

**An Overview of
Public Private Partnerships
in Health**

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In today's world of complexity and rapid pace it is almost impossible to do anything alone. This is especially true in health where constantly rising prices, changing disease patterns, and increasing use of sophisticated technology for diagnosis and treatment have made it virtually impossible to imagine any single organization providing services without some type of institutional partnership. These partnerships may take many forms, ranging from global partnerships between multinational companies and multilateral donors to local partnerships between private physicians and government clinics. The partners, too, may vary from private—for—profit companies, not—for—profit organizations, governments, donor organizations, to community groups. Partnerships may vary in terms of financing from millions of dollars to the sharing of non financial resources. However, all partnerships have one thing in common: they have come about because both partners believe they have something to gain from the partnership agreement. This paper looks at why these varied types of partnerships have formed, what are the various models of partnership, and what are some of the challenges that they face in Asia and the Pacific. First, however, we will agree on a common terminology of what is meant by a partnership.

What is a partnership?

In its most general terms, a partnership is an agreement between two or more parties. However, most partnerships are more formal than merely a handshake or verbal agreement, and require a written agreement that specifies the reciprocal rights and obligations of each party, the objectives of the partnership, and how the partnership will be managed or governed. Put simply, a partnership is “a relationship based upon agreements, reflecting mutual responsibilities in furtherance of shared interests.”¹ Two elements of this definition are critical: one is the specification of the shared interests or objectives of the partnership.

Partnerships only work when both parties benefit from the relationship, and the expected benefits are made clear in advance. A second key element is the mutual responsibilities. Partners must understand that they will share both the risks and the benefits of any joint venture, and how this sharing will occur must also be specified in advance.

If partnerships are to be successful, and have both clear mutually agreed upon objectives and risks, there are some underlying characteristics that must be in place. In their article on global partnerships, Buse and Walt summarize these characteristics as follows:

- (1) *clearly specified, realistic and shared goals;*
- (2) *clearly delineated and agreed roles and responsibilities;*
- (3) *distinct benefits for all parties;*
- (4) *the perception of transparency;*
- (5) *active maintenance of the partnership;*
- (6) *equality of participation;*
- (7) *meeting agreed obligations.*²

This list is very similar to a list that was prepared as a joint exercise by a conference held by The Asian Development Bank Institute on Public-Private Partnerships in The Social Sector in Japan in July, 1999. The list that was developed at that conference was in response to the question: *What is needed for successful Public Private Partnerships in the Social Sector?* The responses from the workshop are shown on the next page. What is most striking about these two lists is the emphasis both place on transparency and accountability and on a common understanding between the parties of what is expected. The implication of this element is that successful partnerships will in many cases require a reevaluation of the partner organization in terms of transparency, accountability, and forthrightness in defining expectations both of itself and of its partners. In many Asian countries, this is true both in the private and public sector.

¹ Shaping the 21st Century: the contribution of development cooperation. Paris, OECD, 1996.

² K. Buse and G. Walt, *Global public-private partnerships: part II –what are the health issues for global governance?* (Bulletin of the World Health Organization, 2000, vol. 78, no. 5, p.704)

What is needed for successful Public Private Partnerships in the Social Sector?

*responses from The Asian Development Bank Institute conference on
Public-Private Partnerships in The Social Sector, July, 1999 Tokyo, Japan*

Legal and regulatory framework

- Legal and regulatory framework.
- Common regulation in public – private.
- Minimum standards for quality of services.

Transparency and Accountability

- Accountability and Monitoring.
- Transparency and Fairness.
- Social accountability.
- Competition for inputs and outputs (both).

Suitable Public policies

- Policies / Rules. Regulations / Law. (Government).
- Enabling environment.
- Continuity of policy.
- Avoid duplication.

Commitment to Public Good

- Private Sector
- To provide non-profit services.

Common Understanding

- Clear demarcation of responsibility.
- Clear objectives and efficient organization on the structure (both).

Sharing of Resources

- Mutual benefit.
- Incentive and concessions.
- Joint projects in system improvement (public – private).
- Share cost and responsibility.
- Communication and information sharing (public + private).
- Provide manpower and financial resources (both).

Consumers and Community

- Consumer's informed choice.
- Community involvement in planning and monitoring of services.
- Consumer participation

Thus we find that a partnership is an agreement between two or more partners with a common interest in some outcome of the partnership, a common understanding of what is expected from each partner, and a belief that each partner will perform in accordance with the agreement that has been established. Partnerships, to be successful, require work, transparency, and a shared set of operating principles among the partners. It is often difficult to be a good partner.

Why partnerships?

Given the effort that is required to form and maintain a successful partnership, one might sensibly ask why bother. This is particularly true, given the air of mistrust that has typically existed between the private and public sectors in health. There are three primary reasons that partnerships in health have become a major force in health care. These are

- a shift in philosophy about the roles of the private and public sectors;
- a recognition by both the public sector and private sectors of their interdependence; and
- a better understanding of how each party can gain from partnership.

