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CASE STUDIES ON PUBLIC-PRIVATE PARTNERSHIPS

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CASE STUDIES ON PUBLIC-PRIVATE PARTNERSHIPS

The private sector is playing increasingly important roles in producing goods and providing services that were once considered “public” and therefore exclusively the responsibility of governments. Public-private partnerships (PPPs) and other forms of cooperation between the private sector and governments are used frequently around the world to develop and expand utility networks and services, including basic social services like water and sanitation, health and education. In many developing countries, governments are also using PPPs to finance and manage toll expressways, airports, shipping ports, and railroads and to reduce environmental pollution and build low-cost housing. Many governments, both in developed as well as developing countries, are resorting to PPPs as a means of improving management efficiency, cost control and as a means of augmenting resources needed for investment and current expenditure. The experience in regard to how successful the PPPs are has varied in different sectors and countries. There is also concern whether they serve the larger social objectives of a society or not. This study aims to draw on the experience with PPPs in social sectors in Pakistan and other developing countries.

This paper has three parts. The first part presents an overview of PPPs, raising a number of important questions regarding PPPs in general. The second part describes a PPP in the education sector and the third part a PPP in the health sector of Pakistan.

1. OVERVIEW OF PPPs

A number of key questions arise in the context of PPPs as follows: Why is there a global trend towards public and private sector partnership for delivery of services and infrastructure? What are the potential advantages of such partnerships? What are the various forms of PPPs? What conditions are necessary for effective public-private cooperation? And finally, in the context of our chosen sectors –health and education-what is the experience of public private partnerships in developing countries?

1.1. The Case for PPPs

Interest in PPPs and other forms of government-private sector cooperation has emerged in countries around the world for a variety of reasons. Neither national nor sub-national governments in most countries have sufficient budgetary resources to extend services and infrastructure for full coverage or to subsidize inefficient state enterprises or agencies. Public dissatisfaction with the quality and coverage of government-provided services and the slowness with which governments extend infrastructure often pressurizes them to seek more private sector participation. Prior to the introduction of private sector participation in the telecommunications sector in Jordan and Thailand, for example, the countries had a waiting time for a telephone line of nearly nine and ten years respectively.[1] Experience suggests that many goods and services for which people can pay can be delivered more efficiently by involving the private sector.[2] Involving the private sector often brings stronger managerial capacity, access to new technology, and specialized skills that governments cannot afford to develop on their own.

Economic globalization is also creating strong pressures on private firms to respond more flexibly to rapidly changing world markets and to gain access to modern infrastructure systems that facilitate international trade and investment. They can fill the gaps where governments are slow to respond to demands for the technologically sophisticated infrastructure and services and thereby improve economic competitiveness

1.2. Potential Advantages of PPPs

Forming public-private partnerships to assume functions that were formerly public sector responsibilities have potential benefits for both citizens and governments. PPPs can increase competition and efficiency in service provision, expand coverage, and reduce delivery costs. Involvement of the private sector ensures that projects and programs are subject to commercial discipline and sound financial diligence. Public-private partnerships can bring new ideas for designing programs and projects, and greater synergy between design and operation of facilities. Partnering with the private sector gives governments the ability to take advantage of economies of scale and benefit from the strong incentives for private firms to keep costs down and eliminate waste. Often, private firms can avoid the bureaucratic problems that plague governments, and they can experiment with new technology and procedures. PPPs allow government to extend services without increasing the number of public

employees and without making large capital investments in facilities and equipment. Private firms can often obtain a higher level of productivity from their work forces than can governments. PPPs can usually respond more flexibly to "market signals," more easily procure modern technology, and develop stronger capacity to maintain infrastructure than can public.

At a time when private transfers outpace the flow of official development assistance, partnerships are often the most effective way for governments in developing countries to mobilize private and foreign investment capital for infrastructure expansion or improvement. And to the extent that PPPs achieve their objectives they can contribute to increasing national productivity and economic output, assuring a more efficient allocation of scarce capital resources, accelerating the transition to a market economy, and developing the private sector.

1.3. Forms of Public-Private Partnerships

Some ways in which governments and the private sector partner for provision of infrastructure and delivery of services are presented in Box 1. Partnership most frequently takes the form of: contracting for services and facilities management, co-ownership or co-financing of projects, build-operate-transfer arrangements and government financing of the private provision of services.

BOX 1
SOME SERVICE DELIVERY AND INFRASTRUCTURE PROVISION ARRANGEMENTS THROUGH PPPs

Contracts	Manager	Production	Financing	Owner	Example
Service Contracts	Private Sector	Private Sector	Government	Government	Government hires NGOs/private sector to provide services
Management Contracts	Private Sector	Government	Government	Government	Government hires private sector to manage existing facility
Lease Contracts	Private Sector	Private Sector	Government/ PS	Government	Government lease parking areas to private firms to manage and finance
Joint Ventures	PS/ Government	PS/ Government	PS/ Government	Government	Government engages company for improvements of ports.
Build-Operate-Transfer Agreements	PS	PS	PS	PS/ Government	Mega infrastructure like highways are made by PS and acquired by Government after an agreed period
Investment or Grants to Private Sector	PS	PS	Government	PS	Government provides grants to NGOs who submit proposals for service provision

Contracts: Governments in countries with both advanced and developing economies are increasingly outsourcing the provision of services and infrastructure

to private sector firms. Contracting is the method most frequently used by governments to elicit stronger private sector participation in providing public services and infrastructure. It allows provision of services or facilities that meet government specifications.

Generally, governments contract with private organizations to provide a service through three mechanisms: service, management and leasing arrangements. Under *service contracts* arrangement a government agency contracts with a private firm to provide a specific service for a specified period of time. This way the government uses public-private partnerships to modernize and expand schools, hospitals, housing etc. For example, the government in Combodia expanded health services through contracting of Rural Primary Health Centers (PHCs) and district hospital services through service delivery contracts. Likewise, in Bangladesh contracting expanded service coverage for over 20 million people through rural community nutrition services and Urban PHCs.[3] Contracting has also become one of the most important methods of providing water and wastewater treatment services in many countries. Governments of Chile and Guatemala, for example, offered territorial concessions in large cities to companies that procure, purify, distribute, meter, and charge for water. In both countries, tariffs were approved by the national government, which also monitored water quality. In Peru, the government contracted out to private companies many of the activities involved in water supply, such as meter reading, computer services and billing and collection.[4] This tantamounts to outsourcing activities related to the provision of services

Governments are also using *management contracts* in both developed and developing countries to provide services and infrastructure more efficiently while maintaining ownership control. Governments have contracted with international firms to manage state-owned agro-industries in Senegal, Cote d'Ivoire and Cameroon, and mining operations in Latin America and Africa. In Bahia, Brazil, the state government has contracted with private firms to manage new public hospitals that the government constructed and financed.[5] The district government in Rahim Yar Khan in Pakistan sought management contracts with the private sector in order to improve the quality of medical care, and increase service efficiency. Abu Dhabi sought to bring commercial discipline and efficient management of its utilities by contracting with the private sector to manage electricity generation. In Cote d'Ivoire, the

government joined with SODECI (Societe de distribution d'eau de la Cote d'Ivoire), a private corporation, to supply piped water to households and to public fountains.[6]

Lease contracts are also used extensively for both public services and commercial operations. In Latin America and Africa state-owned industries are leased to private companies for long-term operation. The government has leased electricity and water supply enterprises in Cote d'Ivoire; steel mills and refineries in Togo; and hotels and farm holdings in Jamaica. Companies leasing facilities assume responsibility for operation, maintenance and replacement of non-fixed capital assets.

