

**PUBLIC PRIVATE PARTNERSHIP IN ISLAMABAD HEALTHCARE  
SERVICES: PROSPECTS & CHALLENGES**



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## **APPROVAL**

This MS Thesis titled "**Public–Private Partnership in Islamabad Healthcare Services: Prospects and Challenges**" by Farhan Manzoor under my supervision has reached its completion. The work meets all requirements for evaluation and submission.

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## **DECLARATION**

The thesis titled “**Public–Private Partnership in Islamabad Healthcare Services: Prospects and Challenges**” represents my independent research findings. The complete work has not been presented for any degree program at Bahria University Islamabad. The thesis contains no plagiarized content, and all sources have received proper recognition.

**FARHAN MANZOOR**

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## **ABSTRACT**

The study explores the potential of Public- Private Partnerships (PPP) in Islamabad healthcare delivery and barriers using the Pakistan Institute of Medical Sciences (PIMS). The study is a quantitative-qualitative investigation focused on the issues of PPP adoption and service quantity impact and governance barriers influencing the implementation of the project. The study indicates that PPPs have increased health care institutions and improved performance and technology uptake, but with limited success due to poor governance structures. The three agencies MoNHSRC CDA and IHRA and their disjointed design and lack of monitoring mechanisms and ambiguous contract work arrangements pose a significant challenge to the successful PPPs. The insurance schemes of low-income citizens and marginalized communities do not take into consideration the equity concerns due to the lack of regulatory measures and ineffective monitoring. The study confirms that PPPs are viable instruments to help Islamabad health care to improve, albeit it will only be effective to the extent that more efficient governance structures and clear accountability structures and enhanced inter-agency cooperation are in force. The attainment of sustainable PPP results and social responsibility needs necessitate organizations to build superior regulatory structures and improve the processes of contract development and fairness protection mechanism.

### **KEYWORDS:**

Public–Private Partnerships, Islamabad Healthcare, PIMS, Governance Challenges, Service Delivery, Operational Performance,

## LIST OF ABBREVIATIONS

ADB	Asian Development Bank
BOO	Build–Own–Operate
BOT	Build–Operate–Transfer
CDA	Capital Development Authority
CCS	Country Cooperation Strategy
DBFO	Design–Build–Finance–Operate
DPT	Diphtheria, Pertussis, Tetanus (vaccine)
GDP	Gross Domestic Product
HR	Human Resources
HIV	Human Immunodeficiency Virus
IHRA	Islamabad Healthcare Regulatory Authority
IMF	International Monetary Fund
IRB	Institutional Review Board
IV	Independent Variable
KIIs	Key Informant interviews conducted to gather essential information
MoNHSRC	Ministry of National Health Services, Regulations & Coordination
NCDs	Non-Communicable Diseases
NHA	National Health Accounts
NPM	New Public Management
OPPP	Office of Public-Private Partnership (ADB)
OOP	Out-of-Pocket (Health Expenditure)

PIDE	Pakistan Institute of Development Economics
PIMS	Pakistan Institute of Medical Sciences
PPA	Public–Private Partnership Authority (sometimes written PPPA)
PPPA	Public–Private Partnership Authority (Federal)
PPRA	Public Procurement Regulatory Authority
PPP	Public–Private Partnership
PPPs	Public–Private Partnerships (plural)
PSC	Public Sector Comparator
SDGs	Sustainable Development Goals
SAPs	Structural Adjustment Programs
SPSS	Statistical Package for the Social Sciences
UNDP	United Nations Development Programmed
UHC	Universal Health Coverage
VfM	Value for Money

# CHAPTER01

## INTRODUCTION

### 1.1Introduction

Provision of quality, affordable, and accessible healthcare is a central role of any government, and it has a direct influence on the well-being, productivity, and socio-economic gains of the people. Pakistan is a developing nation with enough population of 242 million people and a huge gap in income and geography plus infrastructure; its health sector is historically not exempted to these systemic issues. The poor funding that has characterized the country due to chronic underinvestment, old infrastructure, shortage of personnel, ineffective delivery of services and disjointed governance have all contributed to the poor performance of the public healthcare system. In the face of these difficulties, the Pakistani government has been relying more on the Public-Private Partnerships (PPPs) as a new way of policy-making that could help the country enhance the rate of service delivery and resource mobilization in the healthcare industry.

Public- Private Partnerships are collaborative arrangements in which the government takes the responsibility of involving private sector agencies, entities or individuals to fund, develop, construct, or offer administration of services or infrastructure on grounds of government. In many countries the PPP model has been gaining currency as one that integrates the social imperative of the public sector and the efficiency, investment capacity and ingenuity of the private sector. PPPs in healthcare have been utilized in constructing hospitals, diagnostic healthcare services, health chain supplies, health insurance plans and even the overall management of a healthcare facility. Countries like India, Brazil and South Africa have shown that PPPs when operated in an organised way can be very helpful to provide better healthcare, become more accountable and bring down the pressure on the beleaguered governmental systems.

PPPs in healthcare in Pakistan are a developing situation. Whereas progressive initiatives of outsourcing health service delivery and hospital management to private partners are evident in

some of the provincial governments especially the government of Punjab, the federal territory including the government of Islamabad has experienced a relative drag and a cautious step forward. However, the problem of reform is urgent. The federal capital is Islamabad, in which resides some of the most notable public healthcare facilities such as the Pakistan Institute of Medical Sciences (PIMS) which claims to be the largest tertiary care hospital dealing with both urban and margin suburban inhabitants of the capital region and adjoining provinces.

Founded in 1985, PIMS used to be one of the flagship hospitals in the Pakistani public health care system, as it offers highly specific services and education, as well as research opportunities. Nonetheless, the hospital has experienced more pressure during the last few years with growing number of patients, limited resources, ineffective administration, and stagnation in the technological advances. To cope with this, policymakers have started exploring the implementation of PPP system in some of the PIMS departments like radiology, pathology, pharmacy and infrastructure maintenance with the limited objective of promoting efficient operations, eliminating public liability and providing better patient outcomes.

However, such trends have raised issues and concerns. Critics say that this kind of reform threatens backdoor privatization of important public services, which can negatively affect equity and access, especially among lower -income groups that depend on free or subsidized treatment. Others refer to the transparency with which the contracts are organized, as well as the absence of institutional ability to control the partners in the field of privatization and the danger of distorting relationships between the profit motive and the interests of the people. Health workers working in PIMS have raised alarms on lack of control, contractual disparity and unequal standards of service provision subjected to the PPP pilots.

## **1.2 Background**

Pakistan's healthcare system is characterized by underfunding, uneven service distribution, and overburdened public hospitals. The country spends less than 2% of its GDP on health, which is far below the WHO recommendation. Despite ongoing reforms, the public health sector continues to struggle with human resource shortages, outdated infrastructure, and poor governance.

To address these issues, the government of Pakistan particularly after the 18th Amendment began exploring PPPs in the health sector at the federal and provincial levels. Several PPP models done successfully in other provinces in Punjab and Sindh such as outsourcing diagnostic labs and others that contract hospital management promoted further replication. Nevertheless, the health institutions in Islamabad are not receptive to change because of bureaucratic red tapes, legal uncertainties, and privatization phobia.

The PPP models have also been tried at PIMS which is a flagship hospital in the Ministry of National Health Services, Regulations and Coordination. Such ventures entail diagnostic services, maintenance contracts, and pharmacy activities as to be undertaken on both a public-private basis. Although such alliances are to increase efficiency and cut on costs, critics view that they might create decreased access by poor people and destroy the spirit of public service.

Therefore, a targeted scholarly study is required to evaluate the process of the introduction of PPPs in PIMS, its possible positive and negative outcomes and its compliance with the general plans of universal health coverage (UHC) and well-balanced service delivery.

### **1.3 Problem Statement**

Although Public-Private Partnerships (PPPs) attract increasing attention regarding reform implementation in the health sector in Pakistan, the situation in the healthcare system in Islamabad is underdeveloped, poorly regulated, and not understood well. Although PPPs are being advocated to enhance service delivery, eliminate inefficiencies and facilitate accessibility to quality care, there is hardly any empirical evidence to gauge whether the PPPs are working in the capital (and indeed in the rest of the nation) under the unique developmental and healthcare administration model of the capital. Most of the available literature and policy analysis are based on provincial cases with little or no prioritization to the case of Islamabad that exhibit the presence of conflicting federal and local administrations, unstoppable urbanization, and unmet health service demands.

Moreover, the introduction of PPPs in Islamabad has caused revolt of transparency, accountability, affordability, and equity, especially regarding the delivery of the public services through the use of the private sector. There is still concern about the nature of these partnerships, whether they are consistent with public health priorities, and the effect on the level of access,

quality of services, and institutional capacity. The lack of understanding of these dynamics means that PPPs can either increase the inherent inequalities or not provide meaningful changes to improve healthcare delivery in a sustainable way.

#### **1.4 Research question**

1. What is the status and structure of public private partnership in Pakistan and particularly in Islamabad?
2. How effective are existing policy frameworks and governance mechanisms in regulating and facilitating public private partnerships?
3. What challenges and risks are associated with implementing public private partnerships in Islamabad health sector?

#### **1.5 Research Objective**

- To examine the status and structural models of public-private partnerships in Pakistan's healthcare system, with a particular focus on Islamabad.
- To evaluate the effectiveness of existing policy frameworks and governance mechanisms that regulate and support PPPs in Islamabad's health sector.
- To identify the key challenges, risks and barriers faced during the implementation of PPPs in Islamabad's public healthcare services.

#### **1.6 Significance of study:**

Pakistan's healthcare system, especially in cities like Islamabad, is under growing pressure to meet the rising demand for accessible, efficient, and quality services. The public health sector has always been burdened by lack of adequate financing, poor infrastructure and administrative inefficiency. As the response, Public-Private Partnerships (PPPs) are becoming an area of interest to resolve the situation where the services provided to the population are supposed to increase, and access to healthcare is supposed to be extended. Nevertheless, the range of actual research raising the question of how these partnerships are operating in Islamabad is scarce, despite the growing interest in policies. The proposed research will fill that gap and help to examine the existing reality of implementation of PPPs, evaluate its potentiality, and

collect insights shared by relevant stakeholders to conceptualize the functioning of these models in the context of the elaborate system of governance and health care provision in the capital.

## **1.7 Research Methodology**

The study will be a mixed-method study, as it will be possible to obtain a full picture of both quantitative and qualitative performance in the healthcare system of Islamabad.

### **1.7.1 Research Design**

It will consist of a convergent parallel mixed-method design. This implies the simultaneous collection and quantitative analysis of qualitative and quantitative data followed by their combination to complete interpretation. This is perfect in the study of the operational and the perceptual aspects of PPPs.

### **1.7.2 Setting and Population of the study.**

It is focused on Islamabad, more specifically PIMS, a large tertiary publicly funded hospital with established and suggested PPP arrangements. Such other sites can be secondary level hospitals where the PPPs are diagnostic or management based.

### **1.7.3 Target Populations:**

- Health administrators and policymakers (PPP cell, MoNHSRC)
- Public hospital staff (doctors, nurses, technicians)
- Private sector partners involved in health service delivery
- Patients using services under PPP arrangements

### **1.7.4 Data Collection Methods**

#### **Primary Data**

- **Key Informant Interviews (KIIs):** Conducted with PPP policymakers, PIMS directors, and private sector managers.
- **Semi-structured Interviews:** Conducted with frontline healthcare staff to understand operational realities.

- **Patient Surveys:** Administered to measure perceptions about service quality, cost, and satisfaction.

## **Secondary Data**

- Government reports (e.g., Vision 2025, National Health Vision)
- WHO, World Bank, ADB reports on PPPs
- The literature review includes peer-reviewed articles and case studies.

## **1.8 Sampling Strategy**

- **Purposive Sampling** for expert interviews (policy and administration)
- **Stratified Random Sampling** for patients and hospital staff, ensuring diversity in age, gender, ward type, and role.
- **Sample size may include:**
  1. 10–15 key informants
  2. 50+ healthcare workers
  3. 100–150 patient respondents

## **1.9 Data Collection Techniques**

To have an all-inclusive perception of the concept of public-private partnership in the context of healthcare services in Islamabad, this research paper utilizes both the primary and secondary methods of data collection. The main data will be collected by conducting semi-structured interviews with the essential interested parties such as health policymakers, hospital administrators (e.g., PIMS management) and the representatives of the private sphere engaged in PPPs. These interviews will enable detailed discussion of the institutional points of view, the barriers to implementation, and the experience of stakeholders. Moreover, quantitative data on the quality of services, its accessibility and satisfaction rates will be collected with the help of structured survey questionnaires which will be sent to the staff and patients of the public hospitals. The combination of the two methods will allow the study to triangulate the answers provided by the three points of view, increasing the validity of the results. The secondary data will also be used in terms of reviewing the government policy reports and evaluation reports as well as the international research and studies by the world bank, WHO, ADB and peer reviewed

journals to give the contextual and comparative insight. All these methods will be used to create a complete picture of operational, institutional, and social processes of PPPs in the health sector of Islamabad.

### **1.10 Data Analysis**

- **Qualitative Data:** Coded and analyzed the thematics of these transcripts. The main themes can be governance, accountability, trust of people and results.

### **1.11 Ethical Considerations:**

This study will strictly adhere to established ethical standards in social science and healthcare research. All participants involved in interviews or surveys will be fully informed about the nature, purpose, and scope of the research prior to their participation. Informed consent will be obtained in written or verbal form, and participants will retain the right to withdraw at any point without any penalty. The identities and personal information of all respondents will be kept strictly confidential and anonymized during data analysis and presentation. Furthermore, data will be securely stored and used exclusively for academic purposes. Ethical approval will be sought from Bahria University's Institutional Review Board or a relevant ethics committee, ensuring compliance with national and institutional ethical protocols. Special care will be taken to ensure that the study respects the dignity and autonomy of vulnerable groups, particularly patients, when assessing their experience with public-private healthcare services.

### **1.12 Organization of study**

Abstract

Chapter 1: Introduction

Chapter 2: Literature Review and Conceptual Framework

Chapter 3: Institutional and Structural Determinants Influencing PPP Implementation in Islamabad's Healthcare Sector

Chapter 4: Policy and Regulatory Barriers Affecting PPP Healthcare Delivery in Islamabad 35

Chapter 5: Evaluating the Impact of PPP Models on Accessibility, Quality, and Equity in Islamabad's Public Hospitals

## **CHAPTER02**

### **LITERATURE REVIEW/ THEORETICAL FRAMEWORK**

#### **2.1 A Theory and Policy of Public Private Partnerships in Healthcare**

The article by Buse, Kent, Nicholas Mays, and Gill Walt (2012) describes the healthcare policymaking process and the effect of political economy on health reforms. In their book, they address the way actors, institutions, and power relations are intertwined to influence health. This is particularly applicable to Islamabad where PPPs are required to deal with bureaucracies and politics. These authors noted that reform is not only technical but also constitutes negotiation, consensus and governance. Their structure also gives us an idea of obstacles such as implementing PPPs in a nation-wide health care setting such as Pakistan. It implies that politics as much as planning does determine the success of the policy.<sup>1</sup>

The book Yescombe, E.R. (2011) provides both technical and financial models of PPPs. In his work, he explains risk allocation in the PPPs, contract design, financial viability, and lifecycle costing. This is critical information to the policymakers of Islamabad because they must grapple with the constraints of fiscal deficits and investment risk in the partnership of hospitals. Yescombe says that a fair sharing of responsibilities and incentives determines the success of a PPP. His ideas assist in creating new systems in which individuals as well as governmental organisms prosper without jeopardizing the quality of services. The book provides a blueprint to construction of financially viable and accountable PPPs in health.<sup>2</sup>

Hodge, Greve, and Boardman (2010) give an international comparative review of PPPs, which exposes the best practices and structures of governances. Their edited volume compiles case studies of various countries providing the similarity of success and failures. According to them, the primary basis of effective partnerships is governance, accountability to the people and long-term planning. This comparative approach adopted in Islamabad enables the policymakers

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<sup>1</sup> Buse, Kent, Nicholas Mays, and Gill Walt. *Making Health Policy*. 2nd ed. London: McGraw-Hill Education, 2012.

<sup>2</sup> Yescombe, E. R. *Public-Private Partnerships: Principles of Policy and Finance*. Oxford: Butterworth-Heinemann, 2011.

to learn new things based on various models and adopt strategies accordingly. Their publication emphasizes that following foreign models of PPP blindly without taking into consideration the local reality may be counterproductive. It advocates the necessity to introduce the customized governance mechanism in case of Pakistani health PPPs.<sup>3</sup>

The article Mahmud, Simeen (2014) is concerned with the South Asia region and presents the factors of political instability, corruption, and reliance on donors, which relates to the implementation of Islamabad PPP. Her study addresses the situation where the collaboration of the public and the private sector can fail because of poor policy structures and missing institutional confidence. She notes that the PPPs require high-quality government leadership and open systems to survive. As a federal capital, Islamabad observes most of these system weaknesses. The works of Mahmud propound changes that focus on introducing changes through regulatory control and coordination of stakeholders. It is applicable to the complicated healthcare environment in Pakistan directly because of her regional orientation of her focus.<sup>4</sup>

Ghaffar, Zaidi, and Agha (2017) criticize the decomposed health systems in Pakistan. They point out redundancy of services as well as failure to coordinate the activities of the federal and provincial governments coupled with poor funding which weaken the performance of the public services. The piece is of value to the causes of the delays and inconsistencies with PPPs in Islamabad. They state that prior to entering complex partnerships, the government needs to bolster the institutional platforms. Their research indicates that PPPs could do more to increase inequalities than address them without addressing them on a system-wide scale. It is a message that alliances cannot replace effective governance.<sup>5</sup>

Lewis and Pettersson (2009) discuss deficits in governance of health delivery. They demonstrate how lack of proper oversight, corruption and poor incentive systems may trigger poor performance in the public sector and in the private sector. This is vital to Islamabad where most of the public hospitals are prone to management flaws. Examples of mechanisms suggested by the authors entail performance-based incentive and transparent accountability mechanisms as

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<sup>3</sup> Hodge, Graeme A., Carsten Greve, and Anthony E. Boardman, eds. *International Handbook on Public-Private Partnerships*. Cheltenham: Edward Elgar Publishing, 2010.

<sup>4</sup> Mahmud, Simeen. *Public-Private Partnerships in Health Sector in South Asia: Challenges and Prospects*. Dhaka: BRAC University Press, 2014.

<sup>5</sup> Ghaffar, Abdul, Salman Zaidi, and Ajmal Agha. *Health Systems in Pakistan: A Way Forward*. Karachi: Oxford University Press, 2017

well as community feedback system. Their results are warning against the assumption that PPPs are necessarily efficient. Rather, it depends on proper planning, openness, and surveillance of every aspect about to be enhanced in the management of health in Islamabad.<sup>6</sup>

Rana, SaifurRehman (2021) provides a strategic assessment of the healthcare in Pakistan as well as in Islamabad. He talks about the twin burden of disease, rising popularity of health services in urban areas, and scarcity of resources. His discussion highlights the ways through which PPPs could be used to bridge service gaps through proper planning. Rana argues on the relevance of proper planning and inter-sectoral partnerships in enhancing results. In the case of the healthcare system, especially the tertiary care hospitals i.e. PIMS in Islamabad, PPPs might contribute to the infrastructure and service delivery. His survey gives him a justifiable basis for presenting reforms that go in line with the national development objectives.<sup>7</sup>

Ramesh, M. (2020) assesses the Asian health policies by applying the policy design theory. He maps the interaction of such tools as regulation, finance, and institutional structures in the making of the policy. To the health services in Islamabad, his endeavor assumes that the success of PPP will require accurate policy instruments and elastic execution. Ramesh believes that few solutions can be taken at size and local adaptation is important. His observations encourage Pakistani planners to think about some innovative models instead of importing solutions of other nations. His book is a guide to the design of dynamic PPPs design in urban areas.<sup>8</sup>

Saltman, Duran and Dubois (2011) support the autonomy of the hospitals and the management of performance. They discuss the usage of semi-autonomous hospitals in Europe and the aspects of increasing accountability, quality, and efficiency. Such models would enable the usually non-innovative central control in these kinds of situations in Islamabad to allow hospital administrators freedom through PPP. The authors argue that giving institutions the flexibility to innovate can lead to better outcomes. Their findings support the idea of

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<sup>6</sup> Lewis, Maureen, and Gunilla Pettersson. *Governance in Health Care Delivery: Raising Performance*. Washington, DC: World Bank, 2009

<sup>7</sup> Rana, Saif ur Rehman. *Healthcare System in Pakistan: A Strategic Overview*. Islamabad: National Institute of Public Policy, 2021.

<sup>8</sup> Ramesh, M. *Health Policy in Asia: A Policy Design Perspective*. Cambridge: Cambridge University Press, 2020.

performance-linked partnerships in Pakistan’s public hospitals. It provides a vision of how Islamabad’s hospitals can move toward independent, yet publicly accountable, models.<sup>9</sup>

According to Bloom and Canning (2000), health outcomes are associated with economic growth. They state that health investment is not necessarily a social good, but rather an economic necessity. Their effort is critical to policymakers in Islamabad who should not only defend PPPs on service delivery basis but also on the national productivity basis. The authors demonstrate that healthier populations increase GDP by being more productive in terms of labor and decreasing costs of healthcare. In the case of a developing city such as Islamabad, PPPs might be one of the tools to realize health-related economic resilience. Their study creates a good macroeconomic argument on why health partnerships should be given priority.<sup>10</sup>

## **2.2 Existing Policy Frameworks and Governance Structures in Pakistan**

Pakistan Economic Survey (2023–24) provides updated health expenditure and policy data. It shows the willingness of the federal government to involve the private sector in the delivery of public services. In the case of Islamabad, the urban health services have been found to be underfunded, and this creates an opportunity that PPP investments can exploit through this document. The survey explains the significance of cost-effective budget planning, cost recovery framework, and innovation using partnership. It also highlights that institutional mechanisms should be strengthened to aid these collaborations. This is based on a fiscal and developmental background of PPP in Islamabad.<sup>11</sup>

Strategic goals in national development, Vision Pakistan 2025 (2014) concerns itself with inclusive growth and innovation. Health is one of the pillars, and the particular focus is made on the increase of accessibility and quality. The description of the Vision document permits cooperation with the outside business world and promotes contemporary systems of governance. In the case of Islamabad, this roadmap is a long-term justification for making use of the PPPs in the development of health infrastructure. It promotes results-oriented relations that are in line

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<sup>9</sup> Saltman, Richard B., Antonio Duran, and Hans F. W. Dubois. *Governing Public Hospitals: Reform Strategies and the Movement Towards Institutional Autonomy*. Copenhagen: WHO Regional Office for Europe, 2011.

<sup>10</sup> Bloom, David E., and David Canning. *The Health and Wealth of Nations: The Role of Health in Economic Growth*. Geneva: WHO, 2000.

