Leveraging the Private Sector to Strengthen Public Service Delivery

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I. Introduction

Governments worldwide are under public pressure to provide universal access to affordable, reasonable quality health care. This poses challenges for most governments including the role of the state in health care delivery, levels of coverage for people who cannot afford to pay out of pocket, and most particularly the ability of the state to subsidize health care costs. As a result, many governments turn to private sector health insurance and service providers to complement public health care provision.

Private sector financing and delivery of health care exist in all nations. Private sector financing includes patients' out-of-pocket payments, private insurance, and free or reduced cost health care delivered by charity hospitals/clinics. On the health care delivery side, private hospitals, clinics, pharmacies and indigenous practitioners could be major suppliers of health care.

The private sector could strengthen the delivery of public health services, but it could also be a hindrance. That depends on whether the government knows how to harness the strong points of the private sector to serve the well-being of society. The private sector may possess the capital and the desire to invest in health facilities, as well as superior knowledge and management skills to manage insurance operations, functions of hospitals and clinics, and construction of facilities. The private sector could also be relatively free of corruption in its operations. On the other hand, the private sector could damage the publically financed health services delivered by private providers charging exorbitant prices, garnering excess profits by exploiting patients' ignorance of medical needs, and siphoning off the most skilled physicians and nurses from the public sector with much higher compensation.

"Private sector" is a broad term. By their nature, private sector organizations, including for-profit, charity (non-profit) and hybrid entities, behave very different than public sector organizations. We should clearly recognize that for-profit organizations have the obligation to produce the highest profit for their investors (e.g. stockholders.) and they may use any legal means to generate the largest profit. The organizational goals of charity organizations are different; they are not pursuing profits but instead, they aim to financially break-even while serving noble social purposes. Hybrid organizations could be pursuing profits as well, but a portion of the profit is allocated for charity, such as providing free health services for the poor. Well-known examples of these organizations are the Aravind Eye Hospital and the Narayana Heart Hospital in India.

This note serves two purposes. First, it gives a concise explanation of the roles of the private sector in public health care by organizing private sector activities into different types. We examine the *evidence* of the contributions, if any, that the private sector has made for public interest. Second, we present vexing health policy problems confronted by three nations and asking whether these nations can be better off by leveraging the private sector to deliver public health services. If so, how should they do it?

II. Types of public service delivery by the private sector

Historically, most nations have had a mixture of public and private financing and provision of health care. In developing nations, we have a large number of faith based charity hospitals and clinics. However, the public and private sectors had traditionally been very much separated. The government financed, directly managed and delivered health services in public facilities, while private providers charged patients directly for services delivered in private facilities. Often, the publicly financed and directly managed public facilities were inefficient and not responsive to patients' preferences because they were public monopolies and managed with rigid bureaucratic rules. In the worst cases, political interference, patronage and corruption crept in.

The following are the major types of how private sector engaged in public health services:

1) Purchaser/Contractor model for public health services

A new idea of how to reform publically financed and directly managed public health facilities swept the world 25 years ago: separate financing from delivery of services. The government would finance health care for equity reasons or/and for pooling risks, but would purchase/contract from public and private providers for the provision of services. This required autonomous governance of public facilities so that public facilities can compete with private facilities on costs and quality of health care. In this model, the government reduces its bureaucratic management of public hospitals and replaces it with management by independent boards with community representatives. A good example is England's Foundation Trust model. The purchaser (e.g. England's NHS) represents the public interest and negotiates with the public and private providers for the lowest prices and the best outcomes performance.

This new conceptual approach brings up an array of complex issues such as: 1) Who can be the most effective purchaser for the public interest? 2) What information and negotiation skills must the purchaser possess? 3) How much is the administrative cost for purchasing/contracting versus directly managing public facilities? 4) How can quality of health care and health outcomes be defined, and what quality and health outcomes can be measured for a contractual agreement?