In some countries, governments lease to private investors the development rights to land, water or air space in order to provide services or infrastructure. The State of California, for example, leases space proximate to above public highways and freeways to develop commercial buildings, hotels, and other infrastructure. In Sri Lanka, for example, local governments have for a long time rented municipal markets to private merchants. In Malaysia, the Municipal Council of Petaling Jaya, turned to the private sector during the 1980s when it experienced declining revenues, mismanagement, and rising costs in the collection of parking fees. The State Railway Authority of Thailand successfully experimented during the decades of the 80s and 90s with contracts with private firms to provide service on three intercity rail routes that were incurring substantial losses.[7]

All three forms of contracting -- service, management and lease arrangements -- allow the government to maintain ownership of public facilities and control over public services but also to benefit from private sector management and operation and derive an income from leases, management fees, or service concessions. Contracting with the private sector has increased efficiency, decreased vulnerability to employee actions and contractor failures, ensured protection against monopolistic behavior of contractors or government agencies, provided dual yardsticks for measuring and comparing performance, and provided more substantive knowledge and understanding of service delivery.

Public-Private Joint Ventures: In some cases government's may prefer to retain share of the stock in profitable or politically strategic companies making them, in effect, joint ventures. In Oman, the government developed a joint venture between Omani public and private companies and Maersk Sealand to expand and maintain its

Salalah container shipping port.[8] In Colombia, the government developed a joint venture with Aqua Pura S.A. to bring together five regional public sector groups and two regional private enterprises to manage coffee waste in several municipalities in the State. The joint venture partners helped coffee producers adopt new coffee washing technology to reduce water consumption and waste water from coffee processing.[9] China has used joint ventures between foreign investors and state enterprises to obtain foreign technology and capital, learn foreign management and marketing techniques, increase foreign exchange-generating capacity, and promote joint research and development projects.[10] The Chinese government also used joint ventures between SOEs and private foreign companies to make new investments in infrastructure and manufacturing facilities. The expansion of telecommunications equipment facilities in the Shanghai area, for example, was financed through joint ventures.

Build-Operate-Transfer Agreements: Governments around the world use turnkey projects with consortia of private companies to build telecommunications, transport, shipping, airport, utility, and water and sewerage infrastructure. Governments in countries with both advanced and developing economies use build-operate-transfer (BOT) agreements in which they buy or lease completed facilities constructed by private investors after the companies have recouped their investment and a reasonable return by operating the facilities for an agreed-upon period of time. The government of South Korea, for example, is using the BOT arrangement to develop and operate the Seoul Beltway and Daegu-Pusan highway as toll roads. It has given the Pusan NewPort Company sponsored by the Samsung corporation, CSX World Terminals, and local Korean contracting companies a 50-year secured concession to develop a $900 million Pusan port expansion project using the PPP approach.[11] BOT or Build-Operate-Own (BOO) arrangements have also been used extensively in Malaysia and Turkey to build telecommunications systems, highways, utilities, and water supply systems, and operate them under a concession from the government. Debt financing is usually highly leveraged and the private consortium takes a small equity position. It also seeks loans from international financing agencies and commercial banks using future revenues from the projects to repay them. In Australia, the federal and state governments have used BOOs to expand public hospitals. Private firms build, own and operate a public hospital under government supervision for about 15 years.

Grants to Private Sector/Public Investment: Governments make grants, equity investments, loans or guarantees to induce private sector organizations to participate in offering goods and services or construct infrastructures that are deemed to be in the public interest. This is very commonly resorted to in developing countries to promote education for low income groups, whereby non-government organizations (NGOs), for profit or not for profit, submit proposals to the government for needs identified by community or NGOs. For example, The Punjab Education Foundation selects private sector low income schools for grants. This form of PPP arrangement can also involve vouchers. Female sex workers for example in Thailand are provided vouchers for curative care, which they can redeem at practitioners of their choice.

The government of Barbados created a Housing Credit Fund (HCF) in the Ministry of Housing and Lands during the 1980s to provide capital at below-market interest rates to private banks, trust companies, the Barbados Mortgage Finance Company, and other financial institutions to make loans -- using regular commercial procedures -- for low-cost housing in urban areas.

1.4. Determinants of Success of Public-Private Partnership

PPPs are frequently complex arrangements and can create potential problems for both the public and the private sectors if they are not properly designed and administered. They often displace public workers, thereby generating political opposition among public officials, labor unions, and public employees. Poorly designed and inadequately analyzed PPPs have failed in both developed and developing countries. If not designed and supervised properly, they can potentially become more expensive compared to public provision. Corruption can undermine public trust in PPPs if the contracting process is not transparent and carefully supervised. Lack of sufficient competition can turn PPPs into private monopolies that operate as inefficiently as SOEs. Overly restricting concessions or creating too many can deprive PPPs of economies of scale. An important pre-condition is the setting up of an appropriate regulatory framework, especially when PPPs lead to natural monopolies. If government regulation is too stringent it can lead to deficiencies in service provision and if it is too lax it may not hold private service providers sufficiently accountable[12] and lead to overcharging of consumers.

The transaction costs of contract management can be substantial. There are important equity issues also. The involvement of the private sector in providing

services that were formerly free or that were subsidized by the government can increase their price and place poor segments of the population at a significant disadvantage. Governments of jurisdictions with large numbers of poor people must make adequate provision to serve those who may not be able to afford them under PPPs.

Experience suggests that if PPPs are to succeed, governments must[13]

- Show a strong political commitment to partnership with the private sector.
- enact adequate legal reforms to allow the private sector to operate efficiently and effectively;
- develop and enforce regulations that are clear and transparent to private investors and protect the right of consumers;
- remove unnecessary restrictions on the ability of private enterprises to compete in the market;
- expand opportunities for local private enterprises to develop management capabilities;
- create incentives and assurances to protect current state employees to the extent possible after PPPs take over service provision; and
- retain responsibility and accountability for deciding among competing objectives, define chosen objectives for services provision, set standards, criteria, and output targets; and safeguard the broader public interest.43
- have the capacity to decide on the level of services needed and the financial resources available to pay for them, set and monitor safety, quality, and performance standards;
- be receptive to finding alternative mechanisms to traditional public service provision and be willing to accept private-sector participation.
- choose appropriate projects that are conducive to private sector management, and properly package the projects in order to avoid disproportionate transaction costs.

PPP projects work best and are sustainable when both the public and private sector partners have project “champions” as catalysts and the projects are mutually beneficial to both government and private sector partners. In other words, “synergy” among partners is vital for success of a PPP. Ultimately, the success of PPPs depends not only on developing mutual trust between government officials and private sector executives, but on building and maintaining public confidence in the

integrity of the partnerships. Trust and confidence can be undermined when the goals of the partners are ambiguous or when their objectives are unrealistic or in conflict. Incompatible organizational systems and management practices can also weaken PPPs. Box 2 presents some procedural conditions pointed out by UNDP which lead to the success of PPPs.

BOX 2
SOME PROCEDURAL CONDITIONS FOR SUCCESS OF PPPs

The UNDP points out that the tendering, procurement and contracting procedures must be financially and operationally sound, open, transparent, and fair. 46 In addition, the procurement process should 1) state the desired end goal or output targets of the agreement and minimize overly specific requirements, so that the private sector can innovate and manage flexibly; 2) ensure that the potential private sector partners can be adequately compensated for or retain their intellectual property; 3) include monitoring provisions of performance measures by a third party or autonomous government agency; and 4) make provisions for renegotiating the terms of the agreement over time.[14]

1.5. Experience of Public-Private Partnership in Health and Education Sectors

Like other infrastructure and services, PPPs in health and education sector are motivated by government capacity constraints to expand and improve service provision, make provision more efficient and increase the quantum of resources devoted to these important sectors. To achieve the health and education-related Millennium Development Goals (MDGs), developing countries, in particular, will have to make all possible effort and utilize various service delivery arrangements, particularly for the poor. Nearly 6 of 10 child deaths in developing countries could be prevented through full implementation of a few effective and low cost interventions[15]. Additional resources for the public sector will not be enough, especially as most curative health care services are provided by the private sector in developing countries[16]. Likewise education is a basic service with high social returns. Given that high illiteracy levels continues to be a feature of many developing countries, it is important that partnering with the nongovernmental organizations (NGOs) or other nonpublic entities to manage and deliver education services is one approach to improve both coverage and quality.

