

# **Contracting out of Basic Health Facilities in Pakistan: Are the Lessons Generalizable?**

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## **Abstract**

Amid growing support within international development agencies for the privatization of health facilities in developing countries, contracting out of the Basic Health Units (BHUs) in Pakistan has been presented as a success. This article argues for caution in generalizing results from this model. It shows that the model improved service delivery because the organization taking over the BHUs was itself a government-owned NGO; similar concessions would not have been granted to a private provider. Further, the article shows that, given the strong resistance that the model continues to receive from administrators within the state system, development agencies have to consider whether models that try to sidestep the bureaucracy, instead of working towards installing good practice within the state system, can be viewed as a success.

*Key words:* Public–private partnerships; privatization of health facilities; Basic Health Units (BHUs); good governance; Pakistan.

## **Introduction**

Pakistan's health sector suffers from the standard challenges of limited resources and poor governance that are common to most developing countries (PRSP, 2006; Usman et al., 2015). Starting from 2003, in Punjab, the largest and most populated province of Pakistan, a public-private partnership model was introduced to improve the working of government-owned Basic Health Units (BHUs). In the district of Lodhran, the management of the BHUs was contracted out to a third party. This model, which was piloted a few years ago in Rahim Yar Khan district, has been widely regarded as a success (Loevinsohn and Harding, 2005; World Bank, 2006). The World Bank encouraged its replication in other provinces, approving a loan of US\$ 16 million for Khyber Pakhtunkhwa (World Bank, 2016); other major donors, such as the UK Department of International Development (DFID), have also pledged their support (UNISON, 2016; Prentis, 2016). The main appeal of the model is that under it the management of the BHUs is contracted out to a private party, while the government continues to provide the budget. This is viewed as providing an ideal balance between pro-market and pro-state solutions. Market-based health interventions are critiqued primarily from an ethical standpoint, on the grounds that such facilities remain inaccessible to the very poor (Bano et al., 2016; UNISON, 2016). By ensuring that the government continues to shoulder the financial burden of running the BHUs, the model arguably makes it possible to overcome these equity concerns while improving efficiency.

This article, however, questions such readings of this particular model, as well as its generalizability. It argues that before such interventions are promoted at the global

level, as has been done in this case (Loevinsohn and Harding, 2005; World Bank, 2006), it is important not only to assess their impact on service delivery but also to examine their political economy: a factor which is key to determining their long-term viability. Further, it is important to be cautious in generalizing results from such models, especially if they have some unique features. Key to the success of contracting out of the BHU model in Pakistan is that these BHUs have not really been privatized: they have been handed over to a government-run NGO, Punjab Rural Support Programme (PRSP), a semi-autonomous government institution, not an NGO or a private provider. The PRSP senior management consists of ex-bureaucrats; and, when recruiting employees to manage the BHU model, PRSP appoints serving bureaucrats from within the relevant government departments on two- to three-year secondments. Their strong personal networks within the government have been key to ensuring that the model will work.

To date, all replications of this model in other provinces have been implemented through PRSP's sister organizations in other provinces, collectively referred to as the Rural Support Programme Network (RSPN) (RSPN, 2017). Further, despite being managed by a semi-government organization, the programme has remained highly contentious within the Ministry of Health, with its long-term sustainability still in question. PRSP is continuing to manage the BHUs on short-term contracts which require renewal every three years. Further, its expansion to additional districts in Punjab has slowed down: between 2008 and 2016, it has expanded to only three new districts, when initially it went from zero to thirteen districts between 2003 and 2008 (PRSP, 2017).

This article shows that resistance to the formal adoption of this model by the health bureaucracy stems from the latter's loss of control over state resources and employees of the BHUs. While the development agencies backing this model have successfully lobbied the political leadership to continue to endorse the programme, the health bureaucracy remains highly resistant to loss of control over a major tier of state health infrastructure. The fieldwork suggests that the sustainability of this forced partnership is thus highly conditional on the push that it receives from development agencies, most noticeably the World Bank. The role of development agencies in promoting the privatization of basic health care in developing or fragile states is well recorded (Palmer et al., 2006; Sabri et al., 2007). Such top-down lobbying to embed this model in the Pakistani health system makes the long-term sustainability of this model highly questionable. Given that the PRSP model has established that the actual management reforms required at the BHU level to improve service delivery are not very complex (see Section 3), it is important to consider why the development agencies cannot prioritize working with the health bureaucracy to ensure that those good-practice guidelines are absorbed. Is it feasible to push for a contracting-out model that is successful simply because it artificially circumvents the government's standard operating practices? This is particularly important to consider, given that studies such as Judith Tandler's *Good Government in the Tropics* have shown that good governance, especially at lower tiers of government, can be introduced despite the standard challenges.

