Public-Private-Partnership and Social Protection in Developing Countries: The Case of the Health Sector

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Public-private-partnership and social protection in developing countries: the case of the health sector

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Executive Summary:

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

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1 Introduction

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

Given this background, this paper analyses the potentials of PPP to provide social protection in the health sector. The outline is as follows: We briefly discuss the theoretical foundations of the concept of PPP and describe different forms of a co-operation. The major part of the paper discusses experiences which have been made with PPP in the health sector of developing countries in different regions of the world. Following that, we use the presented case studies as well as the insights from the theoretical overview in order to derive determinants for a successful PPP. The identification of conditions under which PPP can contribute to an increase in access to social protection at lower costs is helpful to design appropriate social policies. The paper closes with open questions for discussion and future research needs.

2 The evolving idea of PPP in developing countries

Origins and definition

The current debate of the role of PPP in the development process has its roots in the discussion of a welfare reform in the industrialised countries, notably the US and UK. The concept of PPP in itself is therefore not new and dates back to the early eighties when Thatcher and Reagan took over the government in the UK and the US respectively.

Privatisation of services, deregulation and *new public management* were the key words which characterised a new area of administration reform and a redesign – "reinventing" – of government activities. At the center of their policy was a cut-back of public sector expenditure, a delegation of responsibilities to the private for-profit sector and the fostering of voluntary engagement aiming at providing local public goods (Michell-Weaver and Manning 1992). The re-evaluation of the structure and function of governments in terms of providing public goods was driven by the argument that the hierarchical bureaucracy is inherently inefficient and that the introduction of market mechanisms will substantially enhance the efficiency of public service delivery (Hood 1991, Moore 1996). This argument has been theoretically developed by public choice theory, mainly arguing that it cannot be assumed that politicians and bureaucrats always act in the public interest, but either pursue their own interests or those of powerful interest groups (Walsh 1995).

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

There has been much confusion of using the term PPP. Often donor agencies and governments promoted privatisation and subsidies to private entrepreneurs in the name of building public-private partnerships (Vickers and Yarrow 1988, World Bank 1986). However, as Mitchell-Weaver and Mannig (1991, p. 49) point out "privatization is privatization and subsidies are subsidies; public private partnerships they are not". They define PPP as "primarily a set of institutional relationships between the government and various actors in the private sector and civil society". It is very important to state that PPP is neither a development strategy nor a loose interaction between different agents. In order to fulfil the criterion of a "partnership" there must be some ongoing set of interactions, an agreement on objectives and methods as well as a division of labor to achieve the goals. Public-private-partnerships are therefore not equivalent to the promotion of a free market economy, in fact they are corporatists (Peters 1987, Salomon 1981). In the context of this paper PPP is defined as *"institutional relationships between the state and the private for-profit and/or the private not*

for-profit sector, where the different public and private actors jointly participate in defining the objectives, the methods and the implementation of an agreement of cooperation".

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

Partners, roles and types of cooperation

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

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

The government, the private for-profit and the private non-profit sector are not monolithic blocs in themselves, but a variety of actors at various levels with different interests, also regarding their interest in participation in a PPP. So it is not clear whether local authorities and the national administration – both entities of the government – might have the same interest. Conflicts between these different levels have been frequent in times of decentralisation and the devolution of political and financial power from the national to the local level. The same holds true for the private-for profit sector: Partnerships always happen in a particular case, they are locally and demand driven. Local enterprises may not have the financial backing as multinationals to contribute to infrastructure projects, however with their specific local knowledge and with their ties to the customer base they are essential participants in successful partnerships on the local level. Finally, the variety of organisations which are placed under the umbrella of the not for-profit sector make it clear, that depending on the specific activity of an organisations its contribution to a PPP may be quite different. For example, an NGO operating at the national level and aiming and lobbying for its clientele is very different from a small scale and locally based community organisation which delivers services for its members (Gentry and Fernandez 1998).

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

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

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

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

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

- The degree of control desired by the government;

- The government’s capacity to provide the desired services;

- The capacity of private parties to provide the services;

- The legal framework for monitoring and regulation;

- The availability of financial resources from public or private sources

Having described a general outline and framework of the origins and contents of a PPP, we now look at more specific characteristics of PPPs in the health sector.

Why PPP in the health sector?

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

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

- Economic: the replacement of direct, hierarchical management structure by contractual relationships between purchasers and providers will increase transparency of prices, quantity and quality as well as competition which will lead to a gain in efficiency.

- Political: In the context of welfare systems reform world wide, decentralisation of services from the national to the local level is frequently suggested in conjunction with an improved participation of the population in determining and implementing the services. Contracting out could be an element in this overall strategy.

Beside these attributed benefits to contracting out which are also often attributed to a PPP, others argue that the cost side should not be overlooked. Contracting out and PPP will increase transaction costs, e.g. for negotiating and monitoring, costs related to the loss of monopsony purchasing power and bring about social costs arising from equity problems (Robinson 1990, von Otter and Saltman 1992). In addition to these direct costs, the impact on the wider health system should also be taken into account. As Mills (1995) argues, the introduction of contracts may (a) lead to a fragmentation or lack of co-ordination within the broader public health system, (b) could have an impact on staff resources with a drain of key personal to the for-profit providers and (c) might drive scarce resources into a particular allocation.