PPPs in these two social sectors have generally taken the form of contracts-service delivery, management and lease- and public interventions in the form of grants and vouchers. A review of international experience reveals success in well designed initiatives. For example, quick improvement in service delivery indicators was seen following contracting of health care in Combodia, Bangladesh, Bolvia, Guatemala, Haiti, India, Madagascar, and Pakistan. (See Box 3).

BOX 3
SUMMARY OF CONTRACTING EXPERIENCES

Country and Service	Contract and Intervention	Scale	Main results	Subsequent history
Cambodia Rural PHC and district hospital services	SDC compared with MC and CC, that is, Government provision of services.	1.5 million population	SDC and MC much better than CC. Median double difference" on 7 indicators for SDC vs. CC was 21.3%; for MC vs. CC double difference was 9.3%.	Expanded to twice as many districts.
Bangladesh Rural community nutrition services	SDC with NGOs compared with control areas with no organized nutrition services (that is, normal government health services with no nutritional component).	15 million population	Malnutrition rates declined 18% in SDC upazillas compared with 13% in controls (double difference = 5%. Double difference for vitamin A was 27%.	Expanded to more than 30 million populations.
Bangladesh Urban PHC	SDC with NGOs compared with government provision of services, that is, CCC.	4 million population	Coverage data not yet published. Double difference for availability of specific services (immunization, family planning) was very large, 57% to 92%.	Contracts not yet completed. Planning for expansion of contracts far advanced and funding secured.
Bolivia Urban PHC	Limited MC in phase 2. MC with expanded authority in phase 3. Control area had continued public sector management.	250,000 population	Double difference for deliveries between MC and control was 21%, and l% for bed occupancy.	Unknown
Guatemala Rural PHC in mountainous areas	MC in selected municipalities and SDC in more remote areas, compared with government revision control .		Median difference between MC and control on 5 indicators was II % (range 5-16%).	Started as small pilot but expanded rapidly. Now covers 27% of coun
Haiti Bonuses for NGOs delivering PRC in rural areas	NGOs with SDCs offered performance bonuses based on agreed targets.	534,000 population	Average of follow-up minus baseline ranged from -3% (prenatal care) to +32% (vaccination coverage).	Expanded to cover 1.5 million people, 19% of Haitian population.
India Urban TB control services in Hyderabad	NGO under SDC delivered TB control services in defined population and worked with private providers. Compared with publicly managed area of similar size.	500,000 population	NGO found 21% more TB cases and had 14% better treatment success rate. Cost per successful treatment $118 for NGO vs. $138.	Being scaled up in various parts of India with ongoing evaluation.
Madagascar and Senegal Community nutrition services	Madagascar: SDCs with 50 NGOs. Senegal: SDCs with NGOs that worked through small groups of unemployed youth.	460,000 in Madagascar; 490,000 in Senegal	Severe and moderate malnutrition declined 6% and 4%, respectively. Participation was 72% in project and 35% in control areas.	Continued with NGOs in both countries, but in different format.
Pakistan Rural PRC	MC for the 104 basic health units in district.	3.3 million population	Nearly fourfold increase in number of outpatient visits.	Only started in May 2003.
India Improving quality of care by private practitioners	SDC for NGO working with private providers to improve MCR services.	54,000 population	Rapid improvement in provider skills ranging from 25% to 57% compared with baseline.	Unknown

PHC, primary health care; MC, management contract; SDC, service delivery contract; CC, control contract; NGO, nongovernmental organization; TB, tuberculosis; MCH, maternal and child health. Double difference = difference between follow-up and baseline results in the experimental group minus the difference between follow-up and baseline results in the control group.

Source: Adapted from Levinsohn and Harding[17]

From the 10 studies summarized in the Box, contracting with NGOs appears to deliver effective primary health or nutrition services and impressive improvements rapidly. Good results have been achieved in a variety of settings and for a variety of different services.[18] All the studies found that contracting yielded positive results. The most rigorously evaluated cases demonstrated the largest impact. Also, of the 10 studies, 6 compared contractor performance with government provision of the same services. All 6 found that the contractors were consistently more effective than the government, based on a variety of parameters related to both quality of care and coverage of services. Some of the lessons learnt from the successful case studies are presented in Box 4. Likewise experience with PPPs in education is positive, if the projects are designed to maximize the optimal roles of the public and the private sectors in terms of policy framework, governance structure and financing (see Box 5)

BOX 4
LESSONS LEARNT FROM CONTRACTING OF HEALTH SERVICES

Some of the lessons learnt from the successful case studies are:

- the higher the autonomy given to contractors the more successful the arrangement was
- there are economies of scale and that larger contracts may be less expensive on a per capita basis than smaller ones.
- Contracting is not necessarily more expensive than government provision of the same services. Basic primary health care services, including first-level referral hospital care, can be delivered for US$3 to US$6 per person per year.
- concern that nongovernmental entities will not want to work in remote or difficult areas and are less capable of providing services to the very poor appears to be unwarranted, given resources and the explicit responsibility
- Considerable concern has been expressed that governments will not have the capacity to manage contracts effectively. The experience thus far is that contract management has sometimes been an issue and will require further attention. However, it has not prevented contracting efforts from being successful.
- In most of the situations studied, contracts appeared to have made it easier for governments and NGOs to have a productive relationship. Because of its sensitive nature, it is difficult to know whether corruption was an important issue. However, those with intimate knowledge of the contracting experiences generally believed that it was not a significant issue.
- seven of the nine cases reviewed have continued and expanded, demonstrating that contracting in those countries has been sustainable.

To conclude, many approaches to public-private partnerships have been experimented with in both developed and developing countries around the world. Experience suggests, however, that no single approach is suitable for all countries or for all types of services and infrastructure. Public-private partnerships are not the only solution for all the problems confronting governments in providing services and infrastructure. They have potential problems and are complex but if carefully planned and implemented PPPs can help governments to improve the quality, reduce the

price, and extend the coverage of services and thereby facilitate the achievement of development goals.

We turn now to in-depth case studies of Pakistan of PPP, one in education and one in the health sector.

BOX 5
KEY INDICATIVE ROLES FOR THE PUBLIC AND PRIVATE SECTORS IN EDUCATION

Public Sector	Private Sector
Overcoming market failures Where needs are likely to go unmet because of market failure or where social benefits or services exceed the private benefits	Improving quality In needing to maintain and develop their businesses, they tend to innovate and transmit best practice
Providing for the poor, rural and under-served Provision of a safety net for citizens that cannot pay market prices, either through providing services directly or by creating incentives for the private sector to undertake the task Implementing appropriate regulations to ensure quality Setting, monitoring and accrediting standards, disseminating information to guide choice	Improve customer service Better customer focus - an assertion supported by the number of poor parents that send their child to a private school even when a public school is available at lower cost Improve management standards Businesses can act as a partner in transferring important management skills
Controlling costs Arguably a necessary task where there is little competition, no parallel public provision, or where consumers are poorly informed	Developing new services An essential role where demand is expanding or the patterns of demand are changing

2. CASE STUDY OF PUBLIC-PRIVATE PARTNERSHIPS IN EDUCATION

2.1. Introduction

Pakistan has been ranked 136th by the UNDP in its latest human development index ranking. One of the key reasons for the low ranking is that Pakistan does not perform well in the education indicators. The literacy rate stands at 53% in 2005, showing an increase from 39% in 1995. Gender differentials are pronounced, with the literacy rate at 65% for males as compared to 40% for females. The net enrolment rate is estimated at 65% at the primary level, 28% at the middle level and 16% at the matric (secondary) level.

