

# private sector

## Private Health

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### Policy and Regulatory Options for Private Participation

**Many developing countries face a critical gap between the demand for health care services and their supply. Public resources often fall short of what is needed to provide universal health care, and the typical incentive structure in the public sector may not always be conducive to expanding access, improving the quality of care, and ensuring efficient use of limited funding and expertise. This Note defines options for mobilizing private resources to achieve public health objectives.**

#### The range of options

A government seeking to encourage private participation in health care provision can choose among six basic policy and regulatory options that vary widely in the risks and responsibilities borne by the private (for-profit or nonprofit) entity. At one end of the spectrum the private sector takes on limited responsibilities while the public sector remains the primary provider of health care services (table 1). At the other, the government establishes a policy environment in which qualified private entities may freely enter and exit the health care market. In this option private providers assume the full risks and responsibilities associated with service provision, and the public sector limits its role to regulation.

The responsibilities that make up comprehensive health care provision can be divided into five main categories:

- Service delivery—providing specific services relating to health care.

- Management—coordinating services and administering the operation of clinics or hospitals, responsibilities that may or may not include the authority to make employment decisions.
- Asset maintenance—maintaining public facilities such as hospital buildings.
- Construction and rehabilitation—investing in constructing and rehabilitating facilities (excluding the purchase of equipment needed to provide services).
- Asset ownership.

#### Service contracts

Under a service contract a government pays a private entity to perform specific tasks. For example, a public hospital might contract a private entity to provide routine procedures (laboratory services) or specialized services (radiology) within the hospital, to complement its own operations. Or a government might contract out functions



**Table Risks and responsibilities transferred to the private sector under different options**

Responsibility	Service contract	Management contract		Lease	Concession <sup>a</sup>	Divestiture <sup>b</sup>	Free entry
		“Contract in”	“Contract out”				
Service delivery	☑	☑	☑	☑	☑	☑	☑
Management		☑	☑	☑	☑	☑	☑
Nonlabor supplies			☑	☑	☑	☑	☑
Labor			☑	☑	☑	☑	☑
Asset maintenance				☑	☑	☑	☑
Construction and rehabilitation					☑	☑	☑
Asset ownership						☑	☑
Demand risk				Sometimes	Usually	Usually	Always
Access to private finance				Sometimes	Always	Always	Always

a. Including build-operate-transfer contracts.  
 b. Including build-own-operate contracts.

such as basic preventive care or a health education campaign to private organizations operating outside public facilities.

One example is the service contracts used in the Dominican Republic to reach communities. In 1999 three provincial health directorates signed contracts with nongovernmental organizations (NGOs) to distribute contraceptives, launch an education campaign on family planning, and train health agents in reproductive health. Most doctors were not trained for such community work, and contracting this function to NGOs proved to be an effective solution. A private firm funded by the U.S. Agency for International Development supervised the contracts on behalf of the government.

Because a service contract assigns responsibility for isolated tasks, it transfers little risk to the private entity. The government remains responsible for coordinating the tasks involved in providing comprehensive health care, maintaining publicly owned assets, and making necessary capital investments.

Service contracts may be a good option for introducing a private entity’s comparative advantage (highly specialized technology, access to rural communities) in a specific task. But because responsibility for coordination still falls to the government, this option is unlikely to improve performance much if overall management is weak.

**Management contracts**

Under a management contract a government pays a private entity to manage public health care facilities and provide a range of services. The management authority transferred to the private sector varies from one contract to another and may include procurement of labor, supplies, medicine, and equipment. Because medical professionals are a key asset in health care provision, this Note distinguishes management contracts under which the public sector makes employment decisions—the “contract in” model—from those under which the private contractor makes these decisions—the “contract out” model. The contract-out model transfers the risks associated with inputs, including labor, to the private sector. Cambodia has experimented with both models in district hospitals (box 1).

Management contracts may be a good way to gain access to the technical expertise and managerial efficiency of the private sector. But because commercial risks are still borne by the government, they may create little incentive to reduce costs and improve the quality of services.

**Leases**

Under a lease arrangement a private entity typically pays the government a fee to use health care facilities and takes on the responsibility for managing and operating them. In return the private entity receives the right to the revenues from the

### “Contracting in” and “contracting out” to improve the performance of district hospitals in Cambodia

**I**n 1999 the government of Cambodia started testing contracting-in and contracting-out models in several district hospitals, transferring to private entities the responsibility for providing a minimum package of primary health care services. The private providers, selected through competitive bidding based on technical and financial proposals, are paid per person covered and according to their bidding price.

A preliminary review after two and a half years of operation shows that the delivery of service improved in both contract-in and contract-out hospitals. While a composite measure based on such indicators as immunization coverage and family planning knowledge among the population rose by 100 percent in districts with public hospitals, the measure increased by 180 percent in contract-in districts and by 320 percent in contract-out districts. Moreover, out-of-pocket health spending by patients fell by 70 percent in contract-out districts, with the greatest impact in the poorest half of the sample.

