Keystone Module Background Paper¹:

Private Participation in Health Services Handbook

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1. Introduction

1.1 Overview
Attitudes toward private health care providers in developing countries are changing. Growing numbers of policymakers are considering or attempting to incorporate private facilities and practitioners into overall sector policy, using methods such as contracting, training of private practitioners, integration into public referral networks, etc. Unfortunately, these efforts are infrequently recorded, making it difficult for policymakers to learn from the experience of others. Rigorous evaluation of these efforts is rarer still, making it difficult, even perilous, to establish guidelines about such policies.

It is possible, however, to review options for enhancing health sector policies related to private service provision, and this paper will do so. The purpose of the review is to familiarize policymakers and sector experts with the full range of policies for enhancing the contributions of private health care providers, both for-profit and non-profit, to sector objectives. Since the objective of this Handbook is to support analysis that feeds into operational policy, attention is focused on this level, avoiding lengthy discussions of theoretical or other more academic issues. This Introductory paper is intended to be comprehensive in nature. Users seeking more detailed information about specific strategies and instruments are referred to subsequent papers in the Handbook.

Section 2 of this paper reviews the basic prerequisites for effective interaction with private health care providers. Section 3 discusses three general strategies that have been used to improve interaction with private health care providers in developing countries. This section also outlines the instruments used to implement these strategies (i.e. contracting, regulatory reform, etc.).

Section 4 discusses strategies to get better health care access and outcomes for the poor by working with the private sector. Following, in section 5, is a discussion of strategies to integrate the private sector into efforts to address public health issues. Section 6 discusses the unique set of challenges facing policy makers implementing changes to improve public policy toward the private health sector. Finally, section 7 draws conclusions and lessons for policymaking toward the private health sector in developing countries.

1.2 Scope
The topic of this paper is formulation of public policy toward private health service providers in developing countries. Experiences in both developed and developing countries will be discussed, though the latter will be emphasized. The range of health service providers examined is a broad one, including bio-medically trained, traditional, and untrained practitioners, as well as retail drug sellers who often deliver health services.

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2 Throughout this paper we will use the term non-profit and NGO interchangeably to refer to formal organizations which have corporate objectives concerned with health service aims concerning groups outside the organization, which are non-profit-making and which are outside the direct control of government.
in the form of advice on which medicines to take (Hudelsohn, 1998). Since the focus is health service delivery—production and distribution of pharmaceuticals, medical equipment, consumables or other inputs are not covered. Nor is private insurance covered. While methods of contracting with or subsidizing private providers will be reviewed—other financing and insurance issues are not examined. The objective of the synthesis is to identify available options and mechanisms for working more effectively with private health care providers. Given the paucity of rigorous evaluation of these reforms, such guidance must necessarily be tentative. The contribution of the paper lies mainly in the comprehensiveness of the review of strategies and instruments for working with private health care providers, and the connection to health systems development. The interested reader or policy advisor would need to dig deeper into a specific topic to formulate sound policies. For a deeper review of some of these topics and guides to further resources, the reader is referred to the “Private Participation in Health Handbook”.

The paper provides a brief synthesis of conceptual and analytical issues related to private provision and the role of the governments vis-a-vis private provision. To support policy discussion and formulation, the review is intended to be pragmatic, avoiding theoretical or ideological discussions of government versus market failures, and idealized versions of public or private operations.

1.3 Background
As shown in Table 1, private health care providers play a large role in developing countries. Sometimes this prevalence is viewed as a sign of government and health system failures. Even where not seen as malign, it is often hoped that their operation is temporary, and that they will be displaced as soon as feasible by expanded and improved publicly provided services.

Recently, the viability and even the wisdom of this approach have been challenged. Examination of highly performing health systems has revealed mixed delivery systems—with private providers playing an integral and productive role enabled largely by a strong direct or indirect government role in financing. This perspective on the public-private mix in well performing health services has generated additional scrutiny of private providers in developing countries, scrutiny that has only served to underscore the urgency of making public policy toward private health care providers more effective. But experience also shows that to pursue both equity and efficiency goals in mixed systems, governments must strengthen their role in financing and allocating funds to providers, a topic which is taken up elsewhere (Musgrove, 1996; World Bank, 1993; World Bank, 1997; Preker and Harding, 1999).

The private sector is involved in all aspects of delivery of health services in developing countries. They are most prominent in delivery of primary and curative care, largely due to lower capital requirements, high demand, and willingness to pay on the part of patients (Hanson and Berman, 1998). This pattern involves them directly in core “public health” activities such as treating malaria, TB, and other communicable diseases, as well as treating sick children and pregnant women. In many of the poorer countries, as illustrated
in table 1, the private sector is the dominant provider—with much health care delivered by unqualified or traditional practitioners, as well as drug sellers (Hanson and Berman, 1998; Bennett et al., 1997). Despite widespread concern about clinical quality, patients often bypass public facilities to utilize private providers—often citing reasons of convenience and responsiveness (World Bank, 2001). Many people in developing countries, including the poor, would have no access to health services without such privately provided services. The negative impact of the charges levied are in some sense an indicator of governments’ failure to secure adequate financing more than a failing on the part of the providers or the health care market.

### 1.4 Rationale

The underlying premise of this paper is that policy makers in developing countries should cease to ignore private health care providers. Indeed, they should pursue options of working with private providers, not for its own sake, but as a integral means to achieving sector objectives. Working with private providers to expand access, coverage and clinical quality are direct mechanisms to improve health outcomes; and, when accompanied by appropriate financing strategies may provide much needed financial protection against the cost of illness. In addition to improving the responsiveness or consumer quality of services, governments are increasingly resourceful in reaching out to private providers to improve the technical quality of care.

In most developing countries, everyone goes to the private sector for at least some health services. The poor often go to the private sector, most often to informal providers (Ronde and Viswanathan, 1995). This pattern is widespread, but even more prevalent in rural areas, where the poor are often concentrated. Since the payments are virtually entirely out-of-pocket, these treatments are a serious burden and source of risk for the poor—for whom a hospital stay or prolonged illness can wipe out savings, assets and precipitate a slide into poverty.
The paper takes from the WHR 2000 framework the premise that service delivery arrangements have a strong impact on health outcomes and responsiveness of health services, while risk protection issues are best addressed via financing arrangements (WHO, 2000). From this perspective, the negative impact of private providers on household incomes has its origins in the absence of effective financing mechanisms, not the ownership of the service delivery system itself. Though publicly provided services are often justified as a means to relieve the poor of the financial burden of illness, the widespread prevalence of informal charges undermines this objective greatly (Lewis, 2001). Further, given the prevalence of usage of private practitioners, and the disappointing evidence regarding the feasibility of altering this pattern of utilization, it is clear that it will be necessary at least in the short to medium term to work with private providers to affect the care that a large portion of the population is getting.

1.5 Theoretical Underpinnings

While evidence is growing that working with private providers is better than ignoring them, and that this can be an effective strategy for pursuing some important sector goals, we must look also at the conceptual basis for different perspectives on the public-private mix in health service delivery. The theoretical literature gives guidance on which activities the government should be involved in, but unfortunately gives no guidance on the method of intervention, or the appropriate ownership of services. A quick review of this literature supports a discriminating approach to structuring a government’s engagement in health service delivery, rather than making the case for comprehensive provision by the public sector.

The traditional public goods criteria from neoclassical economics (non-excludability, non-rivalry, and rejectability) justify government intervention for only a small set of health goods and services. A much broader range of justifications for public intervention in health activities has come to be accepted, including enhancement of equity in access,

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Equity in access problems are better addressed through financing mechanisms such as subsidies, or insurance coverage for the poor than through construction and operation of public clinics. For more discussion see Chapter Five, “Who Pays for Health Systems in the WHO 2000 World Health Report.”
and other social objectives. However, these criteria do not provide guidance on the appropriate mechanism for government intervention. Musgrove and others have proposed that governments ought to utilize the least intrusive instrument to most as required to meet objectives. Such an approach is further justified in reference to the institutional economics literature, under which the governance arrangements of public ownership are viewed as predictably problematic enough to make this the last choice for arranging economic activity (Williamson, 1991).

To provide guidance on which government instrument should be used to ensure supply and/or utilization of identified goods and services, Preker and Harding proposed the criteria of “buyability” (Preker and Harding, 1999). Using this criteria, governments should contract for delivery for goods or services that a government can buy (as defined by its level of measurability and contestability). For goods and services that justify government intervention and are not “buyable” by this criteria, public production is justified.

### 1.6 Empirical Basis

The empirical evidence about the effectiveness of different public-private mixes in service delivery also supports a discriminating approach to the governments’ role in health service delivery. Examination of health system performance among developed countries reveal no consistent differences between the NHS-style systems with predominantly public delivery, and the social insurance systems, which rely on mixed delivery systems (see Table 2). Selecting a long-run end-point of a fully public delivery system cannot be empirically justified in reference to performance of the better health systems. In the short to medium-term, the prevalence and widespread use of private health care providers in developing countries justifies working with them to influence the care people are getting. The empirical case is further strengthened by the often weak

<table>
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<th><strong>Table 2: Government Tools for Influencing the Private Sector</strong></th>
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Source: Musgrove 1996
impact of public delivery focused strategies to reach a range of sectoral objectives related to access and quality.

In the end, the decision of how to structure the government’s role in the health sector depends on society’s values, inherited structure and political processes. The foregoing discussion is presented only to illustrate that a priori there are no technical grounds to rule out working with private providers or allowing private provision of public services.

