Research Report No. 34

PUBLIC-PRIVATE PARTNERSHIPS IN THE HEALTH SECTOR

SOCIAL POLICY AND DEVELOPMENT CENTRE

SUMMARY

This report presents general guidelines for preparing a case study of public-private partnership in the health sector. Based on these guidelines, a case study is undertaken of partnership between a private medical college and a public hospital in the city of Abbottabad in NWFP. This case study highlights how a successful partnership can be evolved in presence of 'synergy' between partners, strong leadership, shared objectives, success in coalition building, appropriate changes in governance structure, proper legal framework, building in of safeguards and outside patronage.

ACRONYMS

ADP	Annual Development Program
BHU	Basic Health Unit
CBO	Community Based Organization
CCU	Casualty Care Unit
DFI	Development Finance Institution
DHA	District Health Authority
DHH	District Headquarters Hospital
ECG	Electro Cardiogram
FLCF	First Level Care Facility
FMC	Frontier Medical College
QUANGO	Quasi Non-Governmental Organisation
ICU	Intensive Care Unit
LHV	Lady Health Visitor
MCH	Maternity and Child Health
MS	Medical Superintendant
NGO	Non-Governmental Organisation
NWFP	North-West Frontier Province
PHC	Public Health Care
PMDC	Pakistan Medical and Dental Council
PPP	Purchasing Power Parity
WHO	World Health Organization

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GUIDELINES FOR PREPARING A CASE STUDY OF PUBLIC-PRIVATE PARTNERSHIPS IN THE HEALTH SECTOR

The case study of a public-private partnership in the health sector should ideally contain eight parts as follows: overview, the partners, process of building partnership, the model of partnership, working of the partnership, evaluation of the partnership, factors contributing to success / failure and lessons learned from the case study.

Desired contents of each part are described below.

1 OVERVIEW

There should be five sections in this part relating to the following: country description, the health sector, role of the private sector and NGOs, the health policy and public-private partnerships in the health sector.

The contents of each section should be as follows:

Country description: key demographic, socio economic and political characteristics of the country in order to provide the overall setting for the case study.

The health sector: latest available magnitude of key health indicators (infant mortality, life expectancy, maternal mortality, etc.); level of health expenditures, public and private; level of health sector inputs (doctors, nurses, beds, etc.) in relation to population; major diseases; key problems of sector development.

Role of private sector and NGOs: some key questions to be answered by the case study are: Does the commercial private sector in the country cater primarily for the market? Is the private sector largely involved in the provision of curative services? What is the regulatory framework? Are NGOs in the country catering primarily for the needs of the poor and hard-to-reach areas in the

country or are they also in competition with the public sector? Is NGO involvement greater in the preventive health area? Do NGOs collectively have enough institutional capacity to undertake larger programs in the health sector?

The health policy: the focus should be, first, on health sector goals and targets, second, on the future role of the public, private and NGO sectors, third, on the regulatory role envisaged for the government and, fourth, on a brief description of major initiatives / programs proposed.

Public-private partnerships in the health sector: this section should highlight existing models and examples of public-private partnerships and opportunities identified in the health policy, leading to the case study chosen, with a statement of the reasons for the particular choice.

2 THE PARTNERS

This part should describe the partners, as follows:

The private sector: The first question to be answered is the private sector party for profit or non-profit? If the answer is the latter, then is it an NGO, CBO, voluntary group, religious group or professional organisation? Beyond this, a description is required of the entity's goals, legal status, history, governance structure, functions performed, existing projects, sources of funding, etc.

The case study should identify the strengths and weaknesses of the particular private sector party. Does the entity have a track record for innovation and effectiveness in provision? Do working procedures and the governance structure give it the flexibility and dynamism to respond successfully to new problems and challenges? If it is profit oriented, does this conflict with the goal of providing service for all or does it lead the sacrifice of quality for profit? If it is an NGO, can it target the poor and unserved effectively? Does it have adequate institutional capacity, financial sustainability and accountability?

The public sector: The first task is to identify if the public sector partner is the national government, provincial / state government, district / municipal authority or a parastatal

enterprise. The next task is to identify its strengths and weaknesses. Strengths could include the presence of a wide network of provision without any price discrimination and equal access to all. Weaknesses may be characterised by poor quality and inefficient delivery, high degree of centralisation of the process of decision making, bureaucratic red tape and procedures, problems in the allocation and management of resources, lack of resources for non-salary inputs and improvement in facilities, underutilisation of available infrastructure, etc.

3 PROCESS OF BUILDING PARTNERSHIP

This part should identify the impediments to the formation of the partnership. These could include conflicting objectives between the public and the private sector, basic lack of trust of the private sector by government functionaries, problems of corruption and cumbersome procedures in the public sector or the presence of divergent interests among the various stakeholders (beneficiaries, employees, etc.).

An explanation should then be given of how these obstacles have been surmounted. In particular, the role of leadership must be highlighted. Most partnerships usually require a strong leader(s) who champion(s) the partnership with vision, energy and enthusiasm. Who was / were the leader or leaders? What were his / her / their motivations and the role played? In addition, formation of a partnership requires visible senior level support and patronage? Where did such support (if any) come from?

Beyond this, the case study should describe how a coalition of support for the partnership was built. How was a convergence of objectives achieved? How were the divergent (and, frequently, competing interests) of different stakeholders reconciled? What inducements were offered to different stakeholders?

4 THE MODEL OF PARTNERSHIP

In describing the model of partnership the case study should focus on how the objectives of each partner contribute to improving quality, efficiency, effectiveness and equity in services provided. This should be followed by a statement of the roles of each party as they relate to financing,

management and provision of services. For example, can the partnership be characterised as one in which financing is by the private sector and provision by the public sector or vice versa? Is management of the project exclusively with one partner or jointly shared?

This part of the report should clear identify the specific responsibilities of each partner. In particular, the presence of safeguards should be highlighted. These could relate to ownership of assets, use of project funds, rights of beneficiaries, status of employees, etc.

This part should conclude with a description of the 'synergy' created by the partnership between the partners. Such synergy arises in the relationship between two parties when the formation of a partnership between them 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.* Establishing the synergy will require a demonstration of how the partnership makes each party potentially better off. This implies a detailed listing by the case study of all the benefits to each party from the partnership.

5 WORKING OF THE PARTNERSHIP

The terms and conditions of the partnership may have been embodied in a formal legal agreement between the two parties. If so, then a copy of this legal agreement should be obtained (and attached as an Annexure to the case study) and the contents of this agreement described in the case study. If not, then the working of the partnership can be determined by observing the practices.

The first key element in the working of the partnership is the governance structure. What are the institutional arrangements that have been put in place for managing the joint initiative? What is the regulatory framework for ensuring compliance by both parties? What are the procedures for resolving problems of non-compliance? What arrangements have been put in place for independent arbitration in the event of dispute?