Current evidence about the benefits of the purchaser/contractor model varies from very positive to negative, depending on the types of services to be contracted and the ability of the government to negotiate and contract as compared to its capability to manage and deliver public health services. The most positive results of the purchaser/contractor model were found in war torn nations after World War II where public health services may have largely been destroyed. In those situations, the government uses donor funds to purchase vaccination and maternal and child health services from private sector providers. There are also several cases of success when purchasers use pay-for-performance payment methods for delivery of primary care services or for delivery of selected medical services such as imaging tests and hip or knee replacements. On the other hand, there have been numerous cases where the purchasers paid excessive prices and received low quality services from the private providers.

2) *Concession model*

Concession is a relatively new approach to leverage the private sector for public service delivery. When a government has difficulties providing adequate capital investments for public health facilities, it may give a long-term concession to a private for-profit firm to jointly fund public facilities and for the private firm to manage the facilities. The firm will receive a guaranteed annual payment for delivering a specified minimum volume of specified quality of health services. If the private firm can improve the productive efficiency and reduce costs, the firm can earn a handsome profit. Meanwhile, the government would not pay more than what it originally budgeted for. The concession model can have various degrees of concession. The best-known case is the Lesotho case which is described in greater detail below. Brazil and Egypt have also tried the hospital concession model. However, the concession model is a recently developed approach, we do not have solid and objective evidence about its performance.

<u>Lesotho Case</u>

By year 2000, it became apparent that Lesotho's national referral hospital in the capital, Queen Elizabeth II Hospital (QEII), had to be replaced. According to Timothy Thahane, the Minister of Finance of Lesotho at that time, the deteriorating infrastructure and high hospital operating costs forced a large number of patients to be transferred to nearby South Africa for treatment. At the same time, doctors were also leaving for South Africa because of the poor working conditions and low compensation. The Lesotho government had to address these serious problems. However, the government lacked adequate funds to rebuild the capital's hospital and to increase physicians' compensations. Minister Thahane made a case for leveraging private sector investment and management know-how to rebuild and renew QEII. He had to overcome the strong reservations of

governmental health leaders and health professionals who had looked at health care as a government responsibility with little role for the private sector.

After a long deliberation, the Lesotho Government issued a tender for private sector investment, posing the following question to the private sector: for the level of expenditure at QEII at that time, how much would the private sector be willing to invest in a hospital, and how much more could the private sector provide in volume, quality, and range of medical services? Several private companies rose to this challenge and bid on the project.

Lesotho lacked lawyers, financial experts as well as negotiation experts to negotiate and prepare contracts. Consequently, Lesotho relied on the analysis and advice from the consultants provided by the International Finance Corporation, the private financing arm of the World Bank, in the negotiating and contracting.

Tsepong (Pty) Ltd, a consortium comprised of the private South African hospital operator Netcare and local partners won the bidding. The resulting contract, signed in 2008, was a concessional package with a joint private and public investments and private management of a new hospital. Tsepong would finance 62.3% ($95.4 million) of the new capital investment needed, with the Lesotho government providing the remaining 37.7% ($57.7 million), for a total investment of $153.07 million. Tsepong would be responsible to design, build and construct a 425-bed (390 public beds, 35 private beds) hospital, the Queen 'Mamohato Memorial Hospital (QMMH) to replace QEII. Tsepong would also responsible for the renovation, re-equipping, and operation of three primary healthcare filter clinics in the capital area. Private and public beds would differ only in their amenities (e.g., privacy, television).

Under the contract, Tsepong would manage and provide all clinical and non-clinical services for QMMH for 18 years. The government would pay Tsepong an annual fixed service payment of $30.3 million towards capital repayment, operating expenses and for delivery of all services, indexed to increase with inflation rate. The unitary payment decided upon was based on the number of outpatients and inpatients treated. The contract would require approval for any patients that exceeded the aforementioned agreed number of patients. According to government officials who were involved in the negotiation, this initial annual payment is approximately equal to what the government expected to pay for services of QEII. After eighteen years, QMMH will be turned over to the government. Maintenance and replacement schedules were also established in the PPIP contract such that equipment and technology will still be current at the end of the 18-year contract in 2026.

