector.

4.3 Safeguards

A number of safeguards have been build into the agreement, which are as follows:

1. **Ownership of Assets:**

   The agreement is only for temporary use of the facilities of DHH. The hospital, all its assets, land and structures shall continue to remain under the ownership and possession of the government of NWFP. Any new building, equipment and other assets constructed and added to the hospital shall become the property of the government of NWFP with full vested rights. It is important to note that even if the new construction is partly financed out of the capitation fees, the FMC will have no ownership rights on the newly created assets.

2. **Rights of Beneficiaries:**

   The hospital will remain part of the health delivery system of the government of NWFP and shall continue to provide services to the public, not inferior to those provided before the signing of the agreement, or provided by equivalent district headquarter hospitals elsewhere in the province. In particular, the hospital shall ensure minimum health cover for the poor patients at the lowest possible cost as provided in sister government hospitals within the province. This provision was necessary to remove the perception that the formation of the partnership was the first step towards privatisation of the hospital, eventually leading to substantially higher user charges.

3. **Status of Hospital Employees**

   The employees of the hospital shall continue to be civil servants and be governed by the relevant government rules. Matters relating to their service conditions shall remain the responsibility of the Department of Health, government of NWFP. There will also be no modification in their pay structure. This safeguard was introduced to allay any fears on the part of the employees that as a result of the partnership with a private party, their employment status could be changed and, in particular, that they might lose security of tenure.

Moreover, the agreement states that district specialists in the hospital, possessing requisite qualifications and experience for teaching purposes (based on the approved requirements of PMDC) shall, during the currency of the agreement (initially of three years), be designated as Assistant Professor or Associate Professor, as the case may be, for teaching purposes of the FMC. In addition they shall be paid a teaching allowance equal to 20 per cent of their basic pay adjusted from the capitation fee receipts. All other staff of the hospital shall be paid a special allowance of 10 per cent of their basic pay out of the capitation fee receipts. Therefore, not only has security of service been guaranteed but the staff of the hospital will get higher remuneration during the tenure of the agreement. This creates a strong vested interest on the part of the employees for the continuation of the partnership.

4. Budgetary Commitments by the NWFP Government

The NWFP government has committed itself to continue to meet recurrent costs on salary and allowances of its employees through the Accountant General's office; additionally the government is to provide non-salary recurrent budget grants to the hospital at the level of budget estimates for 1997-98 duly indexed for inflation. The annual recurring budget of DHH, Mansehra is about Rs.12 million, with a salary component of Rs.9 million. This safeguard was essential to ensure that in view of the sizeable income from capitation fees paid by FMC, the government did not cut back its budgetary allocation to ensure some savings. In the event of this happening, the capitation fees would have been largely diverted to finance recurrent costs and would not then be used for upgrading the facilities of the hospital.

5. Establishment of the Hospital Fund

A further provision in the agreement to ensure that the income from capitation fees is used primarily for development is the establishment of a Hospital Fund. Money which will accrue to the fund includes the following: non salary recurrent grants and development grants from the government of NWFP, receipts of service fees and miscellaneous income of the hospital, capitation fee from the FMC and return on investments made from the hospital fund. The receipts and expenditure on the Hospital Fund shall be audited by the Director General Audit of the government of NWFP. The accounts of the Hospital Fund shall also be audited annually by an internal auditor.

It is significant to note that the hospital is being allowed to retain its income from user charges and not surrender it to the government of NWFP as in the case of deposits in the Provincial Consolidated Fund. This tantamounts to granting autonomous status to DDH, Mansehra.

All amounts credited to the fund (including resources from the capitation fee) shall be utilised for the development and upgradation of the facilities at the hospital, particularly towards the provision of the following:

- Construction of a fully equipped new block of 100 bed ward within the premises of the hospital;

- Expansion and improvement of the existing casualty department;

- Establishment of a fully equipped ICU, CCU and a new operation theater;

- Improvement of existing wards and outpatient department.

The government of NWFP has also committed itself to give a development grant of Rs.8 million from the provincial ADP funds over a maximum period of two years (1998-2000). This grant is to be used in conjunction with moneys from the fund for the upgradation of infrastructure and service facilities at the hospital. Given that the initial payment of capitation fees by FMC on the signing of the agreement is also Rs.8 million, this means that the two partners propose a matching 50:50 contribution to the development of the hospital.