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

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

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

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

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

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

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

- Organising the production of public and merit goods, e.g. disease control

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

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

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

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

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

* insurance universal

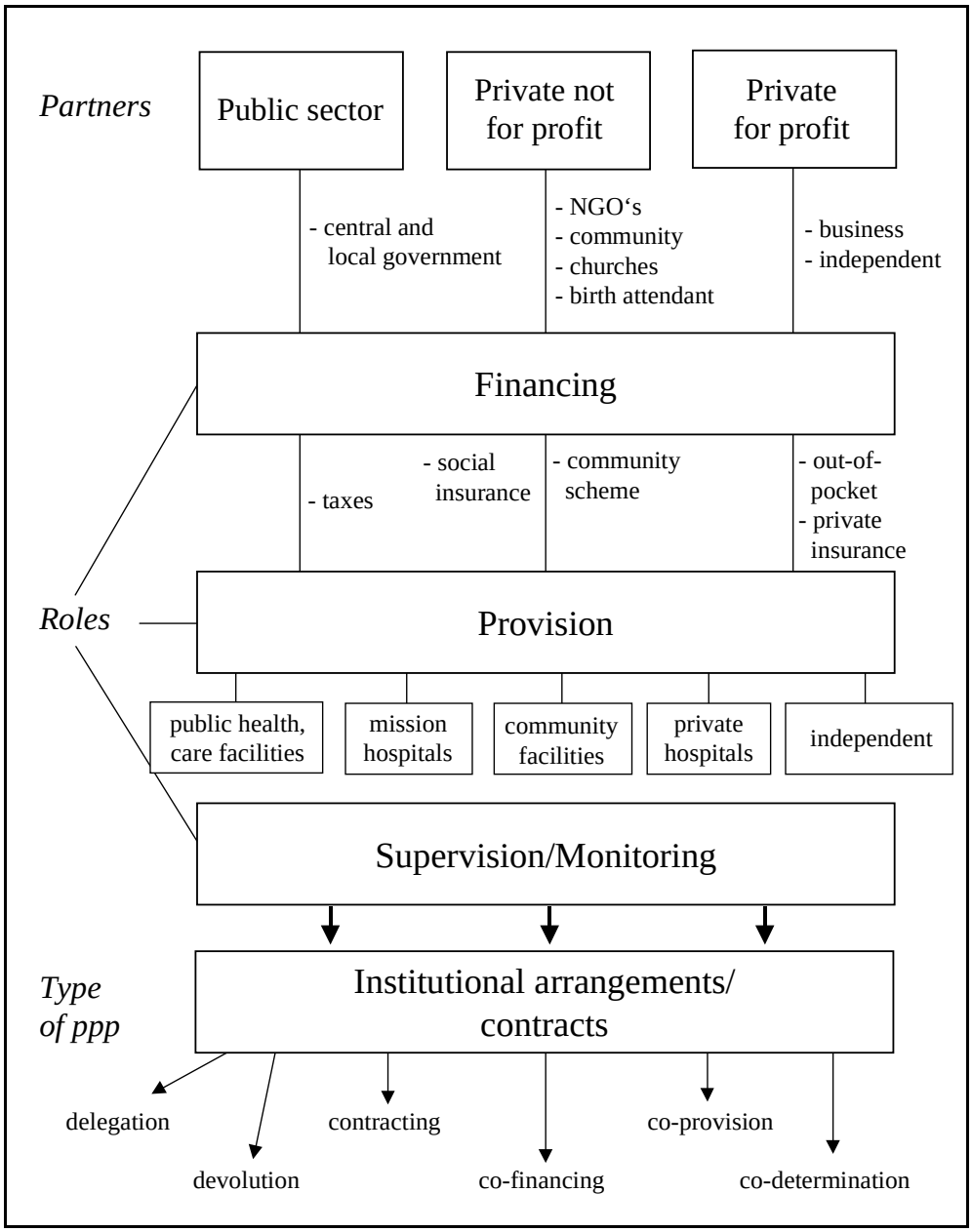
** insurance not mandatory

Source: adapted from Jütting (2000)

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

Given the numerous actors and the variety of roles ranging from financing, to provision and management several types of cooperation are possible. Using our concept of partnership, the following figure gives an overview of the different actors, the roles and the types of a PPP in the health sector of developing countries (Figure 1).

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



Source: Author's Design

The presented diagram sets the outline for a PPP in the health sector. It shows that within the three major sectors – state, for-profit and not for-profit – a variety of individual actors found their place. The opportunities and possibilities of a PPP are nearly unlimited as in addition to the variety of actors they can also play different roles, e.g. financing, provision, management and supervision of health care services. Most common is a cooperation in the area of

financing or provision of health services, e.g. the state subsidises health care facilities which are run by local communities or cost-recovery schemes in which the financing side is with the private sector and the state delivers the service.

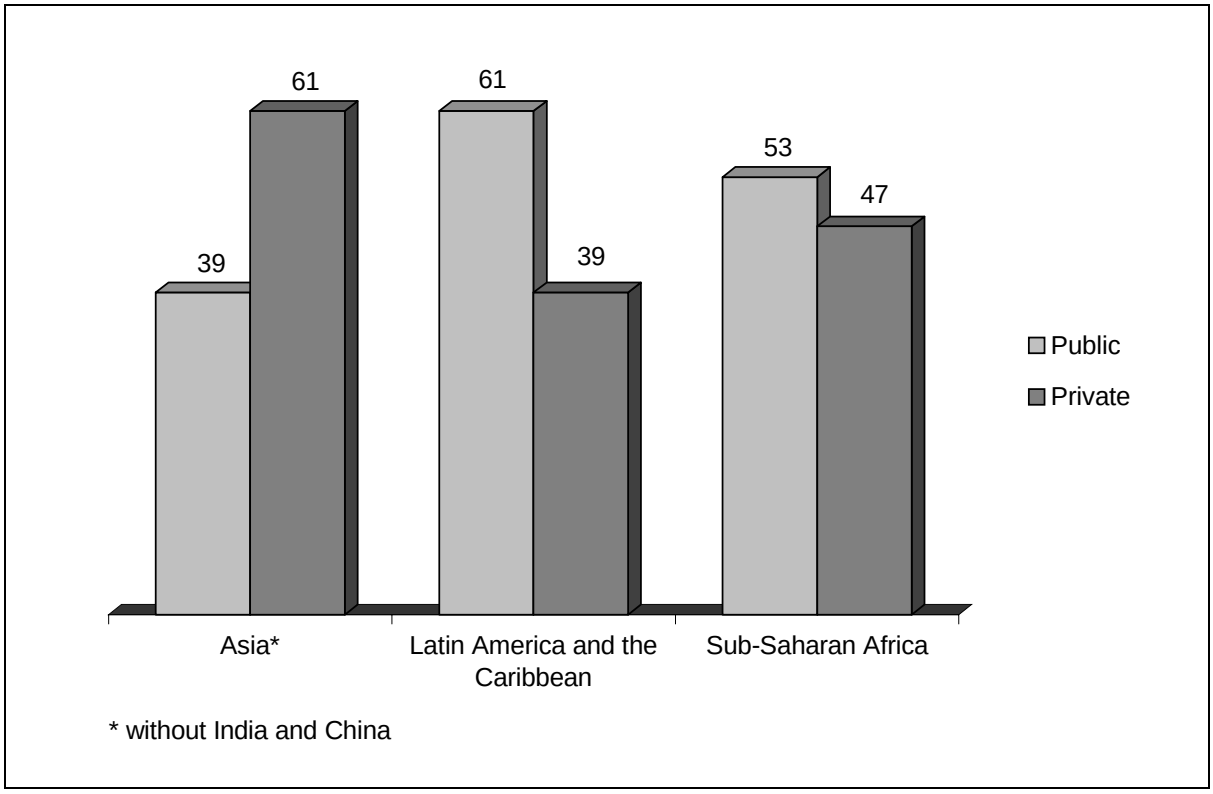
3 PPP and the health care sector: Case studies