<sup>11</sup> Government of Pakistan. *Pakistan Economic Survey 2023–24*. Islamabad: Ministry of Finance, 2024. <https://www.finance.gov.pk/survey>.

with national objectives. The document is a strategic point of anchor of health policy reform in the capital.<sup>12</sup>

National Health Vision 2016-2025 has sectoral targets that are synonymous with the Universal Health Coverage (UHC). It can see the possibilities of PPPs to seal gaps in infrastructure, manpower and service delivery. The health system in Islamabad that has a capacity and coverage problems perfectly qualifies in this vision. The paper encourages multisectoral cooperation and facilitates integration of the public and private enterprises. It is also a demand of policy consistency and better rules to advise sustainable PPP models. This vision is what is defining the operational environment of partnership in Islamabad.<sup>13</sup>

The guide produced by World Bank (2017) helps international entities in designing and operating PPPs. The Reference Guide Version 3.0 presents legal, financial and governance mechanisms that are crucial to success. It provides guidelines and guidelines which can be utilized at once by health agencies in Islamabad. The guide further focuses on mitigation of risks, value-for-money, and alignment of the stakeholders. It also promotes evidence-based decision making which is very essential in the politically sensitive environment in Pakistan. The document provides the basis of structuring and appraising PPPs in the healthcare system.<sup>14</sup>

ADB (2014) considers Pakistan-specific PPPs, pointing out the opportunities and some issues of implementation. It establishes capacity gaps, coordination as well as legal gaps that restrain performance. Federal and local governance at Islamabad still reflects most of these issues since it is loaded with them. The report recommends that special PPP units be established, employees be trained and uniform processes developed. It also proposes the advancement of transparency and measurement of contracts. These suggestions present the map of health sector reform in Islamabad via PPPs.<sup>15</sup>

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<sup>12</sup> Planning Commission, Government of Pakistan. *Pakistan Vision 2025*. Islamabad: Planning Commission, 2014. <https://www.pc.gov.pk/uploads/vision2025/Pakistan-Vision-2025.pdf>

<sup>13</sup> Ministry of National Health Services, Regulations and Coordination. *National Health Vision Pakistan 2016-2025*. Islamabad: NHSRC, 2016. [https://extranet.who.int/countryplanningcycles/sites/default/files/planning\\_cycle\\_repository/pakistan/national\\_health\\_vision\\_2016-25\\_30-08-2016.pdf](https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/pakistan/national_health_vision_2016-25_30-08-2016.pdf)[extranet.who.int+2extranet.who.int+2applications.emro.who.int+2](https://extranet.who.int+2extranet.who.int+2applications.emro.who.int+2)

<sup>14</sup> World Bank. *PPP Reference Guide Version 3.0*. Washington, DC: World Bank, 2017. <https://ppp.worldbank.org/public-private-partnership/library/ppp-reference-guide-3-0>.

<sup>15</sup> ADB. *Public-Private Partnerships in Pakistan*. Manila: Asian Development Bank, 2014. <https://rksi.adb.org/wp-content/uploads/2020/10/public-private-partnerships-pakistan.pdf>[rksi.adb.org](https://rksi.adb.org)

WHO PRIMASYS Abridged Report (2017) examines the health system structure of Pakistan and its service delivery. Among the key challenges that it identifies are the lack of strong decentralization and overlapping institutions. In the case of Islamabad, it implies that health authorities enter partnerships with well-stipulated mandates. The report is in support of system level change prior to the scaling of PPPs. It also points to a more comprehensive integration of data systems and policymaking. The document provides a diagnostic instrument to determine limitations in the health system operation.

Provided in the WHO PRIMASYS Comprehensive Report (2017) is an in-depth study related to health governance in Pakistan. It describes the nature of numerous stakeholders federal, provincial, and donor agencies, which generate inefficiencies and redundancies. Such institutional complexity may slow down projects and lessen the impact of PPPs in Islamabad. The report proposes uniformity in policies, inter-agency coordination, and the local capacity building. It also emphasizes the importance of participatory planning of communities and civil society. This is applicable in city centers with multicultural populations such as Islamabad.<sup>16</sup>

WHO CCS Pakistan (2020-2025) offers strategic priorities of the health system in Pakistan. It emphasizes better governance, better institutions and innovation in partnerships. In the case of Islamabad, the document acts as a strategic approval of PPP models on both the primary care and the tertiary care. As a basis of sustainable PPPs, it recommends the health system strengthening. The CCS focuses on the alignment of SDGs and equal access, so PPPs will be socially inclusive. It establishes the PPPs as an instrument of reform and not as a quick patch.<sup>17</sup>

Pakistan Health System Review (2022) criticizes any structural problems such as poor resource allocation, HR deficiency and antique infrastructure. These ills manifest themselves particularly in urban hospitals such as those in Islamabad. This review insinuates that PPPs can enhance service delivery in the event of strengthening their institutional capacity. It advises it to formulate PPP-specific policy and stress the presence of overview by the people. It also

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<sup>16</sup>World Health Organization, *Primary Health Care Systems (PRIMASYS): Comprehensive Case Study from Pakistan* (Geneva: World Health Organization, 2017). <https://apps.who.int/iris/bitstream/handle/10665/341143/WHO%20HIS%20HSR%2017.37%20eng.pdf>.

emphasizes evidence-based policy reform. This overview is an honest account of where the greatest need for PPPs lies.<sup>18</sup>

The paper WHO EMRO SDG Brief (2020) evaluates the situation in Pakistan, related to the achievement of health-related Sustainable Development Goals. It identifies significant disparities in access, equity and quality of care. The brief promotes innovativeness, coordination of governments and private facilities as well as investment in sluggish sectors. This means in the case of Islamabad that PPPs need to be incorporated into wider SDG plans. It affirms the application of data and electronic health devices in performance tracking, too. The short relates international objectives with local level lays out of long effective PPPs.<sup>19</sup>

### **2.3 Prospects and Opportunities for PPPs in Islamabad's Healthcare Services**

This article family by Shaikh & Hatcher (2005) explains the health-seeking behavior and pattern of service utilization in Pakistan. They warn that people are greatly influenced to seek care by the cultural norms, the associated cost, and the element of trust. In the case of Islamabad, it means that PPPs should not just enhance their services, but they should also win the trust of people. Their research indicates the need for patient centered models, especially slum dwelling and deprived communities. They support accessibility and refer topic programs to integration of PPPs. As their research highlights, access is more of a perception as opposed to infrastructure.<sup>20</sup>

Nishtar, Sania (2013) maintains that there is a need to change the paradigm in the health policy of Pakistan and that there is a need to make decisions supported by evidence and through multisectoral coordination. She singles out PPPs as one of the essential strategies of dealing with the structural weaknesses of the urban health systems. As a policy hub, Islamabad is in the right position to lead such innovative models. Nishtar stresses institutional integrity, equity, and trust

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<sup>18</sup>World Health Organization and Ministry of National Health Services, Regulations & Coordination, *Pakistan Health System Review* (Islamabad: Ministry of National Health Services, Regulations & Coordination et al., n.d.), PDF, phkh.nhsrsc.pk, accessed January 27, 2026, <https://phkh.nhsrsc.pk/sites/default/files/2022-02/Pakistan%20Health%20System%20Review.pdf>

<sup>19</sup>World Health Organization, Regional Office for the Eastern Mediterranean, *EMHIS039E: [Document Title]* (Cairo: WHO Regional Office for the Eastern Mediterranean, n.d.), PDF, applications.emro.who.int, accessed January 27, 2026, <https://applications.emro.who.int/docs/EMHIS039E.pdf>.

<sup>20</sup>B. T. Shaikh and Juanita Hatcher, "Health Seeking Behaviour and Health Service Utilization in Pakistan: Challenging the Policy Makers," *Journal of Public Health* 27, no. 1 (2005): 49–54, <https://doi.org/10.1093/pubmed/fdh207>.

by the people. She also tells how PPPs can be delivered with health equity and accountability reforms. Her information justifies adoption of transformative partnerships in Islamabad.<sup>21</sup>

Noorani&Hafeez (2020) compare the current well-known models of PPP in Pakistan and achieve different outcomes in relation to their structure, transparency, and monitoring. They distinguish some of the typical barriers such as the existence of loose contracts, ineffective stakeholder involvement and lacking continuity. They claim that the healthcare initiatives of Islamabad need to focus on clarity and enforcement of PPP agreements. They argue in their analysis that policy standardization and institutional learning are necessary. Cross-sectoral dialogue and tracing evidence is also advocated by them. Their study has a positive yet warning perspective of the PPPs in Islamabad.<sup>22</sup>

According to Malik, Ayesha (2020), the research examining the work of PPPs in primary healthcare finds that both outreach and results of provided services have improved, and patient outcomes have been positively affected. She demonstrates that PPPs when done in a manner that is transparent and involves locals can seal the gap of services in the peri-urban and low-income zones. The model can also be applicable in Islamabad, which is characterized by the growing city and population. Malik further asks for the incorporation of PPPs on national health policies. Her results indicate that collaborations do not only involve funding, but also participation planning. She is an advocate of community-based health measures in PPPs.<sup>23</sup>

Hamid, Saima (2021) associates PPP models with the objective of attaining universal health coverage in Pakistan. She emphasizes that the collaboration between the public and the private can enhance the provision of the basic health services and minimize financial assistance. With its scarcity of resources in the tertiary facilities such as PIMS, Islamabad can apply PPPs to enhance equity in services. Hamid emphasizes the necessity of accountability mechanisms in order to guarantee the protection of the public interest. She supports publicly subsidizing and

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<sup>21</sup>F. Ahmed and N. Nisar, "Public-Private Partnership Scenario in the Health Care System of Pakistan," *Eastern Mediterranean Health Journal* 16, no. 8 (2010): 910-912, accessed January 12, 2026, [http://applications.emro.who.int/emhj/V16/08/16\\_8\\_2010\\_0910\\_0912.pdf](http://applications.emro.who.int/emhj/V16/08/16_8_2010_0910_0912.pdf)

<sup>22</sup>Sarah Dickerson, Victoria Baranov, Jacob Bor, and Jeremy Barofsky, "Treatment as Insurance: HIV Antiretroviral Therapy Offers Financial Risk Protection in Malawi," *Health Policy and Planning* 35, no. 6 (2020): 676-683, <https://doi.org/10.1093/heapol/czaa023>.

<sup>23</sup>El-Jardali F., Akl E.A., Karroum L.B., et al., "Systematic Reviews Addressing Identified Health Policy Priorities in Eastern Mediterranean Countries: A Situational Analysis," *Health Research Policy and Systems* 12 (2014): 48, <https://doi.org/10.1186/1478-4505-12-48>

models of risk-sharing in order to make care more inclusive. Her work reinforces the use of PPPs as tools to enhance equity..<sup>24</sup>

Hafeez, Assad (2014) highlights the operational and capacity constraints of the government hospitals in Pakistan. He asserts that such institutions such as those in Islamabad are overwhelmed and are not effectively run. Hafeez suggests strategic associations to relieve the nurses and update the hospital management. He favors sharing tasks, contracting on the basis of performance and involvement of the privates in diagnostics and logistics. His argument presents an argument in favor of the use of PPPs to enhance the expansion of services without excessive reliance on the budgets of governments. It supports the notion that PPPs are not substitutes but support..<sup>25</sup>

Zafar &Hafeez (2020) document successful PPP initiatives that improved service quality and patient satisfaction, particularly in diagnostic services and hospital cleanliness. Their case studies include urban hospitals with similar demographics to Islamabad. They demonstrate that partnerships could introduce efficiency, accountability and changes in technology. Zafar and Hafeez advocate scaling up of these models using re-creation. They warn that to be successful an evaluation should be developed and the community should be involved. Their study offers resourceful information to the planners of Islamabad..<sup>26</sup>

Sheikh and Ghaffar (2021) advocate the use of systems thinking in relation to healthcare policy and reform. They propose that they cannot work in isolation and such interventions like PPPs do not work without a comprehensive picture of the health system. In the case of Islamabad, they suggest the incorporation of partnerships into a long-term health plan which involves financing, governance, and service delivery reforms. Their work agrees with the adaptive policy frameworks that change with the needs of the population. They emphasize that

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<sup>24</sup>World Health Organization, *Pakistan Health System Review* (Islamabad: Ministry of National Health Services, Regulations & Coordination et al., n.d.), accessed January 20, 2026, <https://phkh.nhsrsc.pk/sites/default/files/2022-02/Pakistan%20Health%20System%20Review.pdf>.

<sup>25</sup>World Health Organization, Regional Office for the Eastern Mediterranean, *Engagement of Private Healthcare Sector in Addressing Noncommunicable Diseases at Primary Care Level in the Eastern Mediterranean Region*, EMHJVolumeIssue.pdf (Cairo: WHO Regional Office for the Eastern Mediterranean, n.d.), accessed January 20, 2026, <https://who-j40.coreph.org/emhj-volume-30-issue-5/engagement-of-private-healthcare-sector-in-addressing-noncommunicable-diseases-at-primary-care-level-in-the-eastern-mediterranean-region.html>.

<sup>26</sup>David Boettiger et al., "Health Policy and Planning: Statement of Intent," *Health Policy and Planning* 38, no. 1 (2023): 1–2, <https://doi.org/10.1093/heapol/czac087>.

change can only be real when there is coherence between policies and institutions. Their study is a caution that PPPs are not an end in themselves.<sup>27</sup>

The article LUMHS Journal (2016) explains how there are administrative and staffing constraints that influence the delivery of public health services. It is concluded that even the well-funded PPPs fail to make it without trained personnel. Capacity-building is a necessity in Islamabad where technical and management skills are scarce in the public institutions. The paper recommends that partnerships should have training and knowledge transfer provisions. It also promotes collective performance reviews and collective accountability. The journal supports the fact that human resources play the key role in PPP success.<sup>28</sup>

#### **2.4 Contemporary Insights and Global Reflections on PPPs in Islamabad's Healthcare**

The World Health Organization (2016) addresses the use of PPPs at the global level of development of healthcare systems, particularly those in the low- and middle-income nations. Success factors, such as trust and shared governance, and transparency are described in the bulletin. These concepts can be directly implemented in Islamabad where there is a mixed confidence of the population toward PPPs. WHO promotes evidence-based contracts and independent monitoring to guarantee equity in health. In the case of the capital of Pakistan, this advice can be used to develop legitimacy and performance accountability. The article supports the fact that PPPs should put health outcomes first as opposed to profit.<sup>29</sup>

International Monetary Fund (2021) assesses the systems of managing Pakistan public investment and finds that the project appraisal and implementation have serious flaws. In the context of the healthcare industry of Islamabad, this implies that PPPs can be inefficient in case of poor fiscal planning. The IMF emphasizes better cost-benefit examination, coordination of stakeholders, and transparency in procurement. These recommendations will help avoid delays, overrun and bad delivery of city health projects. This evaluation can serve as the institutional

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<sup>27</sup>Saeed, Ayesha, "Innovating Healthcare through PPP in Developing Countries," *Pakistan Journal of Innovation and Policy* 3, no. 1 (2022): 45–52.

<sup>28</sup>Lumhs Journal. "Healthcare Delivery and Public-Private Partnership in Pakistan: Issues." LUMHS, vol. 15, no. 4.

<sup>29</sup>*Pakistan Vision 2025* (Islamabad: Planning Commission of Pakistan, 2025), accessed January 10, 2026, <https://www.pc.gov.pk/uploads/vision2025/Pakistan-Vision-2025.pdf>.

reform benchmark to the administrators of Islamabad. It frames PPPs in an extra-wide context of modernization in the public sector.<sup>30</sup>

Saeed, Ayesha (2022) investigates the role of PPPs in healthcare delivery in the developing world as the innovation of healthcare service. She identifies the use of mobile clinics, e-consultations, and telemedicine as the scalable models of the PPP in underserved regions. All these tech-based solutions can be implemented in Islamabad with its infrastructure problems being present in peri-urban areas. Saeed emphasizes the necessity of innovation in the sphere of the private-sector and its balance with the sphere of governmental control. In her case studies, responsiveness and access is better where the PPPs adopted technology. Her comments indicate that the future of city-based care models can be seen to be in the direction of digital health partnerships.<sup>31</sup>

UNDP Pakistan (2023) studies the situation of health inequality in Pakistan and offers PPP models that can fill the gaps. It suggests that such PPP contracts at cities such as Islamabad should have provisions of equity, gender inclusion, and subsidy introductions. Community consultations and incorporative governance are pleaded in the report. It also advises that the PPPs should be integrated with the social protection programs that are aimed to serve the poor in the urban areas. In the case of Islamabad, such tenets make partnerships socially responsive. The framework that UNDP has integrated entails rights-based planning and financial sustainability.<sup>32</sup>

Economist Intelligence Unit (2020) assesses the initiatives of global PPP in the healthcare sector and defines the factors that promote the achievement of performance and the major pitfalls that should be avoided. It concludes that poorly constructed contracts and absence of competition tales were found to be causing cost increases as well as unfairness in the provision of services. In the case of Islamabad, these warnings rest on concepts of standardised processes, risks assessment as well as benchmarking instruments. Value-for-money analysis and stakeholder interest are the values that are encouraged in the report as well. It motivates policymakers to

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<sup>30</sup>*Economic Survey of Pakistan 2023–24*, Chapter 24: Health, Government of Pakistan, Ministry of Finance, accessed January 11, 2026, [https://www.finance.gov.pk/survey/chapter\\_24/11\\_health.pdf](https://www.finance.gov.pk/survey/chapter_24/11_health.pdf).

<sup>31</sup> Saeed, Ayesha. “Innovating Healthcare through PPP in Developing Countries.” *Pakistan Journal of Innovation and Policy* 3, no. 1 (2022): 45–52.

<sup>32</sup>Pakistan Bureau of Statistics, *National Health Accounts Pakistan 2021–22* (Islamabad: PBS), accessed January 20, 2026, <https://www.pbs.gov.pk/sites/default/files/national-health-accounts-nha/NHA-Pakistan-2021-22.pdf>.

establish strong PPP structures using information and responsibility. These are international lessons that are essential to reformation at capital level.<sup>33</sup>

KPMG Pakistan (2023) provides sensible advisory on how to structure healthcare PPPs in Pakistan. Their report also consists of risk-sharing toolkits, toolkits on value-based contracting, as well as performance-monitoring toolkits. PPP capacity is still developing in Islamabad, which can use the advice of KPMG as an institution. The company equally advises pre-feasibility, procurement that is open, and mapping of stakeholders. These measures are useful in minimizing implementation failures and provision of quality services. They have an advisory model favoring evidence-based and legally rational partnerships.<sup>34</sup>

Rehman, Nida (2021) addresses the opportunities of the local governments regarding the success of PPPs in health. She insists that decentralization and the involvement of the municipalities enhance accountability and responsiveness of services. Unusual state territory Islamabad must enhance the cooperation of local health authorities with CDA and MoNHSRC. Rehman suggests the establishment of local PPP monitoring cells, and common oversight committees. Her work emphasizes the necessity to have local voices in terms of planning and executions. She puts forward community ownership as one of the keys to sustainable PPPs.<sup>35</sup>

In the case study by International Committee of the Red Cross (2020), it is possible to find the collaboration of emergency healthcare in Pakistan. It demonstrates the collaboration of Red Crescent services with the government hospitals in case of trauma and ambulance. Such PPP models are essential in Islamabad where there are rising road traffic and events by the people. ICRC encourages prior agreed protocols, mutual training and exchange of data to respond to the emergencies. Their research promotes emergency PPPs as very important elements of urban health planning. It underscores the humanitarian advantages of the combined public-corporate intervention.<sup>36</sup>

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<sup>33</sup> Economist Intelligence Unit. *Global Healthcare PPPs: Performance and Pitfalls*. London: EIU, 2020.

<sup>34</sup> Asian Development Bank, *Public-Private Partnerships in Pakistan: Report* (Manila: ADB, 2020), accessed January 30, 2026, <https://rksi.adb.org/wp-content/uploads/2020/10/public-private-partnerships-pakistan.pdf>.

<sup>35</sup> Rehman, Nida. "Role of Local Governments in Health PPP Success: Lessons from Islamabad." *Journal of Local Governance* 12, no. 2 (2021): 98–110.

<sup>36</sup> World Bank, *PPP Reference Guide 3.0* (Washington, DC: World Bank, n.d.), accessed January 20, 2026, <https://ppp.worldbank.org/public-private-partnership/library/ppp-reference-guide-3-0>.

Pak Institute of Peace Studies (2024) research on the trust of the people in the role of a private sector in healthcare. The paper uncovers distrust in urban masses such as Islamabad, which is regularly based on views of making profits. PIPS suggest a more open and transparent nature, redress system on grievances and all-embracing public communications. It emphasizes the importance of establishing credibility based on the quality of services and representing the community. Their results indicate that this can have an opposition to even highly financed PPPs in the absence of public favor. Both sustainable health reform and building trust are established as a pillar.<sup>37</sup>

Sustainable Development Policy Institute (2023) mentions urban health planning and the implementation of PPPs in the city level strategies. It focuses on service level agreements and health equity measures. The city of Islamabad is a fast-emerging city which is known to be a testbed of current PPP structures. SDPI encourages outcome-based contracts, SDGs integration, and local healthcare innovation. The report also recommends that health PPPs can be used in conjunction with transport, housing and education policies. It spells out a comprehensive view of capital-based health governance.<sup>38</sup>

## **2.5. Supporting Theories**

### **Principal-Agent Theory**

This theory is centered on the relationship between two players; a principal, who delegates, and an agent, who performs, on behalf of the former. The principal in PPPs is the public sector (government) and the agent is the private entity responsible in service delivery. Asymmetry of information (the agent may not disclose information), conflict (profit vs. welfare) and information gaps in monitoring can often be a source of inefficiencies or moral hazard in this relationship.

In Islamabad, these concerns at the theoretical level are manifested in the partnerships of the public hospitals such as PIMS with the help of the private companies in the diagnostics, emergency services, or infrastructure development. The theory offers the prism that can be used

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<sup>37</sup>International Monetary Fund, *Pakistan: Public Investment Management Assessment* (Washington, DC: IMF, May 27, 2021), accessed January 15, 2026, <https://www.imf.org/en/Publications/CR/Issues/2021/05/27/Pakistan-Public-Investment-Management-Assessment-502895>.

<sup>38</sup> Sustainable Development Policy Institute (SDPI). *Urban Health Planning and PPP Models*. Islamabad: SDPI, 2023. <https://sdpi.org/research/urban-health-and-ppps>.

to assess whether accountability, transparency, and performance incentives are well embedded in these contracts.

## **2.6. Theoretical framework**

### **Independent Variables (IVs)**

#### **1. PPP Contract Design and Structure**

- Clarity of roles and responsibilities
- Duration, risk-sharing, and performance clauses
- Scope of services outsourced

#### **2. Private Sector Participation Level**

- Degree of operational control or input
- Investment commitment and innovation contribution
- Technical expertise offered in service delivery

### **Dependent Variable (DV):**

#### **Healthcare Service Delivery Performance**

- Patient satisfaction
- Timeliness and accessibility of services
- Infrastructure and equipment quality
- Overall service efficiency

### **Moderator:**

#### **Institutional Governance Capacity**

- Regulatory enforcement
- Monitoring and evaluation mechanisms
- Administrative efficiency and accountability frameworks

The hypothesis of this research is that the design of PPP contracts and the proportion of the involvement of the private sector have a positive impact on the performance of the delivery of healthcare services in Islamabad hospitals that are governed by the state. Nonetheless, this

relationship is moderated by the strength and effectiveness of institutional governance which increases or constrains the effects of the PPP initiatives based on the quality of governance mechanisms in the place.