It is also important to determine the degree of transparency and accountability in the arrangement. Was the partnership evolved on the basis of bidding? If so, what were the terms of the bid and how was it evaluated? Is the governance structure open and allows for representation by different stakeholders, including potential beneficiaries?

Answering all the above questions is essential for the case study to be able to adequately portray the working of the partnership.

6 EVALUATION OF THE PARTNERSHIP

Ultimately, the success of a partnership hinges on increasing the universality, equity, efficiency and accountability in the delivery of the service. Universality refers to access for all who are eligible for the service. Equity is an elaboration of the universality criterion in terms of ensuring acceptable quality of service to all, sharing of costs equitably and special attention to disadvantaged groups. Efficiency has two aspects. Internal efficiency relates to operations and management of an activity to achieve maximum output at least cost. External efficiency is concerned with achieving the best results based on the objectives of the activity for the least cost. Accountability refers to the holding of the providers of services answerable to beneficiaries and other stakeholders regarding both process and outcome of a program. The case study must identify how the model and working of the partnership contributes to the attainment of these objectives.

For quantitative measurement of success, three types of indicators can be used relating to inputs, outputs or impacts. For proper analysis of change it will be necessary to have benchmark data relating to the service prior to the formation of the partnership. Input indicators include level of expenditure, staffing, buildings and equipment. Outputs relate, for example, to number of patients handled of different types. Impact indicators relate to disease prevalence, mortality, etc. The first two sets of indicators are relatively easy to measure and can usually be obtained from the facility. Quantification of impact indicators will require a sample survey of the population served and could involve significant costs.

Based on the above analysis, the case study should make a judgement of the degree of success achieved by the partnership.

7 FACTORS CONTRIBUTING TO SUCCESS / FAILURE

Following the assessment of the degree of success achieved by the partnership, this part of the case study should highlight factors which contributed to the success or factors which have inhibited the successful outcome of the partnership. Success factors could include shared objectives, scope for 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. As opposed to this, factors inhibiting success could include lack of mutual trust, non-compliance by one or both parties, failure in conflict resolution, pressure of vested interests, lack of transparency and accountability, etc.

8 LESSONS LEARNED FROM CASE STUDY

This should be a summary statement based on the case study of either what makes a public-private partnership work or why a partnership fails. At the end, the issue needs to be taken up of the replicability of the case study (if it has been adjudged a success). The degree of success will hinge on the potential scope for 'synergy' in the particular model of partnership and the extent to which benefits are actually realised by each party. If leadership and external support have been among of the main factors responsible for success, then the replicability of the model is less certain and will hinge on the presence of these special factors in other settings also.

A CASE STUDY OF PUBLIC-PRIVATE PARTNERSHIPS IN THE HEALTH SECTOR

A CASE STUDY OF PUBLIC-PRIVATE PARTNERSHIPS IN THE HEALTH SECTOR

1 OVERVIEW

1.1 Country Description

Pakistan is a low income developing country of South Asia with a population of 138 million and a per capita income of US $ 480 ($ 1560 in PPP terms). The economy is pre-dominantly agricultural, with 40 per cent of the labor force in agriculture and 65 per cent of the population living in rural areas. Pakistan's economy has suffered a loss of growth momentum in recent years. While the growth rate was over 6 per cent during the decade of the 80s it has fallen to about 4½ per cent in the 90s. Pakistan has been ranked 132nd by the UNDP in its latest human development index ranking. One of the key reasons for the low ranking is the low literacy rate of 45 per cent, with illiteracy among females being as high as 75 per cent.

1.2 Health Sector

The health status of Pakistan is characterised by a high rate of population growth (about 2.4 per cent currently) and poor health indicators like infant mortality rate of 92 per thousand live births, under five mortality of 137 per 1000 live births, life expectancy of 60 years and child malnutrition of over 40 per cent (see Table 1). The major killers are diarrohea and pneumonia in children, complications of pregnancy in women of child bearing age, cardiovascular disease and cancer in the elderly. Drug abuse has emerged as a public health problem while malaria and tuberculosis continue to be potential threats. Communicable, infectious and parasitic diseases remain a severe problem, although significant gains have been made recently under the expanded program of immunisation.

The availability of health facilities and personnel is given in Table 2. Combined private and public expenditure on health is about 3.5 per cent of the GDP. The public sector accounts for less than 1 per cent of the GDP. A serious problem is that investments in health infrastructure cannot be maximized because of shortage of funds for salaries, drugs and maintenance. Very little expenditure is covered by health insurance.

TABLE 1
COMPARATIVE POSITION OF PAKISTAN IN HEALTH INDICATORS*

INDICATOR	Unit	Pakistan	Average for	
			South Asian Countries	Low Income Developing Countries
Infant Mortality	per 1000 live births	92	73	58
Under 5 Mortality	per 1000 live births	137	106	101
Immunisation:				
Measles	%	77.0	84.2	86.2
DPT	%	81.0	88.6	89.1
Child Malnutrition	%	40.4	61.5	38.2
Life Expectancy	Yrs	60	61	63
Total Fertility Rate	No	5.4	3.6	3.3

*Most recent estimates
Source: World Bank, Social Indicators

TABLE 2
HEALTH PERSONNEL AND FACILITIES IN PAKISTAN

Years	Hospitals	Dispensaries	RHCs	BHUs	MCHs	Total Beds	Population per Bed
1970	495	2136	87	249	669	34077	1804
1980	602	3466	217	812	736	47412	1716
1990	756	3795	459	4213	1050	72997	1480
1998	872	4551	514	5155	852	90659	1450

Years	Doctors	Nurses	Midwives	LHVs	Population per	
					Doctor	Nurse
1970	3913	946	522	51	15256	63104
1980	10777	5336	4200	547	7549	15246
1990	51883	16948	15009	3106	2082	6373
1998	82682	32938	22103	4959	1590	3991

Source: Pakistan Economic Survey.

Pakistan has a serious problem of maldistribution of doctors and an overall shortage of para-medical personnel, especially nurses. The annual output of doctors is about 4000. Bulk of the doctors are concentrated in urban areas and rural coverage is poor. Medical colleges concentrate on treatment of individuals and less on community health care.

Two fundamental problems which plague the sector are of equity and effectiveness. The provision of health services is highly inequitable. Although rural dwellers comprise almost two thirds of the population, the majority of health services, like doctors, are located in the urban areas. Recent attempts to offset this bias by developing primary health services in rural areas have met problems of understaffing and underutilisation. This has contributed to the lack of effectiveness of investments already made.