There are instances where a public delivery focused strategy may be the best way to pursue certain objectives, for instance in areas of low population density, or where the needed service is monitoring or evaluation or is related to establishing systems for dissemination of health information. However, in many instances, the presence and capacities of private health care providers will render it effective to work with and through these providers to pursue desired objectives. In particular, benefits of working with private providers come from their often being more responsive to patients, more flexible, more aware of local circumstances, and less politicized in operation (Filmer et al. 1998, Griffin 1989). This paper therefore takes as a starting point that it is possible to have a well functioning health system with substantial private delivery. Thus, the discussion will focus more on reviewing options for moving towards such a system.

2. Basic Prerequisite for Getting More from Private Health Care Providers

Examination of the public-private interface in well performing health systems reveals several mechanisms for interaction that appear necessary for private providers to play an effective role in a health system. This includes: a) policy makers having knowledge about the private sector; b) on-going dialogue between public and private stakeholders; and, c) institutionalized policy instruments for interacting (especially financing, regulation and dissemination of information) with the private sector. Regardless of sector priorities, or the modality for working with the private sector under consideration, all

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<th>Type of Health Service Delivery System</th>
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<td>Infant Mortality Rate (per 1,000 live births in 1999)</td>
<td>Under Five Mortality Rate (per 1,000 live births in 1999)</td>
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<td>Mixed Delivery</td>
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<td>Predominantly Public Delivery</td>
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<td>Finland</td>
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three factors must be at least minimally in place to support effective public policy toward private health care providers.

2.1 Knowledge
A system must be in place for collecting accurate information about the capabilities of private health care providers and their activities, in order to assess and channel their contribution to national health priorities. The collection and processing of this information can be done by outside organizations as well as the government. In most cases, the government must take the lead in funding and coordinating such efforts.

In France, the National Agency of Accreditation and Evaluation in Health (ANAES) is a quasi-independent public agency, created to collect information about the operation of health care facilities, both public and private.

In the United States, the Joint Commission on Accreditation of Health Care Organizations collects and assesses information about nearly 19,000 health care organizations and programs. It is an independent, not-for-profit organization, and is the predominant standards-setting and accrediting body in health care in the country. Since 1951, the Joint Commission has developed state-of-the-art, professionally based standards and evaluated the compliance of health care organizations against these benchmarks.

Unfortunately, many developing country governments do not collect information on private providers or their patients. In this context, they have no opportunity to identify and utilize positive features or address problems associated with private provision.

2.2 Dialogue
In addition to being aware of the private sector, policy makers must also ensure on-going communication between government officials involved in policy design and implementation and private health care providers. Such communication will enable policies to be designed better, taking into account the likely perspective and reactions of private health care providers. Good regulation in particular has proven to be a matter of on-going interaction between regulator and regulated. In addition, communication during policy formulation will aid in getting policy changes implemented, since affected providers will already be informed and likely will be preparing for the changes. Examples of countries who have institutionalized such dialogue include Australia, Canada, Germany, Netherlands and the United States.

Due to historical segmentation, hostility towards the private sector, and weak institutional capacity, such dialogue between policy makers and the private sector is usually absent in developing countries.

2.3 Institutionalized Policy Instruments
A review of the highly performing health systems with substantial private delivery, reveals a range of institutionalized policy instruments for dealing with the private sector.
as well as capable government officials, comfortable with using these instruments. These institutions almost always include: an insurance system; a framework for direct regulation and support for self-regulation; and, a system for licensing and certification of health personnel. The most critical instrument is a universal system for financing providers that contributes to equity, sustainability and financial protection. It is interesting to note that several of these mixed systems have recently been moving toward improved capacity to analyze and “cost” policy alternatives that include private health care providers—a trend which is both a cause and a result of the increasing role of private health care provision (Busse et al. 1999; Kendall, 1999).

In many developing countries, the public sector is extensively involved in the production of health services, even where the financing of services or other critical stewardship and financing activities are not being addressed. This structure of intervention in the health sector is often seen as contributing to access and quality problems in health care delivery. In health, as in other sectors, an overextended role is frequently associated with poor performance of key government functions (World Bank, 1997; Filmer et al., 1998).

3. Strategies for Getting More from Private Health Care Providers

Over the longer term, developing country governments may strive to establish the range of capacities outlined above. However, the more immediate question remains as to what can be done in the short run to increase the contribution of the private sector to health objectives. Below we outline the range of strategies a policy maker has at hand to bring about such improvements. Depending on the objectives identified, and the current status of private providers in the country, policy makers may consider the following approaches.

3.1 Harnessing the Existing Private Sector

In many countries, the private service delivery sector is large—including in many low-income countries. Governments in these countries are increasingly trying to get more out of these providers—recognizing the importance of influencing these interactions with the population, if critical goals related to public health and health systems performance are to be reached. These steps can motivate large improvements, especially in countries with a large private sector and where government is currently interacting little with these providers. This segmented situation is fairly common among developing countries. The most often used instruments for reaching these providers are: contracting; regulation; and, a range of outreach mechanisms which include: information dissemination; education; and, persuasion.

3.1.1. Contracting

There is growing reliance worldwide on contracting for social services in general (Salamon and Anheier, 1993). As noted above, in health there is likewise growing awareness of the effectiveness of indirect instruments for ensuring service delivery. In

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particular, contracting is emerging as a powerful tool for harnessing the resources of the private sector to help achieve sector goals. Contracting is a process whereby the government or a government agency contracts with a private provider for delivery of health services. Providers’ interest in maintaining revenue flows associated with contracts, give the contractor the ability to influence the behavior of the providers.

Naturally, first and foremost, contracting requires financial resources. For many developing countries, all resources for health services are devoted to public production—which makes it impossible for governments to engage private providers through contracting (DeRoeck, 1998; Jeon, et al, 1998).

In addition, contracting for health services is a complex process. It requires substantial government capacity to plan, negotiate, implement and monitor on an on-going basis the services contracted for. While it is a very useful tool, governments must approach contracting strategically—weighing costs and benefits of direct provision versus contracting for each service considered. This is very similar to the “make or buy” decision faced by managers in most industries.

For public officials, contracting requires a substantial mind shift, from thinking of themselves as administrators and managers of public employees and other inputs, to contract managers with ultimate responsibility for the delivery of services. While contracting does not involve public officials in the day-to-day business of delivering services, it expands their responsibilities in providing strategic direction. Contract management can reside in a subordinate organization—but senior policy makers must provide the strategic direction and framework within which contracting takes place. Contracting is the means by which private providers are involved in the social health insurance systems of continental Europe, for example (Busse et al, 2000). In this case, quasi-independent state agencies contract with health care providers.

The prototypical example of health services that are contracted for is clinical services, either at the primary or tertiary level. However, the range of services which may be contracted for in health is much broader—and often non-clinical services are easier to contract for than clinical. Examples of non-clinical services which are relatively easier to contract for include: educational services to teach health workers; public health outreach efforts (i.e. conducting an anti-smoking campaign); auxiliary services in health facilities (cleaning, catering, etc.), delivery of nutritional supplements, etc. In addition, governments may contract for regional coverage of a range of services rather than specific services. Governments in both developed and developing countries are exploring these options plus many more.

While there are wide ranges of services that may be contracted for, there are also many contractual options for engaging the services. The most common mechanism is “contracting out”—where the government purchases a service from an outside source that provides the service using it’s own workforce and resources. However, governments can also hire outside managers to come in and manage an internal workforce or service—which is referred to as “contracting in”. Less formal “subsidy” arrangements may be
established, often with non-profit providers. In this case, the government gives financial support in exchange for the alteration or expansion of service provision in targeted areas. In some cases, a provider may be given a franchise—or the right to provide specified services to a specific clientele and to collect revenues. In exchange for this right, the service provider may either pay the government, or agree to undertake specified service delivery to public patients.

Contracting looks very different from the perspective of the service provider compared to the government. Contract management must take their perspective into account. In particular, the contract arrangements must be sufficient to attract competent health care providers. Even non-profit organizations must sustain their operations and hence usually requires contractual pricing to cover average costs.

Obviously the issues of payment methods and price setting mechanisms are critical to determining the incentives providers have. Appropriate selection in this area is a key design issue. The options and their advantages and disadvantages are discussed in the Background paper on Contracting from the Handbook.

Setting up effective arrangements for monitoring of contracted for services is equally important as the payment and pricing mechanism. It is also important that these two complement one another. Capitated payment arrangements for instance lead to cost savings, but also can motivate skimping on quality—which makes it doubly important to monitor quality under capitated contracts (Slack and Savedoff, 2000). Fee-for-service arrangements on the other hand enhance the need to monitor volumes and appropriateness of services, due to the incentives for overservicing.

The length or term of the contract is very important. Policy makers must choose the length, balancing their desire for predictability and constraint of expenditure, against the disadvantage of inflexibility or “lock-in” that occurs with regard to service delivery over the term of the contract. Policy makers with longer-term contracts may find themselves in the position of buying services which they no longer want, or which are delivered in an outmoded fashion, due to contract terms being outstripped by innovation in service delivery.

Market structure must be taken into account. Therefore, it is important that contracting be done with an eye toward the impact on competition. In particular, over time, a sufficient number of providers should remain in the market, to establish and maintain competitive pressures.

3.1.2. Regulation

An alternative or complementary strategy for enhancing the contribution of existing private providers is through expanding the effectiveness of health service regulation. In many discussions, regulation is primarily considered as a means of improving quality of care. Regulations are used to pursue a much broader set of objectives. For example, regulations may be established or expanded which are aimed at reducing inequality and disparities in (geographic, economic) access to and quality of health care received. Other
regulations can be put in place that are aimed at improving technical and allocative efficiency and reducing waste and corruption. Finally, regulations may be established or expanded which contribute to sustainable health system performance by constraining cost escalation.

