Issue #3

handshake

IFC's quarterly journal on public-private partnerships

In this issue

HEALTH + PPPs

IFC International Finance Corporation
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IFC's quarterly journal on public-private partnerships

Issue #3 – October 2011

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Editorial
Tanya Scobie Oliveira • Alison Buckholtz

Art & Design
Jeanine Delay • Victoria Adams-Kotsch

Outreach
Chrysoula Economopoulos

Disclaimer

Letter from IFC

It is impossible to overstate the importance of healthcare—after all, worldwide economic growth and development depend on it—but governments' ability to provide affordable, quality healthcare dwindles every year. The challenge is now to engage private partners to deliver public benefits. Innovative, forward-looking public-private partnerships in healthcare do this, giving businesses an unparalleled opportunity to do well while doing good.

This issue of *Handshake* delves into the details of healthcare PPPs that work, pushing past the numbers to ask why they succeed and how they can be replicated. We look at projects from multiple angles, in one case examining an initiative from the perspective of the client, the private network provider's Chief Operating Officer, and the IFC team that shepherded the initiative to completion. The overview demonstrates how differing priorities evolved into a coherent solution to serve a large number of people for many years into the future.

Although there are many different approaches to crafting healthcare PPPs, some as unique as the countries behind them, we can extract lessons to generate creative ideas. From these lessons, lives will benefit.

Laurence Carter, Director

Tanya Scobie Oliveira, Editor

IFC Advisory Services in Public-Private Partnerships

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Contributors

Meng-Kin Lim
is Associate Professor of Health Policy and Management at the Yong Loo Lin School of Medicine, National University of Singapore; he was also Chief Executive Officer of the Health Corporation of Singapore.

Rui Monteiro
is a Senior Public-Private Partnerships Specialist at the World Bank Institute.

Nathaniel Otoo
is the Director of Administration and General Counsel of the National Health Insurance Authority in Ghana.

Wajiha Ahmed
is an infrastructure consultant for GPOBA based in Washington, DC.

Tekabe Belay
is Senior Economist, Health, Nutrition and Population, in the South Asia Region of the World Bank.

Alison Buckholtz
is a communications consultant in IFC's Advisory Services in Public-Private Partnerships and a *Handshake* writer and editor.

Carla M.N. Faustino Coelho
is an Investment Officer in IFC's Advisory Services in Public-Private Partnerships, based in Johannesburg, South Africa.

Inaam ul Haq
is a Senior Health Specialist at the South Asia Region of the World Bank, working on health programs in Afghanistan and Pakistan.

Mohammad Tawab Hashemi
is a health specialist with the World Bank, based in Kabul, Afghanistan.

Kees Kostermans
is Lead Public Health Specialist, South Asia Region, at the World Bank, working on health programs in Afghanistan, Pakistan, and Sri Lanka.

Matthias Loening
is an advisor to IFC on healthcare PPPs.

Claudia Macias
is a Senior Operations Officer at the World Bank who works on healthcare and education initiatives in the Dominican Republic and Mexico.

Tayyeb Masud
is a Health Specialist at the South Asia Region of the World Bank, working on health programs in Pakistan.

Catherine O'Farrell
is a Senior Investment Officer in IFC's Advisory Services in Public-Private Partnerships, based in Washington, DC.

Naoko Ohno
is Operations Officer at the South Asia Region of the World Bank, working on health, education, and social protection programs in India and Pakistan.

Dr. Peter Okwero
is a Senior Health Specialist in the World Bank's Africa Region's Human Development Department, based in Uganda Country Office, Kampala.

Ghulam Dastagir Sayed
is a senior health specialist with the World Bank, based in Kabul, Afghanistan.

Lindsay Stowell
is a finance specialist and a consultant in IFC's Advisory Services in Public-Private Partnerships.

Robert Taylor
is Principal Financial Analyst in IFC's Advisory Services in Public-Private Partnerships.

Leslie Villegas
is an Infrastructure Specialist and Lead Advisor for health infrastructure for GPOBA, based in Washington DC.

By Robert Taylor

The healthcare challenge

Healthcare is now the greatest challenge facing governments

Photo © Jason Florio

PERSPECTIVE

Healthcare spending represents about 10 percent of GDP globally, and in the U.S. that number reaches nearly 20 percent, or $7,000 per person per year. This figure is rising faster than any other expense due to a variety of factors, including economic growth (which increases demand for treatment), changing demographics and epidemiological trends (aging populations and more chronic diseases), and advances in medical technology (leading to more expensive equipment and tests). Governments worldwide are struggling to meet these demands and challenges within their limited fiscal space, but simply lack the resources to provide healthcare to their citizens. This issue of *Handshake* explores innovative and successful approaches by governments that are tapping the private sector for healthcare infrastructure, service delivery, and insurance to meet these pressing demands.

PPPS FOR HEALTHCARE INFRASTRUCTURE AND SERVICES

Many governments are turning to public-private partnerships (PPPs) to provide healthcare services and/or infrastructure for their citizens. Several OECD and middle income countries have used the PFI model to finance, build, and maintain new health infrastructure, especially hospitals, while leaving the core health services within the public sector. At the same time, we see governments in emerging economies adopt PPPs involving full service delivery by the private sector. This approach is particularly important because in many emerging markets, the problem isn't simply the lack of modern equipment or facilities, it is the lack of sufficient medical staff and hospital managers.

Handshake's article on Brazil's new Hospital do Subúrbio depicts the progression of a PPP that will maximize the benefits from private sector delivery of core health services.

But transferring responsibility and risk to the private sector creates new challenges within contract management. Most governments have experience managing infrastructure PPPs and concessions, often through independent regulators. There is no ready equivalent in health, even though health PPPs, like all PPPs, inevitably face challenges during implementation—challenges often related to unforeseen increases in demand as well as cost-shifting (where the provider shifts higher-cost patients to other facilities). Rui Monteiro's article outlines how governments can convert challenges in PPP contract management into opportunities for improving policymaking and healthcare delivery.

In some cases, governments can mitigate risks in contract design by bundling a PPP to cover a network, rather than single facility, thereby encouraging the provider to manage treatment and referrals at the most cost-effective level. *Handshake*'s interviews with Lesotho's Minister of Finance and with the COO of Netcare (the provider awarded the Lesotho PPP contract) shed light on the process from two different, though complementary, points of view.

> Innovative healthcare PPPs can play a vital role in quickly upgrading health infrastructure and services in regions scarred by natural disasters or wars.

Innovative healthcare PPPs can play a particularly vital role in quickly upgrading health infrastructure and services in regions scarred by natural disasters or wars. Naoko Ohno's article on the revitalization of Pakistan's primary healthcare services following the 2005 earthquake describes how a district government successfully contracted with an NGO to deliver basic

healthcare to the affected population. Also of great relevance to the region, Tekabe Belay and his Kabul-based colleagues explain how Afghanistan implemented country-wide contracting of NGOs for delivery of primary and secondary care.

THE FISCAL CHALLENGE

Affordability and sustainability remain the major hurdles for governments. After all, PPPs cost money in the form of availability and/or service payments by governments or public insurers. The incremental cost may be minimal if the PPP involves replacement of an older, outdated, and costly public facility with a modern, more efficient (and often smaller) PPP facility. Typically, a modern hospital of 300 beds can treat more patients than an outdated hospital of 600 beds through a more efficient layout, much greater use of outpatient care and day surgery, and more efficient hospital management.

But new services and facilities for underserved areas or populations will have a fiscal cost and governments should not embark on PPP projects without a good idea in advance of the fiscal impact. To aid this process, this issue includes "PPP basics," an affordability analysis intended to guide government officials who are considering partnerships.

One way for governments to maximize value is to select projects with the greatest reach for the money and to allow the private sector to be creative and flexible in providing solutions. In many countries, improved primary and outpatient care may be what is most needed, but this is often overlooked as governments focus PPPs on more costly tertiary care.

> Growing global demand for more and improved healthcare…will require governments to tap the private sector for healthcare financing and delivery.

In most countries, sustainable and adequate funding will need to be developed through a broad national insurance program (with employer/employee contributions), combined with patient deductibles and copayments where feasible. A rapid increase of population coverage under national insurance plans has been achieved in several countries, highlighted here in the article by Nathaniel Otoo, Ghana's Director of Administration and General Counsel of the National Health Insurance Authority, and in Claudia Macias' snapshot of Mexico's Seguro Popular.

Another remarkable example is Andhra Pradesh in India, where the state government introduced a low-cost catastrophic health insurance plan that now covers 80 million poor people. Srikant Nagulapalli, CEO of Aarogyasri Health Care Trust, the government body in charge of

implementing the insurance program in Andhra Pradesh, speaks candidly to *Handshake* about his company's outreach to the poorest populations in India through village-wide health "camps."

Meng Kin Lim of the National University of Singapore also shares lessons on how to customize outreach and implementation to a specific population and culture. In "Singapore's secret to healthcare," he describes that country's unique healthcare system and how it achieves enviably high health outcomes at a fraction of the cost of most developed economies.