The low quality of education is reflected by the fact that the average number of students per teacher at the primary level is as high as 38 and the drop-out rate is high, with less than 60% of children who entered primary education reaching class V. Public expenditure on education remains low at about 2% of the GDP, lowest among South Asian countries. The share of primary education in this expenditure is about

36% while that on secondary education is 23%, with the remainder, 41%, being accounted for by college, university and technical education. The cost per child enrolled in a public primary school was estimated at Rs 5400 per annum in 2006 while the corresponding cost at the secondary level was Rs.8000.

The private sector, both for profit and non-profit has acquired a major presence in the education sector of Pakistan. According to the Education Census of 2005, the share of enrolment in private schools was 13% at the primary level, 58% at the middle level and 45% at the matric level. These shares are expanding rapidly.

Contrary to perceptions, the market penetration of private schools has increased greatly. Private schools no longer cater only to children from rich families in metropolitan cities only, they also enroll children of poor families that are present in rural areas and low income neighborhoods. According to the Pakistan Living Standard Measurement Survey of 2005-06, 25% of the children in the urban areas and 12% in rural areas from low income households now go to private schools.

The case study of PPP described in the paper from the education sector relates to the **Punjab Education Foundation, which involves the provision of a state subsidy to private schools catering to children from low income families.**

Government of the Punjab in the middle of the current decade introduced Punjab Education Sector reforms. These reforms illustrate a bolder vision of the Government of the Punjab for improving education in the province. The education vision is to:

- Ensuring universal primary education by 2015
- Ensuring gender equality at all levels by 2015
- Ensuring economic opportunities for the poor with the help of education.
- Empowering communities through education
- Increasing access to all communities to physical and social assets.

However, if the education vision of the province is to be realized, concerted efforts need to be put in not only by the government but also the private sector, perhaps in association with the government. In line with this Punjab education sector reforms programme was introduced in 2004. The programme envisages a two year time frame to implement a programme based on the following strategic pillars:

- Re-alignment of public sector finances towards education.

- Devolution and public sector management reform.
- Improvement in access, quality and governance of education.

The government of Punjab has made an effort to implement the reforms agenda by bringing a number of structured strategic changes. The share of public development expenditure has increased significantly, with a rise in the share of education. Public sector management and governance reforms involve the following: developing partnership between provincial government and district governments for improved education service delivery; restructuring and capacity building of the education management structure at both the provincial and district level; re-vitalization of community based school councils.

The third pillar, improving access and quality of education has led to a number of bold initiatives. Education has been made free up to matric level. Annual allocation of Rs. 5 billion has been given to the districts for providing the missing infrastructure in 63000 schools which require improvements. Free text books are being provided to all students in public schools up to class 8. Also to improve the gender ratio, stipends are being given to girls students at elementary level in low literacy districts.

To improve quality of education, 29000 higher qualified teachers were recruited on facility based contracts and a new improved model of teacher professional development was initiated with the help of private sector. The government also focused on designing and implementing education assessment system to measure student learning. An important policy reform was to restructure Punjab Education Foundation to energize public private partnership to expand coverage and quality education. As such a promotion of PPPs in the education sector was one of the important policy decisions of the government to achieve its education vision.

There are, in fact, a number of promising areas for public - private partnerships in the education sector of Pakistan. One such model would involve the leasing out of government schools at the district / tehsil level with the condition that investment would be made to upgrade the facility, strengthen the staff and collect reasonable user charges. Another model could be the placement of government schools (with their cost borne by government) under the management of NGOs / private sector, through schemes like ”adopt a school”. Another potential approach is government

subsidy to private schools either directly to the school or through voucher per student.

2.2. Description of PPP

The partners are as follows:

Private Sector

The private sector partners are private schools catering to the education demands of low income families. These schools have the following characteristics:

1. Minimum enrollment of 100 and maximum of 750.
2. Location of the private educational institutions in the following districts: Lahore, Khushab, Bahawalpur, Chakwal, Sialkot, Bahawalnagar, Narowal, Gujrat, Bhakkar and Mianwali. Excluding Lahore, most of these districts are relatively backward.
3. Charging fees up to a maximum of Rs.300 per month.
4. Geographic location of the schools in rural/slums/backward areas.
5. Physical infrastructure of schools in terms of building, classrooms, library and laboratories (in case of elementary and secondary schools) should be hygienic, congenial and conducive.
6. The school should have qualified and experienced faculty.
7. Schools providing a minimum quality of education. Students of the short listed schools are administered a skill-based test in English, Urdu and Mathematics before entering into partnership agreement.
8. Priority is given to girls' schools.

Overall, the desired strengths of the private sector party include its existing infrastructure, penetration into low income clients residing in slum areas of large cities or backward districts of Punjab. The partner schools have demonstrated dynamism and initiative in their recruitment and marketing efforts and have been able to attract faculty and students. Also, the schools are motivated to improve the quality of their services. Their potential weakness is their limited coverage and that the relatively high level of fees precludes access to meritorious but relatively poor students.

Public Sector

The Punjab Education Foundation is an autonomous statutory body established under an Act of the Provincial Assembly with its head office at Lahore. It was established in 1991 and restructured under the Punjab Education Foundation Act X11 of 2004 for the promotion of education, especially encouraging and supporting the efforts of the private sector in providing education to the poor, through public private partnership.

The vision of the Foundation is to:

> *Promote quality education through Public-Private Partnership, encourage and support the efforts of the private sector through technical and financial assistance, innovate and develop new instruments and enable private educational institutions to champion wider and better quality educational opportunities at affordable cost to the poor*

The functions of the Foundation are as follows:

1. Provide financial assistance for the establishment, expansion, improvement, and management of educational institutions and allied projects;
2. Provide incentives to students, teachers, and educational institutions;
3. Promote public-private partnerships relating to education;
4. Provide technical assistance to educational institutions for testing policy interventions and innovative programmes for replication;
5. Rank private educational institutions based on educational standards;
6. Raise funds through donations, grants, contributions, subscriptions etc.;
7. Assist educational institutions in capacity building, including training of teachers, and
8. Undertake any other function as may be assigned to it by the Board with the approval of the Government.

Prior to the restructuring of the Foundation, which became effective in July 2005, The PEF functioned as a government department under the Chairmanship of the Punjab Chief Minister. Due to the divided attention of the Foundation's Board leadership and the bureaucratic set-up of the Foundation, PEF's performance was lacking in its initial stages. It was realized that if the Foundation has to meet its set objectives the setup has to be changed. Consequently, Punjab Education Foundation Act X11 of 2004 was passed which granted autonomy to the Foundation.

Complete administrative and financial autonomy was vested in the 15 member Board of Directors. Seven of these are ex-officio and eight are nominated directors, each with a term of three years. As such majority of the Directors are from the private sector. Shahid Kardar, from the private sector, was inducted as the Chairman of the Board with Directors nominated for their demonstrated commitment to quality education in Pakistan. The Board not only gave vision to PEF, introduced innovative programs to achieve its objectives, improved its functioning through removal of red-tapism, but also emphasized on effective monitoring and evaluation,(Director M&E reports to Chairman and Board), and transparency and accountability.

Overall, the strengths of the public sector partner consist primarily of its ability to build the financial and academic capacity of the private sector. Its mandate gives it the strength to complement private sector in providing a basic social service to perhaps the neediest sections of population, at relatively low cost.

2.3. The Model of PPP

Description of PPP

This case study was chosen because of its innovative character, its multi-dimensional approach, 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. The partnership is spread over the following initiatives:

- Foundation Assisted Schools (FAS): per student subsidy to private schools
- Continuous Professional Development Program (CPDP) and School Leadership Development Program (SLDP): training of teachers and principals of selected schools
- Teaching in Clusters by Subject Specialists (TICSS): capacity enhancement of partner schools through qualified teachers in key subjects
- Education Voucher Scheme (EVS): vouchers to needy students to choose any private school
- New School Program: construction of new schools in backward districts or where the enrolment rates are below the provincial average.