4.4. Synergy in the Partnership

Synergy arises in the relationship between two parties when the formation of a partnership between the two makes each party better off in relation to the situation when such a partnership had not been formed. In other words, the partnership can be characterised as a *positive sum co-operative game.*

In the context of this particular case study, it is necessary to demonstrate how the nature of the partnership makes each party potentially better off. In order to do so we consider the case of the DHH, Mansehra and in what sense it has benefited from the partnership. The following benefits can be attributed to the study of DHH:

- Inflow of substantial amounts of money as capitation fees from the FMC, which can be used for improving and upgrading the facilities at the hospital;

- Inflow of additional development funds from the government to match the contribution by FMC at a time when there appears to be a severe fiscal squeeze on the provincial government and there has been a contraction in real allocations to the health sector;

- Enhancement in the status of the hospital as a teaching hospital and with the expansion in capacity, enhanced ability to offer more and better services to the population in Mansehra district and adjoining districts;

- Presence of senior students from FMC enables an improvement in the quality of medical care.

As far as the FMC is concerned, benefits accruing from the partnership include the following:

- Linkage with a teaching hospital. This has substantially reduced the start-up costs of the college. If the FMC had gone in for an independent teaching hospital it would have had to come up with an initial investment of Rs.50 to Rs.60 million. Arranging this volume of funds would have delayed the execution of the project. Besides, it would have had difficulty in gaining recognition from the PMDC of its medical degree in the absence of a teaching hospital.

- Initial investment in a teaching hospital attached to the college would have also required an annual recurring subsidy of Rs.10 to Rs.15 million which would have substantially drained the college's financial resources. Given the presence of a large number of public and private hospitals in Abbottabad, including the 1000 bed teaching hospital at Ayub Medical College, it would have been difficult to attract patients at the relatively high fees being demanded. The payment of capitation fees to gain access to the DHH, Mansehra, not only saves expenditure for FMC but also given the large number of patients at the hospital and the wide range of diseases treated, enhanced exposure for the students; further, the quality of clinical teaching is significantly better.

- The founding principal of FMC, Prof. A. J. Khan, who is the key project sponsor, also views the development of DHH, Mansehra, and its

enhanced ability to provide better services to local residents as a worthwhile objective, especially since he is himself from the district of Mansehra. Moreover, he sees the investment of capitation fees in upgrading the hospital facilities as being beneficial to the college because it improves the quality of future clinical training of students through establishment of the ICU, CCU and a range of new specialities.

Section V: Workings of the Partnership

5.1 Governance Structure

A number of changes in the governance structure were necessary for the smooth functioning of the partnership. A critical step forward was the granting of operational autonomy to the DHH with the establishment of a Hospital Management Board. Such autonomy was essential for the public sector partner to have the flexibility to be able to effectively manage the partnership. This autonomy has generally not been granted to DHHs.

District Coordination Officer	Chairman
Executive District Officer (Health)	Co-Chairman/Member
Principal of the College	Vice Chairman
Nazim	Member
Two prominent citizens to be nominated by the first party	Member
One representative of the College	Member
Medical Superintendent, District Headquarter Hospital, Mansehra	Member

The functions of the management board lie in the administration and management of the hospital. This includes disciplined clinical coaching, upgrading and development, annual and revised budget estimates to be submitted to the government, review of the quarterly annual report and its submission to respective boards, establishment of a regulatory framework and collaborative arrangements in the interest of the hospital. The Board is expected to meet at least once every quarter.

There are a number of significant points to note about the composition of the Board. First, both partners have representation on the board. For the FMC there are two seats, one for the Principal standing as the Vice Chairman and the other for a representative nominated by the college as a member. This implies that the private sector partner has been given an important role in the management of the hospital. The Medical

Superintendent of the hospital acts as the Secretary of the Board. Second, the Chairman of the Board, the District Coordination Officer is an outsider. He can effectively act as an arbitrator in the event there is any dispute between the two parties. Third, the board has representation from two prominent citizens nominated by the government of NWFP. This introduces an element of external accountability and potentially makes the board more responsive to the needs of the people of the area.