TRANSFORMING GOVERNMENTS

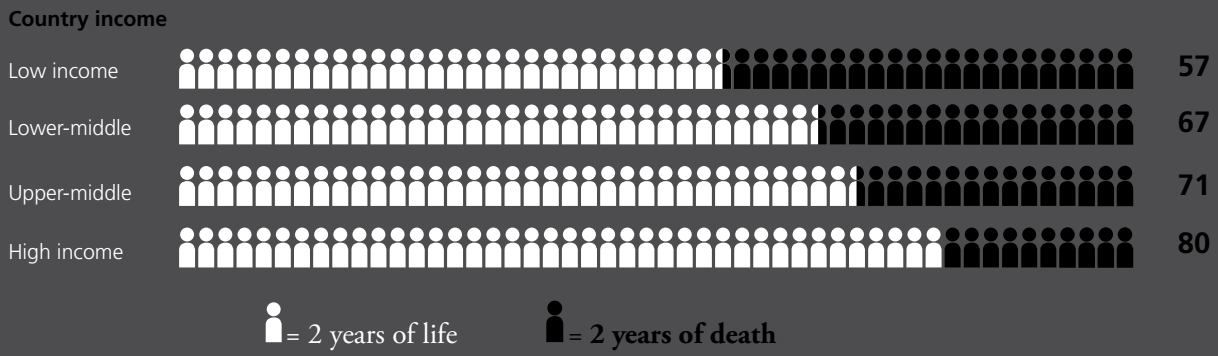
PPPs are a transitional step in the transformation of government from provider to purchaser. This shift involves three major elements:

- Definition of standard services or packages of services.
- Setting of standard reimbursement rates, regardless of provider (public or private).
- An accreditation mechanism allowing only accredited providers to be eligible for contracts.

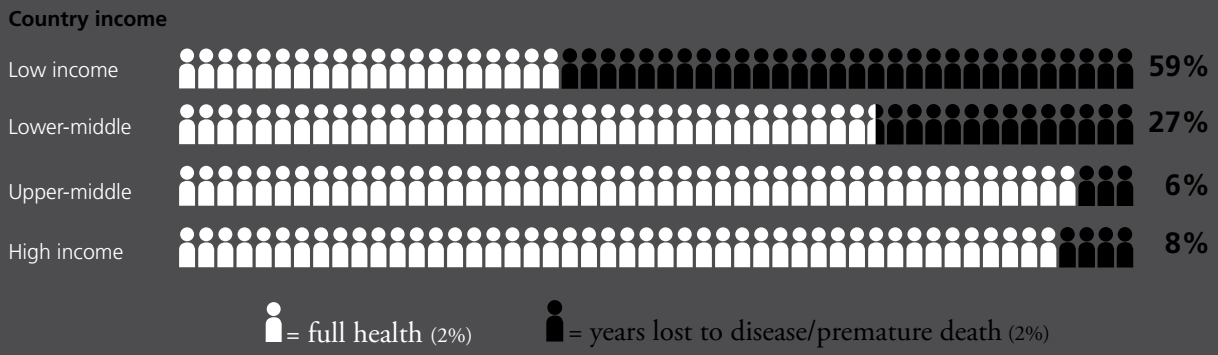
Under this system, all accredited providers would be treated equally and be eligible for reimbursement by the government or public insurer. Providers would be free to choose their location, which market forces would dictate, and facility size, which is subject to accreditation requirements. Reimbursement would in principle be sufficient to amortize capital costs, so that a separate PPP payment would not be necessary. In lower-income countries, however, it will be difficult to immediately establish fully cost-reflective rates. Some reimbursement premium may also be needed to attract providers to more remote and rural areas.

Growing global demand for more and improved healthcare, coupled with ever-increasing cost pressures, will require governments to tap the private sector to a much greater degree for healthcare financing and delivery. Countries which effectively integrate their systems through large-scale contracting will provide their citizens with the greatest choice and quality standards.

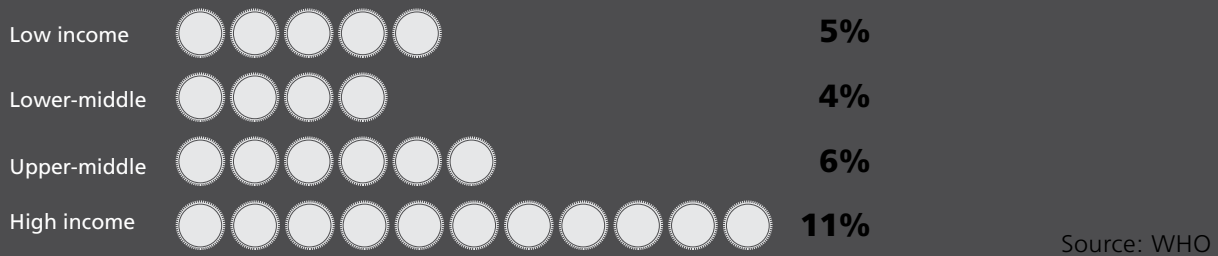
Life expectancy in low income countries is 23 years lower than in high income ones



Many years of active life are lost due to disease or premature death



Low income countries spend substantially less on health as percentage of GDP



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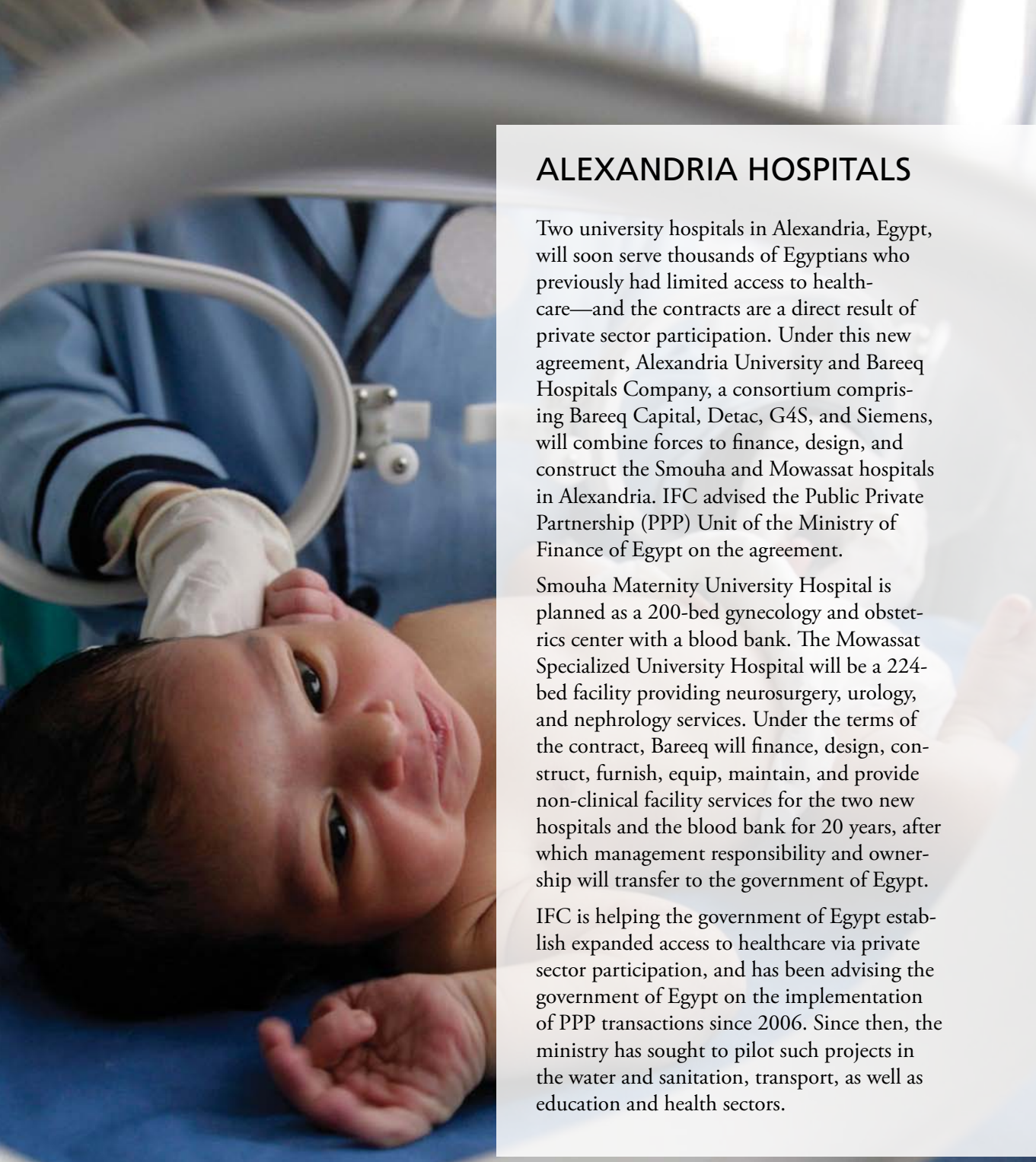


ALEXANDRIA HOSPITALS

Two university hospitals in Alexandria, Egypt, will soon serve thousands of Egyptians who previously had limited access to healthcare—and the contracts are a direct result of private sector participation. Under this new agreement, Alexandria University and Bareeq Hospitals Company, a consortium comprising Bareeq Capital, Detac, G4S, and Siemens, will combine forces to finance, design, and construct the Smouha and Mowassat hospitals in Alexandria. IFC advised the Public Private Partnership (PPP) Unit of the Ministry of Finance of Egypt on the agreement.