This article is structured as follows. Section 1 maps the current move within many international development agencies towards supporting the involvement of private providers in the provision of basic social services to the poor, be it in the area of education or health. Section 2 sets the context of the poor state of health facilities in Pakistan, outlines the core features of the BHU contracting-out model, and records evidence of its success in improving service delivery. Section 3 identifies the managerial reforms that improved service delivery at the BHUs. Section 4 shows how key to the successful implementation of this model was the fact that the BHUs were handed over to a semi-government organization run mainly by ex-bureaucrats, not by private providers or NGOs – a fact which therefore limits the generalizability of this model. Section 5 concludes by questioning whether models aiming to contract out the management of state-owned social-service facilities while expecting to retain the financial burden on the state are viable in countries with weak democratic institutions and strong bureaucracies. Such models run the risk of either being abruptly terminated or losing state funding and depriving the very poor of the few facilities that the state once did offer for free.

## **Section 1. Privatizing basic health care: the case of BHUs in Pakistan**

Health is one of the basic social-service sectors with a strong moral argument for deserving public subsidy; the right to live a healthy life free of preventable and curable diseases is the most basic of human entitlements. Within international development policy and discourse, health remains a priority sector, and achieving improvements in universal basic health indicators remains one of the key pledges under global commitments expressed in the form of Millennium Development Goals

(MDGs), now renamed Sustainable Development Goals (SDGs). The heavy financial burden of maintaining state-run health facilities, however, makes the provision of free health care a challenge even in the developed world. Finding ways to finance basic health-care provision for all that are both efficient and equitable remains a major public-health challenge (Palmer et al., 2004). The genuine resource constraints faced by health bureaucracies in developing countries, combined with concerns about corruption and poor governance, have led many donors to explore the role of the private sector in the provision of basic health facilities to the poor (Kazi et al., 2013; Bano et al., 2016). Loevinsohn and Harding (2005) outline ten different examples of such programmes endorsed by the development community.

In addition to these specialized interventions, new market-based initiatives are also being trialled under the banner of Making Markets Work for the Poor (M4P), a framework popular with many development agencies. Programmes operating under the M4P framework aim to introduce incentives in the market whereby private providers of services emerge even for the poor (Bano et al., 2015). Katalyst is a good example of a market-based health programme being implemented in Bangladesh under the M4P framework (Bano et al., 2015). Under this programme public-private health-care partnerships are being promoted by making training financially accessible to health professionals from low-income backgrounds who normally cannot access such specialist training. While such market-based interventions are indeed showing positive results across different sectors, the evidence to date shows that reaching the very poor through this approach in any sector, education and health included, remains a challenge (Liu et al., 2008; Bano et al., 2015). Private facilities remain out of reach

for the very poor, and the facilities that even the better off among the poor can afford offer very poor quality (Bano et al., 2015). Consequently, most reviews of the contracting out of health facilities in developing countries end up arguing for great caution in the actual design of such plans (Palmer et al., 2006; Siddiqi et al., 2006; Liu et al., 2008).

Thus, while on the one hand the international development community is trialling more market-based models to provide basic health services to the poor in the developing world, there is also a recognition that for the very poor some kind of government financing or subsidy is needed. The debate on whether private health care can address the health needs of the poor thus remains highly contested (Hanson et al., 2008). It is against this background, where concerns for efficiency are coupled with concerns for equity, that the BHU privatization model in Pakistan appears reasonably promising. Under this model the government is expected to continue to finance the basic health facilities that are utilized mainly by the poor, especially in rural communities, thus honouring its moral commitment to guarantee access to basic health care, while ensuring that performance is improved by handing over the management of those facilities to private providers. In terms of basic outreach, Pakistan has a good network of basic health-care units, inherited from the British colonial period (PRSP, 2006). Operating at the divisional level, the BHUs in principle provide access to a trained doctor, dispenser, and female health visitor, and access to basic medicine; it is the first point of call for the sick among poor communities, especially in the rural areas. The justification for privatizing the management of the Units, however, came from growing evidence of their poor performance and low utilization (Chaudhry, 2015; Usman et al., 2015).

