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Public-private partnerships in the health sector:
Experiences from developing countries

Johannes Jütting

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Summary

This paper analyses the prospects of a public-private partnership (PPP) the health sector of developing countries. PPP is defined as institutional relationships between the State and the private for-profit and/or the private not for-profit sector, where the different public and private actors jointly participate in defining the objectives, the methods and the implementation of an agreement of cooperation. Whereas the idea of a PPP in general and in the health sector specifically is theoretically appealing, the review of selected case studies has shown that the implementation is still not very common in developing countries, but that PPP has potential positive effects. Through increasing competition, delegation of power to the local level, active participation of the concerned population and interactive effects, positive impacts on the efficiency, equity and quality of health care provision can be observed. Former excluded people have now gained the chance to set up their own systems according to their specific needs and with public support. The conditions which have been identified on a macro level and which work in favor of the setup of a PPP are a political environment supporting the involvement of the private sector, an economic and financial crisis forcing the public sector to think of new service provisions and a legal framework which guarantees a transparent and credible relationship between the different actors. On the micro level, the capacities of the actors, e.g. their personal interest, skills and organizational and management structure are important.

Acronyms

FGPA	Family Group Practices Association
FONSA	National Health Fund
ISAPRES	Institute of Private Health Insurance
LAC	Latin America and Caribbean
MAS	Medical Aid Societies
PPP	Public-private partnership

Introduction

The increasing interest in the potential of a public-private-partnership (PPP) to provide social protection in developed and in developing countries can be explained mainly by three factors: First, due to fiscal pressures, governments have to reallocate resources with the utmost effectiveness. In this respect various studies have shown that there is a large potential for gains in efficiency in the social sectors. Secondly, private providers, both non-profit and for-profit, play an important role in social service provision, a role that has been largely neglected by governments. As the example of India shows, more than 80 per cent of the health care expenditure goes to private providers. Third, given the intrinsic, albeit different strengths and weaknesses of the State for-profit and non-profit institutions, the question arises as to what extent a complementarity can be organised in the provision of social services. The call for cooperation between the different sectors is not new, neither in industrialised nor in developing countries. However, the discussion about welfare reform in developed countries, notably the US and UK over the past two decades and the increasing recognition of a "Third Sector" or "Economie sociale" has fuelled the debate. In this respect it is not surprising that increasing attention has been devoted to exploring the complex issues of inter-institutional coordination to which new systems of provision give rise.

Given this background, this paper analyses the potentials of PPP to provide social protection in the health sector, outlined as follows. Theoretical foundations of the concept of PPP are briefly discussed and different forms of cooperation are described. The major part of the paper discusses PPP health sector experiences in developing countries in different regions of the world. Following that, the case studies and the insights from the theoretical overview are presented in order to derive determinants for a successful PPP. The identification of conditions under which PPP can contribute to an increase in access to social protection at lower cost is helpful to design appropriate social policies. The paper closes with open questions for discussion and future research needs.

1. The evolving idea of public-private partnership (PPP) in developing countries

1.1 Origins and definition

The current debate about the role of PPP in the development process has its roots in the discussion of welfare reform in industrialised countries, notably in the United States and the

United Kingdom. The concept of PPP in itself therefore is not new and dates back to the early 1980s when Prime Minister Thatcher and President Reagan took over the government in the UK and the US, respectively. Privatisation of services, deregulation and *new public management* were the key words that characterised a new area of administration reform and a redesign – "reinventing" – of government activities. At the center of their policy was a cut-back of public sector expenditure, a delegation of responsibilities to the private for-profit sector and the fostering of voluntary work that had a social impact for the local community as a whole (Michell-Weaver and Manning 1992). The re-evaluation of the structure and function of governments in terms of providing public goods was driven by the argument that the hierarchical bureaucracy is inherently inefficient and that the introduction of market mechanisms will substantially enhance the efficiency of public-service delivery (Hood 1991, Moore 1996). This argument has been theoretically developed by public choice theory, mainly arguing that it cannot be assumed that politicians and bureaucrats always act in the public interest, but rather either pursue their own interests or those of powerful interest groups (Walsh 1995).

Whereas the focus of PPP at first had been on the relationship between the state and the for-profit sector, recently there has been a shift towards the non-profit sector and its possible contribution in providing (public) goods and services. In the US the notion of PPP changed from an earlier stress on the voluntary participation of individual citizens in the production of public goods by local governments to an increasingly broad conception involving a greater range of actors, including civic organisations and private-sector firms (Weschler and Mushkatel 1987, Warren 1987). The discussion in the UK has focused heavily on the institutional and managerial consequences of the mixed economy of care in social service provision, with a managerial mode of coordination in a multi-provider system (Robinson and White 1997).

There has been much confusion use of the term PPP. Often donor agencies and governments promoted privatisation and subsidies to private entrepreneurs in the name of building public-private partnerships (Vickers and Yarrow 1988, World Bank 1986). However, as Mitchell-Weaver and Mannig (1991, p. 49) point out, "privatization is privatization and subsidies are subsidies; public private partnerships they are not". They define PPP as "primarily a set of institutional relationships between the government and various actors in the private sector and civil society". It is very important to state that PPP is neither a development strategy nor a loose interaction between different agents. In order to fulfil the

criterion of a "partnership" there must be an ongoing set of interactions, an agreement on objectives and methods as well as a division of labor to achieve the goals. PPP are therefore not equivalent to the promotion of a free-market economy; in fact they are corporatists (Peters 1987, Salomon 1981). In the context of this paper PPP is defined as *"institutional relationships between the State and the private for-profit and/or the private not for-profit sector, where the different public and private actors jointly participate in defining the objectives, the methods and the implementation of an agreement of cooperation"*.

However, looking at the reality of PPP in developing countries, Robinson and White (1997) point out that the debate on PPP has so far very much concentrated on "complementarity" and not on cooperation, essentially reducing PPP to the fact that the State provides an enabling environment for the other social actors. Evans' (1996, p. 1119) definition of synergy goes beyond mere complementarity and includes "embeddedness". He describes the basis of the partnership as "(an) intimate interconnection and intermingling among public and private actors [...] with a well-defined complementary division of labour between the bureaucracy and local citizens, mutually recognised and accepted by both sides".

1.2 Partners, roles and types of cooperation

When organising a PPP three major points have to be considered, namely (Gentry and Fernandez 1998):

- the parties who are potential participants,
- the different roles those parties may play as part of the partnership; and
- the forms the partnership might take

The Government, the private for-profit and the private non-profit sector are not monolithic blocs in themselves, but a variety of actors at various levels with different interests, including their interest in participating in a PPP. So, it is not clear whether local authorities and the national administration – both entities of the Government – might have the same interest. Conflicts between these different levels have been frequent in times of decentralisation and the devolution of political and financial power from the national to the local level. The same holds true for the private-for profit sector. Partnerships always happen in a particular setting, they are locally and demand driven. Local enterprises may not have the financial backing as multinationals to contribute to infrastructure projects, however with their specific local knowledge and with their ties to the customer base they are essential

participants in successful partnerships at the local level. Finally, the variety of organisations that are placed under the umbrella of the not-for-profit sector makes it clear that, depending on the specific activity of an organisation, its contribution to a PPP may be quite different. For example, an NGO operating at the national level and aiming and lobbying for its clientele is very different from a small-scale and locally-based community organisation which delivers services for its members (Gentry and Fernandez 1998).

Besides a clearer definition regarding the type of parties involved in a PPP, one also has to recognise that their individual functions can differ substantially. Each of the parties identified can principally undertake any of these roles in any particular case. In order to establish a sustainable PPP, it is necessary to have a fair dialogue among the partners as to their roles in order to ensure that the needs of the different parties are met. The following roles are usually common:

- Provision: These are the parties who actually supply the desired service, e.g. health care, education, housing, etc. The incentive for the provision changes according to the type of parties, e.g. government for public interest, the private for-profit sector to make profit and the non-profit sector in meeting their social or environmental objectives.