Smouha Maternity University Hospital is planned as a 200-bed gynecology and obstetrics center with a blood bank. The Mowassat Specialized University Hospital will be a 224-bed facility providing neurosurgery, urology, and nephrology services. Under the terms of the contract, Bareeq will finance, design, construct, furnish, equip, maintain, and provide non-clinical facility services for the two new hospitals and the blood bank for 20 years, after which management responsibility and ownership will transfer to the government of Egypt.

IFC is helping the government of Egypt establish expanded access to healthcare via private sector participation, and has been advising the government of Egypt on the implementation of PPP transactions since 2006. Since then, the ministry has sought to pilot such projects in the water and sanitation, transport, as well as education and health sectors.

This is MAYA...

Help Maya take her first breath in this World Bank video about prenatal healthcare systems.

Follow Maya's story as she celebrates her second birthday and smiles her biggest smile ever.

PPP basics: Is your project affordable?

By Lindsay Stowell & Matthias Loening

PPPs in health are distinct from typical infrastructure projects for a few key reasons. Primarily, private revenue contribution is usually low, and as a result, these projects require a large and ongoing payment from the government. In addition, the ongoing expenses of operating a hospital or other medical facility represent the vast majority of project costs, as opposed to a typical infrastructure project in which capital expenditures (capex) are the main cost element. Thus, there must be money available to fund the project post-construction.

Given that most projects face financial limitations, assessing the government's funding capacity and the resulting affordability level of a project early on is critical. This will allow for a timely commencement of discussions with the government regarding financial viability, key priorities, and project scoping options. When projects are not sized and scoped according to affordability levels, the projects need to be downsized after construction has already begun. Worst-case scenario: construction is completed but there is no funding to operate the hospital, resulting in the many "white-elephant" hospitals, where beautiful new facilities sit and gather dust while waiting for equipment, medical personnel, and patients.

Analysts must be able to identify how much the PPP project will cost and what the level of government support will be. Analysts must also ensure that the government is committed to making the project work given the financial obligations required. Assessing the affordability of a project can be done using a high-level financial model that is tailored to health PPPs. There are three key drivers that will help determine if the project is financially viable:

- Estimated capital expenditures: number of beds, gross area per bed, construction and equipment costs.
- Revenue drivers: estimated demand, public funding, copayments, and other private revenue opportunities.
- Estimated operating expenses: salary costs, maintenance costs, supplies and utilities.

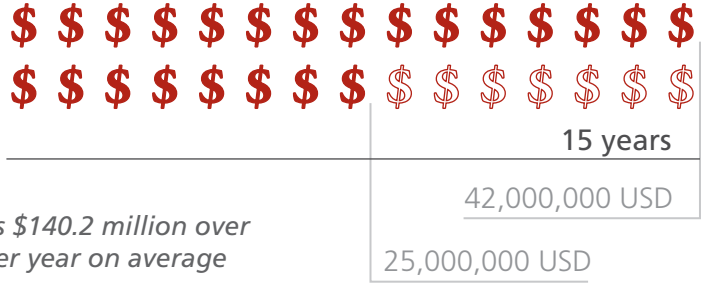
With a bit of research and analysis around these key assumptions, we can ultimately derive an expected annual PPP payment that can be compared to the current government budget available for the project.

Once an availability payment is derived from the financial model, analysts can assess the potential financing gap. The chart below displays the expected annual availability payment required to be paid by the government to the private operator during the life of the contract, along with the current annual budget allocation available for the project. The difference between the two is the financing gap that must be addressed with the client. Will the client be able to bridge this gap? If not, are donors or other sources of funding available, such as co-payment revenues or private patient revenues? Alternatively, can the project be scoped and sized to match the government's affordability level? Options to consider include assessing the appropriateness of the standards for the hospital or phasing the project in terms of size and/or services.

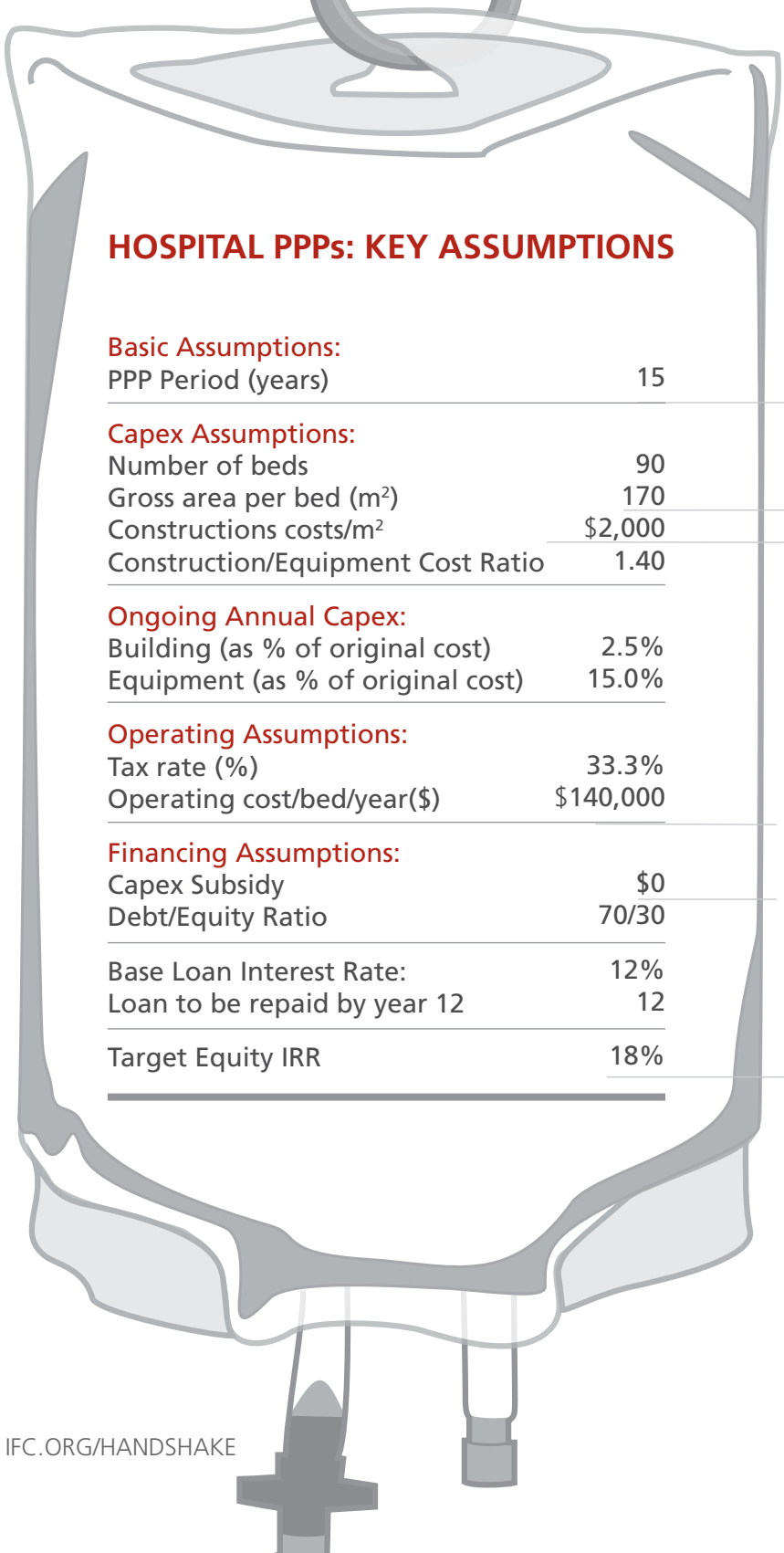
> Conducting an early-stage financial analysis helps clients understand the financial obligations and cost breakdown.

Conducting this early-stage financial analysis can also be useful in explaining the financial obligations and cost breakdown of the project to the client. The graphic on the next page, extracted from a hospital financial model, highlights the key components of project cost over the life of the PPP. Used together, these tools for affordability analyses can ultimately lead to more successful project closings, fulfilling client expectations and serving the health needs of large numbers of people around the globe.

FINANCING GAP



In this example, the financing gap is $140.2 million over the life of the PPP, or $9.3 million per year on average



HOSPITAL PPPs: KEY ASSUMPTIONS

Basic Assumptions:	
PPP Period (years)	15
Capex Assumptions:	
Number of beds	90
Gross area per bed (m^2)	170
Constructions costs/m^2	$2,000
Construction/Equipment Cost Ratio	1.40
Ongoing Annual Capex:	
Building (as % of original cost)	2.5%
Equipment (as % of original cost)	15.0%
Operating Assumptions:	
Tax rate (%)	33.3%
Operating cost/bed/year($)	$140,000
Financing Assumptions:	
Capex Subsidy	$0
Debt/Equity Ratio	70/30
Base Loan Interest Rate:	12%
Loan to be repaid by year 12	12
Target Equity IRR	18%

A long-term contract reduces the annual PPP payment.