Tsepong agreed to treat all patients who present at the hospital and 3 filter clinics, up to a maximum of 20,000 inpatients and 310,000 outpatients annually. The private operator is

responsible for the delivery of all clinical services with only a few exceptions. Tsepong has full authority over human resources, including the recruitment and retention of doctors, nurses, and other health professionals; it also responsible for all medical equipment, pharmaceuticals and supplies. Under the contract, patients can be seen at QMMH only by referral, either from the three filter gateway clinics, or from other district hospitals or private practitioners. The QMMH referral system was developed to support a primary care based health care system that directs patients to the primary care clinics and they refer complicated and serious patients upward. Such a system would be most cost-effective and also manage the demand for hospital services.

Under the terms of the contract, QMMH and the 3 filter clinics would collect the Ministry of Health set user fees from patients. Tsepong would remit these fees to the national Treasury just as public district hospitals and health centers do. User fees at QMMH remain the same as at any other public facility in the country, thus achieving cost neutrality for the patients.

The project has an independent monitor, a unique role specifically jointly created and appointed for this project by the government and Tsepong. This monitor performs a quarterly audit of Tsepong's performance against the contractual performance indicators and determines penalties where performance has not been achieved.

Interim Result: The new hospital, QMMH, was constructed successfully and started its operation with some delay in October, 2011. However, there is a controversy about whether QMMH is achieving its original goals. The hospital reached its maximum capacity very early when its tertiary services attracted patients to flock to the hospital without proper referrals, regardless of whether they needed the expensive and sophisticated tertiary services provided by QMMH. Resources were thought to be wasted while other patients who needed QMMH services were not able to access them. To mitigate that situation, the Lesotho government realized that it had to reform its whole health care system for QMMH to function properly as a tertiary hospital. As a result, while QMMH were opening its doors in 2011, the Lesotho government also undertook a major investment and effort to renovate and improve more than 150 health facilities, including 138 primary health centers.

3) *Outsourcing models*

Managing and operating a social health insurance program require capable managers and many experts, including physicians, actuaries, insurance risk analysts, information technologists, claim operation managers, accountants, etc. International experience shows that may take a decade for a new social insurance program to establish sound operating systems and a capable administrative organization.

Managing and operating a large hospital faces a similar challenge. Hospital management consists of a set of complex functions. It requires a team of leaders who understand clinical medicine and how to organize, motive, and manage the back-bone of any hospital-- the numerous physicians who are autonomous professionals. At the same time, the hospital has to satisfy patients' expectations and demands, assure quality of services, maintain its financial soundness, plan its future, etc. Operationally, hospitals are not just providing medical services, they have to run hotel services for hundreds if not thousands of patients, food, laundry, internal security, IT services, etc. Hygiene and sanitation are also of paramount importance.

When does the government possess the know-how and the capable human resources to manage and operate social insurance programs or public hospitals efficiently and effectively? If a government does not have the capability, would it better for the government to outsourcing the function to the private sector? In some cases such as food service and cleaning, private companies specialize in these particular function might enjoy the economies of scale and can produce the service cheaper.

For efficiency and effective gains, many nations outsourcing several key functions to the private sector. We give illustrations of three types of outsourcing:

A. Outsourcing administration of social health insurance

Fifty years ago, the USA established the social health insurance for the elderly (i.e. the US Medicare program). The government decided to outsource the administration of the health insurance to private health insurance firms because the government lacked the knowledge, technical expertise, and skills to manage such a large and complex insurance operation that involved more than 400 million of medical interactions between patients and physicians/hospitals each year. The United States also decided to outsourcing for political reasons; it reduced the opposition of the health insurance industry against the passage of the Medicare program.