Shift in philosophy

In the past, the private and public sectors in health operated more or less independently in most countries. The theory was that the private sector provided services mostly to the wealthy in any country, while the government served the poor who were unable to pay for services. However, recent evidence has suggested that this model does not accurately represent reality, and that the private sector often is the primary source of treatment for the poor while the government system often provides far more services to the rich than the poor.^{3, 4, 5} From this evidence, and from recent work done by the World Bank⁶ in which an analysis is done of who receives the major benefit of government spending, it now appears that in fact the government is not really providing a safety net for the poor and furthermore, it would appear that it is often the wealthy urban population rather than the poor who benefit the most from government spending. This is largely because such a large portion of health care budgets in all countries is spent on sophisticated hospital care, usually found in urban settings, rather than primary care or preventive care that serves the needs of the rural

³ Nancy Birdsall and Estelle James, "Health, Government, and the Poor: The Case for the Private Sector" World Bank Policy Research Paper, (1992)

⁴ Peter A. Berman, "Rethinking Health Care Systems: Private Health Care Provision in India." *World Development* 26:1463-1479 (1998)

⁵ D.R. Gwatkin, Health Inequalities and the Health of the Poor: What do We Know? What can We Do?, Bulletin of the World Health Organization, 2000, **78**, (1), pp. 3-17

⁶ J. Knowles, Benefit Incidence Analysis of Safe Motherhood Services in Vietnam, WBI Core Course materials.

poor. The result is a predominance of resources used for upper income, urban groups with little left over for the kinds of programs that are geared towards basic health services.

At the same time, as countries have trained more and more doctors, newly trained doctors are finding the prestigious specialty jobs in urban settings are more difficult to find, and so are beginning to start private practices in the more rural areas. Indeed, in many countries in Asia, we find that over half of all health services are provided by private providers, as the following chart⁷ indicates.

	GDP	per capita spending on health	% of health expenditures that are private
Bangladesh	\$270	\$13	54.0%
India	\$390	\$23	87.0%
Pakistan	\$490	\$17	77.1%
Indonesia	\$1110	\$18	63.2%
Philippines	\$1220	\$40	51.5%
PNG	\$940	\$36	22.4%
China	\$860	\$20	75.1%
Thailand	\$2800	\$133	67.0%
Malaysia	\$4680	\$110	42.4%
Korea	10,550	\$700	62.3%
Vietnam	\$320	\$17	80.0%
Singapore	\$32940	\$876	64.2%
<i>source: WHO: World Health Report 2000 (figures for 1997)</i>			

For this reason, many of those who in the past supported a pure government system on philosophical grounds are now more willing to consider the private sector as an integral part of the national program, and find ways that partnerships can be used to make the entire system more productive.

Another shift in philosophy has occurred with regard to the private sector. Whereas most developing country governments and most donors paid very little attention to the private sector in the past, the recent focus on health sector reform has shined a spotlight on the role of the private sector, and especially on the qualities of innovation and efficiency that

⁷ source GDP: World Bank 1998/9 World Development Report—figures for 1997, Health figures: WHO: World Health Report 2000 (figures for 1997)

are generally seen as more common in private enterprises than in government bureaucracies. It is generally felt that the private sector, as a result of the competitive environment and the subsequent need to survive, is more able to respond to change and more able to deliver services at low cost when there is an appropriate stimulus to do so. Thus, as cost pressures and the need for change have been increasingly felt by the public health sector, they have looked to the private sector both for models of how to delivery services more efficiently, and also as a source of innovative approaches to reaching hard to serve populations.

From the donors perspective, too, there has been a change of perspective. At one time, most donors felt that money should only be given to the public sector since the primary goal of donor funding in health is to ensure services that serve the poor. However, both frustration with the ineffectiveness of many Ministries of Health, and a belief in the free market as the ultimate source of efficient, effective services led many donors to favor funding that went to either non-government organizations (NGOs) or even to private companies that delivered services to the poor. This led to a growth of the international NGO community as well as the growth of techniques such as social marketing that uses private-for-profit companies to achieve social goals. Today, donors better understand both the strengths and limitations of the private and public sectors, and thus have shifted to a sector-wide approach in which both private and public sector have an important role to play.

Interdependence of the public sector and private sectors

Perhaps there was once a world in which the private and public sector were completely independent, but today that world does not exist. There is probably no country in which the private sector is not deeply affected by government regulations and laws, by policies on practice and pharmaceuticals, and increasingly by government funding of private services. Similarly, almost all governments today rely on the private sector for pharmaceuticals and equipment, and increasingly contract with private (often not-for-profit) organizations for training, IEC development, and often for direct service delivery in areas where the government does not provide services.

Furthermore, as government programs move toward social insurance programs and contracting mechanisms as ways to expand coverage, the interdependence of the public and private sectors has deepened. Governments are increasingly directly funding private

providers and service delivery institutions to expand the impact of their programs in areas such as childhood immunizations, antenatal and maternity care, family planning, and infectious disease reporting and control.

Governments have also become more rigorous in their regulation of the private sector in a effort to ensure quality, access and controlling price. Since regulations affect who can provide medical care, what types of treatments are acceptable, pricing, taxation, and other elements of the health care industry, the private sector has learned to work within the regulatory boundaries that are set by the government. A more complete discussion of regulation is presented on page 21 of this paper.

