Chapter 10
Public–Private Partnerships as Decentralization Strategy in Health Sector

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Abstract Recently, there has been considerable shift towards market mechanisms encompassing different forms of partnerships to make public services more efficient and effective. Public–private partnerships (PPPs), a form of partnership, combine government resources with the private institutions to achieve government and social goals. PPPs for health now have been considered as a process or strategy of collaborating between private sector organisations and a health programme at different levels—international, regional, national and local levels. The notion of PPPs in health is to promote collaboration in order to improve health system performance as opposed to divesting in public service provision. It is also believed that PPPs would equally bring some negative effects on public service delivery. Although approaches vary from contracting, outsourcing, privatisation and PPPs, the purpose of adopting PPPs in health systems is to prioritise competition, efficiency and effectiveness in response to globalisation, changes in technology and new approaches to managing public service delivery. Is that often the case? This chapter highlights the concepts of PPPs and their roles in health care decentralization and explores to what extent private providers working in partnership with public sector departments would bring positive effects on health service delivery, care provision and health infrastructure development.

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At the End of the Chapter, You Will Be Able to

- *Define the concept of public–private partnerships and examine the roles of PPPs in health care*
- *Understand the perceived benefits, risks and the drivers/enablers of public–private partnerships in health sector of decentralising through public–private partnerships in health sector*
- *Explore and discuss the PPP experience in sub-Saharan Africa and UK health sectors*

Introduction

Since 1990, public–private partnerships (PPPs) worldwide have been recognised as a key tool of public policy (Osborne 2000). The meanings of PPPs are much contested, and people interpreted this differently in different disciplines and contexts. Skelcher (2005) views PPPs as strategy which 'combine the resources of government with those of private agents (business or not for profit bodies) in order to deliver societal goals' (p. 347).

Recently, there have been considerable discussions about the roles of PPPs in health systems across the world. WHO (2012) conceptualises PPPs as a wide variety of ventures involving a diversity of arrangements, varying with regard to participants, legal status, governance, management, policy-setting prerogatives, contributions and operational roles. In this chapter, authors will examine public–private partnerships (PPPs) as a paradigm shift for decentralization within health systems. The chapter focuses on five key issues linking between decentralization and PPP in health. Decentralization and PPP concepts are defined to show ways in which the former subsumes the latter as one of the strategies through which services within health systems are increasingly being shifted from nationalised to privatised delivery along descriptions in Fig. 10.1 (p. 3). The perceived benefits and risks of PPPs within health systems are also discussed. The chapter then presents the key factors driving PPPs within health systems. Since PPPs are increasingly being used as decentralization strategy worldwide, there is an interest to understand the important preconditions for their progress within health system, and this is presented in the fourth section of this chapter. Profiles of experience with PPPs for health delivery in low- and high-income countries are finally provided in the fifth section. The experiences are drawn from sub-Saharan countries and the UK to illustrate differences and variation in complexity of PPPs adopted across health systems.

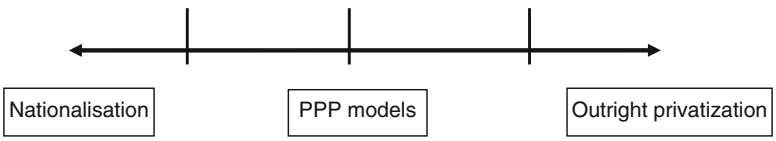


Fig. 10.1 Conceptualising PPPs and decentralization. *Source:* Adapted from Atun (2007)

Concept of Decentralization and PPPs

Decentralization is understood as the transfer of power and authority for delivery of selected functions from central to lower levels of organisations (Rondinelli 1980; Saltman et al. 2007). It does not matter whether it is a public or private organisation; decentralization technically occurs as long as power and authority for service delivery is shifted from the centre to periphery. Until the 1980s, decentralization within public organisations and health systems were perceived to involve two approaches. First, there was the transfer from national to lower governmental levels. In this case, regions or provinces or districts and local authorities were allowed enhanced power and authority to deliver functions previously provided by central government. Second, there was the transfer from national to organisational levels. In this case, hospitals or health centres and other administrative units were given enhanced power and authority over functions previously provided from national level. Thus, the essence of decentralization is that it initiates administrative rearrangements in order to transfer power and authority to deliver selected functions from the centre to peripheral levels whether within a government department or private entity.

Substantial development in public service delivery has to an extent influenced agreement to treat strategies that transfer power and responsibility to deliver health functions from public to private providers as decentralization (Atun 2007; Bennett et al. 1997). Health functions that can be potentially shifted for delivery by private providers fall under the following broad categories involving (1) service delivery, (2) care provision, (3) financing and (4) health infrastructure development. The functions can be delivered when the private providers operate individually and/or jointly in partnership with public sector departments. The scope of this chapter concerns a discussion of private providers working in partnership with public sector departments to deliver any of the functions between service delivery, care provision and health infrastructure development.