For developing nations where the government's capacity is weak, particularly if patronage and corruption is widespread, the government will not be able to administer any social health program efficiently and effectively. The nation has to consider leveraging the private sector to implement and administer the country's social health insurance program. Recently, when India introduced its social health insurance for the poor, it also outsourced the insurance administration to private firms.

However, nations that have capable and effective governments found the costs of public administration of universal health insurance are less than the private sector. It incurs less administrative costs. Good cases include Canada, Taiwan and China.

B. Outsourcing specific departmental functions

The government can outsource certain functions to private firms and improve the efficiency and quality of public health services. Sometimes private firms can specialize in the production of certain products or services at a lesser cost. For more than thirty years, public and private hospitals in advanced economies found that outsourcing cleaning, laundry, internal security, and food services to private firms that specialize in these services can reduce their costs. More recently, small hospitals and clinics found that outsourcing laboratory services to private clinical laboratories can reduce their costs.

C. Outsourcing management of public facilities

Outsourcing hospital management is a more recent type of outsourcing to gain greater efficiency is management. A good example is Battagram, a poor district in Pakistan, which wanted to improve its primary healthcare services through better management of the public facilities and health workers. The Department of Health of Battagram contracted out management/delivery of primary healthcare services to a NGO--Save the Children USA. Battagram used donor funds to contract the NGO who agreed to provide a package of primary care services. The NGO was given the full administrative control of the staff and operations of the district health facilities, responsible for paying the staff and procurement of medicines, supplies and equipment. It's one of the few contracting arrangements where salaries of government staff were paid through the NGO.

With the flexibility to use funds across budget lines, Save the Children paid staff a salary based on the market rate—roughly triple the government rate—plus a bonus for good performance. The NGO was able to increase the number of medical staff by 53%, especially recruiting female health staff and strengthening community-based outreach to address gender constraints in a traditional society. As a result, people gained much greater access to primary care. Pakistan plans to replicate this outsourcing of management to other districts.

For your discussion, we prepared three cases below to illustrate the issues confronted by some nations:

Kenya

Kenya, a nation of 41 million people, has made significant improvements in prevention and primary care that resulted in impressive reductions in infant mortality and controlling HIV/AIDS. Kenya has also been planning a national health insurance (NHI) program to achieve Universal Health Coverage (UHC) by 2030. In this effort, it has chosen to prioritize the coverage of poor people and maternal health care first. Meanwhile, the new Kenyan Constitution has decentralized

the budget, power, and responsibilities from the national government to forty-seven counties. As a result, the management and operation of public health services (staff and facilities) is being devolved to the counties. The NHI plans to purchase and contract public and private providers for services. The key question is: should Kenya rely on the existing government social health insurance agency—the National Hospital Insurance Fund (NHIF) — to administer the National Health Insurance?

The NHIF was established in 1966, aiming to eventually offer a social health insurance to all Kenyans. However, NHIF suffered a long history of mismanagement with patronage and corruption. NHIF spent more than one-half of its annual premium revenue for administrative expenses, while the international average is about 10% for developing nations. In the 2003 scandal when the Euro Bank collapsed, the biggest casualty was the NHIF, which lost Sh479 million of its insurance reserve fund in the collapse. Executive members of the NHIF were accused of being involved in the collapse of the bank itself. More recently, in 2011, the NHIF was supposed to use tenders to purchase and contract the most competent and efficient providers. However, the Parliament's subsequent investigation showed that the NHIF awarded Sh318 million to two controversial private firms operating private clinics. The Central Organization of Trade Unions revealed that the NHIF money was awarded to some non-existent clinics while it was also found that 77 illegal clinics were licensed to receive money from the NHIF.

Recently, Kenya is trying to reform the NHIF agency with changes in governance, organization and management. The reform of the NHIF is moving forward, albeit slowly. The latest figures show that the NHIF still spend 40% of its premium revenue on administrative costs.