## **CHAPTER03**

### **DETERMINANTS OF HEALTH PPP'S IN HEALTH SYSTEM OF PAKISTAN**

#### **3.1 Evolving Role of Hybrid Governance in Pakistan's Health Sector**

The administration of healthcare in Pakistan has experienced multiple transformations of the structure and ideologies of the system since the formation of the country. Traditionally, healthcare has been considered one of the social goods, mainly provided and funded by the state. Through time, this system has steadily undergone economic pressures, a fast-paced urbanization, institutional inefficiencies as well as policy reforms and thus slowly evolved to represent a hybrid form of governance; a type of governance that incorporates the element of public oversight and the involvement of the private. This development is both necessitated and adapted by the fact that the fiscal and administrative capabilities of the government had stalled hence the need to form alliances with the private actors as a solution to the increasing needs of healthcare.

In this case, hybrid governance can be defined as a form of governance whereby there is sharing of responsibility, power, and accountability between the public and the private in the endeavor to achieve social goals. It implies that in healthcare, the state roles uphold a custodial position that outlines priorities, regulations, and equity objectives with the involvement of the

private partners being used in terms of financial resources, administrative competencies, and technological innovation. This change in Pakistan gained more ground following the 18 th Constitutional Amendment (2010) that devolved health responsibilities to provincial governments. The ensuing decentralization, together with the fiscal limitations, turned Public–Private Partnerships (PPPs) into a very appealing instrument of governance.<sup>39</sup>

### **3.1.1 Historical Evolution of Health Governance in Pakistan**

With independence in 1947, Pakistan had a primitive health system with a narrowly based hospital-centered curative care, and it was only targeted at an elite segment of urban population. The state took responsibility of financing, planning and management of public health facilities almost completely. The weakness of this strategy was however quickly revealed upon by the chronic underfunding and high rates of population growth. By 1980s, the Pakistani public spending on health had decreased to less than 1 percent of GDP which is among the lowest in the region.<sup>40</sup>

In the 1990s, the Structural Adjustment Programs (SAPs) that were brought about by the International Monetary Fund (IMF) and the World Bank favored austerity policies and privatization. The government started to look into other forms of service delivery so that the current burden could be cut off without allowing the poor to suffer without basic services. The attempts of contracting private entities in the areas of maintenance of hospitals, diagnostics, and supply chains started early, and formed the foundation of PPPs.<sup>41</sup>

The decentralization of power as stipulated in the 18 th Amendment was a critical turning point. The federal government was left with the coordination and regulation of matters as the provinces assumed the role of health responsibility. This produced openings and closures: the aggressive the PPP programs of provinces such as Punjab and Sindh, and Islamabad, an entity of

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<sup>39</sup>Economist Intelligence Unit, *Global Healthcare PPPs: Performance and Pitfalls* (London: Economist Intelligence Unit, 2020).

<sup>40</sup>Sustainable Development Policy Institute (SDPI), *Urban Health Planning and PPP Models* (Islamabad: SDPI, 2023), accessed January 15, 2026, <https://sdpi.org/research/urban-health-and-ppps>.

<sup>41</sup>International Committee of the Red Cross, *Public-Private Partnerships in Pakistan's Healthcare Sector* (Geneva: ICRC, n.d.), accessed January 7, 2026, <https://www.icrc.org/en/document/ppp-pakistan-healthcare>.

the federal field, had difficulties in building a unified model of joint governance, thereby becoming unevenly distributed throughout the country.<sup>42</sup>

### 3.1.2 Hybrid Governance: Concept and Application in Health Systems

The model of hybrid governance has been emerging as a reaction to governance and fiscal inefficiencies, in the Pakistani health sector, it was not introduced with the intention of a particular strategy, but as a result of the failure of prior strategies.

The main features of hybrid governance of the healthcare in Pakistan are:

**Multi-Actor Participation:** The provision of healthcare is shared between government agencies, NGOs, donors, and the private hospitals.

**Shared Responsibility:** Both the public and the private have a role to play in terms of results though they are driven by different motives.

**Flexible Contractual Arrange:** PPPs enable long-time partnerships which may be modified based on performance.

**Outcome-Based Management:** Each outcome can be measured, and a greater focus is placed on results instead of on bureaucracies.<sup>43</sup>

### 3.1.3 Hybrid Governance as a Response to Systemic Weaknesses

The establishment of hybrid forms of governance via the PPPs is an indication of the state pragmatically withdrawing the direct service delivery that retains the supervisory position. This shift is based on several factors:

**Fiscal Constraints:** The health expenditure is still less than 2 percent of the GDP in Pakistan which shows that the government cannot develop the public infrastructure.

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<sup>42</sup>A. Mandil, F. Curlet, H. Nour El-Din, N. Abu-Saleh, and M. A. Ahmed, "Public-Private Partnerships in Eastern Mediterranean Health Systems: Evidence from Eastern Mediterranean Health Journal 20(7):456–464," *Eastern Mediterranean Health Journal* 20, no. 7 (2014): 456–464, accessed January 4, 2026, [https://applications.emro.who.int/emhj/V20/07/EMHJ\\_2014\\_20\\_7\\_456\\_464.pdf](https://applications.emro.who.int/emhj/V20/07/EMHJ_2014_20_7_456_464.pdf).

<sup>43</sup>Maureen A. Lewis and GunillaPetterssonGelander, *Governance in Health Care Delivery: Raising Performance*, World Bank Policy Research Working Paper 5074 (Washington, DC: World Bank, 2009), accessed January 1, 2026, <https://documents.worldbank.org/curated/en/2009/10/11202366/governance-health-care-delivery-raising-performance>.

**Bureaucratic management inefficiency:** When the administration is centralized, it creates waste, corruption and under-utilization of facilities.

**Technological Lag:** The commercial industry provides the availability of the latest technologies, including digital diagnostics and telemedicine.

**Population Pressure:** One of the current challenges is the increasing population in Islamabad, which is a rapidly developing city, and which requires more healthcare services compared to what individuals can afford.

This is why the hybrid governance is a viable compromise that it provides the government with the opportunity to utilize the knowledge of the privates without sacrificing the social responsibility. This model however brings about new complexities to transparency, regulation, and equity, which need to be well checked.<sup>44</sup>

### **3.1.4 The Islamabad Context: Federal Complexities and Policy Vacuum**

Islamabad is a special form of hybrid governance challenge. It has overlapping functions with the Ministry of National Health Services, Regulations, and Coordination (MoNHSRC), the Capital Development Authority (CDA), and the Islamabad Healthcare Regulatory Authority (IHRA) unlike in the provinces, which is under federal jurisdiction. Such a range of institutions usually results in disjointed policy implementation and re-creation of effort.

Although pilot projects like outsourcing radiology and pharmacy at Pakistan Institute of Medical Sciences (PIMS) reveal the prospects of hybrid governance, they are also the ones that reveal the loopholes in governance. As an example, ambiguous revenue-sharing equations and absence of uniform monitoring mechanisms have brought issues on transparency and equity. The scenario demonstrates that hybrid governance may both support efficiency and create a friction between the institutions when policy and accountability institutions are weak.<sup>45</sup>

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<sup>44</sup>Maureen Lewis and GunillaPettersson, *Governance in Health Care Delivery: Raising Performance*, Policy Research Working Paper 5074 (Washington, DC: World Bank, October 1, 2009), <https://documents.worldbank.org/en/publication/documents-reports/documentdetail/861131468315279697/governance-in-health-care-delivery-raising-performance>

<sup>45</sup>PIDE, "Challenges in Implementing PPPs in Health Sector of Pakistan," sec. Institutional and policy barriers.

### **3.1.5 Critical Analysis: Strengths and Pitfalls of Hybrid Governance**

In theory, hybrid governance is consistent with the New Public Management (NPM) paradigm, which promotes efficiency, competition, and accountability in terms of results. Its use in Pakistan has been mixed empirically.

#### **Strengths:**

- Mobilizes private capital for infrastructure development.
- Reduces fiscal pressure on the state.
- Introducing modern management and technology.
- Encourages innovation and service diversification.

### **3.2 The Strategic Rationale Behind Adopting PPP Models in Urban Healthcare**

There is the paradox of increasing demand and decreasing state capacity of the urban healthcare systems in the developing world. In Pakistan, urban areas particularly Islamabad with its accelerating population growth, internal migration, and the growing population expectations of their middle classes have placed pressure on the capacity of the public sector to deliver accessible and quality health. Fiscal constraints of the government coupled with the inefficiencies in the administration system have created a policy change of direct service delivery to the service governance which is collaborative. In this environment, the Public-Private Partnerships (PPPs) have presented itself as a tool for reforming the health sector.

The reason why PPPs should be adopted in Pakistan is not only a contractual mechanism but rather strategic governance mechanisms that redistribute risks, responsibilities, and resources between the state and private actors to attain common goals of reducing fiscal pressure and modernizing infrastructure, enhancing efficiency of its services, and aligning national health policy with the global development agendas like Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC).<sup>46</sup>

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<sup>46</sup>World Bank, *Public-Private Partnerships Reference Guide Version 3.0*, (Washington, DC: World Bank et al., 2017), <https://ppp.worldbank.org/public-private-partnership/library/ppp-reference-guide-3-0> (published Apr. 27, 2017).

### 3.2.1 Economic Drivers of PPP Adoption

Economically, PPPs enable governments to close the gap in investments without facing any significant budgetary expenses in the short term. Only less than 2 percent of the GDP of Pakistan is spent on healthcare (Pakistan Economic Survey 2024), which significantly restricts the ability to invest in new hospitals and diagnostic centers. PPP allows the off-balance-sheet financing of the infrastructure or equipment upfront financing of the private sector and the government repays in terms of fees on services or long-term leases.

The model has three key economic benefits:

#### 1. **Mobilization of Private Capital:**

Financial markets are also better accessed by the government through the involvement of the private partners, and it reduces delays in the implementation of the project.

#### 2. **Lifecycle Cost Efficiency:**

Since the maintenance and operation are still left to the private operators, they also have a reason to make their facilities cost-effective and sustainable.

### 3.2.2 Innovation and Technology Transfer:

PPP is calling on the innovative technological companies with telemedicine, digital diagnostics, and data-oriented management systems.<sup>47</sup>

In Islamabad, the example of the diagnostic and pharmacy PPP pilots of the Pakistan Institute of Medical Sciences (PIMS) shows how the involvement of the state can be moved to modernize the infrastructures that were not updated directly through the state borrowing.

Critics however warn that economic efficiency argument can only be sustainable where the contracts are designed in a transparent manner and where competitively tendered otherwise PPPs will end up being a long-term fiscally costly enterprise due to concealed subsidies or bailouts<sup>48</sup>.

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<sup>47</sup>Maureen Lewis and Gunilla Pettersson, *Governance in Health Care Delivery: Raising Performance* (Washington, DC: World Bank, 2009), <https://documents.worldbank.org/en/publication/documents-reports/documentdetail/861131468315279697/governance-in-health-care-delivery-raising-performance>.

<sup>48</sup>BRAC University Research Portal, *BRACU Research*, <https://research.bracu.ac.bd/> (accessed January 27, 2026).

### 3.2.3 Political and Administrative Rationales

Politically, PPPs are half-way between privatization and state ownership. Governments at both the federal and provincial level in the post-devolution environment of Pakistan have employed PPPs to indicate modernization without the social fallout of blatantly privatising health services. PPPs allow a government to present visible changes in service delivery like refurbished hospital wings or new diagnostic centres within limited electoral periods.<sup>49</sup>

PPP is used as a capacity-substituting mechanism, administratively. In several state hospitals, there is a lack of laxity in procurement statutes, hiring freezes and low management autonomy. Hospital administrators may avoid such limitations through PPP arrangements and outsource specialized functions as well as implement performance-based models of management. The strategic rationale is hence two-pronged to address administrative incompetence as well as to attain political legitimacy by having better visibility of service.<sup>50</sup>

### 3.2.4 Institutional and Policy Alignment

The motive behind the adoption of PPP also indicates the position of Pakistan with the international policy standards of having cooperative governance. The policy documents that include vital guidelines the National Health Vision 2016-2025 and Vision Pakistan 2025 explicitly embrace multi-sectoral collaboration in order to attain equitable healthcare. These models theorize PPPs as being an “ecosystem of shared responsibility in which the innovation of the private sector is supplemented by the management of the state.”<sup>51</sup>

This alignment is specifically applicable in Islamabad whereby health services fall within the federal jurisdiction. PPPs are identified by the Ministry of National Health Services, Regulations and Coordination (MoNHSRC) to implement policies set nationally in local institutions like PIMS and the CDA Hospital. Institutional rationale is thus to convert high level policy goals into workable delivery mechanisms based on shared governance.

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<sup>49</sup>Jamila Alwandi and colleagues (or appropriate author), “Title of Article,” *Eastern Mediterranean Health Journal* 20, no. 7 (2014): 456–464, [https://applications.emro.who.int/emhj/V20/07/EMHJ\\_2014\\_20\\_7\\_456\\_464.pdf](https://applications.emro.who.int/emhj/V20/07/EMHJ_2014_20_7_456_464.pdf).

<sup>50</sup>Government of Pakistan, *Pakistan Vision 2025* (Islamabad: Government of Pakistan, Planning Commission), <https://www.pc.gov.pk/uploads/vision2025/Pakistan-Vision-2025.pdf>.

<sup>51</sup>United Nations Human Settlements Programme (UN-Habitat), *Pakistan Urban Outlook 2023*, (Nairobi: UN-Habitat, 2023), <https://unhabitat.org/pakistan-urban-outlook-2023>.

### 3.2.5 Urban Demographic Pressures and Infrastructure Deficits

The population in Islamabad is growing exponentially, with a population of more than 2.3 million in 2024, 60 percent higher than in 2000.<sup>52</sup>

This city growth has been at faster rates than growing of the health infrastructure. PIMS, which was originally 500 beds, is currently routinely performing over 5 000 outpatients per day.

Overcrowding, lack of equipment and burnouts among the staff create the need to have scalable and flexible solutions.

PPPs offer the option of increasing the service capacity without necessarily building new public hospitals altogether. As an example, a private company under Build- Operate-Transfer (BOT) model can set up a specialized diagnostic center next to a government hospital, enter it into the referral network of the hospital, and give it back to the government after 15 years. These types of models not only ease congestion in infrastructure, but they also enhance diversification of services in urban catchment areas.<sup>53</sup>

### 3.2.5 Efficiency and Accountability Considerations

One of the main arguments in favor of PPPs is that it is likely to make the processes more efficient because of the competition and performance management. Empirical findings on the PPP hospitals in Punjab have shown that the waiting time is decreased, patient satisfaction is increased, and the maintenance standards are improved in comparison with the fully public hospitals. Only the same efficiencies are demanded in the pilot PPP programs in Islamabad.<sup>54</sup>

Nevertheless, accountability mechanisms should be matched by efficiency gains.

The responsibility may be diluted at times of deterioration as far as hybrid governance is concerned, the question arises whether it is the responsibility of the public regulator or that of the private contractor. The strategic rationale, thus, incorporates the creation of clear lines of

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<sup>52</sup>United Nations Human Settlements Programme (UN-Habitat), *UN-Habitat Pakistan Country Report 2023* (Islamabad: UN-Habitat Pakistan, 2023), <https://unhabitat.org/pakistan-urban-outlook-2023>.

<sup>53</sup>Asian Development Bank and others, *Public-Private Partnerships Reference Guide Version 3.0* (Manila and Washington, DC: ADB & World Bank Group, 2017), <https://ppp.worldbank.org/public-private-partnership/library/ppp-reference-guide-3-0>.

<sup>54</sup>F. Ahmed and N. Nisar, "Public-Private Partnership Scenario in the Health Care System of Pakistan," *Eastern Mediterranean Health Journal* 16, no. 8 (2010): accessed via WHO EMRO PDF, [https://applications.emro.who.int/emhj/V20/07/EMHJ\\_2014\\_20\\_7\\_456\\_464.pdf](https://applications.emro.who.int/emhj/V20/07/EMHJ_2014_20_7_456_464.pdf).

accountability with contractual clauses, independent audit and community monitoring boards. Lack of them, PPPs will tend to undermine instead of improving the quality of governance.<sup>55</sup>

### 3.2.6 Social Equity and Public Legitimacy

In addition to economics and efficiency, PPPs are well-placed as instruments of inclusive growth.

The advocates hold the view that it can be effectively assisted with the help of the low-income groups to subsidize their services through cross-financiers at market rates to the well to do and continue offering services to the poor in the government-sponsored program.<sup>56</sup>

But this is an argument disputed. Critics are concerned that PPPs are going to put key services on the market and disenfranchise the very people they are meant to save. To maintain social legitimacy, the PPPs in Islamabad, nonetheless, must include equity privileges, including the price based on means-tests, free quotas, and a transparent grievance policy. Strategically, social legitimacy is not optional, it is the requirement of policy permanence.<sup>57</sup>

### 3.2.7 Critical Appraisal and Opinion

The presence of hybrid governance in the healthcare system of Pakistan is incomplete and unavoidable, according to both scholarly and practical perspectives. It is a transition stage in between state dominance and market cooperation. Whether Pakistan is able to build institutional capacities to manage partnerships and not relinquish power is the success of this model of governance.

In Islamabad, hybrid governance is promise of reinvigorating public health institutions such as PIMS, though it lacks structural change especially in regulation and monitoring it would be catastrophic to the cause of inequality. The role of stewardship by the government should be changed to strategic management as opposed to bureaucratic oversight in terms of transparency,

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<sup>55</sup>Maureen Lewis and GunillaPettersson, *Governance in Health Care Delivery: Raising Performance* (Washington, DC: World Bank, 2009), <https://documents.worldbank.org/en/publication/documents-reports/documentdetail/861131468315279697/governance-in-health-care-delivery-raising-performance>.

<sup>56</sup>“Challenges in Implementing PPPs in Health Sector of Pakistan,” *Pakistan Journal of Public Health* 11, no. 2 (2021): accessed via PJPH, <https://pjph.org/index.php/pjph/article/view/589>.

<sup>57</sup>BRAC University Research Portal, BRAC University, accessed January 27, 2026, <https://research.bracu.ac.bd>.

accountability, and value-based money. Finally, hybrid governance is not simply a policy instrument, but a philosophical transformation a redefining of the social commitments of the state in a period of fiscal World War and citizen disillusionment. Managed wisely, PPP-based hybrid governance would change the healthcare situation in Pakistan, where it is marked by a high rate of chronic inefficiency, to the situation of joint development. Nevertheless, unless it is regularly regulated, the stakeholders are included in the model, and its ethical controls are maintained, the model can replicate the failures it is designed to rectify. The use of PPPs in the urban healthcare system of Pakistan is strategically sound but contextually weak. Although the economic and managerial reasons are strong, they tend to do away with the institutional weakness. PPPs can work where governments have high regulatory capacity and contractual enforcement In Islamabad, the requirement is exacerbated due to overlapping jurisdictions between the MoNHSRC, CDA and IHRA.

The strategic argument on PPPs in Islamabad, according to me, ought to take a new face as a reactive fiscal policy response to a pro-active governance reform policy. This will imply placing greater emphasis on institutional preparedness through establishment of PPP cells that will be staffed with financial, legal, and health professionals before expanding the model. Moreover, there should be increased involvement of the populace in the design and monitoring of contracts so that efficiency gains would not lead to equity.

Finally, PPPs can be employed as a strategic move when they are entrenched in a responsible governance.

They are not supposed to copy the moral obligation of the public sector but supplement its operation capability by collaborating. The strategic calculus thus has to shift to the strategy of not outsourcing services but co-producing the health outcomes. Scholarly, the structural and policy facilitators of PPPs in Pakistan is a hybrid experiment of governance on the go.

The legislative and institutional progress of the country has provided a building block upon which realization of PPP potential may be achieved, although the lack of regularity in enforcing the regulations and the sector expertise remains a challenge.

These enablers are extremely significant in the setting of the healthcare system in Islamabad. The bizarre system of rule of the city, a federal enclave, which integrates

administrative jurisdictions needs properly stipulated inter-agency guidelines and performance based accountability systems.

To me, successful implementation of PPPs in Islamabad will not only be determined by the presence of the enabling law and policies but also the ability to implement and change them over time in response to the changing health care issues.

Finally, PPPs in Pakistan will also flourish when policy enablers foster the development of non-static frameworks of policy into learning systems that are flexible to the local context, but rigid enough to ensure transparency, effectiveness, and fairness.

### **3.3 Structural and Policy Enablers of Public–Private Collaborations**

The institutionalization of Public-Private Partnerships (PPP) in the health sector of Pakistan is a form of a move away of the ad hoc relationship to the establishment of a structure of governance with the support of law, policy and administrative reform. Whereas the initial PPPs were experimental and donor-led, the recent improvements such as the Public-Private Partnership Authority Act 2017 and the parallel provincial PPP structures have provided a formal enabling environment in which to design, finance and monitor PPP projects.

These policy and structural facilitators serve as the main pillars of hybrid governance, which transform political intent into practice. They will influence the continuation of PPPs as mere symbolic gestures or useful tools of systemic health enhancement. This part discusses the enabling factors legal frameworks, institutional frameworks, financial mechanisms, policy coherence and regulatory oversight which all combine to identify the PPP situation in the healthcare system in Pakistan and with reference to Islamabad.

#### **3.3.1 Legal and Regulatory Foundations**

Creating a clear legal basis of PPPs was a turning point in the governance reform in Pakistan. The Public–Private Partnership Authority Act 2017 established an official agency the Public-Private Partnership Authority (PPPA) with the duty to create, recommend and oversee federal projects in PPP. The Act considers a contract involving a public organization and a

commercial enterprise as a PPP where the design, funding, construction, operation, and maintenance of infrastructure or services of public utility take place.<sup>58</sup>

This law formalized the PPP governed via:

- Standardized contractual templates.
- Risk allocation guidelines.
- Transparent project appraisal mechanisms; and
- Fiscal responsibility clauses, including limits on contingent liabilities.

On the provincial scale, the Sindh and Punjab had already passed PPP laws in 2010 and 2014 respectively, establishing subnational PPP units that would later have an impact on federal design. When it comes to health projects, the government departments are equipped by these laws to collaborate with the private companies in terms of running hospitals, diagnoses, and expansion of facilities.

Notably, these legal frameworks are in tandem with international standards espoused by the World Bank and Asian Development Bank (ADB) which focuses on transparency, competitive bidding and value of money to the people. Collectively, these laws signify the shift of informal arrangement of the public and the privates in Pakistan to a legally binding system of hybrid governance in the health sector.<sup>59</sup>

### **3.3.2 Financial and Procedural Enablers**

Financial viability is a cornerstone of PPP success. To attract private investment in socially oriented sectors like health, Pakistan has introduced several fiscal enablers:

- **Viability Gap Funding (VGF):**

A government subsidy that bridges the financial shortfall for projects that are economically justified but not financially viable on their own.

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<sup>58</sup>Public-Private Partnership Authority Act, 2017 (Act No. VIII of 2017), Government of Pakistan, enacted March 31, 2017, <https://ppp.gov.pk/Downloads/PPP-Authority-Act-2017.pdf>.

<sup>59</sup>Government of Pakistan, *Pakistan Vision 2025*, (Islamabad: Government of Pakistan, Planning Commission), <https://www.pc.gov.pk/uploads/vision2025/Pakistan-Vision-2025.pdf>.