Decentralization can take place either vertically or horizontally. Mills et al. (1990) argue that within say a Ministry of Health, vertical decentralization transfers power and service delivery from the headquarters to regional or district health offices. This decentralization involves deconcentrating power, authority and responsibility for health functions from the headquarters to lower administrative governmental levels. Horizontal decentralization takes place when the ministry devolves power and authority for delivery of health services to other ministries and governmental departments (Rondinelli 1983). In Nepal, for example, the Nepalese Rural Development Foundation (2005) advocates transfer of enhanced power and responsibility for health activities to the Ministry of Local Government or local authorities. The recipients of enhanced roles should lie outside of the Ministry of Health's direct control for horizontal decentralization to take place.

Alternatively, decentralization can involve extensive delegation of power and authority to deliver health functions to semi-autonomous and private entities. Traditionally, this trend was not practised in public administration where preference was to enhance power and authority of departments that are directly controlled by the government. This has influenced disagreement on what really constitute

decentralization (Savas 2000; Saltman et al. 2007). However, a number of analysts (e.g. Mills et al. 1990; Saltman 2003; Bossert 1998) argue that within health systems, activities that involve semi-autonomous and private organisations, whether working independently or in partnerships with the government, should be considered in decentralization discourse. This chapter's remit is to locate public private partnerships within decentralization discourse. The merits and demerits of involving semi-autonomous and private organisations in health service delivery are reserved for consideration in other sections of this book.

Public–private partnerships (PPPs) involve government formalising working relationships with non-governmental organisations as a way of collaborating to deliver desired public functions (World Bank 2006). PPPs for health have been considered as a process or strategy of collaborating between private sector organisations and a health programme at different levels—international, regional, national and local levels (Walley and Wright 2010). Thus, the definition adopted for this chapter is that PPPs are a form of decentralization that concerns government collaborating with the wide range of non-governmental organisations in public service delivery, which is echoed with the concept of WHO (2012). The involved non-governmental organisations may be private companies, voluntary organisations or even community groups with interests in given health functions. Such a broad definition risks disagreement with some analysts who consider efforts that promote involvement of private companies in public service delivery as privatisation (Savas 2000). But applying Saltman et al. 2007 and Atun's (2007) logic, PPPs and privatisation are distinct stages within the nationalisation–privatisation continuum that is described in Fig. 10.1.

Renda and Schrefler's (2006) argument that PPPs mainly involve transferring assets and responsibility to deliver public service from the public to private organisations also reinforces their being distinct from privatisation. An important point that is raised by World Bank (2006) is that with PPPs, the government's underlying motive is always to promote collaboration in order to improve health system performance as opposed to divesting in public service provision. Thus, PPPs essentially represent changes in ways public service is conventionally provided. It is therefore logical to recognise them as a decentralization strategy that is backed with legal or statutory arrangements unlike the conventional trends in public administration.

Perceived Benefits and Risks of Decentralising Through PPPs in Health Sector

There has been a debate flying over few decades about the role of private and public sectors. This section outlines the justifications for governments opting for PPPs as decentralization strategy in health sectors. An examination of the arguments shows that the concepts of decentralization and PPPs are linked in the sense that they share more or less similar benefits and risks. And the benefits and risks are from the standpoint of the policymakers, health professionals, analysts and consumers.

The Benefits

Using PPPs as decentralization strategy in health sectors has been recommended in many countries across the world. It is generally believed that private sector would be more 'efficient and provides higher quality services' (Walley and Wright 2010, p. 109). Even some organisations argue that 'private sector offers all the answers to public health problems in developing nations' (p. 109). Other proponents also cite a number of objectives that can be fulfilled within health sectors better than when governments act alone to deliver selected services. In particular, the objectives listed in Table 10.1 below are considered appropriate for this analysis. An important linkage between the concepts of decentralization and public–private partnerships (PPPs) relates to the strength and similarity of rationale observed to justify the strategies when used within health sector (Table 10.1).

A number of the benefits cited revolve around risk transfer from the public to the private sector partners and in some cases the sharing of risks for public service delivery between the public and private partners. For example, the World Bank (2006) and the World Health Organization (WHO) (2000) argue that PPPs may help governments to reduce administrative and financial burdens that are usually associated with public delivery of the functions. There is also the argument that despite rapid economic growth and social transformation in many developed and developing nations, countries continue to face challenges in ensuring access to quality health care services for their populations. Adopting PPPs is therefore an important innovative approach in delivering health care services (Asian Development Bank 2012). The private sector partners are presumed to have administrative skills that the public sector can exploit to improve service delivery without sidetracking public sector objectives. At the same time, the private sector partners come with financial resources that augment or replace what otherwise the public sector would be expected to provide. This helps in transferring and/or sharing risks for health service delivery.

