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Leveraging the Private Sector Role in Human Development

The Millennium Development Goals (MDGs) strongly emphasize human development–related outcomes, with five of the eight MDGs having health, nutrition, and education results as key indicators for monitoring progress. Governments have a special responsibility to their citizens, especially their poorest citizens, to ensure attainment of primary education, basic maternal and child health and nutrition, and control of communicable diseases. Previous *Global Monitoring Reports* have largely focused on strengthening this government role. Yet experience in many countries, including some of the poorest, shows that the private sector is also extensively involved in the delivery of services that address these MDGs.

Governments can act to enhance the contribution of the nongovernment sector to the human development MDGs as an integral part of efforts to accelerate national progress. Recognition of this potential is growing. Important new roles are emerging for private actors in human development, in financing government and nongovernment actions, in new service delivery organizations and strategies, and in innovative partnerships. These opportunities for new approaches to the MDGs require governments to develop new capacities to design, manage, and regulate mixed strategies to achieve better outcomes.

The current global economic crisis makes this discussion about leveraging private sector contributions to human development especially timely. Human development needs have become more acute, both in terms of safeguarding past gains and achieving further progress. At the same time, financial constraints on all sectors have increased, and global interdependence has become more visible. Development partners and national and local actors may want to be more open to thinking about new strategies, including engaging the nongovernment sector in maintaining or increasing the momentum for achieving the MDGs.

Leveraging the private sector to accelerate human development outcomes has potential rewards and risks. Nongovernment partners can be a source of innovation and can help to rapidly expand access to services, which supplement government efforts. But working with the private sector poses new challenges to ensure quality in providers that are not directly under government control and to introduce new mechanisms of incentives and accountability. To maximize the rewards and minimize the risks, governments must choose the most appropriate modalities for partnership, given local needs and conditions, and must devote resources and efforts to acquire new skills and capacities in contracting, monitoring and evaluation, and

regulation. Governance and accountability arrangements are critical. They affect what is feasible and what skills and capacities governments need to develop.

Several premises guide this chapter's investigation of the potential for leveraging the private sector's role in health and education. First, one should start with a focus on outcomes. The MDGs themselves provide a list of monitorable outcome indicators against which to assess progress. Second, it is important to be pragmatic rather than normative or ideological. Strategies that improve or increase outcomes sustainably over the long term are desirable, regardless of which sector is carrying them out. Government's role is central, but there are also potentially valuable contributions from the nongovernment sector. Engaging the private sector more in human development will also require government to develop better regulation and learn to manage relationships with new partners. Third, one should draw on the available evidence to support analysis and recommendations wherever possible and to recognize that more evidence is needed.

To explore how to leverage the private sector's role in human development, this chapter examines four topics. It first provides a brief review of concepts needed for clear thinking and discussion about the private sector's role. This is followed by an examination of current patterns of government and private sector roles related to the delivery of services that increase MDG-related outcomes in health and education. Private sector roles in health and education are expanding rapidly, beyond just service delivery, into areas such as insurance, production and distribution of essential inputs, and charitable financing from both for-profit and not-for-profit sources and from both international and domestic agencies. These "new vehicles" are reviewed before the chapter concludes with a discussion of opportunities and challenges for the future in further leveraging private sector roles in health and education.

In working with the private sector, governments have many options to consider and examples worldwide from which to learn. Considering the large gaps in MDG achievement that need to be spanned, these opportunities should not be ignored.

Framework for Thinking about the Private Sector's Role in Health and Education

What is "the private sector"? It is typically defined in terms of what it is not—that is, the "nongovernment" or "nonstate" sector. A key concept used for these distinctions is ownership.[1] Organizations that belong to (are owned by) government can be distinguished from those that are not government-owned. The people employed directly by those government organizations, the work they do, and the services they provide are those of the government. Everything else is the domain of the nongovernment, nonstate, or private sector.

The private sector includes both for-profit (where for-profit includes proprietary enterprises, recognized or not, and publicly listed companies) and not-for-profit organizations, as well as individuals and community groups operating outside the government's ownership, such as traditional practitioners.

Normative Views of the Private Sector's Role

There is ample evidence to confirm the significant role played by the private sector in health and education. Such observable facts, however, are not always accepted as justifying such arrangements or further efforts to engage with, support, or even enhance them. Discussions about the private sector in human development are often driven by value-based positions about whether this role is a good or bad one. Such normative views influence debates about government action. Understanding the basis for these views is important.

It is helpful to consider at least three different value-based positions that often underpin views about the private sector's

role in health and education. The first perspective draws on economic theory centered on the role of markets. According to this view, reasonably well-functioning markets exist for goods and services, and better outcomes for human welfare (which economists define as "efficiency") are obtained when government roles are kept limited and mainly focus on improving the functioning of these markets.[2] This view suggests that the private sector should be encouraged to deliver those goods and services for which there is private demand and little market failure and that the government role should emphasize public goods for which markets may not exist or significantly fail to provide optimal outcomes.

Debate then focuses on whether significant market failures exist for specific health- and education-related goods and services, and, if they do, what are the best strategies for government action? A straightforward example of market failure relates to environmental control of disease-transmitting vectors. The market is unlikely to deliver adequate control services because individuals who do not pay for them cannot be excluded from enjoying the benefits they generate. Government action is needed to ensure the appropriate level of disease control investment. Immunization and primary education provide more complex examples. These services have important externalities—meaning their consumption by some individuals affects the well-being of others; the result is that markets may not produce the optimal level of services for overall social welfare. This market failure provides the justification for dominant government financing and provision, especially in poor countries. Despite the market failure, however, there is some private demand for immunization, and as national incomes rise, private capacity to deliver immunization increases. Government strategies often change as markets develop. In the case of immunization, nongovernment provision may increase, and then governments can shift their efforts to financing and regulation. Similar arguments are given for primary education. Schools require some collective investment. Social benefits exceed private benefits. Yet there is private demand for schooling, and government provision of schooling may not be the only way to ensure education.

A different perspective is propounded by those who argue that all citizens have a right to health and health care as well as education. Rights are typically the responsibility of the state to define and to ensure. Calls for comprehensive and universal health and education services with government financing and delivery are often justified as the appropriate way to fulfill these rights, with the corollary that the private sector's role should be limited. Rights-based arguments need not always promote a central role for government in service provision. Many advanced countries have universal systems with mixed provision.

A third perspective, a pragmatic or results-oriented approach, argues that strong normative positions about government and private sector roles should be avoided. The focus should be on what works to improve outcomes in health, learning, and equity. This approach fosters acceptance of more pluralistic strategies for financing and delivery of health and education services, and this is the position taken in this chapter. This view does not preclude strong conclusions about preferred government and private sector roles in health and education, based on theory and evidence about how markets relevant to human development succeed or fail to produce optimal outcomes, as well as the strengths and weaknesses of government.

Understanding How the Government and Private Sector Roles Relate to Each Other

This debate about government and private sector roles in health and education has been going on for many years. The published literature is extensive.[3] One basic framework of proven utility and wide use emphasizes the different roles government and private sector actors play in the financing and delivery

of goods and services. Each actor can act alone—examples are publicly owned and operated facilities such as government hospitals or schools, where the government funds service delivery directly; and private health insurance or out-of-pocket payments, where private financing pays for services delivered by nongovernment providers such as private clinics or private schools.

There are also the widespread examples where government and private roles combine in different ways to produce services. Governments may purchase services from private providers; for example, paying private clinics to provide birthing services to poor mothers, or funding tuition in private schools that offer services unavailable in government schools. Private payers may also fund services delivered in government facilities; examples include user charges in public hospitals or schools or private donations to government facilities.

A display of real-world examples of these cases might look like table 3.1.

Of course, the real world can be much more complex than the one represented in the table 3.1 matrix. Several stages in the delivery of services may be financed in different ways, such as the education of medical personnel, the development of new pharmaceuticals and vaccines, teacher training, and school construction. Government and private organizations themselves display a variety of different ownership arrangements.

The next section explores in more detail what the current global evidence says about the relative importance of these four cells in the delivery of services for the health- and education-related MDGs. The picture is highly variable across countries, and even within countries, where evidence is available for different regions or socioeconomic groups.

It is clear, however, that privately financed and delivered services make up a significant part of all services that address the different MDGs in many low- and middle-income countries, and that is also often true for services being used by the poor. The picture is somewhat different for health and education, with government-financed and -provided education being more prevalent than government-financed and -provided health care. There are also many examples of innovations located in the "mixed" cells of the matrix.

Policy makers and planners want to know which type of arrangements for financing

TABLE 3.1 Matrix of financing and delivery arrangements in health and education

		DELIVERY	
		Government	*Private*
FINANCING	*Government*	■ Publicly owned health facilities and schools financed from public budgets	■ Contracting out with nongovernment providers ■ Vouchers and cash subsidies given to poor clients for service use
	Private	■ Out-of-pocket payments for patients and students ■ Private health insurance payments to government providers ■ Community contributions of land, buildings ■ Student loans	■ Privately owned health facilities and schools financed from private sources

and delivery are best. Unfortunately, the available global evidence on this question is limited and often lacking in sound evaluation and valid comparisons. The answer, which is not fully satisfying, is that the performance of the different arrangements depends much more on organizational capacities, incentives, and governance and accountability arrangements than on the simpler variables of structure and ownership. The extreme cases—all unitary financing and provision by either government or private sector—are almost unknown. Rarely is it a choice between exclusively government and exclusively private roles; rather, the question is how to develop and regulate mixed strategies for better outcomes.

Following the pragmatic, results-focused approach described above presents questions on whether and how government should engage with the private sector. This engagement should be based on evidence and sound expectations about whether unitary government, unitary private, or mixed models are most likely to produce better outcomes, given the existing incentive, governance, and accountability arrangements in different countries or even parts of countries. Leveraging the private sector's role can contribute to improving health and education outcomes when certain conditions exist. For example, government contracts or purchasing arrangements with private service providers could enhance MDG achievement and be an efficient alternative strategy to simply expanding government delivery. To succeed, these arrangements must have the right incentives and sufficient monitoring and accountability measures to increase service coverage and ensure adequate quality at a cost equal to or lower than the comparable cost to the government. Even at a higher cost, this approach might be desirable if comparable improvement in government service delivery were not feasible.