3.1 Health care systems in developing countries: an overview

The current situation of the health systems in developing countries is characterised by a variety of different systems which often have their roots in the organisational approach favored by the relevant colonial power. Before we turn to country specific case studies of PPP, we briefly describe some basic characteristics of health care systems in the different regions of developing countries.

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

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



Source: Murray et al. (1994)

The important role of the private sector in health care financing world-wide is underlined by the fact that roughly an estimated 50 % of all global spending comes from the private sector, although the amount varies considerably across countries and regions (Figure 1).

As shown in Figure 1 Asia has more than 60 % of private sector contributions (excluding China and India) *and* is the part of the world where the private sector plays a dominant role. This is not only true for financial aspects but also for the provision of services, with a steadily growing importance over time. This trend is the reflection of the overall development process in most Asian countries with rising demand for health services where government provision cannot keep up with the need of the population. In Malaysia, for example, the proportion of physicians in private practice rose from 43% in 1975 to 70% in 1990. In Indonesia about half of the hospitals are private run. In Thailand the share of beds in private hospitals grew from 5.4% in 1970 to 13.7% in 1989 (van der Gaag 1995). However, despite this general trend towards a privatisation of health service, private health insurance as in other countries of the world plays only a very limited role. Less than 2 % of the population are covered by private insurance schemes even in countries in which social insurance is widespread (Table 3). Private health insurance schemes are clearly restricted to the better-off part of the population with low health risks.

Table 3: Health insurance coverage in selected Asian countries

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

Source: Newbrander (1997), p. 117

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

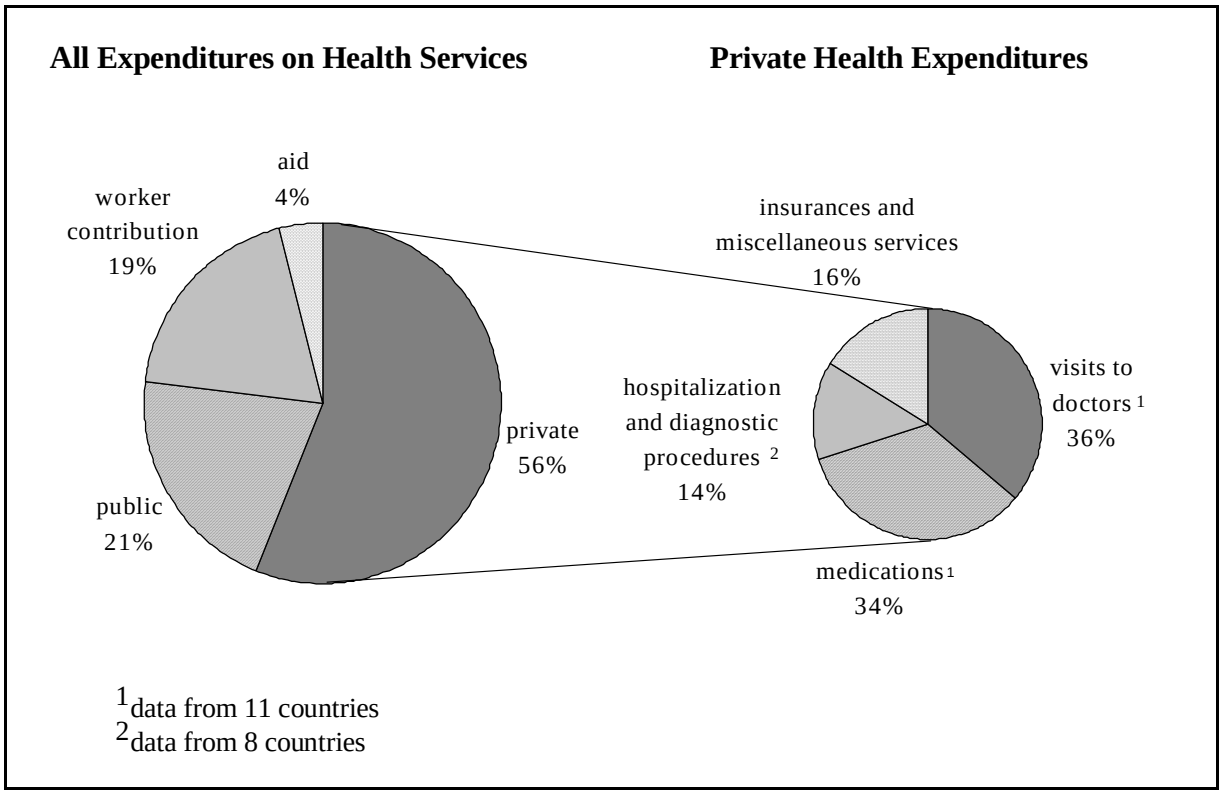
Table 4: Extent of non-State provisioning of health services in Africa

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

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

The financial contribution of the private sector in *Latin America* in the health sector varies among different sources from roughly 40 % up to 60 %. As in other regions as well recently there has been a shift towards more private funding of health services. Regarding the provision of services the trend is the same: private health services are fast expanding for both the rich and the poor. The spectrum of private providers varies from those who provide expensive high-tech on a for-profit basis for the better-off to those non-profit providers operating mainly in areas where public services are not available.

