

Contracting for health services – Private provision for public benefit

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Governments worldwide are grappling with rising health costs and increased demand for healthcare services. A number of factors are pushing demand and costs, such as aging populations, changing disease patterns, and increased use of high-cost technology and prescription drugs. As governments struggle to stretch their healthcare funding, many are considering and increasingly turning to the private sector as a means to reduce rationing in the public system, fund new equipment and facilities, expand services, and increase efficiency.

Global context

At the global level, healthcare spending has risen from an average of 3% of GDP in 1950 to 8% (US\$3 trillion) in 2000. Over the same period, the average life expectancy has risen from 48 to 66 years. However, these global averages mask important differences between countries and regions. In 2000, expenditures ranged from a low of 1.5% of GDP (US\$11 per capita) in Somalia to a high of 13.7% of GDP (US\$3,724 per capita) in the United States¹.

Similarly, life expectancy varies considerably between countries, from 33.2 years (males) and 35.4 years (females) in Sierra Leone to 74.9 years (males) and 83.6 years (females) in France. Despite a continuous global trend upwards, some countries are actually experiencing significant declines in life expectancy, principally due to HIV/AIDS.

Health financing and delivery systems also vary considerably between countries. Health expenditures are generally funded by a mix of public funding (including tax revenue and payroll taxes for national health insurance) and private funding (out-of-pocket and private health insurance). The

proportion of spending from public sources ranges from a low of less than 1% in the Democratic Republic of Congo to a high of 99.3% in the Solomon Islands. Generally, public funding is lowest in the poorer countries, where governments lack fiscal resources and healthcare is financed primarily by out-of-pocket spending. Public funding tends to be highest in those countries with national health insurance programmes funded either from tax revenue (e.g. Canada, UK), payroll taxes (most European countries) or a mix of both. Surprisingly, the US, which most consider to be a predominantly privately-funded and privately-delivered healthcare system, has 44% of its healthcare expenditures funded from public sources, due to its Medicare and Medicaid programmes.

Role of the private sector in healthcare delivery

There is not yet good comparative data on the proportion of healthcare *delivered* by the public vs. private sectors. Generally, those countries with predominantly publicly-funded systems also deliver healthcare principally through public sector

Figure 1: Global healthcare expenditure in 2000

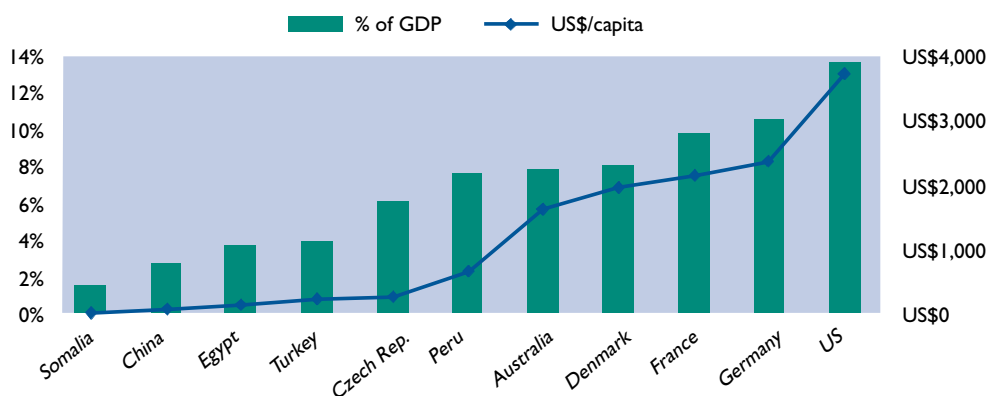
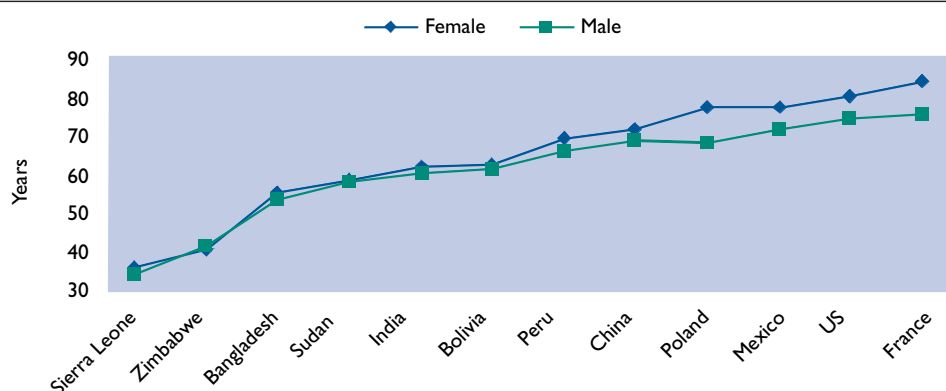


Figure 2: Life expectancy



systems. And those countries with predominantly privately-funded systems often have very limited public sector delivery.