- Financing: The Financing of services can be carried out in many ways. Taking the example of the health sector, public financing means financing by the central or local government and state-owned enterprises. Private financing includes private out-of-pocket payments, private insurance premiums or service provided by the private corporate sector (see also Figure 1).

- Regulation and monitoring: The setting of price and quality standards in the provision of services is a pre-condition for a functioning PPP. In situations where there are multiple providers of a service, customer demand and other market forces are likely to ensure that the service price and quality is acceptable. However, in situations where there are monopolies and only a small number of providers, more extensive government regulatory structures are needed to address potential market failures. Of course, this job is generally done by the public sector, but civic organisations and others might be involved as well. Regulation and monitoring is necessary in order to achieve a guaranteed minimum outcome in service provision.

Taking the variety of roles that the actors in a PPP could play it becomes clear that a PPP can take on very different forms. Gentry and Fernandez (1998) argue that choosing among these different forms depends on a number of issues, including:

- The degree of control desired by the Government,
- The Government's capacity to provide the desired services,
- The capacity of private parties to provide the services,
- The legal framework for monitoring and regulation,
- The availability of financial resources from public or private sources.

1.3 Why PPP in the health sector?

The discussion of new public management also had an impact on health policy debates in developed as well as in developing countries. The specific term used here is "contracting out" meaning the outsourcing to the private sector of activities formerly done by the public sector. The private sector is not under the direct control of the Government and it can function according to a different set of objectives and norms. Private providers can choose which services to offer, determine their own levels of quality, mix of inputs and costs (Berman 1997.

Two lines of argument are used as to why contracting out improves health care systems (WHO 1998):

- Economic: The replacement of direct, hierarchical management structure by contractual relationships between purchasers and providers will increase transparency of prices, quantity and quality as well as competition and will lead to a gain in efficiency.
- Political: In the context of welfare system reform world wide, decentralisation of services from the national to the local level is frequently suggested in conjunction with an improved participation of the population in determining and implementing the services.

Beside the advantages of contracting out which are also often attributed to a PPP, it is argued that the cost side should not be overlooked. Contracting out and PPP will increase transaction costs for, e.g. negotiating and monitoring, the loss of monopsony purchasing power and social costs arising from equity problems (Robinson 1990, von Otter and Saltman 1992). In addition to these direct costs, the impact on the wider health system should also be taken into account. As Mills (1995) argues, the introduction of contracts may (a) lead to a fragmentation or lack of coordination within the broader public health system, (b) could have

an impact on staff resources with a drain of key personnel to the for-profit providers and (c) might drive scarce resources into a less than optimal allocation.

Berman (1998, p.113) has summarised four major concerns on the effects of private health care provision from the perspective of national health policy goals and objectives:

1. Private providers respond to the population's willingness to pay for health care. As a result, they serve those groups who are most willing to pay, such as affluent urban residents. The result will be increased inequity in access and use of health care.

2. Because of lower willingness to pay, private providers will undersupply socially desirable services, such as immunizations and personal preventive care. This will worsen allocative efficiency in the health sector.

3. Driven by the profit motive, and because they have significant control over demand, private providers will take advantage of patients by supplying more health care than is required. This is inefficient and may result in health-impairing actions.

4. Private providers can also take advantage of patients by providing low-quality health care, which may result in health and welfare losses.

Turning to the role of the public sector, the question arises as to why and which role the government should play in health care provision and financing. First, the private sector faces constraints that the public sector can principally overcome. Economic theory suggests that market failure and equity considerations call for public sector intervention. Market failure in the case of the health sector means essentially an underprovision of socially desirable services, e.g. non-patient-related preventive services, disease control and vaccination/immunisation programs, the existence of externalities, e.g. that the welfare of infants depends heavily on the health status of the mother and the existence of asymmetrical information. The latter problem may arise when drugs are sold on the open market and the manufacturer is better informed on the efficiency and safety of the drug than the purchaser. Looking at equity, a society might be interested in correcting the final allocation of goods and services as it heavily depends on the initial distribution of ownership. Therefore the state might want to correct these imbalances by a policy which directly benefits the poorer part of the population, e.g. through exemption from payment for certain services. An often-quoted example of market failure, which leads to an unequal coverage of health care services are private-run insurance schemes. Due to the problem of adverse selection and moral hazard,

private insurers will only include good risks in their schemes. This, however, makes risk pooling among a society difficult and leaves the bad risks to the public sector.

To address the described market failures, the state could respond in several ways such as:

- Organising the production of socially desirable services, e.g. disease control
- Organising goods and services with externalities, e.g. vaccination programs
- Organising information campaigns, e.g. on family planning, prevention of diarrhoeas
- Taking steps to eliminate asymmetric information, e.g. the official registration of health professionals and official recognition of drug quality

The following table summarises advantages and drawbacks of the different actors in the health sector from a theoretical perspective. The table should be interpreted with caution, because the + and – only indicate a relative comparative advantage and not an absolute one. It mainly shows that the state has a comparative advantage with respect to the insurance problems "adverse selection" and "covariate risks", the private for-profit sector regarding "cost-efficiency" and "quality" and the private not-for-profit sector in controlling for "moral hazard".

These stylised facts on the advantages and drawbacks of the private and public sector have been mainly derived from theoretical considerations. In practice, however, some of the above-mentioned points have to be modified. If one looks for instance at the role of the state's performance in practice one has to acknowledge that due to allocative inefficiency, operational inefficiency and equity problems the state sometimes poses more problems than it solves. An example is the concentration of resources to the tertiary sector, e.g. hospitals, clinics in urban areas, etc. This has lead to a clear underprovision of health care in rural and remote areas. If health care is provided for free and is accessible, then the quality is often so bad that people prefer to go to a private provider and to pay fees with a certain guarantee of quality treatment.

Table 1: Strengths and weaknesses of social actors in the health care sector

	Moral hazard	Adverse selection	Covariate risks	Cost efficiency	Quality	Equity of access
Public sector*	--	+++	+++	--	-	++
Private for-profit sector**	+	--	++	++	+++	---
Private not-for-profit sector	++	-	?	+/-	+/-	++

+++ Strong comparative advantage / (---) strong disadvantage

* Insurance universal / ** insurance not mandatory

Source: Adapted from Jütting (1999).

Given the numerous actors, and the variety of roles ranging from financing to provision and management, several types of cooperation are possible. Figure 1 provides the conceptual framework developed in this paper that indicates the different actors, roles and types of PPP in the health sector of developing countries.