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



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

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

The described role of the private for-profit and non-profit sector in health care provision has revealed two important points: First, in all three continents the private sector accounts to a substantial amount for the health care expenditure and in the provision of services with a trend upwards. Second, there are some indications – coverage rates, mode of financing – which hint at a problem outlined earlier that the private sector alone cannot solve the problem of an equitable provision of health care, which underpins the theoretical argument above to think about a synergy between different actors in order to overcome their individual weaknesses.

3.2 Latin America: examples from Chile and Venezuela

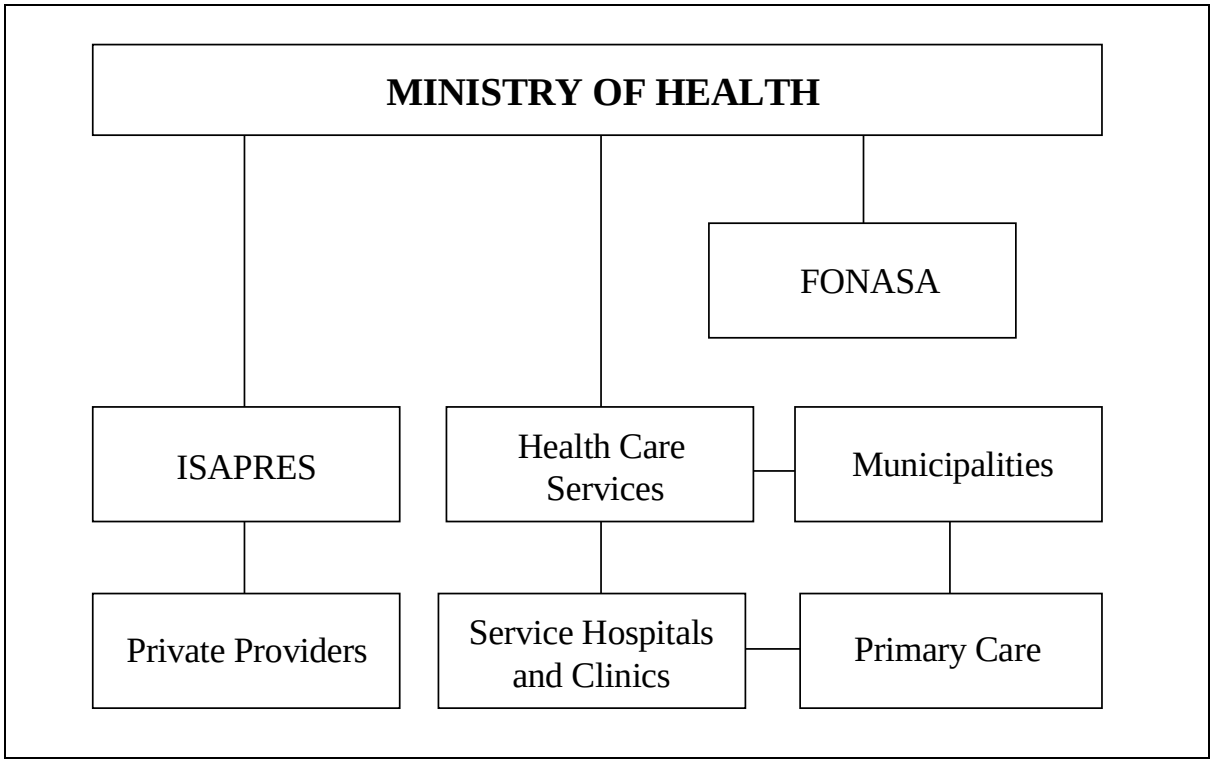
Chile

Partners

Before we discuss the different roles of the partners in the case of the health sector in Chile, we will give a short overview of the structure of the health sector, discuss coverage and funding issues and then describe efficiency and equity outcomes within the public and private sub-sector.

The following Figure 4 gives an overview of the structure of the health care sector in Chile.

Figure 4: Structure of the health care sector in Chile



Source: : Larranaga (1997)