The PRSP used this evidence to convince the government to hand over the management of BHUs in Lodhran district on a trial basis in 2003; this request was based on the positive experience of privatizing the management of three BHUs by outsourcing it to the National Rural Support Programme (NRSP) in Rahim Yar Khan district (World Bank, 2006). While doing community mobilization work, PRSP maintains, it found the BHUs to be highly under-utilized. The doctors and other staff were often absent, and the medicines were routinely out of stock; the ordinary public instead relied on semi-trained private health providers and quacks. The World Bank (2006) report argued that the 3,060 BHUs in Punjab attracted only 16 per cent of the rural population, and in 2002 they saw only 22 patients per day (or about .33 visits per capita per year, which is fairly low by global standards); other studies present similarly low BHU-utilization rates in other provinces (Tanzil et al., 2014). Once PRSP took over the management, things improved dramatically. An external evaluation of the programme in Rahim Yar Khan district sponsored by the World Bank showed that the utilization of BHU facilities had increased substantially since the handing over of the BHUs in Rahim Yar Khan to NRSP (World Bank, 2006). It recorded that the number of outpatients increased by 200 per cent; and about 83 per cent of the patients who had used the BHUs both before and after the PRSP take-over reported improvements (World Bank, 2006).

This article draws on in-depth fieldwork conducted between 2006 and 2008, with follow-up fieldwork carried out in 2016. The fieldwork involved engaging with PRSP management and the Punjab health bureaucracy to understand the basic working of this model, and to assess the sustainability of this intervention. In-depth interviews



were conducted with key officials from the government, as well as with the PRSP at the head office in Lahore and in two selected districts: Faisalabad and Lodhran. Faisalabad district was selected because it included the largest number of BHUs out of all the districts; the Faisalabad programme covered 168 BHUs, 68 Zila Council Dispensaries, and three Unani Centres. Lodhran, though having only 58 BHUs, was selected because it was the first district in which the pilot was established in 2003.

Much of the fieldwork was conducted at the actual BHUs. It involved in-depth interviews with the BHU staff, district government officials, community members, and most importantly the patients utilizing the services at the BHUs. In Lodhran as well as in Faisalabad, I spent a number of days observing activities at the selected BHUs, which allowed me time to talk to the medical doctors, the dispenser, and other members of the staff. Most importantly, the time spent at the BHUs also allowed me to observe interactions between the patients and the BHU staff. I was given permission to interview the patients. Thus, at each BHU I interviewed both male and female patients of different ages. This fieldwork within the BHUs and the interviews with the staff and the patients were key to verifying the quality of services provided and to identifying factors that enabled the model to improve service delivery. However, it also showed that the factors that made PRSP effective were not generalizable to the private providers. In total, across the five BHUs in the two districts in which fieldwork was carried out, a total of 30 interviews were conducted with the patients, and 20 interviews with the BHU staff members. During the follow-up fieldwork in 2016, the focus was on tracing the success (or lack of it) in embedding the model in the Ministry of Health. Thus, during the follow-up fieldwork, the focus was on gathering actual evidence on whether or not the Ministry of Health

had formally adopted this model, and on recording the views of the government officials about its future sustainability.

## **Section 2. What made the model work?**

Since the launch of the pilot programme in 2003, a growing number of studies have confirmed that handing over the management of BHUs to PRSP improved service delivery (Callen et al., 2013; Hatcher et al., 2014; Usman et al., 2015). The indicators used by these studies to measure improved efficiency include patient turnout, staff attendance, and availability of medicines. The detailed fieldwork conducted between 2006 and 2008 with BHUs in Faisalabad and Lodhran had helped to verify these claims. Performance at the BHUs had indeed improved dramatically: the Units visited had high patient turn-out, their infrastructure was well-maintained, the facilities were clean, the staff were on duty, and basic medicines were in stock. The BHU staff as well as the patients interviewed at the BHUs spoke highly of the changes. As a doctor in one of the BHUs visited noted: ‘The change is astounding, we have oxygen, nebulisers, glaucomatous, and diabetes drugs’. He explained that formerly they would have expected to find this level of equipment only at district-level health facilities. His view was that utilization rates had doubled, with patients attending the Units because of the availability of medicines. The patients similarly acknowledged major improvements in the BHU services, in terms of the regular attendance of the medical officer and the other staff members, and the availability of medicines. The success of the PRSP in improving services at the BHUs, compared with when they were under state management, is thus not disputed. Nevertheless, both the generalizability and the

sustainability of this model need to be questioned. It is important, however, to begin by studying the factors that helped to improve the service on the ground.