Engaging with the private sector could have other advantages as well. Private funds can complement limited public financing, which would increase the overall funding available for health or education. Competition in service delivery markets could increase incentives for the public sector to perform better. Government may be able to share some risks with private partners. Flexibility and innovation could be enhanced through engaging the private sector. Private organizations may be more willing to finance new approaches as well as test new service delivery strategies than governmental systems where innovation is more constrained. In all of these examples, the advantage of leveraging the private sector is conditional on whether government-financed and -delivered services can be made to fulfill the desired objectives at an acceptable cost. If the private sector role is already large, the relative costs and benefits of improving it, compared with efforts to substitute new public capacity for it, may make leveraging the private sector a more attractive strategy.

Implications of the Framework for Government Action to Improve Outcomes

For government to support more pluralistic approaches to financing and provision of MDG-related services it must enhance its capacities to design, regulate, and manage finance and delivery arrangements that differ substantially from government "business as usual." Indeed, one argument against more government engagement with the private sector is that these capacities may not exist in government and may be quite difficult to create. Although government might be able to contract out some of these functions, some base of government capacity to "buy" rather than "make" will be needed.[4] In the absence of such capacities, governments may risk worse outcomes with the private sector than with current government-focused arrangements.

Thus the decision of whether government should try to leverage the private sector role also depends in part on government's current and potential ability to manage new

TABLE 3.2 Matrix of government capacities needed to manage various finance and delivery models

FINANCING	DELIVERY: *Government*	DELIVERY: *Private*
Government	■ Improve financial and operational management and accountability mechanisms for better performance	■ Ability to design, bid, award, monitor, and evaluate contracts, voucher schemes, and similar arrangements
Private	■ Ability to collect, manage, and account for fees and donations without corruption ■ Ability to use funds effectively including at the local level	■ Ability to monitor and regulate nongovernmental providers for quality and law-abiding behavior

arrangements. Some of the requirements are illustrated in table 3.2.

Policy makers wanting to follow a more pragmatic approach should consider a number of key questions. Is there in place a large private sector presence that could contribute to access and quality? Can the private operators be effective partners? Should the government focus more on policy, finance, and regulation than on service delivery? Can government service delivery be made to work well at an acceptable cost? Can government carry out new tasks by partnering with the private sector? For many of these questions, ex ante answers may be hard to come by. Trying innovative approaches and evaluating results should contribute to the answers.

The Private Sector's Role in Health and Education Services

Private sector actors are already playing a significant and increasingly diverse role in both the financing and delivery of health and education services. This section looks first at that role in health and then in education.

Private Financing of Health Care

A widely used summary measure for the extent of private health care at the country level is the share of total health expenditure coming from private sources, and more specifically, from out-of-pocket payments. Government services are often delivered free of charge or with low fees, so most out-of-pocket spending usually goes to private providers, including clinical providers of care, pharmacies and drug sellers, and providers of other ancillary health services such as diagnostic tests.

Figure 3.1 presents recent estimates of the share of total health expenditure at the national level that comes from private sources. Across the range of country income levels, private spending accounts for more than half of all health expenditures in about 47 percent of low-income countries and about 51 percent of lower-middle-income countries (figure 3.1 upper). For the low-income countries, private health spending is almost entirely out-of-pocket spending, because private insurance and formal employer-provided benefits are limited. Figure 3.1 (lower) shows that in 80 percent of low-income countries and 93 percent of middle-income countries, out-of-pocket spending makes up over 50 percent of private spending.

Private Delivery of Services Related to the Health MDGs

Despite the widely held view that services supporting the health- and education-related

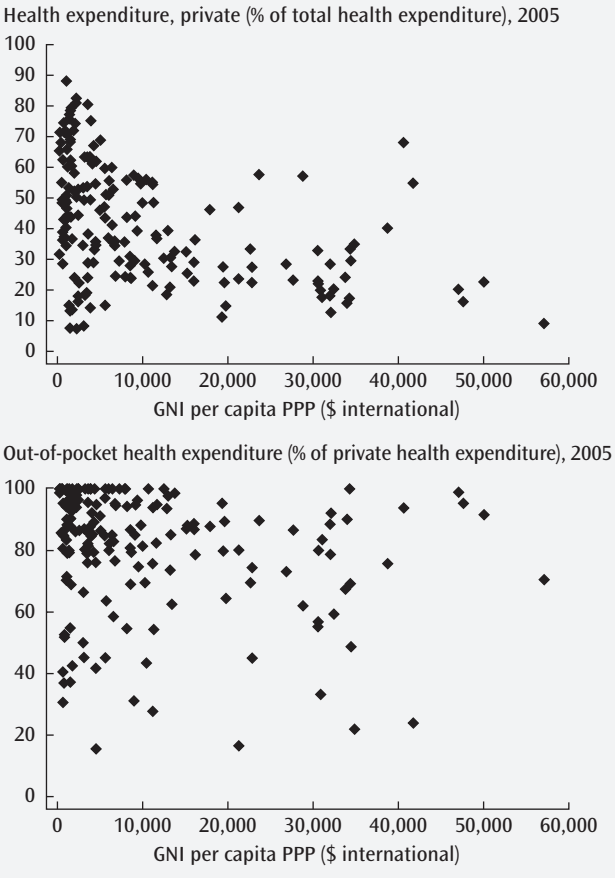
MDGs should be supplied mainly by government, ample evidence shows that when measured on a population basis, many of these services are being delivered by nongovernment providers. For MDGs 4 and 5—the maternal, reproductive, and child health goals—an excellent source of data on private provider roles is the Demographic and Health Surveys (DHS) supported by the U.S. Agency for International Development (USAID) that have been carried out in 80 countries over the last 23 years, with many countries having multiple surveys.[5] A recent review of these surveys shows the share of services provided by formal and informal private health care givers for four key indicators related to MDGs 4 and 5 for those countries in Sub-Saharan Africa and South Asia where DHS surveys have been done (figure 3.2).[6]

The shares of private formal and informal health care provision vary widely from country to country. Many surveys report private provision at more than 50 percent of MDG-related maternal, reproductive, and child health services in recent years. The levels are high across all the indicators: sources of contraception, most recent delivery, and treatment of childhood infections. The informal sector is supplying a very significant share of privately provided services.

Private providers also play a significant role in the treatment of communicable diseases such as tuberculosis (TB), malaria, and HIV/AIDS. Figure 3.3 summarizes results from a recent survey of 22 countries with a high TB burden regarding the participation of a wide range of government and private providers in TB referral and treatment. Authorities in 22 high TB burden countries were surveyed as to their perceptions about whether "all," "some," or "none" of the government and nongovernment providers are involved in TB case-finding and referral as well as treatment with approved TB drug regimens. The responses indicate that private providers participate in TB-related activities at about the same rate as public providers and that they are involved in both case-finding and referral as well as treatment with approved drug regimens. Lonnroth, Uplekar, and Blanc (2006) report positively on experiences in 15 different initiatives to involve private for-profit providers in government-initiated and -supported TB control programs.

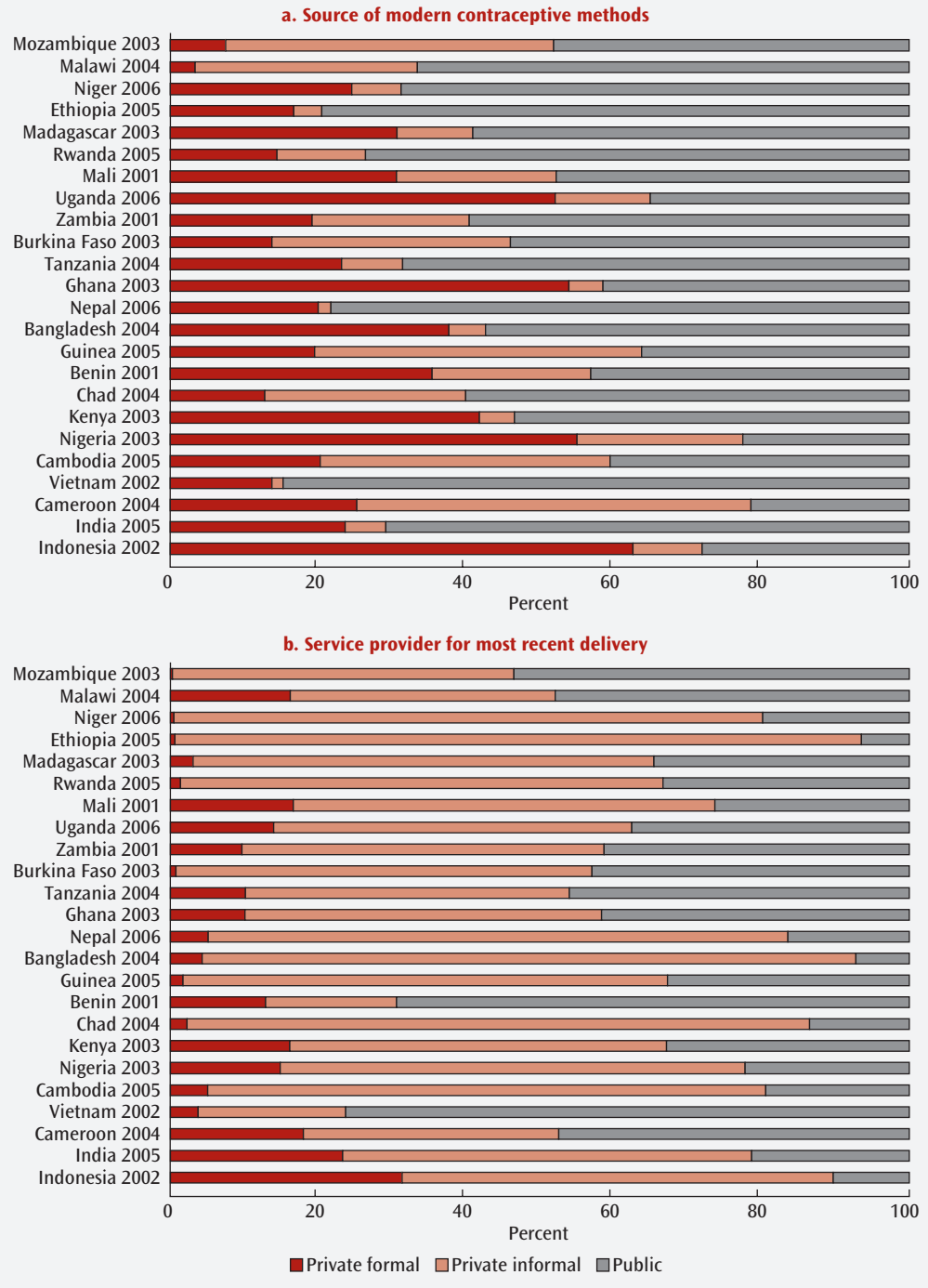
Because the DHS surveys have often been done several times in an individual country, it is possible to examine trends in the use of private providers of maternal, reproductive, and child health services. Figure 3.4 summarizes the data for those countries with multiple observations and shows whether the share of private use has increased, decreased, or remained unchanged.