The function of health services regulation is to protect the public by countering market failures, bringing efficiencies to areas in which the market has been retarded, or correcting the market’s emphasis on a single dimension (such as cost). Some regulations have an economic focus, aiming to address provider monopolies, combat scarcity of certain necessary services (such as primary care) or curb wasteful service utilization in insurance arrangements. Other, more socially oriented regulation aim to improve equity and access through geographic redistribution and anti-discrimination statutes; or protect the public by controlling the quality of the health services they receive.

a) The Target of Regulation
As the objectives themselves are varied, so are the targets of regulation. Regulations may be established which target various phases of the health care production process (input, output, outcome). Traditionally, regulation focuses on the first two stages, the quality of input factors of production (human resources, consumables, pharmaceuticals, capital stock, equipment) and the quality, quantity and prices of health services as well as their regional distribution. More sophisticated regulation targets the third stage, that is, the production of health outcomes (outcome-targeted regulation). This type of regulation is complex, and not very common in developing countries. The majority of health sector regulation is targeted at: prices of health services; quantity and distribution of health services; and, quality of health services.5

b) Regulatory Strategies and Instruments
A wide range of instruments are available for regulating health care services. In general, the three categories are regulation through control, incentives, and structuring market pressures.

The most familiar type of regulation consists of legal restrictions or controls that require providers to conform to legislative requirements. If they do not abide by these laws then they are liable to punishment. Types of regulation that are usually done via control include: price regulation; capacity regulation (i.e. volume and distribution of services); regulation of market entry and levels of service; regulating entitlements; regulation of anti-trust and market structure; regulating quality of care; health facility licensing; health care facility accreditation; health personnel credentialing; utilization reviews and medical audits; outcomes research, practice guidelines and clinical protocols. A more complex form of regulation is to encourage providers to change their behavior in response to incentives, thereby leading to changes in the target variable (e.g. price, quality). Incentives could be both economic and non-economic. A yet more sophisticated form of regulation is to take steps to alter market structure, so as to cause the market to create pressures to undertake the desired behaviors.

5 Much regulation of health services is done indirectly via regulation of health insurance. However, this paper is only covering direct regulation of health services.
c) Institutional Structures of Regulation

Regulation is more than laws and directives. Effectiveness of health care regulation is directly related to how the processes are structured. Therefore any efforts to enhance the regulatory framework require analysis of the existing arrangements for regulation, and often requires these arrangements to be altered. Reviewing the structural options used in other countries can provide some guidance, though naturally these insights must be tailored to the local context.

d) Regulatory Agents

Government officials and agencies can undertake many regulatory actions. However, in OECD systems with extensive private delivery, it is clear that a number of agents and organizations support and complement the governments’ role. The most important regulatory agents outside government are self-regulatory organizations and professional associations. Increasingly however, community and consumer organizations are coming to play more influential roles. A government seeking to enhance the effectiveness of the regulatory framework will need to ensure that the various organizations performing regulatory functions are working in a coordinated manner. Examples include: self regulation; professional associations which have better information, and potentially may be motivated by their desire to maintain and enhance their reputation.

e) Designing Regulatory Institutions

Once it has been established that the government will perform a regulatory function, there are still a number of important design issues to be considered. Issues include: scope of operations: single versus multi-sector agency; organizational form: regulatory agency versus a commission; governance: intra-governmental versus a separate agency; degree of regulatory discretion; administrative procedures and judicial review; accountability and regulatory oversight; agency staffing; terms of reference; and, agency funding.

f) Moving Toward an Effective Regulatory Framework

To improve the functioning of regulation of health care services, a number of issues will need to be addressed. Policy makers will need to select a balanced package of sticks (controls) and carrots (incentives). All these decisions will need to take into account the limited capacity of government—and therefore to build up and complement regulation forces provided by professional and other non-governmental organizations, as well as community and patients organizations. In many areas, these groups, sometimes with strategic support or review by government has both more motivation and capacity to regulate important health care activities and objectives. It is important that the government have an overview of all the sources of pressure on health service providers, so that they can use their own resources efficiently, and also to ensure that regulation does not undermine system integration and cohesiveness.

Despite all the technical criteria outlined, regulation is an inherently political and cultural process. Efforts to improve regulation must necessarily build on knowledge related to stakeholders’ perspectives, and acceptable and appropriate standards for the situation. While there are a number of critical health service issues that require regulation, regulation itself is a costly undertaking. In addition, regulation may bring about
unintended and negative consequences (i.e. creating unnecessary barriers to entry, or costs of operation; or reducing competition). It is therefore critical that regulatory reforms be designed taking into account both the benefits and costs of existing regulations and the impact of new ones under consideration. In some cases, removing ineffective or counterproductive regulations will be an important part of regulatory reform.

Perhaps more than any other regulated sector, with the exception of telecommunications, health care is a fast changing activity. Innovations in terms of diagnostics and treatments are occurring on an escalating basis. It is therefore critical that regulation in general, and the government’s role in regulation in particular, be an on-going and adaptive process.

3.1.3. Outreach to Providers and Patients

The third set of instruments for influencing the behavior of private providers consists of outreach mechanisms, including information dissemination, education and persuasion. Whether targeted toward providers or patients, each of these tools have proven useful in improving health services. These are discussed below in order of intensity of effort.

a) Information Dissemination

Making information available to patients and the population can be a powerful mechanism for empowering them to demand appropriate care. Both governmental and non-governmental organizations can play such a role. In the Netherlands for example, patients organizations play a strong role in patient education about specific diseases and treatment options, have increased patient participation in treatment decisions, have increased the prevalence of information on provider products (including quality and price), and enhanced communication between patients and providers (Sommers, 1999). The Uruguayan Cystic Fibrosis Foundation has been instrumental in improving the treatment of that disease. For non-governmental patients’ organizations to develop and flourish—many of the issues related to the enabling environment for non-profits come into play, just as it does with service delivery (see Box 11). Regardless of who is initiating the information dissemination, various mechanisms have been successfully used: community leaders, peers, user groups, public providers and mass media (Smith et al 2001). Information dissemination can be used for a wide range of purposes, outlined below.

*Expand Demand Among Identified Groups.* Behavior change communication can be used to expand demand and hence utilization by target populations (the poor, sex workers, mothers).

*Raise Awareness of Service Quality and Consumer Rights.* This mechanism is commonly used in developed countries to pressure providers to deliver high quality care. An example of such efforts include the establishment of physician profiles that are made available to potential patients, aiding them in their decision of practitioner. Due to the complex nature of health care, even in developed countries, these efforts have a greater impact on consumer than clinical quality. Patients’ organizations usually play a substantial role in raising such awareness directly. Government efforts are frequently
A few developing country governments have initiated efforts in this area recently (India). Patients’ organizations in developing countries are relatively rare, but have begun to be active in a few countries (Uruguay).

**Publish Information to Users on Maximum Permitted Prices.** This method is most often used in regard to pharmaceuticals. Governments have implemented required listing of prices in pharmacies, publication of pricing guides, publication of prices in the media and printing on the packages. There is some evidence that widespread publication of prices to users does bring pressure to bear on providers and retailers to contain prices.\(^6\) Examples of successful implementation of such strategies are found in Cambodia, Philippines and Colombia (Smith et al 2001, p 56).

b) Education

Instead of, or, in addition to disseminating information, more intense educative efforts may be necessary to alter the practices of private health care providers and demand for their services.

**Expand or Alter Demand by Educating Users.** For especially critical services or individuals, focused educational efforts can be instrumental in expanding or altering their demand for goods and services. Examples include education efforts targeted to sex workers to expand their demand for treatment of STD, or mothers in slum areas, to get them to expand their demand for appropriate treatment of child illness.

**Increase Demand for Services Through Community Education.** Another means for increasing the use of priority services is by implementing community education efforts, structured to enhance demand for identified goods or services. Such programs have been successfully used to expand demand for vaccination, malaria treatment, nutrition supplements, and treatment for key childhood illnesses.

**Training Support to Providers.** Such training may take the form of regular programs such as Continuing Medical Education (CME) for allopathic providers, or may focus on providers who are not bio-medically trained—depending on where the targeted diseases or populations are treated, and which providers are “reachable” (Marsh V. *et al* 1999; Hudelsohn 1998). In Kenya, for example, shopkeepers were trained in the proper use of drugs for childhood fevers. A study showed a substantial improvement in the behavior of the use of these drugs, as a result of shopkeepers’ verbal advice and printed information given out in the shops.\(^7\)

c) Persuasion

Evidence indicates that it is often necessary for knowledge to be reinforced, since knowledge alone is frequently not sufficient to change provider or prescriber behavior (Soumerai *et al* 1989).

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\(^7\) Marsh, V., quoted in Smith *et al* 2001.
“Detailing”. Detailing consists of face-to-face interaction and guidance through personal encounters with practitioners. Pharmaceutical companies have used this method very effectively to influence prescription practices throughout the world. More recently, governments have utilized these methods to improve physician behavior in targeted areas. Such efforts have proven effective in changing physician behavior in treating common childhood illness Kenya and Indonesia (Tawfik, 2001).

Negotiation. Negotiation may be viewed as an intensive form of persuasion. An example of this method is Private Practitioner Treatment Improvement Intervention or PRACTITION. PRACTITION is a systematic initiative that starts with assessing current private practitioner behavior. Policy maker subsequently negotiate an agreement or informal contract for modified behaviors with the practitioner. It has been implemented successfully in India, Indonesia and Pakistan (Northrup, 1997).

3.1.4. Subsidies
Besides paying for goods or services directly, as with contracting, governments can use public funds in other ways to influence the behavior of private health care providers. This form of interaction with private providers is most common with regard to non-profit organizations. One means of doing so, is to provide financial subsidies to certain organizations, which are delivering activities or products important for achieving social objectives. The most common form of financial support for private providers is earmarked grants. This is especially common with regard to preventative services. The state government of Tamil Nadu pays part of the cost of family planning services provided by private hospitals. The Government of India provides a grant to some private facilities for maintenance of family planning beds and to pay patients cash incentives for acceptance of family planning (DeRoeck, 1998). Another common mechanism for providing financial support to private providers who are serving public objectives are “bed grants”, whereby the government provides funding based on the number of beds allotted to serving indigent patients. In Tanzania, the Government provides a payment per approved bed to NGO hospitals designated as district hospitals (Gilson et al 1994). Governments also occasionally opt to provide financial subsidies to private facilities in exchange for their establishing an exemption mechanism for poor patients (McPake and Banda, 1994).