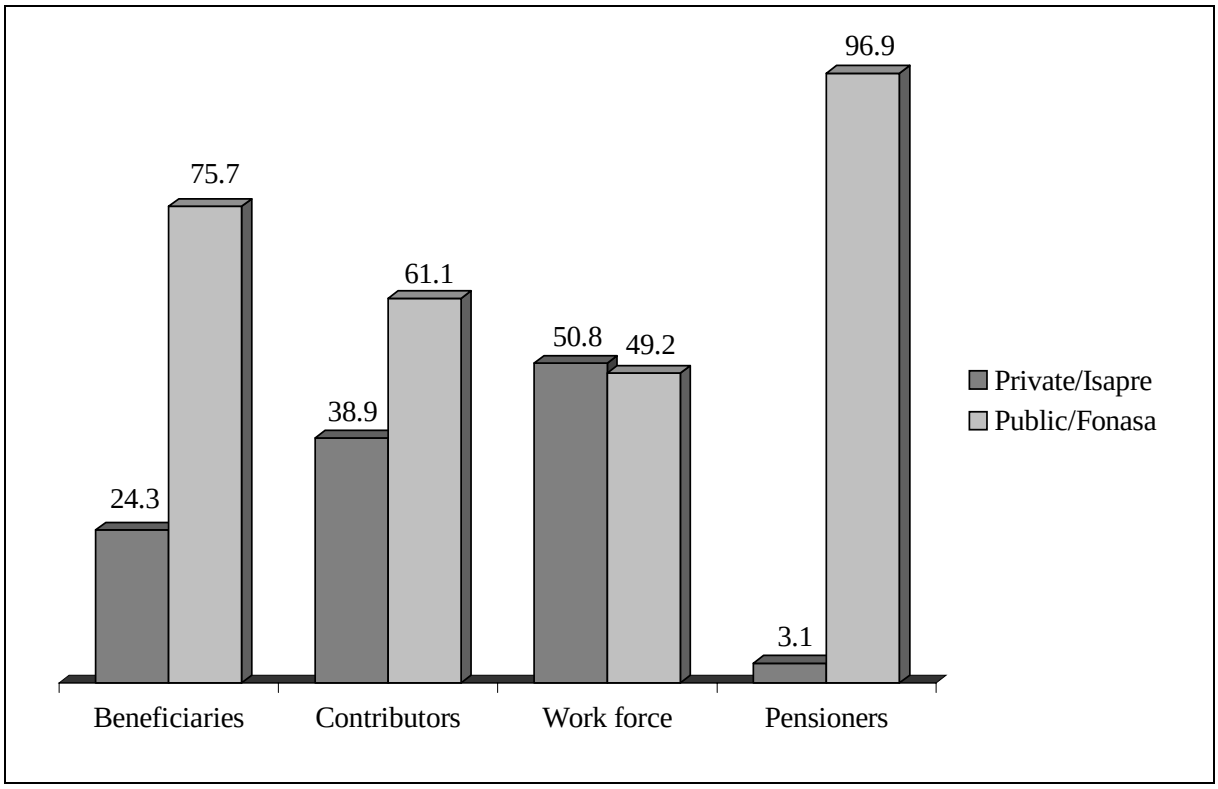
The presented structure is the outcome of a reform which took place in the beginning of the 80s aiming at separating the regulatory, funding and production functions of the public health care system, decentralisation of the administration of primary care to the municipalities and encouraging the creation of private insurance schemes, ISAPRES. The following partners and roles can be identified: There is the central government which is in charge of policy design, institutional coordination and supervision. The National Health Fund (FONSA) is a decentralised service that is in charge of the functioning of the public system. On the community level primary health care centers administered by the municipalities are in charge of the provision of curative services, health promotion and prevention activities. Within the

private health care system there is an open one and a close one, the latter one serving only the employees of specific companies.

Roles and impact on efficiency and equity

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

Figure 5: Coverage of health care systems (in %)



Source: : Larranaga (1997)

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

- To belong to the younger part of the population. With a share of 22,5 % of the overall population belonging to the private system, its relative share of 27 % in the low risk group

of age 20 – 39 is high, falling below a share of 5 % for the high risk group of over 60 years.

- To live in urban areas. The coverage with private insurance lies with more than 30 % ten percentage points above the nation-wide average.

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

The described characteristics of a "typical" member of the private insurance scheme clearly indicates the adverse selection problem. Therefore, there is no wonder that this has serious consequences for the efficiency of both systems. Zuckermann and de Kadt (1997) depict the following principal inefficiency in the Chilean health care system:

Table 5: Principal inefficiencies in health care systems

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

Source: : Larranaga (1997)

Interesting enough the problems with the private scheme can be fairly well explained by the concerns of private health care provision in general which were presented earlier. Adverse selection problems leading to an unequal coverage, the oversupply of high quality and cost intensive services while at the same time undersupply of prevention services and high administrative costs are the major factors explaining the inefficiencies. Concerning the public schemes health care management and delivery are the major source of inefficiencies. Especially after the decentralisation of primary health care service and the delinking of higher level services doctors have no interest in working in these facilities as their prospects of professional development seem to decline.

Types of a PPP

We have chosen the Chilean example to illustrate the difference between a public-private mix and a real public-private-partnership. The Chilean health sector is characterised by two different and independent subsectors; a public one and a private for-profit one in which no real interlinkages can be observed. In an environment of a general privatisation of social services, the Chilean government has devoluted basic health services to the lowest of government, the municipalities, in conjunction with the setting up of a private scheme under the supervision of the Ministry for Health. Whereas this is nothing special and occurs even in advanced economies, the missing interlinkages and pooling of risks leads to efficiency and equity problems in so far as roughly two thirds of the population cannot afford private services and the public sector cannot provide competitive and curative services for all without the resources of the better-off contributors. Having said this, in the Chilean case we can hardly speak of a partnership, as we have defined it above with clear institutional arrangements for co-operation between the public and the private sector. It is a form of a public-private-mix which is the outcome of decentralisation and privatisation, without institutional arrangements and incentives for a closer cooperation.

Venezuela

Partners

The Venezuelan health care sector has for a long time been mainly influenced by the government which has the principal responsibility for the financing and provision of health care. Still today, a highly centralized administrative structure guarantees services and establishes the rules for the overall health care system. Three models of health care provision can be distinguished: First, there is the open access public care system, which is universal and free of charge. Second, there exists a closed public system where care is based on prepayment plans provided by social security institutions and in the third model health care is provided by the private for-profit and not for-profit sector.

Roles

With respect to the public system the World Bank identified the following major weaknesses: low levels of internal efficiencies in personnel, equipment and program management, poor efficiencies in allocating funds, inequitable access to services and a lack of information for decision making (World Bank 1993). In order to solve some of these problems in 1994 Venezuela embarked on a health sector reform leading to a flexible health care management

and delivery model in each of the states. The outcome of the reform has been rather mixed with successful and unsuccessful cases.

In comparison to Chile the private for-profit sector plays even after the health sector reform only a minor role. The difficulty to set up a private for-profit health system in a situation of economic distress and financial cut-backs is a reasonable explanation. Additionally, management problems and the exclusion of the majority of the population due to high premiums have lead to a drop in demand.

Types of PPP and impact

In the following we describe selected successful cases of a public-private partnership, which involve an active participation of communities in primary health care provision, the creation of new management models for public hospitals and the setting up of alternative insurance schemes based on risk sharing and solidarity (Table 6).

Table 6: Public and private participation in health care

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

Source: based on Cartaya (1997)

The few selected cases show that in the Venezuelan case study PPP in the health sector is mainly a relationship between the public, i.e. the national and local government and the not-for profit sector, i.e. foundations and community associations (Table 6).