Another benefit often cited relates to PPPs' ability to increase efficiency and effectiveness of health services (Wollmann 1990). It is argued that private sector

Table 10.1 Rationale for decentralization and PPPs within health sector

Perceived benefit to government	Decentralization	PPPs
Less administrative and financial burden	√√	√√
More efficient and effective service delivery	√√	√√
Access additional resources, skills and expertise	√√	√√
Better value for money in service delivery	√√	√√
Diversity and competition in service delivery	√√	√√
Improved technology and innovation in services	√√	√√
Responsiveness to consumer expectations	√√	√√
Democracy and voice to service purchasers and users	√√	√√
Specialisation in service delivery	√	√

√√—strong link of the benefit to strategy or (√) weak link of the benefit to strategy

management systems prioritise efficiency in their activities in order to achieve value for money in service delivery. The government therefore benefits because the private sector partners use their skills and management practices to deliver more public services with as minimum resources as possible. Thus, there is higher cost-effective service delivery through both decentralization and PPPs. In fact, both the World Bank (1993) and WHO (2000) strongly argue that a great deal of public sector resources is wasted because government staff lack skills to cost-effectively deliver services. Yet working in partnership with the private sector may help to solve the problems of inefficiency and ineffective delivery of health services.

Proponents of PPPs also argue that the strategy helps the government to promote diversity within health systems (Atun 2007; Milburn 2004a, b). Whatever the PPP arrangement's purpose, there is the notion that diversity generates competition in the decentralised function. This in turn triggers reductions in cost per unit of services delivered to ultimately improve the relative efficiency health systems (Costa-Font and Rico 2006). Besides suppressing the cost of services, diversity and competition due to PPPs also increase choice for purchasers and consumers (Atun 2007). Since the 1990s, many health systems have been under pressure from especially international organisations to reform the ways health systems are managed by giving extended responsibilities to private sectors (Stingl and Wilson 1996; Mwale 1999). The World Bank (2004) particularly recommends health systems working in partnerships with private sectors in order to achieve desirable efficiency, equity and pro-poor health objectives.

One of the strengths associated with the private sector partners in health sector concerns their ability to innovate and use better technology in order to improve the quality of services along demand and expectations of consumers (Milburn 2004a, b; Normand 2012). The attraction of PPPs therefore emanates from the government pursuit for quality and keeping up to date with improvements in health care technology in order to satisfy consumer demand. According to Milburn (2004a, b), knowledgeable patients are more likely to prefer private than public sector services in search for better technology. So, PPPs may not only increase responsiveness to patients' demand for increased quality and better technology. They may also be a way of government controlling private activities and retaining influence over health activities that the private providers have to provide. There is interest on the part of government to reduce market failures within health sector. Hence, PPPs being potentially viewed as a better compromise between the two extremes of nationalisation and outright privatisation of health service delivery.

There are also implied economic and political arguments for decentralising health activities through PPPs. One of the issues that are seldom discussed concerns pressure exerted on governments to liberalise economic activities. This includes recommendations for substituting government role for multiple providers in health and other social services. Under the circumstances of resource shortage and budgetary cutbacks for public services, it is presumed that involving private providers, whether directly or in partnerships, in all economic activities helps the government to mitigate resource shortfalls (World Bank 1993; Rajasulochana and Dash 2010). Furthermore, there is the notion that the private providers that the governments are

urged to engage are also citizens with legitimate rights to participate in national economic activities. The implications are that PPPs may be perceived as a strategy for opening up economies in line with philosophies of citizenship and democracy promoted by the influential international bodies. The World Health Organization (WHO) (2000) also argue that PPPs improve health system performance in the sense that the selected services will be delivered by people that are specialists in those activities rather than by health workers who may be untrained for non-health tasks. This relieves staff of daunting administrative and financial burdens, leaving them to focus on caring for patients. Hence, the argument that decentralising through PPPs may help to improve the quality of services, especially when responsibilities are allocated on the basis of suitability and ability to perform by all citizens.

The Risks

From the above discussion, it is clear that the objective of public–private partnerships (PPPs) in health sector may convey a number of benefits. These range from efficiency, quality improvement and competition-driven patient choice to innovative technology that is responsive to consumer needs and enhanced social solidarity when citizens get involved in national health activities.

However, several authors (Bossert 1998; Gaffney et al. 1999; Saltman et al. 2007; Aldred 2006; Beck et al. 2009) suggest that PPPs present a number of both opportunities and risks in decentralising health functions. The major concern is that PPPs within health sector have not been able to show convincing evidence about their ability to deliver on the anticipated benefits. Table 10.2 below shows some of the often cited risks associated with decentralization and PPPs within health sector. The table also indicates the extent to which the perceived risks aptly describe either or both decentralization and PPPs when implemented in health sector.