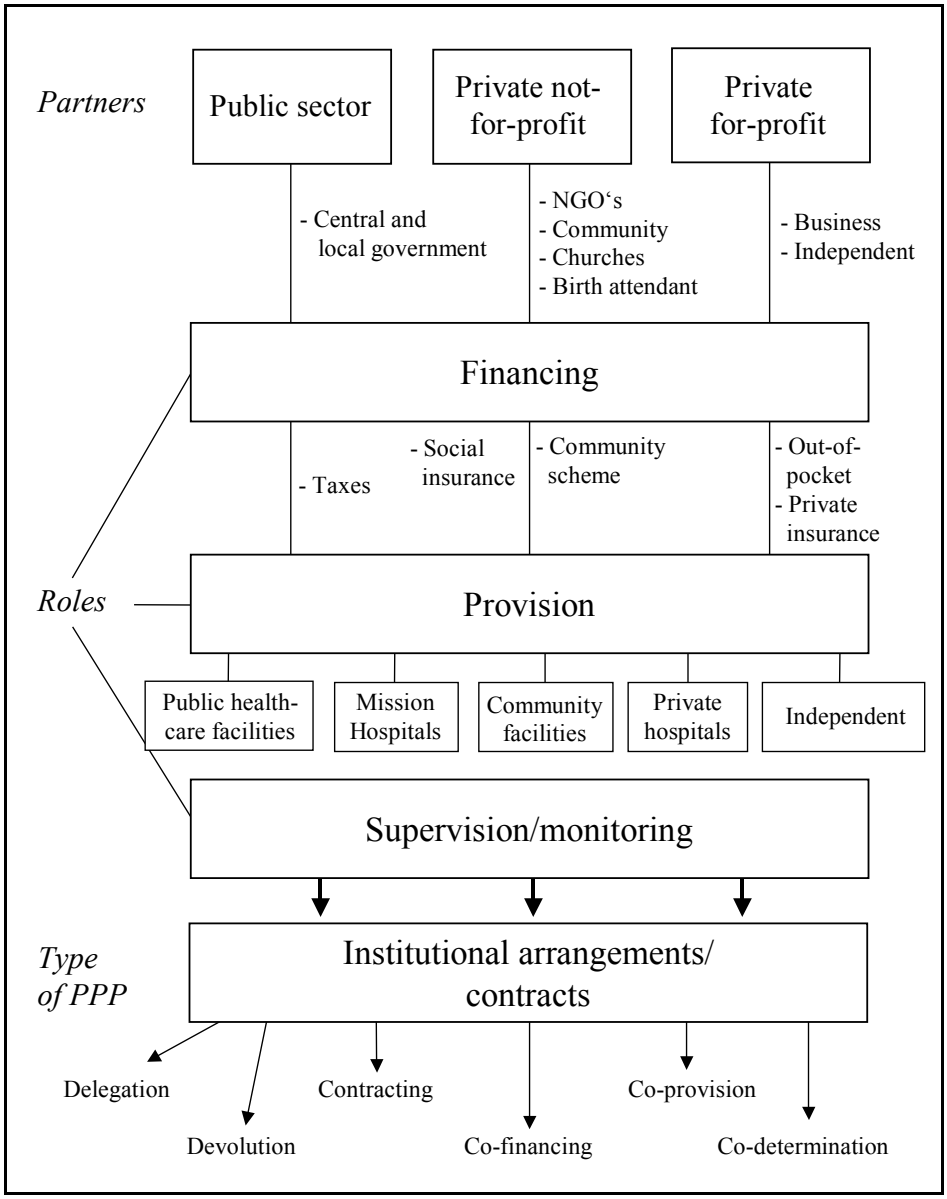
Figure 1 is a diagram of the outline of a PPP in the health sector. It shows that within the three major sectors – state, for-profit and not-for-profit – a variety of individual actors found their place. The opportunities and possibilities of a PPP are nearly unlimited: it can have a variety of actors, and it can also play different roles such as in financing, provision, management and supervision of health-care services. Most common is cooperation in the area of financing or in the provision of health services, e.g. the State subsidises health-care facilities that are run by local communities, or cost-recovery schemes in which the financing side is with the private sector and delivery of service is with the State.

2. PPP and the health-care sector: Case studies

2.1 Health-care systems in developing countries: An overview

Health systems in developing countries are varied in nature and often have their roots in the organisational approach favored by the relevant colonial power. Before turning to country-specific case studies of PPP, some basic characteristics of health care systems in the different regions of developing countries are described.

Figure 1: Conceptual framework of a PPP in the health sector



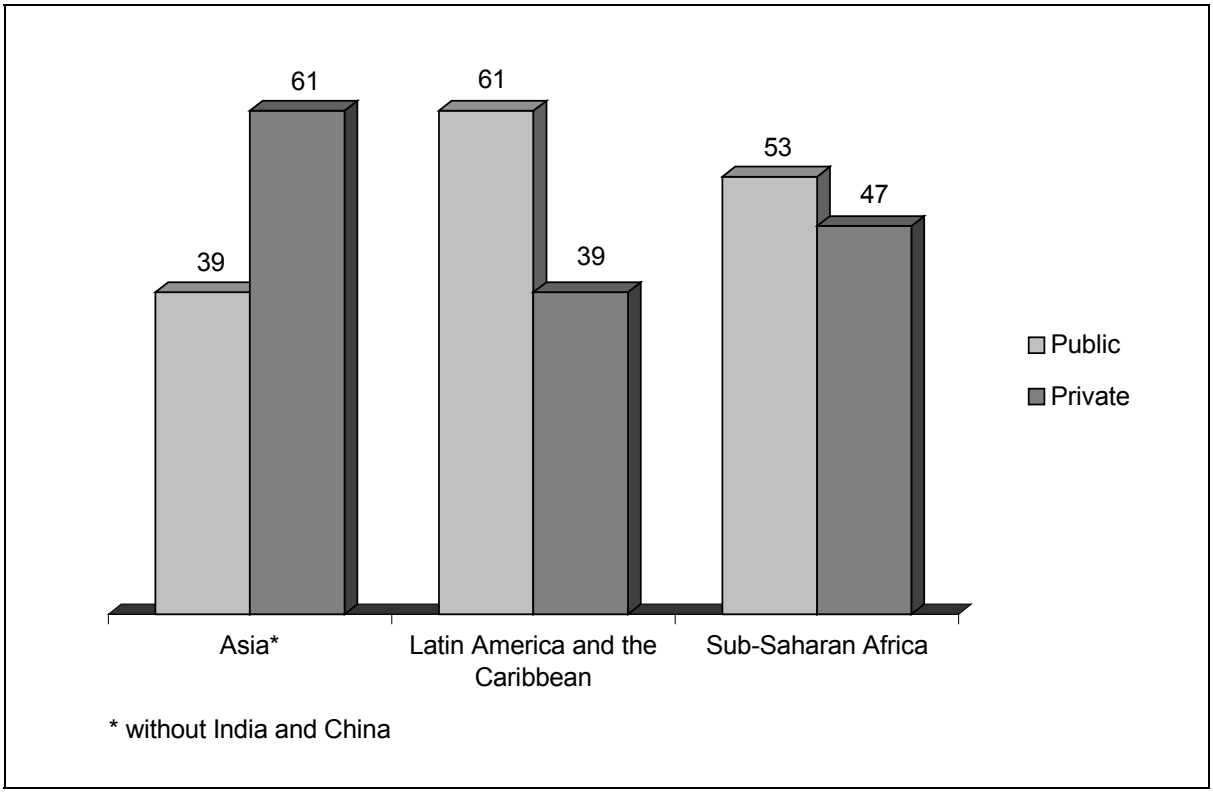
Source: Author's design.

In Asia more market-oriented systems are in place reflecting to some extent the US system of private insurance and health maintenance organisations, whereas in large parts of Africa either the French or English model is followed. In Latin America, a mixture between large public direct-delivery systems and the provision of health services by private providers can be observed. In several countries, however, more homegrown strategies are in use as well. In China, for example, public hospitals are largely financed by user fees and insurance collections. With its old rural health-care delivery systems largely dissolved, however, a variety of private-sector initiatives have arisen to meet the country's needs (van der Gaag 1995).

The important role of the private sector in health-care financing worldwide is demonstrated by the fact that an estimated 50 per cent of global spending comes from the private sector, although the amount varies considerably across countries and regions (Figure1).

As shown in Figure 2, Asia has more than 60 per cent of private sector contributions (excluding China and India) *and* is the part of the world where the private sector normally plays a dominant role. This is not only true for financing but also for the provision of services, with a steadily growing importance over time. This trend is the reflection of the overall development process in most Asian countries with rising demand for health services where government provision cannot keep up with the need of the population. In Malaysia, for example, the proportion of physicians in private practice increased from 43 per cent in 1975 to 70 per cent in 1990. In Indonesia, about half of the hospitals are privately run. In Thailand, the share of beds in private hospitals grew from 5.4 per cent in 1970 to 13.7 per cent in 1989 (van der Gaag 1995). However, despite this general privatisation trend private health insurance plays only a very limited role in most countries of the world. Less than 2 per cent of the population are covered by private insurance schemes even in countries in which social insurance is widespread (Table 3). Private health insurance schemes are clearly restricted to the higher income sector of the population with low health risks.