Community involvement is essential in sustaining Public and Private Partnership over the long term. It is observed that significant local involvement makes public programmes more effective and the use of public resources increasingly efficient (Van Der Gaag, 1995). The absence of institutional changes like delivery of services by enhancing the implementation capacity of line departments, exploration and community involvement of the private sector in choice, execution, management and financing of projects were a few of the reasons already mentioned regarding the failure of the Social Action Programme (SAP) (Pasha, *et. al,* 1992).

Within the functions of the Board there are some which relate directly to the working of the partnership. The first is the establishment of a regulatory framework for collaborative arrangements in the partnership; the second is concerned with the regulation of clinical teaching and discipline among students during teaching at the hospital and the third concerns the approval of development plans for the hospital.

5.2 Process for Review of Partnership

Senior to the Hospital Board, a special Review Board has been constituted to monitor the implementation of the agreement. The Review Board comprises the chairman who is the additional chief secretary to the government of NWFP whereas the five members on the board are secretary finance department, secretary health services and general administration, principal of the college and two members cum secretaries from the hospital board who are not civil servants and finally chairman of the hospital management board. The Board is expected to meet at least once a year.

It may be observed that the prime purpose of this Board is to review the implementation of the agreement and the audited accounts of the Hospital Fund. Here again, it is significant to note that even at this high level there is representation both from the private sector partner and of citizens. The Review Board can be seen as the final authority for any conflict resolution between the two parties.

At the operational level, arrangements have been made to ensure that clinical training by doctors at DHH, Mansehra, does not cut into the prime time devoted to the treatment of patients. Clinical training sessions are held in the early morning hours from 8:00 to 9:00 am before OPD timings. Students also accompany doctors during their visits to the wards. Their presence has apparently made doctors more careful in their diagnoses.

Section VI: Evaluation of the Partnership

6.1 Success Indicators

The prime indicators of success for a public-private partnership are the efficiency, equity and effectiveness of services provided. For purposes of undertaking the evaluation the following stakeholders were interviewed.

Stakeholders

Hospital	College
Hospital Administration	College Administration
Hospital Staff	College Staff
Patients	Students
Citizens	

Perhaps the most powerful visual indicator of success is completion of the construction of the new wing of the hospital. This wing has a capacity of 150 beds, far in excess of the expansion stipulated in the agreement. It includes an ICU, CCU and a number of operation theaters. The construction cost of Rs.15 million has been financed by the first installment of the capitation fee paid by FMC of Rs.8 million and a development allocation from the ADP by the provincial government as per the agreement.

The construction of the new wing more than doubles the capacity of the DHH and makes it equivalent to the DHH in some of the other more developed districts of the country. Consequently, the hospital will be able to avoid overcrowding and congestion in the use of its facilities. Not only will it be possible to more effectively serve the population in its catchment area, but also the quality of service will increase significantly. All this has been achieved without any increase in user charges, which remain very low. For instance, the OPD charge is Rs.3 (6 cents), the admission charge is Rs.15 (30 cents), X-ray charge is Rs.35 (70 cents) and ECG charge is Rs.40 (80 cents). Operations are carried out at no cost. Equity considerations have not been sacrificed. This is a major achievement.

The success of this model of the partnership has also induced support from elsewhere. The provincial authorities are proposing to donate furniture and equipment which will become surplus when the DHH, Abbottabad, closes down. This will considerably reduce the costs of furnishing and equipping the new wing. In addition, the provincial government has shown interest in investing in some of the more specialised facilities.

6.2 Views of Stakeholders

Beyond this, other indicators of success as determined from interviews of stakeholders are as follows:

i. FMC College Administration / Faculty:

The respondents are extremely satisfied that the DHH, Mansehra, has been upgraded and has expanded so rapidly, and that the money paid as capitation fees has been used primarily for development purposes. They feel that the expansion in medical staff at the hospital, the offering of new specialities and the commissioning of an ICU and CCU will greatly contribute to improving the quality of clinical training being imparted at the hospital. The faculty also feels that the presence of senior students in the wards have made doctors more alert in their diagnosis and treatment of patients.