An important challenge in implementing decentralization and PPPs in health sector concerns issues around public sector workers' role to monitor and supervise activities of the PPPs set up to deliver the decentralised functions. Studies by Beck et al. (2009) raise concern that the government rarely train or prepare public sector

Table 10.2 Risks of decentralization and PPPs within health sector

Perceived risks to health sector	Decentralization	PPPs
Administrative and financial challenges in monitoring	√√	√√
Inadequate skills and expertise by recipients of roles	√	√√
Increased cost and neglect of decentralised services	√	√√
Lack of experience/commitment to public sector goals		√√
Reduced competition and growth of monopolies		√√
Mosaic providers and coordination challenges	√	√√
Privatisation of decentralised functions	√	√√

√√—strong link of the risk to strategy or (√) weak link of the risk to strategy

workers in assuming the roles to monitor and supervise PPPs. The result is that the staff lack skills and take too long to develop effective expertise in administrative and financial matters of monitoring the partnerships. Thus, partly for this reason, some have argued that PPPs within health sector have not been able to demonstrate convincing evidence about their effectiveness within health sector (Boyle and Harrison 2000). Walley and Wright (2010, p.109) highlight that 'private sector operates as evil profiteers, contributing nothing to the public health'. In the UK, studies of the National Health Service (NHS) experience have associated PPPs with increased cost in service delivery (Gaffney et al. 1999; Pollock et al. 2005; Aldred 2006). There are strong arguments that PPPs have the risk of financing health activities through expensive borrowing from private banks. In one way or the other, private borrowing has the effect of transferring interest repayments to the public sector. At the macroeconomic level, the ripple effects include escalating health care costs that are more often than not funded by the government (Pollock et al. 2005). One of the consequences is that government investment in additional programmes that are essential from the standpoint of consumers may be curtailed. Thus, PPPs may mean that the private partners only assume superficial role to deliver and manage health service, while in reality the risk to finance is retained by the government. There is a legitimate argument that the health sector is unlike other sectors (e.g. transport, communication or manufacturing) which can adopt market mechanisms with minimum adverse effects on patient welfare. The unique nature is the reason why health sectors in many countries across the world have some form of protection against extended private participation (Equinet 2007).

But governments' efforts to protect health systems may mean that when they participate, private partners lack the benefit of prior experience in health sector issues. Consequently, PPPs risk failing to effectively deliver the decentralised functions especially by those participating in health services for the first time. Furthermore, some critics argue that the private partners either lack commitment or their interests mismatch the primary goals that government may intend to achieve through PPPs. An important problem observed by Aldred (2006) and Gaffney et al. (1999) is that profit motive of the private partners almost always tempts most PPPs to ration or neglect high cost but essential health services. Thus, PPPs risk cutting back on service availability especially where the public sector staff lack skills to monitor and power to influence compliance with the contracts by the private partners. Work by Fitzsimmons (2009) and Beck et al. (2009) actually attribute PPPs' ineffectiveness in delivering against their intentions to inadequate preparation and empowering of civil servants to monitor and supervise decentralised functions by the government.

An important reason why PPPs as decentralization strategy may be viewed unfavourably is to do with occasional market failure within health sectors. Research on effectiveness of PPPs has shown that adverse selection of patients, inefficient allocation of resources and information asymmetries influence progress against intended benefits more than the ways in which PPPs are designed (World Bank 1993; Perrot 2006; Renda and Schrefler 2006; Equinet 2007; Rajasulochana and Dash 2010). There is also cultural inertia by the private partners to shift from profit towards altruistic practices that are consistent with most health care objectives. Aldred (2006) also observes another important cultural factor that describes threats from

PPPs. While its exact mechanisms are complex, she raises the dangers of PPPs evolving into huge monolithic corporate entities that may be too big and influential for the health departments to regulate. The effects include reduced competition in service delivery and missed opportunities to benefit from diversity and wider patient choice despite them being proffered to rationalise PPPs within the health sector.

In some countries, there is concern that unless PPPs are stringently regulated, health systems may experience problems associated with fragmentation. This concern arises largely from observations that when health service providers are too mosaic, coordination of national activities is problematic and causes rapid growth in costs. Yet PPPs are viewed as a strategy to conceal government debt and costs of service delivery (Rajasulochana and Dash 2010). There is chance that inequities in health are risked especially in absence of government incentivising PPPs to invest in perceived less profitable public goods as safety nets for ordinary consumers. According to Pollock and Price (2006), PPPs also risk being used as the springboard for privatisation of health services. It does not matter whether the privatisation is intended or unintended. The paramount concern is that privatisation comes with several significant problems pointing at inequities that governments have the primary role to address.

It is clear that both decentralization and public–private partnerships (PPPs) have discrete benefits and risks, yet they are jointly adopted in many health systems. In fact, simultaneous decentralization has substantially advanced to an extent that it is no longer a case of either internal decentralization (within health departments) or using PPPs to improve health system performance. For several reasons, health systems choose to decentralise through one way or the other. Walley and Wright (2010) nicely capture the remit of PPPs in health by noting that:

> 'When we discussed financing, it becomes clear that there is a strong case for public financing of health systems—at least, a substantial minimum portion of them—to ensure social solidarity, risk-sharing and access for the poorest. When it comes to provision, however, there are less consensus on the public and private roles. Perhaps more than public or private status, what matters is the context, the incentives and the management framework which governs a facility'. (p. 109)

Activity 1

What is your understanding of PPPs? List down any three advantages and disadvantages of PPPs in health sector.