This interdependence of governments and the private sector has led to a change in the relationships between the two. Although often still mistrustful on each other, both government and private organizations have had to learn how to work together, making it possible to work as partners rather than as adversaries. The interdependence has also made each sector understand how cooperation and partnership might be mutually beneficial despite the effort that is required to maintain the relationship. Although many governments and private organizations find the need for trust and transparency difficult, they also recognize that their interdependence must lead to an environment of mutual cooperation.

What each partner gains

Forming partnerships, especially among partners that have a history of mistrust requires significant effort; an effort that will be invested only if all partners believe the partnership is in their long term interest and therefore worth the investment.

Although not the only incentive, by far the most common reason for the development of a partnership is financial. This might take the form of increasing resources (for example as direct payment for service delivery) or through reductions in cost (for example contracting for food services in a hospital.) In either case, each of the partners sees a long or short term financial gain that will come about from the partnership. In some cases, the financial mechanism is simple, as in the case of a contract for food or cleaning services at a public health facility. The expectation is that the contracted service can be done more cheaply through a private contractor than doing it directly with government employees. The savings in this case comes about from greater efficiency of the private cleaners who are not bound by

government policies on hiring, firing and conditions of service and so have a cheaper labor pool to do this type of work.

However, financial arrangements may also be very complex and may involve savings from third parties who are unintentionally a part of the partnership. This is often the case in international drug donations. An example is the program by Pfizer to donate Zithromax® for use in trachoma prevention programs. In this case, a very expensive drug is donated free of charge to an international trachoma control program that serves a very large number of people who would not otherwise be able to afford the treatment. The financial benefit to the program, government, and populations is clear. The benefit to Pfizer is more subtle. In this arrangement, they donate the drug at market value to a US based charitable organization, and are therefore able to deduct the price of the drug from their tax obligations to the US government. Through this mechanism, the US Government is subsidizing the distribution of Zithromax® for use in Trachoma prevention program, and are thus an inadvertent partner in this activity. In fact, this type of financial arrangement is very common, and the financial benefit of private multinational companies such as Pfizer is often difficult to understand. The important point however is simply that most partnerships are built on the basis of mutual financial gain by both partners.

Although often the financial benefits are direct, they may also be indirect. For example, a private company (or sector such as pharmaceuticals) may enter into a partnership with the government in order to ease the regulatory control over the industry. An example of this may be to streamline to approval process of new drugs or equipment in partnership with the industry's making all industry information on these products available to the government. A similar indirect benefit may come to a donor government who is willing to support partnerships between its private companies and host governments in the interest of opening new markets for its national industries. Again, the financial benefit to the donor country is indirect, in the form of new investment opportunities for its companies.

However, financial gain is not the only benefit of partnership, and in many cases of partnership, other considerations provide the incentive. A common one is the transfer of technical knowledge between partners. This is often the case in partnerships between the public sector and NGOs, where both partners have knowledge and skills that is useful to the other are able to learn from each other.

In their paper on global partnerships⁸ Buse and Walt discuss many other non-financial reasons for partnerships, noting that the benefits of the partnership are often a function of the type of partner involved. In the case of the private sector, the reasons may range from publicity for philanthropy, legitimacy in terms of working with respected organizations, research that they can use in the future for product development, or enhancement of brand or corporate image or name recognition through donation programs. For multilateral organizations such as WHO, UNICEF, or the World Bank, the partnership may provide knowledge and skills from leading corporate sponsors, legitimacy for technical and moral leadership, or enhance the agency's influence in a particular technical area or country program. These agencies are also interested in partnerships that will have a demonstrable impact on improving global health. For countries, the benefit may be access to products they could otherwise not afford, improved infrastructure that promotes development, incremental resources with less "red tape", knowledge and expertise that the private sector can provide, and crucial linkages within a country to the business community with whom they must work. For non-government organizations (NGOs) the benefit may be enhanced opportunities to work in a country, national or international legitimacy, or the ability to learn from larger players how to expand their programs on a national and international level.

Thus, there are many, many different ways that partners can benefit from partnerships. The most common by far is financial, but as partnerships have grown more complex, the benefits may include many other elements such as prestige, influence, and publicity that are not directly financial. Nevertheless, it is important to once again stress that successful partnerships have mutual benefits for all parties, and these benefits must be explicit and transparent. Partnerships that are formed in which one side benefits and the other side does not are not sustainable and will not be successful.

⁸ K. Buse and G. Walt, *Global public-private partnerships: part I – A new Development in Health?* (Bulletin of the World Health Organization, 2000, vol. 78, no. 4, p.549-561)

Types of Partnership

Types of partnerships are as varied as the organizations that participate in them. For the purpose of classification, I will introduce four dimensions by which we can describe the partnerships. These are:

- **Scope**
- **Partners**
- **Level of commitment**
- **Type of objective**

Scope

Although there has been increasing attention to partnerships between large multinational companies and international agencies involving broad strategies and large sums of money^{9, 10, 11}, most partnerships are more modest and very operational, occurring at the local level in the form of a contract or financing agreement. Thus, the first dimension of partnership that we will consider is scope.