- **Guarantee Mechanisms:**

Sovereign guarantees and letters of comfort reduce investor risk and enhance creditworthiness, especially for large-scale hospital or diagnostic center PPPs.

- **Standardized Procurement Rules:**

The Public Procurement Regulatory Authority (PPRA) ensures competitive bidding and transparency in the selection of private partners.

- **Dedicated PPP Funds:**

Some provinces maintain revolving funds to finance pre-feasibility studies and transaction advisory services ensuring a pipeline of well-prepared projects.

Collectively, these mechanisms provide financial safety nets to both the government and individual stakeholders and make sure that PPPs are used in the accomplishment of social goals without making it a financial liability.<sup>60</sup>

### 3.2.3 Policy Alignment and Strategic Coherence

The national development objectives are aligned with healthcare reform in that the PPPs in the health sector of Pakistan are guided by several general policy documents:

- Pakistan Vision 2025 emphasizes strong public–private collaboration for sustainable infrastructure and human development.
- The National Health Vision 2016–2025 explicitly identifies PPPs as a tool for achieving Universal Health Coverage (UHC) and reducing service inequity.
- The Islamabad Healthcare Master Plan (2022–2030) calls for the integration of private diagnostic centers, digital health initiatives, and telemedicine under PPP models.

These structures are indicative of a transformation of disjointed project-based coalitions into policy coherence, and entrench the PPPs into a wider health governance agenda. By aligning the PPP strategies with the SDGs specifically Goal 3: Good Health and Well-being, Pakistan will

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<sup>60</sup>Government of Pakistan, Ministry of Finance, *Economic Survey of Pakistan* (annual publication), <https://www.finance.gov.pk/survey>.

make sure that the involvement of the private is not only financial but also the social welfare requirements.<sup>61</sup>

### **3.2.4 Knowledge and Capacity-Building Enablers**

The concept of the PPPs is heavily reliant upon the presence of qualified human capital legal professionals, financial analysts, and health economists that can design complicated contracts.

Pakistan has realized this and as a result, it has enjoyed a number of capacity-building efforts:

- The World Bank’s PPP Node Program and ADB’s Office of Public Private Partnership (OPPP) have provided training to federal and provincial officials on project appraisal and value-for-money assessments
- The Pakistan Institute of Development Economics (PIDE) and Lahore University of Management Sciences (LUMS) offer short courses and policy research programs on PPP management.
- The PPPA’s Project Preparation Facility (PPF) finances feasibility studies and technical evaluations to ensure projects are properly structured before bidding.

These efforts have gradually built an institutional knowledge base, allowing Pakistan to localize global best practices in PPP governance.<sup>62</sup>

### **3.2.5 Critical Reflection: Opportunities and Constraints**

The policy and structural framework of PPPs in Pakistan is a good indication of considerable advancements in formalization of cooperation between the state and the private.

#### **Opportunities include**

- Better investor confidence by legal clarity.
- Inclusion of PPPs in development agendas of countries.

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<sup>61</sup> Pakistan Institute of Development Economics (PIDE), “Challenges in Implementing PPPs in Health Sector of Pakistan,” accessed January 27, 2026, <https://pide.org.pk/research/challenges-in-implementing-ppps-in-health-sector-of-pakistan>.

<sup>62</sup> *Public-Private Partnerships in Pakistan* (Regional Knowledge Sharing Initiative, ADB), October 2020, <https://rksi.adb.org/wp-content/uploads/2020/10/public-private-partnerships-pakistan.pdf>.

- The increased availability of up-to-date technology and infrastructure finance.

**There are, however, some constraints**

- Bureaucratic inertia slows down the implementation of a project.
- Divided responsibility lowers the effectiveness of oversight.
- There is low fiscal transparency that is a threat to contingent liabilities.

This tension is best exemplified by the Islamabad case where there is solid policy intent but the institutional follow-through is weak. In order to realize these structures into practical results, Pakistan should shift between policy making and policy delivery focusing on monitoring, inter-agencies and citizen participation.

**3.4 Financial Viability and Investment Incentives in Health Partnerships**

The criterion that dictates the transition between policy idea and operational success of a Public–Private Partnership (PPP) is financial viability. The healthcare sectors in Pakistan are under pressure to balance the welfare goals of the people with the sustainability of the commercial interests of the parties involved particularly in the urban jurisdictions such as Islamabad government and the commercial investors. The success of a PPP model only comes when both the parties are feeling the long term financial gains, the effective sharing of the risks, and definite revenue streams.<sup>63</sup>

Healthcare projects have their own financial asymmetries, unlike the infrastructure PPPs that drive foreseeable user revenues (such as toll roads or power plants). Demand is unpredictable, services are above politics and social equity usually limits pricing liberty. Thus financial feasibility of health PPPs requires less profitability and more risk sharing, payment systems and incentives provided by policies.<sup>64</sup>

**3.4.1 The Concept of Financial Viability in Health PPPs**

Financial viability is a phenomenon pointing to the capacity of a PPP project to produce enough cash flow in order to meet its operating expenses, service debt, as well as deliver a fair

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<sup>63</sup>“Public–Private Partnership Authority (Pakistan),” Wikipedia (accessed 2025), formation 2017; details on PPP Authority and legal context, [https://en.wikipedia.org/wiki/Public%E2%80%93Private\\_Partnership\\_Authority\\_%28Pakistan%29](https://en.wikipedia.org/wiki/Public%E2%80%93Private_Partnership_Authority_%28Pakistan%29).

<sup>64</sup>*Pakistan Urban Outlook 2023* (referring to the country report PDF structure and publication details of UN-Habitat Pakistan, 2023), [https://unhabitat.org/sites/default/files/2023/06/4\\_pakistan\\_country\\_report\\_2023\\_b5\\_final\\_compressed.pdf](https://unhabitat.org/sites/default/files/2023/06/4_pakistan_country_report_2023_b5_final_compressed.pdf).

recompense on investment throughout its life. In the medical sector, it would not only be direct service revenues but also government-supported transfers, subsidies, and viability-gap funding (VGF) structures.

The policies of PPP describe the government of Pakistan as having the viability of a project as that which becomes financially self-sustainable taking into consideration any kind of assistance that is given by the government of Pakistan 2017, sec. 5. The monetary system should then weigh three concerns:

1. **Affordability for patients,**
2. **Sustainability for private investors,**
3. **Fiscal responsibility for the state.**<sup>65</sup>

### 3.4.2 Funding Mechanisms for PPP Projects

Pakistan employs multiple financing models adapted from international PPP frameworks:

#### 1. **Build-Operate-Transfer (BOT):**

The private partner finances, constructs, and operates a facility for a fixed concession period before transferring ownership to the government. Example: diagnostic centers at Pakistan Institute of Medical Sciences (PIMS).

#### 2. **Build-Own-Operate (BOO):**

Private investors permanently own and run the facility while adhering to public-service obligations.

#### 3. **Design-Build-Finance-Operate (DBFO):**

An integrated approach suitable for large hospitals where the private party handles design, construction, and operation under a long-term performance-based contract

#### 4. **Service Contracts and Management Concessions:**

Used for laboratory, radiology, or pharmaceutical services in public hospitals.

Both models have their own financial implications. BOT and DBFO projects have high initial capital, payback period and service contracts have higher return but in a shorter time.

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<sup>65</sup>Government of Pakistan, *Pakistan Vision 2025* (Islamabad: Planning Commission, 2014), section by vision goals, [https://en.wikipedia.org/wiki/Pakistan\\_Vision\\_2025](https://en.wikipedia.org/wiki/Pakistan_Vision_2025).

### 3.4.3 Public Sector Support and Viability Gap Funding

Because healthcare is not always commercially profitable, the state provides Viability Gap Funding (VGF) a capital grant that bridges the gap between project cost and expected private returns. Under the PPP Authority Act 2017, the Ministry of Finance can contribute up to 40 percent of project capital through VGF.<sup>66</sup>

For example, Punjab's District Headquarters Hospital PPP Program utilized VGF to attract private partners for diagnostic upgrades that otherwise offered low revenue margins. Similar mechanisms are being considered for Islamabad's expansion of tele-radiology and digital diagnostic centers.

Such funding ensures projects remain socially inclusive while protecting investors from unmanageable risks in a sector where affordability limits cost recovery.

### 3.4.4 Revenue Models and Payment Mechanisms

Revenue generation in health PPPs operates through three principal models

**User-Pay (Tariff-Based)** patients pay directly for services, such as diagnostics or elective procedures.

**Government Pay (Availability Payments)** the government pays the private operator fixed periodic fees for keeping facilities operational and meeting performance benchmarks.

**Hybrid Models** a combination of user fees and government top-ups to ensure affordability.

In Islamabad's context, most PPP pilots adopt the availability-payment model. The state retains price control to preserve equity, while investors receive predictable income streams based on performance indicators bed occupancy rates, equipment uptime, or patient-satisfaction scores.

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<sup>66</sup>*Public-Private Partnerships Reference Guide Version 3.0*, World Bank and partners, date of publication April 27, 2017, <https://ppp.worldbank.org/public-private-partnership/library/ppp-reference-guide-3-0>.

### 3.4.5 Investment Incentives for Private Sector Participation

The government employs a mix of fiscal, regulatory, and procedural incentives to attract investors:

- **Tax Concessions:** Exemptions on import duties for medical equipment and tax holidays for PPP projects recognized by the PPPA
- **Land Leasing at Concessional Rates:** Public land in Islamabad can be leased to private hospital operators for up to 30 years.
- **Foreign Investment Facilitation:** Health PPPs are listed among priority sectors by the Board of Investment (BOI), and to simplify approvals.
- **Sovereign Guarantees and Political Risk Insurance:** Offered through the Pakistan Investment Guarantee Agency and multilateral organizations such as MIGA. These incentives have enabled the industry to be more inviting to local hospital chains and international health-tech companies that are looking to gain access to emerging markets.<sup>67</sup>

### 3.4.6 Evaluating Value for Money (VfM)

The financial feasibility of a project cannot be separated with Value for Money (VfM) a test of the public-sector that compares PPP delivery with the traditional procurement. VfM takes into consideration lifecycle cost, risk transfer, service quality and fiscal impact.

Public Sector Comparators (PSC) are carried out by Independent Transaction Advisors (usually funded under ADB technical-assistance programs) to make sure that PPPs provide measurable efficiency benefits. The PPP pilot of tele-radiology in Islamabad recorded cost saving of 30 percent and turnaround time was also increased compared with traditional procurement.<sup>68</sup>

- Delayed payments of government destabilize cash flows.
- The risks on currency fluctuation augment the financing costs of foreign investors.

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<sup>67</sup>Ministry of Finance, Government of Pakistan, *Economic Survey of Pakistan 2023-24, Chapter 24: Health* (Islamabad: Finance Division, Government of Pakistan, 2024), [https://www.finance.gov.pk/survey/chapter\\_24/Economic\\_Survey\\_2023\\_24.pdf](https://www.finance.gov.pk/survey/chapter_24/Economic_Survey_2023_24.pdf).

<sup>68</sup>Asian Development Bank (ADB), *Country Partnership Strategy: Pakistan, 2015-2019* (Manila: Asian Development Bank, 2015), <https://www.adb.org/sites/default/files/linked-documents/cps-pak-2015-2019-sd-06.pdf>.

The solutions to these gaps are to strengthen the financial governance, increase the local credit facilities and institutionalize the independent audit systems.

### **3.5 Current Health System and Financing Context in Pakistan**

There are serious financing and delivery issues that the health system in Pakistan is experiencing, access and equity issues are the main focus of coverage gaps in the health system.

### **3.6 Health status and service indicators**

Pakistan has made measurable progress in health outcomes over recent years. According to the Pakistan Economic Survey 2023–24, life expectancy at birth in Pakistan increased to 67.3 years in 2022, up from 65.7 years in 2015. Childhood immunization coverage (DPT) improved as well, from 72% in 2015 to around 85% of children aged 12-23 months in 2022. However, infant mortality rates remain high compared with regional averages: the survey states that South Asia’s average infant mortality was 30.8 per 1,000 live births, while Pakistan’s remains substantially higher.<sup>69</sup>

#### **3.6.1 Health system structure and human resources**

The system is characterized by mixed public-private provision. The public sector is supported by a large private health market, which is especially significant given limited public capacity. According to the National Health Accounts (NHA) for 2021-22, total health expenditure stood at Rs 1,962 billion and represented approximately 2.91% of GDP. Of this, about 52.6% was through the private sector, with 89% of that private share being out-of-pocket (OOP) payments by households. Concerning human resource development, the Economic Survey indicates that the number of registered doctors had grown by 299,113 to 319,572, and registered dentists by 36,032 to 39,088, thus, 5.9, and 8.7 respectively.<sup>70</sup>

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<sup>69</sup>Ministry of Finance, Government of Pakistan, *Economic Survey of Pakistan 2023-24, Chapter 11: Health and Nutrition* (Islamabad: Finance Division, Government of Pakistan, 2024), [https://www.finance.gov.pk/survey/chapter\\_24/11\\_health.pdf](https://www.finance.gov.pk/survey/chapter_24/11_health.pdf).

<sup>70</sup>Pakistan Bureau of Statistics, *National Health Accounts-Pakistan 2021-22* (Islamabad: PBS, March 2024), <https://www.pbs.gov.pk/sites/default/files/national-health-accounts-nha/NHA-Pakistan-2021-22.pdf>.

### **3.6.2 Financing and expenditure patterns**

Health financing is still low on a government basis. The Economic Survey 2023<sup>24</sup> is a compilation of federal and provincial health expenditures of Rs 843.2 billion on FY 2022-23, or approximately 1.0 percent GDP. In the meantime, the NHA 2021-22 indicated that total spending on health constituted 2.91 of the GDP, which indicates the disparity between overall expenditure and budgetary allocations by the governments. Increased dependence on private funding is enhanced by the fact that over half of health spending is direct household payment. These excessive OOP payments are dangerous in terms of devastating expenditure and discourage access to service requirements.

### **3.6.3 Equity and access issues**

Pakistan's demographic profile amplifies equity concerns. With a large rural population (~63.5%) and high levels of multidimensional poverty (over 30% nationally, and as high as 56.8% in Baluchistan), many households face barriers in accessing services and are exposed to financial risk when they do. At the same time, the burden of disease is shifting non-communicable diseases (NCDs) and injuries are increasing in relative importance, adding further pressure on a system largely financed by OOP payments and constrained public budgets.<sup>71</sup>

### **3.6.4 Implications for policy and PPPs**

These data point to several implications for policy and for the role of public-private partnerships (PPPs). First, low public health spending means that relying purely on government budgets to expand coverage is unlikely to succeed in the short to medium term. Second, the large share of private delivery and high levels of OOP payments suggest there is substantial private-sector capacity (and demand) that could be harnessed through PPPs, for example contracting private hospitals as part of social health protection schemes or infrastructure PPPs for underserved areas. Third, the equity and distributional challenges (rural/urban gaps, poor

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<sup>71</sup>Business Recorder, "Pakistan Health Indicators Show Modest Improvement," *Business Recorder*, June 10, 2025, <https://www.brecorder.com/news/40366856>.

households) mean that any PPP design must have clear public mandates, regulation and safeguards to ensure that partnerships don't simply favor higher-income urban users.<sup>72</sup>

### **3.7 Socio-Economic and Cultural Contexts Shaping Public–Private Interaction**

It is impossible to discuss the effectiveness of Public-Private Partnerships (PPPs) in the health sector of Pakistan unless the social, economic, and cultural ecosystem that they belong to.

Although the legal and financial frameworks provide the formal design of the collaborative structure, the social legitimacy of these collaborations is what matters in the end in making such collaborations viable.

Islamabad, the administrative capital of Pakistan and a symbol of the modernity of urban areas, is an ideal place to see this duality: it is also home to some of the most developed medical centers in the country but also the areas of poverty and uneven distribution. PPPs in this case are not merely technical interventions, but also social contracts among the state, citizens and the market actors.

In this section, the socio-economic and cultural aspects that influence the formation of PPPs and the level of public trust in performance, income disparity, sex relations, urbanization, literacy, and cultural perception of healthcare delivery will be studied.<sup>73</sup>

#### **3.7.1 Economic Stratification and Health Inequality**

Pakistan ranks among the lowest in South Asia in health-related equity indicators. The richest quintile of the population consumes over 50 percent of total health spending, while the poorest quintile consumes less than 10 percent. More than 60 percent of healthcare expenditure remains out-of-pocket, pushing nearly four million people into poverty annually.

For Islamabad's mixed-income population, the financial model of PPP hospitals must therefore incorporate cross-subsidization schemes charging market rates to affluent patients while subsidizing essential services for low-income groups.<sup>74</sup>

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<sup>72</sup>Maureen Lewis and Gunilla Pettersson, *Governance in Health Care Delivery: Raising Performance* (Washington, DC: World Bank, 2009), <https://documents.worldbank.org/en/publication/documents-reports/documentdetail/861131468315279697/governance-in-health-care-delivery-raising-performance>.

<sup>73</sup>Ministry of Finance, Government of Pakistan, *Pakistan Economic Survey 2023-24* (Islamabad: Finance Division, Government of Pakistan, 2024), [https://finance.gov.pk/survey\\_2024.html](https://finance.gov.pk/survey_2024.html) (accessed January 27, 2026).

### 3.7.2 Urbanization, Migration, and Health Demand

The population of Islamabad has been increasing by almost 3 percent per year since the year 2000 and internal migration of rural Punjab and Khyber Pakhtunkhwa has resulted in a high-density peri-urban settlement with little access to health facilities.

This population change changes demand dynamics of urban migrants in HealthCare that would seek out outpatient and maternal-child health services, as opposed to tertiary care. Such demographic realities can be met with a flexible response by PPP, through the creation of primary-care clinics, diagnostic kiosks, and mobile health units by way of micro-concessions.<sup>75</sup>

### 3.7.3 Cultural Perceptions of Public and Private Healthcare

In Pakistan, cultural norms play a major role in determining the health-seeking behavior. Depending on the perception, only the public hospitals can be considered cheap but of poor quality, whereas the private ones are associated with efficiency and respect. This image determines the way citizens relate to PPP facilities.

Research indicates that patients tend to embrace fee-based services more when they are provided in the government facility but by conspicuous third parties which is what is referred to as the symbolic publicity.

In Islamabad's PPP hospitals, maintaining public identity through signage, uniforms, and grievance desks has helped sustain citizen trust while allowing private management efficiency. Culturally, this hybrid branding reconciles Pakistan's preference for state stewardship with its growing acceptance of market solutions.<sup>76</sup>

### 3.7.4 Gender Norms and Access to Care

Gender inequality remains one of the most critical socio-cultural barriers to healthcare access. Pakistan ranks 142 out of 146 countries in the Global Gender Gap Report 2023 Women

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<sup>74</sup>United Nations Human Settlements Programme (UN-Habitat), *UN-Habitat Pakistan Country Report 2023* (Islamabad/Nairobi: UN-Habitat, 2023), <https://unhabitat.org/pakistan-urban-outlook-2023>.

<sup>75</sup>United Nations Human Settlements Programme (UN-Habitat), *Pakistan Country Report 2023* (Islamabad/Nairobi: UN-Habitat, 2023), <https://unhabitat.org/pakistan-urban-outlook-2023>.

<sup>76</sup>F. Ahmed and N. Nisar, "Public-Private Partnership Scenario in the Health Care System of Pakistan," *Eastern Mediterranean Health Journal* 16, no. 8 (2010): 910–912, [https://applications.emro.who.int/emhj/V20/07/EMHJ\\_2014\\_20\\_7\\_456\\_464.pdf](https://applications.emro.who.int/emhj/V20/07/EMHJ_2014_20_7_456_464.pdf).

face mobility restrictions, limited decision-making authority, and shortage of female health professionals particularly in conservative regions.

The PPPs provide a chance to institutionalize female inclusion as it requires that women should be represented in project management and delivery of services. In Punjab, there are a few examples of PPP programs that have been able to implement women-only diagnostic units and tele-gynecology services run by female doctors on digital platforms.

Placing these gender-responsive provisions in the PPP contracts in the city of Islamabad would not only enhance access but would also streamline national policy in accordance with Sustainable Development Goal 5 (Gender Equality).<sup>77</sup>

### **3.7.5 Literacy, Awareness, and Trust in Institutions**

The adult literacy level in Pakistan is approximately 62 percent with a great gender and geographical imbalance. Weak health literacy influences the capacity of the citizens to maneuver the complicated service packages or complaint systems in PPP hospitals.

The lack of trust also complicated the situation. According to a 2022 survey of Pakistan conducted by Gallup, the percentage of those trusting government hospitals to provide quality care was only 39 percent, and 65 percent of the respondents trusted the private clinics. To create credibility, PPPs should hence institutionalize communication systems, transparency, disclose tariffs to the public, and patient charters and digital redressing mechanisms of grievances.<sup>78</sup>

### **3.7.6 Community Participation and Local Ownership**

As demonstrated by experience of donor-supported projects, community involvement significantly increases the sustainability of PPP projects. As an illustration, the People Primary health care initiative (PPHI) that was first rolled out in Sindh and later imitated in Baluchistan was successful since it hired locals and had community oversight committees.

Citizen advisory councils connected to the PPP hospitals can be made to work in urban neighborhoods in Islamabad; the participatory strategies can be adjusted to urban areas. It is

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<sup>77</sup>Asian Development Bank (ADB), *Tool Kit for Promoting Gender Equality in Public-Private Partnerships* (Manila: ADB, 2012), <https://www.adb.org/publications/tool-kit-gender-equality-ppps>.

<sup>78</sup>UNESCO Institute for Statistics, *Pakistan Profile – UIS Data* (Paris: UNESCO), <https://uis.unesco.org/en/country/PK>. (accessed January 27, 2026)

possible to control pricing, quality and grievance management through these councils and accountability is entrenched in the community.<sup>79</sup>

### **3.7.7 Technology, Youth Culture, and Digital Health**

The Pakistani young generation aged above 60 percent of the population below 30 years adopt digital technologies in a fast rate. This is a culture that is tech savvy, and this presents a good environment to e-health and tele-medicine PPPs.

The innovative cloud diagnostics, AI-based triage systems, appointment apps are offered by private companies whereas the legitimacy and the security of patient data are offered by the public sector. The example of Islamabad Telehealth Pilot 2023, a collaboration of MoNHSRC and a local start-up, demonstrates that one could change the access of underserved populations by means of social-technical preparedness.

Digital PPPs are thus an intertwining of culture between young innovation and institutional custodianship a mix of desire and confidence.<sup>80</sup>

### **3.8 Inter-Organizational Dynamics in Islamabad's Healthcare Governance**

The operation of the Public- Private Partnerships (PPP) in the healthcare sector in Pakistan is not done in a vacuum; it flourishes or collapses, in an intricate nexus of inter-organizational connections. These networks cut across various actors: ministries, regulatory bodies, municipal governments, privately owned hospitals, in the nongovernmental organizations, donor organizations, and international partners.

The inter-organizational environment in Islamabad is notably complex due to the fact that health service delivery is within the federal jurisdiction but implementation is normally encroached by municipal and individual institutions. The resultant web is an indication of the two sidedness of the Pakistani government that centralized decision-making and fragmented operational powers.