*Full control over the budget as well as the BHU staff*

The contracting out of BHUs to PRSP was regulated by a formal contract. The five-page contract, which was signed by the District Coordination Officer (DCO, the highest-ranking bureaucrat at the district government level) and the Chief Executive Officer of PRSP, had seven sections: the role of District Government, the role of PRSP, staff recruitment and management, finance and auditing, commencement and duration, dealing with difficulties, and arbitration. In the district-government section, it was made clear that the authority over the BHUs was to be handed over to the PRSP; in the PRSP section, the emphasis was placed on its obligation to ensure the smooth running of the BHUs. The most critical clause from the PRSP perspective, however, was that the contract gave PRSP full control over the use of the budget and management of the government-paid BHU staff: ‘The PRSP shall be authorized to allocate and reallocate to the staff appointed, posted or assigned at the BHUs such function and responsibilities as it considers most appropriate for the best delivery of the services which are or can be expected to be provided at the BHUs’.<sup>1</sup> The section on staff further clarified that supervisory control of the government staff at the BHUs was also to be entirely the responsibility of the PRSP. In addition, PRSP was allowed to engage additional staff, under the terms of the PRSP’s contract. Interviews with the PRSP senior management showed that assigning complete control over the spending

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<sup>1</sup> A copy of the contract was provided during the fieldwork. This extract is from page 3.

of the budget and the management of the staff proved key to improving the services on the ground.

### *Improved financial incentives and professional growth*

Giving good incentives to the staff of the BHUs to encourage them to work more effectively was an important part of the new management practices introduced by PRSP. A significant feature of the reform was that PRSP doubled the doctors' salary. Health workers were given incentives in terms of better working conditions and ensuring the smooth supply of drugs, which made their work much more effective. In addition, fieldwork showed that the PRSP management complemented these financial incentives with other kinds of incentive. It paid salaries on time and involved the field staff in the decisions and took their views seriously. As the PRSP District Support Manager in Faisalabad explained, listening and responding to the challenges faced by the Medical Officers (the job title of the BHU doctor) in a BHU was very important. PRSP also invested in building staff capacity at the BHUs. It introduced the system of holding a monthly review meeting with the Medical Officers of a selected number of BHUs and organizing a lecture by a leading medical authority as part of this meeting. It also held capacity-building sessions for other staff members, including Lady Health Visitors (LHVs). Finally, PRSP found that another way to motivate the staff was to trust them and give them some authority. The Medical Officers were thereby given authority to undertake essential purchases without prior permission. This enabled the immediate execution of many decisions, whereas under the government system the BHU doctor cannot purchase anything without prior approval. This small degree of

authority, as argued by the PRSP senior management, increased the respect accorded to the Medical Officers, which in turn improved their morale.

### *Effective mentoring and leadership*

In addition, the PRSP management placed emphasis on building team spirit and developing personal trust. According to the PRSP District Support Manager, Faisalabad, 'In mobilizing the team, it has been very important to create a family atmosphere'. He was of the view that creating this kind of an environment requires a high level of skills on the part of the manager. He referred to his own 20-year experience of holding senior managerial positions in government, including the posts of District Controller and Assistant Commissioner. In his words, 'This personal experience and exposure is very important in building trust and credibility'. Elaborating on the role of the good leader, he noted that it was important to make the staff feel that their concerns were being taken seriously. He explained that he was currently actively following up with the Head Office in Lahore the request of one of his Medical Officers to change the BHU cleaner because he had not been turning up for work. The district government had failed to take action, despite repeated reminders. The manager in question, however, was keen to ensure that the case was pursued at the top level, to reassure the Medical Officer that he had support within the system to implement appropriate decisions.

### *Strong monitoring mechanisms*

While trying to motivate staff by providing good financial incentives, a pleasant working environment, and moral support, PRSP management also introduced very strict monitoring mechanisms. This rigorous system has, in the view of all PRSP managers, been critical to improving services on the ground. The PRSP District Support Managers spend three to four hours on regular monitoring visits to the BHUs every day of the week. These visits occur at random. In addition, telephones were installed in the BHUs to check staff attendance on the phone. During fieldwork, PRSP managerial staff repeatedly emphasized that surprise checks and unannounced field visits were critical. They reported that they were out at 8.15 am every day, not returning to the office until 4pm. Most of the office work would thereby happen in the afternoon. ‘On the average I cover 200 km per day’, explained the PRSP District Support Manager in Lodhran. As part of the monitoring, PRSP management looks at staff attendance, observes the patient turn-out, and reviews the medicine inventory in each BHU.