In general terms the scope of a partnership will be at one of three levels: local, national or global. At the local level individual organizations, public and private will work together to achieve some goal. This may be an agreement between a mission hospital and a government clinic to provide services jointly or have a coordinated system of referrals. This may be a contract between a local food company and a public hospital to provide food to the patients. What typically characterizes local partnerships is that trust and agreements are primarily formed on the basis of individual relationships rather than institutional ones. For this reason, the partnerships work well as long as the individual relationships work well, but these types of partnerships can easily break down when, for example, one of the principal parties is transferred to another location. Another feature of these local partnerships is that they are typically less complex than national or global ones. The benefit may be financial as

⁹ Reich, M.R. & Govindaraj, R. Dilemmas in drug development for tropical diseases: experiences with praziquantel. *Health Policy* **44**, 1-18 (1998)

¹⁰ Smith, R. Vaccines and medicines for the world's poorest: public-private partnerships seem to be essential. *BMJ* **320**, 952-953 (2000).

¹¹ Lucas, A.O. Public-private partnerships: illustrative examples. Paper presented at the Workshop on Public-Private Partnerships in Public Health, Dedham, MA, 7-8 April 2000.

in a contract, or cooperation, as between multiple service providers, but is generally straightforward and operational.

At the national level, partnerships are somewhat more varied, although the majority may still be quite simple. These may be national agreements (or contracts) between the government and NGOs for provision of service in underserved areas, or between pharmaceutical distributors and the government for procurement and distribution of essential drugs. One type of national partnership that is having a major impact on health systems worldwide is the establishment of a national health insurance system in which private providers participate in an insurance scheme at negotiated rates that is financed jointly by employers, individuals, and the government.¹² Thus the types of national partnerships are very varied in nature.

At the global level, partnerships are typically between a multinational company, often a drug company, and a donor or research organization. The most common form of this type of partnership is perhaps a drug donation program, in which drugs for a specific purpose are donated or given at reduced price to international organizations that can ensure the drugs are used for the specified purpose in an appropriate way. Examples of this are the recently announced program of drug price reductions for HIV/AIDS, the donation of Zithromax®, and Mectizan® for use in blindness prevention programs, and the donation of Malarone® for malaria control. Although pharmaceutical firms are often involved in these types of partnerships, more recently, large charitable foundations, such as The Bill and Melinda Gates Foundation, and the Rockefeller Foundation, fostered partnerships between private and public entities to develop better ways to deliver health interventions such as vaccines or specific treatments. Indeed the increasing importance in international public health of private foundations with their strong ties to the private sector makes it likely that there will be an increasing number of these types of global partnerships in the future.

As one might imagine, these global partnerships are often quite complex in nature. There are often multiple partners involved, with complex financial arrangements, and institutional objectives that often include legitimacy in terms of working with respected organizations, research that will be used for future product development, or enhancement of

¹² Paul J. Gertler, "On the Road to Social Health Insurance: the Asian Experience." *World Development* (1998)

brand or corporate image.¹³ At the global level, although individual relationships can still be quite important, it is typically the institutional goals that are the driving force in the relationship, and these types of partnerships will usually endure changes of personnel. One factor that enhances the durability of these partnerships is they are often more formal in nature with complex written agreements.

Partners

Just as the scope of partnerships varies tremendously and helps define the partnership, the nature of the partners will also define the partnership. Since this paper is about public—private partnerships, I will not discuss partnerships between private groups, but these obviously exist and are perhaps the most common type of partnership existent in the world today. However, even within public—private partnerships, there are many different types of partners. These include private-for-profit companies and individuals, private-not-for profit organizations that are often but not always community or religious based, donor organizations that include multinational donors such as the Asian Development Bank, bilateral donors such as USAID or JICA and private donors such as the The Bill and Melinda Gates Foundation. Partners also include, governments at the national and local level, public organizations such as the medical associations or college of nurse-midwives, and community groups who may be either public or private depending on their purpose and structure.

Perhaps the most common type of partnership is that between the government and not-for-profit service delivery organizations such as religious groups, family planning associations, or training institutions. In these partnerships, both government and NGOs share a common philosophy and set of values, and so agreements to coordinate, co-finance, and provide reciprocal services are often easily negotiated and straightforward. That does not mean that these types of partnerships are not without their difficulties. Governments, because of their nature and size often feel obliged to “coordinate” the NGOs rather than act as true partners, while NGOs often feel their relative efficiency and simple operational approaches

¹³ K. Buse and G. Walt, *Global public-private partnerships: part I – A new Development in Health?* (Bulletin of the World Health Organization, 2000, vol. 78, no. 4, p.549-561)

makes them the moral and intellectual authority in the partnership. As in all partnerships, the ability to share control often becomes the key determinant of the success of the partnership. It should be noted that in these partnerships between the public sector and NGOs, the driving force behind the partnership may not be financial, but rather the expansion of services to the underserved population.

One of the interesting shifts that has occurred in the past 5 years is the emphasis on “civil society” as a dominant player in national and international development. Although civil society includes many players, one of the most important is the community based organization. Thus, these community based organizations have increasingly become partners with both the private and the public sector in the development and delivery of health services. Community groups come in many forms. Some are formed for the purpose of community development such as the women’s groups of Indonesia or Thailand. Some community groups are formed to make money such as cooperatives or small businesses. Some are primarily social, but have political influence. All of these types of community groups are becoming more involved in health delivery through sales of contraceptives and essential drugs at the local store, community based distribution programs and village midwives in reproductive health, and community health workers who report to local committees for supervision and their funding.