1.3 Role of the Private Sector and NGOs in Health

In Pakistan, the private health sector is large, as in most developing countries. It is a thriving sector with private spending accounting for almost 70 per cent of all health expenditures. This sector is dominated by private clinics managed by general practitioners (almost 25 per cent in the private sector, the remaining 75 per cent in government facilities). In-patient and out-patient services are also provided by 800 small to medium sized hospitals (with 15000 beds, as compared to 76,000 in the public sector). There are also 500 private diagnostic laboratories of various sizes located mainly in the urban areas. In addition, there are a large number of traditional health care providers, especially in the rural areas.

The private sector provides more extensive health services than the public sector. But there is much variation in the quality of services provided. The poor quality is reflected by out-dated equipment, lack of para-medical staff and nurses and misuse of prescription drugs.

The role of NGOs in the curative health sector is small in relation to the private or public sector. There are, however, examples of large, state-of-the-art curative health facilities set up and operated by trusts and foundations, usually on government land provided at low cost and with customs duty exemptions on machinery and income tax exemptions. Two such large initiatives

are the Al-Shifa Trust Hospital in Islamabad and Shaukat Khanum Cancer Hospital in Lahore (run by Imran Khan, the famous cricketer - turned - politician). In addition, there are 104 hospitals operated by NGOs.

NGOs are playing a more important role in the population planning and preventive health areas. There are over 250 registered health care NGOs, operating mostly in the provinces of Punjab and Sindh, while there are 131 NGOs for the disabled. Multi-sectoral QUANGOs like the National Rural Support Program, Balochistan Rural Support Program and Sarhad Rural Support Program are organising communities for receiving an integrated basic health services package. NGOs have also begun to play a major role in the program for immunisation of children.

1.4 Health Policy

The current health policy of the Government of Pakistan, which was approved by the federal cabinet in 1998, and is likely to be incorporated in the three year medium term plan (2000-01 to 2002-03) to be announced shortly, envisages an expanded role in curative health services of the private sector and NGOs. In addition, the private sector will be encouraged to participate in preventive and promotive services.

The policy proposes a number of government incentives for financing private provision of health services. All development finance institutions (DFIs) will be allowed to lend to private parties in the health sector. The rules of business will be developed by a Commission proposed to be set up for regulating the private sector. Selected non-profit institutions, focusing on preventive and MCH components and on reaching the under-served, will be supported through contributions to recurring budgets.

The health policy emphasises the need to set up an appropriate legal and regulatory framework to improve the quality of small-scale private healthcare, discourage unauthorised practice (by 'quacks') and close down inadequately equipped facilities. Accredition of private hospitals and clinics will be carried out.

In addition, functional linkages between the PHC program and NGOs / CBOs / private sector will be developed and effective mechanisms for community involvement will be promoted (e.g. health committees, district health authorities (DHAs)). Community participation will help in identifying needs, as well as in implementing and evaluating programmes.

1.5 Public – Private Partnerships in Health

Perhaps the most important initiative proposed in the area of public - private partnerships in the health sector of Pakistan is the National Health Care (NHC) Scheme. The objectives of this scheme are, first, to improve the quality and utilisation of existing services, second, to decrease the cost of care to the public and the government and, third, to extend basic health care to all.

The main components of the NHC Scheme are as follows:

- District Health Authorities (DHAs) with representation from Government departments and the community, to supervise the management of the district health system
- Autonomy to selected District Headquarters Hospitals run by Hospital Management Boards, under the supervision of DHAs, with authorization to levy user charges
- Contracting of selected First Level Care Facilities (FLCFs) to private physicians, NGOs or existing staff, to deliver standard package of services at user charges, under the supervision of CBOs
- National Health Cards for families in rural and under served urban areas, to provide essential health services at nominal charges (and free for poor families) through privatized health facilities.

There are a number of other promising areas for public - private partnerships in the health sector of Pakistan. One such model would involve the leasing out of a government hospital at the district / tehsil level with the proviso that investment would be made to upgrade the facility, strengthen the medical staff and collect reasonable user charges. Another model could be the placement of government medical personnel (with their cost borne by government) in NGO /

private health facilities like MCH centres or clinics/ hospitals. A good example of this is the placement of a government doctor in the TB Association Hospital in the city of Hyderabad in Sindh.

Given the financial constraints to expansion of medical colleges in Pakistan, which have very high start up costs because of 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 in the province of NWFP of Pakistan.**

This case study was chosen because of its unique character, its scale (in terms of flow of funds between the partners) and because the partnership had reached a mature stage where it could be subjected to evaluation. Other public - private partnerships in the health sector of Pakistan have been relatively small in nature and with less impact on the provision of services.

2 THE PARTNERS

2.1 Private Sector

The private sector partner is the Frontier Medical College, located in Abbottabad, a divisional headquarter in the province of NWFP of Pakistan (see Map 1), with a population of 120000. The city of Abbottabad is situated on the Karakoram Highway, leading from Islamabad (the capital of Pakistan) to Gilgit, the Chinese border and the Central Asian states. Abbottabad is famous for its scenic beauty and pleasant climate throughout the year. This has encouraged the location of many important educational institutions in the city, which have both national and local intake of students. A key military institution, the Pakistan Military Academy, Kakul, which trains officers for the Pakistan Army, is located here. Altogether, there are 105 schools and colleges. Students in schools like the prestigious Burn Hall come from all over Pakistan and abroad. Recently, a public sector medical college, the Ayub Medical College, with a large 1000 bed teaching hospital complex has been set up in Abbottabad.

MAP - 1
NORTH WEST FRONTIER PROVINCE

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. For example, in NWFP about 3200 students passed the F.Sc (Higher Secondary School) pre-medical examination in first division in 1996 and only about 400 got admission in the two public sector medical colleges in the province while the remaining 2800 were left out. There is also a significant gap in the supply of doctors in the country. The number of doctors registered in Pakistan is about 80000, of which over 10000 are working abroad. The remaining 70000 serve a population approaching 138 million, implying the ratio of one doctor per about 2000 population. 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 140000. Accordingly, another 70000 doctors are required to fulfil the needs. Given this shortage, it is not surprising that medical education continues to command a premium.

Realising the importance of training more doctors, the government increased the number of seats in public sector medical colleges. This resulted in overcrowding, leading to a deterioration in the quality of education. The Pakistan Medical and Dental Council (PMDC), the registration and accredition body for doctors and the controlling authority for standard of medical education, pushed through a reduction in the number of seats in government colleges and the private sector was encouraged to assist in the training of doctors. The first private sector initiative in medical education was the Aga Khan Medical University in Karachi, which has done exceptionally well and earned a good reputation for private medical education. However, a number of other private medical colleges that were established did not come up to the standards of PMDC regarding quality and number of faculty, equipment, presence of teaching hospital, etc., and were closed.

Frontier Medical College is fairly well-endowed. It has about 50 acres of land, and is housed in a four storey building with about 50000 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 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, an 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 dead body rooms, an auditorium with capacity to seat 500, 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).