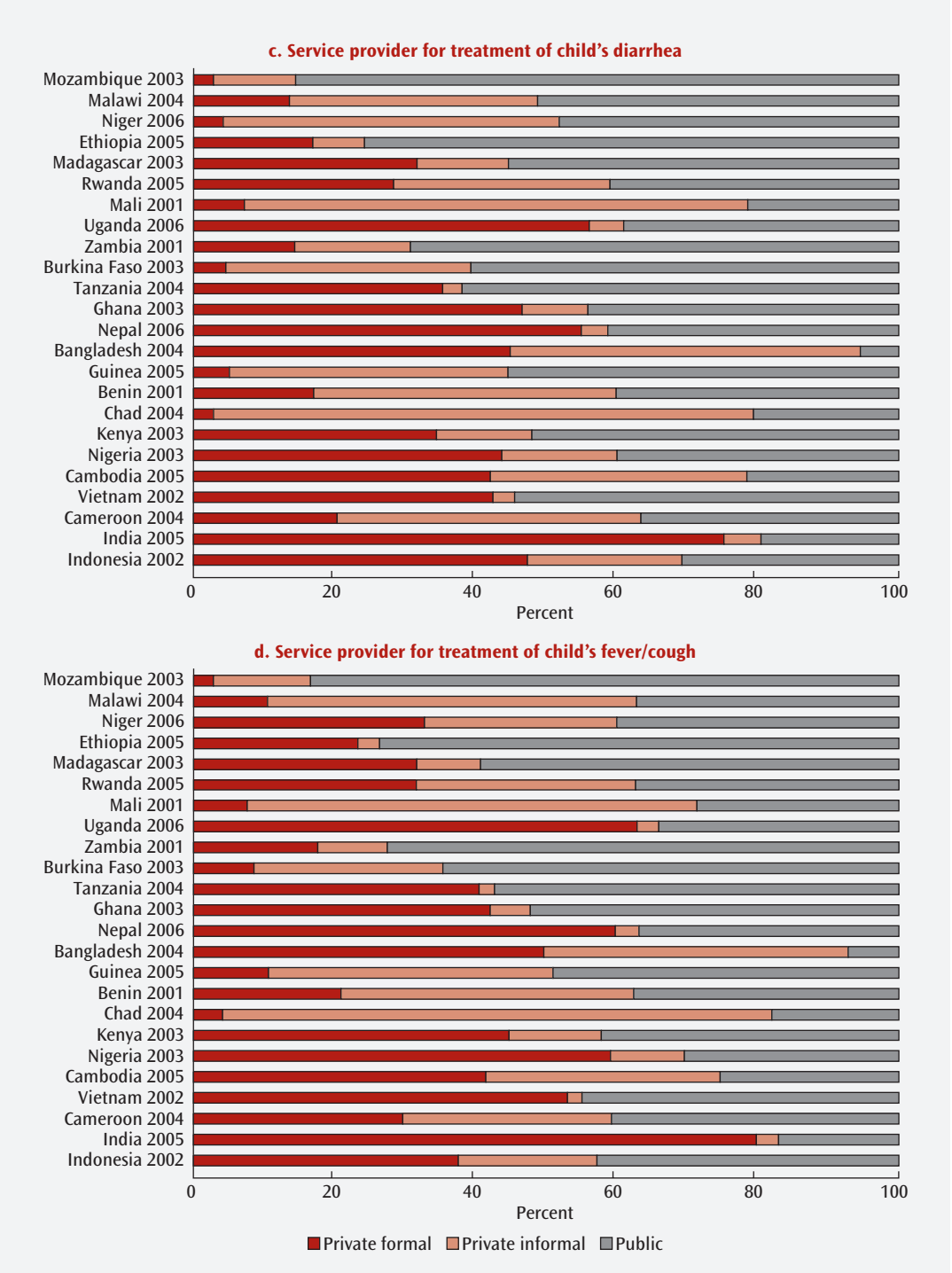
FIGURE 3.1 Private and out-of-pocket shares of health expenditure



Source: World Bank 2008.

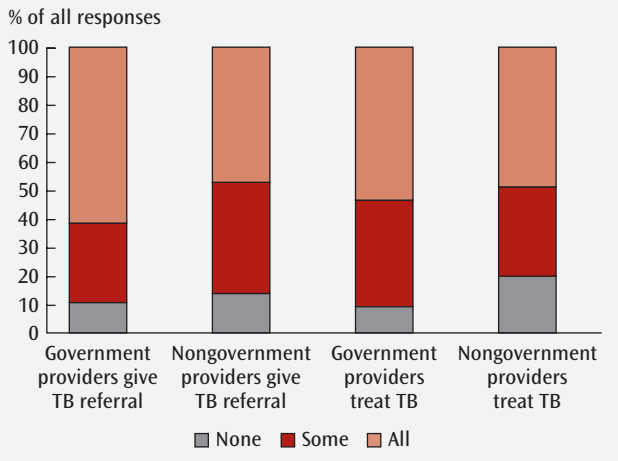
FIGURE 3.2 Use of private maternal and child health care services, Sub-Saharan Africa and South Asia





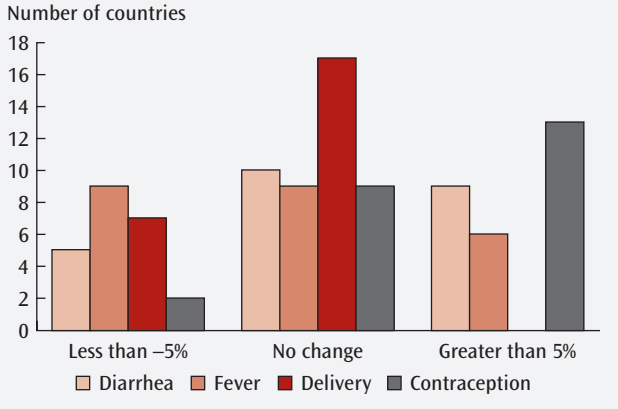
Source: Supon 2008, using most recent DHS data for Sub-Saharan African and South Asian countries. Countries arrayed by purchasing power parity GDP level. Year of survey shown next to name of country.

FIGURE 3.3 Public and private providers of TB services in 22 high-burden countries



Source: WHO 2009.

FIGURE 3.4 Trends in the use of private providers in Sub-Saharan Africa and South Asia



Source: DHS survey data used by Supon (2008).
Notes: The chart shows change in the share of private providers between two recent DHS surveys. Negative change indicates reduction in private sector shares. Changes less than 5 percentage points positive or negative are shown as "no change."

Overall, the chart presents a picture of little significant change in the shares of private providers delivering services related to maternal, reproductive, and child health in low-income countries. The only clear reduction in the private shares has been for delivery, reflecting a shift from traditional birth attendants and home delivery (private informal) to qualified institutional deliveries in government facilities. The absence of widespread reduction in the use of private providers in these surveys is interesting, because most of these surveys were conducted after the mid-1990s during a period of significantly increased effort to expand government roles in service delivery.

Figures 3.2, 3.3, and 3.4 show the highly significant role played by nongovernment providers in delivering services related to the health MDGs. These data indicate the important role of private providers in offering *access* to health care. However, concerns are often raised about whether private providers reach the poor (equity) as well as about the quality of the service they provide.

The data available from the DHS surveys can be used to examine where low-income households (proxied by a ranking based on household assets) obtain MDG-related health services. Figure 3.5 shows results for the four measured services—diarrhea, fever/cough treatment, source of delivery, and source of contraception—comparing the two lowest asset quintiles (or bottom 40 percent of the asset index distribution) with the average for the whole population. Points above the 45 percent line indicate higher use of private providers by the lower quintiles than by the general population. Overall, there is no clear indication that private sector use is mainly among the better-off while the poor largely use government services. In fact, the results point slightly in the other direction with government providers favored by the poor mainly as a source of contraception.

Informal private providers play a large role. When these results are separated for formal and informal private providers, it is clear that the poor rely significantly on the informal sector. In a relatively unregulated market, formal private providers will gravitate to those more able to pay, and informal providers will be more accessible to the poor.

Private providers, formal and informal, account for a large share of service use

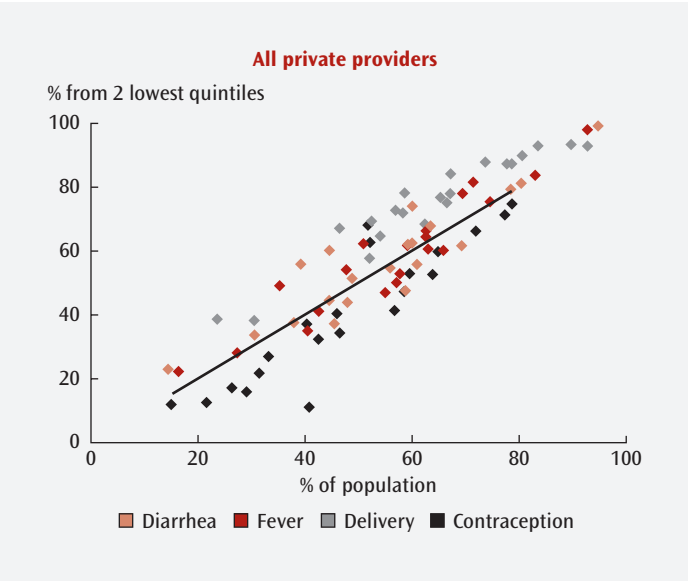
related to the MDGs, even for the poor. But usage data say little about the *quality* of the services people are receiving from private providers or about how this quality compares with that of government providers. Unfortunately, the evidence on quality is fairly weak.