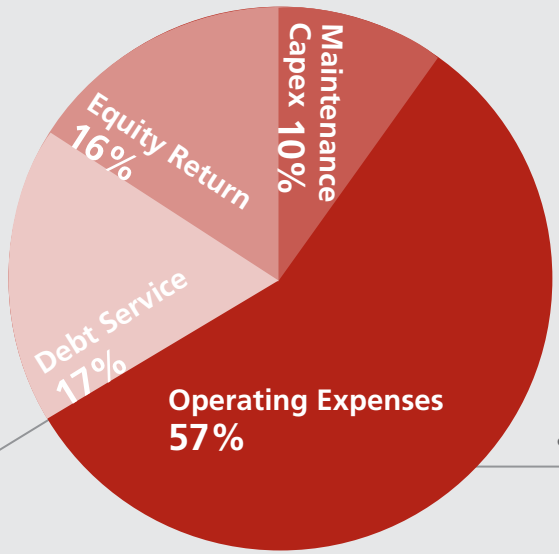
Upfront capex subsidies reduce the annual PPP payment.

Estimate 18% to 20%.

Standards drive
gross area per bed.
Rule of thumb:
Emerging Markets: 120m^2
Western Europe: 170m^2
U.S.: 360 m^2

Construction costs vary by region.
Estimate $2,000/m^2

Operating expenses per bed figures vary depending on standards and salaries. Estimate between $120,000 to $160,000.



The debt service component of a PPP payment can be reduced if an upfront capex subsidy is provided by the government.

Operating expenses, not capital expenditures, are typically the largest component of a PPP project in health.

Previous page: *This graphic, from a hospital PPP financial model, displays in more detail some of the major assumptions, along with some notes regarding specific inputs. Note that for other subsectors of the health industry (such as diagnostic imaging, primary health centers, laboratories, and dialysis, among others), assumptions will vary.*

8 KEY TRENDS
in the evolution of HEALTHCARE PPPs

Build and Beyond: The Revolution of Healthcare Public-Private Partnerships, a 2010 report from Pricewaterhouse Coopers, tracks the evolution of the PPP models and explores how the capital and operational structure provided by PPPs can be leveraged more broadly to address governmental demands for greater efficiency in health spending.

1 **Government spending on healthcare is growing** at a pace that is likely to be unsustainable unless new funding sources are found.

2 With the global recession, **governments are increasingly looking to PPPs** to solve larger problems in care delivery and wellness that are driving spending.

3 **The larger scope of PPPs means a much larger potential market for private organizations**. Infrastructure represents only five percent of health spending. However, health spending beyond infrastructure—95 percent—will total more than $88.1 trillion. This huge spend will become a target for government efficiency and create a market for private investment and management.

4 **The measurements of success in PPPs are evolving toward health outcomes and performance**. Healthcare infrastructure PPPs are more focused on better procurement and value for money.

5 In service delivery, **PPP arrangements open broader conversations about how to create and maintain locally-based sustainable health systems.** Governments typically agree to build in profit margins to induce private sector involvement. Competition and later reductions in government payments are then used to generate long-term savings and improve quality.

6 **PPPs are increasingly developed by local, rather than national governments**, that are closer to local health needs. However, national governments are important to setting a policy framework that enables local regulations.

7 **Technology was often left out of PPP infrastructure deals, but is central to the new generation of PPPs** in which manufacturers are often risk partners themselves, as service delivery becomes more integral to PPPs.

8 **PPPs are challenging the notion that private healthcare is for the rich**, and public healthcare is for the poor. Rather than creating or exacerbating inequities in care, PPPs can equalize care across all populations.

Managing healthcare PPPs: Building public sector capacity

By Rui Monteiro

Developing public sector capacity for managing healthcare public-private partnerships (PPPs) contracts is critical to the success of the initiative. Both for infrastructure and for service contracts, the efficiency (and, in some cases, even the effectiveness) of PPP procurement relies on adequate contract management knowledge and institutional development. Because contract management is focused on healthcare performance, it allows contracting authorities to convert PPP challenges into opportunities for improving policymaking and healthcare delivery.

PPPs for the delivery of hospital infrastructure and hospital services are long-term performance-based contracts. Infrastructure contracts link rewards to a set of key hospital performance indicators; similarly, service contracts, such as those for radiotherapy or imaging, as well as all-inclusive hospital contracts that incorporate clinical services as well as infrastructure, are based on a set of service performance indicators. Many of these indicators form the core of healthcare public policy. These PPP contracts require that the procuring authorities carefully manage the contractual relationship during the full length of the contract.

THREE COMPONENTS OF PPP CONTRACT MANAGEMENT

As in any other PPP, the management of those contracts by the procuring authority requires a mix of: (a) enforcement, (b) cooperation, and (c) prevention of potentially negative strategic moves.

1. Enforcement

Enforcement requires the monitoring of contractually established performance indicators for the PPP project, and often for a larger set of hospitals (in order to build benchmarks for performance evaluation), as well as the application of penalties and fines. It requires a delicate combination of rigor (in measurement) and common sense (in disclosing information in order to prevent problems or incentivize improvements, without being bureaucratic or punitive).

The long-term partnership, by necessity based on an incomplete contract, requires a significant degree of cooperation between public and private partners, primarily to solve issues that arise in the relationships among the private partner

and public entities. For infrastructure PPPs, the critical area is the interface between the private provider and the public sector management and staff of the hospital. For all-inclusive contracts, the critical areas are the interfaces with other healthcare units (primary care, lower- and higher-level hospital, long-term care), and with policymakers not used to having PPP hospitals in the healthcare system.

For infrastructure PPPs, concerns tend to focus on day-to-day issues such as catering, cleaning and laundry, while for all-inclusive contracts, public sector concerns focus on healthcare policy and health-system regulation. It is important to note that the former are typically management issues, while the latter tend to be policy issues.

The incompleteness of contracts is unavoidable, because long-term contracts will necessarily face technological, demographic, managerial, and political changes. This creates opportunities for the private partner to manage change and its consequences, pushing for additional business without facing competitive pressure. For example, when change is calling for contract adaptation but the public sector is not preparing for that, it is easy for a well-informed private operator to create the conditions for forcing the public partner to face some *fait accompli* and then either pay a premium or face nasty disturbances to healthcare delivery if the PPP hospital is not providing a new needed service or technology. The contracting authority is therefore required to have a game-theory approach to contract management, carefully assessing change and evaluating all possible strategies by stakeholders, in order to prevent or mitigate potentially negative strategic moves by the private partner.

The incompleteness of PPP contracts is unavoidable, because long-term contracts will necessarily face technological, demographic, managerial, and political changes. Contracting authorities must manage change in the way most compatible with healthcare policy.

With hospital contracts, two main characteristics are noteworthy, as they influence the way procuring authorities should address contract management: high political sensitivity, and fast technological change. Both are present in PPP and non-PPP healthcare delivery. However, under PPPs, the higher sensitivity and the higher fiscal risks linked to change may be (and should be) more than compensated for by better healthcare delivery and/or higher benefit/cost ratios.

2. Improving the institutional framework and capacity

Institutional capacity. The ability of procuring authorities to manage the PPP contract and guarantee effective and efficient delivery of health services depends on having the required technical knowledge and personal abilities. It also requires an adequate institutional framework. This includes not only dedicated teams, but also empowerment and effective links with other public sector stakeholders, allowing for good and timely decision making.

Hiring, training, and motivating staff. Hiring contract managers and their teams is challenging. The task requires particular abilities: game-theory reasoning, a problem-solving approach, the ability to negotiate mixed with strong willingness to enforce rules and agreements, good personal relationships, and the ability to link with other public sector entities. The contract manager need not be a trained hospital manager, but does need to have a good basic understanding of hospital operation in order to usefully link with the private partner and with healthcare policymakers. The diversity of job requirements and the complexity of the task suggest that it should be delivered by a team, and not by an isolated contract manager. Scale economies invite cooperation among other healthcare PPP contract managers.

3. Auditing

To allow contract managers to focus on their problem-solving and preventive tasks, it is important to support them with effective audits of PPP activities (and also of PPP contract management). Efficiency audits held by Courts of Auditors, as well as independent audits by external experts, can relieve contract managers of stress and allow legislators and citizens to measure the quality and efficiency of healthcare delivery.

THE COMING ERA OF CONTRACT MANAGEMENT

As the PPP hospital experience is still scarce (especially for all-inclusive hospital PPPs), contract managers are in short supply all over the world. Training opportunities are rare, and procuring authorities tend to rely on learning

by doing, a costly and lengthy approach. Often, contract managers do not interact enough with their peers in the same country and in other countries, preventing them from learning from other projects' successes and failures. Motivation is typically not high enough to prevent frequent turnover and retain the best people in the job. Additional challenges are created by real or potential conflicts of interest in a context where both public and private partners are trying to build capacity for dealing with PPPs, and competing for the best people.