Teaching started in FMC in 1996. The annual intake of students is 50 from all over Pakistan and from abroad. The course of studies for the MBBS is five academic years (each of nine months). The total hours of subjects is 4825. There are five parts to the professional examination, held once each year. There is a special entry test (with weight of 40% for admission). Currently, the total enrollment in the college is 200. 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 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 of 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 founder Principal of the college is Professor A.J. Khan. He is the former Principal of the Bolan Medical College, Quetta, Balochistan and the founder Principal of Ayub Medical College, Abbottabad, both public institutions. He has served as Director General of Health, Government of Pakistan, and has acted as President of the PMDC. He has received the highest civil award of Pakistan for public service.

The Dean of the college is Prof. Mujahid Akbar. He was formerly the head of the department of anatomy and principal of Ayub Medical College. The Dean acts as the head of academics at

the college. Academic matters of the college are decided by a academic council consisting of heads of departments and professors.

Tuition fees are relatively high at FMC at Rs 195000 (US $ 3750) per academic session (of one year). For foreign nationals (there are 29 enrolled currently) the annual fees is $ 10000. In addition there is an admission fee of Rs 30000, initial caution money of Rs 30000 and other miscellaneous fees of Rs 10000 annually. The hostel accommodation fee is Rs 30000 per academic session. Despite these relatively high fees, FMC received 430 applications for 50 seats last year.

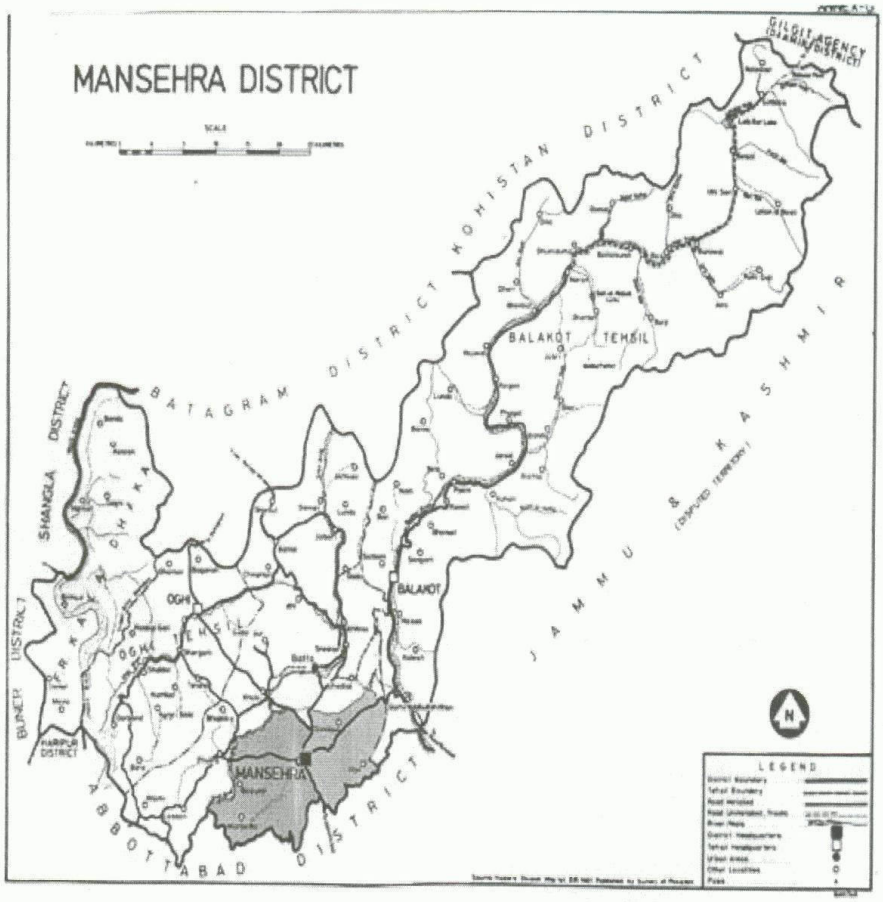
Overall, the strengths of the private sector party include dynamism and efficiency. For example, construction of the college campus was completed in less than one year and the design of facilities represents very efficient utilisation of space. The college has been aggressive in its recruitment and marketing efforts and has been able to attract faculty and students not only from throughout Pakistan but also from abroad. Its potential weakness is the that the relatively high level of fees precludes access to meritorious but relatively poor students.

2.2 Public Sector

The partnership of FMC is legally with the government of NWFP which owns the District Headquarters Hospital in Mansehra, the effective partner. Mansehra is a neighbouring district to 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 52000, 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 (see Map - 2) of Batagram, Shangla, Buner and Kohistan (with a combined population of 1.7 million).

Mansehra is pre-dominantly a rural district with rainfed agriculture essentially on hill slopes. The principal crops are wheat, maize and rice. Production and yield levels are relatively low.

MAP - 2


MANSEHRA DISTRICT
SCALE
KOHISTAN DISTRICT
GILGIT AGENCY
BATAGRAM DISTRICT
SHANGLA DISTRICT
BUNER DISTRICT
HARIPUR DISTRICT
ABBOTTABAD DISTRICT
JAMMU & KASHMIR
(DISPUTED TERRITORY)
BALAKOT TEHSIL
BALAKOT
OGHI
MANSEHRA
N
LEGEND

Household incomes in the region have been substantially enhanced by the inflow of home remittances from migrants out of the area to the large cities of Pakistan and the Middle East. *Consequently, consumption standards are relatively high, including mostly permanent housing* structures and high demand for services like 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 while a district hospital has upto 250 beds and 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 obstretics, opthamology, otolaryngology, pediatrics, orthopedics, dentistry, radiology and clinical pathology exist in the hospital. The total complement of doctors and senior staff is 30. The students of FMC are using this hospital for their clinical training since the commencement of their first clinical class in the beginning of 1999.

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

3 PROCESS OF BUILDING PARTNERSHIP

3.1 Impediments

The process of building 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 fundamentally in conflict with the objective of increasing the outreach of health services to essentially poor unserved populations at 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 may be sold land in Mansehra at relatively low cost for establishing a teaching hospital there. But the local land owner demanded a high price, well above the prevailing market rate, and this idea had to be abandoned.

Thereafter, the FMC made a bid for using the large 600 bed DHH at Abbottabad 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 good clinical training of students. But there was no clear cut response from the authorities because the future of this hospital was uncertain. Abbottabad city has 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. This is what was ultimately decided and the hospital is currently in the process of being closed down.

The third option presented by FMC was for establishing a partnership with DHH, Mansehra, which was not as well endowed with 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.