Another type of financial support used is the provision of seed funding for the start-up of services or activities. An example of this is the support given by the government of India to PSS to cover 75% of the costs of starting a new clinic.

In some cases, financial subsidies are provided indirectly through the use of tax subsidies or exemptions. For example, in Nepal non-profit organizations receive tax exemptions for health commodities and services on the recommendation of a national NGO umbrella group (DeRoeck, 1998). Church NGOs in Malawi receive an indirect subsidy by buying drugs from the government’s central medical store at subsidized rates (Gilson et al, 1994).
Alternatively, *in-kind support* may be supplied to the providers. There are many examples of such support being provided to NGOs, though it is occasionally used with for-profit practitioners too. In several African countries, governments either second staff to mission facilities, as in Uganda, or pay their staff salaries, as in Ghana and Malawi (Gilson, *et al* 1994). The Ministry of Public Health in Bolivia subsidizes staff salaries in PROSALUD clinics located in rural areas (DeRoeck, 1998).

In-kind support may also include other inputs, such as a medical supplies, or even facilities. In Guatemala, the government provides Rxiiin Tnamet (a local NGO) with medical supplies for its preventative health outreach services (DeRoeck, 1998). In Ghana, the government provides buildings, equipment, and drugs for NGO hospitals (Gilson, *et al*).

Some governments use these same methods to influence private practitioners (for-profit entities) by supplying critical supplies free or at a discount (i.e. vaccine, nutritional supplement), while allowing the practitioner to charge a fee and make a profit in order to expand delivery of important goods and services. This type of intervention has been successfully used in Malaysia.

Alternatively the government may expand demand for priority services by subsidizing their purchase via “vouchers”. In this case, vouchers may be given to a targeted population to expand their utilization of a priority service. In Nicaragua, a scheme was implemented which distributed vouchers for STD treatment to sex workers—who were able to redeem them at a range of public and private providers. The scheme was successful in reaching poorer groups, and the overall incidence of gonorrhea has declined (Sandiford, 2001).

3.1.5. Production of Public Goods and Other Strategic Services

Another instrument which governments use to influence the environment for and behavior of providers is their own production of goods and services. There are a range of such goods and services that the private sector is unlikely to produce at appropriate levels (such as some forms of highly specialized care, research and training activities which take place in a university hospital setting). However, their own operations will be strengthened by their production—hence, the governments activities in this area may complement and hence strengthen the activities of private health care providers.

3.1 Grow the Private Sector in Targeted Areas

While working better with existing private providers will often be a useful strategy for improving system and service performance, there are additional strategies to consider. As noted above, in many developing countries, governments appear to be overextended in their activities in the health sector. In some of these cases, governments are exploring ways to rebalance or refocus their efforts. Often this includes allocating a greater role in service delivery to the private sector. Such efforts can be pursued through two alternative strategies, either through “growing” the private sector or converting (or privatizing) public services. Where a group or groups of private health care providers have been identified as contributing to critical sector objectives, governments have undertaken to
expand these activities, using various mechanisms. We will discuss this strategy here, and conversion below.

3.2.1. **Contracting and Subsidies**

The most direct means of supporting the expansion of private provision in identified activities or regions is through ongoing purchasing of their goods or services. Alternatively, services or goods may be financed on the demand side, that is, through endowing users with a reimbursable claim to targeted services via “vouchers”. Governments use a range of additional financial mechanisms to encourage the expansion of the private sector in certain areas, mechanisms such as tax exemptions, subsidized-targeted credit are examples. In Pakistan for example, the government provides tax exemptions to practitioners setting up in rural areas. In some countries, the government will allocate land to encourage the construction of a health care facility in an underserved area.

3.2.2. **Regulatory Reform**

Governments may also use indirect means to encourage targeted expansion of private provision. They may take steps to reduce unnecessary constraints that increase the cost of operation, for example, by reducing or abolishing import restrictions. “Sometimes governments create monopolies unnecessarily and deny entrepreneurs (and other providers) the opportunity to compete fairly with established service providers by erecting entry barriers, blocking credit and access to foreign exchange, taxing dividends and profits inequitably, imposing unfair import duties, and establishing bureaucratic hurdles” (Kessides, 1993). Though this quote refers mainly to utilities, it is equally valid for health infrastructure and services.

Regulation is undoubtedly necessary to prevent opportunism, and protect patients. However, there are often unnecessary constraints on providers---some specific to the health sector, others present in the overall enabling environment. In developing countries, there are often burdensome and unnecessary costs of registering an organization as well as problems obtaining access to critical inputs, including human resources, pharmaceuticals, consumables, and essential public services (i.e. predictable electricity, access to clean water). Obviously these issues can create serious constraints to the expansion of health care services by private operators.

Non-profit organizations face yet another set of issues related to the enabling environment. In many developing countries, the legal framework supporting non-profit operation is weak, unfavorable or non-existent. Often there is no support for contributions or other forms of philanthropy. In particular, developing countries often lack a clear and supportive regulatory framework regarding tax-exempt status of non-profit organizations or donations to them (Simon, 1995). (see also Box ***: on NGOs)

In some instances, governments impose needlessly cumbersome and time-consuming demands on NGOs by demanding detailed financial accounting and planning of activities (DeJong, 1991). Removing these requirements is one way to expand private sector activities.
Governments can also encourage expansion of private health care delivery by engaging in behavior change communication to expand demand for their services. The range of goods and services for which this approach is being utilized has expanded from population and reproductive health goods and services, to include bed nets and chemicals to treat them.

3.3. Conversion
Throughout the world, a trend has emerged of turning over operation of public services to private hands—momentum has gained as experience has built up and positive results have been achieved (Savas, 2000; Domberger, 1999; Donahue, 1989). Based on the consistently positive results from conversion of other social and public services, governments are expanding such efforts to publicly run health services (GAO Report 1998; Melia, 1997; De Kadt and Zuckerman, Torres and Mathur 1996; Lyon, 2000). Various reasons are put forth. If a government appears to be overextended, conversion can be part of a strategy aimed at getting back to their “core competencies”. Alternatively, or in addition, governments often may feel the private sector will run the service(s) more efficiently and/or provide a higher level of quality. Governments have also recently gained interest in capturing private investment funds for expanding facilities and services—which may entail the transfer of facilities to private hands (UK, Chile, Thailand, S. Africa). From the fiscal perspective, many governments are motivated to consider conversion in order to better manage the risk associated with different health related expenditure streams (Blair, 2000).

Because of the need for an on-going government role to ensure services are delivered, and universally available, conversion in the health sector is usually much more complex than conversion of other public services. In addition, the health care service market are often subject to monopoly power. These conditions make it necessary to address several issues, when undertaking conversion of health care provision.

If the provider is to continue to deliver public services, then the transaction itself will need to be directly tied to ensuing service contracts. These two sets of agreements must be viewed together to ensure adequate performance of the provider. The ability to be able to set up sensible service contracts necessitates that funding arrangements for the service providers be at a relatively high level of sophistication. If funding of public conversion may be

| Box 2 : Port Macquarie Base Hospital Conversion: Obtaining and Demonstrating Gains are Critical |
| In the late 80s, the New South Wales Department of Health needed to increase the range and quantity of hospital services in the Macleay-Hastings District. After extensive review, they decided to proceed with a build-own-operate arrangement with the private sector. The tender was completed in 1991, and the contract signed with the Hospital Corporation of Australia in 1992. The hospital began operation in November, 1994. It is widely accepted that the privatization has led to improved quality and access to hospital services in the region. The project is nevertheless viewed unfavorably by many. The biggest problems can be traced to the service contracts, and more fundamentally to the hospital funding arrangements. In essence the funding system didn’t generate sufficient information about the cost of services, to allow the Department to set sensible prices for the services provided by the new hospital. The service agreements therefore ended up reimbursing the hospital at a high rate (referred to as “top cover private health” rate), in addition to a lumpsum “availability charge”. A number of reviews have been undertaken, and conclusions as to how “bad” a deal the Department is getting have ranged widely. In any event, the conversion is not judged a success. The funding and fee setting arrangements are neither sufficient to ensure good value for the Department, nor to verify the gains of private participation. |

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provision is currently based on inputs, or even on blocks of services, serious changes will need to be implemented to enable the conversion to proceed. Whether or not it is applied system wide, contracting with private health care providers requires fairly “active purchasing” (Langenbruner, et al, 2001). The case of Port MacQuarie Base Hospital illustrates the difficulties of undertaking hospital conversion, when the funding arrangements didn’t support sensible service contracts.

In addition to the service contracts, it is likely that the regulatory framework for service delivery will need to be enhanced to ensure social objectives continue to be met. When services are being provided via public providers, critical issues such as quality, cost containment and efficiency can be addressed administratively. However, if the providers are to be operated privately, adequate regulatory instruments will need to be in place so that governments and other regulatory bodies can takeover this responsibility.

A further issue that must be taken into account is the market environment in which the converted providers will be operating. As noted above, many health service markets exhibit monopoly power. The transaction and service contracts are also judged as to their influence in this regard. For the full benefit of conversion to be obtained, action may be required to ensure the degree of competition in this market.9

Any needed changes to the regulatory and purchasing framework as well as the market environment must be considered, planned and implemented along with the transaction to ensure conversion brings about desired results. This complexity makes health service conversion a complex and challenging reform.