The PRSP management philosophy thus involved giving good monetary incentives but combining them with strict monitoring mechanisms. Also, an integral part of this monitoring process was the willingness to stay responsive to needs and problems observed on the ground. The observations from the field visits thus routinely fed back into the planning process and led to adaptations. The model had started with one doctor for every three BHUs. However, to improve performance the PRSP changed the model to one doctor per two BHUs. Then, after noting the special needs of the female patients, in December 2004 PRSP Faisalabad introduced the position of

Female Medical Officer in the BHUs to facilitate women's access to medical services. Thus, monitoring of performance and responding to needs went hand in hand.

### *Consultative management and credit sharing*

The PRSP experience shows that when working with the government it is important to make the administrators feel that they are being consulted, and to let the politicians take credit for the success of the programme. The PRSP staff were keen to explain during the interviews how they actively involve the district-level bureaucracy in BHU staff selection. Senior district-level officials are requested to sit on the interview panel for all BHU-related appointments, and interviews are actually conducted in their offices. In the view of PRSP staff, keeping district government officials involved was important in order to ensure that they co-operate with the PRSP-appointed staff. As one PRSP official explained, the contract was just one document guiding the relationship; in reality careful negotiations had to be carried out at each and every step.

When dealing with the politicians, the PRPS management was, on the other hand, very clear that for the success of the project it is important to let the politicians take credit for the programme. As one PRSP official in Faisalabad explained, in order to win the support of the *nazim* (elected district officer) it was important to let him take credit for the improvement of services at the BHUs. The PRSP team made a point of always expressing public appreciation for the *nazim's* support. Transfers of government officials are the most important tool for political reward or punishment.

Since the *nazims* exercised this power, which gave them an important tool with which to build political leverage, initially they had concerns about the programme, due to their fear of losing the power to dictate transfers. But PRSP found that the *nazims* can see the political advantage they will get if they take formal ownership of the project and take credit for improved facilities within the BHUs.

### **Section 3. Can we generalize from the unique character of the rural support programmes?**

In analysing the factors that helped PRSP to work effectively and win relevant concessions from the government, it is important to remember the special status of PRSP, as a government-owned NGO. The Punjab Rural Support Programme (PRSP) is a government-established NGO and the Punjab government's very own parastatal organization. It is part of a country-wide network of five Rural Support Programmes (RSPs), which are part of the Rural Support Programmes Network (RSPN) established in 2001. Inspired by the success of the Aga Khan Rural Support Programme (AKRSP) in the northern areas of Pakistan, the government of the time sought to emulate the programme by creating a National Rural Support Programme plus four provincial Rural Support Programmes, with the help of grants from multilateral and bilateral donor agencies.<sup>2</sup> During the fieldwork, many NGOs argued that part of the government's motivation for establishing the RSPs was to balance the growing influence of NGOs by setting up these semi-autonomous structures which can attract aid funds that are being diverted to NGOs. PRSP was established in 1997

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<sup>2</sup> Information about the donors supporting the Rural Support Network, including the PRSP, can be accessed at <http://rspn.org/>; and <http://prsp.org.pk/Home/Home.aspx>.



with an endowment grant of Rs 500 million from the Punjab government (PRSP 2017).

The Board of Directors decided to invest this grant, and the operational cost of PRSP is met from the profit on this investment; in addition, like other RSPs, PRSP constantly bids for projects and grants from international development agencies. DFID, IDRC, USAID, and the World Bank–Japan Social Development Fund are examples of some of the donors who work with the RSPs (RSPN, 2017). The semi-government status of the RSPs assures them special access to the government, while enabling them to avoid many of the usual bureaucratic hurdles encountered in public-sector operations (PRSP, 2006). The basic thrust of the RSPs model, including PRSP, is to mobilize poor communities (mainly but not exclusively rural) to improve the management and delivery of basic services.

Fieldwork with the PRSP and government officials leaves no doubt that this semi-government status of PRSP was of critical importance in enabling it to secure the BHU contract from the Punjab government and to undertake day-to-day activities at the BHUs. As the most senior official within the PRSP leading the BHU programme explained, ‘No, it was not difficult to get the government officials to agree to our demands, be it the demand to give us one-line budget or for other things. It was a matter of supporting a government’s own non-governmental programme. Representatives of government sit on the RSPs boards. Out of ten members, three are serving government secretaries. So they knew exactly what was happening within the

PRSP. So there was a comfort level.’ The Chief Executive of RSP Network similarly emphasized that the reason why government likes to work with RSPs is that they are more familiar with the government systems. In her words, ‘In particular, we have seconded staff from the government. We know the system better and are better able to change it from within than other NGOs.’ She also noted that another important attraction of RSPs for the government is that they operate on the appropriate scale. ‘An ordinary NGO goes and asks for one district. This does not impress the government. We can take up a large number of districts, thus making it easier for the government to work with us,’ she explained.