Anecdotal evidence and casual observation suggest that a lot of the health care available in low-income countries with widespread private provision—including widespread self-treatment and treatment by untrained or unlicensed providers—is of poor quality. But there are few systematic and representative studies of quality of care in low-income countries and even fewer comparing government and nongovernment providers. In general, nongovernment providers are less likely to follow standard diagnostic and treatment protocols for communicable diseases and much more likely to use a wider range of less-preferred and more costly diagnostic and treatment actions.

Researchers distinguish between *technical quality* (the degree to which services adhere to best-practice processes likely to ensure health impact) and *patient-perceived quality* (which relates to the nontechnical characteristics of care that lead to patient satisfaction). Studies of private provider quality often raise concerns about the low quality of treatment practices.[7] Some disease-specific assessments have reported low quality of health care in the private sector, such as in the treatment of TB in India,[8] treatment of sexually transmitted diseases in South Africa,[9] and distribution of antimalarial drugs in Kenya.[10] In many low-income countries where regulation is weak, private providers often do not follow guidelines, may be poorly trained, and may have inadequate drug stocks and low quality drugs. Unsound prescribing, for example, leading to antimicrobial resistance, is one quality problem that is often cited.

Patients themselves often give private providers good marks on characteristics such as flexible working hours, convenient location, better equipment, more confidential care and attentiveness to patients, and greater availability of physicians and pharmaceuticals.

FIGURE 3.5 Probability of using private health care providers by whole population and the lowest two asset quintiles in Sub-Saharan Africa and South Asia



Source: DHS survey data used by Supon (2008).
Note: The diamonds in this chart show the percentages of reported service utilization of private formal and informal health care providers by the whole population (x axis) and the lowest two quintiles in the asset index distribution (y axis) for four MDG-related health care services measured by the DHS surveys.

Very few studies compare government and nongovernment providers systematically. A recent study in New Delhi found poor technical quality in both sectors.[11] Some studies have also found the quality of private sector providers to be superior to that of public sector providers. Examples include antenatal care in Tanzania[12] and the quality of care for sexually transmitted diseases in Uganda.[13]

Overall, the limited available evidence suggests that governments and donors should be much more concerned about the quality of health care. There are great risks of poor quality with informal private providers. Recognition of the quality problems in the private sector often leads to simplistic calls for government regulation—but experience suggests that regulation is difficult to implement, especially in weaker states and in less accessible locations. Quality

improvement may require more inputs. Increased costs will need to be financed somehow, such as through new purchasing mechanisms, higher volume, or subsidies. More evidence is needed to assess alternative approaches to expanding access and ensuring quality with both government and private providers.[14]

Examples of Innovation in Leveraging the Private Sector's Role in Health

Given the large presence of private providers in many developing countries, there are many examples of private providers engaged in delivering services to enhance achievement of the health MDGs. The following cases (box 3.1) illustrate some of the innovative ways that have been used to leverage existing private capacity. They also reinforce the messages introduced in table 3.2 that such innovative arrangements require new actions and capacities on the part of governments to design, implement, regulate, and evaluate.

In the first example, the Chiranjeevi scheme in Gujarat, India, the state government has developed an innovative contracting mechanism to pay private obstetricians to provide institutional deliveries to poor women. This example shows how a government committed to ensuring access to

BOX 3.1 Examples of innovative approaches to expand access to health services via the nongovernment sector

1. Chiranjeevi Yojana "Long Life of Mothers and Babies": Engaging Private Obstetricians in Improving Access and Quality of Institutional Deliveries in Gujarat, India

To meet the MDG targets for maternal and child health in the state of Gujarat, the state government set up a public-private partnership in 2005 that contracted with private obstetricians already practicing in rural areas to provide pregnancy and birthing care to poor women who otherwise likely would have had their babies at home. The program was initially implemented in five pilot districts within the state. Based on its initial success in raising the share of babies delivered in institutions from 38 percent to 59 percent, this program was expanded to cover the whole state with a total population of 55 million (see source below).

One key to the program's success was an innovative funding mechanism developed by the state government to improve the incentives for private practitioners to participate. Providers were given a contract for assisting with a given quantity of births for Chiranjeevi beneficiaries; a significant advance payment helped to overcome concerns about delays in payment. Payments were also replenished on a regular basis to assure participating doctors that they would be compensated for their work. A small sum from the payments was given to the women to cover their transportation costs. The total value of the contract included an agreed-upon estimate for a share of more complex deliveries, including caesarian sections.

The results of this partnership have been impressive. In less than two years, the number of obstetricians providing delivery care through the government program increased from the original 7 in the public sector to more than 800 in the private sector. Overall, the additional cost of the program for the whole state was estimated to be around 3.5 percent of the total health budget. Funding was provided by both the state and the central governments.

Sources: http://gujhealth.gov.in/Chiranjeevi%20Yojana/M_index.htm; Bhat and others 2006.

2. Child and Family Welfare Stores: Social Franchising of Low-Cost Pharmaceuticals in Kenya

The HealthStore Foundation's Child and Family Welfare (CFW) model is a private network of micro pharmacies and clinics whose mission is to provide access to essential medicines for marginalized populations. The CFW outlets target the most common killer diseases including malaria, respiratory infections, and dysentery, among others. CFW was launched as a nonprofit organization but today is planning to convert to for-profit status.

The CFW model incorporates all the key elements of successful franchising: uniform systems and training; careful selection of locations; and, most importantly, strict controls on quality, backed up by regular monitoring and inspections. Using a centralized procurement operation that works through the Mission for Essential Drugs and Supplies (MEDS) and other suppliers, HealthStore is able to obtain quality medicines at the lowest possible cost.

The network operates two types of outlets: basic drug stores owned and operated by community health workers, and clinics owned and operated by nurses who provide a deeper list of essential medicines as well as basic primary care. As the franchisor, HealthStore can revoke a franchisee's right to operate an outlet if the franchisee fails to comply with the franchise rules and standards.

HealthStore's customers are primarily low- or middle-income women and children subsisting on agriculture, although people of all ages and incomes are treated. CFW outlets are located at market centers in agricultural areas of approximately 5,000 people. The CFW network has 17 drug outlets and 48 basic medical clinics in operation. Central subsidies allow CFW outlets to offer lower prices and more predictable quality than competing private shops. Recently, CFW clinics have supported pilots for the introduction of artemisinin-combination therapy (ACT) for malaria, and the network has been included in the National Malaria Strategy.

Source: www.cfwshops.org.

3. Contracting out with Nongovernmental Organizations (NGOs) in Post-Conflict States

To address the inadequacies in its health care system, the Cambodian government decided to contract out the delivery of primary health care services to NGOs. A randomized trial was carried out starting in 1999 to compare the outcomes in the contracted districts with government provision of health services. Districts were randomly assigned to one of three health care delivery models: (1) contracting out, where the contractors were given full line responsibility for service delivery, including organizing health facilities; hiring, firing, and setting wages; and procuring and distributing essential drugs and supplies; (2) contracting in, where the contractors worked within the Ministry of Health (MOH) system to strengthen the existing administrative structure; they could not hire or fire health workers, although they could request that they be transferred. Drugs and supplies came through normal MOH channels. The contractors also received a nominal budget supplement for staff incentives and operating expenses; and (3) government provision, where the government district health management team (DHMT) continued to manage the services; drugs and supplies came through normal MOH channels, and the DHMT also received a budget supplement for staff incentives and operating expenses. The results showed that by 2003 contracted districts outperformed the government districts in terms of the coverage of services, quality of care, utilization by the poor, and out-of pocket expenditures on health by the community, especially the poor.

Source: Schwartz and Bhushan 2004.

In Guatemala, a similar effort was launched in 1997 with the goal of extending a basic health care package to 3 million people living in rural, impoverished, and indigenous communities that had previously been involved in conflict. Three different delivery methods were chosen: (1) direct contracting out, where NGOs were contracted to directly provide services; they received payments and were responsible for the purchase of all inputs (apart from vaccines); (2) a "mixed method," where the government contracted with NGOs to act as financial and administrative managers for services delivered by government service providers; these NGOs also received a set payment and were able to hire additional staff and purchase supplies, allowing them to bypass the notoriously slow hiring and procurement process; and (3) the traditional method, where current health posts operated by the government were strengthened. The results showed that women and children serviced by the mixed model had significantly better results for many key health indicators, compared with the other two models. The results also showed that the direct contracting out had higher productivity than either of the other two methods but was more costly, in part because the directly contracted NGOs were assigned to more distant and difficult-to-access areas than those contracted under the mixed model.

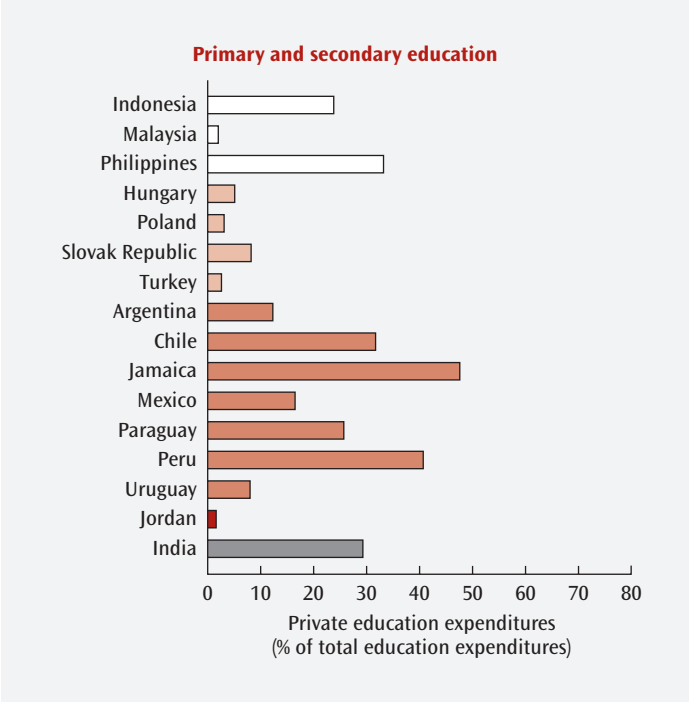
Source: Danel and La Forgia 2005.

certain services can creatively combine existing government and private provision capacity. With this scheme, the number of women who use qualified private providers to assist them at birth in public clinics has rapidly expanded. This innovative program also addresses a staffing issue, because public clinics typically encounter difficulties in recruiting and retaining qualified medical staff. The payment arrangement also gives some incentive to providers to avoid unnecessary services. The financial burden on the state government appears to be manageable, and it substitutes for government spending on expanding its own service delivery.