Probably the type of partnership that has been most fully discussed in the past^{14, 15} is that which is between a for-profit company or individual and the government. These types of partnerships take many forms, and are often described in terms of the role of the private or public sector in either the delivery or the financing of services, sometimes referred to as the provider—purchaser split. This description of this public-private partnership models is typically characterized in a 2 x 2 matrix.¹⁶

¹⁴ Marc Mitchell, *Models of Service Delivery* (Asian Development Bank Institute Working Paper Series) vol. 1, no. 1, April, 2000

¹⁵ Sara Bennett, *The Mystique of Markets: Public and Private Health Care in Developing Countries*, London School of Hygiene and Tropical Medicine (1991)

¹⁶Based on World Health Organization, “Report on Interregional Meeting on the Public/Private Mix in National Health Systems and the Role of Ministries of Health,” 1991. Geneva.

		Provision of Services	
		Public	Private
Financing of Services	Public	public health facilities surveillance programs health education	Contracts Social Insurance programs Social Marketing
	Private	user fees autonomous hospitals drug donations vaccine development	Fee for service Regulation Participation in national control programs (eg.HIV)

In this model, the predominant forms of partnership are found in the two shaded boxes. These describe the models of partnership in which the private sector provides financing while the public provides services, and the opposite in which the public sector finances and the private sector provides services. In the private provision – public financing model, the services, or at least some part are delivered by the private sector in the belief that the quality and efficiency of these services will be better than if they were provided by the government directly. The two most common models of this type are contracting and insurance programs. Most governments have long experience with contracting of health services often in rural areas with church groups, but are increasingly developing partnerships with for-profit groups to provide services. Contracting, however, is being used much more widely for a wide array of services ranging from ancillary services such as food, maintenance, and logistics to the direct delivery of care by private groups. The effectiveness of this type of contracting in terms of quality and cost reduction are still inconclusive¹⁷.

It should be stressed that while shared financing mechanisms are common in these types of partnerships, there are other models in which financing is not a major consideration. A good example of this are the many HIV/AIDS control programs in Asia in which hotels have agreed to provide condoms and information to their clients in each room in an effort to reduce the spread of HIV/AIDS. This is a type of partnership in which both financing and

¹⁷ Ann Mills, To contract or not to contract? Issues for low and middle income countries, *Health Policy and Planning*; 13(1) 32-40, 1998

service delivery are provided by the private sector, but a partnership with the public sector in terms of materials used, and overall objectives is reached.

Level of commitment

Another dimension of partnership is the level of commitment of the partners to the partnership and to each other. Some partnerships involve a minimal level of commitment from each partner, for example an agreement to provide service delivery in different geographic location or in different technical areas, or a contract to provide a piece of equipment to a public facility. At the other extreme is a partnership in which two organizations agree to pool all their resources in a particular area, share all decision making, and market and provide services jointly. Between these two extremes lie a wide range of levels of commitment between the partners. One way to look at the level of commitment between two (or more) organizations is the level of decision making which will be shared. Does the partnership occur at the governance level as for example with a joint board overseeing strategic decisions, at the managerial level with shared funding and control in only a limited area or at the operational level at which tasks but not strategies are shared. A good example of a partnership at the governance level is a public hospital in which the Ministry of Health agrees to give up all financial and staffing control to a local community board, but continues to fund operations at a specified level. At a managerial level, a private international NGO may work as partners with the government to develop, fund and manage a disease control program using government personnel and equipment for the day to day operations. At an operational level, an international organization may agree to procure pharmaceuticals at reduced prices on behalf of a small country. From these examples, we can see that the level of commitment does not necessarily relate to the scope or level of the organization at which the partnership is formed. Rather it is a measure of the sharing of resources including funds, people, and information.

Type of objective

The fourth dimension by which partnerships vary is in the type of objective that is to be achieved through the development of a partnership. As noted earlier, many partnerships are formed on the basis of financial goals, and in general the objective in these instances is to reduce the total cost of the production of services or goods through improvements in efficiency. As an example, if a hospital purchases food service from a private firm at lower cost than producing the food itself, both the hospital and food service can benefit through a negotiated price which is set between the cost of the hospital producing food itself and the cost of production of food by the food service. In this case, through improvements in efficiency (the cost per unit of production) both the hospital and the food service benefit and the funds saved (through efficiency) can be split among the partners.

Although many partnerships have financial objectives, in health there are other health objectives as well. many of the global partnerships, for example, are formed with disease specific objectives: the eradication of polio, the elimination of trachoma as a cause of blindness, the control of HIV/AIDS, or the elimination of river blindness. In each of these cases, the objective is the control/elimination of a specific disease that is the driving force behind the partnership. Disease specific objectives are very effective for partners who are interested in the public relations advantages of the partnerships, since it is easy to present in a very few words the humanitarian benefit of the activity. The same is true in terms of organizations in search of enhanced legitimacy. The perception of The World Health Organization was greatly improved by its role in the elimination of smallpox, and is probably one of its primary motivations in its drive to eliminate other tropical diseases.