The Drivers of Public–Private Partnerships in Health Sector

To a large extent, the factors that drive public–private partners (PPPs) tend to emphasise economic, technological and societal changes on the ways public services are delivered. The factors are fuelled by changes in people's perceptions about approaches to improve the management of public services. Therefore, when viewed together, the following contextual factors are important drivers for PPPs within

health sectors: (1) new approaches to public service management, (2) increased cost of health care and the need to mobilise resources for public service, (3) globalisation of economic activities including health and social care, (4) improvements in technology and managerial changes and (5) increased consumer expectations.

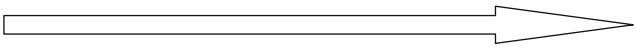
New Public Management

New public management (NPM) advocates private sector management techniques and market mechanisms in order to achieve success in government services. There is the underpinning perception that efficiency and effectiveness in service delivery achieved in the private sector is attributable to unique private management techniques and market mechanisms used (Pollit et al. 1998). So, when applied within health sector, NPM emphasises the shifting of health service roles (e.g. the management and operationalisation of selected health functions) from central government to peripheral units including private providers, financiers, community groups and a host of other non-governmental organisations. Although central government is expected to retain the role to regulate the decentralised functions, better health care outcomes are anticipated than would have been the case through government-led management practices. Proponents of NPM therefore argue that it makes sense for government to either privatise or work in partnerships with the private sector in order to improve health system performance (World Bank 1993; WHO 2000).

The European Observatory on Health Care Systems (2002) observes that a number of countries are increasingly substituting private provision and management practices for government role because of their perceived appropriateness within health. To a large extent, this approach to public service delivery is a worldwide phenomenon driven by the NPM ideas (Pollit et al. 1998; Saltman 2003). For example, since the 1990s, successive governments in the UK have been prioritising performance management compared to active role in administering NHS service delivery. Government bureaucracy within the NHS is replaced with regulated market mechanisms under the 'Third Way' (see Table 10.3) approach that in many ways mimic the NPM (Powell 2000).

Table 10.3 Dimensions of the 'Third Way' and connections to NPM

Delivery dimensions	Old labour	The third way	New right
Approach	Leveller	Investor	Deregulator
Outcome	Equality	Inclusion	Inequality
Mixed economy of welfare	State	Public/private civil society	Private
Mode	Command and control	Competition	
Citizenship	Rights	Cooperation/partnership	Responsibility
Accountability	Central state/national	Both	Market/local
Social expenditure	High	Both? Pragmatic	Low



Source: Adapted from Powell (2000), p. 42

As described in Table 10.3, NHS activities are delivered and managed through processes of contracting, public–private partnerships (PPPs), internal markets and occasional privatisation of non-clinical services (Saltman et al. 2007; McKee et al. 2006).

However, some critics are concerned about the suboptimal impact of NPM when applied in health sector. Stevens (2004) argue that private management practices fundamentally remove government role in guaranteeing equity and accountability in health. This has been supported by the work done by Pollock (2007) and Gaffney et al. (1999) who point at pro-market initiatives within the British NHS' effect of increasing health care costs. They also suggest that private management practices have failed to deliver against the anticipated efficiency and effectiveness benefits claimed by the government.

Resource Mobilisation

One important paradox in public administration is that people are unwilling to pay more taxes, yet they are not prepared to also demand less of the health services. It forces governments to explore strategies for sustaining and increasing service delivery without recourse to public funds. Thus, from government standpoint, public–private partnerships (PPPs), contracting or privatisation of selected health activities helps to (1) mobilise resources without burdening taxpayers and (2) substitute government so that better value for money is achieved with available public funds.

This is important because the cost of providing health care and services is ever escalating due to public sector staff being averse to management practices that save money in situations of declining budgets for health (World Bank 1993, 2004). The World Health Organization (WHO) (2000) also argues that there is wastage of public funds because of government's tendency to invest in less cost-effective health interventions. They therefore stress the beneficial effects of different models of PPPs and application of market mechanisms in health. According to Milburn (2004a, b), PPPs simultaneously mitigate financial shortages and mobilise equipment, technical skills and expertise abundant and otherwise suboptimally utilised in the private sector. Within developed economies—mainly the UK and central Europe—to some extent health sector reforms favouring PPPs have been influenced by governments' desire to mitigate shortage of resource needed for governments to sustain health care provision (Saltman et al. 2007). Considering the economic recession and financial liquidity problems experienced across the world between 2009 and 2012, it may be legitimate for governments to be inclined to using PPPs as alternative sources of health care finance.

Globalisation

There are also global changes that in many ways induce health systems to adopt public–private partnerships (PPPs) as decentralization strategy. Globalisation increases intensity of international competition in health. It also gives patients better patient knowledge and increased consumer demand and expectations in relation to diversity, quality, relevance and cost of services. No government wants to be found wanting in terms of delivering its health care responsibilities. These changes therefore more or less compel governments to adopt strategies that may help in meeting patient and consumer expectations more appropriately. Otherwise, there are risks of people leaving their countries to seek health care from other countries as regional and international health care boundaries are blurred by globalisation.