Prof A.J. Khan, the principal of FMC, has made the telling observation that frequent changes in the provincial government (in 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 the partnership lie in the divergent interests of the various stakeholders. The staff members of the DHH, Mansehra, 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 and 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, Mansehra, as the first step towards the ultimate privatization of the latter facility. It was feared that user charges would be raised drastically making the facility out of the reach of the poorer segments of the population in Mansehra district. These concerns had to be allayed by a number of meetings of the Medical Superintendant of DHH, Mansehra, 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, founder Principal of FMC. Despite the many impediments, Prof.

Khan pursued with determination his goal of establishing a private medical college in 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.

Prof Khan's big 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 of functionaries in the government of NWFP but he has also widely respected in the health department of the province and in PMDC. Given that he was from the district of Mansehra, there was a general trust in his desire to do something for the people in his 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. On top of this, the partnership was strengthened at the operational level by the strong understanding and cooperation between the Principal, FMC, and the Medical Superintendant, DHH, Mansehra.

4 THE MODEL OF PARTNERSHIP

4.1 Objectives of Partners

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

4.2 Inputs by Partners

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

- Capitation fee of Rs 50000 per student per year for three classes over three years (from January 1, 1999 to December 31, 2001) totaling to Rs 15 million as under:

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 8.0 million as first installment of the capitation fee shall be paid immediately on signing of the agreement. The remaining amount of Rs 7.0 million shall be paid within 18 months of signing this agreement.

Therefore, the model of partnership is essentially one of 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 as follows:

Ownership of assets: The agreement is only for temporary use of the facilities of DHH, Mansehra. 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 new assets created.

Rights of beneficiaries: The hospital will remain part of the health delivery system of the government of NWFP and shall 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 minimum cost as provided in sister government hospitals in the province. This provision was necessary to remove the perception that the formation of the partnership was the first step towards privatization of the hospital leading eventually to substantially higher user charges.

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 change in their pay structure. This safeguard was introduced to remove 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.

On top of this, 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 and shall be paid a teaching allowance equal to 20 per cent of their basic pay out of 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.

Budgetary Commitments by Government of NWFP: The government of NWFP has committed to continue to meet recurrent costs on salary and allowances of its employees through the Accountant General's office and 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 achieve some savings. In the event this happened, the capitation fees would have been largely diverted for financing recurrent costs and could not then be used for upgrading the facilities of the hospital.

Establishment of 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 as in the part to the government of NWFP for deposit in the Provincial Consolidated Fund. This tantamounts to granting autonomous status to DDH, Mansehra.

All amounts credited to the fund (including the 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:

(a) construction of a fully equipped new block of 100 bedded ward within the premises of the hospital
(b) expansion and improvement of the existing casualty department
(c) establishment of a fully equipped ICU, CCU and a new operation theater
(d) improvement of existing wards and outpatient department.

The government of NWFP has also committed to give a development grant of Rs 8 million from the provincial ADP funds over a maximum period of two years (1998-2000) 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 it 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 them 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 *positive sum co-operative game.*

In the context of the particular case study, it is necessary to demonstrate how the nature of the partnership makes each party potentially better off. We start with the DHH, Mansehra. How does it benefit from the partnership?

The benefits include the following:

(a) 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

(b) inflow of additional development funds from the government to match the contribution by FMC at a time when there is a severe fiscal squeeze on the provincial government and there has been a contraction in real allocations to the health sector

(c) enhancement in the status of the hospital as a teaching hospital and with the expansion in capacity increase in the ability to offer more and better services to the population in Mansehra district and adjoining districts

(d) presence of senior students from FMC enables an improvement in the quality of medical care.

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

(a) linkage with a teaching hospital has substantially reduced the start-up costs of the college. If FMC had gone in for its own teaching hospital it would have had to initially invest an additional Rs 50 to Rs 60 million. Arranging this volume of funds would have delayed execution of the project. Also, it would have had difficulty in getting recognition from the PMDC of its medical degree in the absence of a teaching hospital

(b) 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 relatively high fees. 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 the exposure of students and the quality of clinical teaching is significantly better

(c) the founder principal of FMC, Prof A.J. Khan, who is the principal project sponsor, also sees the development of DHH, Mansehra, and its enhanced ability to provide better services to local residents as a worthwhile objective as he is himself from the district of Mansehra. Also, 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 to students through establishment of the ICU, CCU and a range of new specialities.

5 WORKING OF THE PARTNERSHIP

5.1 Governance Structure

A number of changes in the governance structure were necessary for smooth functioning of the partnership. A critical step forward was the granting of operational autonomy to DHH, Mansehra, by 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 DHH's.

The composition of the Board is as follows:

(d)	Commissioner Hazara Division	Chairman
(e)	Deputy Commissioner Mansehra	Co-Chairman/Member
(f)	Principal of the College	Vice Chairman
(g)	Two prominent citizens to be nominated by the First Party	Members
(h)	one representative of the College	Member
(i)	District Health Officer Mansehra	Member
(j)	Medical Superintendent, District Headquarter Hospital, Mansehra	Member - cum Secretary

Functions of the Management Board include the following:

(a) administration and management of the Hospital;

(b) establishment of regulatory framework for operation of the Hospital and the collaborative arrangements with the Second Party within the overall framework of the Agreement;

(c) regulation of clinical coaching and discipline amongst students during clinical coaching at the Hospital;

(d) approval of development plans within the Hospital based on a master plan to be prepared for upgradation and development of the Hospital;

(e) submission of annual budget estimates and revised budget estimates to the Government on the recommendations of the Finance and Planning Committee;

(f) review of quarterly reports prepared by the Medical Superintendent of the Hospital; and

(g) preparation of annual report of the Management Board, and its submission to the Review Board.

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 FMC there are two seats, one for the Principal as the Vice Chairman and the other for a representative nominated by the college as member. This implies that the private sector partner has been given an important role in the management of the hospital. The Medical Superintendant of the hospital acts as the Secretary of the Board. Second, the Chairman of the board, the Commissioner of Hazara Division, is an outsider. He can effectively act as an arbitrator in the event there is any dispute between the 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.

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 the collaborative arrangements in the partnership, the second is concerned with regulation of clinical teaching and discipline among students during clinical teaching at the hospital and the third with approval of development plans for the hospital.

5.2 Process for Review of Partnership

Above the Hospital Board, a special Review Board has been constituted to monitor the implementation of the agreement. The Review Board comprises of the following:

(a)	Additional Chief Secretary to Government of North-West Frontier Province	Chairman
(b)	Secretary to Government of North-West Frontier Province, Finance Department	Member
(c)	Secretary to Government of North-West Frontier Province, Health Department	Member
(d)	Secretary to Government of North-West Frontier Province, Services and General Administration Department	Member
(e)	Principal of the College	Member
(f)	Two members from the Hospital Management Board who are not civil servants	Member
(g)	Chairman of the Hospital Management Board, constituted under para 8(iv) of this Agreement	Member-cum-Secretary

The Review Board shall be responsible for:

(a) review of the implementation of this Agreement;
(b) review and approval of the Annual Report of the Chairman of the Hospital Management Board;
(c) review of the Audited Accounts of the Hospital Fund;
(d) any other matter assigned to it by the First Party.