Figure 2: The distribution of health-care spending between the public and private sector, by region (as percentage)



Source: Murray et al. (1994).

Table 3: Health insurance coverage in selected Asian countries as percentage of population

Country	Social health insurance coverage	Private health insurance coverage
Taiwan	100	0
Thailand	27	2
Papua New Guinea	0	<1
Vietnam	38	<1
India	3	<1
Korea	100	<1
Indonesia	17[g]	1[h]
China	19	<1
Philippines	42	NA
Sri Lanka	0	1.5

Source: Newbrander (1997), p. 117.

According to Murray et al. (1994), the contribution of the private sector to health care financing in Africa is 50 per cent, slightly lower than in Asian countries. In contrast to Asia, the role of the private not-for-profit sector in health care provision in Africa is much larger. The high level of non-state provision in the early 1990s is shown in Table 4. For a majority of the countries selected, church organisations are the dominant providers. In Tanzania, 40 per cent of the hospitals are run by church organisations and in Zimbabwe church missions provide nearly 70 per cent of all beds in rural areas. In Kenya, about one-third of the total health services and 40 to 50 per cent of the family planning services are provided by NGOs (Kanyinga 1995).

Table 4: Extent of non-State provisioning of health services in Africa (as percentage)

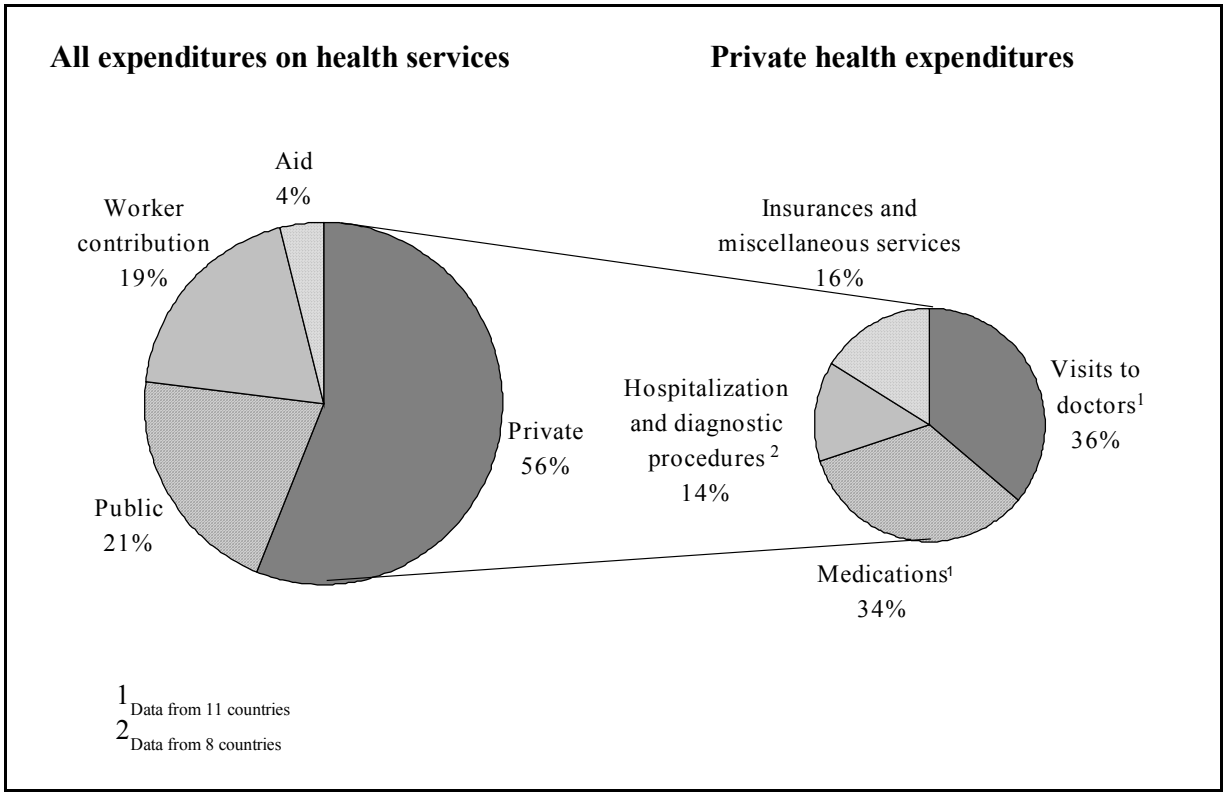
Country (organisation)	Percentage of total no. Hospital/ hospital beds	Percentage of total services/contacts
Cameroon	40 (facilities)	
Ghana (church)	20 (beds)	40 (population) 50 (outpatient care)
Kenya (NGOs)		35 (services)
Lesotho (non profit)	50 (hospitals) 60 (clinics)	
Malawi (church)		40 (services)
Tanzania (church)	40 (hospitals)	
Uganda (church) (NGOs)	42 (hospitals) 14 (facilities)	31 (services)
Zambia (church)		35 (services)
Zimbabwe (church)	68 (beds/rural areas)	40 (contacts)

Source: DeJong (1991), Gilson et al. (1994), Nabaguzi (1995).

In *Latin America,* the financial contribution of the private sector in the health sector varies according to source from roughly 40 per cent to 60 per cent. As in other regions recently, there has been a shift towards more private funding of health services. Regarding the provision of services, the trend is the same—private health services are rapidly expanding for both the rich and the poor. The spectrum of private providers varies from those who provide expensive high-tech on a for-profit basis for the better-off to those non-profit providers operating mainly in areas where public services are not available.

The two main components of most LAC private health expenditures are out-of-pocket spending for visits to doctors and for medications, which account each for one-third of the total sum of private-health expenditure (Figure 3). This is a strong indication of inequality as private out-of-pocket payment put people at risk at a time when they are most in need.

Figure 3: Expenditures on health services in Latin America and the Caribbean



Source: Zuckermann and de Kadt (1997), p. 4/5.

As described, the role of the private for-profit and non-profit sector in health care provision has revealed two important points: First, on all three continents the private sector accounts for a substantial amount of the health care expenditure and the provision of services, and its share is increasing. Second, there are indications—concerning coverage rates and the mode of financing—hinting at a problem outlined earlier, that being that the private sector alone cannot solve the issue of an equitable provision of health care, which underpins the theoretical argument for synergy between different actors in order to overcome their individual weaknesses.