The risks are usually averted through restructuring of the ways public service is delivered within countries. For example, protected health systems in the former communist countries were restructured to accept public–private mix provision. Where open economies already existed, health care and services as well as education previously delivered through government monopoly are decentralised to public–private partnerships or delivered through privatisation, contracting and other market-based initiatives. Furthermore, international development agencies like the World Bank, International Monetary Fund and the WHO encourage these as strategies for improving health system performance in the wake of overall decline of budgets for public service.

Technology and Managerial Changes

Technological changes and managerial practices are also the pillars of public–private partnerships (PPPs) in health. Health care technology should not be considered only in terms of new techniques, equipment or drugs. It also concerns better understanding as well as changes in ideas to reduce cost of health outputs and outcomes. This broader definition is appropriate to understand the drivers for PPPs in health (Normand 2012). PPPs are generally perceived as more responsive to changes in technology compared to government management practices. There is government recognition of the importance of investing in processes that keep pace with improvements in technology in order to reduce costs and meet consumer demand for services that reflect improvements in technology. Strategies that encourage private sector involvement are therefore viewed to have the benefits of speed and appropriate response to consumer demands and expectations.

Managerial changes are important in the sense that current focus of most governments is on improving the inputs and processes that are central to production of essential health care and service outcomes. In general, the private sector is perceived to have better skills, expertise and resourcefulness than the government in executing the managerial changes. Strategies like PPPs are therefore perceived to

improve resource allocation and utilisation and organisational rearrangements while retaining government influence. This makes the health systems competitive and enhances performance and the quality of services.

Increased Consumer Expectations

There is a linear relationship between globalisation and changes in technology on one hand and rising consumer demands and expectations in health. Works by Atun (2007) and Normand (2012) indicate that both globalisation and technology create patients' awareness about alternatives in health care interventions. The end result is that patients increasingly demand choice and better access because they are more knowledgeable about innovations that improve quality of life. They expect health systems to meet their needs and conform to international standards without making them bear the burden of higher cost. For example, in the UK, NHS patients are believed to be intolerant to drab services provided at public facilities (Milburn 2004a, b). So PPPs are justified on the grounds of helping the government to meet patient expectations in order to curtail their drift to unaffordable private sectors. There is also the perception that unmet consumer expectations go against the founding ethos of the NHS and can therefore politically risky for the government (Milburn 2004a, b).

Preconditions for Progress with PPPs

One key challenge to progress with PPPs is the level of scrutiny provided by the public. Most critics, purchasers and service users perceive PPPs as politically conceived to cover for government cuts on investment in health. It implies that the public may be unaware or do not understand PPP benefits and how they may help the health sector to mobilise local resources in order to improve outputs and care and service outcomes. So, the general call may be for proponents to revisit rationale for PPPs in order to mesh them with the public's real expectations from decentralising health activities.

In addition, and depending on the nature of health functions targeted for decentralization, institutional capacity development may be required (McKee et al. 2006). The majority of PPPs in health are monitored by health workers who may be found wanting for experience in monitoring administrative and financial aspects of PPPs (World Bank 2006). Research in the English NHS has shown that strong institutional capacity in planning and developing PPPs is crucial for local staff to avoid relying on external technical assistance (King's Fund 2008).

Another important precondition is the legal frameworks to give PPPs the necessary security of status especially since they use public assets and resources along more or less private interests (Bennett et al. 1997). PPP laws are designed to resolve

specific and potential problems known to occur as a result of operationalising the partnership. Per se, legal frameworks cannot impede progress with PPPs unless expectations and deliverables by the partners and PPP mechanisms are unclear. The legal frameworks are also linked to the regulatory frameworks. In this case, public sector staff and stakeholders entrusted with monitoring PPP activities perform better if they are conversant with the contexts and procedures for executing effective PPPs.

A seldom mentioned precondition for successful PPPs regards private providers' readiness to assume responsibility over functions they may lack familiarity with. When comparing between developed and low-income countries, differences in impact give the impression that existence of well-developed and experienced private sectors is important precondition for successful PPPs. In general, where the private sector is well developed, PPP impact is very high. And the converse is also true.

PPP Experience in Sub-Saharan Africa and UK Health Sectors

Different PPP models have substantially helped to improve performance of health systems in high- and low-income countries. However, noticeable differences exist in terms of ingenuity at initiating and managing new models to enhance their ability to deliver the anticipated benefits considering the complex nature of health care environments. Unless initiated and adopted with foreign technical assistance, health systems in low-income countries are prone to adopting simple and time-tested PPP models. Those in high-income countries tend to explore opportunities for innovation in order to try new models for a variety of health care activities. For example, in low-income countries, only care and services are delivered through PPPs that contract and outsource from individual and private providers (Bennett et al. 1997). They may also devolve service delivery to local authorities or municipalities (Bennett 1990). But in high-income countries, it is now common for public sector health care physical infrastructure to be delivered and managed through PPP arrangements and resources (McKee et al. 2006). Such initiative is missing in developing countries despite the lack of government funding for public sector hospitals and health centres.