For the purpose of this case study, we will focus on the first initiative, the Foundation Assisted Schools (FAS) program, which accounts for over 87 percent of PES program expenditure. The total budgetary outlay of PEF for 2008-09 is Rs. 3.3 billion. PEF launched the FAS as its flagship program soon after its restructuring in

2005. As mentioned earlier, FAS is a program of providing financial assistance on per child enrollment basis to schools already in the business of providing education to low income families. A brief description of the other initiatives of PEF is presented in Box 6.

BOX 6
A BRIEF DESCRIPTION OF OTHER PROGRAMS OF PES

Continuous Professional Development Program (CPDP)/ Cluster Based Training (CBT), School Leadership Development Program (SLDP): Cluster Based Training (CBT) program targets teachers in a cluster, which is a venue for conducting training, and inviting the teachers of 7-10 private schools falling in close proximity (walking/transportable distance), thus making a group of 35-50 participants having similar training needs, though diversified educational background.

The CBT is conducted mainly on the content knowledge of Mathematics, English, Science, Physics, Chemistry and Biology. The primary thrust is in urban, semi-urban and rural areas of the province. In addition some sessions are also held to meet the training needs related to classroom management, teaching slow learners, lesson planning, group work, use of teaching aids, etc. The training is for teachers of those institutions which largely are serving low income families.

In addition, considering the school principals' pivotal role and their decisive input in managing the affairs of the schools, PEF launched a separate training program for the school principals/heads & second-in-command focusing on school administration and management under the SLDP Program in February, 2007.

Teaching in Clusters by Subject Specialists (TICSS): Low cost schools in rural and less affluent urban areas cannot afford qualified teachers of professional standing due to financial constraints. A good subject specialist has a salary demand of Rs 20,000 —25,000 while an average salary for teachers in a low cost schools is Rs 3000—Rs 5000 The idea is to arrange a subject specialist who will be teaching in a cluster of schools, which are not already funded by PEF. Specialized teachers are hired for Maths, English and Science. PEF not only hires these teachers, but monitors their performance and pays their salaries. The subject specialist teaches in a school 2-3 times in a week.

Education Voucher Scheme (EVS) is one of PEF's programs, which aims to provide quality education to children with weak educational prospects in marginalized and less affluent areas in urban slums and shanty towns of Punjab. Unlike the Foundation Assisted Schools in which a school gets per student funding, EVS is direct funding of students, and allows the flexibility to the student to choose the private school. Currently PES gives vouchers only to students belonging to a shanty area of Lahore and is essentially at the pilot project stage.

'Synergy' in the Partnership

'Synergy' in the partnership would arise if the two parties make each other better off in relation to the situation when such a partnership had not been formed. Starting with the private sector partner-the private schools, the benefits include the following:

- inflow of significant amounts of money as per student subsidy from the PEF which can be used for improving and upgrading the facilities at the school

- enhancement in the status of the school as a quality teaching institution and with the expansion in capacity increase in the ability to offer more and better services
- enhanced opportunities of improving the capabilities and skills of teachers and management through access to PEF's other training programs, at no cost.

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

- achievement of the goal of enhancing coverage of good quality education for the poor sections of population at substantially lower cost.
- high and rapid success rates without putting together additional physical infrastructure and human resources
- given the reputation of public schooling in the country, it would have been difficult to attract the current number of students
- also, the rapid success can also be seen as beneficial for public sector due to the high social returns on education. The development of backward areas and the enhanced ability to provide better services to local residents is a worthwhile objective in itself.

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 generally prevails between the two parties. The government views the private sector schools as profit maximization entities and thereby incapable of effectively serving its target group- essentially poor 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. This fear had to be put to rest by streamlining the modalities of the partnership. In particular, the private sector partners have no interaction with the public sector partner for collection of monthly subsidy, which is automatically credited to their bank accounts on a regular basis.

The partnership between PEF and private schools has evolved over time and, in fact has structurally changed. Initially, PEF gave grants/loans for construction of private schools. This scheme continued till the restructuring of PEF in 2004 when PEF

functioning was taken over by the Board of Directors (BOD). Under the BOD, PEF introduced a number of schemes focusing not only on expansion of coverage of education for the poor, but also ensuring that quality of education provided improved. This led to closer monitoring of the schools funded by PEF. For example, one of the requirements for continued funding from PEF is that two-thirds of the students should secure at least 44 percent marks in key subjects in the Quality Assurance Tests (QAT) administered by PEF. In fact QAT is administered in the beginning of the partnership. But partner schools in backward districts have made the case, which PEF has accepted, that the threshold score for QAT should be lower, otherwise most of the schools will not qualify for funding. Therefore, the threshold score has been reduced to 33 per cent for schools in backward districts.

Other impediments to the development of the partnership lie in the divergent interests of the various stakeholders. Teachers of private schools were initially hesitant to participate because of the fear that it might affect the terms of their service, impose additional workload on them and interfere with the discharge of their normal duties. However, the institution of special rewards by PEF for extraordinary performance, in particular, gave a motivational boost to them. PEF gives Rs50,000 for best performing schools in districts and Rs 50,000 for best five teachers in schools in which 90 per cent of students tested score of greater than 40 per cent marks.

Role of Leadership

Perhaps a critical element in the successful restructuring of PEF and eventual formation of the partnership was the leadership role played by Shahid Kardar, the Chairman of the BOD of PEF. Despite the initial impediments, Mr. Kardar pursued with determination his goal of improving the functioning of PEF, and bringing structural changes in the programs of PEF so that the partnership with the private schools is more productive and meaningful. Despite being from the private sector, not only did he donate his own time to the partnership but he also mobilized support from other Punjab Government Departments for PEF and its programs.

Furthermore, Mr. Kardar along with the other members of the Board of Directors gave both a vision to PEF and the ability and willingness to implement structural changes in the functioning and programs of PEF. By improving design and modalities of programs along with greater monitoring and evaluation he was able to establish a trust between the partners and the ultimate clients-the students and their parents.

Mr. Kardar and the nominated Directors of the Board, in particular, had the big advantage of knowing the education sector of Pakistan, being experienced researchers or practitioners. Also, they not only had contacts with the highest level of functionaries in the government of Punjab but were also widely respected in the private sector educational circles of the province. As such, they were able to create an environment of trust and cooperation. In addition, the introduction of transparent and accountable procedures following the restructuring of PEF removed any residual mistrust that may have existed in the minds of officials of government and private sector school administrations. On top of this, the partnership was strengthened at the operational level by the strong understanding and cooperation between the PEF and the management of the partner schools.

2.4. Implementation of PPP

Working Arrangements

The target schools under FAS are those charging up to a maximum of Rs.300 per month as tuition fees and related/allied charges. The monthly financial assistance on per child enrollment basis, of Rs. 350 for primary and middle level and Rs. 400 for secondary level, provided by PEF is to be spent on the promotion of education i.e. salaries of teachers, development of teaching material, library, classrooms, furniture, laboratory, science equipment, etc. There are ceilings on management cost as a proportion of total expenditure on the running of the schools. The recipient educational institution is expected to indicate the management cost and the expenditure on the management cost will be part of terms of partnership.

The delivery of quality education is the most significant variable for continued financial assistance by PEF. The financial assistance to the recipient institution can be discontinued in case the school does not meet the quality standards set by the PEF. It is mandatory that the two-thirds students of the partner school under FAS must pass QAT, with at least 44% marks, for continuation of partnership. The test initially administered by PEF is now outsourced along with grading of the tests. Setting of the test continues to be the responsibility of PEF. The one-third leverage given to schools in QAT scores to enable some students from underprivileged backgrounds, in particular, who may not perform well in the tests to continue in the partner schools.

In view of equity considerations, preference is given to schools in districts with lower rates of literacy. The Punjab Economic Research Institute's (PERI) ranking of districts on the basis of backwardness, as revealed by the Multiple Indicators Cluster Survey (MICS, 2003-4) is used for budgetary allocation among districts. 60 per cent of the allocation is on the basis of population and 40 per cent on backwardness. Within a district, 60 per cent is allocated to the rural and 40 per cent to the urban areas.

