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PRIVATIZATION AND PUBLIC-PRIVATE PARTNERSHIP IN PAKISTAN

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ABSTRACT

Pakistan has a mixed health system of public and private sectors that are unregulated and without formal evaluation and studies. There is lack of sources for reliable data on health systems. Private sector ranges from small clinics and pharmacies to large tertiary hospitals and foundations. In the last 25 years, public-private partnerships have increased, leading to large scale evaluations by international organization. These partnerships are essentially taking place in primary health care services with negligible public-private partnership in secondary and tertiary organizations. Private and Public sectors are operating in a detached manner with no governmental specific regulatory framework for private sectors. This paper focuses on the private sector and public-private partnership in the country. Various reasons for privatization are discussed along with positive lessons and outcomes that can be derived from public-private partnerships in the country.

Keywords: Public Sector; Private Sector; Privatization; Public-Private Sector Partnerships;

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INTRODUCTION

Pakistan, the most populous member country of the World Health Organization (WHO) Eastern Mediterranean Region (EMR), has an estimated population of 188.9 million, including 21.3 million children under 5 years of age, and 61.4 million children under 15 years of age.[1] The Gross Domestic Product (GDP) growth was 5.5% with the GDP of $270 Billion in 2015.[2] Administratively, Pakistan is divided into four provinces: Punjab, Khyber Pakhtunkhwa (KP), Sindh and Baluchistan; two federal areas: the Federally Administered Tribal Areas (FATA), and the Islamabad Capital Territory (ICT); and two administrative areas: Azad Jammu and Kashmir (AJK), and Gilgit-Baltistan (GB). Pakistan is one of the least developed countries in the EMR, with a gross domestic product per capita of $1,429 in 2015.[1] Life expectancy at birth in the country is 67 years. Pakistan's health indicators are not promising, with an infant mortality rate of 66 per 1000 live births, an under-5 mortality rate of 81/1000 live births, and a maternal mortality ratio of 178 per 100,000 live births.[2]

Pakistan's Health System

Pakistan has a mixed health system with both public and private sectors running in parallel. The country has struggled to reform the system over the years. Different strategies were used by the country and international organizations to change the system for the better. After the passage of 18th amendment in April 2010, the health system was devolved to the provinces.

In the last few decades, privatization has increased due to multiple reasons such as enhancing efficiency of the existing system and market demands. Furthermore, different forms of privatizations and public-private partnerships have occurred in the country. Private institutions range from small private clinics in both Urban and Rural areas to large Tertiary Hospitals primarily in Urban areas like Islamabad, Karachi,

Lahore and Peshawar. There are about 73,650 private clinics and about 692 private hospitals with 20,000 beds in the country.[3] Moreover, 73% of pharmacies and 60% of diagnostic facilities are in the private sector. There is shortage of workforce in both private and public sectors but twice as many physicians work in private sector. Majority of these physicians also work in public sector in the morning. There are about 19 physicians per 10,000 population in the private sector as compared to 7.8 in the public sector.[4]

Besides the large private sector, the country has also a big public infrastructure for the delivery of health services. According to Pakistan Economic Survey for 2014-15, there are 1167 hospitals, 5695 dispensaries, 5464 basic health units, 675 rural health centres, 733 mother and child health centres. Health Care Professionals in public sector include 184711 doctors and 16652 dentists. The total number of beds are 118869 in the country.[5] According to the World Bank, Pakistan spends 2.64% of its GDP on health, of which 1.695% is private, while 0.99% comes from the government. The per capita expenditure on health is about $36.[1] The government sources cite a much lower figure for government spending. According to Pakistan Economic Survey of 2015-2016, the public health expenditure is 0.45% of GDP, which has increased by 17% from last year. Public Expenditure on Health is progressively increasing since 2010-11, when it was 0.23% of GDP.[5]

Due to lack of data and proper studies on private sectors, the above figures are old and would have underestimated the real situation on the ground as there is substantial growth in this sector. According to Pakistan Social and Living Measurement Survey 2010-11,[6] 71% of the people who consulted a health provider went to a private facility, while only 22% went to a public facility and 6% went to a chemist or a pharmacy. As previously mentioned, different forms of privatizations have occurred in Pakistan over time, such as independent private clinics, large private medical centres, teaching hospitals associated with medical schools, outsourcing of health facilities to non-state providers, donor-funded health facilities especially after disasters, and funding of vertical programs by international organizations. This paper is looking into the broad categories of private facilities and out-sourcing of facilities to non-state providers.