PPPs in Sub-Saharan Africa

Since the colonial years, African countries have accessed private sector resources to fund health care (Mills et al. 1990). The objective was to facilitate private for-profit providers serving consumption for the affluent urban populations. In remote and rural areas inaccessible to government structures, the private not-for-profit providers would service the indigent population. According to Bennett et al. (1997), a considerable proportion of consumers in sub-Saharan Africa received health care from the private not-for-profit providers. Work by the Regional Network for Equity

in Health in Eastern and Southern Africa (Equinet) (2007) indicates that health care partnerships are predominant in Southern, Eastern, Central and Western Africa. In these regions, missionaries (faith-based providers) work in partnership with central governments to contribute up to 10 % of health care finance (WHO 2000) needed to provide both curative and preventive services to as much as 70 % of the rural population (Equinet 2007).

Following independence, health systems in sub-Saharan countries delegated extended roles as recognition of the importance of not-for-profit providers in improving performance. For example, in Zimbabwe, Zambia and Tanzania, the governments designate Mission Hospitals to provide district or provincial level hospital care where government facilities are inadequate (Mudyarabikwa and Madhina 2000). Such partnership arrangements are fashionable across a number of sub-Saharan countries where local private facilities may be bigger or provide wider range of services than public facilities. McPake and Hongoro (1995) observe that mining and agricultural corporations owning health facilities are occasionally contracted by government to provide clinical and preventive services to local public patients. The private health facilities are primarily for attracting or retaining employment of critical staff in remote areas. This is predominant in sub-Saharan regions where PPPs are relied upon for primary care level consumptions. However, PPPs are not often used to deliver health care physical infrastructure despite their potential as a means of funding public sector capital projects.

Experience in the UK

Public–private partnerships (PPPs) have been invariably used to decentralise health care and service delivery in several countries across Europe to the extent of making it difficult to distinguish between public and private health sectors (Saltman 2003). But the UK has been arguably at the forefront in terms of exploring opportunities to extend PPPs into other health functions. Successive UK governments have adapted PPP models traditionally reserved for decentralising infrastructure development for application within the health sector (Boyle and Harrison 2000; McKee et al. 2006). Although their level of success is variable, two prominent PPP initiatives originating from the UK concern the Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) designed to improve the delivery and management of hospitals and primary care buildings, respectively.

The Private Finance Initiative

The Private Finance Initiative (PFI) in health sector was a strategy introduced in 1992 to decentralise the financing, development and management of hospitals within the NHS. PFI involved central government, encouraging and supporting private

companies to create consortiums that would be contracted by NHS trusts to construct desired capital assets and provide necessary operational services for periods up to 30 years. What distinguishes PFI from other PPP arrangements in health sector is that the new consortiums do not provide direct care or services to patients. Instead, their remit is to manage and maintain the new facilities for continuous availability to hospital trusts that retain the role to provide patient care and services.

Like other decentralization strategies, PFI within the health sector is criticised for a number of reasons. Several evaluations of PFI projects within the NHS (e.g. Gaffney et al. 1999, Pollock et al. 1999; Boyle and Harrison 2000; McKee et al. 2006) argue that it has pitfalls including the following risks: (1) substandard buildings due to poor workmanship, (2) poor maintenance of facilities caused by lack of health sector experience, (3) increased cost for the public sector due to expensive borrowing by the SPVs and (4) risk of rationing of essential care and services when hospital trusts strive to save in order to repay mortgages. Notwithstanding the concerns, PFI was adopted as decentralization strategy for developing health sector capital projects in several countries within the European Commission (Barretta and Ruggiero 2008).

Local Improvement Finance Trust

In many ways, Local Improvement Finance Trust (LIFT) is considered a second-generation PFI mechanism to finance primary care buildings at local levels. Typical LIFT partnership within the NHS involves the Department of Health, local Primary Care Trust (PCT) and interested private sector companies forming a partnership company—Local Improvement Finance Trust Company (LIFTCo)—to spearhead the planning, designing, construction and maintenance of desired primary care buildings. The Liftco is obligated to lease the delivered facilities to the PCT in return for agreed rentals from the latter for periods lasting to 25 years. What it means is that LIFT facilitates PCT investment in public buildings without direct recourse to government funds. It is argued that to LIFT partnerships have been key in influencing delivery of better looking, fit-for-purpose and appropriately maintained primary care buildings (King's Fund 2008; Beck et al. 2009).