In health, as in other sectors, governments have found it necessary to engage in “unbundling”. In health this has involved undertaking actions to ensure that certain services that may be unprofitable and less contractable are separated from services more easily contracted for (research and medical education for example). The unprofitable or hard to buy services may either be provided within the public sector, or within the converted organization. If the latter is the case, then some arrangements will need to be made to ensure the operator continues the service. Though unbundling may make sense in terms of the easing the purchasing arrangements, it is important to take into account synergies in production (and impact on efficiency) as well as integration of services (and impact on quality) when determining how to bundle and transfer different services.

3.3.1. Transactions

The transaction is the mechanism used to transfer publicly operated services, facilities or public employees to private ownership, management or employment. In health services, types of transactions that tend to be seen can be categorized in the following manner.

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9 There are however many cases of conversion of service provision, even in the case of monopoly power. In these cases, alternative mechanisms are used to ensure efficient operation (i.e. benchmarking, or other performance assessment; concessions, etc.)
a) Transaction Categories

*Conversion of Existing Facility/Operations.* When a government undertakes to convert existing public facilities or operations to private hands, they may use a range of options. They may sell outright or lease the facility to an investor or non-profit organization. Alternatively, more incremental methods may bring in a private party to operate the facility under a management contract—this allows the government to keep greater control over the operations, and can be structured to provide stronger or weaker incentives for profitability. Facility staff may be kept in public sector employment. Another alternative to bring efficiency gains while maintaining public sector management of the facility is to compel facility managers to contract out (and establish competition) for auxiliary services—such as laundry, food services, billing, etc.

In some cases, primary care operations are transferred to private hands by converting publicly employed doctors to self-employed status, while they are subsequently contracted by the government payer or social insurance organization. This form of conversion is particularly common in Central Europe, where many countries have moved from a vertically integrated Semashko (Soviet) model, to a social insurance system with mixed delivery.

**Box 3: Conversion of Public Hospitals in South Africa**

South Africa has extensive experience with funding hospital services delivered by both for-profit and non-profit facilities. In 1995, approximately 17% of all hospital beds were operated by private organizations. Broomberg et al evaluated three conversions in detail. Two were build-own-operate (BOO) transactions where the private sector constructed and operated district hospitals, supplying acute, district level hospital services under 10 year service contracts. In a third hospital, the government contracted for private management for what was still a publicly owned facility. The study matched these hospitals against similar public facilities, and compared their performance. The privately operated (or managed) hospitals demonstrated higher productive efficiency, largely tied to lower staff costs, and more efficiently deployment of staff resources. The study concludes that conversion “appears to hold the potential to generate substantial efficiency gains, both through the securing of services of comparable or higher quality at lower cost, and through the ability of the contractors to fill temporary or permanent gaps in government capacity”. Weak contract implementation and management appear to have rendered the government unable to capture the gains. For more on this topic, see the Contracting background paper.


“wrap-around” arrangements.

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10 Please see Annex 1 for a table listing examples of each transaction.
11 A wrap-around deal takes place when a private firm expands a government owned facility, owns only the expansion, but operates the entire facility.
**Construction of New Facility or Capacity.** To take advantage of private sector advantages in construction of a new facility, or new capacity in an existing facility, governments use a range of transactions.

In some cases, the private sector builds a facility, and then the public sector takes ownership upon construction, called a build-transfer-operate contract (BTO). In other cases, the private sector builds, and then operates the facility for a period of time—at the end of the period the facility is transferred to public ownership, a build-operate-transfer (BOT) contract.

To complement existing publicly run health services, some health policy makers have undertaken co-location arrangements. This transaction entails the establishment of a privately owned health operation in the grounds of, or in the immediate precinct of, a public facility (usually a hospital). The co-located facility may be held by an investor-owned (for-profit) or not for-profit entity. It may provide comprehensive or selected services. It may not only be physically located on premises leased from the public hospital; it may even comprise an additional floor of, or a separate pavilion within, the public facility. Co-location refers strictly to the physical proximity of the two facilities, not to any particular form of ownership or contractual relationship. In Australia, where wide coverage of private insurance expands the demand for private hospital services, this type of arrangement is becoming quite common.

**New Operations to be Undertaken.** In some situations, health policy makers may decide to expand operation of publicly funded services into new areas or product lines by contracting for these services with private providers.

**Conversion to Non-profit Status.** Occasionally, policy makers will determine a preference for service delivery by non-profit organizations—and hence will transfer public facilities or services to either existing or a new non-profit provider organization.

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**Box 4: Ensuring Access to Privatized “Safety-Net” Hospitals: Non-Profit Conversion in the US**

Many US community hospitals have been privatized in the past fifteen years. Conversion of these facilities has been especially complicated due to some unique aspects of the US system. Unlike other OECD health systems, the US lacks universal insurance, with an estimated 40 million Americans uninsured. The large network of community-owned hospitals has traditionally functioned as a “safety-net” for uninsured individuals. Therefore, access for these people was believed to be threatened by conversion of these facilities, assuming they would expand their focus on the “bottom-line”. Communities sought to deal with the issue through different mechanisms. Some set up or expanded existing funding channels to reimburse providers for uncompensated care. Others sought to maintain access via channeling patients to other facilities. Some communities chose to restrict the pool of potential operators to non-profit organizations—believing that their commitment to serving under-privileged patients would alleviate any access problems. Evaluation has led to a generally positive conclusion about the impact of these reforms—with no clear distinctions according to the method of ensuring access.

Sources: ESRI. 1999.

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12 Bloom, 2000b.

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This institutional arrangement (lack of universal coverage, access insured indirectly via providers) makes conversion in the US perhaps the most relevant.
case for developing countries with similar problems.

**Facility Ceases Public Services.** When a government identifies excess capacity in the public system, they may decide to undertake true divestiture, that is, divestiture not just of ownership, but also of responsibilities for service provision (and hence funding) to private hands. Such a transfer can be done with or without conditions on the subsequent use of the facility—that it continue as a health facility or not.

Such conversion is undertaken in accordance with health service planning analysis—to ensure that there is in fact excess capacity, and to identify where publicly supported services may cease without harm to the nearby population. This type of divestiture is sometimes used inappropriately to reduce government responsibilities for critical services, in essence constituting budget driven downsizing rather than changes to improve the functioning of the health system.

Technically, this type of transaction is much simpler---since the conversion is in essence no more than a straightforward transaction—with none of the complications related to ensuring that important services continue to be delivered. One aspect of these conversions can be much more difficult—and that has to do with labor relations. In all the transactions above, the governments purchasing plans give it a great deal of leverage to smooth any labor adjustment that may be entailed in the conversion. If the government is no longer going to be buying from the facility in a substantive way, then treatment of the staff of the converted facility will be left completely to the new operator’s discretion.

The method of conversion selected will depend on the objectives sought, the level of profitability of the existing facility or operations, availability of interested providers or management companies, specificity or “buyability” of services, infrastructure/ up-front capital requirements, and the risk each party is prepared and capable of taking on.

b) Transaction Issues
In addition to determining what the objective is for the conversion, and which type of transaction is appropriate, there are additional transaction related issues to deal with.

**Allowed Buyers/Investors.** Governments must decide who is permitted to participate in conversion of health care services. They must develop criteria to ensure capable, financially sound operators of health services are involved. They must also decide whether they will permit all forms of participants or if they will restrict participation (non-profit only versus open, domestic bidders only versus open).

**Unbundling of “Non-Buyable” Services.** It may be necessary to separate services for which the government will still be responsible from those which will be delivered by the converted organization. For instance, it may make more sense to separate medical education and research activities, from health care delivery services, as these are significantly more difficult to contract for.
3.3.2 Contracting-Financing Arrangements

Just as governments can use contracting to involve existing private providers in ensuring service delivery objectives are met, they can also use contracting to ensure a converted provider continues to deliver services to publicly funded patients. Since most conversions take place in order to improve service quality and availability (rather than to end them), changes in the mechanisms to allocate funds to the providers are an integral part of conversion reforms.

Reforms that convert health care facilities are somewhat unique in that the transaction must be directly linked to the new contracting arrangements. This is so because the new operator will inevitably be relying on the government payer for a substantial portion of revenue—so that the provisions for determining the volume of services to be purchased as well as the price setting mechanism will directly influence the profitability and sustainability of the operation. Thus the service contract is as important as the structure of the transaction for the potential private operator.

In designing the service contract, government must seek to “get a good deal” but also must take into account the sustainability of the operation. For the operations of the converted facility to be sustainable, the funding arrangements must ensure that everything is paid for, or otherwise provided for in the transaction contract or regulatory framework. For example, if certain services are currently being cross-subsidized, incremental funding will likely be required to ensure their continued availability—since facilities operating in a competitive market usually cannot sustain cross subsidization (the net contributor will leave as a patient). Payments must at least cover costs (though NGOs may be able to deliver certain services at a discount, over time, they too must ensure the operational viability; at most, contributions to non-profits will support capital, not operating costs.)

To attract responsible operators to participate in the conversion, the funding arrangement must be understood and believable. This will require that the governments service and expenditure commitments are sustainable in their current fiscal environment. Otherwise a responsible operator will not be interested, fearing unpredictable revenue shortfalls. If the government or relevant agency is known to be an unreliable payer, as is often the case in developing countries, conversion will require some sort of guarantee for the revenues associated with the service contract.