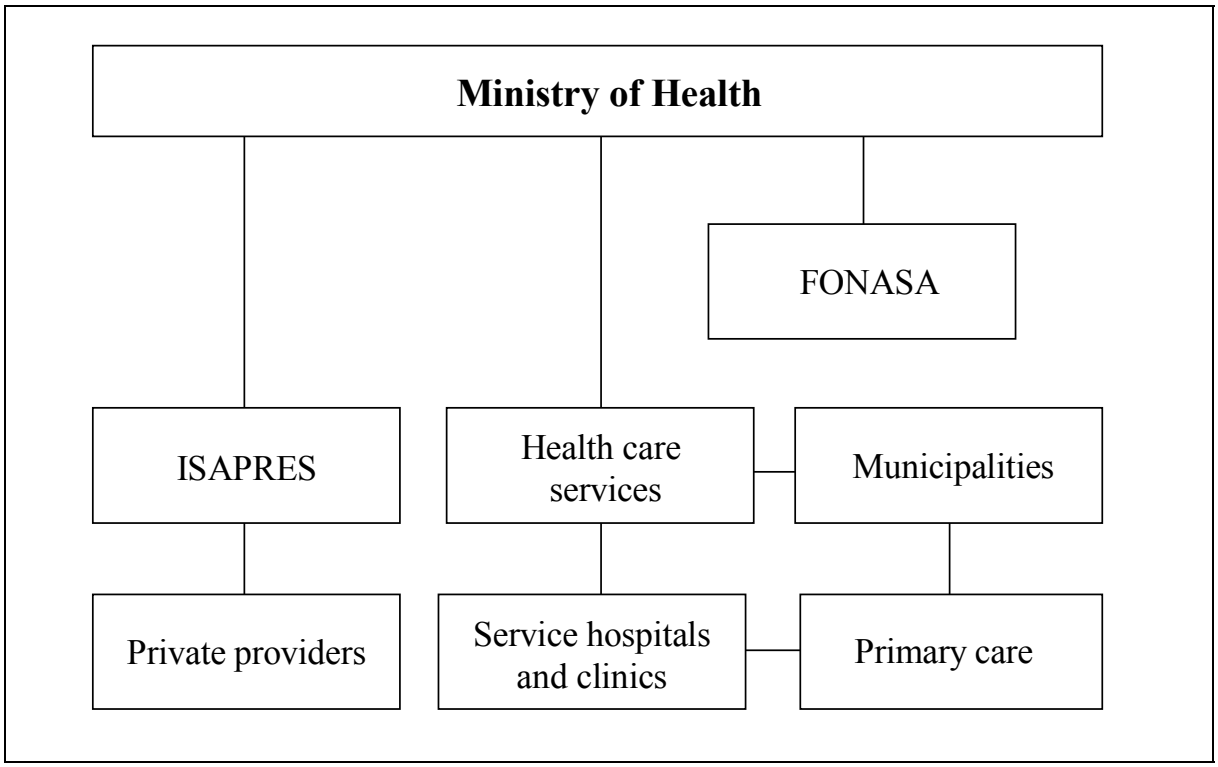
2.2 Latin America: Chile and Venezuela[1]

2.2.1 Example from Chile

Partners

Before we discuss the different roles of partners in the health sector in Chile, a short overview of the structure of the health sector will be provided, coverage and funding issues will be addressed and efficiency and equity outcomes within the public and private sub-sector will be described. The following figure gives an overview of the structure of the health care sector.

Figure 4: Structure of the health care sector in Chile



Source: Zuckermann and de Kadt (1997), p. 39.

This structure is the outcome of a reform that took place in the 1980s with the aim of separating the regulatory, funding and production functions of the public health care system, decentralising the administration of primary care to the municipalities and encouraging the creation of ISAPRES private insurance schemes. The following partners and roles can be identified. The central government is in charge of policy design, institutional coordination and supervision; the National Health Fund (FONSA) is a decentralised service in charge of the functioning of the public system; and on the community level, primary health-care centers

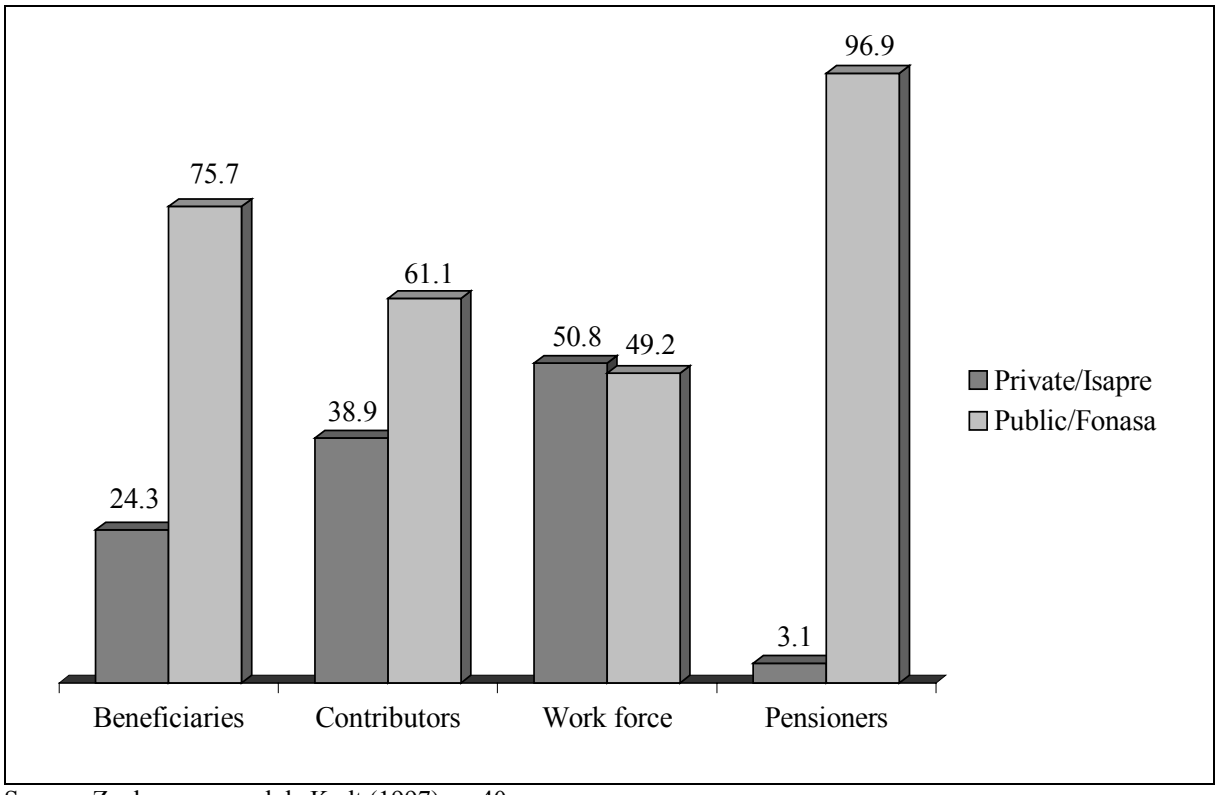
[1] The presented data and figures in the two case studies are taken from Zuckerman and de Kadt (1997).

administered by the municipalities are in charge of the provision of curative services, health promotion and prevention activities. Within private health care there is an open and a closed system, the latter serving only the employees of specific companies.

Roles and impact on efficiency and equity

Approximately three-quarters of the Chilean population is covered by the public health-care system, whereas one-quarter has private coverage (Figure 5). The distinction between beneficiaries and contributors reveals an interesting discrepancy—40 per cent of contributions goes to the private system, from which 25 per cent of the members benefit. It is also interesting to note that the private health sector spent 2,5 times more for each beneficiary than the public system.

Figure 5: Coverage of health care systems in Chile (as percentage)



Source: Zuckermann and de Kadt (1997), p. 40.

The public scheme offers equal health care regardless of the amount of premiums and co-payments, which represents an incentive for higher earning individuals to opt for the private system where care depends on the premium paid. As the public system has serious quality problems and often has long waiting lists, the better-off increasingly join the private ISAPRE system leaving the "bad risks" for the public sector. "Better-off" in this sense means:

- *To belong to the younger population*. While 22,5 per cent of the overall population belongs to the private system, a relative high 27 per cent of the low-risk group aged 20 to 39 is privately insured, compared to a low of 5 per cent for the high risk group of over 60 years.

- *To live in urban areas*. The coverage with private insurance lies with more than 30 per cent, ten per cent above the nation-wide average.

- *To belong to the richer part of the population*. With an increasing income, the relative percentage of people joining a private scheme increases.

These characteristics of a "typical" member of private insurance schemes clearly indicate the adverse selection problem. It is therefore not surprising that this has serious consequences for the efficiency of both systems. Zuckermann and de Kadt (1997) depict the following principal inefficiencies in the Chilean health care system:

Table 5: Principal inefficiencies in health care systems in Chile

Private/ISAPRES	Public/FONASA
Temporary nature of health insurance (does not cover old age, catastrophe)	Funding not linked to results
Distortions in resource allocation ▪ Use of nonessential services ▪ Undersupply of prevention	Restrictions on management of health-care institutions
Excessive administration and sales	Delinking of primary care and higher-level services
Excessive spending on medical leave	Inadequate information systems

Source: Zuckermann and de Kadt (1997), p. 47.