The inability of the public and the private for-profit sector to set up adequate health care systems has lead to the building of schemes in which the local people participate in the design, financing and implementation of services. The success of these small scale initiatives and innovations had a double effect: It had an impact on the government, which has been forced to think about further activities to strengthen its own activities via more decentralised services, new ways of financing and a change in the health care and management model. It also had an impact on the private for-profit sector to improve its efficiency and to deliver health care services at a lower price and with good quality.

The need to think about a PPP in the Venezuelan health sector resulted from a serious economic and financial crisis and a strong dissatisfaction with the public and private for-profit

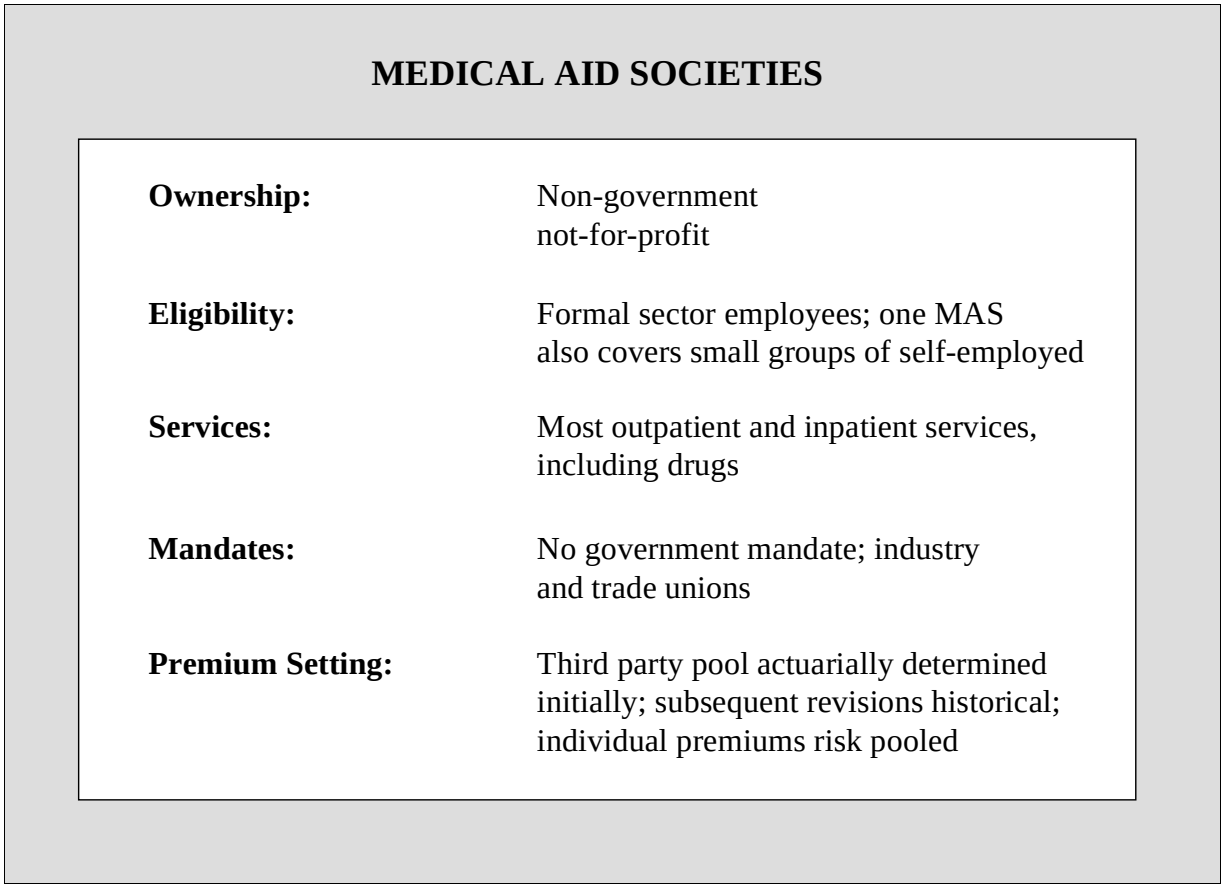
sector. In contrast to the Chilean example in this case we can speak of a real partnership where the public and the not for-profit sector are both involved in determining, financing and management of services. Despite the limitations of a generalisation due to the selective character of the presented "successful" cases, some general conclusions can be drawn. First, the overall political commitment for a shift of financial and political power from the national government level to the local level and to other actors is a pre-condition for any PPP. Without a political will to challenge vested interests, particularly among suppliers of medical inputs and equipment it is nearly impossible to get other actors involved. Beside the political factors the overall economic situations also plays a role in so far as it defines the manoeuvre for innovative social policy activities. The economic crisis on one hand gave a strong incentive to think of alternative ways of financing and therefore also to think about the involvement of other actors. However, in the mid to long term these new arrangements will need public money to some extent, if they want to work on a sustainable basis with otherwise excluded people. Finally, without the important contribution of volunteering work, services would have not been delivered at current prices. The contribution of communities to make service available is a necessity for an effective PPP.

3.3 Zimbabwe

Partners

Zimbabwe is one of the rare countries in Africa in which privately run health insurance plays a significant role thanks to the existence of the so-called "Medical Aid Societies" (MAS). These are not-for-profit companies, which offer health insurance for approximately 800,000 people, 8 % of the total population. Their origin goes back to former health insurance plans developed by large firms and groups of firms and are quite similar to the "Betriebskrankenkassen/sickness funds" in Germany. A difference, however, lies in the fact that groups of self-employed people can be accepted for membership. The 25 MAS have built a National Association of Medical Societies and their existence can to a large extent be explained by the relatively extensive formal sector compared to many African countries. In Figure 6 some characteristics of Medical Aid Societies are presented.