The second example, the Child and Family Welfare (CFW) stores in Kenya, illustrates the strategy of "social franchising," which uses techniques developed in commercial franchising to engage private providers in offering quality-assured, standardized, and branded services under agreed price and service conditions. This is a purely private initiative, where local entrepreneurs have sought to meet an evident need with a viable but low-cost business model. The HealthStore Foundation's CFW program has expanded access to essential pharmaceuticals to low-income consumers.

The third set of examples, contracting out of primary health care services in post-conflict settings in rural Cambodia and Guatemala, shows government engaging the capacities of the nonprofit sector to expand access to basic health services in rural areas where the government's own capacity to deliver services was very limited. Both programs tested several alternative contracting-out strategies and carried out substantial impact evaluations. The evaluations indicate that the programs performed well in several respects (increasing coverage and achieving a more pro-poor distribution); however, the evidence also suggests that these successes may not necessarily be reproduced in another country setting.

FIGURE 3.6 Private spending on education



Source: UNESCO, EdStats (www.worldbank.org/education/edstats).

Private Sector in Education

The private sector is also an important provider of education. Over the past two decades, private participation in education has increased dramatically throughout the world, serving all types of communities—from high-income to low-income families.[15]

Unlike for health, information for education is available only for a relatively small set of countries and indicators. Figure 3.6 shows recent data on the share of education expenditure from private sources for countries with available information. In some countries, such as Jamaica, Peru, and Zambia, the private sector contributes more than 40 percent of the total expenditures in education. In several others—such as Chile, Haiti, Kenya, Paraguay, and the Philippines—the percentage fluctuates between 30 and 40 percent.

Although governments remain the main financiers of primary and secondary education, in many countries private agents deliver a sizable share. Table 3.3 shows the

participation of the private sector in primary and secondary education for 1990 and 2006 for those countries with available information. Private enrollment shares at the primary level increased by a large magnitude in countries in most regions, particularly in Sub-Saharan Africa, the Middle East, and Southeast Asia. At the secondary level, private enrollment has also increased, although less uniformly across countries. However, private enrollment shares typically remain higher in secondary education than in primary education.

Figure 3.7 presents data for private enrollment shares by region in 2006, based on the countries with available information, while

TABLE 3.3 Private enrollment shares in education, selected countries, 1990 and 2006
percent

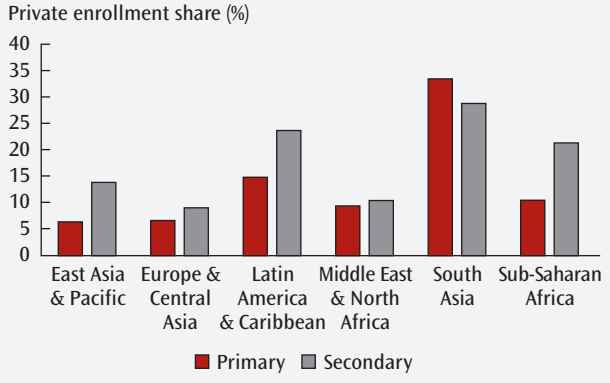
		Primary		Secondary	
Country	Region	1990	2006	1990	2006
Burkina Faso	Sub-Saharan Africa	8.6	13.7	41.1	38.8
Cameroon	Sub-Saharan Africa	25.2	22.5	42.8	28.2
Guinea	Sub-Saharan Africa	2.4	22.0	4.1	15.9
Mauritania	Sub-Saharan Africa	0.7	7.4	2.5	16.8
Indonesia	East Asia & Pacific	17.6	15.9	49.2	43.5
Philippines	East Asia & Pacific	6.7	7.8	36.4	20.4
Thailand	East Asia & Pacific	9.6	16.7	16.2	15.0
Poland	Europe & Central Asia	0.1	1.9	0.4	2.8
Turkey	Europe & Central Asia	0.6	1.8	2.8	2.3
Chile	Latin America & Caribbean	38.8	52.9	49.0	53.7
Costa Rica	Latin America & Caribbean	4.7	7.0	7.9	9.8
Mexico	Latin America & Caribbean	6.2	8.1	16.6	15.0
Peru	Latin America & Caribbean	12.6	17.6	14.6	24.3
Jordan	Middle East & North Africa	22.9	31.2	6.1	17.0
Morocco	Middle East & North Africa	3.6	7.3	2.7	5.2
Syria	Middle East & North Africa	3.5	4.3	5.6	4.0
Tunisia	Middle East & North Africa	0.5	1.2	12.0	4.7
Bangladesh[a]	South Asia	15.2	38.9	NA	NA
Nepal[a]	South Asia	4.7	14.7	NA	NA
Pakistan[a]	South Asia	14.0	35.0	NA	NA
OECD average[b]		10.1	11.8	17.6	17.9

Source: UNESCO; EdStats (www.worldbank.org/education/edstats).
Note: The table shows most recent data available within two years of the year indicated.
a. Based on data from background paper prepared by the Aga Khan Foundation for the *Global Monitoring Report 2008*, UNESCO. Comparability across countries is limited because of different definitions of education expenditure. However, comparability within each country across years is assured.
b. Average estimate based on OECD countries for which data are available for both years.

figure 3.8 presents the same information, dividing the sample by country income level. It is noteworthy that a larger share of education is provided privately in low-income countries than in high-income countries.

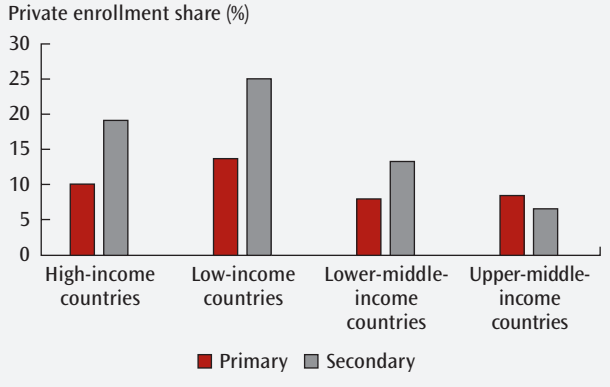
Countries provide different examples of mixes between public and private sector roles in education financing and provision. Some countries make a sharp distinction between the role of the public sector as the education financier and the private sector as the education provider. For instance, in the Netherlands, all education is publicly financed, including private schools, which enroll more than two-thirds of all students. In other countries, such as Chile, the private sector plays an important role in providing education, but the government subsidizes only some of the students who attend private schools. Several African countries have different types of nonpublic schools, including government-subsidized independent schools (for example, in the Gambia); partially subsidized mission or religious schools (for example, in Lesotho); and partially subsidized community-organized schools (for example, in Kenya). Elsewhere, public schools are supported financially by the private sector in the form of user fees or corporate sponsorship (for example, in Pakistan).

FIGURE 3.7 Private enrollment share by region, 2006



Source: UNESCO, EdStats (www.worldbank.org/education/edstats).

FIGURE 3.8 Private enrollment share by national income, 2006



Source: UNESCO, EdStats (www.worldbank.org/education/edstats).

Examples of Innovation in Leveraging the Private Sector's Role in Education

Evidence on the impact of the private sector on the quality of education is limited and shows mixed results. Some of the evidence comes from cross-country studies that are mainly correlational studies. For instance, Woessmann (2009) shows that publicly operated schools deliver lower test scores than privately operated schools do, but publicly funded private schools are associated with higher academic achievement than publicly operated institutions. Therefore, one might conclude that partnerships in which the private sector is the operator and the public sector is the financier have the potential to increase the quality of education while keeping the education budget in check. Nonetheless, this evidence is correlational, and needs to be treated with caution.

Country studies provide a better source of evidence. The cases discussed below are examples of the delivery modalities shown in table 3.1, which help illustrate the issues regarding government role and capacities outlined in table 3.2. They are models either of government finance and private delivery or of private delivery and finance in which the government provides a framework for development.

The cases presented are of two types. First are examples of *systemic* involvement of the private sector in the provision of education. Systemic involvement implies a clear strategy by the government to form alliances with the private sector. In these cases, the private sector typically provides a large share of education in the country, and the public sector serves as the financier. Universal voucher systems, such as the one in Chile, continue to be rare. They are also difficult to evaluate, thus leading to different conclusions in different studies (box 3.2). The bottom line seems to be that without targeting or special measures, the positive effects of vouchers on quality may be the result of sorting, because the best students leave their public schools to attend private institutions. Contracting programs, such as the ones for educational services in Côte d'Ivoire and Bangladesh, can increase the supply of schooling and enrollments (box 3.3). The case of Côte d'Ivoire is an example of a pragmatic approach to addressing a lack of public school capacity. The government retains the responsibility for ensuring basic education but uses the private sector to make up for short-term gaps. In Bangladesh the government relies on private schools to deliver the great majority of secondary schooling; 97 percent of secondary school enrollment is in private schools. In addition, the government finances stipends to support girls' enrollment in secondary school. The stipend program has been credited with contributing to a significant increase in girls' enrollment and to reducing the male-female gap, but it has been less successful in terms of improving quality.

Overall, the evidence on the impacts of private partnerships from *systemic* interventions is mixed. On the one hand, the private sector is an efficient vehicle to increase access. On the other, the effects on the quality of education are unclear. The empirical evidence on the effects of vouchers on educational outcomes outside the United States is small, though growing. While there are few rigorous impact evaluations and even fewer random evaluations of voucher programs, the most rigorous studies available

BOX 3.2 Systemic involvement of the private sector in the public provision of education: vouchers in Chile

In the 1980s, Chile introduced a universal voucher system with the objective of making the education system more efficient. This reform enabled students to select the school of their choice, either public or private, and tied per-student public funding to school enrollment. The rationale behind this policy was that student choice would encourage school competition and increase accountability at the local level by making schools responsive to parental preferences. The provision of public funding to private schools led to the development of a school market in which more than 20,000 new private schools were created, and private enrollment rates increased from 32 percent of all enrollments in 1985 to 51 percent in 2005. Today 94 percent of all schools in Chile receive voucher funding, and 36 percent of those schools are private.