Interestingly enough, the problems with the private health insurance scheme can be fairly well explained by the problems with private health care provision in general. Major inefficiencies associated with adverse selection problems are an unequal coverage, the oversupply of high quality/cost intensive services, an undersupply of prevention services and high administrative costs. Concerning public schemes, health-care management and delivery are the major sources of inefficiencies. Especially after the decentralisation of primary health care service and the delinking of higher-level services, doctors have little interest to work in these facilities as their prospects for professional development seem to decline.

Types of PPP

We have chosen the Chilean example to illustrate the difference between a public-private mix and a real public-private-partnership. The Chilean health sector is characterised by two different and independent subsectors, a public one and a private for-profit one in which no real interlinkages can be observed. In an environment of general privatisation of social services, the Chilean government has devolved basic health services to the municipalities, in conjunction with the setting up of a private scheme under the supervision of the Ministry for Health. Although this is not unusual and occurs even in advanced economies, the missing interlinkages and pooling of risks leads to efficiency and equity problems in so far as roughly two-thirds of the population cannot afford private services and the public sector cannot provide competitive and curative services for all without the resources of the better-off contributors. In Chile one can hardly speak of partnership as defined above, i.e. one with clear institutional arrangements for co-operation between the public and the private sector. Rather, it is a form of public-private-mix, which is the outcome of decentralisation and privatisation, without institutional arrangements and incentives for closer cooperation.

2.2.2 Example from Venezuela

Partners

The Federal level of government of Venezuela has the principal responsibility for the financing and provision of health care. Even today, a highly centralized administrative structure guarantees services and establishes the rules for the overall system. Three models of health-care provision can be distinguished—the open-access public-care system which is universal and free of charge; a closed public system where care is based on prepayment plans provided by social security institutions; and where health care is provided by the private for-profit and not for-profit sectors.

Roles and impact on efficiency and equity

With respect to the public system, the World Bank identified the following major weaknesses: low internal efficiencies in personnel, equipment and program management; poor efficiencies in allocating funds; inequitable access to services; and a lack of information for decision making (World Bank 1993). In order to solve some of these problems, in 1994 Venezuela embarked on a health-sector reform leading to a flexible health-care management and delivery model in each of the States. The outcome of the reform has been mixed, with successful and unsuccessful cases.

In comparison to Chile, the private for-profit sector plays only a minor role even after the reform, the difficulty to do so explained in the main by the situation of economic distress and financial cut-backs. Management problems and the exclusion of the majority of the population due to high premiums have also lead to a drop in demand.

Types of PPP and impact

In the following table selected successful cases of a public-private partnership are described. They involve an active participation of communities in primary health-care provision, the creation of new management models for public hospitals and the setting up of alternative insurance schemes based on risk sharing and solidarity.

Table 6: Public and private participation in health care in Venezuela

Examples	Partners	Roles / types of cooperation	Impact
Primary health-care provision in Aragua and Lara state	State/municipality with community participation	Involvement of communities in management/ administration	Increasing coverage and quality in poor zones lacking services
Hospital management	State and charity foundations, autonomous services	Co-financing, management, administration	Increase in service efficiency
Insurance	State and staff associations	Co-financing	Used as management tool for other Venezuelan health-care centers
Community activities	State and communities	Self-management and exchange of services voluntary work	Set up of a medical care plan for microentrepreneurs

Source: Adapted from Zuckermann and de Kadt (1997).

These few cases show that in Venezuela PPP in the health sector is mainly a relationship between the public—national and local government—and the not-for profit sector—foundations and community associations.

The inability of the public and the private for-profit sector to set up adequate health care systems has lead to the creation of schemes in which local people participate in the design, financing and implementation of services. The success of these small-scale initiatives and innovations has had a double effect. It had an impact on the government, which has been forced to think about further efforts to strengthen its own activities via more decentralised

services, new ways of financing and a change in the health care and management model. It also had an impact on the private for-profit sector, which had to improve its efficiency and deliver health care services at a lower price and with good quality.

The need to think about a PPP in the Venezuelan health sector resulted from a serious economic and financial crisis and a strong dissatisfaction with the public and private for-profit sector. In contrast to the case of Chile, a real partnership exists in Venezuela where the public and the not for-profit sector are both involved in determining, financing and management of services. Despite the small and selected number of "successful" cases presented in this paper, some general conclusions can be drawn. First, an overall political commitment for a shift of government financial and political power from the national to the local level and to other actors is a pre-condition for any PPP. Without a political will to challenge vested interests, particularly among suppliers of medical inputs and equipment, it is nearly impossible to get other actors involved. Beside the political factors the overall economic situation also plays a role in so far as it defines the space parameters for innovative social policy activities. On the one hand, the economic crisis gave strong incentive to think of alternative ways of financing and therefore the involvement of other actors. On the other hand, in the mid- to long-term, these new arrangements will need public money to some extent, if they want to work on a sustainable basis with otherwise excluded people. Finally, without the important contribution of volunteer work, services would have not been delivered and available at current prices; this contribution is a necessity for an effective PPP.

2.3 Africa

2.3.1 Example from Zimbabwe

Partners

Zimbabwe is one of the rare countries in Africa in which privately-run health insurance plays a significant role thanks to the existence of the Medical Aid Societies (MAS). These are not-for-profit companies, which offer health insurance to approximately 800,000 people, or 8 per cent of the total population. They originate from former health insurance plans developed by large firms/groups of firms and are quite similar to the "Betriebskrankenkassen/sickness funds" in Germany. A difference, however, lies in the fact that groups of self-employed people can be accepted for membership. The 25 MAS have built a National Association of Medical Societies and their existence can be explained to a large

extent by the relatively extensive formal sector when compared to many other African countries. In Figure 6 some characteristics of Medical Aid Societies are presented.

Figure 6: Characteristics of Medical Aid Societies (MAS) in Zimbabwe

Medical Aid Societies

Ownership:	Non-government not-for-profit
Eligibility:	Formal sector employees; one MAS also covers small groups of self-employed
Services:	Most outpatient and inpatient services, including drugs
Mandates:	No government mandate; industry and trade unions
Premium Setting:	Third party pool actuarially determined initially; subsequent revisions historical; individual premiums risk pooled