Indeed, more—and more experienced—professionals will be required in the coming years. In Asia, Europe, Africa, and Latin America, more countries (not only national governments, but also sub-national ones) are procuring healthcare PPP contracts and starting to engage in healthcare PPP contract management activities. In this process, new PPP models are being tested and new public sector institutions are being developed.

In the years ahead, analysts will also see the large potential benefit to be extracted from healthcare PPPs by linking contract management to health policy. The positive outcome from PPP focus on performance includes creating benchmarks and improving healthcare public policies and their delivery. With some additional government efforts in improving contract management institutions and teams, contract managers will be allowed more time for their strategic tasks and will be able to interact more with policy advisers and policymakers, returning quality and performance to the core of healthcare public policy.

WBI's ROLE

The World Bank Institute is focused on public sector capacity building through training, institutional development, and knowledge exchange. Its activities include helping governments design institutions that improve contract management, training and advising contract managers, and linking them to their peers through regional and global networks, as well as through knowledge-interchange joint activities.

wbi.worldbank.org/wbi/

Lesotho Hospital PPP

A model for integrated healthcare delivery

In 2006, the government of Lesotho launched a project to dramatically improve the quality of its citizens' healthcare. To maximize the use of limited healthcare resources and ensure long-term improvement in healthcare facilities and services, the government implemented a landmark public-private partnership (PPP) to build a state-of-the-art 425-bed National Referral Hospital to replace its dated main hospital.

This pioneering PPP serves as a model for increased private sector participation in Sub-Saharan Africa's overburdened health sector. In addition to the hospital, the project included an adjacent gateway clinic, the renovation of three strategic filter clinics, and the private management of facilities, equipment, and delivery of all clinical care services for 18 years. It also includes a clinical training component to improve the availability of well-trained healthcare professionals.

In this feature, *Handshake* examines the details of this innovative transaction from three perspectives.

IHS

IFC, a member of the World Bank Group, creates opportunity for people to escape poverty and improve their lives. We foster sustainable economic growth in developing countries by supporting private sector development, mobilizing private capital, and providing advisory and risk mitigation services to businesses and governments. This or article was commissioned by IFC through its Advisory Services in Public-Private Partnerships Department, which provides advice on designing and implementing public-private partnership transactions to national and municipal governments to improve infrastructure and access to basic services such as water, power, health and education.

A pioneering healthcare transaction

By Carla M.N. Faustino Coelho & Catherine O'Farrell

The Lesotho healthcare PPP is a first for Africa. In addition to the design, build, and full operation of the hospital and associated healthcare facilities, the private operator will deliver all clinical services, providing vastly improved, high-quality healthcare services at an affordable cost.

PPPs in the health sector typically range from simple outsourcing of support services (such as catering or laundry) to the more complex design, build, and facilities management of hospitals. The Lesotho PPP structure is a first for Africa—and one of only a handful of similar projects worldwide. In addition to the design, build, and full operation of the hospital and associated healthcare facilities, the private operator will deliver all clinical services, with the objective of providing vastly improved, high-quality healthcare services at an affordable cost. Here are some key differences from other infrastructure-focused hospital PPPs:

COMPLETE HEALTHCARE SERVICES DELIVERY

The private operator is responsible for delivery of all clinical services, including recruitment of doctors, nurses, and other health professionals, and provision of all medical equipment and all pharmaceuticals necessary for clinical services delivery. In addition to the new facility, which will operate as the national referral hospital as well as the district hospital for the greater Maseru area, the private operator will be responsible for the refurbishment, re-equipping, and operation of three primary healthcare clinics at Qoaling, Mabote, and Likotsi in the greater Maseru area. The new structure will allow it to: a) manage a mini healthcare-network, and b) filter and treat less severe cases at the clinic level, freeing up as much hospital capacity as possible.

SERVICE PAYMENT

The private operator delivers budget certainty as well as patient-centered care. It assumes full patient risk from project inception and agrees to treat

all patients who present at the hospital and filter clinics, regardless of the type of condition—up to a maximum of 20,000 inpatients and 310,000 outpatients annually, with very few clinical exceptions. The government provides the private operator with an annual fixed service payment for delivery of all services, escalated only by inflation annually. Private operators in similar PPPs have historically opted for direct-cost-plus-margin payments until patient profiles and disease patterns could be established, because they have been reluctant to commit to a fixed cost for clinical care.

PERFORMANCE MONITORING

The Lesotho PPP agreement includes typical performance monitoring, such as payment and penalty mechanisms related to facilities management, equipment, and other nonclinical service outcomes. This includes independent certification of delivery of facilities and equipment. But it also requires additional monitoring.

- The Lesotho agreement includes a detailed list of clinical and non-clinical service indicators that the private operator must meet in order to receive full payment from the government. Failure to meet a performance indicator will result in a severe penalty deduction (a percentage of the total service payment). The relative importance of clinical versus facilities performance indicators is reflected in the percentages deducted. A ratchet mechanism for repeated service failure for the same problem increases the penalty deduction for each repeated failure, and service failure that is not remedied can result in termination of the agreement.
- The Lesotho project has an independent monitor, a unique role specifically created for this project and jointly appointed by the government and the private operator. This monitor performs a quarterly audit of the private operator's performance against the contractual performance indicators (clinical and nonclinical). Where performance has not been achieved, the monitor determines the penalty deduction that applies. The independent monitor is a consortium of companies with specialized experience in PPPs, clinical services, hospital operation and management, medical and nonmedical equipment, information management and technology, and soft and hard facilities management.
- The private operator is required to obtain and maintain accreditation from the Council for Health Services Accreditation of Southern Africa, and failure to do so can result in termination of the agreement.
- The project provides for a Joint Services Committee, established by the government and the private operator, to review performance and discuss and develop mechanisms, procedures, or protocols to improve the services at the hospital and filter clinics. Given the long-term nature of the project, this committee provides a mechanism for altering the hospital's services, by agreement, to address new disease patterns, new technologies, or new national priorities, thereby ensuring that the project remains relevant for the country.

A low-income country can embark on a very ambitious project that is affordable for the country and patients, is attractive to top-quality private investors, expands services to more people, and has the potential to deliver high-quality health services.

The PPP agreement for this project was signed by the government and the private operator on October 27, 2008, and financial close occurred in March 20, 2009. Construction began on March 23, 2009. The filter clinics were opened in May 2010 and the new hospital is scheduled to open in October 2011.

OUTCOMES

This PPP has demonstrated that it is possible for a low-income country to embark on a very ambitious project that is affordable for the country and patients, is attractive to top-quality private investors, expands services to more people, and has the potential to deliver high-quality health services that address Millenium Development Goals and the critical shortage of health professionals. These are all key constraints for many developing countries.

Although the project is still in its early stages and the expectation of success is high, there will certainly be challenges and obstacles for the private operator and the government to overcome. A key risk is the high probability that the hospital will reach maximum capacity very early in the project term, requiring the government to rapidly improve the service offering at other hospitals to relieve the pressure on the national referral hospital.

To mitigate this risk, the government is working with the Millennium Challenge Corporation to fund a program of refurbishment of over 150 health facilities in Lesotho, including 138 primary healthcare centers. The projects include design, renovation, expansion, and construction of health centers in Lesotho to an appropriate standard. These projects have all started construction and are expected to be completed in 2013. Once renovations are complete, the government will assume responsibility for ongoing facilities management at these health centers. In order to ensure the long-term sustainability of the refurbishment program, the government is considering a new PPP for facilities management, Information and Communication Technologies and equipment maintenance.

The private partner

Helping Lesotho's government care for its people

Dr. Victor Litlhakanyane has been Chief Operating Officer of Primary Care Partnerships and Diagnostics of Netcare Limited since 2006. Prior to assuming an executive directorship position with Netcare, Dr. Litlhakanyane served as the Superintendent General of Department of Health of Free State province. He serves as a technical advisor to the World Health Organisation World Alliance for Patient Safety.

Can you explain, in layman's terms, the mechanics of this PPP?

Yes, this PPP was actually very, very simple. Basically we entered into an agreement with the government of Lesotho for Netcare, as a private party, to build a new referral hospital to replace the Queen Elizabeth II, to rebuild and expand one clinic, renovate two others, and build a gateway clinic next to the hospital. We will manage and operate the hospital for the next 15 years. During this time, the government will pay us a fixed fee to cover original capital outlay and operational costs. To ensure that there will be value for money, they have appointed an independent monitor, insuring that the operator [Tsepong] achieves the required level of services and quality stipulated in the PPP agreement. If we do not achieve those targets, we get penalized with a deduction from our fee. And therefore this will assure we will always comply with the requirements of the project.

This project brought back dignity to the people.

Why was Netcare attracted to an unproven project like this? A healthcare PPP of this scale had never been attempted before.

Simply because we saw it as an opportunity for us to permit the government to provide better care to the people of Lesotho.