A third type of objective to be reached through partnership is the expansion of access to services in a country. A good example of this is the partnership formed in Indonesia between the National Family Planning Coordination Board (BKKBN) and the private midwives and doctors. In this partnership, BKKBN paid the start up costs for midwives and some doctors to delivery family planning services in their private clinic. Through this mechanism, many new points of distribution for contraceptives were made available and access to services was improved. Another similar example is the partnerships that often take place between religious NGO hospitals and the government through which the government

subsidizes the NGO hospital that provides services in an area where there are no government facilities.

A fourth type of objective for a partnership is the development of new, innovative approaches to address public health issues. This may take the form of new drugs or vaccines, as is the case in the International AIDS Vaccine Initiative or Malaria Vaccine Initiative¹⁸, or the development of Norplant contraceptive implants. Innovation may also be in the form of new approaches to service delivery, as in the case of marketing condoms together with Gillette razors. Other innovative approaches include the sale of cell phones to community women's groups by The Grameen Bank in Bangladesh. These phones, which are fully sustainable through the sale of use to individuals (like a rural pay phone) also provide isolated communities with emergency access to communications for use in health programs such as safe motherhood, or other medical emergencies.

One of the few areas in which both economists and doctors agree is that Public-Private Partnerships in health offer the potential for improved services with greater access at lower cost. Yet, while the potential may exist, these benefits are not always realized. Indeed, while partnerships can provide real improvements in the availability of services, there is also the potential for abuse through corruption, for neglect of a commitment to the poor, and deterioration of quality. Although partnerships can provide an important injection of capital and expertise into the health system, we must also keep ourselves focused on the challenges that these health systems face in the future to ensure that the growth of partnerships results in improvements in the health status of the population.

¹⁸ Smith, R. Vaccines and medicines for the world's poorest: public-private partnerships seem to be essential *British Medical Journal*, 320, 952-3, (2000)

Challenges

As the pressures of cost control, globalization, and reputation continue to influence health care worldwide, public-private partnerships will continue to become both more common and more varied in the future. Partnerships can be a powerful force in the shaping of health care, and can lead to improvements in efficiency, innovation, access to services. However they are not a panacea for all the challenges that remain for the delivery of health care in Asia. If partnerships are to be used as a positive influence in the improvement of health care, we must pay careful attention to the values of the partners and the way in which partnerships are planned and implemented.

There are three issues in particular that are of paramount importance to the health systems of Asia (and other countries) in the next 20 years. These are:

- Equity
- Quality
- Costs.

Equity

Most people feel that the public sector has as one of its roles, the provision of a safety net of services to the poor who cannot pay market prices for services such as health or education.¹⁹ Further, an increasing number of scholars, led by Nobel prize laureate, Amartya Sen²⁰ believe that development relies as fundamentally on the distribution of wealth and the elimination of poverty as on the macro economic indicators of development (such as GDP) that are typically used. This sentiment has now been voiced by The World Bank²¹ and the Asian Development Bank²² both of which make the argument that poverty elimination rather than aggregate growth should be the objective of development. Yet we know that today poverty is common in most countries of Asia and there are wide disparities in both income and health among the wealthiest and poorest parts of the society. This has been demonstrated by recent work by The World Bank in which levels of health and health care are analyzed for

¹⁹ Bloom, David, Patricia Craig, and Marc Mitchell, *Public and Private Roles in Providing and Financing Social Services: Health and Education* (Asian Development Bank Institute Working Paper Series) vol. 1, no. 1, April, 2000

²⁰ Amartya Sen, *Development as Freedom*. New York: Alfred A. Knopf, 1999

²¹ The World Bank, *World Development Report (2000/2001): Attacking Poverty*

²² Asian Development Bank, *Global Poverty Report*, 2000

the different economic quintiles of a country. (A quintile is a fifth of the population, and in this study, the quintiles represent the population quintiles according to wealth from the wealthiest fifth of the country to the poorest fifth. The following table shows the results on one indicator, infant mortality rate for 4 Asian countries.

IMR PER 1000	Poorest 20%	Richest 20%
Bangladesh (1996)	96.3	56.6
India (1992)	109.2	44.0
Nepal (1996)	96.3	63.9
Pakistan (1990)	88.7	62.5
<i>source: Gwatkin, 2000</i>		

What we see in this table is the very wide differences between infant mortality rates of the wealthiest quintile and the poorest. Although the results are not surprising, this type of analysis highlights the differences in a quantifiable way that can be followed as efforts are made to improve the health of the poor in each country.

This objective, equity, poses a particular challenge for private-public partnerships, since the private sector, with its goal of profit maximization is typically less concerned with issues of equity and poverty than of increasing revenues. As a general rule, the private sector is less interested in the poor who are not able to pay the full cost of services and focus their attention on the wealthy. Although this should not be a concern when the government forms a partnership with the private sector through purchase of services, there remains a concern that the private sector may attempt to maximize its profits by providing lesser quality services to the poor.

Many other issues must also be addressed with the use of partnerships in the delivery of health care. One is that some parts of health care are far more profitable than others, and private companies may be in a better position than governments to make profitable services available and push to government to provide non-profitable services to both rich and poor.