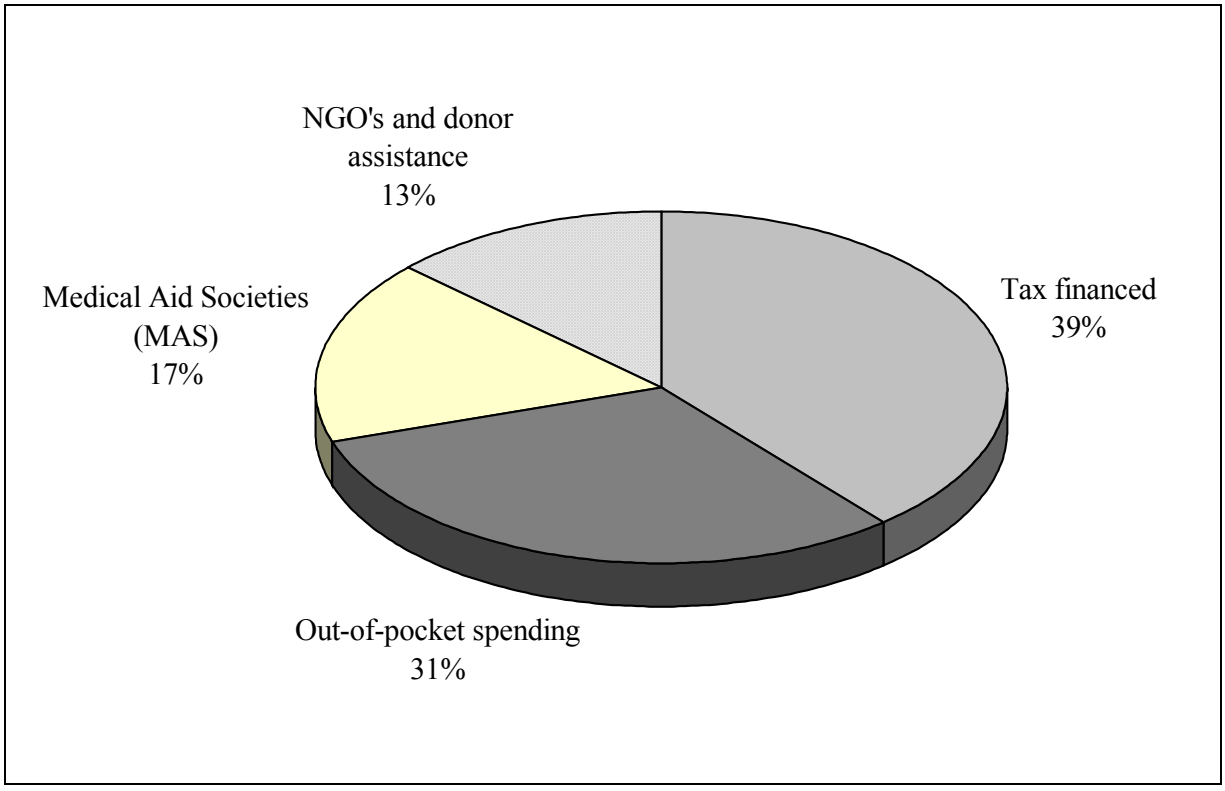
Source: Based on Chawla and Rannan-Eliya (1997), p. 19.

Despite the relative importance of the MAS—compared to the role of other privately-run insurance schemes in Africa—the overall health care financing and provision is carried out and controlled by the State. In 1980 the Government introduced free health care for low-income people that lead to a declining role of user fees in financing services. User fees have either not been implemented or there was a high exemption ratio and a failure to adjust them for inflation. Despite these negative experiences—leaving aside the whole problem of the impact of access for poor people—in 1990, in conjunction with the Structural Adjustment Program, more emphasis was placed on fee collection. The health policy changed again in 1995 with a suspension of all user fees. The current situation can be described by saying that the Government intends to decentralize health care provision and financing, which should increase the role of municipalities in the management of health funds.

Roles and the impact on efficiency and equity

As Figure 7 shows, two-thirds of the health sector resources come from general taxation and out-of-pocket payments from private households, and approximately one-third comes from the contribution of insurance premiums collected by the MAS and from donor assistance.

Figure 7: Health care financing in Zimbabwe (1994)



Source: Chawla and Rannan-Eliya (1997), p. 9.

The MAS offer a possibility for formal workers—mostly public, a small and wealthier fraction of the population—to be covered with health insurance. Most often they work through employers who contribute to some extent to the financing of the premium. The system contains elements of solidarity within the individual MAS societies but not between them, which reduces the possibility of cross-subsidization. Chawla and Rannia-Elyia (1997, p.33) characterize the MAS as "well run and efficient" with administration costs of 8 to 12 per cent of the turnover. As an intermediary organization, the MAS negotiates with the providers of health care, e.g. hospitals and practitioners and they can keep charges relatively low due to their large purchasing power. Adverse selection plays no role as insurance is compulsory for all employees within an organization.

Types of PPP

Similar to the Chilean case there is no partnership between the public and the private not-for-profit sector. The reason for this lies in the policy makers' inability to accept MAS as a serious partner in health-care financing. A legal framework has not been developed and the MAS have developed according to perceived needs. In the mid- to long-term the non-existence of rules and codes of conduct reduces the potential of further development of the MAS. This is a pity in that the MAS seem to be a promising platform for the establishment of a social insurance that bypasses boundaries of occupation and could then also be opened up for people in the informal sector. The important point to be made is the same as for the Chilean case: Without the commitment from the State to set up a partnership, two parallel systems will continue to operate.

2.4 Asia

2.4.1 Examples from Khazakhstan and Kyrgyzstan[2]

Partners and roles and impact on efficiency and equity

Transitional countries do not receive very much attention in the current discussion on the public-private mix in health care provision. This is due to a health system in the former Soviet Union and other East-European countries in which the government did not allow other actors to play a role in health care provision or financing. The health system of the Soviet Union was centralized, hierarchical and standardized. Policies, practices and treatment norms were developed in Moscow and passed to each republic for implementation. The health ministries of each republic issued directives to provinces ("oblasts"). The system emphasized tertiary care and specialty services. Hospitals and polyclinics received most of the resources, while primary health care was underfunded.

Given this background, Kazakhstan and Krgyszstan in Central Asia are two interesting case studies as these States have the greatest experience in reforming their health sectors. The reform consists principally of four elements: introduction of health insurance schemes, cost reduction, separating service provision from financing and rationalization of health services. The core of the reforms was the introduction of a mandatory health insurance fund, a capitated provider system, and the development of a basic benefit package in selected "oblasts". The institutional "innovation" in the health sector was the creation of family-group

[2] This section reports the findings of a Report of the Partnership for Health Reform Project (PHR), http://www.phrproject.com/publicat/si/sir19sum.htm

practices (FGP), not-for-profit, voluntary-based entities which provide primary health care on a decentralized level to all family members of a group from a single location. The creation of FGP set the stage for FGP associations, which are intermediary organizations between the government and the FGP. The FGPAs work closely together with government health services and participate in direct service provision, health status monitoring and reporting. Although in both countries the role of FGPAs includes the representation of their members and the lobbying for a better access to health services, it seems that in neither of the countries was health advocacy of FGPAs achieved.

The public sector still plays the major role in the health sector of both countries. However, due to the need and willingness of health-care reformers to downsize the public sector, FGPAs as not-for-profit health care providers gain increasing importance on the "oblast" as well as on the national level. It is presently far too early to measure any detailed impact on efficiency and equity, yet it appears as if the devolution of some regulatory functions and shared approaches to quality assurance have been useful in contributing to the resolution of major problems of the health sector in both countries.

Types of a PPP

The case of both Central Asian countries is very similar to that of Venezuela, in that the PPP is based on a relationship between the State and the not-for-profit organizations. The commercial sector does not play a role at all. Moreover, in both cases, a severe financial crisis has lead to the pressure on the Government to devolve some of its power to the not-for-profit-sector.

However, there are also important differences to the experience of Venezuela, the most important being that the Government itself established, with donor support, these not-for-profit organizations. It was not as in Venezuela the result of the actions of an existing vibrant civil society. This implies that these organizations might develop a quite different relationship to their founders than in Venezuela. Moreover, as briefly mentioned before, in Kazakhastan and Krgyzstan donors have played an important role in so far as that they have helped to strengthen the institutional capacity of the FGPA's, which enabled them to fulfill their new roles and responsibilities. These have been important means to demonstrate to the State that these organizations can be viable partners.

The preliminary lessons learned from the experience with a PPP in the health sector of Kazakhstan and Krgyzstan are positive. The limitations of the former publicly-controlled and

publically-driven health system can, partly, be overcome by introducing more demand-based, flexible and open elements. The promotion of not-for-profit organizations operating on a voluntary basis at a local level is an important step in that direction. A long-term successful partnership will depend to a great extent on the commitment of government officials vis-a-vis the new organization once donor support is reduced, and on the ability of the new groups to extricate themselves from State control.