Before entering into Agreement/Terms of Partnership with a particular school/educational institution for the purpose of financial support, PEF carries out an inspection to ascertain the suitability of the school according to the approved criteria presented in an earlier section. The schools submit Quarterly Enrollment Reports to PEF on the basis of which financial assistance is deposited in the bank account of partner schools. The recipient educational institution cannot charge any form of fees from the students or their parents after entering into partnership under FAS. In case an educational institution makes any violation, PEF reserves the right to withdraw its financial support and cancel the agreement. The recipient educational institution also has to display on its main gate and on its official notice board that the PEF is sponsoring the full fee payment of all children enrolled. The format of display is provided by Punjab Education Foundation. Also, partner schools are to display the ranking of schools in QAT scores on the notice board. This is to encourage healthy competition among partner schools and to facilitate choice of schools by parents. Some features of the FAS program are presented in Box 7. Currently, there are 1085 partner schools with a student enrolment of 470,000.

BOX 7
PARTNER SCHOOLS

Location Wise Distribution	**Rural**	**Urban**		**Slums**
	599	407		79
Gender Wise Distribution	**Co-Education**		**Female Schools**	
	894		191	
Level Wise Distribution	**Higher Secondary**	**High**	**Middle**	**Primary**
	3	**373**	**633**	**76**
Geographical Distribution	**District**	**No. of Schools**	**District**	**No. of Schools**
	Chakwal	26	Bahawalnagar	172
	Khushab	30	Sialkot	16
	Gujrat	15	Lahore	19
	Bahawalpur	229	Narowal	06
	Bhakkar	11	Mianwali	12
	Vehari	01	Muzaffargarh	154
	Nankana Sahib	01	Jhang	92
	Lodhran	91	Multan	138
	Rajanpur	70	Sheikhupura	02
Students Benefited	**Total**	**4,70,000**		

Inputs by Partners

The private schools are expected to provide quality education using existing facilities and faculty. In return, PEF makes payment of Rs. 350 to Rs. 400 per student, up to a maximum of 750 students, subject to conditions enunciated earlier. Therefore, the model of partnership is essentially one of financing by the public sector, with monitoring of quality, and provision of services by the private sector.

Safeguards

An understanding on a number of safeguards has been reached between the two parties as follows:

Ownership of assets: The arrangement is for funding of schools, which continue to be the property of current owners. This is in no way the first step towards nationalization or public sector take over of private educational institutions.

Rights of beneficiaries: The school shall provide services to the public, not inferior to those provided before the formation of the PPP, or provided by equivalent public sector schools elsewhere in the province. In particular, the school will not charge any type of fees/charges from the students or their parents

Budgetary Commitments by Government of Punjab: The government of Punjab, through PEF will continue to pay the subsidy to private schools as long as the private schools continue to meet the standards specified by PEF. The PEF will ensure continuous flow of funding so that the functioning of the partner schools is not disrupted.

2.5. Evaluation of PPP

The prime indicators of success of a public-private partnership are the expansion in service coverage, improvement in the quality of service provided and equity and effectiveness of services provided. There has been 47 percent overall increase in enrolment in partner schools. Also, there is clear evidence that the schools have invested in infrastructure to increase enrollment. Due to the increased demand through expansion in enrollments, PEF has had to cap the enrollment ceiling at 750 per school to enable those schools who were unable to apply to access the FAS facility.

Another indicator of success is the rapid expansion in the number of partner private schools and the districts covered. The project started in 2004 as a pilot with 54 schools in five districts: Lahore, Khushab, Bahawalpur, Chakwal and Sialkot. The program scaled up next to seven more districts. The number of partner schools has increased to 1,085. The partnership with 17 schools was discontinued because of poor results in two consecutive tests. Currently there are 2000 pending partnership applications with PEF. The plan of PEF is to expand partnership to 1,500 schools by the end of 2008.

The partner schools, relieved from fee collection responsibilities- have focused on improving quality of education. This is illustrated by the results of QATs, which show a significant improvement. The mean test score is 63 per cent for QAT-1, 77 per cent for QAT-2, 79 per cent for QAT-3 and greater than 80 per cent for QAT-V. Furthermore, the schools have disproportionately benefited girls. The gender ratio is 52:48. There are also few drop outs from the schools which clearly indicates two things: first, schools are making an effort to retain students partly with improved teaching methods, and; second, parents think that the education of their children is worthwhile and therefore, are willing to bear the opportunity cost of foregone children's income because of continued schooling.

BOX 8
COMPARISON OF OVERALL BOARD EXAM RESULTS WITH FAS SCHOOL RESULTS

Sr. #	Board	District	Boards		FAS	
			Passing %age	Failing %age	Passing %age	Failing %age
1	Bahawalpur	Bahawalnagar Bahawalpur	53.98	46.02	81.09	18.91
2	D.G. Khan	Muzaffargarh Rajanpur	51.51	48.49	75.79	24.21
3	Faisalabad	Jhang	54	46	87.47	12.53
4	Gujranwala	Gujrat Narowal Sialkot	52.67	47.33	88.66	11.34
5	Lahore	Lahore Nankanasahab Shiekhupura	52.81	47.19	92.06	7.94
6	Multan	Lodhran Multan Vehari	49.62	50.38	78.89	21.11
7	Rawalpindi	Chakwal	53	47	95.31	4.69
8	Sargodha	Bhakkar Khushab Mianwali	45.79	54.21	79.03	20.97

Another powerful indicator of improved partner school performance at high levels (9 and 10 grade) is the comparatively better results in Board of Education administered standardized annual examination. Boxes 8 and 9 clearly show that not only did more partner school students pass the Board exams, they also had higher scores.

BOX 9
RESULTS COMPARISON

Sr. #	Board	District	Boards Above 70 %	FAS Above 70 %
1	Bahawalpur	Bahawalnagar Bahawalpur	11.09%	21.96%
2	D.G. Khan	Muzaffargarh Rajanpur	26.21%	20.52%
3	Faisalabad	Jhang	29.40%	29.64%
4	Gujranwala	Gujrat Narowal Sialkot	11.13%	15.23%
5	Lahore	Lahore Nankanasahab Shiekhupura	24.92%	25.93%
6	Multan	Lodhran Multan Vehari	20.62%	25.70%
7	Rawalpindi	Chakwal	13.59%	31.09%
8	Sargodha	Bhakkar Khushab Mianwali	19.93%	16.94%
Average Percentage			**19.61%**	**23.38%**

The contribution of the PPP to the cause of equity is self evident. Clearly quality education opportunities are expanding for the low income families. This is perhaps the best route to vertical social mobility for such families. Also, the fact that by design the target districts are relatively backward, with lower enrollment rates, the PPP is instrumental in promoting regional equality also.

Finally, government intervention is cost effective. Through the PPP arrangement, government achieves its objectives of enhanced education provision at the cost of only Rs. 350 to Rs. 400 per month per child, depending on the grade of the students. The estimated overhead cost of PEF for managing the FAS program is only about one per cent of the program cost. This is an extremely low ratio of overhead to program cost and testifies to the effectiveness of the model of partnership.