Private Sector Clinics, Hospitals, Pharmacies and Diagnostic Facilities

The World Bank include all actors outside of government including for-profit, non-profit, formal and informal entities in private sector. According to this criteria, pharmacies, pharmaceutical companies, shopkeepers and traditional healers are included in private sectors. Despite its relatively larger role, private sector suffers from lack of attention from both government departments and international organizations. Its role in providing health services cannot be ignored as it is providing health services to a substantial portion of the population. More than 70% of health expenditure is in private sector and 86% of it is out of pocket expenditure.[4]

There are several reasons for the expansion of private sector in Pakistan. The provision of health in the country is the responsibility of the state and historically Ministry of Health has been responsible for managing health professionals, building hospitals and health facilities and providing health supplies to these hospitals. Due to economic instability, fiscal constraints, corruption, lack of stable political environment and commitment to social sectors, the public sector suffered from continuous deterioration. This process has negatively affected the image and quality of services of the country's health facilities. Additionally, the public sector was also unable to cope with the new challenges of population growth, urban migration and poor infrastructure. Major portion of the national

budget goes to debt re-servicing and defence, which has negatively affected the social sector spending by the government. Structural Adjustment Policies and the overall shift towards market-based economy have also encouraged businessmen to invest in health sectors.[7] Along with these reason, higher level of satisfaction and better perception of private sector has led to expansion of private sector in Pakistan.[8] Both government and private sectors operate in a detached manner, though there are few examples of co-operation in areas like Maternal and Child Health services and primary health care services. There are some challenges which need to be recognized and elaborated to understand the private sector to be better informed for future health reforms in the country.[4]

Formal analysis about the role and services by the private sector is still lacking. The range of services offered is variable with different standards. The private institutions in Pakistan offer curative care and are mostly reluctant to invest in preventive care and are based in urban areas.[4] Several large tertiary care hospitals are investing in high-tech technology which is contributing to the rising medical costs. Due to a weak regulatory system, the fees and charges of the private sector are not assessed and hence hospital and doctors set their own standards for user fees. This aspect is contributing to economic shocks for the poor households as catastrophic health expenditures accounts for more than 70% of economic shocks for poor households.[9]

The problem of pharmacies and diagnostic facilities should not be ignored as more than 70% of pharmacies and about 60% of diagnostic facilities are privately owned and largely unregulated. This has led to irrational prescriptions and use of counterfeit medicines which contributes towards antibiotics resistance, ineffective treatment, drug dependence and adverse effects of drugs.[4] In Pakistan, there is a serious shortage of qualified pharmacists and health technologists. This is due to the lack of coherent planning and so the country could not train enough pharmacists. The diagnostic facilities are used for routine and tertiary diagnostics such as blood tests, computer tomography and magnetic resonance imaging. Majority of the diagnostic facilities are unregulated with very poor quality of care which contributes towards misdiagnosis and financial problems.[10]

In the light of the above challenges, Pakistan needs to have better regulatory bodies and licensing and accreditation mechanisms for overseeing the different malpractices in both private and public sectors. Similarly, the country needs a federal drug regulatory authority, along with revision of national drug polices and laws to streamline the usage of medicine in the health sector.[9] Increased regulation and oversight should eventually lead to evaluation, assessment, information gathering and disease surveillance tools for both public and private sectors.[10] This will help in facilitation of evidence based decision making in future which is lacking in the current system. This will lead to increase public-private partnership. Inputs can also be taken from the better managed hospital like the Aga Khan and Shaukat Khanum hospitals. These steps will help in increasing the role of private hospitals for achieving the National Health Vision (2016-2025).

Outsourcing of Health Facilities to Non-State Providers

Pakistan has a vast network of health facilities in rural and peri-urban areas which were operated by the government till the turn of this century. These facilities consist of Basic Health Units (BHUs), Dispensaries, Maternal and Child Health Centres, and Rural Health Centres. The country has spent resources on maintaining these facilities all over the country. There was a widespread recognition that these facilities were under-utilized and surveys showed that only 23%

of patients in rural areas were visiting public facilities for their health needs. Various reasons were cited for this under-performance, such as staff absenteeism, under-staffing, poor management, inadequate supervision, poor maintenance of facilities, and lack of quality inputs.[11]

Pakistan has a long history of cooperating with Non-State Providers (NSPs) to enhance the performance of these basic health facilities. NSPs include both not-for-profit non-governmental organizations (NGOs) and for-profit sector. The not-for-profit providers include small community-based NGOs, large international NGOs, and religious and philanthropic organizations.