Yet some critics have also raised problems of LIFT replicating the risks associated with PFI. Aldred (2006), Fitzsimmons et al. (2009), Pollock and Price (2006) and Beck et al. (2009) have used different perspectives to examine LIFT's impact on NHS primary care. Their conclusions of variable evidence for effectiveness against the intended benefits suggest that lessons learnt from PFI may have not been helpful in shaping the implementation processes. It is argued that LIFT inadvertently increases the cost of procuring primary care buildings, which triggers cutbacks in essential service delivery because PCTs hard pressed to save money in order to pay rent. A recent evaluation of LIFT (Mudyarabikwa 2012) also raised the concern about commercial secrecy in implementing LIFT. Staff at the front line feels excluded in making critical decisions about how the programme is

implemented. As a result, the overall perception is that, in terms of quality, the services that LIFT offers are not commensurate to the costs and risks. Even senior managers within PCTs signed up for LIFT worry about the strategy's ability to sustain investment in public buildings given liquidity problems faced by the banks financing the partnerships. Currently, the UK government promotes 'localism' in public service procurement. In a way this may be viewed to courting to work in partnerships with individuals, community voluntary groups, charities and a raft of other public but not state-run organisations in order to deliver important social and public goals.

Activity 2: What are the ethical and operational/process-related challenges involved in PPPs in health sector? List down any five key challenges.

Conclusion

There is considerable shift towards market mechanisms encompassing different forms of PPPs to provide health care in many systems across the world. In high-income countries, health care provision has evolved substantially to being not an 'either-or' case between public and private sector involvement. Although the roles of private sectors differ significantly on the aspects of policymaking, financing, provision of services and regulation (Merson et al. 2012) and approaches vary from contracting, outsourcing, privatisation and public–private partnerships, it is evident that most health systems are now characterised by collaborative coexistence between public and private providers (Saltman et al. 2007). This is because PPPs are perceived to enhance health systems' response to consumer needs and demand for quality services (Bossert 1998; Milburn 2004a, b). Health systems that adopt PPPs are perceived to prioritise competition, efficiency and effectiveness in response to globalisation, changes in technology and new approaches to managing public service delivery (Powell 2000, Atun 2007; Normand 2012). In addition, PPPs may be a means to optimising technical skills, expertise and excess resources from the private sector to benefit service users (McKee et al. 2006; Beck et al. 2009). However, there is no consensus about the theory, conceptual process and impact of PPPs experienced within health sector. They are perceived to promote entrepreneurialism leading to assortments of inequitable outcomes in health (Aldred 2006; Gaffney et al. 1999). Furthermore, PPPs risk being stepping stone to privatisation well as expensive for the government because they are financed through private borrowing (Pollock and Price 2006). Because the private sector initiates and manages the borrowing even though government is involved in interest repayment, PPPs are viewed as a strategy to conceal public debt (Rajasulochana and Dash 2010).

Notwithstanding the lack of agreement on impact or conceptual approaches for increasing effectiveness, there is evidence for increased reliance on PPPs to deliver health functions (WHO 2000; World Bank 2006). In European high-income countries, more physical infrastructure for health is developed through PPPs than the governments (Perrot 2006; McKee et al. 2006; Saltman and Bankauskaite 2006).

So rather than wishing PPPs away, they may be taken advantage of provided governments consider to:

- Disseminate experiential information for managers, service users and stakeholders to be convinced about the impact of PPPs on health sector performance.
- Capacitate public sector staff so that they are more effective at monitoring performance of PPPs to reduce risks for questionable outcomes.
- Reduce negative perceptions by putting in place transparent procedural and regulatory frameworks so that PPPs' underlying intentions are not questioned.

There is a general observation that people are more amenable to PPP arrangements involving not-for-profit than for-profit providers. Besides covering large population groups, private not-for-profit providers are thought to prioritise equity and service-user satisfaction in health care compared to the latter whose profit motive may be disincentive to invest in less profitable services demanded by consumers.

Further Discussion

- What is needed for successful public–private partnerships in the health sector? Discuss.
- Why do you think that health care should not be left to the private market? Or should it? Discuss.
- What would be the role of private sector (contractors or consultants) in delivering effective technical assistance in both health policy development and health service delivery? Discuss.

Further Reading

Nikolic, I. A., & Maikisch, H. (2006). *Public-private partnerships and collaboration in the health sector: An overview with case studies from recent european experience*. Washington, DC: The International Bank for Reconstruction and Development/The World Bank.

This provides an overview of the topic of public–private partnerships in the health sector. This also highlights the types of PPPs and the associated benefits and risks and good practices for ensuring success.

Merson, M., Black, R., & Mills, A. (2012). *Global health: Diseases, programs, systems, and policies*. London: Jones & Bartlett Learning.

This book is a highly sensitive, multidisciplinary approach to the health challenges and offers many new and emerging perspectives, and it makes an important contribution to the field of health sciences globally.

Nishtar, S. (2004). Public—private 'partnerships' in health—a global call to action. *Health Research Policy and Systems, 2*, 5. doi:10.1186/1478-4505-2-5

This article conceptualises the meaning of public–private 'partnerships' in health sector exampling from the perspective of global context. This also highlights that the dynamics of public–private partnership arrangements might help to initiate global and country-specific actions.

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