Is this a model that can be applied elsewhere?

We believe this model can be implemented elsewhere on the continent, and in many parts of the world. As it is applied here, a private party comes to assist the government to improve access to healthcare. It is very straightforward.

What are the critical success factors for healthcare PPPs?

The critical success factor for health PPPs is political will. There has to be the will from the highest level of government, from the president and prime minister on down. The relevant ministers have to come to the party and say, "We appreciate the support we get from the private sector. We have to work with the private sector." The second thing is that governments have to have the right advice. IFC has played a critical role in the project in Lesotho.

Some countries see healthcare PPPs as controversial. Is that changing?

Many countries believe that health is a public good to be provided by government. But there is a slow realization that private business can play a role to provide access to healthcare, in the provision of capital and the expertise and resources.

There is a realization that private business can play a role to provide access to healthcare, in the provision of capital and the expertise and resources.

So I've been to a number of countries on our subcontinent and I have seen a change in perspective. I foresee that in the future we will see similar projects coming through on the continent.

Has this project unfolded the way you expected? Have there been any surprises?

It has gone very, very well overall. There have been things we had not planned for that turned out to be very good parts of the project. For example, we have managed to have a bigger impact on local economic development than we thought. The curtains and the bed screens at the clinics were sewn by local women in Lesotho. Local artifacts and photographs in the clinic were done by local Lesothos. That has been a very positive impact indeed.

The most difficult part has been access to health professionals. Most of our doctors are foreign nationals. Lesotho has lost many of its doctors to South Africa and the rest of the world, so we are hoping that this project will attract doctors back to Lesotho.

What impact did IFC's involvement have?

IFC used its knowledge and expertise from projects all over the world to advise Lesotho. From the time they developed the concept to the time we got to negotiations, they were involved. They had a very tight plan, and managed to meet tight time frames. This is the most efficient project with the shortest period of negotiations that Netcare has ever embarked on.

How have the people of Lesotho benefitted from this project so far?

This project basically brought back dignity to the people of Lesotho. The story that illustrates this best is from when we opened one of the clinics. One morning there was an old gentleman from a local village who came to the clinic and at the door, he asked if he should take off his shoes. The reason was that the clinic was so clean he thought his shoes would make the clinic dirty. And we said to him that he can walk in with his shoes on—that this clinic belongs to him. He had tears in his eyes.

Photo © Victoria Adams-Kotsch

The government's perspective

Meeting demand with limited financial resources

The Honorable Timothy Thahane is Lesotho's Minister of Finance and Development Planning and a member of the nation's Senate. He has served as Lesotho's ambassador to the United States (1978-1980) and became Vice President and Secretary to the World Bank in 1980. During his 16 years at World Bank, he served on the Financial Policy; Managing; Reorganization Steering; Personnel and Administration; Policy and Research Committees as well as becoming a Member of the President's Council. Following that, he was Deputy Governor of the South African Reserve Bank (1996-2001).

What was the motivation behind this PPP project?

The motivation for the project lies in the need to address the health problems of Lesotho. How do you deal in today's world with the high social demand for medical services, alongside the constraint in terms of the financial resources in the public sector? For a long time Lesotho faced the problem of the Queen Elizabeth II Hospital, which is over 50 years old. One saw the high expenditures and operating costs, coupled with a deteriorating infrastructure. This forced a lot of patients to be transferred to South Africa. At the same time, the doctors and professionals found the surroundings of the hospital uninspiring. The challenge for me was to get a modern facility that will reduce the number of patients being referred to South Africa and that would also attract and motivate doctors and health professionals to work here in Lesotho.

How did you begin to tackle that challenge?

The first step for me was to understand what the disease profile in the country was. We had to understand how many people were suffering from what diseases and how far they came from and all that. Boston University had done some work earlier on that analysis, and we took that data. With that information we moved on to the next question: What results are we getting for our money? We engaged IFC, they went to the private sector, and the analysis began.

This PPP is a first for healthcare. Was it difficult to sell to the stakeholders?

The difficulty was whether or not you can get the private sector participating in and financing a health project. It hadn't been done. There is a shortage of government and public funds, but we knew the private sector has the skills, the money, and the management. Ultimately, we had to convince the government, and we also had to convince the health professionals, who over the years have looked at health as a government responsibility with no role for the private sector.

Do you think, in retrospect, this was the right path ahead?

Definitely. We were able in the final analysis to bring in the private sector to put in its own money and put its money at risk. We convinced the government to put its money in as an upfront capital contribution, and define the costs they would contribute. Most important, the patients are not paying any more than they were paying before this launched.

What aspects of the project have worked well?

What has worked well is the political commitment of the government. The cabinet and myself were committed to make this project work in order to supplement limited resources address-

We had to convince the government, and we also had to convince the health professionals, who over the years have looked at health as a government responsibility with no role for the private sector.

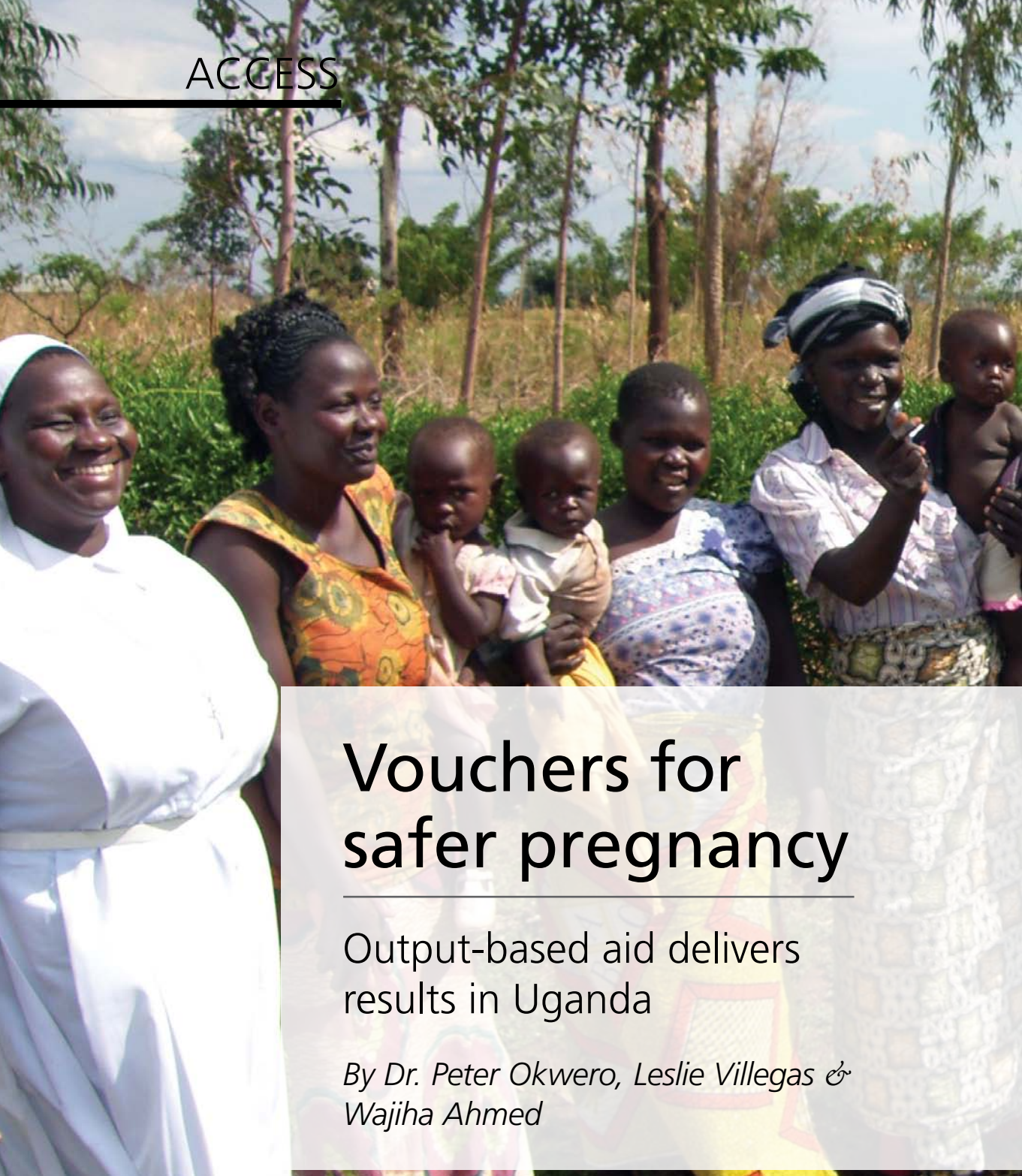
ing public disease in the country. You need that strong commitment and leadership. You also need a technical advisor who understands public policy and private requirements and we were able to work with IFC in that respect. We also succeeded in bringing together the doctors and nurses in the design of the facilities. They are the ones who are going to use the facility; they have to say where the tap in the surgical theater should be, and dictate other important elements of the design from the start.

What was most difficult about the project?