The PRSP's semi-government status was thus critical in enabling it to gain initial access to state systems. It was due to this that PRSP senior managers were clear from the start that to manage the BHU programme at the district level, PRSP needs to engage government officials on secondment to run the programme. A senior manager at PRSP's BHU project office in Lahore, who was himself a public servant with the Punjab government working on secondment with PRSP, was of the view that for the top officials recruited to run the programme prior experience in the government sector is critical for its success. In his view, private-sector recruits will have no idea of how the government system works. As he noted, ‘For example, he won’t even know how the government budget works or what are the inventory rules. To successfully manoeuvre within the government system, PRSP has as a policy to recruit public servants to head the programme at the district as well as the head office level.’ He was clear that the support of the Chief Minister was important in getting the government to transfer BHUs to PRSP; but even more important was the involvement of some senior

bureaucrats. As he argued, ‘without their help even the minister could not have gone very far. The private-sector person cannot enter the secretariat.’

He went on to express appreciation of the role of the PRSP senior manager responsible for the overall running of the BHU model: ‘Because he is a senior ex-bureaucrat, he was able to negotiate with the Finance Secretariat to give PRSP a one-line budget. This meant that PRSP was given the authority to break down the budget among different heads as it wanted.’ This, he maintained, had been critical for the success of the project, as by these means PRSP had the flexibility to move the budget from one head to another according to need. Normally, the government budget is tied to specific heads, which makes it impossible to shift funds around according to need.

Having staff with experience of working in the government was critical also by virtue of their social networks within the bureaucracy. The District Support Officer and the Assistant District Support Officer (the two top positions in the PRSP District Office) in Faisalabad were from the public service. They were of the view that their prior knowledge of the public sector was critical for the success of this programme. The PRSP Assistant District Support Officer in Faisalabad added: ‘Our prior networks in the government are very important. The people in the government offices know us. Some of them were our colleagues or batch mates. So they listen to us. Also, we know how the system works, so we know who to approach and how for any specific issue.’ He went on to explain how the personal credibility of their District Support Officer had been very important in winning the co-operation of the district officers: ‘He has

held important positions within the government in Faisalabad. He was also the Assistant Commissioner and most importantly he had very good reputation. So when people know that he is the one who is heading the PRSP programme, they are more willing to engage with the initiative.’

Similarly, employing public servants to head the PRSP programme had been critical to the model’s success even in Lodhran. The PRSP District Support Officer, Lodhran/Vehari Division, was also a public servant currently seconded to PRSP for three years. He emphasized that knowing the government system had multiple benefits: ‘The file work, the audits, the financial system, all of this has a specific language in the government system that an individual from the private sector is not familiar with. Being from the public service one knows how these things work and what are the challenges. Therefore, one is better placed to engage with the system and avoid the hurdles.’ He further noted that being from the public service also meant that many of his own colleagues and batch mates were currently in the district government. They therefore gave him due respect and facilitated the working of the programme. As he argued, ‘In my case, they also know that I can later be back in this area at a senior government position where they might be reporting to me, so they won’t challenge me.’

Thus, when presenting the experience of the contracting out of BHUs in Pakistan as a successful case of privatization or public–private partnerships, there is a need for caution. The model works mainly because, in the words of one senior PRSP official,

‘there are government bureaucrats negotiating on both sides’. Without their experience of having worked in government, without the prestige accorded by the bureaucracy to some of the senior PRSP managers due to their prior employment as senior civil servants, and without having current government staff working on secondment who can use their networks to obtain the co-operation of the health bureaucracy, the model would not work. A private provider or an NGO cannot win these concessions. Thus, the replicability of this programme is much more restricted than is normally perceived.

More critically, despite being so deeply embedded within the state system, the model has managed to survive but not thrive within the health bureaucracy. The health bureaucracy on the whole remains resistant to the contracting-out process and has been attempting to win back control of it; in 2007, in fact, the Chief Minister of the time made an announcement to this effect. Interviews conducted in 2008 indicate that without the strong backing that the PRSP has received from the World Bank and the powerful lobbying of the Punjab Chief Minister, the model would have been scrapped at that point. Despite having improved service delivery on the ground, the Health Department remains reluctant to formally absorb the model, and the model’s continuity in the districts in which it operates remains contingent on winning three-year extension contracts. In the words of the PRSP senior manager: ‘The biggest challenge to the programme has been the civil service. The lower you go, the problem becomes more difficult. It is a very simple issue of turf. There is an issue of financial control as well as authority. It has been a very painful process.’ This puts the whole sustainability of the model into question. Further, it raises an even more pertinent

question: why can the same government bureaucrats improve efficiency within the BHUs when in their government positions they cannot?