3.3.3 Regulation

When conversion is taking place, it is often necessary to expand regulations of health services and facilities. Post-conversion, the government will likely purchase many

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**Box 5: Primary Care Conversion in Central Europe**

Most Central European countries have abandoned their centrally planned “Semashko” type health systems and started to develop the institutional arrangements of a “social insurance” or “Bismarckian” system (Jakab et al, 2000). The newly created social insurance agencies are increasingly tying reimbursement to outputs. This change has made it possible to establish contracts with private providers. Hence, in several countries, including Estonia, Croatia, Germany (eastern part), Hungary, and Slovenia, social insurance contracting, has allowed primary care conversion to proceed without threatening access.

services, which will give them influence via their contracts and monitoring processes. However, some critical services may not be contracted for, and so their availability may need to be otherwise ensured (requirements to continue to operate money-losing core services, such as emergency services and trauma units, burn units, neo-natal intensive care units). In countries where the private sector is not currently involved in operating these services, this may entail substantial enhancement of regulations and enforcement capacity, especially as regards service quality, access and cost containment.

3.3.4 Market Structure.
Many government run facilities are geographic monopolies. While under direct government control, exploitative monopoly behavior is constrained. After conversion, monopoly power could well be used to the detriment of the patients and the government payers. Therefore, in selecting and designing transactions governments must plan to reduce highly concentrated market power where possible. Unfortunately, in many cases, potential investors have demanded long “exclusive” service contract agreements (up to 20 years), often endowing the operator with a geographic monopoly. More recent conversions have sought to reduce the length of this commitment. Where monopoly power is created, or maintained, governments have necessarily taken steps to create at least competition “for the market” or contestability.

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Box 6: Public-Private Partnerships:
There is a great deal of literature on public private partnerships. The term is used to refer to virtually any on-going relationship between the public and private sector. There are three different partnership categories relevant for the health sector are:

- Global Public-Private Partnerships;
- Public-Private Partnerships with Commercial (production/distribution) Sector;
- Public-Private Partnerships with Health Care Providers.

In this paper, we are looking only at the latter category, that is, domestic public-private partnerships with providers of health care (not including partnerships with the commercial production/distribution sector except as related to changing health service provision).

Such partnerships provide a method of involving private health care providers in delivery of public services and securing the use of assets necessary to deliver public services. They also provide a vehicle for coordinating with non-governmental actors, to undertake integrated, comprehensive efforts to meet community needs.

Note: In this paper, only domestic public-private partnerships are being discussed, as distinct from global public-private partnerships among international organizations, corporatization and NGOs. This latter type of partnership is becoming increasingly common in health, but is not confined to the realm of one country’s public policy decisions, and therefore is not within the remit of this paper. Good reference on Global Public-Private Partnerships http://www.hsph.harvard.edu/partnerships (papers from a Workshop on Public-Private Partnerships in Public Health)

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13 Contestability may be established by tendering the right to be the service provider every ten years, for example, or via management contracts.
4. Private Health Care Providers and the Poor

Despite the financial burden, numerous recent surveys indicate that in many countries the poor are getting a large portion of their health services from the private sector. Recognition of these utilization patterns has caused private health care providers to be seen as more central to strategies to improve the health of the poor. (See box)

4.1 Improving Service Quality for the Poor

As noted, the poor often utilize private providers extensively. More importantly, the poor more often seek care from unqualified and poorly skilled practitioners or pharmacists. Since most attempts to alter these utilization patterns have failed, in some countries policy-makers are exploring methods to improve the quality of care these providers offer as the most direct instrument to improve health care for the poor.

An analysis of DHS data shows that

- Sixty-six percent of the poorest quintile of the population in the Dominican Republic obtained treatment for acute respiratory infections (ARI) from private facilities (see Box 8)
- In Zambia, 52 percent of the poorest quintile obtained treatment for ARI from public facilities (see Box 8), compared with 18 percent of the richest quintile.

A major challenge to this approach is that private providers in general are harder to reach than those in public clinics. And, the providers used by the poor are often even more difficult, as they tend to be informal and less organized. Instruments used include:
a) Purchasing Tools
To improve the quality of services which poor patients receive, governments can contract or otherwise finance key services, using their financial leverage to enhance quality standards. Services might be purchased directly for identified, poor patients. Otherwise, governments may focus their contracting and funds on diseases which disproportionately affect the poor, or for services of great importance to the poor, such as maternal and child health services. Ex. Guatemala, NGO contracts (Nieves, et al, 2001).

b) Regulation
To improve the services received by poor patients, governments may work to extend and enhance quality regulations to providers used by the poor (rural, slum locations). Alternatively, they may wish to create regulations targeted at services of import to the poor.

c) Information, Education, and Persuasion
Outreach efforts to enhance the services provided by private health care providers are growing increasingly common. Such efforts can be targeted on services that the poor use frequently, providers they frequent; regions they inhabit, or can target poor patients directly (where feasible or cost-effective).

d) Mandates
Mandates are effective only when there is either enforcement capability or incentives for the providers to comply. Enforcement requires a relatively high level of monitoring capacity, which is rare in developing country governments, especially for informal and traditional practitioners. Incentives are most often provided through the financing mechanisms—discussed above.

4.2 Expanding Services to the Poor
Dissatisfaction with the results of outreach to poor clients via publicly run services has led some governments to experiment with methods for enabling poor patients to enhance their utilization of private providers as a means to expand services. Governments wishing to do this, first must identify which providers are currently serving the poor, or are in a position to do so by reason of location, orientation or service profile. Once identified, instruments for guiding these providers to expand service provision to the poor include:

a) Financing Tools
The most powerful instrument for expanding privately delivered services to poor patients is by paying for these services with public funds. Such financial support can be allocated to the providers or to users. Funding to providers for services to the poor can be done via contracting or other less specific subsidies (input or in-kind subsidies). Service delivery to poor users can also be generated through the allocation of vouchers—which the patients can use at private clinics, while the government or other payer reimburses these claims.
As with all forms of transfers to needy populations, effective targeting is an issue. Some governments have focused on contracting with NGOs whose patients were already mainly drawn from poor populations, as a means of targeting (often geographical and process advantages) (Nieves et al, 2000). This is especially useful in instances where individual targeting is not possible, or is excessively costly. An alternative form of targeting is to contract for services which are particularly important to the poor—such as maternal and child health services, or for treatment of diseases particularly prevalent among the poor (TB, malaria, etc). The Reproductive and Child Health program in India, used three methods to expand access to the poor: contracting with NGOs who were better at reaching the poor (located in poor areas); setting targets related to reaching poor populations; and, focusing on services of particular import to poor populations (Rosen, 2000).

To expand services, governments may give direct subsidies to providers (especially NGOs) that predominantly serve the poor, or operate in areas inhabited by the poor. Vouchers can also be used to relieve poor users of payment at the point of service—with the government redeeming the voucher subsequently. An example would be the voucher program for STD treatment established for poor sex workers in Nicaragua.

b) Expanding Community Financing
To increase access for the poor to insurance, and/or reduce the payment at point of service, governments can pay part or all of the contribution for poor members in community financing schemes. Alternatively they can subsidize the scheme directly based on set criteria regarding socio-economic status of membership. For schemes whose members are predominantly poor, governments are exploring options to ensure the availability of reinsurance---to enhance the sustainability of these schemes.

c) Mandates
Another method for expanding services available to the poor is through promulgation and enforcement of mandates, for instance, requiring doctors or other medical staff to serve in poor areas in order to receive their license. For hospitals, the government can require a certain number or proportion of beds to be used to serve the poor in hospitals. Caution must be used in this regard, as these efforts often lead to monitoring problems and hence empty “poor” beds.

d) Regulation
A commonly used form of regulation that is aimed to enhance access to services for the poor is to make registration as a non-profit, with attendant benefits, contingent on devoting a proportion of their services to serving poor populations.

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14 Poor people often experience quite high under five mortality partly due to poor access to health services. (Gwatkin, 2001).
5. Private Health Care Provision and Public Health

Public health services are oriented to directly benefit the public, either as individuals, communities, or larger populations. These type of services are often public goods, as is the case for most oversight functions, or they may have significant externalities. Examples include:

- population or community based services, such as water chlorination and salt iodization.
- individual preventive health services, such as immunizations.
- individual or community health promotion activities, including nutrition education (e.g. messages on breast-feeding, weaning practices), hygiene education, increasing awareness of symptoms and treatments for better home management (e.g. oral rehydration therapy for diarrhea), safe sexual behavior, or anti-smoking/tobacco and drug and alcohol use.
- special campaigns of public priority, which use multiple approaches against specific diseases or risk factors with high externalities, such as AIDS, tuberculosis, malaria, or substance abuse.

Commonly, the private sector is excluded from national public health programs—sometimes simply from habit, occasionally from fear that involving unqualified private providers could be seen as formal recognition and encouragement for them to continue their sub-standard practices. Recently, these providers are coming to be seen as integral to addressing public health concerns (Pathania, 1998; Tawfik, 2001; Uplekar, et al, 1991). For instance, private practitioners are now acknowledged to be important source of treatment for diarrhea, ARI and malaria—which, combined, account for over half of childhood mortality in developing countries. In many countries, private providers treat a large proportion of TB symptomatics, especially in South-East Asia and the Western Pacific where the disease burden is highest (Uplekar, et al, 2000). Private drug retailers are usually the first, and often the only point of contact with the health system for a wide variety of conditions of public health concern, including maternal and child health (Kafle, et al, 1996). Private provision essentially raises two major issues with regard to public health: insufficient attention to and delivery of promotive and preventive services; and, poor quality of diagnostic and curative services.

5.1 Expanding Provision of Promotive/Preventive Health Care Services

Many people in developing countries see private health care providers for their everyday health needs. Unfortunately, these interactions often leave out critical promotive and preventive care such as vaccinations, and health education. Individuals place insufficient value on these activities relative to curative care—with the result that providers too underemphasize them. Public health programs are often administered exclusively through public facilities, exacerbating this tendency further. Recently some governments
are taking steps to include private providers in implementation of public health efforts to expand utilization of promotive and preventive health care services (World Bank, 2001). This undertaking is challenging. Private providers are often interested in participating in these efforts, since it may well enhance their attractiveness to patients (i.e. immunization, nutrition supplements). However, care must be taken to match the task with the providers. Hudelsohn proposes several criteria:

- provider must be **well placed** to undertake the task
- provider must be **capable**
- provider must be **willing**
- it must be **feasible to train** the provider to undertake the task
- it must be **acceptable to the users** that the provider perform the task.
- Perhaps the most critical factor is the **willingness of the government** and government officials to work with the private sector, and the **adequacy of resources** devoted to the tasks (Hudelsohn, 1998).