Azad Jammu and Kashmir (AJK) is a state in a northern part of Pakistan. AJK's Health Department has collaborated with two NGOs, the Marie Adelaide Leprosy Centre/Foundation (MALC) and the Family Planning Association of Pakistan (FPAP). This endeavour was expanded from 1996-2000 by a World Bank loan "Northern Health Project, which provided funding to these NGOs. After the ending of NHP, AJK's Government and these NGOs extended this partnership.[12] Under NHP, FPAP provided training and technical and managerial support to delivery of family planning and reproductive health services. Later, a proposal was made to extend this partnership between government and NGOs. Along with providing commodities, facilities and some staff, it was suggested that the government also pay the salaries of specialists' personnel employed by FPAP. Memorandum of Understanding (MOU) was signed in 2003, but the issue of funding to an NGO at that time created several problems. Similarly, MALC partnership with NGOs goes back to 1965-66, when MALC started to use government health infrastructure to deliver various services partnering with leprosy/TB control personnel.[12]

The People's Primary Care Initiative (PPHI), formerly known as the President's Primary Health Care Initiative was launched in 2005-2006 in several provinces. This decision was based on the implementation of this model in Lodhran and Rahim Yar Khan (RYK) district in Punjab province of the country. The district government of RYK (DGRYK) signed an MOU with a national NGO, the Punjab Rural Support Program (PRSP) in March 2003.[13] This MOU transferred the management of all the BHUs in the district to PRSP to improve service delivery by efficient management. After two years, an evaluation was done by World Bank to assess the implications of this project. They compared RYK BHUs with another district where this initiative was not implemented. According to the evaluation, utilization of BHUs, community satisfaction, physical condition of BHUs improved in RYK BHUs as compared to non-PRSP BHUs while Out-of-Pocket expenditure was lower in RYK than in non-PRSP BHUs. Technical quality of care, availability of drugs and preventive services did not improve in RYK and were similar to non-PRSP districts. This model was extended to the whole country and 2,382 BHUs and 721 other Health Facilities in 81 districts were managed by PPHI for several years.[13] In all the districts under PPHI management, the funding was provided by the federal government with contributions from provincial governments. A third-party Evaluation of PPHI was completed by Technical Resource Facility which has outlined the various aspects of this public-private partnership. They have concluded that PPHI is a systematically organized structure and is managed by competent administrators. Furthermore, its "objective of flexibility and authority for quick decision making while working with the government financing and administrative system" is praised by the evaluation team.[13]

PPHI is a time specific initiative which will exit after achieving its objectives as the managers are

career bureaucrats who will go back to their parent organizations. It is funded by federal government and run Rural Support Programs. These NGOs do not have the capacity to run these programs once the current managers go back to their parent organizations. It is proposed to develop the Health Department's capacity at provincial and district level to handle public-private partnerships in health in future. Other NGOs who have the expertise can also be involved in future for public-private partnerships.[14]

For the past two decades, several models for Primary Healthcare (PHC) were used in the country to increase efficiency and decrease ineffectiveness in PHC system. The basic components of PHC as described in the Alma Ata Declaration are provision of preventive, minor curative, health promotional, and rehabilitative services under one umbrella, decentralized management of PHC, Community participation, intersectoral collaboration and strengthening of referral linkages. What are the outcomes and outputs of these different models of PHC? As the health promotion, disease prevention, community outreach and preventive services are included in first level health care facilities, what is the success in these aspects of health? PPHI has certainly increased the utilization and renovation of BHUs but success in these other aspects should be also taken into account while evaluating the outcomes of PPHI BHUs.[14] The long-term sustainability should also be taken into account. When these MOUs end and the facilities are again run by provincial health department, will they be able to sustain the successes achieved by PPHI? If these projects were run by government bureaucrats, their expertise in this could be availed in the future to properly manage PHC in the country. Several other NGOs like Merlin International, Doctor Without Borders, and Save The Children, are assisting the government in different activities. Some of them are running healthcare facilities while others are assisting in different sectors.[15] What can be learned in terms of PHC management to be used in the long-term? The contractual documents need to be worked out diligently while contracting PHC to private entities to avoid friction and confusion between vertical programs run by the governments and other services provided by NGOs like PPHI.[16] Rural Health Centres, Tehsil Headquarter Hospitals and District Headquarter Hospitals need to be revitalized to serve the population. The government needs to develop its capacity to properly run and manage the health system.