The Principal of FMC has expressed the desire to renew the agreement with the government of NWFP at the time of expiry of the present agreement in July 2001. However, work has recently commenced on the construction of a hospital on the college campus. Prof. Khan believes that the relationship with DHH, Mansehra, should continue even after the commissioning of the FMC hospital, because the latter is unlikely to have the same volume and diverse nature of patients.

ii. FMC Students:

Some of the students have highlighted the problem of inconvenience faced in commuting between the college and the hospital. However, they emphasise that they have greatly benefitted from the exposure to the various kinds of patients at DHH, Mansehra. They have also praised the doctors of the hospital for being very cooperative and taking interest in clinical training. An intangible benefit is the exposure of students to patients and illnesses / diseases in a rural setting. This may motivate some of them to set up practices in small towns rather than congregate

to the large cities like Lahore and Karachi, which already have an abundance of doctors.

iii. Hospital Administration / Staff:

The hospital administration and staff are proud that their hospital has been granted autonomous status and has truly become a DHH, with the status of a teaching hospital. This has enhanced their standing in the medical profession. Further, they are content that their remuneration package has been enhanced due to the partnership without any change in their conditions of service. No staff member has complained about the additional workload. The hospital administration is looking forward to the time when the government will sanction posts for more doctors in the new wing and thereafter, some students on completion of their MBBS may join as residents. This will greatly expand the capacity of the hospital to handle even more patients.

iv. Patients / Citizens:

Interviews of patients and a group of citizens revealed that they too were pleased that the DHH, Mansehra had been successfully upgraded without any enhancement of user charges. They admitted that their initial fears of the privatisation of the facility have proven to be unfounded. Interestingly, some patients have remarked about a visible improvement in the quality of service due to greater presence of doctors. Apparently, they are unable to distinguish between doctors and students, all of whom wear white coats. Some citizens remarked that this successful model of partnership, first developed in Mansehra should be tried elsewhere in the province of NWFP.

Section VII: Conclusions

7.1 Factors Contributing to Success:

A number of factors can be identified which have contributed to the success of the model of partnership between the government of NWFP (through the DHH, Mansehra) and the FMC, involving the provision of clinical and teaching facilities by the hospital and the payment of capitation fees by the college for this service. The success factors include the following:

i. High Premium on Medical Education:

An underlying favourable factor is the high level of demand for medical education in Pakistan. Despite high capital costs, private medical colleges have become financially viable because of the relatively high fees that can be charged. FMC's annual fees and other charges per student exceed Rs.200,000. This has made it possible for FMC to offer to pay high capitation fees of Rs.50,000 per student to DHH, Mansehra, and thereby make the partnership financially attractive to the latter.

ii. Large Scope for Synergy:

This particular model of partnership chosen also has great potential for synergy, whereby each party benefits significantly from the partnership. FMC was able to reduce its start-up costs and gain faster recognition from PMDC while DHH, Mansehra got enhanced status and substantial additional funds to upgrade the hospital. This synergy greatly increased the incentive for forming the partnership and also increased the likelihood of success of the arrangement.

iii. Quality of Leadership:

The role of Prof. A. J. Khan in piloting through the concept of public-private partnership in the field of medical education for the first time in Pakistan must be emphasised. Given his status and past positions held in the government, he was able to surmount the obstacle of mistrust of the private sector in the bureaucracy. Formation of a Trust and establishment of a Board of Governors of the college helped further in surmounting this lack of faith. Prof. Khan demonstrated successfully that his goal was not profit maximisation by donating land free of charge for the construction of the college campus.

iv. Shared Objectives:

Prof. A. J. Khan's offer to pay relatively high capitation fees was partly motivated by the desire to contribute to the upgrading of DHH, Mansehra, so that it could provide enhanced and improved services to residents of Mansehra district, a district to which he himself is a resident. Therefore, he shared the same objective as the government of NWFP in expanding the coverage of medical services. Also, the Medical Superintendant of DHH, Mansehra had an established good standing with Prof. A. J. Khan, which made it possible for both of them to work together for the improvement of the hospital.

v. Success in Coalition Building:

Initially different stake holders had varying perceptions about the partnership. Citizens of the area were worried that this was the first step towards privatisation of the government hospital and that subsequently user charges would be raised. This fear was allayed by a series of meetings of the MS with notables of the area and by including representatives of the citizens in the Hospital Management Board and Review Board. This ensured a degree of public accountability of the arrangement.