Evidence on the impact of the voucher system on the quality of education is mixed. Some studies found that the program had positive effects on beneficiaries' test scores, and others found no differences between private independent schools and public institutions. Moreover, there is evidence of sorting in private schools; that is, private schools choosing the best students and the rest remaining in public schools. There is evidence that the best students in public schools used the vouchers to attend private institutions.

More recently, Chilean students demonstrated significant improvements in their reading performance in the Program for International Student Assessment (PISA) tests between 2000 and 2006, making Chile the top Latin American country participating in PISA. The Chilean experience suggests that it may take some time for school choice policies to yield improvements in average academic achievement.

Source: Patrinos, Barrera-Osorio, and Guaqueta 2009.

BOX 3.3 Contracting out education programs: Bangladesh and Côte d'Ivoire

1. Bangladesh

The government subsidizes almost 90 percent of the base teacher salaries in community-managed, not-for-profit, nongovernment secondary schools. The government subsidizes enrollment increases by paying for additional teachers as long as the school meets the state criteria. Private schools are managed by local committees and are accountable to the government through the accreditation process required to be entitled to receive teacher salary subsidies.

A second type of public-private engagement is the provision of stipends to support girls' enrollment in secondary schools. Scholarships cover the cost of tuition of girls' secondary education. Additionally, girls receive a stipend expected to cover 50 percent of school fees. Stipend programs to support enrollment increases have been accompanied by curriculum reform, development of instructional materials, teacher training programs, improvement of school infrastructure, and institutional capacity-building initiatives. These are the main outcomes of the stipend program: (1) a significant increase in girls' secondary enrollment, from 442,000 in 1994 to more than 1 million in 2001; (2) a significant reduction in the enrollment gap between girls and boys; and (3) a significant reduction in the proportion of 13- to 15-year-old married girls, from 29 percent in 1992 to 14 percent in 1995.

Assessed weaknesses of the program include the low correlation between enrollment increases and improvement of completion and attainment rates at the secondary level, which suggests that access programs are not necessarily linked to the strengthening of core education components at the school level.

2. Côte d'Ivoire

The government established contracts with the private sector for education services with the objective of increasing the supply of education to meet student demand. In short, the government gives a payment to lower- and upper-secondary private schools for each public student that they enroll. Schools must be "chartered" to take on additional students, and placement depends in part on the educational performance of the school. The amount of the subsidy varies with school location and is loosely tied to the number of students enrolled. The number of students in the private school sponsorship program was 223,000 in 2001, up from 116,000 in 1993. Unfortunately, no systematic study has been done on the effects of this type of intervention, but research shows that the subsidy system is progressive, because it covers more of the expenditures for lower-income families. Thus the program promotes enrollment increases among the poor.

Sources: Sakellariou and Patrinos (2004) for Côte d'Ivoire; World Bank (2003) and Patrinos, Barrera-Osorio, and Guaqueta (2009) for Bangladesh.

show that voucher programs lead to significant improvements in access to secondary schooling for relatively poorer students. These programs can also lead to significant increases in test scores. Additionally, studies show that voucher recipients are more likely to complete secondary school, enter university, postpone marriage, and increase their earnings.

The second set of examples deal with public-private partnerships for *specific* programs. Usually, these are local programs without a systematic involvement of the private sector in the wider objectives of the government. For example, these programs may take advantage of the existing private sector to increase enrollment among underserved segments of the population, as is the case in the Punjab Education Foundation's program in Pakistan. A program partnership may also use the public sector in innovative ways, such as when the public sector constructs new buildings in underserved areas and contracts out the teaching to the private sector. This is the case of concession schools in Bogota, Colombia (box 3.4).

BOX 3.4 Public-private partnerships for specific education programs: Colombia and Pakistan

1. Concessions Schools in Bogota, Colombia

The concept of concession schools was introduced by the municipal authorities of Bogota in 1999 as a way to provide high-quality education to low-income and high-risk students. Concession schools are public but are managed by private school operators whose students have a record of scoring above average on the national secondary exit examination for five consecutive years. Private operators are granted autonomy over school management and receive a per-pupil payment. In Bogota, 25 public schools are run as concession schools under 15-year contracts. Empirical results from a rigorous impact study reveal significant increases in math scores; significant increases in reading scores; significant reductions in dropout rates; and some evidence of competition effects on nearby public schools.

2. The Punjab Education Foundation Assisted Schools Program, Pakistan

The Punjab Education Foundation was established in 1991 and restructured in 2004 into an autonomous institution to promote high-quality education for the poor through partnerships with the private sector. It is funded by the government of Pakistan's Punjab province, and it is headed by a 15-member, government-appointed board of directors, the majority of whom are from the private sector. The Foundation Assisted Schools Program aims to improve education quality by taking full advantage of the capacity of the mushrooming private schools in Punjab. Approximately 33 percent of children ages 6 to 10 who attend school are enrolled in private schools, and private enrollment shares are on the rise. The program attempts to improve quality through three fundamental components: vouchers, teacher training, and financial incentives to schools for improved academic performance. A preliminary evaluation of the initiative shows evidence of large positive impacts on the number of students, teachers, classrooms, and teaching materials.

Sources: www.pef.edu.pk; Barrera-Osorio and Raju 2008; Barrera-Osorio 2009.

Finally, the Kenya Private Schools Financing and Technical Assistance Program is an initiative of the International Finance Corporation (IFC) to provide local currency financing and technical assistance to private primary and secondary schools. In 2006 the IFC signed a risk-sharing agreement with K-Rep Bank of up to 120 million Kenyan shillings (US$1.7 million) on loans extended to eligible private schools in Kenya. Under this agreement, the IFC shares 50 percent of the risk on the pool of loans made to schools after an initial 5 percent first loss is taken by K-Rep Bank. Schools use these loans to finance construction projects, purchase educational materials, including computers, and cover other capital expenditures. To support the risk-sharing agreement, a technical assistance program was prepared.[16]

New Vehicles for Private Sector Contributions

The potential for leveraging the private sector role in human development outcomes extends well beyond service provision. Nongovernment actors are playing a variety of relatively new roles that include financing of both government and nongovernment actions and the introduction of new service delivery organizations and strategies. Private actors are increasingly visible and vocal in international, national, and local policy development and planning. New models of public-private partnership are also emerging internationally and nationally, although there is still limited evaluative evidence to help assess their benefits and costs. This section explores some of these new roles and their implications.

New Private Funders: Philanthropy, Health Insurance, Development Financing

The ascendance of the MDGs on the global stage has been accompanied by significant increases in development assistance in the last decade, redressing some of the previous declines. These increases have been particularly large for health, less so for education. Much of the increase has come from traditional sources of international funding—bilateral and multilateral agencies. But major new international philanthropies have also emerged as significant sources of new financing. Probably the best known of these is the Bill and Melinda Gates Foundation, but several others have also increased their funding for global health and education.[17] Beyond the obvious benefit of being a new source of funding, these new developments in private financing open up new avenues for innovation in delivering MDG-related health and education services.

The world's foundations contributed an estimated $4.5 billion to work in the development field in 2005. Of this amount, foundations from the United States contributed $3.8 billion, double the amount they gave in 1998. Prior to the current crisis, philanthropic contributions were increasing, although this trend may not continue to the same extent. Greater contributions by U.S. foundations in the international arena could be driven by their availability of greater financial resources and experience in giving practices.[18]

Growing international philanthropy has taken several forms. In the recent scale-up of private giving for global health, significant funding has been provided to support existing and new international organizations as well as a variety of new global "alliances." For example, the Global Alliance for Vaccines and Immunization and the Global Fund to Fight AIDS, Tuberculosis, and Malaria have both received large contributions from government and nongovernment funders. Box 3.5 discusses the emerging role of the Bill and Melinda Gates Foundation in global health, and how it supports several new actors in this field.

The education sector receives a significantly smaller share of total philanthropic giving relative to the health sector. According to the Foundation Center, 43 percent of U.S. foundation support to international activities went to health programs, while 6 percent was earmarked for education. Nonetheless, recent major corporate and individual donations to education in developing countries

BOX 3.5 The growing role of the Bill and Melinda Gates Foundation in global health

One of the largest private foundations working in global health is the Bill and Melinda Gates Foundation, which has had a significant impact on the field since it was founded 14 years ago. Its other two focuses are reducing global poverty and increasing access to education for low-income Americans.

The foundation has committed over $11.6 billion since 1994 for global health programs. To date, the largest grants have been US$750 million for the Global Alliance for Vaccines and Immunization; followed by US$500 million for the Global Fund to Fight AIDS, Tuberculosis, and Malaria; and US$200 million each to the Aeras Global TB Vaccine Foundation and the Foundation for the National Institutes of Health. It was also a major founder of the Global Alliance for Improved Nutrition, a vehicle for collaborations with private organizations and industry, and it continues to give significant amounts in support of nutrition programs.

Source: www.gatesfoundation.org.

highlight the potential of philanthropic foundations to improve education outcomes and have attracted increasing interest from governments and multilateral agencies.

Private philanthropic contributions may have a significant impact on national education systems through several pathways. First, the flow of additional resources could ease resource constraints in education, and the resources can be targeted to underserved areas or populations. Second, private expertise in management can generate efficiencies in the implementation of education programs supported by philanthropy and provide useful lessons for greater efficiencies in public service delivery. Third, targeted support to research and analysis of policies and programs at the primary and secondary levels may be of added value to governments in developing countries that often lack the resources and expertise to invest in this area. Lastly, strategic involvement of the private sector may help redirect education policy toward the adoption and expansion of successful privately developed initiatives.

The role of new actors in the health and education sectors does not come without challenges. Uncoordinated and isolated actions of private donors may not generate systemic impacts and may benefit only selected groups of patients or students. There is a risk of overcrowding resources in certain countries or programs. The flow of private resources may substitute rather than supplement budgets, by creating incentives for governments to withdraw funding from public education or public health problems or to shift funding between levels within the sector. Withdrawal of resources from basic education, for example, may reduce the quality of the service provided and raise equity concerns. Finally, privately funded interventions raise the risk of lack of sustainability once the initial grants are exhausted.