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 that even at this high level there is representation both of 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.

5.3 Working Arrangements

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 treatment of patients. Clinical training sessions are held early morning from 8:00 AM 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.

6 EVALUATION OF PARTNERSHIP

6.1 Success Indicators

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

STAKEHOLDERS

HOSPITAL	COLLEGE
Hospital Administration	College Administration
Hospital Staff	College Staff
Patients	Students
Citizens	

Perhaps, the most powerful visual indicator of success is the completion of construction of the new wing of the hospital, which is ready to be commissioned within the next few weeks. This wing has the capacity for 150 beds, in excess of the expansion stipulated in the agreement. It includes a 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 promised in the agreement.

The construction of the new wing more than doubles the capacity of the DHH, Mansehra, and makes it equivalent to the DHH in some of the more developed districts of the country. Consequently, the hospital will now be able to avoid the 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 the quality of service will go up significantly. All this has been achieved without any increase in user charges. These remain very low. 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 free. Therefore, equity considerations have not been sacrificed. This is a major achievement.

The success of this model of 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 more specialized facilities.

6.2 Views of Stakeholders

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

FMC College Administration / Faculty: The respondents are happy that the DHH, Mansehra, has been upgraded and 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 in 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 visits to 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.

FMC Students: Some of the students have highlighted the problem of inconvenience in commuting between the college and hospital. However, they emphasise that they have greatly benefitted from the exposure to all kinds of patients at DHH, Mansehra. They have also praised the doctors of the hospital for being very cooperative and taking interest in the 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 in large cities like Lahore and Karachi, which already have an oversupply of doctors.

Hospital Administration / Staff: The hospital administration and staff are rightfully 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. They are, no doubt, also happy that their remuneration package has been enhanced due to the partnership

without any change in their conditions of service. No staff member complained about the additional work load. The hospital administration is looking forward to the time when the government will sanction posts for more doctors in the new wing and some students on completion of their MBBS may join as residents. This will greatly expand the capacity of the hospital to handle more patients.

Patients / Citizens: interviews of patients and a group of citizens reveal that they are happy that the DHH, Mansehra has been successfully upgraded without any enhancement of user charges. They admit that their initial fears of the privatization 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.

7 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:

High premium on medical education: a major 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 200000. This has made it possible for FMC to offer to pay high capitation fees of Rs 50000 per student to DHH, Mansehra, and thereby make the partnership financially very attractive to the latter.

Large scope for 'synergy': The 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 quicker recognition from PMDC while DHH, Mansehra got

enhanced status and substantial additional funds for upgrading the hospital. This synergy greatly increased the incentive for forming the partnership and also increased the likelihood of success of the arrangement.

Quality of Leadership: The exceptional 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 for the construction of the college campus.

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 more and better services to residents of Mansehra district, a district to which he belongs. 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 a good personal equation with Prof A.J. Khan which made it possible for both of them to work together for the improvement of the hospital.

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,

a coalition of support for the partnership from the various stakeholders was skillfully built by the parties to the arrangement.

Appropriate Changes in Governance Structure: A fundamental change that was made was the granting of administrative autonomy to DDH, following the granting of status of a teaching hospital, by the establishment of a Hospital Management Board. This has 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 representation on the board.

Proper Legal Framework: The terms and conditions of the partnership have been clearly specified in a legal agreement for three years between the government of NWFP (which owns DHH, Mansehra) and FMC. This ensures proper transparency in terms of the obligations of each party and provides the necessary regulatory framework for monitoring the implementation of the agreement.

Building In of Safeguards: The legal agreement is a comprehensive document and careful builds in safeguards for proper utilisation of funds, for protection of 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 well-drafted and can become a model for similar partnerships elsewhere in Pakistan.

Outside Patronage: The government of NWFP has honored its commitment of giving a development allocation of Rs 8 million for upgrading DHH, Mansehra. The divisional / district administration has also taken an active interest in the project. The Commissioner / Deputy Commissioner 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 after the closure of DHH, Abbottabad.

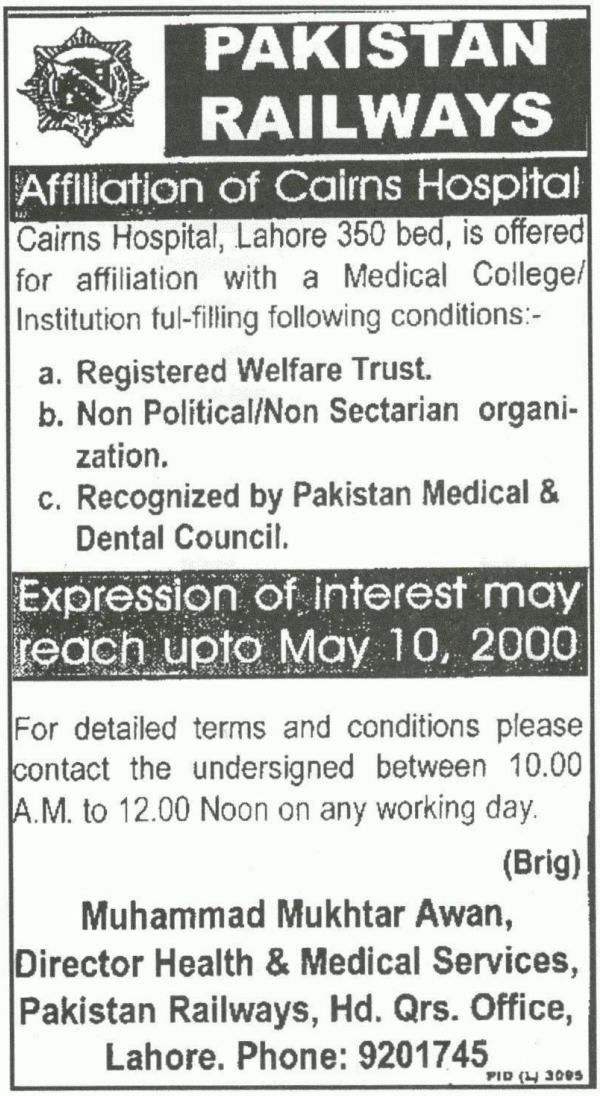
Altogether, a large number of factors including the high premium on medical education, large scope for 'synergy', quality of leadership, shared objectives, success in coalition building, appropriate changes in governance structure, proper legal framework, building in of safeguards and outside patronage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

8 LESSONS LEARNED FROM CASE STUDY

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 commitment to common objectives, if attempts are made to build coalition of support by resolving divergent interest 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 (see Chart I). However, success in forming partnerships will hinge 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.