We did not have enough trained lawyers, and IFC had to supplement our legal expertise. We also did not have knowledge of the international market—there are investors all over—or how to tap in and test the market; we did not have that network. It needs to be put in place early.

What advice would you give to other governments contemplating a healthcare PPP?

Government and policymakers must be able to think very innovatively. We see PPPs being applied in all sectors—why not health? That was our question. You must also educate the public so they can come along and understand it's not business as usual. They can judge whether services are being delivered appropriately, correctly and cost-effectively.



Vouchers for safer pregnancy

Output-based aid delivers results in Uganda

By Dr. Peter Okwero, Leslie Villegas & Wajiha Ahmed

Photo © GPOBA

A voucher system for prenatal care in Uganda helps thousands of women give birth safely and more affordably

According to a 2006 study, about 435 women die per 100,000 live births in Uganda because of lack of access to health service facilities and professional healthcare. The high cost of healthcare in Uganda, where most people live on less than a dollar a day, remains a significant obstacle. The Global Partnership on Output-Based Aid (GPOBA), a partnership program administered by the World Bank, is using output-based aid (OBA) to extend access to safe delivery services for poor mothers through public-private partnerships (PPPs). Vouchers for maternal care link payment of public funding directly to the delivery of specific services, in this case a "safe delivery" package of four prenatal visits, a delivery attended by a trained medical professional, and one postnatal visit.

A NEW APPROACH TO AN OLD PROBLEM

Hoima—a tranquil district located 203 kilometers from Kampala—is one of 20 districts participating in a pilot project to help poor communities gain access to reproductive health services via a voucher system. In Hoima, women like Grace Nyakato, a 37-year-old mother of three who is pregnant with her fourth child, can buy the "safe delivery" voucher for about $1.20. She uses the voucher to pay for services at local clinics.

GPOBA, working with Uganda's Ministry of Health, subcontracted Marie Stopes International (Uganda) (MSI) to implement the project. MSI accredits local clinics that offer services to patients in exchange for the pre-paid vouchers. This arrangement was first tested in Uganda by KfW (Germany's development agency), also a partner in the OBA plan.

These OBA vouchers are achieving results, according to Peter Okwero, World Bank Task Team Leader for the Reproductive Health Vouchers in Western Uganda project. "By using the voucher scheme, women have been empowered to choose their preferred service providers; the providers have increased revenues, and they have recorded major improvements in knowledge and clinical practice as well as quality of care," he said.

Once approved services have been delivered, clinics submit claims for payment to MSI. Mobile phones can be used to manage the claims process. A GPOBA grant of over $4 million makes vouchers affordable for the poor by paying the difference between actual cost of services and the amount people are willing or able to pay. Grace and other mothers-to-be pay about $1.20, for a voucher. Services cost from around $24 to around $78 for more complicated cases.

Leslie Villegas, GPOBA adviser for the project, emphasized that women became aware about the health vouchers through the project's communications campaign. Campaign activities focused on the target beneficiaries, emphasized behavior change messages, and promoted voucher value. Communications efforts built on relations with community groups.

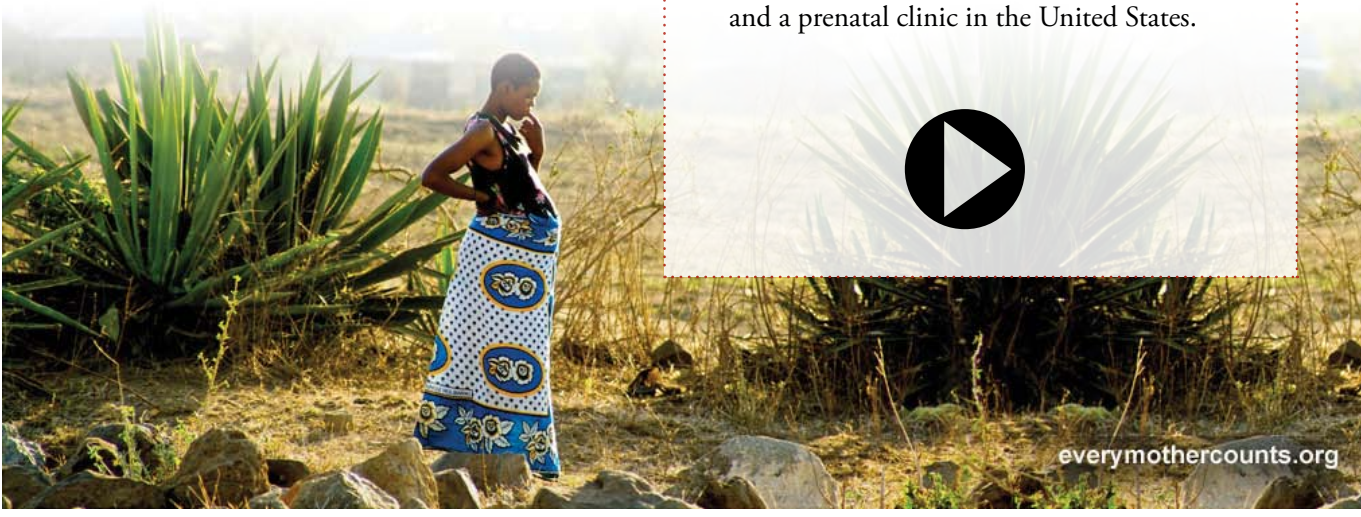
LOCAL SERVICE PROVIDERS

Sister Kerezin, a midwife, runs Uganda's nonprofit St. Jude Thaddeos clinic, one of the small, local service providers that have made the OBA partnership possible. The clinic serves an estimated 50,000 people, mostly refugees from the Congo and Sudan and internally displaced people from Northern Uganda. The facility is a one block-long building housing offices, a maternity ward, and a general ward where wall partitions are made of papyrus mats.

Sister Kerezin encourages expectant mothers to buy a voucher as soon as they know they are pregnant. She observes that the "safe delivery" package has made it easier to "monitor a pregnancy from the beginning to the end," helping avoid preventable tragedies.

VIDEO: NO WOMAN, NO CRY | TRAILER

Activist Christy Turlington Burns shares the powerful stories of at-risk pregnant women in four parts of the world, including a remote Maasai tribe in Tanzania, a slum of Bangladesh, a post-abortion care ward in Guatemala, and a prenatal clinic in the United States.



DELIVERING RESULTS

Justine Asaba, a 28-year-old mother of four, is also a project beneficiary. Asaba dropped out of primary school after HIV/AIDS claimed both her parents, and she was forced to marry at an early age. She receives little financial support from her husband and cannot afford private healthcare. Asaba was able to obtain quality care for her last pregnancy through the OBA voucher system. As she explained to GPOBA: "At first I could not believe it when they told me about it [the voucher system]. So I went to the Local Council leaders to ask for more information and I was referred to the clinic where I found other women who were using this service." The OBA voucher was "sent from heaven" for her, she said. She made use of all of her prenatal appointments and gave birth to a healthy baby boy.

So far, over 34,000 babies have been safely delivered to mothers participating in the OBA voucher system. By the time the pilot ends in December 2011, 136,000 women will have received a range of reproductive health services from maternal care to screening and treatment for sexually-transmitted diseases.

HealthStore Foundation's micro-franchising model

A turnkey management system for community health

A short number of inexpensive generic drugs can effectively treat 70-90 percent of the children suffering and dying from infectious diseases in the developing world—but too often people do not have access to these drugs. The HealthStore Foundation seeks to improve access with a micro-franchise business model.

With the CFW shops—storefront medical centers serving neglected communities—the HealthStore Foundation has combined established micro-enterprise principles with proven franchise business practices, creating a model which has received recognition from the Clinton Global Initiative. Building on its results, HealthStore aims to expand the CFW network in Kenya to 200 outlets serving up to 1,500,000 patients and customers per year, and to expand the CFW brand of franchised healthcare to more countries.

Franchisees operate small drug shops or clinics strategically located to improve access to essential medications. These trained workers treat the diseases that cause 70–90 percent of illness and death in their communities.

CFW outlets are located at market centers in agricultural areas of approximately 5,000 people; customers are primarily lower or middle-income women and children subsisting on agriculture.

ACCESS

Why franchise?

According to the HealthStore Foundation, the 20 poorest developing countries spend less than $33 per person each year on healthcare, compared to over $2,500 in the 20 most developed countries and $7,000 in the U.S. Even a doubling of public health funding would fall short of meeting the need. While public funding will always be needed, at least part of the full solution to the distribution of medicines must incorporate a sustainable market-based model with effective incentives.

The CFW model incorporates 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 inspections. HealthStore also uses the combined buying power of the full network to obtain quality medicines at the lowest possible cost. The HealthStore Foundation is pursuing several key innovations to its CFW model, most notably the integration of a third-party payment system to target current subsidies toward bottom-up and output-based reimbursement of care at the franchisee level, rather than top-down and input-based infusions of grants.