Social Marketing Pakistan (SMP) was established by government of Pakistan and USAID as a local NGO for the facilitation of Social Marketing of Condoms and other contraceptive methods. In the mid-1990s more contraceptive methods and other family planning services were offered through these NGOs. This required ensuring of quality and better management, so Green Star network of providers were established. It was a franchise for privately owned and managed clinics and pharmacies. In this model, SMP would establish partnership with selected providers, and they would agree to use a defined package of reproductive health services in their private practice. The quality standards were agreed upon with SMP. The government did not fund SMP or the Green Star network, but they were treated as partners by channelling money to them through donors.[12] Now it has grown as a large private organization and provides services in the areas of family planning, maternal and child health, tuberculosis control, nutrition Pakistan and water purification. It is now a large private organization providing about 31% of all the contraceptives in Pakistan.[17] They have achieved this through social franchising and social marketing funding from donors. Green Star Social Marketing is also a successful example of public-private partnership. They have trained

thousands of private sector Physicians and Lady Health Visitors (LHVs) in reproductive health and family planning. Green Star distributes the subsidized products to more than 62,989 retail outlets and more than 33,209 medical stores/pharmacies.[17] They count community outreach and interpersonal communications as one of their strengths. Providers and Outreach workers are continuously trained to achieve successful outcomes. SMP promotes Green Star through community activities such as free medical camps, community events, Mohalla (Neighbourhood) meetings, trade promotion and involving opinion leaders. These activities have resulted in increased consumer demands as well as interests among service providers to become member of the franchise.[18]

SMP and Green Star marketing is unique in this sense that it is working with private providers to enhance reproductive health service to the population. They not only provide services but they also go to the communities to increase awareness and address the misconceptions about family planning and contraceptives. Health Reformers can work with the managers to learn about the applicability to other sectors. It would be difficult to replicate it in a similar way but still in Pakistan's context, it was a novel idea at that time and has worked in the society. Green Star ensured both availability and quality of services by the private providers. Health Service Researchers can look in to this idea for using it in other health sectors by tailoring it in an appropriate way as quality of care is a major issue in both public and private sector in the country.

Aga Khan Development Network's (AKDNs) is involved in community health services through Aga Khan Health services. Along with that Aga Khan University Hospital is a leading tertiary hospital run by AKDN. They started their health services in 1924 by establishing a 42-bed maternity hospital in Karachi. Today, Aga Khan Health Services (AKHS) range from primary health care to diagnostic services and curative care. It reaches to about 1.1 million people in rural and urban Sindh, Punjab, Gilgit-Baltistan and Chitral. AKHS run about 57 basic health centres, seven comprehensive health centres, 50 bed Gilgit medical centre in Gilgit-Baltistan and Chitral. Some of their facilities are run through public-private partnerships. AKHS have reiterated their support for government health policies and public-private partnership, and health needs of people of northern areas. Moreover, AKHS want to scale up health insurance and social protection schemes along with implementation of global standards by working closely for training and operations research with Aga Khan University and other partners.[19]

The Aga Khan Foundation has worked all over the world in health, education and rural development including Pakistan. They are often praised for their services and are counted in best practices in primary healthcare and other development projects.[12] Both the government and private sectors can learn from their experiences in these rural and urban areas in Pakistan where they are providing services to the people. Pakistan government need to support a formal strategic framework to work with the Aga Khan Foundation. The public-private partnership with Aga Khan should be expanded to use their management teams to deliver health services in remote rural areas in the country.

CONCLUSION

Article 38 of the constitution of Pakistan guarantees the right of citizens to have "*necessities of life, such as food, clothing, housing, education and medical relief, for all such citizens, irrespective of sex, caste, creed or race, as are permanently or temporarily unable to earn their livelihood on account of infirmity, sickness or unemployment* (Constitution of Pakistan, 1973)." It is the responsibility of the state to ensure the

health of its citizens to achieve a long and happy life. The National Health Vision (2016-2025) also recognizes the issues of low health expenditure, lack of preventive services in private sectors, unregulated public and private sectors, and the problem of accreditation and licensing for health care workers. Governance, management challenges and research in all sectors including health services need to be prioritized.

Social Determinants of Health should not be overlooked. Pakistan is a low-income country which is among the only six nuclear world powers and have a comparatively large standing army. A large chunk of the national budget goes to defence budget.[5] The country needs to work with its neighbouring countries to achieve a lasting peace in South Asia. Trade deals with all the neighbours should be promoted which will contribute towards economic stability in the long-term. The use of non-state actors to achieve foreign policy objectives need to be abandoned. All these aspects will promote peace and economic stability in the country and will have indirect and direct effects on the health of the population.

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