CHART - 1
ADVERTISEMENT* BY HOSPITAL FOR PARTNERSHIP WITH MEDICAL COLLEGE



PAKISTAN RAILWAYS

Affiliation of Cairns Hospital

Cairns Hospital, Lahore 350 bed, is offered for affiliation with a Medical College/ Institution ful-filling following conditions:-

a. **Registered Welfare Trust.**
b. **Non Political/Non Sectarian organization.**
c. **Recognized by Pakistan Medical & Dental Council.**

Expression of interest may reach upto May 10, 2000

For detailed terms and conditions please contact the undersigned between 10.00 A.M. to 12.00 Noon on any working day.

(Brig)

Muhammad Mukhtar Awan,
Director Health & Medical Services,
Pakistan Railways, Hd. Qrs. Office,
Lahore. Phone: 9201745

PID (L) 3095

*Appeared in the daily, Jang, on 28th April 2000

ANNEXURE I
THE LEGAL AGREEMENT

This agreement made this 20 day of July 1998 between the Governor of the North-West Frontier Province, through Syed Mubashir Shams, Deputy Secretary to Government, North-West Frontier Province, Health Department (hereinafter referred to as 'First Party'), which expression shall include the its successors -in-office and assigns of the first part and Dr. Abdul Jamil Khan s/o Haji Abdu Jalil Khan resident of Al-Jamil Mansehra Road, Abbottabad, presently Principal, Frontier Medical College, Abbottabad (hereinafter referred to as 'the Second Party'), which expression shall include his successors, legal representative and assigns of the second part.

WHEREAS the First Part is desirous of upgrading and improving the health care facilities at the District Headquarter Hospital, Mansehra (hereinafter referred to 'as the Hospital'); AND WHEREAS the Second Party is desirous to obtain temporary teaching facilities for the medical students of the Frontier Medical College, Abbottabad (hereinafter referred as "the College"), and in lieu thereof is willing to contribute financially and provide expertise for the said improvement desired by the First Party.

NOW, THEREFORE, in consideration of the conditions hereinafter contained, the First Party and the Second Party agree as under:

- The Second Party has asked and the First Part has agreed to allow the Second Party the use of facilities at the Hospital for teaching purposes of the students of the College, against payment of a capitation fee on terms and conditions given in this Agreement.
- This Agreement is initially for period of three years commencing from 20th July, 98 and ending on 19th July, 2001, and extendable with mutual consent of the parties to the Agreement.
- This Agreement is only for temporary use of the facilities, mentioned in this Agreement. The Hospital, all its assets, its land and structure thereon shall continue to remain under the ownership and possession, of the First Party, as a part of the health care facilities controlled by the Department of Health. Any new building, equipment and other assets constructed and added to the Hospital, except otherwise provided in this agreement, shall also become the property of the First Party with full vested rights.
- The Hospital shall remain part of the Health Delivery System of the First Party and shall provide services to the public, not inferior to those provided before the signing of this agreement or provided by equivalent district headquarter hospitals elsewhere in the province.
- The employees of the First Part, at the Hospital, and other staff subsequently posted by the First Party therein, shall continue to be civil servants and governed by the relevant Government rules. Matters relating to their service conditions shall remain the responsibility of the Department of Health, North-West Frontier Province.
- The employees of the First Part shall continue to receive their pay and other remuneration, admissible to them under any law/rule for the time being in force, from the Government in the prescribed manner.
- In lieu of the use of the facilities at the Hospital for the teaching purposes of the students of the College, the Second Party agrees to the following:

STEPS TO BE TAKEN BY THE SECOND PARTY

A the Second Party shall pay a capitation fee @ Rs.50,000/- per student per year for three classes over three years (from January 01, 1999 to December 31, 2001) totaling to Rs 15 million as under:

Year 1	50 Students	1 Class	Fee Rs. 2.5 million
Year 2	100 Students	2 Classes	Fee Rs. 5 million
Year 3	150 Students	3 Classes	Fee Rs. 7.5 million
Total	***300 Students***	***3 Classes***	***Fee Rs. 15 million***

B the capitation fee as per (i) above shall be paid in two instalments. A sum of Rs.8.0 million as first installment of the capitation fee shall be paid immediately on singing of this Agreement. The remaining amount of Rs 7.0 million shall be paid within 18 months of signing of this Agreement.

STEPS TO BE TAKEN BY THE FIRST PARTY

The First Party shall take the following measures on signing of this agreement:

(i) It shall constitute a Review Board for the Hospital to monitor the implementation of this Agreement. The Review Board shall comprise the following:

I:	Additional Chief Secretary to Government of North-West Frontier Province	Chairman
II:	Secretary to Government of North-West Frontier Province, Finance Department	Member
III:	Secretary to Government of North-West Frontier Province, Health Department	Member
IV:	Secretary to Government of North-West Frontier Province, Services and General Administration Department	Member
V:	Principal of the College	Member
VI:	Two members from the Hospital Management Board who are not civil servants	Member
VII:	Chairman of the Hospital Management Board, constituted under para 8(iv) of this Agreement	Member-cum-Secretary

(ii) The meetings of the Review Board, shall be convened by its Chairman, as deemed necessary, or on the request of any of the members, if found appropriate by the Chairman, provided that there shall be at least one on annual meeting during the months of November, December every year.

(iii) The Review Board shall be responsible for:

(a) review of the implementation of this Agreement,
(b) review and approval of the Annual Report of the Chairman of the Hospital Management Board,
(c) review of the Audited Accounts of the Hospital Fund, and
(d) any other matter assigned to it by the First Party,

(iv) Immediately after the execution of this Agreement, the First Party shall establish a Hospital Management Board (hereinafter referred to as the Management Board) comprising the following:

(a)	Commissioner Hazara Division	Chairman
(b)	Deputy Commissioner Mansehra	Co-Chairman
(c)	Principal of the College	Vice Chairman
(d)	two prominent citizens to be nominated by the First Party	Members
(e)	one representative of the College	Member
(f)	District Health Officer Mansehra	Member
(g)	Medical Superintendent, District Headquarter Hospital, Mansehra	Member-cum-Secretary

(v) The Management Board shall meet as often as deemed necessary by its Chairman. At least one meeting of the Board shall be convened in every quarter of a financial year.

At least four members, including the Chairman or the Co-chairman, shall be present to constitute quorum of a meeting.

