



Policy Brief

ADDRESSING SERVICE DELIVERY GAPS IN KHYBER PAKHTUNKHWA: A COMPARATIVE ASSESSMENT OF OUTSOURCED AND NON-OUTSOURCED HEALTH FACILITIES. EXAMINING PUBLIC AND PUBLIC-PRIVATE PARTNERSHIP MODELS IN HEALTHCARE DELIVERY

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INTRODUCTION

Public-private partnerships (PPPs) have emerged as key policy instruments in Pakistan's health sector, particularly in response to persistent service delivery constraints in the public system. In Khyber Pakhtunkhwa (KP), the provincial government has adopted outsourcing and PPP arrangements to enhance access, improve service quality, and advance progress toward Universal Health Coverage (UHC). Through institutional mechanisms such as the Khyber Pakhtunkhwa Health Foundation (KPHF), health facilities, particularly in underserved and remote areas, have been outsourced to private and not-for-profit partners.

Despite measurable improvements in service availability and operational efficiency in outsourced facilities, the broader strategic potential of PPPs remains underutilised in the health sector. Evidence suggests that outsourced health facilities outperform non-outsourced facilities across multiple service delivery indicators, weaknesses in governance, regulation, institutional coordination, and policy coherence significantly constrain the long-term system-level impact.

This policy brief synthesises the findings from an evaluation of outsourced health facilities in KP, supplemented by national and international literature. It critically examines the performance of outsourced versus non-outsourced facilities, explores the governance architecture underpinning health sector PPPs, identifies systemic policy and institutional gaps, and proposes actionable reforms to address these issues. The brief argues that PPPs in KP have largely been deployed as a corrective response to public sector failure rather than as a strategically designed instrument for health system transformation. To realise their full potential, PPPs must be repositioned within a coherent policy framework that prioritises quality, accountability, sustainability and population-level health outcomes.



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RATIONALE

Globally, PPPs have been used to mobilise private sector efficiencies, managerial expertise and innovation in pursuit of public health objectives. In low- and middle-income countries (LMICs), they are increasingly viewed as a means to address fiscal constraints, improve service responsiveness, and enhance system resilience. In KP, shrinking fiscal space, human resource shortages, and governance bottlenecks necessitated alternative service delivery arrangements.

However, international evidence cautions that PPPs do not automatically yield improved health outcomes for all. Their effectiveness depends heavily on governance quality, regulatory oversight, alignment with health system goals, and the strength of contractual and accountability mechanisms in place. This brief therefore evaluates not only whether outsourced facilities perform better but also whether the enabling environment allows PPPs to deliver sustained and strategic value.

COMPARATIVE PERFORMANCE OF OUTSOURCED AND NON-OUTSOURCED HEALTH FACILITIES

1. Access, Patient Flow, and Operational Efficiency

Outsourced health facilities demonstrate substantially higher patient throughput and reduced waiting times than their non-outsourced counterparts. On average, outsourced facilities served approximately 641 patients per day, compared with 387 patients in non-outsourced facilities. Average waiting times were also significantly lower in outsourced facilities (16 minutes) than in non-outsourced facilities (22 minutes).

These findings suggest that outsourcing contributes to improved operational efficiency, which is a critical determinant of patient satisfaction and service utilisation. Improved workflow management, flexible staffing arrangements, and responsive procurement mechanisms appear to have underpinned these gains.

2. Service Availability and Utilisation

Outsourced facilities consistently offer a broader range of essential health services. They are more likely to provide blood transfusion services (71% vs. 57%), nutritional support for malnourished children and mothers (100% vs. 71%), comprehensive laboratory services across OPD, emergency, and inpatient settings (100% vs. 57–86%)

Similarly, the availability of Emergency Obstetric and Newborn Care (EmONC) services was higher in outsourced facilities (86%) than in non-outsourced facilities (71%). These differences highlight the potential of outsourcing to expand the service scope, particularly in areas where public facilities struggle to meet minimum service delivery standards.



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3. Quality of Care and Compliance with Standards

Compliance with Minimum Service Delivery Standards (MSDS), as notified by the KP Healthcare Commission (KPHCC), is notably higher in outsourced facilities. Approximately 29% of the outsourced facilities met the MSDS benchmarks, compared to 14% of the non-outsourced facilities.

While these figures remain suboptimal overall, they indicate a relative quality advantage for outsourced facilities. However, the absence of licencing by the KPHCC across both models underscores systemic weaknesses in regulatory enforcement and quality assurance.

4. Human Resources and Health Information Systems

Outsourced facilities outperform non-outsourced facilities in several managerial domains: More efficient emergency procurement processes, better availability and storage of essential medicines, improved human resource management practices, more consistent use of Health Management Information Systems (HMIS). These operational advantages reflect greater managerial autonomy and flexibility in the outsourced settings.

5. Resource Allocation and Financial Efficiency

A comparison of expenditure patterns revealed stark differences in resource utilisation. Outsourced facilities allocate approximately one-third of their budgets to non-salary operational expenses, compared to only one-fifth in non-outsourced facilities. This suggests a more balanced and efficient distribution of resources in outsourced facilities, enabling investments in medicines, diagnostics, and improved service quality.

6. Capacity Constraints and Lack of R&D

PPP management requires specialised expertise in health systems, finance, contract management, and strategic planning. The current institutional capacity is insufficient, and there is no dedicated research and development (R&D) function to support innovation, learning, and evidence-based policy refinement.

7. Delayed Fund Flows and Financial Rigidities

Outsourced facilities experience significant delays in fund disbursement, averaging four months compared to two weeks in non-outsourced facilities. The lack of financial autonomy and clear fund flow mechanisms discourages private partners and compromises service continuity.

8. Fragmented Monitoring and Evaluation

Multiple entities monitor, resulting in fragmented oversight and limited analytical depth. Current M&E systems focus on activity tracking rather than cost-effectiveness, value for money, or population-level impacts.



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POLICY RECOMMENDATIONS

To reposition PPPs as a strategic instrument for strengthening the health system, the following reforms are recommended:

1. Formulate a dedicated health sector PPP policy with a phased implementation framework aligned with UHC and health security goals.
2. Clarify institutional roles and accountability across departments to reduce duplication and delay.
3. Establish a strong interdepartmental coordination mechanism with decision-making authority.
4. A dedicated PPP management unit should be created within the Department of Health to provide strategic oversight and operational facilitation.
5. Enhancing institutional capacity through professional management, targeted training, and development partner support.
6. Strengthen regulatory oversight by linking contracts to quality standards, licensing, and performance-based incentives.
7. Standardise contracts and M&E frameworks to enable cost-benefit analysis, learning, and continuous improvement.
8. Invest in research and development to generate local evidence, support innovation, and inform policy changes.

CONCLUSION

Public-private partnerships in KP have demonstrated tangible benefits in terms of access, efficiency, and service availability. However, their transformative potential is constrained by governance and policy shortcomings. By addressing legal ambiguities, strengthening institutional capacity, and embedding PPPs within a coherent strategic framework, KP can leverage partnerships to manage facilities and build a resilient, equitable, and high-quality health system.