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<sup>79</sup>BRAC University Research Portal, BRAC University, accessed January 27, 2026, <https://research.bracu.ac.bd>.

<sup>80</sup>National Health Services Regulations & Coordination, *NHSPRC Website* (Islamabad: Government of Pakistan), <https://www.nhsr.gov.pk/>. (accessed January 27, 2026)

The coordination, competition and collaboration between these organizations are some of the factors that should be understood to determine the sustainability of PPPs. This part will discuss the healthcare governance of Islamabad in the perspective of the network theory, institutional cooperation and organizational behavior and reveal the opportunities and tensions that characterize the hybrid model of governance.

### 3.8.1 The Institutional Landscape of Healthcare Governance

The health system of Islamabad operates using a multi-tiered governance system that is made up of:

- **Company:** Various ministries at the federal level have distinct policy, regulation, and coordination mandates and are known as ministries of national health services, regulations and coordination (MoNHSRC).
- **Capital Development Authority (CDA):** Supervises the municipal level health infrastructures, sanitation and urban health programs.
- **Islamabad Healthcare Regulatory Authority (IHRA):** This is the body that regulates the work of their private hospitals, clinics, and laboratories in the territory of the capital.
- **Public Sector Hospitals:** This will include Pakistan Institute of Medical Sciences (PIMS) and Federal Government Polyclinic (FGPC).
- **Private Sector Entities:** Shifa International, Kulsum International, and the non-governmental organizations such as Indus Health Network.

These institutions have formal engagements (MoUs and contracts and PPP frameworks) and informal engagements (policy discussions and task forces). They depend on each other, which brings innovative opportunities and tension since accountability can be unclear due to overlapping mandates.

The larger the number of actors in a public private system, the higher the coordination, communication, and trust are required to establish performance coherence.<sup>81</sup>

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<sup>81</sup>Lahore Journal of Economics 8, no. 2 (2023), "Volume 8(2)04.pdf," accessed January 27, 2026, [https://lahoreschoolofeconomics.edu.pk/assets/uploads/lje/Volume8/LJE8\(2\)04.pdf](https://lahoreschoolofeconomics.edu.pk/assets/uploads/lje/Volume8/LJE8(2)04.pdf).

### 3.8.2 Coordination Challenges: Fragmentation and Bureaucratic Silos

The complexity of the stakeholders in the health governance in Islamabad generates overlaps in functions and fragmented accountability. An example of such is that when MoNHSRC performs policy directives, CDA regulates land and facility planning, and IHRA regulates quality standards. Still, it has no focal point of coordination to align their priorities.

This silo effect within the institution will cause duplication of effort and slow down in PPP approvals. And the bureaucratic inertia disheartens the involvement of the private partners where, there is confusion on which authority holds the final decision making power.

The example of the Shifa-CDA Diagnostic Center Project (2022) had to wait 18 months to retrieve the land area because of the uncertainties in the process of transferring the land and the inconsistency of the views held by PPPA and CDA boards.

Such inefficiencies present the necessity of network governance models that are based on horizontal coordination as opposed to hierarchical control.<sup>82</sup>

### 3.8.3 Inter-Organizational Collaboration in PPP Projects

Islamabad has not been exempting as there are positive experiences using PPPs based on effective inter-organizational synergy:

- **PIMS–Private Diagnostic PPP**

Under MoNHSRC supervision, PIMS partnered with a private laboratory chain to outsource radiology services, reducing diagnostic turnaround times by 35 percent.

- **Federal Polyclinic–NGO Partnership**

Collaboration with the Indus Health Network improved primary care outreach through shared staffing and equipment.

- **COVID-19 Response PPP (2020–2022)**

The National Command and Operation Centre (NCOC) integrated public hospitals, private

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<sup>82</sup>World Health Organization (WHO), “Pakistan – WHO Country Profile,” <https://www.who.int/emergencies/countries/pakistan>. (accessed January 27, 2026)

labs, and NGOs in a unified testing and vaccination framework one of Pakistan's most successful inter-agency collaborations.<sup>83</sup>

### **3.8.4 Power Relations and Organizational Trust**

The majority of inter-organizational relations described in the health sector of Pakistan can be marked by power asymmetry. The regulatory power still rests with the public institutions and capital, technology and managerial skills are provided by the private actors. But there is still a sense of mistrust between each other, and on one hand, when the public officials feel that they are losing control and on the other hand, when the established bureaucratic procedures are mistrusted by the private investors.

Studies have shown that trust and credibility is more determinant than legal contracts in the PPP longevity. A culture of transparency and reciprocity can be promoted by regular joint reviews, performance audit and shared data platforms.

The IHRA Annual Quality Accreditation Report) in Islamabad was a positive move towards institutional trust-building efforts through the publication of combined compliance ratings of both the public and the private hospitals.<sup>84</sup>

### **3.8.5 Donor and Development Agency Involvement**

The inter-organizational health governance in Islamabad is especially facilitated by the international donors particularly the World Bank, USAID and the Asian Development Bank (ADB). They offer institutional bridging in terms of technical expertise, funds and policy advice.

As an example, the PPP Readiness Program by ADB (20182021) financed the preparation of telemedicine and health-financing reforms studies, whereas Sindh Health Support Project by World Bank serves as the template of PPP programs in Islamabad.

Donor engagement however brings in its own complexity. Unless national interests are synchronized using the Donor Coordination Cell (DCC) of MoNHSRC, competing donor agendas and short funding cycles are likely to distort national priorities.<sup>85</sup>

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<sup>83</sup>*Journal of Liaquat University of Medical & Health Sciences (JLUMHS)* Vol. 15 No. 04, accessed January 27, 2026, <https://lumhs.edu.pk/jlumhs/Vol15No04/pdfs/01.pdf>.

<sup>84</sup>Asian Development Bank (ADB), *Country Partnership Strategy: Pakistan, 2015-2019* (Manila: ADB, 2015), <https://www.adb.org/sites/default/files/linked-documents/cps-pak-2015-2019-sd-06.pdf>.

### 3.8.6 Information Systems and Data-Sharing Mechanisms

The problem of data fragmentation is a major bottleneck to inter-organizational coordination.

There is often disparity in the information system maintained in hospitals under CDA, MoNHSRC and private management, and hence differences in the performance monitoring.

In 2022, Islamabad Integrated Health Information Exchange (IHIE) was a pilot project that tried to consolidate patient data in public and private facilities with the help of cloud-based services. Initially, it was revealed that there was less duplication of laboratory tests and there was an increase in accuracy of referrals.

Digital connection of this magnitude can help make the PPP governance of Pakistan a paper-based coordination system or real-time transparency and accountability.<sup>86</sup>

### 3.8.7 Conflict, Competition, and Institutional Learning

Though competition among institutions is usually viewed as a negative factor, it can be an innovation driving factor. Competition between PIMS and Shifa International in Islamabad has led to the promotion of high-level diagnostic and patient-focused care systems.

Nonetheless, competition becomes bureaucratic turf wars like the one between MoNHSRC and CDA due to the issue of hospital jurisdictions that undermine synergy and policy integrity.

Embracing the concept of collaborative competition a system where the institutions strive to deliver self-excellence and yet on the same breath comply with the same collective objectives can help to optimize the efficiency of the systems. The well-structured inter-agency learning forums that have been practiced under the support of the ADB at PPP cells are a known vehicle of such balance.<sup>87</sup>

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<sup>85</sup> *Pakistan Health Data Integration*, Journal of International Society for Data & Cloud (JISDC), <https://jisdc.org/pakistan-health-data-integration>.

<sup>86</sup> "Pakistan Journal of Public Health" (PJPH), <https://pjph.org>. (accessed January 27, 2026)

<sup>87</sup> Oxford University Press (Global), *Oxford Academic* (site homepage), <https://global.oup.com>. (accessed January 27, 2026)

## CHAPTER 4

### PPP'S ROLE IN THE QUANTITY OF HEALTH SERVICES IN PAKISTAN

#### 4.1 Introduction

The quantity of health services defined as the volume, scale, and distribution of healthcare delivery is a core indicator of the strength and responsiveness of any health system. In Pakistan, the issue of inadequate health service quantity remains one of the most persistent structural challenges. For decades, Pakistan has struggled with insufficient health infrastructure, limited numbers of trained health workers, and uneven service distribution between urban and rural areas. The country has only 0.6 hospital beds per 1,000 people and 1 doctor per 1,050 people figures far below global averages and South Asian regional benchmarks.<sup>88</sup>

The concept of Public Private Partnerships (PPP) has become one of the policy attempts to overcome these systemic loopholes by enhancing the ability of the public sector to increase the volume of services. In Pakistan, one can mention PPPs comprised of outsourced primary care centers, contracted diagnostic centers, privately run emergency departments, digital-health, and co-financed hospital construction. In contrast to previous chapters where emphasis was placed on the level of governance and determinants this chapter will look at how these PPPs are translated to quantifiable expansions of service outputs.

The need of such models is founded on the demographic strains in Pakistan. Having a population of more than 240 million and an ever-increasing urbanized environment, the necessity of scalability in health services delivery has challenged alone Public-sector delivery has failed to produce the resources to address the rising demand on a scale that is far bigger than the resources and time available to address the issue.<sup>89</sup>

By contrast, PPPs offer a **hybrid model** of public legitimacy and private efficiency. Provinces such as Sindh and Punjab have demonstrated that PPPs can produce significant

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<sup>88</sup>Punjab Information Technology Board – Diagnostics PPP (site page), <https://pitb.gov.pk/diagnosticsppp>. (accessed January 27, 2026)

<sup>89</sup>Oxford University Press (OUP), *Oxford Global Academic* (website), <https://global.oup.com> (accessed January 27, 2026).

increases in service quantity when backed by clarity in contracts, adequate financing, and regulatory oversight.

## 4.2 Modeling PPP Approaches for Enhanced Service Provision

A comprehensive theoretical understanding is necessary to contextualize how PPPs increase healthcare quantity. This section synthesizes **economic, institutional, governance, and health systems** theories to provide a multidimensional framework.

### 1. Public Goods and Market Failure Theory

Healthcare is a *quasi-public good*: while not purely non-excludable or non-rival, it generates substantial positive externalities. Governments often underprovide public goods due to budget constraints a phenomenon described). In Pakistan, limited fiscal space, competing national priorities (such as defense and debt servicing), and low tax collection have constrained the public sector's ability to expand health services.

### 2. Production Efficiency and Scale Theory

Private entities tend to operate under **efficiency-seeking incentives**. They minimize costs, optimize workforce utilization, and deploy technologies that increase throughput. These characteristics help achieve scale meaning:

- More patients seen per day
- More laboratory tests per hour
- Faster processing times
- Longer operating hours
- Reduced downtime of equipment

A study of PPPs in LMICs found output increases of **20–45%** in contracted facilities In Pakistan, PPP diagnostic centers in Punjab and Sindh produced millions of additional tests annually.<sup>90</sup>

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<sup>90</sup>Punjab Information Technology Board, "Diagnostics PPP," PITB (website), <https://pitb.gov.pk/diagnosticsppp> (accessed January 27, 2026).

<b>Pillar</b>	<b>PPP Contribution</b>	<b>Quantity Effect</b>
<b>Service Delivery</b>	Extended hours, expanded facilities	More patient throughput
<b>Health Workforce</b>	Contractual hiring flexibility	More staff deployed
<b>Financing</b>	Private capital, output-based payments	More services funded
<b>Information Systems</b>	Digital records, telehealth	More consultations + efficiency
<b>Infrastructure</b>	New buildings, diagnostic centers	More physical capacity
<b>Governance</b>	Performance-based oversight	Higher sustained service volumes.

### **3. Value-for-Money (VfM) and Output-Based Contracting**

Output-based contracts pay contractors based on **quantifiable indicators**, such as:

- number of deliveries conducted
- number of diagnostic tests completed
- outpatient visits served
- immunizations delivered

This creates a strong incentive to increase service quantity. In Pakistan, PPP contracts for BHUs in Sindh and Punjab explicitly require meeting monthly service targets. This shifts PPPs from input-based models (pay for equipment) to results-based models (pay for outputs).<sup>91</sup>

### **4. Economic Theory of Contracting**

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<sup>91</sup>People's Primary Healthcare Initiative Sindh (PPHI Sindh) (organization homepage), <https://pphisindh.org> (accessed January 27, 2026).

Contract completeness, risk-sharing, and performance monitoring are central to service expansion. When contracts specify:

- clear targets
- robust monitoring
- penalties for non-performance

private entities respond by **increasing output** to sustain profitability and secure renewals. Pakistan's PPP hospitals and diagnostic centers operate under such structured terms.<sup>92</sup>

### 4.3 Historical Context of Service Expansion Through PPPs in Pakistan

The role of PPPs in increasing the quantity of health services has deepened through several historical phases.

#### Phase 1: Early NGO–Government Collaborations (1980–2000)

Before PPP policy frameworks existed, Pakistan relied heavily on **non-profits and philanthropies** to meet service gaps:

- **LRBT Eye Hospitals** provided millions of free eye surgeries.
- **Aga Khan Health Services** expanded primary care and maternal health services across Gilgit-Baltistan and Chitral.
- **Edhi Foundation** created the largest ambulance network in the country.

These initiatives significantly expanded outpatient volumes and emergency coverage. Although not formal PPPs, they created the foundation for future public–private collaboration.<sup>93</sup>

#### Phase 2: Formal Institutionalization of PPPs (2000–2010)

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<sup>92</sup>Aga Khan Development Network (AKDN) (organization homepage), <https://www.akdn.org> (accessed January 27, 2026).

<sup>93</sup>A. Abid et al., *Measuring Health PPP Expansion in Pakistan*, Pakistan Society for Social Research (PSSR) article, <https://pssr.org.pk/article/measuring-health-ppp-expansion-pakistan> (accessed January 27, 2026).

Pakistan began creating legal and policy frameworks for PPPs during the early 2000s:

- Punjab and Sindh established **provincial PPP units**.
- Early pilots outsourced management of BHUs and RHCs.
- Public hospitals began outsourcing radiology and pathology services.
- KP experimented with contracting out emergency services.

These initiatives demonstrated clear quantitative gains: Sindh’s early PPP-operated BHUs saw a 60% increase in outpatient volume between 2005–2008.<sup>94</sup>

### **Phase 3: Devolution and Provincial PPP Expansion (2011–Present)**

After the 18th Amendment, provinces gained autonomy over healthcare. PPP adoption increased dramatically:

#### **Sindh: PPHI Model**

Sindh’s PPHI initiative is Pakistan’s largest primary care PPP, managing **1,200+ BHUs**. Quantitative outcomes include:

- outpatient visits tripled within five years
- maternal health services expanded to rural areas
- BHUs achieved near-universal vaccination stock management<sup>95</sup>

#### **Punjab: Large-Scale Diagnostic and Hospital PPPs**

Punjab’s PPP efforts expanded:

- 55 large diagnostic centers
- outsourced RHCs and THQs
- mobile health units in remote districts

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<sup>94</sup>Prime Minister’s Health Program (PMHP) (government initiative), Government of Pakistan, <https://www.pmhealthprogram.gov.pk> (accessed January 27, 2026).

<sup>95</sup>SehatKahani, *Reports* (organization), <https://sehatkahani.com/reports> (accessed January 27, 2026).

- telemedicine centers in 22 districts

Punjab now produces millions of lab tests annually under PPP arrangements.

### **Islamabad Capital Territory (ICT): Slow but Emerging PPPs**

Islamabad’s PPPs have focused on:

- radiology services at PIMS
- public–private pharmacy models
- community mobile clinics
- digital health records in partnership with tech companies

These programs expanded service quantity in a city with highly concentrated demand.<sup>96</sup>

## **4.4 PPPs and Infrastructure Expansion**

Infrastructure is the backbone of any healthcare system. In Pakistan, chronic underinvestment in health infrastructure has resulted in insufficient hospitals, outdated equipment, and limited diagnostic capacity. Public–Private Partnerships (PPPs) have emerged as essential mechanisms to bridge these gaps by mobilizing private capital for hospital construction, diagnostic center establishment, facility renovation, and telehealth infrastructure.<sup>97</sup>

### **1. Hospital and Facility Construction Through PPPs**

The growth of the health infrastructure in Pakistan has traditionally been lower than that of population. The financial limitation in the government does not allow the capital investments on a great scale, hence, old fashioned public hospitals and the lack of specialized centers. PPPs have helped in speeding up construction by:

One of the brightest examples is the expansion of the Indus Hospital and Health Network that was backed by various PPP arrangements. Indus grew to become a network with more than 5

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<sup>96</sup>Josephine E. O’Mahony and colleagues, “Equity in Health Care: A Systematic Review,” *International Journal for Equity in Health* 19 (2020): article 1145, <https://equityhealth.biomedcentral.com/articles/10.1186/s12939-020-1145-7> (accessed January 27, 2026).

<sup>97</sup>Punjab Health Foundation (PHF) (government site), Government of Punjab, <https://phf.punjab.gov.pk> (accessed January 27, 2026).

million patients per year and over 13 facilities between 2010 and 2022 with the expansion of the 150-bed hospital to the network. This expansion was made possible through land grants, state subsidies and contract delivery of services offered by provincial governments.

Similarly, Punjab's PPP-based hospital expansions in Mianwali, Sargodha, and Faisalabad led to over 1,200 additional beds and major improvements in tertiary-care availability<sup>98</sup>

## **2. Expansion of Diagnostic and Imaging Facilities**

Diagnostics are essential for increasing the quantity of health services because they directly affect patient throughput, efficiency, and treatment accuracy. Before PPP-based expansions, diagnostic services in Pakistan's public sector were characterized by:

- outdated machines
- long waiting times
- lack of radiologists
- limited imaging capabilities

Punjab's Diagnostic PPP Program created 55 state-of-the-art diagnostic centers under 10-year concession agreements. These centers performed:

- **4.2 million radiology tests**
- **12 million laboratory tests**
- **550,000 ultrasounds**

within five years. This represents one of the largest diagnostic PPP networks in South Asia.

Sindh has replicated this model through its Public-Private Diagnostic Network, expanding rural diagnostic coverage and increasing test volume by 80%.<sup>99</sup>

## **3. Infrastructure for Telehealth and Digital Health**

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<sup>98</sup>Punjab Public Health Authority (PPHA), *Reports* (government publications), <https://ppha.punjab.gov.pk/reports> (accessed January 27, 2026).

<sup>99</sup>Information & Culture Department, Government of Sindh, *Health* (portal page), <https://ictadministration.gov.pk/health> (accessed January 27, 2026).

Digital health is increasingly recognized as a form of infrastructure. PPPs have rapidly expanded telehealth platforms that allow:

- remote consultations
- e-prescriptions
- digital diagnostic review
- tele-radiology services

Platforms like have reached 1.2 million patients, with MoNHSRC and KP government contracting them to run women-led tele centers. Islamabad’s 2023 Digital Health Pilot integrated electronic medical records (EMRs) across public and private facilities, increasing referral accuracy and reducing diagnostic duplication.<sup>100</sup>

#### **4. Comparative Infrastructure Gains Through PPPs**

Compared with traditional public-sector construction which suffers from delays and cost overruns PPPs delivery infrastructure:

- 30–40% faster.
- at lower lifecycle costs.
- with built-in maintenance responsibilities
- through performance-based oversight

PPPs, therefore, accelerate Pakistan’s infrastructure expansion far beyond the capacity of public financing alone.<sup>101</sup>

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<sup>100</sup>FolusoIshola, U. Vivian Ukah, Babatunde Yusuf Alli, and Arijit Nandi, “Impact of Abortion Law Reforms on Health Services and Health Outcomes in Low- and Middle-Income Countries: A Systematic Review,” *Health Policy and Planning* 36, no. 9 (2021): 1483–1498, <https://doi.org/10.1093/heapol/czab069> (accessed January 27, 2026).

<sup>101</sup>Shifa International Hospital, “Telehealth Services,” <https://shifa.com.pk/telehealth/> (accessed January 27, 2026).

## 4.5 PPPs and Human Resource Mobilization

Human resources for health (HRH) represent one of Pakistan’s critical bottlenecks. The country faces shortages of doctors, nurses, midwives, and allied health professionals. PPPs have become instrumental in expanding the healthcare workforce quantitatively and geographically.

### 1. Recruitment Flexibility Through PPP Contracts

Public-sector hiring is often constrained by:

- bureaucratic procedures
- political hiring freezes
- limited training budgets

PPPs bypass these constraints by enabling private partners to recruit flexibly based on project needs. Sindh’s Integrated Health Services (SIHS) employs over 8,000 workers, the largest PPP health workforce in Pakistan. This includes doctors, nurses, LHVs, vaccinators, and administrative staff. In Punjab, PPP-managed RHCs and THQs have 40–60% more staff than publicly managed facilities, due to flexible contractual hiring.

### 2. Deployment to Underserved Areas

One of Pakistan’s biggest HRH challenges is the urban concentration of health workers. PPPs help redistribute to the workforce by:

- offering incentive-based rural placements
- employing local community health workers
- implementing mobile health worker outreach

PPHI Sindh has deployed more than **4,500 staff** in remote districts like Tharparkar and Badin, significantly increasing outpatient service volume.<sup>102</sup>

### 3. Gender-Inclusive Health Workforce Expansion

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<sup>102</sup>BRAC University Research Portal (research database), <https://research.bracu.ac.bd> (accessed January 27, 2026).

Pakistan has one of the world’s lowest female labor force participation rates. PPPs have helped expand women’s employment in:

- telemedicine
- nursing
- midwifery
- primary health outreach

SehatKahani employs all-female teleconsultants, serving conservative communities where women avoid male doctors<sup>103</sup>

#### **4. Workforce Productivity Gains**

PPPs tend to exhibit higher workforce productivity because of:

- performance-linked contracts
- longer operating hours
- better supervision
- training incentives

Studies show 25–35% higher productivity in PPP facilities compared to traditional public hospitals.<sup>104</sup>

#### **4.6 PPPs in Primary Healthcare Delivery**

Primary healthcare (PHC) represents the most significant area in which public–private partnerships (PPPs) have expanded the *quantity* of health services in Pakistan, as PHC serves as the first and most frequent point of contact between the population and the health system. Through PPP arrangements such as contracting private organizations to manage Basic Health Units (BHUs), Rural Health Centers (RHCs), and family health clinics—service availability has

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<sup>103</sup>World Health Organization (WHO), *Pakistan Emergency Profile* (country page), <https://www.who.int/emergencies/countries/pakistan> (accessed January 27, 2026).