Source: Loevinsohn 2000; Bhushan, Keller, and Schwartz 2002; Fronczack 2002.

operation. Since the government no longer provides the service in the leased space, the private entity bears all the commercial risks (such as low demand for services or a change in service fees).

The government of Romania opted for lease arrangements for the provision of radiology and laboratory services in a major public hospital, completing a successful tender in 2002. The transactions have led to several benefits: lower costs for providing these services to public patients, high-quality services, full transfer of financial and demand risk from the public hospital to the private providers, and private funding for new equipment.

Lease arrangements give the private provider strong incentives to operate efficiently, because the provider's profitability depends on how much it can reduce costs while still meeting the quality standards specified in the contract. But coordination between the operating program and the investment program can be cumbersome. Thus a lease may be a good option for public health facilities that need to improve operating efficiency, but not for those that need new investment.

### Concessions and build-operate-transfer

Under concession arrangements a private entity pays the government a fee to operate and maintain health care facilities and also takes on responsibility for capital investment. Under build-operate-transfer (BOT) arrangements, a variation of the concession, the capital investment takes the form of constructing new facilities. A private firm builds the facilities, provides services, and then transfers ownership to the government at the end of a specified term (box 2). Build-lease-transfer and rehabilitate-operate-transfer schemes are also variations of the concession.

Concessions and BOT contracts, which typically last longer than other types of arrangements, provide greater incentives for efficiency by transferring to the private sector full responsibility for operation and investment. They also offer a good way to tap the private sector's ability to access private finance and raise funding for new construction and investment.

### Divestitures and build-own-operate

In a divestiture a publicly owned health care facility is sold to a private entity, and ownership is transferred indefinitely. Under a build-own-operate (BOO) contract, a variation of the divestiture, the private entity also takes responsibility for constructing new facilities at its own expense. Thus divestitures and BOO contracts transfer commercial risks entirely to the private entity and take full advantage of its access to private finance.

### Free entry

When qualified private providers are allowed to freely enter and exit the health care market without establishing a contractual relationship with the government, the private providers bear all risks and responsibilities associated with health care provision. But the absence of contractual relationships does not necessarily mean a lack of government oversight. A government may use other regulatory instruments—such as licensing, certification, and accreditation—to protect the public interest by ensuring safety and a minimum quality of care. In addition to legal requirements, a government might use financial and other incentives (taxes, subsidies, training opportunities) to influence the behavior of private providers—such as their choices of

Box

### Using a build-operate-transfer contract to build a district hospital in rural South Africa

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The government of South Africa awarded a 10-year build-operate-transfer (BOT) contract (renewable for another 10 years) to a private company through direct negotiation. The contractor is responsible for employing all administrative and nursing staff, while the government provides medical staff. The private contractor is paid a fixed per diem per patient. But the contract includes a minimum occupancy clause that shifts substantial demand risk to the government.

Source: Broomberg, Mills, and Masobe 1997.

clinic locations and target patients—to achieve public health goals.

In a policy environment allowing free entry, private providers develop their own organizational structures and operational models to achieve the best results. One emerging operational model is franchising, in which a private firm (franchiser) licenses other private businesses (franchisees) to operate under its trade name (see Ruster, Yamamoto, and Rogo 2003).

#### Variation in risk sharing

Each of the six options transfers a different degree of risk and responsibility to the private provider. In practice, however, the risks transferred by an option—and therefore the incentives created—can vary significantly, depending on the contract design, selection process, payment mechanism, and availability of subsidies.

The method used to select contractors affects the efficiency gains that can be expected from private participation. Competitive bidding generally creates stronger pressure for providing services at lower cost (see box 1).

Schemes that link payment of the private provider directly to its performance also give stronger incentives for efficiency. For example, a management contract will create strong incentives for a private entity to reduce costs and improve quality if the contract offers a bonus payment based on services provided. In contrast, such incentives may be weaker under concession or BOT schemes if the government agrees to make minimum payments regardless of the level of service provision (see box 2).

Subsidies may alter the degree of risk and responsibility transferred to the private sector. Because health care is both a merit good (a good that consumers may undervalue and therefore consume in smaller amounts than considered socially optimal) and a public good, governments and donors often provide capital investment and training to private providers. Social franchising, in which the government may construct facilities and provide training, is a type of BOO arrangement that deviates from the typical risk sharing profile of such schemes.

To maximize the benefits of private participation, a government therefore needs to determine which option is best suited for achieving its policy objectives—and then choose the most appropriate contracting and payment mechanisms and the best regulatory framework for monitoring and enforcing the arrangements.

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## viewpoint

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