An example of this is chemotherapy which is a very expensive service to deliver, but has very low profit potential in most countries. As disease patterns change and the demand for chemotherapy has increased, governments are finding themselves spending a very high percentage of their budgets on this type of treatment with less and less money available for other primary health services that would preferentially benefit the poor. Further, since chemotherapy is more often used by wealthier urban populations, this type of service may preferentially benefit the wealthy rather than the poor. The result is that even those with private insurance and who use private care for more health care may use the government safety net for these very expensive services, further draining the ability of the government to provide a safety net of basic services to the poor. In this instance, the private partner benefits while the government has all the financial risk. If partnerships are to help address this issue of equity and delivery of services to rich and poor alike, better mechanisms for risk sharing between the partners will need to be developed as well as a strict regulatory environment to ensure the quality and access of services promotes equity in the population.

Quality

During the past 25 years, Asia has made tremendous gains in the delivery of health care to the majority of its population. Today, most people in Asia have access to health care. However, access to health care is only of value if the care is of high quality. This has been more difficult to achieve, and is one of the hopes for partnerships.

Traditionally, government health services have been known for their poor quality, both in terms of availability of services, client focus and training and motivation of the staff. In recent years, many countries have improved the quality of public health services through mechanisms of reform, improved provider incentives, and more local control. Yet government services, especially in poor rural areas of the country still does not provide the same level of quality of services as are delivered in the wealthy urban areas. This is true for many reasons including lack of accountability, inadequate supervision of staff, inadequacy of equipment, supplies, and drugs, and overly bureaucratic management systems each of which deter from the quality of the services delivered.

The private sector is known for the excellent quality of its hospitals and clinics in capital cities that cater for the wealthy. It is also known for the “quacks” and unscrupulous

private practitioners and clinics that cater to the poor, and provide very poor quality services, including the overuse of unnecessary medications procedures to increase revenues. The question is how to improve the quality of both the public and private sectors through the use of partnerships.

If partnerships are to lead to quality improvements on the part of both the private and the public sectors, there are several areas that will need to be strengthened in most countries in Asia. First and foremost is **accountability**. If we are to use partnerships to improve quality, then the partners need to be accountable to each other and to the consumer for the quality of the products and services they offer. Furthermore, in order to ensure this accountability, we need to make public much better information about partners and the services they offer. For the private sector, accountability to the consumer has always been part of their environment. Yet incomplete and unequal information is the hallmark of health care and must be remedied if the private sector is to be held accountable to the entire public. In developed countries this is being done through regular publications, often on the internet, of quality statistics about hospitals, health care providers, and insurance companies. This type of open information leads to more informed choice on the part of the public and ultimately better quality by all providers who are competing for clients.

For the public sector, accountability is unusual, and it is only in recent times that the public sector is being asked to report on quality indicators such as waiting time, re-admittance rates for surgery, or facility specific morbidity and mortality outcomes. If we wish to ask the private sector to adhere to this type of public airing of information about their care, we must also insist that the public sector collect and make this type of information available to the public, so the consumer can make informed choices about where to go for care. However, the development of these types of information systems has been slow and not well supported by either the public or the private sectors who are concerned that the public scrutiny of their performance will indicate significant room for improvement.

A second requirement for improved quality in both the public and private sector is an **enhanced regulatory environment**, and a robust legal framework through which regulations are enforced. The goal of regulation in health is to (1) protect the individual; (2)

control costs; and (3) ensure access²³. In terms of protection of the individual, regulations rely on control of who is able to provide services (doctors, nurses, hospitals, etc.) and the quality of products that are used by consumers (pharmaceuticals, foods, automobiles, etc.) Regulations provide a baseline of quality that all providers, public and private, must adhere to and is how the public protects itself against unlicensed or unscrupulous practices.

Governments also regulate to ensure the safety of the population in areas such as food production, construction of buildings, and the safety of products such as toys, cleaning materials, and clothing. A further area that has become increasingly important is the use of government regulation to promote public health activities such as the cessation of smoking, the use of motorcycle helmets or seatbelts, and changes in diet associated with better health. Although these latter issues have been most common in wealthier countries, the changing patterns of disease and mortality in Asia indicates that a more active role by the government in these areas is needed.

The second common area of regulation is cost. Quite frequently, government regulation extends to placing a cap on fees private sector providers charge. These are controversial because of the view that they create a market distortion. However, they may be appropriate if users of the health care system are relatively poorly informed about their health status and health care needs. In general, there is a sense that while private organizations should be allowed to make some profit from delivery of health services, excessive profit is not appropriate and should legitimately be controlled by regulation. This is true especially of pharmaceutical costs, where the potential for excess profits is high.

The third common area of regulation is access. In areas where the only provider is private, there is a social justification to regulate that the provider must see all patients, regardless of their ability to pay, at least for emergency services. In the United States, for example, most states regulate that all hospitals, regardless of whether private or public, must treat all emergency cases that come to them. This provides access for emergency services to all people, even if they are not able to afford services. Access to services can also be regulated by directing the location of new health facilities to underserved areas rather than the more profitable cities where services are already available.

²³ Patricia Craig, *The Role of the Public Sector*, paper written for the Asian Development Bank Institute conference on Public Private Partnerships, Tokyo, Japan, July, 1999.