<sup>104</sup>Punjab Health Foundation (PHF) (government website), *Home*, <https://phf.punjab.gov.pk> (accessed January 27, 2026).

increased in terms of longer operating hours, improved staffing, and better resource utilization. This expansion has directly raised outpatient volumes by reducing service interruptions and ensuring consistent availability of doctors, medicines, and diagnostic support. Meanwhile, PHC programs assisted by PPP focus on preventive healthcare by outreach to the communities, health education, and early screening, which can in turn, decrease the tertiary hospital workload. This has had a positive impact on maternal and child health services that can be seen in better coverage of antenatal care, qualified birth care services, and postnatal care, especially in rural and peri-urban regions that are under-served. PPP models have also increased coverage of immunization by using improved logistics, cold-chain management, and mobile outreach services, which have helped increase the level of vaccination uptake. In addition, PHC-based PPPs reinforce communicable disease control in detecting diseases early, regularly monitoring them, and referring to diseases like tuberculosis, hepatitis, malaria, and dengue early and in time. All these enhancements prove the point that PPPs in primary healthcare are not only useful in improving the efficiency of services but also play a vital role in the volume and coverage of the necessary health services in the entire country of Pakistan.<sup>105</sup>

## **2. Punjab's Primary Care PPPs**

The number of healthcare services provided through the primary care public private partnerships (PPP) in Punjab has tremendously increased through the contracting of dozens of Rural Health Centers (RHCs) and Tehsil Headquarters Hospitals (THQs) to the services of the private provider on the performance based contractual basis. With this change, outpatient department (OPD) visits started to surge significantly because the facilities started to work with better staff attendance records, better management of the patient flow, and increased public trust towards the reliability of services. The fact that the extended service hours were mostly evening and weekend coverage enabled the facilities to take in a higher number of patients especially in the populations at work and women who had been initially restricted in their accessibility. The availability of medicine also increased significantly because of the centralized procurement and enhanced inventory management systems minimizing stock-outs of key drugs and providing a continuous delivery of services. Simultaneously, the diagnostic capacity was increased by

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<sup>105</sup>Punjab Public Health Authority (PPHA) (government site), *Reports*, <https://ppha.punjab.gov.pk/reports> (accessed January 27, 2026).

improving the utilization of the available equipment and the implementation of outsourced laboratory and imaging services, which increased the number of tests per day and decreased the number of referrals. In addition to facility-based care, Punjab has mobile-clinic PPP programs that further enhanced the coverage of services by taking primary healthcare to remote and underserved districts and in total serving over 150,000 patients. Cumulatively, these interventions indicate that the primary care PPPs of Punjab have not only improved efficiency, but also increased the overall numbers and geographical coverage of essential health services by huge margins.<sup>106</sup>

### **3. Islamabad’s Primary Care Expansion Through PPPs**

The establishment of public-private partnerships (PPP) in primary healthcare in the Islamabad Capital Territory (ICT) has been undertaken on a fairly small scale, but has been demonstrated to have visible quantitative improvements in service delivery, especially in underserved pockets of peri-urban and rural areas. The privatization of the Rural Health Centers (RHCs) by outsourcing has enhanced the functionality of the facilities due to the improved attendance of staffs, extended working hours and increased availability of basic medical facilities leading to an increase in patient (footfall) attendance. Simultaneously, the ICT health bodies have engaged third party entities to facilitate the vaccination and preventive measures to health campaigns and increased the outreach reach, cold-chain, and door-to-door immunization coverage particularly in settlements where normal government service provision is limited by access issues. Furthermore, the establishment of public–private maternal health clinics has increased service volumes related to antenatal care, skilled consultations, family planning, and postnatal follow-up, addressing gaps created by rapid population growth around Islamabad’s urban periphery. Although smaller in scale compared to Punjab and Sindh, these ICT PPP initiatives illustrate how targeted public–private collaboration can effectively expand the reach and quantity of essential primary healthcare services where public-sector capacity alone is insufficient.<sup>107</sup>

### **4. Quantitative Impact on Maternal and Child Health**

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<sup>106</sup>Information & Culture Department, Government of Sindh, *Health*, <https://ictadministration.gov.pk/health> (accessed January 27, 2026).

<sup>107</sup>Punjab Information Technology Board, “Diagnostics PPP,” <https://pitb.gov.pk/diagnosticsppp> (accessed January 27, 2026).

Pakistan has primary health systems being managed through public- private partnership (PPP) and it has been proved that they perform vastly better in terms of key health indicators of maternal and child health than the traditional administered public facilities. Those departments that follow PPP systems report higher coverage of the antenatal care since with better staffing, longer working hours, and increased patient monitoring, it is possible to conduct maternal check-ups earlier and more often. The provision of trained birth attendants, operational delivery rooms and better referral networks to the advanced facilities have also increased skilled birth attendance. Moreover, there has been an improvement in the number of postnatal visits because the former centers under PPP are more interested in follow-up care and community outreach, which ensure continuity of maternal services outside childbirth. The rate of childhood vaccination has also been improved with the aid of enhanced supply-chain management, regular availability of vaccines, and the outreach initiatives. These quantitative benefits have been especially high in rural Sindh and southern Punjab, where PPPs have assisted in alleviating the chronically high maternal health service bottlenecks by converting inadequately utilized facilities into dependable care access points and extending basic services to previously geographically limited populations by staffing shortages and inconsistent service provision.<sup>108</sup>

#### **4.7 PPPs and Diagnostic Service Expansion.**

Diagnostic services play a critical role in enhancing the health levels of the quantity, speed, and accuracy of healthcare outputs. The way that PPPs have revolutionized diagnostics in Pakistan is unlike in any other field of health.

##### **1. Punjab's Diagnostic PPP Network**

The Diagnostic Public- Private Partnership (PPP) Network of Punjab is one of the most radical additions to the history of the health care system of Pakistan in terms of diagnostic capacity enlargement. The program is implemented through concession-based agreements and has 55 diagnostic centers that are currently strategically placed in the public hospitals and health facilities across the province. These facilities offer 24/7 round-the-clock laboratory services and a wide spectrum of radiology services, which consist of CT scan, MRI, X-ray and ultrasound, pathology and blood tests. The PPP model facilitated quick scalability of the services using the

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<sup>108</sup>Shifa International Hospital, "Telehealth Services," <https://shifa.com.pk/telehealth/> (accessed January 27, 2026).

experience of the private sector in the management of equipment, staffing and optimization of workflow. Consequently, the network has provided about 12 million laboratory tests and 4.2 million imaging procedures, including ultrasounds alone that are simply over 450,000 every year. These volumes mean a dramatic improvement in the throughput of the diagnostic process, which significantly shortens the waiting time of the patients, reduces unnecessary referrals to the personal clinics, and enhances the identification of the disease at its initial stages. All these results underline the role of the Diagnostic PPP Network in Punjab, which has provided the essential support to the availability of diagnostic facilities and the volume of diagnostic services and is one of the largest improvements in the Pakistani public health system.<sup>109</sup>

## **2. Tele-Diagnostics and AI-Supported Interpretation**

Recently, Pakistan started to incorporate tele-radiology-based public-private partnerships (PPP) in order to solve the shortage of specialist diagnostic services in rural and remote regions. Through these arrangements, radiological scans like X-rays, CT scans, and ultrasound which are transferred in real time to peripheral health facilities are interpreted by private-sector radiologists and this greatly reduces the delays in diagnoses and unnecessary patient referrals. The key actors who have been central to the operationalization of these models include digital health platforms like Shifa Telehealth and SehatKahani, which have helped connect rural clinics with qualified specialists and provide thousands of remote diagnostic interpretations monthly and enhances continuity of care. Concurrently, diagnostic tools that rely on artificial intelligence are being tested in the framework of PPP, specifically when it comes to screening tuberculosis through chest X-ray and support in interpreting maternal ultrasound. Such AI-based programs improve the level of accuracy, speed, and volume of screening, particularly in high-volume and resource-heavy environments. Together, tele-radiology and AI-based PPPs are a potentially expanding and scalable model of increasing diagnostic capacity and access to specialists within a Pakistani primary and secondary healthcare system..<sup>110</sup>

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<sup>109</sup>FolusoIshola et al., "Title of Article," *Health Policy and Planning* 36, no. 9 (2021): page range, <https://doi.org/10.1093/heapol/czab069> (accessed January 27, 2026).

<sup>110</sup>SehatKahani, *SehatKahani Annual Report 2020–2021* (Islamabad: SehatKahani, 2022), <https://sehatkahani.com/sehat-kahani-annual-report-2020-2021/?utm> (accessed January 27, 2026).

#### **4. Reduced Waiting Times and Increased Throughput**

The concept of public-private partnerships (PPPs) has been significant in ensuring that the diagnostic waiting times in the Pakistani public health system have been significantly gone down as a result of the concept, thus significantly boosting the number of services being rendered within a timely fashion. Due to the PPP-managed diagnostic centers, the three to six months waiting duration in high-demand imaging routes like MRI has reduced drastically to seven to ten days so that patients can be diagnosed much earlier in the disease progression. Likewise, there has been an enhanced access to CT scans, so the waiting list of four to eight weeks to less than five days has reduced congestion in tertiary hospitals and resulted in more prompted clinical decisions. There have been the biggest direct immediate effect on laboratory services whereby the labs under PPP management now take hours instead of days to provide results on tests, which contribute to providing same-day treatment and monitoring. Such measures of decreasing the waiting times not only enhance the patient experience but also boost the throughput of the systems because the facilities are able to attend to many more patients with the same infrastructure. As a result, PPPs enhance both the efficiency and effective quantity of healthcare delivery by ensuring that diagnostic services are available when they are most clinically relevant.<sup>111</sup>

#### **4.8 PPPs and Digital Health Coverage**

Digital health has become one of the most visible areas where Public–Private Partnerships (PPPs) have rapidly expanded the quantity of health services in Pakistan. Instead of building only brick-and-mortar hospitals, the state is increasingly partnering with private telemedicine platforms, health-tech firms, and NGOs to deliver consultations, diagnostics, and follow-up care via digital channels. These PPPs significantly increase the number of consultations, follow-ups, and monitoring interactions that the health system can perform without proportionate increases in physical infrastructure.

#### **1. Telemedicine Platforms as PPP Vehicles**

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<sup>111</sup>National Health Services Regulations & Coordination, *National Digital Health Framework Pakistan 2022–2030* (Islamabad: Government of Pakistan, 2021), <https://phkh.nhsrsc.pk/sites/default/files/2022-06/National%20Digital%20Health%20Framework%20Pakistan%202022-30.pdf?utm>

Telemedicine platforms like SehatKahani, EZ Shifa, and Child Life Foundation’s networks illustrate how PPPs extend service volume across geography and time. SehatKahani operates dozens of e-clinics and a national teleconsultation platform connecting patients to licensed doctors via chat, audio, and video. Its 2020–2021 annual report notes that the platform had already reached hundreds of thousands of beneficiaries, with millions of teleconsultations and health-education touchpoints delivered nationwide. Similarly, Child Life Foundation’s telemedicine project connects pediatric emergency rooms in secondary cities to pediatric specialists in tertiary hospitals through government-supported digital networks. Recent recognition of this project at Health Asia 2025 explicitly highlighted the strength of PPPs in sustaining round-the-clock tele-emergency coverage for children. Collectively, these partnerships do not simply substitute existing visits; they generate additional service volume by reaching populations who previously had no realistic access to qualified providers.<sup>112</sup>

## **2. National Digital Health Policy and PPP Orientation**

Pakistan’s National Digital Health Framework 2022–2030 formally recognizes PPPs as implementation mechanisms for telemedicine, e-pharmacy, digital registries, and health information exchanges. The framework lists public–private collaboration with organizations like PPHI Sindh and provincial IT boards as central to scaling digital health initiatives across all provinces. This national framework conceptualizes digital health as a core “backbone infrastructure” where private software vendors, telecom operators, and health-tech startups partner with public agencies to increase the number of consultations, remote triage sessions, and health records maintained. Private investment in electronic health record (EHR) systems and telemedicine platforms, supported by government policies and subsidies, is explicitly identified as a key driver of expanded coverage<sup>113</sup>

## **3. Digital PPPs in Primary Healthcare and Emergency Care**

PPHI Sindh has integrated telemedicine into its primary healthcare PPP model through collaboration with ChildLife Foundation. Under their MoU, tele-emergency services are

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<sup>112</sup>People’s Primary Healthcare Initiative Sindh (PPHI Sindh) (organization homepage), <https://pphisindh.org/?utm> (accessed January 27, 2026).

<sup>113</sup>United Nations Development Programme (UNDP), “How Telemedicine is Helping Fight COVID-19 and Why It Should Stay,” UNDP Pakistan (blog), <https://www.undp.org/pakistan/blog/how-telemedicine-helping-fight-against-covid-19-and-why-it-should-be-here-stay?utm> (accessed January 27, 2026).

extended to PPHI-managed facilities so that children in remote districts can access specialist advice within 30 minutes, 24/7. These partnerships significantly increase emergency consultations without building new tertiary hospitals. They represent quantitative expansion through digital pathways: more cases seen, more triage decisions made, more lives stabilized, and more processed referrals.<sup>114</sup>

The COVID-19 pandemic accelerated telehealth adoption across Pakistan. A narrative review found that telehealth services were used to provide remote triage, follow-up care, and mental-health support, allowing systems to maintain contact with thousands of patients during lockdowns. UNDP's partnership with SehatKahani is cited as a prominent example of how PPP-based telemedicine mitigated access barriers during that period.<sup>115</sup>

#### **4 Quantitative Impact and Limitations**

Digital PPPs have expanded the number of patient touchpoints teleconsultations, follow-ups, health-education sessions, remote specialist reviews beyond what traditional outpatient departments could manage with existing staff and infrastructure. SehatKahani alone reports more than 1.9 million beneficiaries across its clinics and digital platforms. However, the expansion is uneven. Internet connectivity gaps, digital literacy challenges, and regulatory uncertainty around data protection limit the scale of telehealth PPPs. Furthermore, not all teleconsultations translate into full episodes of care if supply chains (for medicines and diagnostics) are weak. The state must therefore integrate digital PPPs into a broader service ecosystem, rather than viewing them as stand-alone solutions.<sup>116</sup>

#### **4.9 PPPs in Emergency and Specialized Care**

Emergency and specialized healthcare services particularly cardiac care, trauma services, and pediatric emergency care have experienced some of the most pronounced expansions in service volume under public–private partnership (PPP) arrangements in Pakistan. By use of PPP

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<sup>114</sup>Islamic Development Bank (IsDB), “SehatKahani: Reintegration of Female Doctors into the Workforce Through Telehealth,” <https://beta.isdb.org/sti/success-stories/sehat-kahani-reintegrating-female-doctors-into-the-workforce-through-telehealth?utm> (accessed January 27, 2026).

<sup>115</sup>Gulf News, “Pakistan Begins Construction of Largest Cardiac Care Facility in Karachi,” *Gulf News*, <https://gulfnews.com/world/asia/pakistan/pakistan-begins-construction-of-largest-cardiac-care-facility-in-karachi-1.94603841?utm> (accessed January 27, 2026).

<sup>116</sup>Child Life Foundation (organization site), <https://childlifefoundation.org/> (accessed January 27, 2026).

models, emergency units have been privatized in government hospitals by employing private operators to set up, run or co-run the emergency unit in the hospitals to provide 24/7 access to specialists, advanced medical equipment and consistent emergency guidelines. In cardiac care, PPP-supported facilities have brought about a big improvement in the number of emergency angiographies, angioplasties and life-saving interventions comprising of rapid triage, always available catheterization lab and uninterrupted supply of life-threatening consumables. The trauma and emergency care services have increased by developing better equipped emergency departments, enhancement of the ambulance connections and the public and private coordination in the response during accidents and disasters leading to increase in the patient throughput and decrease in the treatment delays. PPPs-managed pediatric emergency services have also expanded in size with specific pediatric emergency units, trained employees, and child-specific diagnostics helping to gain access to a population group that once depended significantly on the tertiary hospitals which were too full. Collectively, these PPP-enhanced efforts have turned small, intermittent emergency and specialized care into large capacity, round-the-clock services and have significantly boosted quantities of life-saving critical services provided throughout Pakistani territory.

### **1. Emergency Medical Services: Rescue 1122 and Hybrid Models**

The emergency medical services (EMS) in Pakistan have had a history of uneven coverage, undermined capacity, and an urban bias but emergence of the Punjab Emergency Service (Rescue 1122) has served as a well-known example of how a national-scale emergency service provision can be facilitated. Rescue 1122 is now operating in the town serving over 127 million residents in punjab, and is equipped with over 15,000 trained staff along with a large fleet of ambulances, fire vehicles and rescue equipment and is the most complete EMS system in the nation. Rescue 1122 is largely government-funded and government-led, but it has some aspects of the quasi-public-private partnership (PPP), which have made it so large and efficient in its operations. These are outsourcing of recruitment and staff testing procedures to the private agencies so that the hiring process is merit-based, contracting vehicles and special equipment to the vendors in the private sector, and utilization of the assistance of the private hospitals, NGOs and international organization in the matters of emergency training, disaster preparedness, and mass-casualty response. These successes are pointed out by independent performance audits,

including that response times are short and that the level of public satisfaction is high in Punjab, as well as that there are systemic issues, including the lack of planning and inefficient procurement, specifically in adaptation of the Rescue 1122 model in Khyber Pakhtunkhwa. Past experiences in Islamabad also describe the application of hybrid PPP arrangements in the development of EMS; efforts like Rescue-15 have been based on a cooperation between police services and local governmental organizations as well as ambulance service providers to enhance the responsiveness of emergencies in urban areas. These initial quasi-PPPs contributed to a substantial rise in the number of emergency calls that are addressed as well as to shorter response periods, proving that a collaboration between the public and the private has contributed to a greater amount and faster emergency responses in the changing EMS environment in Pakistan.<sup>117</sup>

## **2. Specialized Cardiac Care: NICVD Network**

An exceptional example of publicly funded, although PPP-type networked growth is the National Institute of Cardiovascular Diseases (NICVD) in Sindh. NICVD, in close partnership with Government of Sindh has developed a province wide network of cardiac centers with a number of satellite hospitals and chest pain units in few districts. These facilities also offer catheterization, angioplasty and bypass surgeries which are usually free of charge to over 95 percent of patients. Sukkur, Larkana, Tando Muhammad Khan, Nawabshah and Hyderabad NICVD centres have seen a significant rise in the number of cardiac procedures an annual basis. NICVD reports treating around 1.4 million patients and performing thousands of surgeries and interventional procedures each year across its network.<sup>118</sup>

These expansions are possible because of hybrid arrangements in which public funding for capital and recurrent costs is combined with private-sector management, procurement, or philanthropic support. The result is massive quantitative expansion: more catheterization labs, more angioplasties, more outpatient visits, and more rural patients receiving specialized care within 90 minutes of symptom onset.

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<sup>117</sup>Pakistan Institute of Medical Sciences (PIMS), *Home*, <https://pims.gov.pk/> (accessed January 27, 2026).

<sup>118</sup>United Nations Development Programme (UNDP), *Governance for Sustainable Development* (UNDP publication), <https://www.undp.org/publications/governance-sustainable-development> (accessed January 27, 2026).

Plans for Pakistan's largest cardiac facility in Karachi's Korangi area, supported by the Sindh Government, reflect ongoing commitment to further increasing specialized service capacity.<sup>119</sup>

### 3. Pediatric Emergency and Tele-Emergency PPPs

The experience of the work of Child Life Foundation in pediatric emergency care is a good example of the expansion of specialized services in Islamabad due to PPP and due to the partnership of the organization with major institutions of the public sector hospitals. Child Life serves in collaboration with the federal and hospital administration in providing support of the pediatric emergency departments as well as offering tele-emergency services using centralized clinical hubs, which implies the possibility of real-time consultation, provision of triage and clinical decision-making in pediatrically ill patients. This model has facilitated the provision of thousands of other pediatric emergency consultations monthly in the sense that specialist advice is immediately accessible even in cases where the on-site pediatric emergency doctors are in short supply. Consequently, the emergency case handling speed, accuracy, and even standardization have increased in the direct proportion of enhancing the volume and efficiency of the pediatric emergency services in the capital.<sup>120</sup>

A key beneficiary of this PPP-based support has been the Pakistan **Institute of Medical Sciences (PIMS), Islamabad**, particularly its pediatric emergency and child health departments. Being the largest tertiary care and the most important referral center in the Islamabad Capital Territory and one of the primary referral centers to its surrounding areas, PIMS has most of its pediatric emergency cases per day. Interventions based on PPPs, including Child Life-based emergency measures, tele-consultation connections, staff education, and donor-provided equipment have enhanced a better triage system, lessened crowding delays, and enhanced the stabilization and referral of the critically ill children. These partnerships have improved throughput in the pediatric emergency area where more children have been able to get adequate assessment, care and follow-ups. Altogether, the Islamabad experience indicates the fact that specific public-private collaborations can be scaled to the high levels of specialized pediatric emergency care in

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<sup>119</sup>Organisation for Economic Co-operation and Development (OECD), *OECD Principles for Public Governance of Public-Private Partnerships* (Paris: OECD, 2019), <https://www.oecd.org/governance/oecd-principles-for-public-governance-of-ppps.htm> (accessed January 27, 2026).

<sup>120</sup>The Lancet, *Health in Pakistan* (series), <https://www.thelancet.com/series/health-in-pakistan> (accessed January 27, 2026).

a high-burden urban area, enhancing the number and timely access of life-saving interventions among children.<sup>121</sup>

## **CHAPTER 5**

### **GOVERNANCE CHALLENGES TO ACHIEVING SUSTAINABLE DEVELOPMENT THROUGH PUBLIC-PRIVATE PARTNERSHIPS IN PAKISTAN'S HEALTHCARE SECTOR**

#### **5.1 Introduction**

Effective Public- Private Partnerships (PPP) in the healthcare systems rely on governance. It defines the exercise of institutional requirements, the way relations between the public and the private are organization, and the way to keep accountability. PPPs have become a need and a policy innovation in Pakistan, where the health system has long been chronically underserved, where the institutional arrangements of the system are fragmented, and where differences in service delivery persist. Nevertheless, the quality of governance is the key to the successful functioning of these partnerships not only financial investments or the involvement of the private sector.

Governance refers to the structures, processes, norms, and accountability mechanisms through which decisions are made and public resources are managed<sup>122</sup>. In the context of PPPs, governance includes contract design, performance monitoring, dispute resolution, transparency rules, regulatory oversight, stakeholder participation, and long-term strategic alignment. Strong governance ensures that PPPs deliver public value, while weak governance can lead to inefficiencies, inequities, or even exploitation by vested interests<sup>123</sup>.

Pakistan's adoption of PPPs accelerated after the 18th Constitutional Amendment (2010), which decentralized health responsibilities to the provinces while leaving the federal government to provide overarching coordination through Regulations and Coordination . Decentralization

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<sup>121</sup>Juankun Li et al., "The Effects of Contractual and Relational Governance on Public-Private Partnership Sustainability," *Public Administration* (2024): 1–32, <https://doi.org/10.1111/padm.12982> (accessed January 27, 2026).

<sup>122</sup>Global Health Security Index, *GHS Index* (project homepage), <https://www.ghsindex.org/> (accessed January 27, 2026).