In most countries, the public and private systems operate in parallel, with little integration or crossover of patients: the public sector delivery system provides care to publicly-funded patients and the private sector provides care to privately-funded patients.

There are some important examples of countries where publicly-funded healthcare is delivered primarily by private sector providers. In the US, much of Medicare and Medicaid funding goes to private (profit and not-for-profit) providers of healthcare services to Medicaid/Medicare patients. In Brazil, it is estimated that up to 70% of publicly-funded hospital care is provided at privately-owned and managed hospitals. And, in Lebanon, the estimated ratio is even higher, at closer to 90%. However, these examples tend to be the exception rather than the norm.

Untapped potential

There is considerable untapped potential in the private sector which governments could productively utilise through regulatory and contracting

arrangements. In most countries, private providers could deliver significantly more services to publicly-funded patients through well-structured contracting and regulatory arrangements. Governments could also put in place measures to stimulate private insurance and regulate private providers serving privately-funded patients. Together, these measures could help create a more integrated and seamless healthcare system, with the private sector providing a wide range of quality services to both publicly-funded and private patients at economic costs.

Strategic contracting

Perhaps the most politically feasible method to expand private sector delivery of healthcare to publicly-funded patients is through contracting by governments or national health insurers for service provision. Contracting can be implemented for a wide range of bundled or unbundled services from vaccinations to the highest-level hospital services, as outlined in Figure 3 and in examples throughout this article.

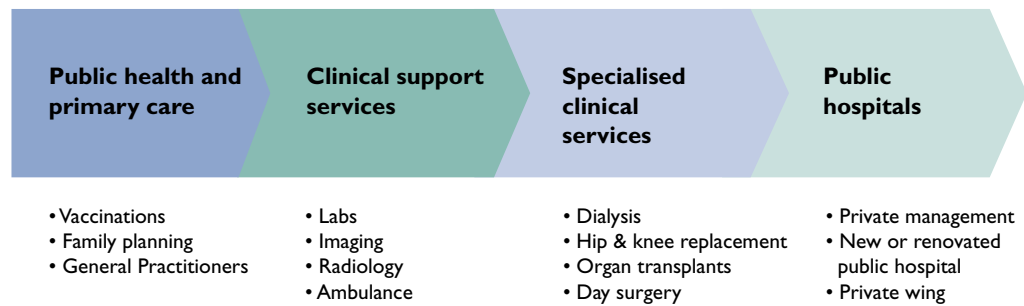
Many governments currently engage in some form of contracting with health service providers. This is generally passive contracting within the public sector, in which government simply fulfills a

Contracting for primary care in Cambodia

The Cambodian Government recently conducted a two year pilot programme in which non-governmental contractors provided primary health services in five districts against a control of four districts using existing conventional government services. Contractors were either “contracted out”, fully responsible for service delivery, management, and staffing, or “contracted in”, providing management of government staff with allocation and disbursement of a portion of the budget. In both cases, contractors significantly outperformed government, providing more effective healthcare services to more people at lower total cost with better health outcomes, as measured by service coverage indicators including types of care delivered, patient education, immunisation rates and percentage of illnesses. Similar examples exist in other regions of the world.

Source: Asian Development Bank: ERD Policy Brief Number 6 “Achieving the Twin Objectives of Efficiency and Equity: Contracting Health Services in Cambodia” March 2002.

Figure 3: Healthcare contracting



budget commitment, thereby forgoing the opportunities provided by strategic contracting which can create both competition amongst providers to improve quality and link service provision (and payment) to outcomes.

The private sector, in this case, comprises all non-governmental healthcare providers, both for-profit and not-for-profit. In fact, this private healthcare sector already exists in most countries and is in often either the provider of choice where public services are not well regarded, or the primary provider where public services are perceived as inadequate.