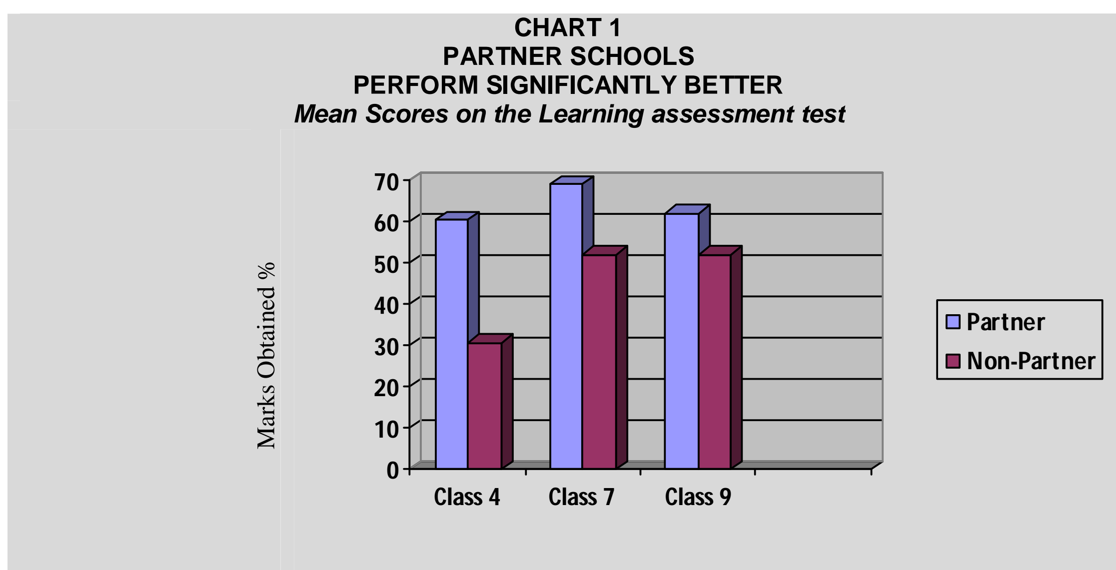
A consulting organization, Innovative Development Strategies and The World Bank have recently undertaken an independent evaluation of PEF and the FAS program with the following objectives;

1. Assess and analyze the overall impact and effectiveness of the program.
2. Evaluate the fairness and transparency of the program's processes specifically its school selection process and distribution of funds.

3. Comprehensively review the overall program architecture to assess its ability as a viable and sustainable model, also exploring the options of replication and scaling up.
4. Comprehensively capture lessons learned with a view to clearly identify merits and weaker areas leading on to devising a strategy for long term sustainability.

The Report has not been finalized yet, but some of its initial conclusions, based on field surveys are as follows:

- There has been a high rate of growth in individual partner schools enrollment, ranging from 13-17 percent a year
- The average budget per school is Rs. 702,000
- An average of three rooms have been added by a partner school in the course of the partnership
- Almost 80 per cent of teachers are certified to teach a subject they are teaching
- Most of the parents report that convenient location and free education was an important determinant in their decision to send their child to the partner school
- Most of the parents agree that they see an improvement in their child's achievement and that the partner school is meeting the needs of students better than the other schools
- Most of the parents were satisfied with the level of instruction offered
- Students in partner schools are academically better than non partner schools as shown in the chart below;



Overall, the case study demonstrates that: a) government should ensure free education through funding but need not necessarily provide the service; and b) better quality education can be provided at lower cost in a PPP framework than that incurred by public sector to educate a child.

However, the scheme, as it is currently designed, has three potential areas of concern. First, there is partial redundancy of benefits. The stipend may be given to students who are already paying fees, and to that extent did not really need an incentive to improve their educational attainment. In that case, the grant is more in the nature of 'cash transfer' to the families. Second, there is likely to be a problem of what is referred to in the literature as "adverse- selection", whereby there is a fall in intake and quality in public or non-partner schools because the better students opt for the partner schools and the public schools are left with the rejects of the partner schools, further deteriorating quality of public schools. Third, to the extent that student are diverted from public to private partner schools because of perceptions of better quality, this may result in excess capacity in public schools and limit overall cost saving in public expenditure on education. The ceiling of a maximum of 750 students in partner schools, in particular may restrict absorption of all students in a particular vicinity into partner schools, thereby necessitating the continuation of public schools. Also, there is the danger that in order to attain the minimum quality standard, partner schools may restrict admission only to high achievers.

2.6. Factors Contributing to Success and Sustainability

A number of factors can be identified which have contributed to the success of the model of partnership between the government of Punjab (through PEF) and the private partner schools. The success factors include the following:

Premium on quality education: a major underlying favorable factor is the demand for quality education, especially "English- medium education", in Pakistan. Despite high costs, people even with low incomes want to send their children to private schools. Access to relatively high quality free education is an attractive option for a large proportion of poor families.

Scope for 'synergy': The particular model of partnership chosen also has significant potential for 'synergy', whereby each party benefits significantly from the partnership. PEF was able to achieve an important objective set forth by

government at relatively low cost and in a short span of time while private schools got enhanced status and substantial additional funds for upgrading the schools without focusing on fee collection. This synergy greatly increased the incentive for forming the partnership and also increased the likelihood of success of the arrangement.

Quality of Leadership and Clarity of Objectives and Roles: The exceptional role of Shahid Kardar, the Chairman, in restructuring PEF, giving it vision, and successfully implementing the innovative programs need to be mentioned. Given his status (former Finance Minister of Punjab) and the status of the other Board members, he was able to surmount the obstacle of mistrust of the private sector in the bureaucracy. The objectives of both the partners were clear and mutually supportive, as both wanted to provide more and better services to residents. The clarity of roles helped. PEF's role was to finance and monitor standards while the private sector schools were the provider of service.

Simplicity of the Model

The model of partnership in FAS program is simple and easy to implement, with features like clear criteria for selection of partners and simple scheme of stipends. Also, the focus is only on monitoring of results in terms of quality of output and not on assessing the inputs into the learning process. This gives considerable flexibility to the school management.

Innovation and Adaptability

An important factor for the success of partnership is the innovative nature of the initiatives launched and the adaptability of the partners to change as the partnership evolved. The FAS scheme launched by PEF was very different from the traditional forms of association of PEF with partners. As mentioned earlier, initially loans were given to private sector for construction of schools, which were either not fully functional or if functional, had severe quality problems. The current scheme clearly better achieves the objective of expansion in coverage and improvement in quality. Also, both partners have demonstrated significant adaptability to accommodate concerns of each other. For example, PEF has introduced increasing slabs in the grant per student for higher grades (9 and 10) in light of partner school concerns of inadequacy of funding at the higher level. Likewise partner schools have accepted quality assessment tests in view of PEF focus on quality.

Success in Coalition Building: Initially different stake holders had varying perceptions about the partnership. Private schools were worried that this was the first step towards nationalization of schools, which is not unprecedented in the history of education in Pakistan. This fear was allayed by a series of meetings of the PEF staff and management with private schools and with the induction of a board of eminent Directors. Induction of private sector representatives in the board ensured a degree of public accountability of the arrangement.

The staff was worried that their employment status might be changed and they may lose their jobs. However, an understanding was given to them that the arrangement in itself has no impact on their employment. In fact, they have been granted special allowances by PEF if they perform well. Also, there were apprehensions about the discontinuity of the arrangements if QAT result were not met at the initiation of the partnership, particularly by schools in backward districts. The initial score requirement was softened such that the required test score was brought down to 33 percent for backward regions. 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 PEF, following the establishment of a Board of Directors and modalities of operation. These changes increased the innovativeness, efficiency, flexibility, transparency and accountability of the management to respond to any problems that may arise during the tenure of the partnership. Also, proper measures were introduced for effective monitoring and evaluation of the private sector partners, who also had to be more transparent in their operation and functioning.

Continued Financial and Administrative Support and Political Commitment of the Government

An important factor of success of the initiative was the government of Punjab's commitment to make a breakthrough in the education sector in the province. It introduced policy reforms, took bold initiatives and was willing to try out new institutional arrangements to achieve its objectives. As a consequence it restructured PEF and granted autonomy to its Board. Also, the allocation of funds from the budget of the provincial government to PEF have shown rapid growth.

Altogether, a large number of factors including the high premium on quality education, large scope for 'synergy', quality of leadership, shared objectives, simplicity of the model, innovation and adaptability, success in coalition building and and government commitment have all contributed to making this model of public - private partnership in education a success. These are also the factors which will ensure sustainability. In addition, its sustainability will require continued transparency, and focus on quality by both partners.