Philanthropy is not the only form of private funding of public health and education activities. For example, in health, another (and somewhat different) form of private financing is risk-pooling arrangements, such as health insurance and community financing/micro-insurance. To date, organized private financing has been of limited importance in low-income countries. Preker, Scheffler, and Bassett (2007) reviewed data from all developing regions and generally found that private health insurance accounted for a very small share of health expenditures. Private health insurance schemes in low-income countries primarily cover urban and more affluent populations and higher-cost services involving hospitalization, although some also have links with primary care services. The main relevance of these risk-pooling arrangements for the health-related MDGs is likely to be in relation to communicable diseases, especially HIV/AIDS and TB, which may be significantly prevalent in adults working in the formal sector. In higher-income Sub-Saharan countries such as South Africa, with high HIV/AIDS prevalence, private insurance arrangements can influence access to both prevention and treatment as well as make formal sector employers more aware of public health issues.

An emerging vehicle for private financing is community financing and micro-insurance. These are typically small-scale schemes initiated by NGOs with community linkages, although there are some examples of government promotion. These schemes typically involve community members in management and supervision and often cover the primary care services relevant to the various health-related MDGs. With a few exceptions, such as the "Mutuelles" found in Rwanda and West Africa, coverage of these schemes is still fairly low.[19] There are instances of these schemes purchasing insurance coverage through the formal private sector insurance providers. This provides a mechanism for formal private insurance to contribute to development of basic coverage. There is also growing interest in linking micro-insurance programs with financial services for rural communities, such as rural banking and micro-credit, exemplified by the programs

of Basix in India, which provide financial services and technical assistance to the rural poor and women.[20]

Health insurance can also play an important role in reducing the financial risks of households experiencing serious illness. This financial risk protection is also related to the MDGs, especially MDG 1 on poverty reduction, because high out-of-pocket spending on health needs has been shown to be a significant cause of financial shocks to poor households (see, for example, Baeza and Packard 2006). This function can be carried out in different ways by both government and nongovernment entities funding different types of "demand-side" entitlements. For example, governments or NGOs could purchase insurance coverage from private insurers for targeted beneficiaries, such as informal sector workers and families, or they could make direct payments for service charges at government or nongovernment hospitals. Investing the users of health care with such entitlements has added advantages of empowering them to demand greater quality and accountability from providers.

Private corporate financing for service delivery programs to achieve the MDGs in the wider population (in contrast to targeting corporate employees) is also emerging as a new area of innovation. Private corporate actors can be multinational or purely domestic. The health sector, in particular, has a large corporate element. Box 3.6 provides some examples of current corporate-supported programs, including one financed by a multinational pharmaceutical company, which target health outcomes in low-income countries.

BOX 3.6 Leveraging corporate finance for disease control

The following are two very different examples of corporate financing of health programs: one private corporate cofinancing of service delivery for HIV/AIDS; the other leveraging private research funding to develop new products for future purchase in public sector programs.

Debswana is a 50/50 partnership between the diamond mining company De Beers Group and the Botswana government to combat the HIV/AIDS epidemic. Debswana staffs and fully funds the Jwaneng Mine Hospital and HIV Clinic in Botswana that was opened in 2003. It originally was formed to treat employees of the mine, then it was extended to cover their families, and it now treats the public. In 2005, 30,000 free outpatient appointments were recorded, and by 2007, 3,100 patients were being treated with antiretroviral drugs, and the program had been expanded to support four satellite clinics offering HIV testing.[a]

Another innovative financing initiative tackles the failure of markets to develop and produce vaccines for the health needs of poor countries. Six donors (Canada, Italy, Norway, the Russian Federation, the United Kingdom, and the Bill and Melinda Gates Foundation) have committed $1.5 billion to an initiative to accelerate the development and production of a pneumococcal vaccine for use in developing countries by assuring vaccine manufacturers that funds will be available for poor countries to buy the vaccines at a predictable, long-term price. The initiative, titled the Advanced Market Commitment (AMC), is results-driven: payments will be made only for vaccines that work well in the poorest countries. It is also demand-led: developing countries have to want to purchase the vaccine.

AMC funds will be used to subsidize the purchase of pneumococcal vaccines that tackle the disease strains most prevalent in low-income countries in Africa and Asia and that meet a required public health efficacy level. When a vaccine meets these requirements and recipient countries want to buy it, the manufacturer is entitled to enter into a supply agreement for vaccines at a subsidized price in exchange for a commitment to provide an established volume level, at an established price, annually for 10 years. Once the private subsidy funds are depleted, the manufacturer must continue to provide the product at an established retail price to meet the continuing demand.[b]

a. Wilson 2007.
b. World Bank 2008b.

New Private Provision: International and National Nonprofits and For-profits

Much of the private health care provision described in this chapter is delivered by small, diverse, and often informal providers. But there are also private organizations that can be significant service providers for the health-related MDGs on a larger scale and scope. These include both international and domestic organizations and both the nonprofit and for-profit sectors.

Medecins san Frontieres, Save the Children, and the Program for Appropriate Technology in Health are just three of several well-known international nonprofits increasingly visible as service providers in developing countries.[21] These international groups may team up with traditional and new private funders as well as with domestic service providers, leveraging local capacities and international financing and often introducing innovative approaches to service delivery.

Nongovernment domestic service providers in developing countries, such as the widespread faith-based providers in Africa (for example, the Africa Religious Health Assets Program) and other regions, the Africa Medical and Research Foundation in Kenya, and the Bangladesh Rural Advancement Committee (BRAC) are also growing in scale and scope.[22] BRAC is a particularly interesting and important example. It provides a significant level of services addressing both the health- and education-related MDGs domestically in Bangladesh with a mix of financing sources, and it is increasingly active in other countries, such as Afghanistan (see box 3.7).

New Models of Public-Private Partnership

This brief review of the expanding landscape of private sector engagement in priority health and education issues in developing countries does not do full justice to the

BOX 3.7 The Bangladesh Rural Advancement Committee: An emerging global NGO

The Bangladesh Rural Advancement Committee (BRAC) was launched in Bangladesh in 1972 and is the largest nonprofit organization in the developing world, employing 125,000 staff. It is funded through a combination of philanthropic support, income-generating enterprises, and borrowings. At present, it reaches more than 110 million people in Africa and Asia with its holistic approach to addressing poverty by providing micro-loans, self-employment opportunities, health services, and education.

BRAC is playing a major role in helping Bangladesh reach its MDGs; it offers preventive, curative, and reproductive health services to more than 92 million people. It helped immunize 82 percent of children under the age of two in Bangladesh, and trained women in 13 million households in how to treat diarrhea—the number one cause of death among children. The organization has been one of the pioneers implementing the "Directly Observed Therapy Short-Course" (DOTS) for treating TB, which has been described as a breakthrough by the World Health Organization. Concerning education, the BRAC Education Program targets out-of-school children and has graduated 3.9 million students from its primary schools (70 percent of whom are girls) and 2.3 million from its pre-primary schools, with nearly 1.6 million children currently enrolled in its 54,000 schools.

BRAC also operates in other countries such as Afghanistan, Liberia, Pakistan, Sierra Leone, Southern Sudan, Sri Lanka, Tanzania, and Uganda. In 2002, in solidarity with the refugees in Afghanistan, BRAC worked with Afghanis to launch microfinance and related programs, including health and education. BRAC is now the largest microfinance provider in Afghanistan, disbursing more than $96 million in small loans. In 2007, BRAC's annual program expenditure was $485 million. It used revenues from its microfinance program and pro-poor social enterprises, combined with debt, to self-finance 80 percent of the budget for its programs in Bangladesh.

Source: www.brac.net and BRAC-USA.

kaleidoscope of innovation and partnership that is emerging in many countries and around many different human development problems. Government and private sector roles are changing as both international and domestic economic and social conditions evolve. As the world strengthens its commitments to scaling up to achieve the MDGs, new models of public-private partnership are likely to come forward.

Several examples of this evolution have been emerging in relation to the World Economic Forum, which functions as a Swiss nonprofit foundation undertaking a range of initiatives in support of public and private action. This includes two major education partnerships: (1) the Global Education Initiative (GEI) brings together international and national private partners into education systems in Egypt, Jordan, Rajasthan (India), and the West Bank and Gaza, with the objectives of supporting national education reforms, developing information and communication technology in education, and demonstrating a model of education reform that may be replicated in other countries; and (2) the Jordan Education Initiative (JEI) was launched in 2003 at the World Economic Forum, and it is now under the patronage of Jordan's Queen Rania. It is the most advanced of these partnerships, with over $25 million in contributions. The partnership model, supported by significant evaluation efforts, has led to the implementation of the Discovery Schools program, reaching over 50,000 students in 100 Discovery Schools with pedagogic methods centered on computers and digital and web-based technologies.

A related effort, the Global Education Alliance (GEA), is being implemented in Rwanda and has potentially significant implications for enhancing attainment of the education MDG (box 3.8).

Another new initiative is the United Nations' High Level Task Force on Innovative Financing for Health Systems.[23] This group, launched in September 2008, seeks to develop innovative mechanisms for raising additional funds to strengthen health

BOX 3.8 The experience of the Global Education Alliance in Rwanda

The Global Education Alliance (GEA) was created in 2007 by the World Economic Forum in collaboration with the Education for All Fast-Track Initiative, a partnership of bilateral and multilateral donors that supports poor countries in their efforts to achieve universal basic education by 2015. The GEA is intended to bring greater private sector support for education, along with the technical expertise needed to effectively integrate information and communications technology into education. The initiative is being implemented in Rwanda, which is far off track for meeting the MDG goal on universal primary education. The GEA recognizes the existence of a variety of initiatives to improve the use of information technology in education and seeks to add value in two ways—by coordinating the multiplicity of public and private stakeholders working on information technology in education in Rwanda, and by contributing business expertise to enhance service delivery and management.[a] Already, the Ministry of Education has released the first draft of a new policy that will govern the use of information technology in the country's education sector. The major aim of the policy is to guide the way information technology is used in the education sector, including the preparation of curricula and maintenance of student achievement records.[b]

Through the GEA, Rwanda has already partnered with companies such as AMD, Cisco, Edelman, Intel, and Microsoft. The country is also testing the One Laptop per Child technology developed by Massachusetts Institute of Technology Media Lab.

a. World Economic Forum 2009.
b. http://allafrica.com/stories/200901160133.html.

care delivery systems with the potential to reach millions of underserved women and children in developing countries. It will review the possibilities and make recommendations on opportunities for the private sector in both raising resources and channeling them to countries.