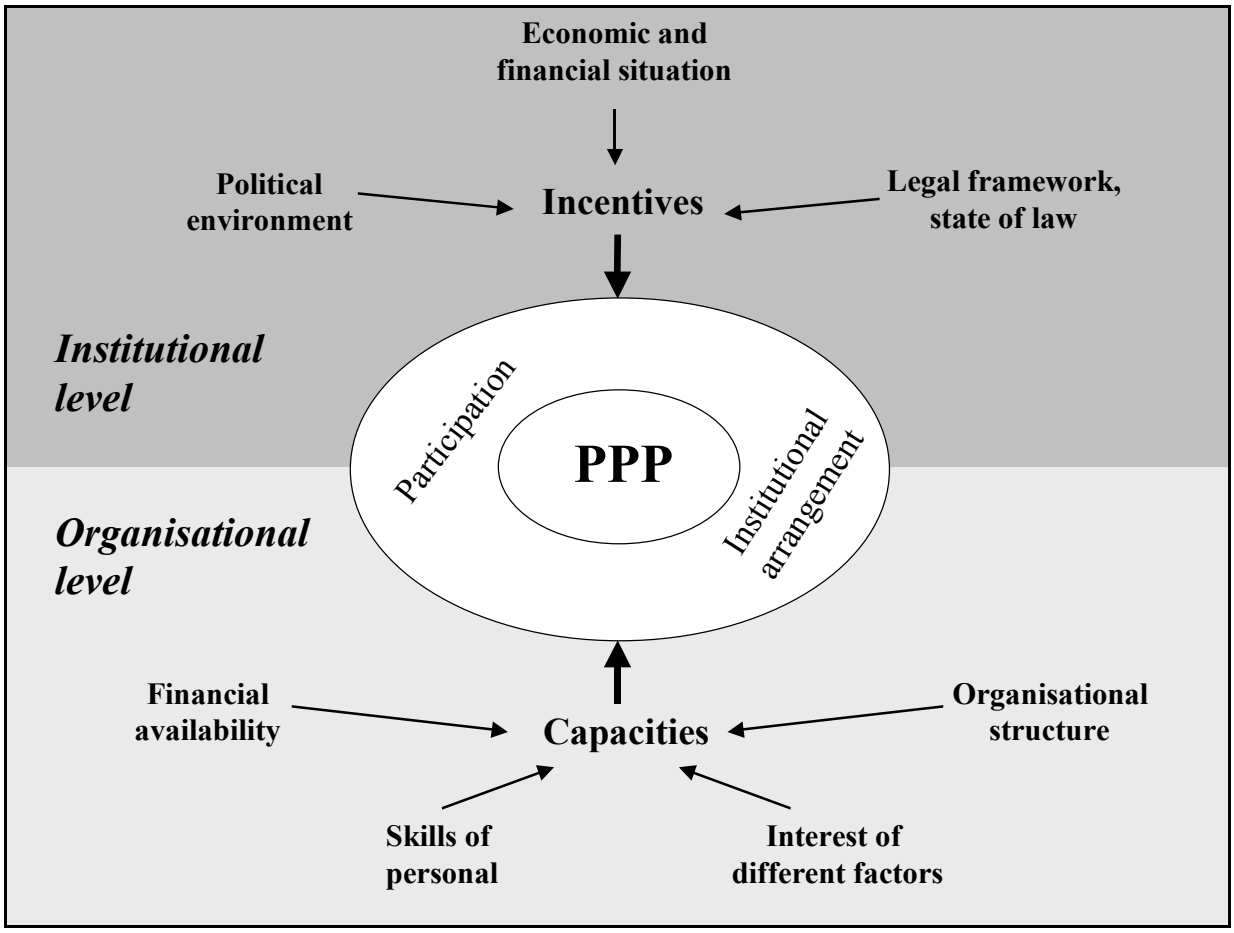
3. Conditions for the establishment of a public-private partnership in the health sector

The review of case studies about PPP in the health sector of developing countries has clearly shown the need to specify exactly what a "partnership" actually means in a country-specific context. Strictly speaking, "contracting out" and the development of two different sub-sectors (public and private) as reported in the Chilean case, is not a partnership. The definition issue becomes even more relevant when looking at the conditions and the outcome of PPP. There are hardly any data and information available in the literature that would allow a rigorous analysis of the costs and benefits of a PPP. It would therefore be very interesting to analyse more specifically the impact of a PPP on the overall health system. The before and after approach would be valuable for such an analysis,

The conditions for the building of a PPP in a specific country can be divided into two parts—those attributed to the incentives for building a PPP (macro level) and those related to the capacities of the different actors to be competent partners (micro level).

Without an overall political environment favouring private for-profit and not-for-profit activities no real partnership can be established. In countries where the civil society and/or the private sector are not taken seriously, the Government will remain the dominant force responsible for social service provision. Apart from the political factor, the economic situation in a country is important. A financial and economic crisis is often the starting point of a rethinking of government activities. However, in the mid- to long-term the financial engagement of the state in the health sector is necessary for the sustainability of a PPP as the poorer part of the population will continuosly depend on public support. Finally, on the macro level, the legal framework is important. The credibility and transparency of the cooperation between the different actors are critical determinants for a long-term success of a PPP.

Figure 6: Conditions for the establishment of a PPP in the health sector



Source: Author's design.

At the micro-level certain conditions are important for establishing a PPP in the health sector. First of all, there must be interest and the commitment of some individuals to make a PPP happen. As seen from in the Venezuelan case the personal involvement of the users of services helped to provide an efficient and equitable service provision. Suppose there is an interest in having a PPP and an acceptance of the different partners to be involved, one then has to look at the capacities of the different actors. Skills of the personnel to provide specific services, the financial availability for an engagement in service provision and the overall organisational and management structure have to be considered.

4. Conclusions

Despite the above noted constraints on available information and data on PPP in the health sector of developing countries, some general conclusions can be drawn.

1. The provision of health care services on the basis of a PPP is still not very common in developing countries, despite its appealing theoretical advantages. In several

countries the role of the private sector in providing social services is still neglected or not taken sufficiently into account.

2. PPP increases competition for the government through the enabling of other actors to participate in the financing, provision and determination/management of health services. This has a positive effect on efficiency, equity and quality of health care provision. In Venezuela, for example, a substantial part of the population has been excluded from both public and for-profit-provided health care. Only after the explicit recognition and building of linkages between the not-for-profit sector and the State, did poor people have the chance to set up their own systems.

3. The poor population depends especially on the support of the public sector. This support can take a variety of forms and must not be restricted to public health care provision in public health-care facilities. There is much room for new innovation, following the implementation of which otherwise excluded people could become members of private for-profit and not-for-profit schemes.

4. Beside the role of the Government concerning social protection, another important role is the setting of rules and standards of conduct. Only then can it be guaranteed that the other actors not only see their own vested interest but also the overall health-system profits. The designing of rules and regulation and its enforcement can only be done by the government and remains a major responsibility.

5. The involvement of and the delegation of power to the local level is important. Without the active participation of the communities and municipalities, it difficult to build a functioning and sustainable health care system. Health-care systems that involve local people in designing, providing and monitoring of services can better deal with information asymmetries and moral hazard problems. Moreover, they can use voluntary work, thereby providing services at lower costs. Finally, through such self-help activities, mid- to long-term benefits in the form of a strengthening of social capital among community members might mature.

6. Country-specific solutions are required. The development of a model on how to build a PPP in the health sector of developing countries is neither possible nor desirable. It depends on a variety of country-specific conditions that set the framework for cooperation between different actors. Moreover PPP vary in target, form, process and parties. The most successful cooperative arrangements stem from a flexible approach,

drawing upon and adapting the experience of other countries (Gentry and Fernandez 1998).

7. Finally, the cost side of building and monitoring a PPP should not be overlooked. The efficiency gains that are attributed to a PPP as a result of more competition, a more transparent cost structure and common activities could to some extent be compensated by increasing transaction costs for negotiating and monitoring of the cooperative arrangements. Future research should specifically analyse how significant the costs of setting up and monitoring a PPP would be and how they could be reduced.

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