Benefits

Contracting for services has many benefits and advantages. It can help expand the availability of healthcare services to the entire population, particularly the poor not currently served by the public sector. When properly structured, it can also improve the overall efficiency and quality of healthcare services. It can also significantly reduce the fiscal burden on governments, as governments can transfer the responsibility for funding new equipment and facilities to the private sector.

Indeed, perhaps the most innovative and far-reaching aspect of contracting is that generally, the government need no longer directly fund the acquisition of medical equipment and supplies, nor the construction/renovation of hospitals. Rather the government can contract for specific services (e.g. MRIs or magnetic resonance imaging) and shift entirely the responsibility to the private sector for financing, providing and maintaining the necessary equipment, supplies and facilities required to provide the service. This can be particularly beneficial in the case of equipment, where public hospitals often face the problem of shortages of crucial equipment or replacement parts. Under a contract for services, the private operator will assume all responsibility (and risk) for installing and maintaining the equipment, and purchasing all related parts and supplies within the overall price of the service. If government is perceived as a reliable purchaser *at rates that cover*

economic costs, providers can be expected to expand their capacity to meet this need.

This can also be very beneficial if extended to the construction or modernisation of major health facilities such as hospitals. While most countries do not suffer from a shortage of hospital beds, many public hospitals are aging and require modernisation and replacement. Rather than proceeding with a traditional public sector investment, the government can contract with the private sector to modernise an existing facility or construct/operate a new public hospital. The most economically efficient approach would be simply for the government to specify the services it will purchase through a tender, allowing bidders full flexibility in determining the most appropriate facility to provide the services (and location within a specified catchment area). Under this approach, the private operator would design, finance, construct, own and operate the facility, with funding contracts with the government to provide hospital services to public patients. The contracts need not be long term, provided there are transparent procedures for government allocation of service contracts between hospitals, so that the private operator will have some assurance that if the hospital is efficient (compared to other hospitals) and there is demand for its services, they will receive an appropriate level of annual funding.

Applicable lessons and benefits from infrastructure

Potential benefits and lessons for contracting for services can be drawn from experience in infrastructure. In the power sector, distribution companies (or single buyers, depending on the market structure) specify their power needs through public tenders, or the market signals the need for increased capacity. Operators then choose the most appropriate location, technology and plant design to meet the market need. If the market or contracting rules are clear, operators will know that they will be dispatched if they are efficient. A similar

approach could be applied to contracting for healthcare and would represent a more market-based approach to allocating health funding.

Governments should consider the possibility of purchasing hospital services from existing private hospitals, rather than tendering for a new hospital. In many countries, the private hospitals are operating at 50% capacity, depending upon overall economic conditions and the extent of private health insurance. Yet, governments may embark on constructing new public hospitals, while a more economically efficient solution would be to purchase hospital services from existing private hospitals. Similarly, governments can contract to purchase other health services (ranging from primary care to day surgery) from the pool of existing private healthcare providers. The savings to public expenditure, through the avoidance of inefficient infrastructure and other costs, can then be directed to other public health objectives.

Contract design and regulation

This approach does create new challenges for governments and national health insurers as they evolve from service providers to strategic purchasers of health services. It requires that governments build new skills to tender with sound contracts that include well-defined service requirements, incentive-based funding arrangements, monitoring arrangements for compliance by both parties, and dispute resolution procedures.

It is likely that new regulatory arrangements and institutions will need to be developed to monitor and enforce contracts between the government and private health providers, possibly borrowing from the infrastructure experience of the 1990s where new regulatory agencies emerged worldwide to deal with the proliferation of privatised infrastructure

providers. While the health sector often has institutional arrangements for medical licensing, certification and accreditation, regulatory arrangements for service contracts require a different focus and set of skills. Independent regulators will likely be required to monitor contract compliance and facilitate contract adaptations that will invariably be necessary to address unforeseen changes in market conditions.

The introduction of private provision of publicly-funded healthcare services will inevitably create higher public expectations regarding service delivery and much lower tolerance for poor service. Indeed, problems that emerge will certainly draw press attention and criticism. These factors highlight the need for careful attention in contract design and regulatory enforcement. Governments cannot afford to make mistakes in these areas, particularly when dealing with sensitive healthcare issues.

Credit risk

An important difference from infrastructure is the added credit risk of collecting payment for services from government health ministries or national health insurers. In most infrastructure services (power, telecom, water/sanitation, transport), private operators collect directly from consumers. When governments contract with private providers for healthcare services, providers will generally be paid by the health ministry, national health insurer or a public hospital (for sub-contracted services). National health insurers are often viewed as more creditworthy than ministries of health, as their revenue (usually designated payroll taxes) tends to be more stable, predictable and secure than budget allocations for health ministries.