As is clear from this list of criteria, a thorough knowledge of the local health system and what private providers actually do is critical to the success of such efforts. Such understanding necessitates effective communication with private providers, a factor which is rare in developing countries.

Once the prevention or promotion related tasks to be performed are identified, as are the providers with which the government is going to work, instruments for working with private providers take several forms.

a) **Outreach to Providers**

   In some cases, private practitioners may be motivated to expand delivery of promotive or preventive care, by simply providing them with relevant information (i.e. related to handwashing and other hygienic practices). Alternatively, they may be influenced by inclusion in government sponsored training programs. In many cases, however, information dissemination and education are not enough. Often increases in knowledge are not accompanied by improvements in practice, a phenomenon referred to as the “KAP” gap (Soumerai, B. et al 1989). Efforts to change the incentives of providers are therefore extremely important. Examples of such efforts are described below.

b) **Outreach to Patients**

   Behavior change communication can be used to increase demand for products and services with a public health benefit (i.e. vaccinations, nutrition supplements, etc.) Patient educational materials may be made available for distribution in private clinics. Social marketing type methods have been successfully used in several cases to make participation in public health programs profitable for private providers.

c) **Direct Payment or Price Reduction of Public Health Goods and Services**

   Governments can pay for promotive-preventive services (contracting) or else subsidize their delivery. Again, the ability to do so depends on the measurability of the good or
service delivered. Nutrition counseling and supplements have proven for example to be relatively easy to get delivered in this way, as has STD treatment (Marek, 2000).

d) Indirect Subsidies/ Supply of Critical Inputs
Government may supply priority inputs to practitioners, to encourage them to deliver related services (i.e. free or discounted vaccines or STD treatments).

e) Subsidizing Inclusion in Insurance Packages
Governments may subsidize the inclusion in insurance packages of goods and services deemed to be high public health priorities (population and reproductive health goods and services, vaccines, etc).

f) Mandating Inclusion in Insurance Packages
Governments may require inclusion of certain goods and services in insurance packages in order for an insurer to be licensed or to provide insurance to publicly insured patients. Examples include: reproductive health goods and services.

5.2 Improving the Quality of Curative Treatments
Private providers and their patients focus heavily on delivery of curative care. However, care is frequently of low quality, an issue that concerns not just the individual, but society at large. Effective curative treatments are critical in the achievement of many critical public health priorities: including effective diagnosis and treatment of childhood illness, malaria diagnosis and treatment, TB diagnosis and treatment, population and reproductive health, as well as maternal health interventions. Mechanisms for guiding these interventions include:

a) Direct Subsidies and Contracting
Some services are more measurable and thus amenable to contracting, thus governments will more easily be able to contract for and monitor their delivery. TB treatment, for example, has proven relatively “contractible” given the verifiability of treatment impact (Pathania, 1998).

b) Outreach to Providers
Methods of outreach to providers to improve their treatment in critical areas have been tried with varying degrees of success. While circulation of information is less costly, these less intensive outreach efforts seem to have less impact on treatment. More intensive methods are being tried with greater frequency in developing countries. In the area of child health, the WHO has developed a guide for investigating retail practice and designing interventions to improve retail dispensing, by discouraging the sale of antidiarrhoeal drugs and antimicrobials and encouraging oral rehydration salts. Trials of

Box 9: Case of Public-Private DOTS for TB
Private doctors in Hyderabad, India were given access to a respected local health institution (Mahavir Hospital) which treats TB patients, and were allowed to supervise their treatment. In the hospital, their patients were able to receive effective and affordable treatment for TB. This expanded the access to effective TB treatment for poor people in slum areas. It also reduced the development of drug-resistant strains and reduced the number of infections.

Box 10: Providing drugs to private sector: Enhancing STD treatment
Under the “Clear 7” program in Uganda, private practitioners, clinics and pharmacists were provided pre-packaged, subsidized drugs for provision to men with urethral discharge. Drug shops enhanced their reputation by selling effective and affordable treatment. The packaging expanded access to a complete and effective course of treatment for men with STD. Reduced development of drug-resistant strains, expanded access to effective treatment for STD.

15 See Hudelsohn, 1998, for a concise review of nine experiences with governments using outreach to private practitioners to improve MCH services.
this guide in Kenya and Indonesia have demonstrated the positive impact of this approach (Ross-Degnan, et al, 1993). In Nepal, a course was developed to improve the practices of unlicensed drugsellers, where successful completion endowed participants with certification and registration as drug “professionals”. Positive impact on prescribing practices were identified (Kafle, 1992). A more intensive outreach method involving negotiation has been developed under the title PRACTION. The Private Practitioner Treatment Improvement Intervention is a program that starts with assessing current private practitioner practices, and then negotiating with them an informal contract for modified behaviors. It has been implemented successfully in India, Pakistan and Kenya with respect to treatment of child illness (Northrup, 1997).

c) Outreach to Patients
Behavior change communication had been used successfully to improve patient receptivity to appropriate treatment (i.e. oral rehydration therapy rather than antibiotics for treatment of diarrhea) or to encourage appropriate health seeking behavior (i.e. for TB or malaria treatment).

d) Access to Public Referral Network
Commonly, private doctors do not have access to public or NGO treatment centers. One way of improving the quality of public health related curative care is therefore to give

<table>
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<tr>
<th>Box 11: Public Policy and Health Service Delivery by Non-profit Organizations</th>
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<tr>
<td>Throughout this paper the discussion of public policy toward the private sector refers to both for-profit and non-profit organizations involved in health service delivery. However, there are several policy issues unique to the involvement of non-profit organizations in the delivery of health services. Non-profit organizations involved in the delivery of social services are usually deemed to merit special assistance from the government, most frequently in terms of tax exemptions, and tax deductions for donations to their operation. Further, some countries exempt social service non-profits from import tariffs for health related equipment and medicines. While many countries strive to support the operation of socially beneficial non-profit organizations, others either by omission or commission have not created a supportive environment. Thus, in addition to being affected by the general state of the economy and enabling environment for businesses, non-profit organizations are affected by the non-profit enabling environment, both regulatory and fiscal aspects. The following factors are important for the operation of health service non-profit organizations:</td>
</tr>
<tr>
<td>• legal environment—the legal environment should be supportive, including being free of state intrusion and inappropriate interference. Clear criteria for qualification as a non-profit organization, while not allowing abuse should be in place. Regulation must respect their autonomy as independent bodies</td>
</tr>
<tr>
<td>• fiscal—the tax framework should provide exemptions for income and profits taxes for non-profit organizations, though this needn’t include business or economic activities; other tax benefits may be appropriate, possibly exemptions from customs duties, and import VAT; individual tax deductions for donations of time or funds</td>
</tr>
<tr>
<td>• other—access to government training schemes; provision of medical supplies at low or no cost may be appropriate.</td>
</tr>
</tbody>
</table>

The legal and fiscal issues are beyond the scope of health sector policy, however, if non-profit providers are to play a vital role in service delivery, then health officials may need to contribute to a process which brings about improvement in the environment for them.

Why non-profit health care providers are important: Non-profit organizations often provide a means to reach the poor and other target populations. This comparative advantage comes from historical pattern of development, their closeness to communities, and their ability to harness volunteer activity

Why problems may occur: NGOs are often politically contentious. They sometimes come to play a role in sing the narrow interests of particular ruling parties, or may be otherwise aligned with opposition political interests. Political aspect of NGO activities may add to a negative stance on the part of the government towards NGOs (and constraining policies), including those providing valuable social services.

However, non-profit organizations whose main activity is service delivery most often have interests closely aligned with those of the government in the health sector.

All too often, even when governments are actively developing policy toward the private sector, they leave out
e) Indirect Subsidies/ Supply of Critical Inputs
In some instances, governments have been successful in improving service quality through supplying related inputs. Treatment of diarrheal disease in children has been improved through the provision of oral rehydration salts. Sexually transmitted disease treatment has been improved through provision of appropriately “bundled” pharmaceuticals.

6. Implementation of Private Sector-focused Strategies

Implementation of health sector reforms in general is extremely challenging, and more often than not goes awry. There are several very useful analytical tools for developing an implementation plan for general health reforms (Reich, 19??; Walt, 19??) This section of the paper will talk about the unique set of challenges that are likely to arise when a government attempts to improve and increase their interaction with private health care providers. These issues are likely to arise regardless of the strategy being implemented or the instruments being used.

a) Lack of Familiarity/Knowledge About Private Sector
A historical pattern of segmentation between the public and private sectors is common, and therefore actors on both sides usually lack knowledge of and familiarity with one another. While most governments have basic data regarding the capacities and activities of public facilities and practitioners, such information about private health care providers is rare.

b) Lack of Forum for Dialogue/Collaboration
The existence and functioning of an on-going consultative mechanism between the private and public sector has proven crucial for successful implementation of efforts to work with the private sector (Stone, ????). However, in developing countries’ health sectors, there is often no forum for dialogue between the public sector (especially policy makers) and private providers. In many countries, the private sector if often not very organized, so there are few representative organizations that could serve as a counterpart in consultations with the government. This lack of organization is even more of a problem with informal and unqualified practitioners—who are of particular importance to the poorer segments of the population.

c) Ideology/Mindset
Efforts to establish policies and mechanisms to work with private health care providers will often face significant challenges associated with a deeply engrained mindset of mistrust toward the private sector on the part of government officials, and health sector staff. Because of the obvious problems with clinical quality and other associated market failures, negative attitudes toward the private sector and in particular the for profit sector will need to be dealt with, if such reforms are to move ahead.