The hospital staff was worried that their employment status might be changed and they would lose their security of service. However, in the agreement their rights have been fully protected. In fact, they have been granted a special allowance during the tenure of the partnership. Altogether, the parties involved to the arrangement skillfully built a coalition of support for the partnership from the various stakeholders.

vi. Appropriate Changes in Governance Structure:

A fundamental change made was the granting of administrative autonomy to DHH, following the granting of the status of a teaching hospital by the establishment of a Hospital Management Board. This increased the flexibility of the hospital management to respond to any problems that may arise during the tenure of the partnership. Also, the private sector partner has been given a significant role in the management of the hospital by due representation on the Board.

vii. Proper Legal Framework:

The terms and conditions of the partnership have been clearly specified in a legal agreement that holds true for three years between the government of NWFP (which owns DHH, Mansehra) and FMC. This is to ensure proper transparency in terms of the obligations of each party and to provide the necessary regulatory framework to monitor the implementation of the agreement.

viii. Building In of Safeguards:

The legal agreement is a comprehensive document and has careful built in safeguards for the proper utilisation of funds, for protection of the rights of patients and hospital employees, and for conflict resolution between the two parties. This minimises potential problems in the working of the partnership. In fact, the legal agreement

is exceptionally well drafted and can become a model for similar partnerships elsewhere in Pakistan.

ix. Outside Patronage:

The government of NWFP honoured its commitment of giving a development allocation of Rs.8 million to upgrade DHH, Mansehra. The divisional/district administration has also taken an active interest in the project. The District Coordination Officer & Executive District Officer have been supportive and monitor the partnership as Chairman / Co-Chairman of the Hospital Management Board. Success in rapid completion of the new wing of DHH, Mansehra, has motivated the government of NWFP to offer equipment and furniture, which will become surplus commodities after the closure of DHH, Abbottabad.

Altogether, several factors including the high premium on medical education, large scope for synergy, quality of leadership, shared objectives, success in coalition building, appropriate changes in governance structure, proper legal framework, building in of safeguards and outside patronage have all contributed to making this a unique successful model of public - private partnership in the health sector of Pakistan.

7.2 Lessons Learned from the Case Study and Policy Implications:

The case study from Pakistan demonstrates that the inherent mistrust between the public and private sectors can be transformed into a mutually beneficial partnership if the gains from co-operation are high, there is strong leadership, and further a commitment to common objectives, if attempts are made to build a coalition of support by resolving the divergent interests of various stakeholders, if appropriate changes are made in the governance structure and if a proper legal and regulatory framework is put in place to ensure transparency and accountability of the arrangement.

The relationship between the government of NWFP (through the DHH, Mansehra) and the Frontier Medical College is currently a unique model of partnership in the Pakistani setting, which evolved because of a combination of favourable factors. Can it be replicated elsewhere? Given the success of the model, the answer is probably a yes. In fact, an advertisement has recently appeared in the leading Urdu newspaper of Pakistan, *Jang*, wherein the Railway Hospital in Lahore has offered its facilities to an interested private medical college. However, success in forming partnerships will hinge as stressed earlier on the quality of leadership, on the ability to build a coalition of support, and

to agree on a legal and regulatory framework (along with appropriate institutional changes) of the type observed in the case study.

The case study also has some significant policy implications for replication of this model of partnership in the province of NWFP and in the country as a whole, from the viewpoint not only of expanding the coverage of basic health services but also of increasing the output of medical personnel. First, the move towards granting of administrative autonomy to district headquarters hospitals, as was done in Mansehra, through the establishment of Hospital Management Boards appears to be a desirable step from the viewpoint of overall supervision and policy direction and creating accountability to different stakeholders. It also increases the ability to respond to opportunities arising, say, from the formation of partnership with private entities.

Second, the NWFP government has done pioneering work in establishing a proper legal and regulatory framework for the working of the public-private partnership. In particular, the legal agreement is well-drafted and covers all relevant aspects of the relationship. A stage has been reached when a model legal agreement can be prepared which could act as the basis for a partnership between a public hospital and a private medical college across the country.

Third, successful public-private partnerships are rare in the health sector of Pakistan. Therefore, the success in Abbottabad-Mansehra should be widely publicised to demonstrate the gains that can be realised from such partnerships. Health policy statements should more strongly emphasise the need for and scope of pubic-private partnerships. This case study can also be more widely disseminated within Pakistan and elsewhere to create greater awareness of the benefits of public- private partnerships.

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