What would you do as the Kenyan Minister of Finance? Given the NHIF is the only public agency with the technical know-how to administer National Health Insurance, would you give the administration of the National Health Insurance to the NHIF or outsource the administration to a private insurance firm?

South Africa

South Africa is a middle income nation with two separate health systems. Sixteen percent of the people, mostly affluent households, pay for private health insurance to finance their health care. They obtain their health services from private clinics and hospitals. Each year, roughly one-half of South Africa's total national health expenditure is spent on this 16% of the population. The other eighty-four percent of the population relies on publically financed and publically managed health care. There is a great disparity in health care between these two groups.

The South African government has been planning the introduction of a National Health Insurance program (NHI) since 2011 to achieve UHC, advocating healthcare as a public good

that should be provided by the state. NHI's aim is to ensure that South Africa progresses towards UHC and all its citizens have access to appropriate, efficient and quality health services.

South Africa faces poor management, inefficiency and corruption in its public health services. According to Health Minister Aaron Motsoaledi, the most corrupt health departments among the nine provinces in the country are Limpopo, Gauteng and the Eastern Cape. For example, in early 2013, newspapers reported a set of devastating corruption incidences in the Eastern Cape Health Department: 544 of the 8,034 department workers were suspected to be ghost employees, 929 department employees were listed as suppliers for the health department, 235 had received payment of R42.8 million from the department for unidentified purposes. The department said there were 35 spouses of employees doing business with the department, and linked to 35 companies which received payments of R11 million.

Similar to the provincial health departments, in some provinces, public hospitals also experience mismanagement and corruption. Public hospitals are highly stressed institutions with poor quality of health services due to inadequate funding, staff shortages, unmanageable workloads and management failures. Meanwhile, the healthcare outcomes produced by South Africa's private healthcare sector have been such that it has been ranked alongside the healthcare sectors of countries such as Australia, Sweden, Belgium, Switzerland and Ireland.

The Ministry of Health is currently fully committed to better governance and management to root out corruption, as well as improving efficiency and quality of health care delivered by the public facilities. The Ministry of Health is also likely to be responsible for the implementation and management of South African National Health Insurance (NHI) when it passes into law.

Given the lack of experience and technical capacity in the government for administration of the NHI and the history of corruption within some provincial and district health departments, what would you do? Would you entrust the administration of the NHI and service delivery to the government or would you outsource them to private entities?

Ghana

Ghana implemented a National Health Insurance Scheme (NHIS) in 2004 to provide more equitable access and financial coverage for basic health services. People have to pay a premium to enroll into the NHIS and the premiums vary with household income; children under age 18 and elderly over age 75 are subsidized by the government and they do not have to pay. Most people are enrolled through the District Mutuelle Health Insurance Scheme (DMHIS) which operates in every district in Ghana. Each DMHIS is in charge of accepting and processing memberships, collecting premiums, and processing claims from accredited facilities. The benefit package offered by the DMHIS is comprehensive, covering up to 95 percent of disease conditions in Ghana.

The NHIS has brought many organizational and management challenges to DMHIS and hospitals. It has been reported that 72 percent of all DMHIS lacked the appropriate and adequate human resources and specialists for insurance operations, financial management, claim payment, and data management. Consequently, there has been a 3-6 month lag period between enrollment and receipt of an insurance card. Without the card, the enrollee is not eligible for benefits. As a result, many enrollees would not re-enroll. By 2010, only about 34% of the total population was an active NHIS enrollee. Providers also complained about long delays in receiving claim payments for services rendered and drugs provided. DMHIS suffered from large financial losses from low enrollment, payment of fraudulent claims for services and drugs, and high administrative expenses. The NHIS faced with deficit of more than GHC47.3 million by the end of 2011.

In 2011-12, Ghana debated a new law to reform the administration of NHIS. What would you have advised the government of Ghana to do? Would you have recommended that the administration of the NHIS be outsourced to a private entity?

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