(vi) The Management Board shall be responsible for:

(a) administration and management of the Hospital;
(b) establishment of regulatory framework for operation of the Hospital and the collaborative arrangements with the Second Party within the overall framework of this Agreement;
(c) regulation of clinical coaching and discipline amongst students during clinical coaching at the Hospital;
(d) approval of development plans within the Hospital based on a master plan to be prepared for up gradation and development of the Hospital;
(e) submission of annual budget estimates and revised budget estimates to the Government on the recommendations of the Finance and Planning Committee;
(f) review of quarterly reports prepared by the Medical Superintendent of the Hospital; and
(g) preparation of annual report of the Management Board, and its submission to the Review Board.

(vii) The First Party shall establish for the Hospital a Finance and Planning Committee as below:

(a)	Additional Secretary to Government, Finance Department, to be nominated by the Secretary Finance	Chairman
(b)	Additional Secretary to Government Health Department to be nominated by the Secretary Health	Member
(c)	Chief of Section (Health), Planning, Environment and Development Department	Member
(d)	Medical Superintendent of the Hospital	Member
(e)	Principal of the College or his representative	Member

(viii) The functions of the Finance and Planning Committee shall be:

(a) to make recommendations to the Management Board on the annual budget estimates and revised estimates for the Hospital; including creation of additional posts and supplementary grants;
(b) to examine the annual accounts and report of the Auditor on the accounts of the Hospital, and submit recommendations to the Management Board;
(c) to examine and make recommendations on development plans for approval of the Management Board; and
(d) any other item assigned by the Management Board.

(ix) The Finance and Planning Committee shall meet at least twice during a financial year. The Chairman of the Committee may on his own accord or on the advice of the Chairman of the Management Board shall convene additional meetings of the Committee for special purposes.

(x) The First Party shall immediately on signing of the Agreement establish a Hospital Fund (hereinafter referred to as 'the Fund') which shall comprise this following:

(a) non salary recurrent budget grants of the First Party;
(b) development grants from the First Party;
(c) any other grants from the First Party or routed through the First Party;
(d) foreign donor finding arranged by the First Party;
(e) receipts of service fees and miscellaneous income of the Hospital;
(f) returns on any investments made from the Hospital Fund;
(g) capitation fee to be received from the Second Party;
(h) donations if any received by the Hospital; and
(i) any other finding related by the Management Board.

(xi) The Health Department of the Government of North-West Frontier Province, shall frame rules and legal framework for the operation of the Fund including procedures for maintenance of accounts and its audit.

(xii) The First Party shall continue to meet recurrent costs on salary and allowances of its employees through the Accountant General's Office and to provide non-salary recurrent budget grants to the Hospital at the level of budget estimates 1997-98 duly indexed for annual inflation

(xiii) The Government non-salary budgetary grants to the Hospital Fund shall be determined each year by the Finance Department in the light of recommendations of the Finance and Planning Committee received through the Management Board.

(xiv) The Finance Department shall release the non-salary recurrent budget to the Management Board in four equal, quarterly instalments at the start of each quarter starting with the first instalment in July of each year.

(xv) The First Party may provide grants from time to time for up gradation and improvement of infrastructure, service and facilities at the Hospital. However, it shall provide a grant of rupees eight million from ADP funds over a maximum period of two years (1998-2000) to be used in \conjunction with moneys from the Fund or extra budgetary receipt for the up gradation of infrastructure, services facilities at the Hospital.

(xvi) First Party shall maintain its existing sanctioned posts for the Hospital and appoint suitably qualified staff on different positions in consultation with the Management Board.

(xvii) This Finance Department, on request of the Health Department, from time to time, may create additional posts to augment capacity for health service delivery at the Hospital in areas not directly related to education of the College students. In particular it shall provide, additional posts for the incremental infrastructure and facilities developed at the Hospital.

GENERAL CONDITIONS

The following other terms and conditions are laid down for the purposes of this Agreement:

(i) The day to day operations of the Hospital shall be the responsibility of the Medical Superintendent subject to the overall direction of the Management Board and its Chairman. However, subject to the terms of this Agreement, he shall accommodate any genuine request of the College with respect to the teaching requirements of the students of the Hospital provided that in case of any difference of opinion the decision of the Chairman of the Management Board shall be final.

(ii) The Medical Superintendent shall, other recommendation of the Management Board, appoint on control basis, an Accountant duly qualified to assist him in the maintenance of Hospital Fund accounts. The salary of the Accountant shall be paid out of the receipt of the capitation fee.

(iii) The First Party shall post a suitable Medical Officer as Deputy Medical Superintendent in the Hospital.

(iv) Within the ambit of the approved annual budget and development program, all expenditures shall be authorized by the Chairman of the Management Board.

(v) The receipts and expenditure out of the Hospital Fund shall be audited by the Director General Audit, North-West Frontier Province. The accounts of the Hospital Fund shall also be audited annually, by an internal auditor as required by the General Financial Rules.

(vi) The Management Board shall approve a phased Master Plan for the up gradation of infrastructure and facilities of the Hospital. All improvements, additions and infrastructure developments in the Hospital within the framework of this Agreement, including approval of cost estimates, award of contract and execution and supervision of civil works, shall be the responsibility of the Management Board.

(vii) ADP grants and other development receipts credited to the Fund including resources from the capitation fee shall be utilized for development and up gradation of facilities and Hospital, particularly towards the provision of the following facilities:

(a) construction of a fully equipped new block of 100 bedded ward within the promises of the Hospital;
(b) expansion and improvement of existing casualty department;
(c) establishment of a fully equipped ICU, CCU and new operation theater; and
(d) improvement of existing wards and out patient department.

(viii) The District Specialists in the Hospital, processing requisite qualifications and experience for teaching purposes based on the approved requirements of the PM&DC shall, during the currency of this agreement, be equated as Assistant Professor or Associate Professor, as the case may be for teaching purposes of the Second Party and shall be paid a teaching allowance equal to twenty per cent of their basic pay out of the capitation fee receipts. All other staff of the Hospital shall be paid a special allowance of ten per cent of their basic pay out of capitation fee receipts.

(ix) To such clinical units of the Hospital where properly qualified staff is not available or is inadequate for teaching requirements of the students, the Second Party may appoint additional qualified staff of its own after obtaining concurrence of the Chairman of the Management Board, provided that the salaries and the allowances of the staff so appointed shall be the responsibility of the Second Party.

(x) Any consultant / Teacher appointed by the Second Party from its own staff shall be a visiting consultant in the Hospital in his relevant field.

(xi) The Hospital staff and other Government servants shall continue to receive health cover at the Hospital as per Government Medical Attendance Rules 1959. The Hospital shall also ensure health cover for the poor patients at minimum cost as provided in sister Government Hospitals elsewhere in the province.

(xii) Any item of equipment not financed out of the Fund but acquired by the Second Party directly at its own cost and installed temporarily at the Hospital for teaching purposes of its student with prior approval of the Chairman of the Management Board may be removed by the Second Party on the termination of this Agreement.