2.7. Lessons Learned and Replicability of the Case Study

This model of partnership between PEF and the private sector schools in Punjab is currently unique in the Pakistani setting. Its success was a result of a combination of favorable factors. Similar foundations exist in the other three provinces, Sindh, North West Frontier Province (NWFP), and Balochistan. They currently function as PEF used to prior to its restructuring in 2004, essentially as government departments under the Ministry of Education of the respective provinces. Obviously, their performance is affected by their structures. Recently, the Governments of Sindh and NWFP have approached the government of Punjab to acquire details of the restructuring of PEF and the modalities of its partnership with private schools. So, efforts are being made to nationally replicate the model. Also, the election manifesto of the Pakistan Muslim League (Nawaz), the current ruling party in Punjab after the elections of February 2008, includes a program of extending the model of education foundations down to the district level.

3. CASE STUDY OF PUBLIC-PRIVATE PARTNERSHIPS IN THE HEALTH SECTOR OF PAKISTAN

3.1. Introduction

Pakistan is characterized by poor health indicators like infant mortality rate of 70 per thousand live births, under five mortality of 99 per 1000 live births, life expectancy of under 65 years and child malnutrition of over 40 per cent. 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. Malaria and tuberculosis have reemerged as potential threats. Communicable, infectious and parasitic diseases remain a severe problem, although significant gains have been made recently under the expanded program of immunization.

Combined private and public expenditure on health is about 3.5 per cent of the GDP, with the public sector accounting for less than 1 per cent of the GDP. Investments in health infrastructure are constrained by shortage of funds for salaries, drugs and maintenance. Pakistan also has a serious problem of maldistribution of doctors and an overall shortage of para-medical personnel, especially nurses. A significant proportion of doctors go abroad. Of those who stay in Pakistan, bulk of them 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, therefore, 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.

The private and non-profit sectors are playing an important role in the health sector in Pakistan, as in most developing countries, 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 organizing 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.

In recent years, the government has taken the initiative of encouraging PPPs in the health sector. Perhaps the most important initiative proposed in this is the National Health Care (NHC) Scheme. The objectives of this scheme are, first, to improve the quality and utilization 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.

3.2. Description of PPP

The partners in the PPP are as follows:

Private Sector

The private sector partner is the Frontier Medical College, located in Abbottabad, a divisional headquarter in the province of NWFP of Pakistan, 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.

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. It 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, is 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). FMC is recognized 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.
Tuition fees are relatively high at FMC at Rs 280000 (US $ 4245) per academic session (of one year). For foreign nationals (there are 29 enrolled currently) the annual fees is $ 12000. In addition there is an admission fee of Rs 100000, initial

caution money of Rs 30000 and other miscellaneous fees of Rs 10000 annually. The hostel accommodation fee is Rs 70000 per academic session. Despite these relatively high fees, FMC received 2285 applications for 50 seats this 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 utilization of space. The collage has expanded significantly over the last decade. 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 that the relatively high level of fees precludes access to meritorious but relatively poor students.

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 neighboring 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 of Batagram, Shangla, Buner and Kohistan (with a combined population of 1.7 million).

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

Household incomes in the region have been substantially enhanced by the inflow of home remittances from migrants 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. It is a 160 beds hospital with about 50 doctors and 130 other medical staff handling over 25000 OPD patients monthly.

The executive head of the hospital is the Medical Superintendent, a senior middle level government official. All essential departments required for the clinical training of under graduate medical students including medicine, surgery, gynae obstetrics, ophthalmology, otolaryngology, pediatrics, orthopedics, dentistry, radiology and clinical pathology exist in the hospital. 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 centralization 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.

3.3. The model of PPP

Impediments

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 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 Superintendent of DHH, Mansehra, with notables of the area.

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 mobilized 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 Superintendent, DHH, Mansehra.

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.

Inputs by Partners

The DHH, Mansehra makes available facilities for teaching purposes of the students of the college. In return, FMC pays capitation fees of Rs 50000 per student per year, totaling to Rs 7.5 million per annum. Therefore, the model of partnership is essentially one of a joint venture with financing by the private sector and access of assets owned by the public sector.

Safeguards

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

Ownership of assets: The agreement is only for 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. Also, this ensures that the key beneficiaries of the PPP remain the relatively poor households who generally access public hospitals. These households gain from the PPP in terms of improved health care at the DHH.

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 duly indexed for inflation. 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 is tantamount to granting autonomous status to DDH, Mansehra.

All amounts credited to the fund (including the resources from the capitation fee) shall be utilized 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 development grants from the provincial ADP funds 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.

'Synergy' in the Partnership

How does the nature of the partnership make each party potentially better off? We start with the DHH, Mansehra. 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 relatively poor 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 a substantial amount. 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.

3.4. Implementation of the PPP

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:

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

Functions of the Management Board include the following:

a) administration and management of the Hospital; establishment of regulatory framework for operation of the Hospital and the collaborative arrangements with the Second Party within the overall framework of the Agreement;

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

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

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

e) review of quarterly reports prepared by the Medical Superintendent of the Hospital;

f) and 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 Superintendent 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.

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.

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.

3.5. Evaluation of PPP

The prime indicators of success of a public-private partnership are the efficiency, equity and effectiveness of services provided. Perhaps, the most powerful visual indicator of success is the completion of construction of the new wing of the hospital. This wing has the capacity for 150 beds, in excess of the expansion stipulated in the agreement. It includes an ICU, CCU and a number of operation theaters. The construction cost of Rs 15 million has been financed by the first installment of the capitation fee paid by FMC of Rs 8 million and a development allocation from the ADP by the provincial government as promised in the agreement.

The construction of the new wing has more than doubled the capacity of the DHH, Mansehra, and has made it equivalent to the DHH in some of the more developed districts of the country. Consequently, the hospital is now able to avoid overcrowding and congestion in the use of its facilities. Not only is it possible to more effectively serve the population in its catchment area but the quality of service has gone up significantly. All this has been achieved without any significant increase in user charges. These remain very low. The OPD charge is Rs 3 (4 cents), the admission charge is Rs 15 (20 cents), X-ray charge is Rs 60 (46 cents) and ECG charge is Rs 40 (53 cents). Operations are free. Therefore, equity considerations have not been sacrificed. This is a major achievement.

Other indicators of success are reflected in the views of the stakeholders taken as part of an earlier evaluation[19] 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.

FMC Students: There is the problem for students of inconvenience in commuting between the college and hospital. However, they emphasize that they have greatly benefited 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.

Patients / Citizens: DHH, Mansehra has been successfully upgraded without any enhancement of user charges. Initial fears of the privatization of the facility have proven to be unfounded. There has been a visible improvement in the quality of service due to greater presence of doctors.

3.6. Factors Contributing to Success and Sustainability

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 favorable 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 had great 'synergy', whereby each party benefited 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 emphasized. 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 maximization 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.

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 privatization 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 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 utilization of funds, for protection of rights of patients and hospital employees and for conflict resolution between the two parties. This minimizes 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.

3.7. Lessons Learned and Replicability of 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 a successful model of partnership, which evolved because of a combination of favorable factors. Can it be replicated elsewhere? Given the success of the model, the answer is a yes. In fact, a number of PPPs of private medical colleges and government hospitals have already evolved in Pakistan as shown in Box 10. Of course, success in forming partnerships hinges 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.

BOX 10
PRIVATE MEDICAL COLLEGES PARTNERING WITH GOVERNMENT HOSPITALS

The following colleges, recognized by the Pakistan Medical and Dental Council (PMDC), are in partnership with government hospitals.

		Located	Affiliated with Hospital
1.	Foundation University Medical College	Rawalpindi	Fauji Foundation Hospital Rawalpindi
2.	Islamic International Medical College	Rawalpindi	Pakistan Railways Hospital
3.	Wah Medical College	Wah Cantt	Pakistan Ordnance Factory's (POF) Wah Hospital
4.	CMH Lahore Medical College	Lahore	Combined Military Hospital, Lahore (Army Lahore)
5.	Women Medical College	Abbottabad	District Headquarter Hospital (DHQ), Abbottabad.

NOTES:

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