Provider payments

Until recently, governments often funded public

Contracting for hospital construction and operation in Australia

Private sector participation in the provision of public hospital services and infrastructure is quite advanced in Australia. For example, in 1999, the Government of Victoria selected a private operator to design, build, own and operate the new Mildura hospital under a 15 year contract. The existing public hospital was closed and its employees were transferred to the new hospital. The Government pays an accommodation services charge and a base services charge in two parts: an annual payment based on the forecast mix of clinical needs, with a funding cap at a specified level of patients; and a block grant to cover such costs as teaching. To ensure service quality, the operator is obliged to maintain the hospital's accreditation by an independent agency, provide monthly reports on clinical indicators, and have high volume treatments reviewed by external peers. The contract provides penalties for noncompliance, including "step-in rights" for government, backed by a performance bond of approximately 5% of annual revenues. Mildura's results to date have been impressive. Capital costs for the new hospital came in 20% below public sector comparators and the hospital provides clinical services at lower cost than similar public hospitals. Moreover, all performance targets have been met, patient volumes increased by 30% in the first year, and the operator has made profits. The hospital is planning further expansion through a joint venture with Monash University.

Contracting for specialised support services in Romania

IFC recently advised the Ministry of Health and Family on two pilot transactions in contracting for the radiology services and laboratory analysis for a major public hospital in Bucharest. The hospital, with a large neurology department, had existing CT (computer tomography) equipment but no money for supplies or maintenance. In fact, of the 21 CT machines in the city, anecdotal evidence suggested that no more than two were reliably functional at any one time. In the first transaction, private operators were invited to bid for the opportunity to provide CT services at an indicative volume to the hospital in accordance with set service and quality parameters. In addition to providing services to publicly-funded patients (a priority in the contract), the operator could accept private patients on a separate fee schedule. The tender resulted in public services offered at a 35% discount to prevailing prices, in a renovated space, and using new equipment, all without government expenditure or guarantees. A similar result was achieved in laboratory services.

providers (particularly hospitals) on the basis of historical or input costs (e.g. salaries, prescription drugs). Over the past decade, there has been an increasing shift to funding on the basis of the clinical mix of the patients being treated. As governments begin to contract with private providers, greater emphasis will need to be placed on linking funding (whether from the budget or public health insurance) to economically efficient costs and performance, while also rewarding quality care and patient satisfaction. Ideally, providers would be paid on the basis of *outcomes*, not *outputs*. This is a complex topic and will be the focus of considerable debate as contracting expands in healthcare.

Universal access

Universal access is a goal of virtually all publicly-funded healthcare systems. However, tight budgets and shortages of key equipment have resulted in rationing and long waiting lists in many countries. Under contracting, private providers will be expected to provide service to all publicly-funded patients. Yet, funding levels under the contract may be insufficient to allow the provider to adequately serve all public patients. To mitigate demand risk, potential providers will seek assurances that funding levels will be adequate or that they will not be expected to bear undue demand risk. Allocating the demand risk in a manner that is acceptable to all parties (government, private providers and patients) may prove to be the thorniest challenge in contracting for healthcare services.

Public safeguards

There is greater sensitivity about contracting for healthcare than for infrastructure services. Governments and national health insurers who choose to contract with private providers will have to pay careful attention to building in contractual safeguards and monitoring arrangements to ensure that standards for service and quality of care are well-defined, satisfactory for the public, and well monitored. Errors under private provision will become a lightning rod for critics. The public must be assured that they will receive the highest quality

of care possible and that their health and safety will be protected under private providers.

Looking ahead

As with infrastructure in the 1990s, fiscal pressures and public demand for expanded and improved services will inevitably push governments and national health insurers to turn increasingly to the private sector for provision of healthcare services for public patients. But, unlike infrastructure, in most countries it will not likely involve the widespread privatisation of public systems. Rather, it will take the initial form of contracting for discrete services, particularly in areas where there are equipment shortages and waiting lists. More ambitious forms of private sector participation (e.g. management of large public hospitals) will take longer to emerge, as the public gains increased confidence in private providers and under the continued threat of fiscal deficits and shortages of service.

Contracting will place new challenges on governments to shift their role from direct providers to purchasers of services, yet holds great promise for governments as a means to expand access to publicly-funded services.

Note:

¹ World Health Report 2000.

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