#### **Section 4. Understanding resistance from the bureaucracy**

Interviews with government health officials showed that, while there was a clear issue of competition over resources and authority, there were also some genuine frustrations. As a senior official in the Punjab Health Sector Reform Programme based in the Lahore secretariat argued, if the success of the model rests in bypassing the routine government procedures, is the model viable? Most government officials acknowledged that the PRSP had introduced a more rigorous monitoring system, which improved staff attendance at the BHUs, and had developed a good medicine-supply system. But they also felt that PRSP was able to do this because it had special advantages. It was allowed to spend money differently: it did not have to abide by government standard procedures for the approval and release of funds. It was pointed out that PRSP was free to give medical officers at the BHUs the right to immediate purchase of items within a set price, as opposed to the standard government procedures. As one government officials noted, ‘government systems cannot be run in the long term on these special privileges’.

The critiques were even harsher at the lower tiers of district government. As one district-level health official argued: ‘In the case of our partnership with PRSP, it is strange that the budget is also ours and the building is also ours. What PRSP is investing into this partnership is not clear.’ Many district-level officials were highly

critical of PRSP's decision to double the salaries of the BHU doctors. In their view, the special incentives given under this programme to the doctors were having a negative impact on the overall government health-management system, as now doctors in the BHUs were being paid higher salaries than doctors in district hospitals. 'When government employees in higher tiers are getting paid less than what the BHU staff are earning,' argued one district level official, 'the resulting system could not be viable and practical.'

Such concerns about special concessions given to PRSP to manage the BHUs were widespread among the district government staff. Another official noted: 'They have been given so much power. The government doctors cannot purchase a pencil without approval, but under PRSP, the doctor can spend up to Rs1,000 without prior approval. Then these people invite the doctors for meetings and give them good lunches. The district officer has no budget at all for entertainment, so how can he offer such lunches at these meetings?' His view was that ideally what should have happened was that PRSP should have been given control of some of the malfunctioning BHUs, but not of the entire system.

The consensus was that the PRSP model had worked not because it had introduced some really innovative practices but because it was not encumbered by red tape, as government officials are. Many examples were given to this effect, in addition to the frequent reference made to differences in spending rules. As one official noted, 'PRSP could recruit doctors from any province, making it easier for it to fill vacant positions

for doctors in some rural BHUs. For us it was difficult to fill those positions, as we can only hire doctors or employees who have a Punjab domicile.’ He further highlighted that the government staff can end up for months without electricity because the bill has not been paid for some technical reason. Similarly, he pointed out the difference in facilities available to government staff: the Grade 19 officer is responsible for monitoring performance, but no facilities are provided for the monitoring. He also pointed that the method of working of the government system is also different: ‘If I have to go for monitoring visit tomorrow, someone from my office will already inform the area people and there will be 100 per cent attendance when I visit,’ he explained.

Given this widespread resistance in the bureaucracy, the question is: can this model be celebrated when its sustainability is constantly under threat? There are only two possible outcomes if the bureaucracy is to stay resistant to this model: one, the model will sooner or later be closed, as was to be the case in 2007 when the Chief Minister announced that the PRSP was to return responsibility for the BHUs to the Health Department; two, the bureaucracy will gradually build a justification for diverting the BHU budget to other health activities, making the introduction of user charges the only way to make the model sustainable. Given that BHUs are the lowest tier of government health provision, and that they cater to the most poor and rural populations, it is worth asking if a better approach would be to take this model as a learning experiment and to see how some of the reforms can be replicated within the government system, instead of presenting the model as an end in itself. Why should contracting out the BHUs to a third party be considered as the optimal option to be



pushed by international development partners? These questions are worth asking when studies show that at times small changes at the top and the introduction of appropriate incentives can make the lower tiers of the government bureaucracy dramatically improve service delivery (Tendler, 1998). Some other studies on the contracting out of health facilities in Pakistan have noted a similar need to retain a degree of focus on improving state capacity to ensure the effective delivery of basic health facilities (Ravindran, 2010; Shaikh et al., 2010; Khan, 2014).