Classification of Regulations²⁴

Practice of Medicine

- training and knowledge base of practitioners
- who can do what
- recertification and licensure
- malpractice

Facility definition and certification

- standards of staffing
- standards of physical facility
- licensure

Pharmaceuticals

- standards and licensure
- importation requirements

Taxation

- tax relief or incentives in health
- duties on medical equipment, pharmaceuticals

Pricing

- maximum
- minimum

Insurance

- what is included, excluded
- who is included, excluded
- pricing, taxation

Health Hazards

- food and restaurants
- toxins
- smoking

Public Health

- surveillance – what must be reported
- immunizations
- job safety
- seat belts

Regulations provide an important protection of the public, and enhance access through controls on pricing and service. However, regulations are not effective if they are not enforced, and this has proved an important constraint to quality in many countries in Asia. Enforcement of regulations requires an effective legal system in which the courts, the police and the other agencies of government are transparent, effective, and operate in a timely manner. In general, this has been the case in only a few Asian countries, and one that has greatly limited the ability of the government to regulate the quality of services in either the public or private sectors.

The basis of regulations, and indeed the basis of quality is the establishment of **standards of practice**. Standards define expectations of care and serve as the basis on which to measure quality. In medicine, doctors have been reluctant to agree to the use of standards, arguing that each client must be treated as an individual and so standards cannot apply. However, increasingly in health, standards have been applied to good result, provided the

²⁴ private conversations with David Mulligan, previously Commissioner of Health, Commonwealth of Massachusetts, USA (1999)

standards are based on local practice, and not applied blindly to every case. While it is true that individual clinical judgement is needed for each case, treatments based on standards that have been developed by local or international specialists will have a higher rate of treatment success than the judgement of clinicians whose training and experience may be out of date and unduly influenced by drug companies and other influences. This has been increasingly recognized by countries and international agencies and is the basis of programs such as the World Health Organization (WHO) *Integrated Management of Childhood Illness (IMCI)* and the United Nations Children's Fund (UNICEF)/WHO *Mother-Baby Package*. In addition to the clinical standards of treatment, standards will also include client-centered quality measures such as waiting times, cleanliness of facilities, and responsiveness to client needs.

Standards also provide planners with guidelines on which to base quality, and are used as the basis of contracting and regulations for both the private and public sectors. With the introduction of standards of care, contracts can be more specific about their expectations and costs, and the practice by a contractor can be monitored and judged.

Costs

It is no longer feasible for any country, rich or poor, to provide all needed health services to its entire population. The reason for this is the extraordinary increases in health care costs throughout the world, and the very real budgetary limitations that all countries face. There are many reasons why health care costs have risen so dramatically. Among the most important are:

- **Changes in the population** – in almost every country, the population has gotten older and more urban, leading to an increased demand for high cost tertiary care health services. As the population ages, their health care needs and costs increase.
- **Changes in disease patterns** – Twenty five years ago, most disease was acute, often infectious, and people suffering from these diseases were either cured or died. Today, most disease is chronic, and patients with chronic diseases such as diabetes, asthma, and heart failure are on expensive medicines for all their lives. Even diseases such as cancer which were once acute are now chronic, and patients can live with cancers in remission for 5, 10, 20 years or longer. The cost of treating chronic diseases is much greater than treating acute disease.

- **Improvements in treatments** – In the last decade new treatments and new diagnostic techniques have made very real and very expensive contributions to health. Treatments for cancer, burns, and neurological disease have saved lives and improved the quality of life for millions of people, but have also increased dramatically the costs of health care.

What is apparent from this list is that the increase in health care costs will continue especially in Asia where these trends are most pronounced. The third challenge to be discussed in this paper is how the use of partnerships will affect these rising costs.

Earlier we discussed the motivation for partnerships, and that the most common motivation is financial through the expectation of efficiency gains as a result of the partnership. (see page 9) We might hope, therefore, that some relief from increasing costs will come from efficiency improvements brought by partnerships. Unfortunately, although some efficiency improvements can be expected, the experience of most developed countries is that the increasing costs associated with technology improvements and shifts in the population are of a much greater order of magnitude than any savings that can be achieved.

Further, there are other troubling lessons to be learned from the experience of the richer countries in cost control and partnerships. One of these lessons is that as medical costs continue to increase, no one, not even the wealthy, will be able to afford the full costs of care, and so better mechanisms for risk sharing are needed, and inevitably the government will become a major player and often a major funder of health care for the wealthy as well as the poor. For this reason, governments have a very strong incentive to become more active players in defining the structure of the overall health system, public and private, and how the entire sector will allocate resources and manage costs. For this approach to be successful, partnerships will therefore become even more important, not only as a source of efficiency, but also in terms of strategic planning so that both the private and public sector can benefit from the advances in health technology without becoming a victim to the financial chaos that has affected the health care system in most western countries.

Conclusion

Public-private partnerships are increasingly seen as playing a critical role in improving the performance of health systems worldwide, by bringing together the best characteristics of the public and private sectors to improve efficiency, quality, innovation, and health impact of both private and public systems. Yet, we also know that while partnerships can be an effective force toward achieving these results, they are not a magic solution to the many problems that now face health systems in Asia and around the world. If partnerships are to be effective in addressing the issues of poverty reduction and equity, quality improvement, and cost containment, considerable work will need to be done to develop the accountability and transparency, the legal and regulatory framework, and the mutual trust that is necessary for partnerships to succeed.

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