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



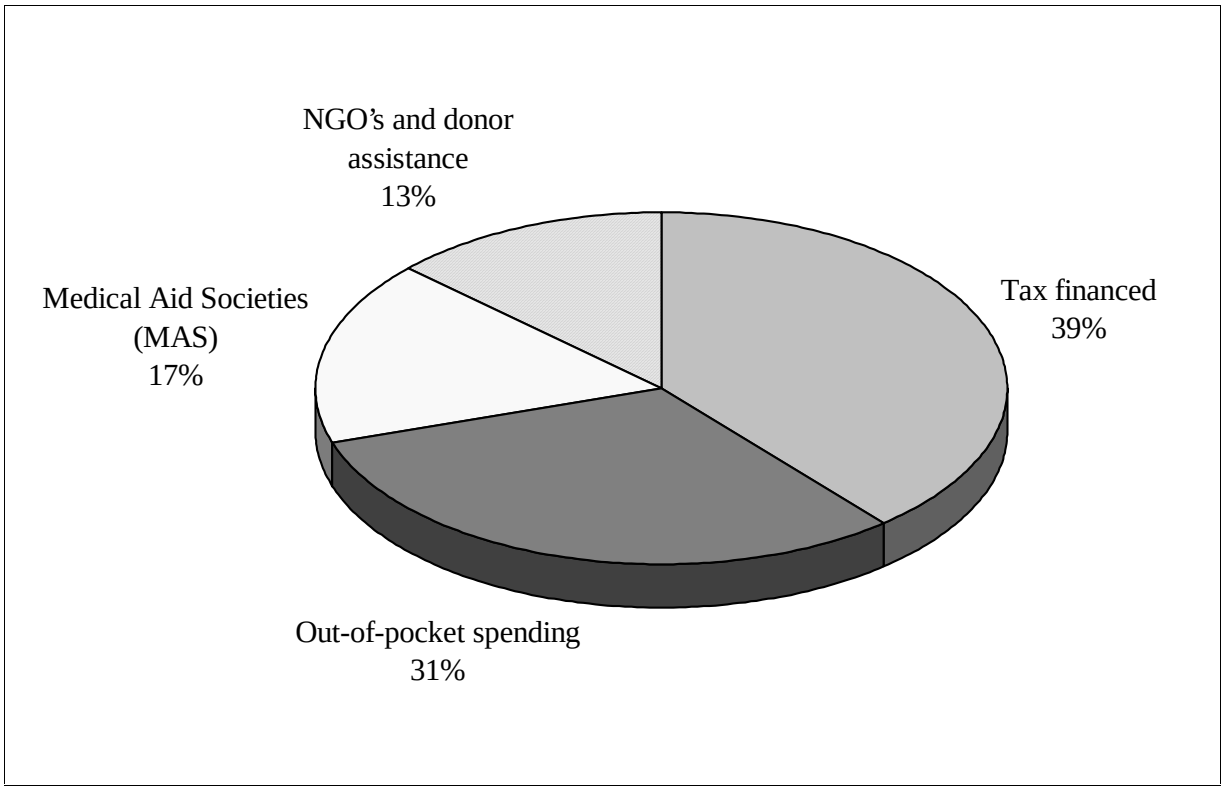
Source: based on Chawla and Rannan-Eliya (1997), p. 19

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

Roles

As Figure 7 shows, the key resources for the health sector come from general taxation and out of pocket payments from private households with approximately one third respectively, followed by the contribution of insurance premiums collected by the MAS and donor assistance.

Figure 7: Health care financing in Zimbabwe (1994)



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

The MAS offer a possibility for formal - mostly public workers - to be covered with health insurance. Most often they work through employers who contribute to the financing of the premium to some extent. It must clearly be said that so far the MAS only cover a small and the wealthier fraction of the population. The system contains elements of solidarity within societies but not between different societies which reduces the possibility of cross-subsidization. Chawla and Rannia-Elyia (1997, p. 33) characterize the MAS as "well run and efficient" with administration costs of 8 – 12 % of the turnover. As an intermediary

organization the MAS negotiates with the providers of health care, e.g. hospitals and practitioners and they can keep charges relatively low due to their large purchasing power. Adverse selection plays no role as insurance is compulsory for all employees within an organization.

Types of ppp

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

3.4 Kazakhstan and Krgyzstan2

Partners and roles

In the current discussion on the public-private mix in health care provision transitional countries do not receive very much attention. This is due to a health system in the former Soviet Union and other East-European countries in which the government did not allow other actors to play a role in health care provision or financing. The health system of the Soviet

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

Union was centralized, hierarchical and standardized. Policies, practices and treatment norms were developed in Moscow and passed to each republic for implementation. The health ministries of each republic issued directives to provinces (oblasts). The system emphasized tertiary care and specialty services. Hospitals and polyclinics received most of the resources, while primary health care was underfunded.

Given this background, Kazakhstan and Krgyszstan in Central Asia are two interesting case studies as these states have the greatest experience in reforming the health sector. The reform consists principally of four elements: introduction of health insurance schemes, cost reduction, separating service provision from financing and rationalization of health services. The core of the reform was the introduction of a mandatory health insurance fund, a capitated provider system, and the development of a basic benefit package in selected oblasts. The institutional "innovation" in the health sector was the creation of family group practices (FGP), not-for-profit, voluntary based entities which provide primary health care on a decentralized level to all family members of a group from a single location. The creation of FGP set the stage for Family Group Practice Associations, which are intermediary organizations between the government and the FGP. The FGPA's closely work together with government health services and participate in direct service provision, health status monitoring and reporting. Although in both countries the role of FGAPs includes the representation of their members and the lobbying for a better access to health services, it seems that in neither of the countries health advocacy of FGAPs was achieved.

The public sector still plays the major role in the health sector of both countries. However, due to the need and willingness of health care reformers to downsize the public sector FGPAs as not-for-profit health care providers gain increasing importance on the oblast as well as on the national level. At this point in time it is far too early to measure any detailed impact on efficiency and equity, yet it appears as if the devolution of some regulatory functions and

shared approaches to quality assurance have been useful in contributing to solve the major problems of the health sector in both countries.

Types of a ppp

The case of both Central Asian countries is very much similar to the Venezuelan case study, in the sense that the ppp is based on a relationship between the state and not-for-profit organizations. The commercial sector does not play a role at all. Moreover, in both cases a severe financial crisis has lead to the pressure for the government to devolute some of its power to the not-for-profit-sector.