The Way Forward

The world is past the midpoint of the target date of 2015 for reaching the MDGs. As shown elsewhere in this report, progress toward many of the indicators is not on track to achieve the goals. Progress toward the health- and education-related MDGs especially needs to be accelerated.

Some believe that the financing and delivery of the health and education services needed to achieve the MDGs should be entirely the responsibility of governments. Shortcomings in government achievements in these areas then have a clear remedy—more public financing and expanding public provision, such as building more health facilities and schools; hiring more health workers for the civil service; and increasing public procurement of pharmaceuticals, school equipment, and other inputs.

The actual pattern of service financing and provision departs dramatically from this normative picture. Substantial funding and service delivery are already coming from outside government and making significant contributions to the health and education MDGs. Given the urgency of the human development challenges and costs (both human and economic) of shortfalls in their achievement, disregarding the potential of the nonstate sector to contribute to the health and education MDGs is shortsighted and wasteful. Leveraging the private sector role should be an essential element of pragmatic policies and programs for achieving the MDGs.

Engaging the private sector does not mean a lesser role for government, which will remain central in efforts to achieve the MDGs. To the contrary, it means additional responsibilities and somewhat different responsibilities for government as part of expanded efforts to increase access and improve the quality of MDG-related services. In a sense, expanding governments' efforts to leverage the private sector in health and education is analogous to moving from a more closed economy to a more open one. There are new risks but also potentially new rewards. Global partners need to support not only more innovation to leverage the private sector role but also investments to strengthen governments' abilities to design, manage, and evaluate new approaches, and to ensure adequate coordination and regulation across a wider range of actors.

For **education,** such a pragmatic approach has the potential to align and mainstream the activities of public and private stakeholders, with the private sector helping to fill gaps where the public sector may be weak, such as in managing programs cost-effectively. More attention could be given to strategies that go beyond the traditional form of public finance and private provision to define new ways of public-private collaboration to achieve the education MDGs. Although still small, nongovernment and philanthropic actors in the education sector increasingly support a significant flow of funds from nonofficial sources to champion such initiatives. New and ongoing international education initiatives, such as the GEI, show promise and some evidence of scale.

Many of these initiatives are dominated by technology companies, suggesting that the corporate sector can provide both financing and productive inputs. Technology in education is in short supply in many developing countries. Technology can help to improve quality, better train teachers, and make information flow more quickly. More engagement with the private sector in this area should be encouraged. Countries could make wider use of contracting out to utilize excess capacity in private schools and to educate more children, as well as to expand access to underserved areas and excluded populations.

International public-private partnerships in education, in combination with domestic contracting, can:

- Increase the flow of resources to the education sector and allow governments to reach goals more quickly
- Bring international expertise and best practice to the sector, and make better use of domestic capacity
- Promote research
- Bring all partners together with a common vision and set of goals

Better coordination of international and domestic public-private partnerships can help:

- Avoid isolated actions, giving the initiatives a greater chance of generating systemic impacts
- Reduce overcrowding of resources in certain areas
- Complement education budgets
- Address the sustainability issue before it becomes a problem

For **health**, the picture is more complex. Four separate MDGs emphasize health-related outcomes, and some of these, such as MDG 6, involve multiple diseases and health problems affecting different populations (and groups within populations) and requiring different technologies and service delivery strategies. The complexity of the health sector places large demands on state capacities to accelerate achievement across a broad scope of services, suggesting that leveraging contributions from the nonstate sector should be an essential part of national strategies where feasible.

Already the private sector role in *both* health care financing and delivery is larger than in education, even in the low-income countries. It is often significant systemwide, including in rural areas and among the poor. The scale and scope of new approaches is expanding, although given the large role of the private sector in health in many countries, these efforts are still modest in terms of the overall health system. Governments in many low-income countries, where progress on the MDGs is most urgent, are increasing their engagement with the private sector, albeit cautiously.

Technical quality issues add a further complexity in the health sector. To be effective, services must be delivered according to technical standards. Not to do so is not only ineffective but can be very harmful both to individuals and to populations. Governments have to ensure quality in their own programs but face an added, and difficult, burden trying to ensure the quality provided by nongovernment partners. The capacities required of government in regulating the nonstate sector are quite different from those required for managing its own service providers.

Thus leveraging the private sector role to achieve the health MDGs requires government to chart a path combining the potential for increased access—especially for the poor—with the need for ensuring safety and quality. Some of the lessons of experience to date are the following:

- Health care financed and delivered solely by government has been expected to produce more equitable, efficient, and effective service delivery aimed at achieving the MDGs than that provided by private actors. There are many positive examples where this expectation has been met, but also many disappointing ones. Insufficient funding, poor governance, and other institutional failings have all been cited as major reasons that government programs fall short. In many circumstances, strong action to remedy weak government performance, including additional resources and innovations in governance and accountability, must be a key element of strategies to achieve the MDGs.
- Totally private financing and delivery arrangements, where feasible, make services physically available but often do not deliver good quality and may impose a

large financial burden on users. In some situations, such as remote rural areas, private formal alternatives are not available. Unitary private financing and provision favors locations and populations who can pay and will trade off quality when users cannot pay for it. There are many opportunities for private providers to take advantage of market imperfections, such as information asymmetry to the detriment of consumers' welfare and specific outcomes. Informal private sector providers raise additional concerns of poor quality, lack of accountability, and illegality. Governments and development partners may consider actions to support unitary private financing and delivery arrangements, but they should also pay adequate attention to regulation and safeguards to ensure quality and financial protection. Development of these arrangements should not work to the detriment of support for essential services for the poor.

- Mixed models, involving government and private financial intermediaries working together, are producing a number of innovative approaches. One promising approach gaining wider acceptance is the use of public financing and private provision to expand access and ensure quality. Those making use of public financing and private provision (such as contracting out) have shown that good health outcomes and financial protection are possible under these arrangements and can be done efficiently compared with government delivery. Use of these approaches is spreading, although high-quality monitoring and evaluation is still limited. These types of public-private partnership place new demands on governments to manage these new relationships effectively. When government skills and capacities to do so are not sufficiently developed, there is a greater risk of poor quality, inefficiency, and inequity.
- The range of experience is also growing for the reverse kind of partnership—private financing and public provision. Much international discussion has focused on one aspect of private financing—user fees for public services. But beyond user fees, there is a wide range of innovative new approaches to mobilize private financing in support of public provision for public health goals more broadly. These seem to be making positive contributions and are getting strong support from new private sector actors in global health. Governments and development partners should support these new initiatives while taking care to avoid duplication of efforts and competition among supplemental funds for scarce system resources like trained personnel.

Perhaps even more than education, in health there are many new vehicles for action in the nongovernment sector that promote innovative strategies. Large private funders have been more receptive to new approaches and to working with a broad range of partners. This is proving to be a promising engine of innovation to which governments are increasingly receptive. One emerging opportunity is the High Level Task Force on Innovative Financing for Health Systems, mentioned earlier, which will be considering a number of different strategies to increase both public and private sources of finance for increased investments in systems to accelerate MDG gains. Concurrently, there are new efforts under way to ensure better coordination and reduce transaction costs, like the International Health Partnership Plus (IHP+). The IHP+ has introduced new mechanisms at the country level to improve coordination among public and private sector partners, and to reduce the transaction costs accompanying increases in the number of partners, as new organizations become more active through joint acceptance of common national plans and reporting standards.

Common to both health and education, a key take-away message from this chapter is that improving service delivery via either the government or the private sector,

or in public-private partnerships of various kinds, will require strengthening of government performance. Whether in terms of its own internal governance and accountability mechanisms, its ability to supervise contracts or diverse new funding sources, or its capacity to regulate nongovernment providers, government has a central role to play in accelerating progress toward the human development MDGs.

Leveraging the private sector role to achieve the human development MDGs is increasingly in the mainstream, and this trend is likely to continue. It does not mean a lesser government role in human development, but rather a somewhat different and even expanded role. It is not a panacea for the problems many countries face in accelerating MDG achievement, and it can be the cause of problems as well as a solution. But ample evidence demonstrates that the private sector can contribute substantially and in increasingly diverse ways to human development. The world needs to mobilize all its tools on the road to 2015.

Notes

1. A number of authors (for example, Bennett et al. 1997) define private sector providers as those not under the "direct control" of the government. While often used, this definition introduces some ambiguity in defining both "direct" and "control."
2. Barr 1993.
3. Bennett, McPake, and Mills 1997; Brugha and Zwi 1998.
4. Preker, Harding, and Travis 2000.
5. www.measuredhs.com.
6. Supon 2008. The distinction between formal and informal private providers captures whether service providers have formal (usually legally recognized) qualifications. In most cases these are qualified practitioners of allopathic medicine including both paramedics and physicians. In some countries where traditional medicine is formally recognized, traditional practitioners could also be classified as formal providers. Informal providers are typically legally unqualified or semiqualified and community based, such as traditional birth attendants or unlicensed village doctors and drug sellers. However, patients and communities may not understand these distinctions and may recognize many different types of providers without reference to this formal-informal distinction.
7. Mills and others 2002; Brugha and Zwi 1998.
8. Uplekar 2000.
9. Chabikuli and others 2002.
10. QAP 2002.
11. Das and Hammer 2004.
12. Boller, Wyss, and Tanner 2003.
13. Walker and others 2001.
14. Berman and Chawla 1999.
15. See Patrinos, Barrera-Osorio, and Guaqueta (2009) for a more detailed account of the private sector role in education.
16. Patrinos Barrera-Osorio, and Gauqueta 2009.
17. http://foundationcenter.org/newsletters/.
18. World Bank 2007.
19. Churchill 2006.
20. www.basixindia.com.
21. For more on these organizations, see their websites: www.msf.org; www.savethechildren.org; and www.path.org.
22. For more on these organizations, see their websites: www.arhap.uct.ac.za/; and www.amref.org.
23. www.internationalhealthpartnership.net/taskforce.html.