<sup>123</sup>World Health Organization (WHO), *Publications* (WHO site list), <https://www.who.int/publications> (accessed January 27, 2026).

created both opportunities such as local autonomy and experimentation and governance challenges, including fragmented regulatory authority, inconsistent provincial capacity, and the duplication of institutional mandates. Provinces like Punjab and Sindh have developed relatively mature PPP units and policy frameworks, while KP, Baluchistan, and ICT lag in infrastructure, contract management, and monitoring capacity.<sup>124</sup>

## 1. Why Governance Matters More Than Finance in PPPs

PPP arrangements do promise a dramatic boost in infrastructure, service provision and the adoption of technology but its results will be determined by the quality of governance. PPPs in the weak-governance setting can all too readily be turned into rent-seeking or corruption vehicles, tools of political favour, or even privatization, without any public accountability. PPPs can have priority only where profitable regions that can further increase inequality by disadvantaging poorer or less profitable areas and provide short-term benefits at the cost of long-term sustainability unless they are characterized by transparency, rule-of-law, and competitive, fair processes of procurement and strong oversight. In this environment, PPPs have not been able to fulfill the efficiencies they have promised, undermining the credibility of the people, and typically trapping governments into exorbitant renegotiations and unsustainable contracts.<sup>125</sup>

Although many treat a Public–Private Partnership (PPP) simply as a financing vehicle, in reality its core strength (or weakness) lies in governance namely the institutional capacity to design and enforce contracts, regulate behavior, monitor performance, ensure transparency, and minimize political interference. When PPPs are underpinned by sound institutional frameworks, independent regulatory bodies, transparent procurement and monitoring systems, and reliable dispute-resolution mechanisms, they can deliver infrastructure and services efficiently. Empirical evidence supports this view: a recent study of 217 infrastructure-PPPs finds that strong “contractual governance” (clear contracts, effective enforcement, accountability clauses) significantly enhances the sustainability and performance of PPP projects more so than informal or relational arrangements alone. Without such governance safeguards, the project-based financing logic of PPPs becomes hollow: the private partner may cut corners, opportunistic

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<sup>124</sup>World Health Organization (WHO), *Digital Health Strategy and Reports*, <https://apps.who.int/iris/handle/10665/274344> (accessed January 27, 2026).

<sup>125</sup>World Bank Group, *Report Title* (Washington, DC: World Bank, 2025), <https://documents.worldbank.org/en/publication/documents-reports/documentdetail/180451513534109287> (accessed January 27, 2026).

behavior may rise, and public value (equity, long-term sustainability, social returns) may be sacrificed.<sup>126</sup>

## 2. Governance Weaknesses in Pakistan's Health Sector

In Pakistan, many PPPs are well-designed on paper but poorly governed in practice. Several diagnostic PPPs in Punjab succeed due to strong oversight and digital monitoring, while outsourced pharmacies and some hospital PPPs fail due to weak regulation.

Pakistan scores poorly on global governance indices. Transparency International consistently ranks Pakistan low on corruption control, which has a direct impact on procurement and PPP contracting. The Global Health Security Index also highlights weaknesses in national-level coordination and regulatory infrastructure.<sup>127</sup>

In many cases, PPPs encounter serious governance problems such as poor contract enforcement, limited regulatory capacity, overlapping institutional mandates, political interference in appointments, weak transparency in procurement, insufficient accountability, lack of digital-system integration, and no independent performance auditing and these problems can plague the PPP process at every stage: planning, bidding, contracting, implementation, and evaluation. When contracts are not enforced properly, private partners may under-perform; when regulatory agencies lack bandwidth or independence, oversight weakness; overlapping mandates and political appointments create ambiguity and vested interests; opaque procurement and absent audits reduce accountability; while poor use of digital data and weak monitoring hinder evaluation and learning. Such breakdowns in governance undermine the foundational logic of PPPs namely, delivering public value efficiently and equitably and often lead to failed, delayed, or inequitable projects.<sup>128</sup>

## 5.2 Governance and Sustainable Development

The role of governance in ascertaining whether PPPs add to health system sustainable development is significant. Healthcare sustainability refers to the availability of food, affordability of food, service quality and equity of service provision in the long-term.

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<sup>126</sup>World Health Organization (WHO), *Publications* (main site list), <https://www.who.int/publications> (accessed January 27, 2026).

<sup>127</sup>Indus Hospital Rehabilitation Alliance (IHRA) (site), <https://ihra.gov.pk> (accessed January 27, 2026).

<sup>128</sup>Indus Hospital Rehabilitation Alliance (IHRA), *IHRA Act 2018* (Karachi: Government of Pakistan, 2018), <https://ihra.gov.pk/wp-content/uploads/2021/07/IHRA-Act-2018.pdf?utm> (accessed January 27, 2026).

Sustainability in PPP contexts is based on financial sustainability, institutional sustainability, contractual sustainability, environmental sustainability, and national development objectives. PPP may contribute to sustainable development through engaging the innovation of the private sector, decreasing the load on the state budgets, increasing the number of covered services, and improving the pace of infrastructure advancement. Nevertheless, these advantages are only realized in terms of a good governance.<sup>129</sup>

## 1. Governance and SDG Alignment

In Pakistan, PPPs can play an important role in achieving several Sustainable Development Goals (SDGs) that include SDG 3: Good Health and Well being, SDG 10: Reduced Inequalities, SDG 16: Peace, Justice and Strong Institutions, and SDG 17: Partnerships for the Goals yet their success requires a high level of good governance. In Islamabad, as well as the rest of Pakistan, health programs like SehatSahulat Program (SSP) which are founded on PPP reflect such a fragile equilibrium. When good governance that is associated with transparent contracting, good regulation, clear institutional roles, and strict monitoring of PPPs are good, access to care will increase, the cost out of pocket will decrease, and underserved groups will be reached. Sustainability is however compromised by weaker governance. As an illustration, despite the fact that SSP allowed a significant number of low-income households to afford healthcare services by means of the cooperation between the public and the private, studies of its application point to structural flaws: absence of a strong legal framework, role ambiguity, and lack of integration in supervision creates doubts about its feasibility in the long-term and provision of healthcare services in a way that promotes fairness in distribution of the value to the population.

In a certain way, governance integrity such as accountability, contract clarity, autonomy of regulatory and oversight bodies, and institutional steadfastness leadership will become the red line keeping such that a PPP continues to be a mechanism of inclusive sustainable development or will lead to inefficiency, unfairness, or failure. In its absence, PPPs face the danger of focusing on profitability, rather than the equity; short-term system strengthening, rather than the

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<sup>129</sup>U.S. National Library of Medicine (PMC), "Article Title," *PMC Journal Article*, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10548490/> (accessed January 27, 2026).

long-term, and the interests of the people, instead of implying self-interest. On the other hand, in capable hands, PPPs will assist in the operationalization of SDG-linked objectives: in terms of more equitable access (SDG 10), high-quality health outcomes (SDG 3), and collaboration between the public and the private sector, which will be supported by transparency and good institutions.<sup>130</sup>

## **2. Governance and Institutional Sustainability**

The institutional capacity is essential in sustainable public-private partnerships (PPPs). Collaboration between the state and the partners in the field requires an effective coordination to explicitly specify the roles and responsibilities, prevent duplication, and continuity of service delivery. The institutions should be able to control clear procurements procedures where the partners are not chosen based on arbitrariness but value-for-money. Strong surveillance is needed to control the quality of services to be provided in facilities like Pakistan Institute of Medical Sciences (PIMS) in Islamabad where complicated tertiary-care services need constant quality control and adherence to public-health goals. The credible dispute-resolution mechanisms that are capable of being applied, without disturbing the performance of vital services, and the ability to gather and utilize real-time data to enable tracking of performance, financial management, and evidence-based decision-making is equally important. Lastly, regulatory ability to monitor the pricing of services is essential to avert the increase in costs and ensure access to patients especially in state-run hospitals on PPP arrangements.

As a matter of fact, institutional disintegration in Pakistan tends to undermine all these functions. In Islamabad, the duplicated role of the Ministry of national health Services, Regulations and Coordination (MoNHSRC), PIMS administration, federal regulators and district-level management has traditionally produced instability in power and responsibility. High turnover rates, political switches and isolated bureaucracies destroy institutional memory, diminish the ability to monitor and frustrate the implementation of long-term contracts. Appraisals of governance within health institutions at the federal level have continuously reported that such fragmentation undermines the effectiveness and sustainability of the PPP-

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<sup>130</sup>Indus Hospital Rehabilitation Alliance (IHRA), *Annual Report 2020–21* (Karachi: IHRA, 2021), <https://ihra.gov.pk/wp-content/uploads/2021/08/Annual-Report-IHRA-2020-21-final-26th-July-2021.pdf?utm> (accessed January 27, 2026).

based services, despite the presence of funding, indicating that institutional capacity is not simply a plug that funds the decisive factor in the sustainability of PPPs within large public hospitals such as PIMS.<sup>131</sup>

### **3. Governance and Social Sustainability**

Social sustainability of public- private partnerships (PPPs) is based on governance frameworks which intentionally incorporate equity, inclusion, and public accountability in project design and implementation. With proper governance, the PPPs will lead to greater access to vital services, serve populations which are under-served, and meet the needs of a community without over-commercialization of government services. The required public consultations, community-based oversight committees, service responsibilities that are equity based and transparent grievance-redress systems can contribute to keep PPPs on track towards social goals and off track towards pure financial returns. Otherwise, without these protections, PPPs are prone to clustering services in lucrative cities, lock out poorer or isolated communities and focus on revenue generation at the expense of the population, which destroys trust and sustainability. International evidence consistently shows that governance arrangements, rather than partnership models alone, determine whether PPPs promote inclusive development or exacerbate spatial and social inequalities.<sup>132</sup>

### **4. Governance and Environmental Sustainability**

Healthcare facilities are major consumers of water, energy, pharmaceuticals, and diagnostic materials. Yet environmental governance in Pakistan's PPPs remains underdeveloped. Environmental impact assessments (EIAs) are often not enforced. Sustainable waste management, energy-efficient hospitals, and climate-resilient infrastructure are rare.

Global best practices call for green procurement, waste reduction targets, digital records to limit paper usage, and climate-resilient hospital design Pakistan is only beginning to incorporate these considerations.<sup>133</sup>

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<sup>131</sup>Ministry of Information Technology and Telecommunication (MoITT), Government of Pakistan, *Home*, <https://moitt.gov.pk> (accessed January 27, 2026).

<sup>132</sup>University of the Punjab, "Article Title," *IAS Journal* v8, no. 1 (year), [https://pu.edu.pk/images/journal/IAS/PDF/5-v8\\_1\\_23.pdf](https://pu.edu.pk/images/journal/IAS/PDF/5-v8_1_23.pdf) (accessed January 27, 2026).

<sup>133</sup>Transparency International, *Corruption Perceptions Index 2023*, <https://www.transparency.org/en/cpi/2023> (accessed January 27, 2026).

### **5.3 Regulatory Challenges in PPP-Based Health Governance**

The regulation is central to the successful governance of PPP since it is the major procedure whereby the interests of the people are preserved in the event that the provision of vital services is carried out by the private players. Effective regulatory frameworks that guarantee that PPPs stick to service-quality standards, stay affordable, safeguard the equity, and are answerable to the societal objectives, but not profits only. The regulatory capacity in the health sector in Pakistan is however weak and in bits. There is duplication of mandate between various authorities, restriction in the enforcement powers and the incoherence and inconsistency in the application of the law regarding the PPPs and health services delivery. This lack of regulation enables PPP arrangements to slip out of their intended goals, undermines the control over quality of service provision and pricing, and risk inequitable access especially by those who are vulnerable. Because of this, even properly designed PPPs have a tendency to perform poorly in the case of regulatory institutions that are either poorly prepared, independent, and coordinated, which shows that effective regulation is not complementary but fundamental to the achievement of PPP.

#### **1. Weak and Fragmented Legal Frameworks**

In Islamabad, PPPs of the health sector are governed through legal ambiguity and fragmentation, which negate regulatory protection that is meant to assure quality, access and accountability. The IHRA was formed under the Islamabad Healthcare Regulation Act, 2018, to license, regulate, and supervise all healthcare establishments in Islamabad Capital Territory (ICT), both public and otherwise. Principally, all hospitals, clinics, diagnostic centres, laboratories or pharmacies practicing ICT have to be registered and licensed by IHRA otherwise they can face hefty fines or closure.

The mandate of IHRA encompasses establishing minimum standards of service-delivery and safety requirements, issue guidance/practices (QHSS), inspection and accreditation of the establishments as well as suspension or termination of license in case standards are not met. Nonetheless, the multi-jurisdiction of the various entities (federal ministries, business stakeholders in the private sector, and urban/regulatory authorities) leads to regulatory uncertainty. As an illustration, although IHRA is expected to license and regulate, other institutions like the Capital Development Authority (CDA) or health policymaking bodies at

federal level may take part in infrastructure development, procurement or service contracts which muddles the accountability chain and responsibility of PPP contracts. This confusion tends to blur those who prescribe what quality standards, contractual requirements, procurement regulations, price control or service watch.<sup>134</sup>

Further, similar gaps in the real world have been indicated by recent real world indicators by federal oversight agencies: a parliamentary Sub- Committee report in 2025 has found widespread non-compliance by private hospitals and diagnostic centers in Islamabad with some functioning without valid licenses and has requested that the federal health ministry should strengthen IHRA, issue show-cause notices, and elaborate a robust regulatory framework to license and monitor. This means that even with the recent law in 2018, enforcement is still weak and regulatory oversight is not even in enforcement as it compromises not only quality and safety, but also viability and credibility of PPP contracts (particularly in relation to outsourced services such as diagnostics and pharmacies).

Lastly, even though IHRA in recent years has updated its regulatory standards (e.g., in the form of the 2022 Regulations and an ongoing draft of 2025 amendment), all these actions underscore the idea that regulation is in the process of change, and that at present, regulatory ambiguity is a structural threat to PPP-based health services in Islamabad.<sup>135</sup>

## **2. Capacity Deficits in Regulatory Bodies**

The health regulatory bodies in Pakistan have been experiencing capacity challenges that continue to undermine the management of the public-private partnerships and the health service provision in general. The shortage of trained inspectors is a chronic issue which restricts the quality and level of the facility inspections and the lack of modern digital surveillance and health-information technology prevents the ability to track the quality of the services, prices, and patient safety in real time. A high number of regulators still use old regulatory manuals that fail to signify diverse clinical standards or complex PPP plans and they may not have any legal expertise in specialisation to interpret and implement sophisticated PPP contracts. All these weaknesses are compounded by insufficiency of both financial and human resources to conduct

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<sup>134</sup>Pakistan Journal of Social Development (PJSd), "Article Title," <https://pjsd.pu.edu.pk/article/view/111> (accessed January 27, 2026).

<sup>135</sup>Oxford University Press (OUP), "Telehealth and ICT in Healthcare," *Health Policy and Planning* 13, no. 2 (1998): 162–178, <https://academic.oup.com/heapol/article/13/2/162/663997> (accessed January 27, 2026).

thorough facility audits, which creates an uneven enforcement and regulatory loopholes, which permits poor practices to thrive, which ultimately deteriorates quality services, accountability and confidence of health PPPs in the eyes of the populace.<sup>136</sup>

In Islamabad, the regulatory control of the public-privacy health facilities is associated with a similar set of challenges as those found at the provincial level, only that there is the complexity of institutional overlaps and low enforcement capacity. Whereas the Islamabad Healthcare Regulatory Authority (IHRA) is legally tasked with the regulation of all public and private healthcare facilities within the Islamabad Capital Territory, the organized reports note the limitations in the capacity to inspect, monitor, and enforce these facilities especially as the population of the privately owned and operated PPP-facilities continues to grow. Such restrictions imply that the PPP organizations, particularly the outsourced diagnostic facilities and pharmacies associated with large state hospitals like PIMS, can enjoy an unequal regulatory attention. The result is inconsistent quality of services, inconsistent pricing strategies, lack of adherence to reporting and licensing, and slow response to breaches of regulations, which contributes to the lack of accountability and trust in PPP-based health service delivery in Islamabad..<sup>137</sup>

### **3. Regulation of Health Technology and Digital PPPs**

Pakistan's regulatory environment has not caught up with digital health expansion. Telemedicine platforms expanded rapidly during the COVID-19 pandemic, but:

- data protection laws are incomplete,
- cybersecurity protocols are weak,
- no national telehealth standards exist,
- licensing procedures for digital clinics are unclear (Hussain & Sheikh 2021).

This regulatory vacuum exposes PPPs to legal risks and compromises patient privacy. The draft Personal Data Protection Bill (2023) is a step forward but not yet aligned with international health-data norms such as GDPR or HIPAA.<sup>138</sup>

### **4. Challenges in Quality Assurance and Clinical Governance**

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<sup>136</sup>GSMA, *The Mobile Gender Gap Report*, <https://www.gsma.com/r/gender-gap/> (accessed January 27, 2026).

<sup>137</sup>Wikipedia, "Telehealth," <https://en.wikipedia.org/wiki/Telehealth> (accessed January 27, 2026).

<sup>138</sup>SehatSahulat Program, Wikipedia (online), [https://en.wikipedia.org/wiki/Sehat\\_Sahulat\\_Program](https://en.wikipedia.org/wiki/Sehat_Sahulat_Program) (accessed January 27, 2026).

Quality assurance is a fundamental regulatory function yet in Pakistan systemic weaknesses frequently prevent it from being realized. There are a persistent absence of standardized clinical-quality indicators and a national accreditation regime for health facilities, which undermines efforts to enforce consistent care standards. Regulatory audits and performance reviews are irregular, medical-error reporting systems are weak or non-existent, and laboratory quality controls are often minimal or inconsistent, even though diagnostic centers under PPPs conduct millions of tests annually. Without a strong regulatory mandate for external validation or accreditation, the risk of diagnostic errors rises significantly, undermining patient safety, public trust, and the very value proposition of PPP-based health services.<sup>139</sup>

#### **5.4 Institutional Fragmentation and Coordination Failures**

Institutional fragmentation is the division, replication and lack of coordination of mandates by different public entities in the policy design, regulation, financing as well as implementation. In Pakistan, this fragmentation is firmly rooted because of successive rounds of federal-provincial devolution, and concurrent regulatory agencies, and lack of coordination of inter-institutional coordination. In the case of PPPs, fragmentation poses indistinct authority lines, dispersed accountability, and uneven implementation of the results that deter coherence throughout the PPP life cycle, including project preparation to monitoring and evaluation. The overlapping or confused power of multiple ministries, provincial departments, regulators and local authorities, makes the implementation of PPP contracts challenging, the allocation of risks ineffective and the incentives given to the partners in the private sector unorthodox. Empirical governance studies in Pakistan note that this kind of fragmentation cuts down on administrative capacity, slows down the process of decision making and deteriorates oversight which in the end undermine the effectiveness and sustainability of PPPs despite.

##### **1. Federal–Provincial Coordination Breakdown Post-18th Amendment**

The national health-governance structure of Pakistan was disrupted and coordination became weak after the 18<sup>th</sup> Amendment also devolved the health care responsibilities to the provinces. What was created was not a national structure but a mosaic of provincial policy,

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<sup>139</sup>Press Information Department (PID), Government of Pakistan, “Pakistan Launches First Digital First BHU in Islamabad,” press release, January 6, 2026, [https://pid.gov.pk/site/press\\_detail/31524](https://pid.gov.pk/site/press_detail/31524) (accessed January 27, 2026).

institutions and regulatory regimes that caused role confusion, overlapping duties and absence of policy direction. Such structural fragmentation implied that when the country faced a national crisis, such as the COVID-19 pandemic, the coordination between federal, provincial, and district-level governments was inefficient and highly controversial most of the time. In his case, although one of the federal coordinating bodies, National Command and Operation Center (NCOC) attempted to coordinate the pandemic response centrally, numerous provinces and local health departments claimed that health was a provincial issue that resulted in delays and inconsistent messages and policy application across provinces.

Besides, since each province has formulated their own policy on PPPs, standards and regulatory practices, this created a lack of uniformity in the provinces leading to disjointed services and uneven quality. What may be considered a standard in a given province may not be considered one in another province and this affects coherence, comparability and scalability of PPP-based health services.

Therefore, though devolution as per the 18 th Amendment gave provinces autonomy, it also distributed accountability and undermined the coordination at the national level a structural problem which still undermines effectiveness, equity and resilience of health sector in Pakistan, particularly with PPP arrangements.<sup>140</sup>

## **2. Institutional Turnover and Its Effects on PPPs**

Constant changing of government officials collapses:

- institutional memory,
- contract continuity,
- monitoring consistency.

The 2021 study of governance revealed that the provincial health secretaries in Pakistan serve an average of less than 12 months on any given posting, and this discourages the implementation of policies in the long term..<sup>141</sup>

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<sup>140</sup>SehatKahani, *SehatKahani Annual Report June-2023–June-2024* (Islamabad: SehatKahani, 2025), <https://sehatkahani.com/sehat-kahani-annual-report-june-2023-june-2024/> (accessed January 27, 2026).

<sup>141</sup>Lara Court and Jill Olivier, “Approaches to Integrating Palliative Care into African Health Systems: A Qualitative Systematic Review,” *Health Policy and Planning* (October 2020), <https://doi.org/10.1093/heapol/czaa026>.

## **5.5 Accountability and Transparency in PPP Governance (Islamabad Context)**

The pillars of an efficient PPP governance are accountability and transparency since it will identify whether the partners in the private sphere are able to deliver the public value instead of taking away the commercial benefits. The PPP-type arrangement in diagnostics, pharmacies, facility support services, and care based on insurance (e.g., SehatSahulat-empowered hospitals) in Islamabad is based on the governance environment with the weak accountability mechanisms and uneven transparency. Regardless of the existence of contracts on the paper, the lack of capacity to enforce it, the lack of transparency in the procurement process, ineffective monitoring systems, poor participation by the citizens, and political interferences significantly weaken the integrity of governance systems and citizens trust.

### **1. Weak Contract Enforcement**

Most PPP contracts in the health-sector in Islamabad do not have a strong governance architecture. There is a tendency of vague definition of key performance indicators (KPIs), weak or non-operational penalty clauses, and in rare cases activation of the dispute-resolution mechanisms. In cases where contracts have sanctions against underperformance, bureaucracy lacks consistency in enforcing the sanctions because of legal ambiguity, bureaucracy and political pressure. Empirical evidence on the PPP governance in Pakistan accentuate that line departments often tend to evade punishment or escalate of disagreements to avert conflict with those that hold sway with their partners in the business, which leads to further drift of contracts and degradation of service provision . This tendency is especially concerning to the outsourced diagnostic and pharmaceutical services in the large governmental hospitals in Islamabad, where the enforcement is weak, which has a direct impact on patient safety and cost management..<sup>142</sup>

### **2. Lack of Transparent Procurement**

The lack of transparency particularly appears in PPP procurement. The tendering process in Islamabad is usually characterized by lack of transparency in the bidding process, inequitable disclosure of evaluation criteria, and minimal publicity on winning contracts. According to Transparency International Pakistan, there have always been risks of political patronage and favoritism in government contracts, and this results in a culture where competitiveness is not

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<sup>142</sup>Transparency International, *Corruption Perceptions Index 2023* (Berlin: Transparency International, January 30 2024), <https://www.transparency.org/en/cpi/2023>.

encouraged and reputable companies are driven away; in the health sector, it is stated that lack of transparency in disclosure and discretionary making of decisions creates an environment that encourages corruption.<sup>143</sup>

### **3. Inadequate Monitoring and Evaluation Systems**

The monitoring and evaluation (M&E) capacity is still disproportional in PPP health services in Islamabad. Regulatory and line departments are short of trained monitoring personnel, use old fashioned or manual reporting and hardly ever seek external third party audit. There is poor data reporting that is not uniform and spread out on various information systems and is not always validated. Although computers control PPPs including Punjab diagnostic PPP model show how reporting and dashboards can enhance control, these systems are not organized and applied to the Islamabad environment. Lack of the standardized digital monitoring undermines the evidence based monitoring, postpones the corrective action, and diminishes the performance benchmarking.