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

The preliminary lessons learned from the experience with a ppp in the health sector of Kazakhstan and Krgyzstan are positive. The limitations of the former publicly controlled and driven health system can - partly - be overcome by introducing more demand based, flexible and open elements. The promotion of not-for-profit organizations operating on a voluntary basis on a local level is an important step toward that direction. A long term successful partnership will depend to a great extent on the commitment of government officials vis a vis

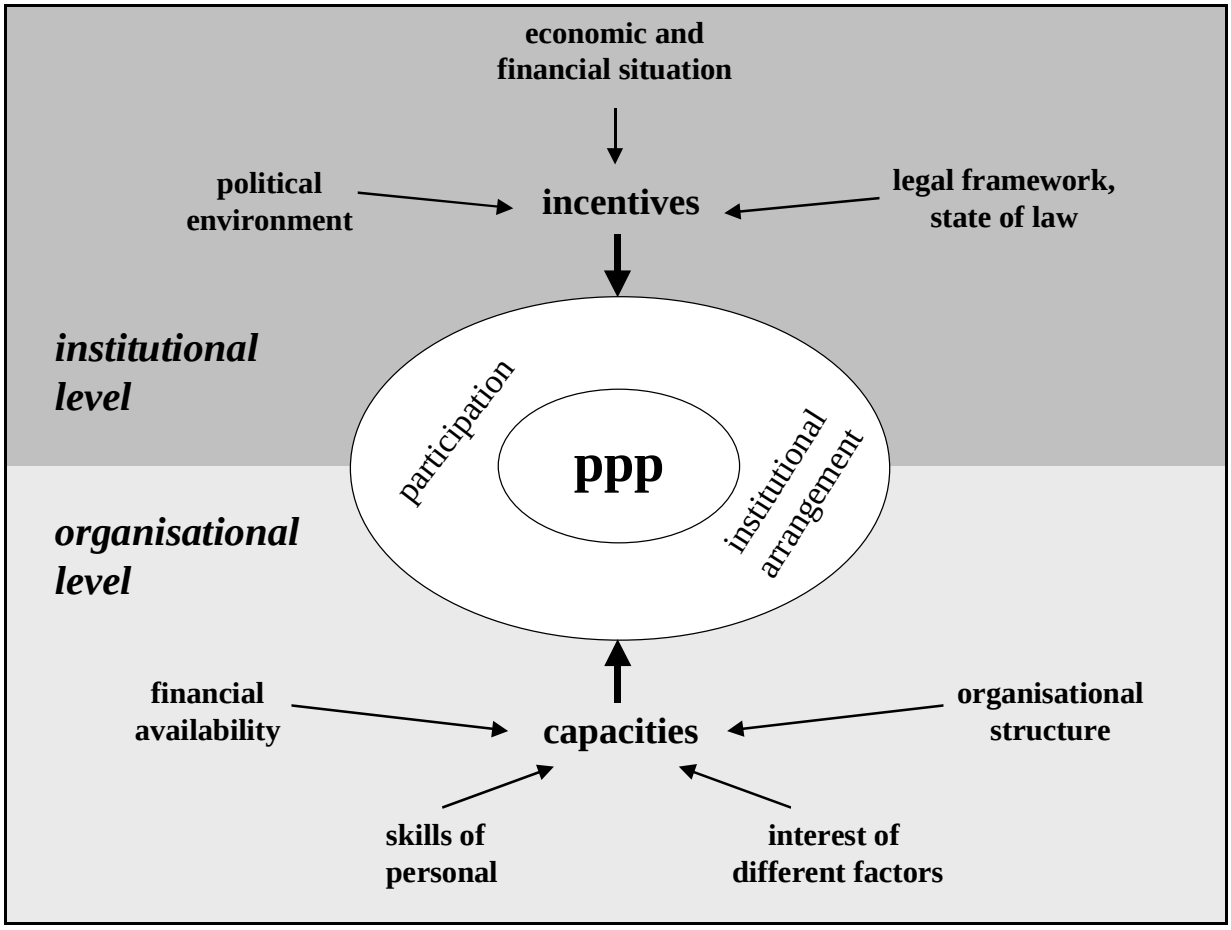
the new organization once donor support is reduced and on the ability of the new groups to dismantle themselves from the overall power of the state.

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

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

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

Figure 8: Conditions for the establishment of a PPP in the health sector



Source: Author's design

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

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

services, the financial availability for an engagement in service provision and the overall organisational and management structure have to be considered.

5 Conlusions

Despite the above described constraints regarding avaiable information and data on PPP in the health sector of developing countries some general conclusions can be drawn:

1. The provision of health care services on a basis of a PPP is still not very common in developing countries, despite its appealing theoretical advantages. In several countries the role of the private sector in providing social services is still neglected or not taken sufficiently into account.

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

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

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

5. The involvement and the delegation of power to the local level is important. Without the active participation of the communities and the municipalities it it difficult to build a functioning and sustainable health care system. Health care systems which integrate the local people in designing, providing and monitoring of services can better deal with information asymmetries and moral hazard problems. Moreover, they can use voluntary work and therefore provide services at lower costs. Finally, through such self-help

activities mid-term to long term benefits in form of a strengthening of social capital among community members might mature.

6. Country specific solutions are required. The development of a blue print on how to build a PPP in the health sector of developing countries is neither possible nor desirable. It depends on a variety of country specific conditions which set the framework for a cooperation between the different actors. Moreover PPP varies in targets, forms, process and parties. The most successful co-operative arrangements stem from a flexible approach drawing and adapting experience of other cases (Gentry and Fernandez 1998).

7. Finally, the cost side of building and monitoring a PPP should not be overlooked. The efficiency gains which are attributed to a PPP due to more competition, a more transparent cost structure or common activities could be to some extent compensated by increasing transaction costs for negotiating and monitoring of the cooperation. Future research should specifically analyse how important the costs of setting up a PPP and the monitoring are and how they can be reduced.

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