The reason why this issue is highly relevant in the case of the PRSP model is that the model has succeeded in improving service delivery at the BHU level mainly because it has been managed by ex-government officials, or those seconded for a few years, who are offered attractive salary packages. The experience of working in the government and these officials' contacts within the bureaucracy have been key to enabling them to navigate day-to-day interactions with the health bureaucracy at the provincial and district levels. If these former and current government officials could be motivated to ensure efficient delivery at the BHU level when working under a PRSP contract, then the programme arguably provides a good model to demonstrate how they can be motivated to do the same under their government contracts. Discussions of this issue with such officials featured complaints about red tapism with the state system. One of the senior managers at PRSP Lahore provided three explanations for the improved performance of the officials in question: first, they had higher job satisfaction, as they could see that their work was having an impact; second, they were paid better in these positions than in their regular government position; third, they did not have to cope with the red tape that they had had to face

within the government system. As he argued, ‘The last factor in particular slows things down and takes away the initiative of officers within the government system’.

This particular officer went on to recount how on the previous day he had been told that the BHUs needed to purchase fresh beds before the arrival of the Chief Minister in a specific area. In the government system it would have been impossible to get these new beds in time, as for every big purchase the government officials first have to advertise for tenders and then select the supplier. Here at PRSP he was able to approve the purchase on the same day. Admittedly, applying major changes to state working practices remains a challenge for development interventions, as is evident in the repeated failure of aid-funded governance programmes; but, given the need for the state to shoulder some responsibility for provision of basic services to the poor, the ambition to improve state facilities cannot be abandoned entirely.

## **Conclusion**

This article has made two key contributions to public debate, one specific to the BHU model and the other, more generic, concerning the donors’ approach to privatization of service delivery. The article has shown that presenting the contracting out of BHU management in Pakistan as an example of the success of the privatization of basic health facilities or of public–private partnerships is questionable. It is not in fact a real public–private partnership, as PRSP is a government-owned NGO, which means that basically government bureaucrats have been negotiating on both sides. Without being so deeply embedded in the state system, PRSP would not have the expertise or

connections to ensure that the government officials co-operate with it to implement the model. Even if a private provider or a regular NGO were to succeed in getting the politicians to sign a contract to hand over the BHUs to them, it would fail to deliver, because the bureaucracy would make the day-to-day interactions extremely difficult. The PRSP could improve services within the BHUs only because of the strong personal networks of the PRSP staff within the government system, and their first-hand knowledge of how government works. Getting a partnership contract signed is not the real challenge; the execution of the contract requires detailed and highly complex ongoing negotiations between the health bureaucracy and the party taking over the management of state facilities.

Further, experience in Pakistan shows that such partnerships cannot be forced. The model has survived so far by effectively lobbying politicians to put pressure on the bureaucracy to comply with the system. The World Bank's strong endorsement of this model has helped in this lobbying process. This approach – applying political pressure to get the bureaucracy to comply, instead of making a genuine effort to convince the government officials to change their working practices – remains highly problematic. Sooner or later the bureaucracy is likely to convince the politicians to reverse the intervention or move towards full privatization of the given facility. The unstable nature of political authority makes intervention that is reliant entirely on political patronage highly vulnerable; change in government leads to the reversal of policies and programmes openly associated with a former government. At the same time, changing political alliances can mean that the same politician who favours a given model at one point in time might abandon it entirely when the alliance changes.

There is thus a need to look at Pakistan's BHU privatization experience through a different lens. Rather than promoting it as a successful case of privatization or public-private partnership in health care, the development agencies need to focus on supporting efforts that can help to replicate the lessons learned from this model to the health bureaucracy, with a view to improving state capacity to manage these basic health facilities. Studies of the contracting out of basic health facilities continue to identify the need to bolster the government health system while promoting the involvement of private and non-profit actors to ensure delivery of basic health care to all (Newbrander et al., 2011; Palmer et al., 2006; Liu, 2008); Admittedly, governance reforms remain difficult to initiate; but the efforts to this effect must not stop (Prentis, 2016; UNISON, 2016). While private health facilities are indeed used even by the poor, government-run BHUs remain critical health platforms utilized by the poor and lower-income groups in Pakistan. It is important that, while supporting the emergence of a vibrant private sector that can cater even to the poor (as many development agencies are doing through interventions funded under the M4P framework), these agencies also keep alive the agenda of improving state provision of basic services for the very poor. Sectors such as education and health cannot ever be entirely left to the market without raising serious concerns about equity (Prentis, 2016; UNISON, 2016).

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