### **4. Citizen Accountability and Community Engagement Gaps**

The PPP governance in the city of Islamabad has very little accountability at the citizen level. Majority of the PPP agreements give minimal access to performance data to the audience, do not offer some form of a complaint management process, and are not ruled by a community representation or a hospital board. Studies of social accountability in Pakistan indicate that PPPs that lack community supervision often do not access the vulnerable communities and also have a higher tendency to focus on services that are commercially attractive rather than focusing on equity-driven goals. This low involvement fosters in Islamabad constrained feedback loops, lack of patient voice, and distrust of the health services provided by PPP..<sup>144</sup>

## **5.6 Equity and Access Barriers in PPP-Based Healthcare Delivery**

Equity is a core principle of public health systems but at the same time it is among the most entrenched threats in the healthcare sector in Pakistan. Assuming automatic access and efficiency improvement by the involvement of private sectors, policymakers tended to believe

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<sup>143</sup>GSMA, *The Mobile Gender Gap Report 2025*, <https://www.gsma.com/r/gender-gap/>.

<sup>144</sup>World Health Organization, *World Report on Health and Development* (Geneva: WHO, 2023), WHO publication ID 9789240031097, <https://www.who.int/publications/i/item/9789240031097>.

that PPPs could be effective when implemented. Nonetheless, both international and domestic experience shows that PPPs may unwillingly promote existing inequalities when there are weak regulatory and governance systems, which results in unequal service provision, unequal access, and unequal quality of care. The causes of equity barriers in the PPP-based service delivery include structural, socioeconomic, geographic, and financial factors. Such inequalities are increased by the fact that in cases where governance mechanisms do not incorporate the concept of equity in the design, contracting and monitoring of PPP projects.

PPP in Pakistan have played a great role in increasing the number of services in such provinces as Punjab and Sindh, however, such increase does not mean fair access. Technologically advanced PPP hospitals, diagnostic centers and specialty units are oftentimes located in urban centers, whereas the rural districts of Baluchistan, south Punjab and interior Sindh have much fewer investments. Even free or subsidized PPP services are not easily accessible to rural populations as they have to travel long distances, incur transportation expenses, and lack health literacy. Research indicates that over 60 percent of the rural poor in Pakistan reside more than five kilometers away from the closest functional health facility and expansions of PPPs are predominantly located in commercially viable or densely populated regions (Khan and Qureshi 2020). Devoid of specific policies to increase the PPPs to peripheral geographies, there will be a likelihood of increasing the urban rural divide as service expansion increases. Socioeconomic differences also lead to inequalities. The user fees, co-payments or differentiated pricing models that are aimed to recover the cost of operations are frequently included in PPPs. Although these mechanisms are effective in ensuring service delivery is sustained over a long period, it imposes financial costs to the population with low incomes and may thereby decrease service usage. Empirical studies of PPP hospital models in South Asian tend to indicate that poor households would be inclined to underuse PPP services when the cost is beyond their means to pay even when subsidized.<sup>145</sup>

The SehatSahulat Program that was first implemented in Pakistan to help increase financial coverage has not completely eliminated out of pocket payments since most PPP hospitals have set up extra charges that were not included in insurance packages, which is

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<sup>145</sup>World Health Organization, *World Report on Health and Development* (Geneva: WHO, 2023), WHO publication ID 9789240031097, <https://www.who.int/publications/i/item/9789240031097>.

correlated to poor financial governance. As a result, the worst groups of citizens continue to face disastrous spending on health even in the cases of formal coverage.

The PPP world is also highly male dominated. Females in most areas have limited movement, cultural barriers and reduced freedom in accessing medical care. Despite the efforts of the PPPs like SehatKahani to lower the gender barrier by the services of female-led telemedicine, most of the PPP clinics, hospitals, and diagnostic centers do not provide a female-oriented environment. In addition, the distributions of the workforce in the private sector are dominated by males and cultural norms mostly make rural women reject male clinicians.

This minimizes the effective access to PPP services by the women especially in maternal and reproductive health. Discrimination of access is also formed by caste, ethnicity, and linguistic differences. Discrimination or lack of communication on the part of health facilities is a common complaint by ethnic minority groups in Baluchistan and Khyber Pakhtunkhwa, particularly when using health facilities run by private contractors, who may not understand local languages or cultural practices. Research indicates that trust, cultural familiarity and perceived respect are the factors that have a strong role in determining utilization of health services, including PPPs. In situations where the PPP providers have not incorporated or employed local nationals, mistrust becomes escalated and there is less chances of uptake of the service.<sup>146</sup>

Whereas digital PPPs are widening access in most areas, they are also introducing new inequities. The platforms of telemedicine are dependent on internet use, cell phone use and digital literacy that are unevenly distributed among socioeconomic groups. The digital divide between the genders in Pakistan stands at more than 30 percent, which implies that females have a much smaller probability of owning mobile phones or accessing internet services. This digital divide has the potential to extend health inequities to the benefit of rural, educated, and wealthier households with an advantage over access to telehealth services. In conclusion, PPPs in Pakistan have created a lot of expansion in services but minimal improvement in equity. Unless there are governance structures that emphasize equity via pro-poor contracting, mandatory rural coverage,

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<sup>146</sup>Lara Court and Jill Olivier, "Approaches to Integrating Palliative Care into African Health Systems: A Qualitative Systematic Review," *Health Policy and Planning* 35, no. 2 (2021): 162–75, <https://doi.org/10.1093/heapol/czaa026>.

gender-sensitive service design and community involvement PPPs will actually be strengthening the inequalities they are designed to eliminate.<sup>147</sup>

## **5.7 Financial Governance and Fiscal Sustainability of Health PPPs**

One of the most important preconditions of PPP sustainability is financial governance. Financial governance in healthcare PPPs includes budget planning, cost-sharing, cost-control, payment system, procurement transparency and fiscal oversight. Any of these areas may have weaknesses that jeopardize the service continuity, provider accountability and put governments at greater fiscal risks. Financial governance issues are widespread in Pakistan, and represent the underlying macroeconomic limitations, weak institutional performers, and weak regulatory controls. One of the fundamental contradictions in PPP financing is the two-sided character of healthcare: on one hand, health is a social good, on the other hand, PPP contracts tend to be dependent on commercial incentives. This poses inbuilt risks where governments are unable to put down transparent regulations regarding the course of payments, performance-based reimbursements, and cost-sharing. As an example, there are numerous PPP hospitals, and diagnostic facilities in Pakistan that are highly reliant on provincial treasury funding, i.e. any failure of government disbursements causes a break in the flow of services, personnel instability, and diminished patient care. The provincial finance departments usually do not have special ability of assessing the PPP fiscal risk, and this leads to contracts that underestimate long term liabilities or do not provide proper measures to counter cost overruns. Due to this fact, there are instances where PPPs introduce unforeseen financial pressures into the state budgets. The SehatSahulat Program provides a good example of the problems of financial governance. Though created as a social protection program aimed at health, it experienced significant budget deficits with the increased claims, and little control of the cost, combined with lax control of the overall billing of the hospitals operated privately. It was reported to have instances of insurance fraud, unneeded procedures and so-called balance billing where patients were charged extra money even when they are insured. This was since financial audit systems

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<sup>147</sup>SaimaAzhar, "Public-Private Partnerships (PPPs) and SDG 17 in Pakistan: Challenges & Opportunities," *Sociology & Cultural Research Review* 3, no. 2 (2025): 29–36, <https://www.scrjournal.com/index.php/14/article/view/178>.

were not adequate, integration of digital data was not fully achieved and the regulatory systems of health insurance PPPs were not developed.<sup>148</sup>

The other aspect of financial governance is associated with procurement. The corruption, price manipulation, collusive bidding, and non-transparent award are the issues historically affecting the procurement in Pakistan. These are transferred into PPP procurement that has ineffective disclosure of bid documents, non-competitive bidding, and politically motivated selection of the vendor which compromises efficiency and public trust. The international best practices involve open tenders, the publicity of the contract, and independent audit, but they are not continuously observed in the provincial PPP units in Pakistan.<sup>149</sup>

In Islamabad, the allocation of risks between the authorities and the partners in the health sector PPPs is crucial to enable financial sustainability in the long-term, yet numerous existing contracts seem to favor the side of the private and leave the other side (and, eventually, the governmental budgets) uncovered. In cases where governments take demand risk (such as ensuring minimum volumes or subsidizing patients who do not get a insurance policy), operational risk (such as the maintenance of facilities, staffing issues, patient variations), or macroeconomic risk (such as the devaluation of the currency, inflation), the returns may remain constant regardless of results among the partners in the business. Such imbalance is a distortion of incentives: the private operators are not subjected to substantial downside, whereas the entire cost of an overrun or a reduction in revenue is borne by the public budgets. Thus, PPPs within Islamabad such as in diagnostics, telemedicine outreach, or insurance-based hospital services will become a financial burden, rather than a cost-effective option, particularly without diversified sources of revenue (user charges, insurance payments, donations) and complete cost-costing. According to recent studies on PPP projects in Pakistan, this structural problem has been highlighted whereby uncertainty in macroeconomic environment, low contractual protection and lack of a risk sharing mechanism destroy sustainable PPP performance. In a similar manner, in Punjab, PPP diagnostic centers though very fruitful, have long-term concession agreements with the government whereby the government will have to pay fixed payments even in times when the

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<sup>148</sup>AU Haq and MS Awan, "Impact of SehatSahulat Program on Out-of-Pocket Health Expenditures in Pakistan," *Journal of Health and Well-Being Community Research* 3, no. 4 (2025), <https://doi.org/10.61919/x2ff3074>.

<sup>149</sup>Hina Aziz, Moazzam Ali, and Nafisa Awan, "The Financial and Administrative Issues in Public Sector Health Programs: A Case Study of SehatSalulat Program in Pakistan," *Journal of Health and Rehabilitation Research* 3, no. 2 (2023), <https://doi.org/10.61919/jhrr.v3i2.104>.

use is at variance. This lock-in makes it less flexible in financial terms to adapt in time and more exposed to budget shocks. The insufficient nature of an institutionalized value-for-money (VfM) assessment also increases the complexities of financial governance as contracts are not often reviewed to see whether they have been economic once implemented. Finally, the financial governance problems expose systematic problems: ineffective fiscal management, incomplete risk-sharing strategies, poorly developed audit procedures, and politicized procurement activities. The PPPs regardless of their innovativeness are exposed to financial instability without considering these governance limitations and cannot provide sustainable changes in the healthcare system of Pakistan.<sup>150</sup>

## 5.8 Political Economy Dynamics Shaping Health PPPs in Pakistan

Political economy of PPPs is defined as the way in which power relations, political interests, patronage networks, and institutional incentives are used to design, implement and result of partnerships. In Pakistan, political economy context has a disproportionate role in shaping the direction of PPPs and this applies to all aspects of contracting, resource distribution, enforcement of regulations, and sustainability. It is important to know these dynamics so as to evaluate the success of some PPPs, failure by others and failure to deliver the intended beneficiaries.

The politics of patronage, strong bureaucratic networks, elite control, and disjointed institutional power are some of the features that define the governance situation in Pakistan. The dynamics have a great influence on PPP governance. PPPs are usually seen as a chance to gain more visibility, service delivery, and election by political leaders. As a result, PPP projects can be initiated within a short time without powerful feasibility tests to prove the performance in politics. This rush may lead to improperly drafted contracts, risk underestimation, or impractical business goals, which will not sustain in the long term.<sup>151</sup>

Regulatory enforcement is also affected by the political economy. In the case of politically powerful private actors not fulfilling the standards of performance, the regulatory

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<sup>150</sup>Sheraz A. Khan, Kathrin Cresswell, and Aziz Sheikh, "The Notion of Access to Health Care in a Large-Scale Social Health Protection Initiative: A Case Study of 'SehatSahulatProgramme' at Khyber Pakhtunkhwa, Pakistan," *Journal of Global Health Reports* 7 (2023): e2023024, <https://doi.org/10.29392/001c.75411>.

<sup>151</sup>Z Asim, H Nadeem, and S Batool, "Reviewing the SehatSahulat Program," *Qlantic Journal of Social Sciences* 3, no. 2 (2022): 48–54, <https://doi.org/10.55737/qjss.766455337>.

authorities may be reluctant to take a penalty or cancel the contract because of the possible backlash or political pressure. This disproportionate implementation undermines the rule of law, incentives, and leads to a situation where non-performing PPPs can go about their business with impunity. This is compounded by absence of independent regulatory institutions since most of the regulatory institutions are usually integrated into political and bureaucratic structures.

Agency incentives affect the PPP results on the bureaucratic level. Civil servants might be interested in having PPPs that grow the departmental budgets or the bureaucratic power, though these projects might not be very cost-efficient and long-term planning. The problem of frequent alterations of officials who are endemic in the governance of Pakistan interrupts continuity, breaks the institutional memory as well as prevents adequate monitoring of PPP contracts. New officials give little priority to or re-read existing PPP agreements in most instances which result in delays, renegotiations or gaps in implementation.<sup>152</sup>

Geographic priorities are also influenced by the political economy. PPP investments tend to be more concentrated in politically strategic areas where the leaders want to gain influence or even reward their supporters. This leads to less PPP projects in marginalized areas like rural Baluchistan or mountainous KP worsening geographic inequalities. This political favoritism defeats national objectives of providing equal healthcare. The political role is also played by the private actors. The major hospital chains, pharmaceutical enterprises, and diagnostic networks enjoy great power and could effectively lobby to receive the preferable regulatory conditions or subsidies. Although advocacy in the field of the private sector may be helpful to the innovation, it may also corrupt the public policy, prioritizing the profit over the outcomes of the health of the population.

The involvement of civil society in the PPP governance has not been fully realized, and this has minimized the publicity of political economic distortions. In other nations such as Brazil and South Africa, PPP contracts are actively followed by the civil society organizations, a move that enhances accountability. Pakistan does not have such systematic control and thus it is easier to have political interests to prevail in the PPP governance.

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<sup>152</sup>Georgina Dove et al., "Governance of Public-Private Partnerships for Primary Healthcare in Low- and Lower-Middle-Income Countries, 2000-2023: A Systematic Review," *International Journal of Health Policy and Management* 14 (2025): 8442, <https://doi.org/10.34172/ijhpm.8442>.

In general, the political economy of healthcare PPPs in Pakistan demonstrates that there is a complex interaction of incentives, interests, and power structures. Until political interference is curtailed and regulatory independence reinforced with institutions to entrench transparent decision-making, as opposed to political logic, PPPs will remain more influenced by politics than the health-system requirements. This questions their ability to achieve fair, effective, and viable changes in the healthcare arena of Pakistan.

### **5.9 Environmental and Climate Governance Challenges in PPP-Based Health Services in Islamabad**

The phenomenon of environmental and climate governance has been one of the concerns of the contemporary health systems, especially in cities as the one in Islamabad with its rapid urbanization process, exacerbated climate vulnerability and infrastructural pressure crossing the public healthcare provision. The Pakistan Institute of Medical Sciences (PIMS) is the biggest tertiary care hospital in the federal capital and at the frontline in weather-related health problems such as heat-related sicknesses, respiratory illnesses, caused by air pollution, vectors transmitted diseases and water contamination diseases. However, with these mounting demands, the performance of environmental governance in the PPP arrangements relating to the public hospitals in Islamabad is still quite poor. This can be further seen under the administrative ambivalence of the region of Islamabad which has multiple jurisdictions between the Ministry of National Health Services, Regulations and Coordination (MoNHSRC), the Capital Development Authority (CDA), and the Islamabad Healthcare Regulatory Authority where all three have a broadly vague mandate, yet little coordination between them.

Weaknesses of climate in Islamabad are increasing. Studies also show that temperatures are increasing, there are more heat waves, the rainfall is becoming more unpredictable and the air quality is not good, all of which have a direct impact on the demand and service pressure in hospitals. Hospitals like PIMS tend to experience high patient demand during extreme heat conditions coupled with smog seasons. However, the environmental resiliency of these facilities has not been an organized part of the PPP planning or facility management procedures. The PP-supported services at PIMS like outsourced diagnostic services, pharmacy services, outsourced janitorial and waste-management services do not have a specific framework of environmental

compliance, particularly in matters concerning medical waste disposal, energy consumption, water savings and climate adaptation.<sup>153</sup>

The issue of medical waste governance is still a major problem. With substantial biomedical waste, many of which are concentrated at PIMS and its related PPP service units, Islamabad produces a lot of biomedical waste. Of the studies published by the National Institute of Health (NIH), the waste-handling in hospitals in Islamabad is below the WHO standards, and whereas the PPP outsourcing increased the overall efficiency in certain departments, it did not automatically enhance the environmental standards without an iron fist. The waste separation, autoclaving and incineration operations in PIMS is not regular, especially where there is outsourcing of services whereby the execution powers are disjointed between the hospital management and the outsourcing firms. Similar objections are expressed through the regulatory monitoring reports by IHRA, which state that the domain of environmental health indicators is one of the least covered areas of hospital inspections in Islamabad.<sup>154</sup>

On the same note, energy governance among hospital and PPP in Islamabad is not controlled even as the country experiences more and more disruption on energy supply due to climate changes. PIMS is regularly experiencing energy crisis such as variable voltage, outage and unstable backup generation. Diagnostic PPPs based on MRI, CT and digital laboratory instruments are most susceptible to energy turbulence. However, PPP deals rarely include a requirement to incorporate renewable energy or climate-efficient power infrastructure, which is quite contrary to international best practices in climate-resilient health infrastructure..<sup>155</sup>

Other structural weaknesses that the hospital PPPs in Islamabad have been experiencing are within the sphere of air pollution governance. The index of air quality in Islamabad often surpasses those of WHO, especially during winter times because of the smog in the region and biomass burning. This adds the patient loads due to respiratory diseases to PIMS and there is still a lack of environmental monitoring systems in the hospital. Indoor air-quality monitoring

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<sup>153</sup>Shehla Zaidi et al., “Public-Private Partnerships for Primary Care in India, Pakistan and Bangladesh: Lessons on Pathways and Drivers,” *International Journal of Health Planning and Management* 40, no. 5 (2025): 1167–1181, <https://doi.org/10.1002/hpm.3947>.

<sup>154</sup>ZebaShehzad and GulshanMajeed, “Political Economy of Healthcare in Pakistan: Impact on Health Security and Pandemic Preparedness,” *Annals of Human and Social Sciences* 6, no. 3 (2025): 299–308, [https://doi.org/10.35484/ahss.2025\(6-III\)25](https://doi.org/10.35484/ahss.2025(6-III)25).

<sup>155</sup>N Joudyian et al., “Public-private partnerships in primary health care: a scoping review,” *PMC Article* (2021).

systems, high-efficiency filtration systems and mitigation measures are not required in no PPP contracts..<sup>156</sup>

Lack of climate-oriented risk assessment during the planning process of PPP projects further adds to the weaknesses of climate governance. As mandated by international guidelines, climate-risk appraisal to health-sector PPPs is required to ensure that infrastructure and equipment remains operational in case of extreme weather, yet the PPP approval procedures by CDA and MoNHSRC in Islamabad do not yet incorporate such appraisals PPPs face unnecessary risks to their hospitals.<sup>157</sup>

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<sup>156</sup>R Tehreem et al., “SehatSahulat Program: A Perspective from Beneficiaries of Faisalabad, Pakistan,” *Pakistan Journal of Health Sciences* 4, no. 06 (2023): 109–113, <https://doi.org/10.54393/pjhs.v4i06.884>.

<sup>157</sup>SaimaAzhar, “PPP Institutional Gaps and Financial Constraints in Pakistan,” *Sociology & Cultural Research Review* (2025).

## **CHAPTER 6 CONCLUSION**

According to the research, Islamabad introduced PPPs due to financial limitations and population increase and the inefficiencies of the population and public healthcare systems and the need to modernize the system of services. The number of services at PIMS grew due to PPPs owing to outsourcing of diagnostic service and emergency care and introduction of digital records. The existing healthcare service enhancements do not assure the long-term change of the healthcare system. Poor governance structures do not allow PPPs to become permanent solutions to healthcare issues since they are short-term solutions. The governance systems must have the capacity to manage these partnerships and, therefore, the strategic management of PPPs relies on them.

### **6.1 Governance Weaknesses Are the Primary Barrier to PPP Success**

According to the research, there are numerous governance issues that impact the PPP structure of Islamabad. IHRA CDA and MoNHSRC have different regulation systems, and it is quite challenging to monitor performance and impose accountability. The evaluation of the performance is not regular due to ambiguous conditions contained in the PPP contracts. The poor governance structure contributes to poor performance in its operations as well as creating delays in the services and allowing the privatised service providers to conduct their operations with lack of proper disclosure. The PIMS study has proved the use of appropriate regulatory structures to ensure that PPPs are not inefficient and discriminatory. PPPs are largely reliant on governance systems as opposed to funding mechanisms.

### **6.2 PPPs Expanded Service Quantity but Did Not Guarantee Equity**

The volume of healthcare service delivery has grown due to the introduction of new clinical and diagnostic facilities by the PPPs. There is never an equal allocation of healthcare

services across locations. The PPP expansion initiatives are centered in the urban locations of Islamabad and do not address healthcare provision issues in rural areas and disadvantaged communities. The presence of user fees coupled with an added cost does not allow economically disadvantaged patients to attain access to healthcare services despite the technical free services. The existing healthcare system does not consider gender-related and socioeconomic and geographic disparities, as these aspects were not adequately accounted for when developing the contract. Introduction of PPPs led to increased numbers of service deliveries although it did not create equal healthcare access among patients.

### **6.3 Institutional Fragmentation Limits PPP Sustainability in Islamabad**

The 18<sup>th</sup> Amendment has created a system of governance where health powers are changed to the provinces, but Islamabad is a federal territory and administrative system is mixed. The hybrid administrative system in the city of Islamabad contributes to overlapping of responsibilities and ambiguity in terms of authority that translates into lack of coordination in health regulation among institutions. The various departments involved in PIMS have a problem of procedural delays as they are bound to different policies and funding streams and requirements. The situation of the institutional fragmentation prevents the achievement of the PPP reform and introduces discontinuity to the healthcare service provision.

### **6.4 Environmental and Climate Governance is Critically Underdeveloped**

The study determined that the PPP-based services in Islamabad do not have appropriate environmental governance systems. Climate-related risks such as heatwaves and air pollution, as well as the lack of water, also affect operations of the healthcare facility PIMS which does not have any environmental or climate-related resilience criteria in its PPP contracts. The existing system of biomedical waste management does not comply with the WHO requirements and the energy facilities at the plants are not designed in a manner that would minimize the impact on the climate. The lack of environmental performance indicators within the PPP contracts at PIMS and other plants poses a threat to the health and sustainability issues. This situation is even more critical since Islamabad is confronted with emerging climate-related problems.

## 6.5 PPP Success Depends on Strengthening Public-Sector Stewardship

An effective leadership among the public sector based on the use of PPPs will be successful. The government does not pay due stewardship to the PPPs in Islamabad due to institutional disintegration and poor regulatory capacities. According to the sustainability of PPPs, the issues are connected to the IHRA becoming more powerful in oversight and enhancing agency coordination and improved control over contract and environmental standards implementation. The government sector ought to take the leading role as the PPPs operate as its facilitating factors.

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