Particular problems are often faced when actions are being contemplated to increase interaction with non-biomedically trained or unqualified practitioners—as this will often
be seen as a threat to the interests of the biomedically trained staff which dominate publicly operated health care operations.

d) Public Employees
In addition to problems associated with ideology or mindset of public officials and health staff, the staff of operations where private sector collaboration or conversion is being contemplated will almost always feel their position threatened. Such concern is often well founded in that these reforms are often at least partly directed toward enhancing productivity and/or flexibility in public sector operations, and may even constitute a threat to employment. Any efforts to enhance collaboration with the private sector therefore must explicitly deal with the views and strength of these stakeholders.\textsuperscript{16} As with all health reforms, these reforms will often be threatened if opposed by medical professionals, who have a great deal of credibility and access to the public and are adept at portraying any reform that they oppose as undermining the “public interest”.

e) Skepticism on the Part of Private Health Care Providers
Due to a historical pattern of segmentation between the public and private sectors in health, private providers may not initially respond to government initiatives.

f) Lack of Capacity for Public Officials to Take on New Roles
Both in terms of the new envisioned structure and in terms of managing the reforms, government officials will find it extremely challenging to operate in new ways and to take on new roles.

Government staff are usually more familiar with dealing with organizations and staff in a subordinate relationship, and therefore have a tendency to approach policy making in centralized and top down fashion, that is, they tend to be “heavy handed”. They may miss out in collecting key information about the private sector and its strengths and weaknesses, and may add to suspicions about the governments intentions (Green and Matthias).

g) Impact on Public Sector
Any initiative to work with the private sector must take into account the likely impact on the public sector. Expanding private sector activity may encourage movement away from public sector work. Governments will need to proactively deal with such possibilities.

h) Outreach Methods
A review of efforts to improve the operation of private providers indicates a tendency to overreach, trying to bring practitioner behavior up to standard on a number of fronts. These unfocused efforts tend to be relatively ineffective. Efforts are more successful with identified and focused on a narrow range of activities. (Chakraborty, 19??). Evidence to date also underscores that successful outreach efforts are not extremely time consuming—since private practitioners value their time highly, and will not be willing to incur the income loss associated with long training programs. This observation

\textsuperscript{16} A political mapping exercise should be considered to design a strategy to manage implementation that will address potential opposition—see Reich, 19??).
highlights a more general point—that all efforts to work with private providers must take into account the incentives they face—their need to earn their keep, and interest in making a profit (for for-profits).

7. Conclusions and Using the Handbook

7.1 Health System Reform and Private Health Care Providers

It costs money to work with private providers, both in terms of paying them directly and in terms of ensuring adequate staffing resources to manage relations with them. Many governments undertake to work with private providers only in conditions of extreme fiscal pressure, thereby undermining the impact of these efforts. While there may be efficiency gains and cost savings from working with private providers, in some cases, it may be more costly to work with heterogeneous, dis-integrated, private practitioners. However, if that is where people are obtaining treatment, this may be the only way to achieve certain objectives.

In developing countries, it may be easier to work with private providers on public health related activities, such as vaccination, treatment of STD, delivery of nutrition supplements rather than clinical activities—since both the service and the outcome are relatively more observable and measurable.

Efforts to work with private practitioners are best thought of as systemic reforms—rather than “stand alone”. Therefore, these changes must be based on a clear strategy for what the private and public sectors will be doing in the medium term, in order to ensure any needed complementary reforms are forthcoming.

Improving public policy toward private health care providers in developing countries requires new and expanded analysis—to assess the current role of the private sector, and to evaluate the effectiveness of instruments for working with them. Dialogue with the private sector is critical, both to identify opportunities and to implement new policies.

7.2 Comparing Strategies

Attempting to harness the existing private sector, or to grow the private sector in a targeted way are relatively low risk strategies. While both strategies require reallocating resources toward new efforts (contracting, regulation, information dissemination, tax breaks, etc.), in both cases, structural changes are incremental—leaving in place most arrangements for service delivery, seeking only to change the behavior of existing private providers on the margin. Therefore, the potential downside from failed efforts consist mainly in not achieving such changes—whereby the status quo remains in force.

Conversion is a relatively riskier strategy, since existing service delivery arrangements are interrupted as operations are transferred to private hands. If efforts go awry, then quality of and even access to certain services may be threatened. Such efforts are most risky when key elements of the enabling framework are missing (i.e. collective funding or risk pooling, health service regulation).
7.3 The Way Forward

While the evidence on effectiveness of instruments for working with the private sector is relatively sparse, the evidence on the folly of ignoring private health care providers is not. It is by now clear that the way forward in virtually all developing countries must include enhanced interaction with private providers.

While recognition of this fact is fairly widespread, most attempts to operationalize it are random and ad hoc—an occasional contract for cleaning a public hospital, the odd delivery of vaccines to a private clinic. These efforts are often undermined by the lack of information about the private sector, and hence are undertaken in a relative vacuum.

Development of public policy toward private health care providers, just like sector policy in general, should be done comprehensively and strategically. This will require policy makers to greatly increase their knowledge of and interaction with the private sector. The private sector is, after all their partner in generating the health of the population.

Though it is wise to move forward cautiously in implementing these new strategies, the opposite approach is appropriate in terms of enhancing information gathering and interaction with the private sector. When programs are undertaken, thorough evaluation is called for, as is a commitment to incorporating what is learned on an on-going basis. While there is growing knowledge of mechanisms and strategies, there is little knowledge of impact and the effect of the institutional context. Further, there is virtually no information on the cost relative to the effectiveness of efforts to work with private providers—hence it is rarely possible to compare the likely impact and cost of pursuing objectives via a traditional public sector approach versus working with or through private providers.
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Annex 1: Transaction Methods for Conversion of Health Facilities or Operations

<table>
<thead>
<tr>
<th>Type of transaction</th>
<th>definition</th>
<th>Examples (countries, states)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conversion of Existing Facility/Operations</td>
<td>Private firm buys facility, operates under franchise(?)</td>
<td>Australian states, Germany (which Lander?), Sweden (Stockholm)</td>
</tr>
<tr>
<td>Sale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lease</td>
<td>Government leases a facility to a private organization, which operates it under a franchise.</td>
<td>Australian states</td>
</tr>
<tr>
<td>Management Contract</td>
<td>Private firm is contracted to maintain and operates a government-owned facility, government pays firm a fee to manage.</td>
<td>S. Africa, Malawi, Kenya, many countries in LAC, S. Arabia, Australian states, Mongolia, US (very common—Quorum Health Care manages over 200 non-profit hospitals under contract).</td>
</tr>
<tr>
<td>Outsourcing of Auxiliary Services</td>
<td>Publicly owned facilities establish contract with private service providers to deliver auxiliary services (i.e. laundry, food services, billing, collection).</td>
<td>Everywhere</td>
</tr>
<tr>
<td>Service/Operation Conversion-Individual contracting-Primary Care</td>
<td>Publicly employed primary care doctors are converted to self-employment and contracted by state/insurance organization for services.</td>
<td>Croatia, Macedonia, Slovenia, Poland, Hungary, Estonia, Sao Paolo municipality-Brazil, Czech Republic, Slovakia</td>
</tr>
<tr>
<td>Service/Operation Conversion-Individual contracting-surgeons</td>
<td>District Government contracts with district surgeons.</td>
<td>S. Africa (district level)</td>
</tr>
<tr>
<td>Service/Operation Conversion-Integrated Care</td>
<td></td>
<td>Sao Paulo</td>
</tr>
<tr>
<td><strong>Existing Facility-</strong>&lt;br&gt;<strong>Requiring Capital Investment for Expansion or Rehabilitation</strong></td>
<td>Lease-build-operate</td>
<td>Private firm leases facility from government, and operates it under a concession, expands and/or rehabilitates it.</td>
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</tr>
<tr>
<td>Wrap-around addition</td>
<td>Private firm expands a government owned facility, owns only the expansion, operates entire facility.</td>
<td></td>
</tr>
<tr>
<td><strong>Construction of New Facility or Capacity</strong></td>
<td>Build-transfer-operate</td>
<td>Private firm finances and builds new facility, transfers to public ownership, then operates (20-40 yrs)</td>
</tr>
<tr>
<td>Build-operate-transfer</td>
<td>Same as above (BTO), but facility is transferred after 20-40 yrs.</td>
<td>Australian states, UK</td>
</tr>
<tr>
<td>Co-location</td>
<td>Private firm develops an additional unit adjacent to or within a gov’t. facility, owns only the expansion.</td>
<td>Australian states, US?</td>
</tr>
<tr>
<td><strong>New Operations to be Undertaken</strong></td>
<td>Contracting for services in new areas</td>
<td>Government initiates contracting for health services in areas not initially served by public facilities.</td>
</tr>
<tr>
<td><strong>Conversion to Non-profit Status</strong></td>
<td>Conversion to new non-profit</td>
<td>Creation of and transfer of facility to non-profit organization</td>
</tr>
<tr>
<td>Sale or transfer to non-profit organization</td>
<td>Transfer to existing non-profit organization</td>
<td>US municipalities and universities, Venezuela</td>
</tr>
<tr>
<td>Facility Ceases Public Services</td>
<td>Sale to private service provider</td>
<td>Facility is sold to be operated in delivering privately funded services (acute, long-term care, specialty care)</td>
</tr>
<tr>
<td>---------------------------------</td>
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<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Sale-non-health facility</td>
<td>Facility is sold to be used for non-health related activities.</td>
<td></td>
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</tbody>
</table>