VIDEO: HEALTHSTORE'S FRANCHISE NETWORK IN KENYA

www.pbs.org

Afghanistan's health sector evolves

Expanding access through PPPs

By Tekabe Belay, Ghulam Dastagir Sayed & Mohammad Tawab Hashemi

Against the backdrop of prolonged war and civil strife, the Afghan health sector has made significant progress toward achieving the Millennium Development Goals. Since 2001, the number of functioning primary healthcare facilities has doubled, coverage of basic health services reached all 34 provinces, the quality of services in publicly-financed facilities improved, the infant mortality rate fell 22 percent, and the under-five mortality rate fell 26 percent. Though significant challenges remain, strengthening the country's Basic Package of Health Services—in part through the introduction of public-private partnerships—has resulted in major health improvements.

Afghanistan's health system was in very poor condition in late 2001, with few preventive and curative health services. The prolonged civil war, the shortage of staff in rural areas, and the absence of explicitly articulated national priorities all resulted in the limited availability and poor quality of services. Life expectancy was only 45 years for women and 47 for men. Coverage of services such as skilled birth attendance, antenatal care, and vaccination was very low, with severe consequences for health outcomes. In 2001 the infant mortality rate (IMR) was estimated at 165 per 1,000 live births, and the under-five mortality rate (U5MR) was estimated at 257 per 1,000 live births. The maternal mortality ratio was 1,600 per 100,000 live births (reaching as high as 6,500 in some parts of the country).

In 2003, the Afghan Ministry of Public Health (MOPH) launched, with donor assistance, a far-ranging reform program to improve basic healthcare services. The Ministry adopted the

Public-private partnerships have proven successful in implementing Afghanistan's Basic Package of Health Services

Photo © isafmedia

role of steward, rather than direct provider, of service delivery; established a Grant and Contract Management Unit to function as a purchasing unit; divided the provinces among donors for accountability; and defined a Basic Package of Health Services.

PUBLIC-PRIVATE PARTNERSHIPS

Through public tenders, NGOs (Non-Governmental Organizations) were then contracted to provide basic health services throughout the country. The services were provided in three levels of care facilities: basic health centers, comprehensive health centers, and district hospitals. The initial three-year contracts were lump-sum, with a performance bonus linked to specified performance targets. The contracts included baseline indicators and three-year targets for

such health aspects as the number of functioning health centers, number of new outpatient visits, equipment functionality, availability of essential drugs and family planning supplies, and medical staffing. Almost all NGOs contracted under the program received a performance bonus.

The average cost of the basic health services provided by the NGOs under these PPP arrangements was $4-5 per capita, with an additional 10 percent for monitoring and evaluation and 0.5 percent for the cost of establishing and operating the Ministry's purchasing unit.

STRIKING RESULTS

Because of the success of the initial contracting, another round of contracting was implemented in 2009. Key achievements from 2002-2009, as measured through independent assessments, include:

- A near-doubling of functioning health facilities from 934 (2002) to 1775 (2009).
- An increase in the number of facilities with skilled female health workers from 25 percent to 84 percent.
- An increase in the number of facilities providing delivery care from 41 percent to 80 percent for basic health centers, 51 percent to 95 percent for comprehensive health centers, and 51 percent to 100 percent for district hospitals.
- An increase in the number of women delivering with the assistance of a skilled birth attendant from six percent to more than 24 percent.
- An increase in the number of pregnant rural women receiving at least one antenatal care consultation from less than 5 percent to 36 percent and an increase in deliveries in rural areas with skilled birth attendance from six percent to 24 percent.
- An increase in the percent of children receiving DTP3 immunization from 21 percent to 43 percent.
- An improvement in TB case detection rates.
- A drop in infant mortality from 165 per 1,000 live births to 111, and the under-five mortality rate from 257 to 166.

Public-private partnerships have been key to implementing the Basic Package of Health Services. Most health services in Afghanistan are being delivered by NGOs under contracts with the Ministry or through grants from a small number of donors. In three provinces near Kabul and parts of rural Kabul province, the Ministry is contracting managers to help strengthen

service delivery using its own staff. This effort, known as the Strengthening Mechanism, involves the competitive recruitment of managers, the provision of a level of funding similar to that provided to NGOs, and the use of the same monitoring and evaluation mechanisms. Both of these approaches have been considered successful based on facility assessments and administrative data.

GOVERNMENT STEWARDSHIP

The Ministry's stewardship role has been central to the success of the Basic Package of Health Services. Before its introduction, NGOs often focused on a variety of priorities. Some emphasized infectious disease control, others reproductive health, and others non-communicable disease control. The various NGOs also established different types of facilities and utilized different types of staff. The Basic Package has helped ensure that there is a standard national set of priorities and a common overall approach, with a particular focus on key health interventions.

Photo © isafmedia

These efforts help to mobilize resources. External assistance to the sector in support of public-private partnerships grew from less than $100 million in 2003 to more than $277 million in 2008 and is increasingly "on budget." Moreover, the proportion of external finance coming through Afghanistan's government budget has increased dramatically.

Earthquake spurs primary healthcare revitalization in Pakistan

By Naoko Ohno, Inaam ul Haq, Tayyeb Masud, & Kees Kostermans

Pakistan's 2005 earthquake, one of the most debilitating natural disasters in their recent history, also damaged the country's health infrastructure.

On October 8, 2005, a magnitude 7.6 earthquake shook parts of Afghanistan, India, and Pakistan. Losses were most severe in Pakistan, where over 73,000 people died and over 70,000 were injured. The earthquake also damaged Pakistan's health infrastructure. Approximately 575 health facilities and management offices were partially or fully destroyed by the earthquake, including 75 percent of first level care facilities and all secondary care and smaller health units. The earthquake also destroyed vehicles, drugstores, cold rooms, health staff accommodations and offices, medical equipment, and records.

This disruption of health services left nearly four million Pakistanis without access to primary and secondary healthcare. Restoring this access was a priority, especially because women and children were the heaviest users of the primary healthcare services, representing 60-65 percent of the clients before the earthquake and 70-75 percent of the reported deaths and injuries from the disaster.

INTERNATIONAL ASSISTANCE

International assistance arrived within days of the earthquake. The World Bank, in collaboration with other development partners, undertook an Earthquake Damage and Needs Assessment and assisted Pakistan in mobilizing resources to finance the reconstruction and rehabilitation efforts. The World Bank also provided assistance through the Japan Social Development Fund (JSDF) under the project "Revitalizing and Improving Primary Health Care in Battagram District." Battagram is an underdeveloped district located in a mountainous setting with land area of 1,300 km^2 and an estimated population of 361,000 (2004-05).

The JSDF project aimed to revitalize primary healthcare services in Battagram, strengthen the capacity of district health management and

health workers, and contract NGOs to manage primary care services. The project envisaged provision of an essential primary health service package with a focus on maternal/child health including obstetrical and family planning services; diagnosis and treatment of major infectious diseases including tuberculosis; basic curative services; nutritional support including improving micronutrient deficiencies, therapeutic feeding and breastfeeding promotion; and carrying out public health functions including disease surveillance and response to epidemics. The services were expected to be provided through fixed facilities, mobile units, and community-based workers.

and stewardship/oversight, and the NGO being responsible for management and implementation of an agreed-upon package of primary care and community-based services. This was appropriate to the needs created by the post-earthquake emergency, as well as to today's needs in areas where militancy and conflict have disrupted the provision of public services.

Certain characteristics of the contracting out model were critical to its success:

1. **The agreement between the Battagram District Government and the NGO gave flexibility to the NGO to manage and to innovate,** including the flexibility to introduce performance-based incentives and hire staff at market rates. Specifically, full budgetary, human resource, and administrative control of all district health services were transferred to the NGO. The NGO was responsible for procurement of medicines, supplies and equipment. The motivation of government employees was addressed by the salary supplement provided by the Performance Based Incentive scheme, which reduced



Photos courtesy of Dr. Amanullah Khan/Save the Children USA

KEY FEATURES

Through a competitive public tender, the Department of Health contracted out management/delivery of primary healthcare services to Save the Children USA with full administrative control of all health facilities and staff, and full financial powers. The contract specified the roles and responsibilities of both parties with the government's role being that of financier

Photo courtesy of Dr. Amanullah Khan/Save the Children USA

the differential in remunerations between government and NGO-recruited employees. This was one of the few contracting arrangements where salaries of government staff were paid through the NGO, which is likely to have contributed to good management and enhanced managerial authority within the NGO.

2. **The project ensured availability and presence of staff in the district, particularly female health providers.** With flexibility to use resources across budget lines, the project recruited additional staff (including a 53 percent increase in the number of qualified professionals) with a special focus on female health providers and strengthening community-based outreach to address gender constraints in a traditional society. Staff members were paid market salaries—roughly triple the government rate—and provided security, fully furnished accommodation, and transport.
3. **Effective coordination was maintained with the provincial and district governments as well as with community stakeholders.** The transfer of execution responsibilities to the NGO allowed the government to focus on its leadership functions. The NGO gained the cooperation of local officials by actively involving them in project activities. The project team also maintained close liaisons with local leaders and influential community members.
4. **Alliances within the local community were key** as the security situation in the province deteriorated during the project period, and

international NGOs were especially targeted. Close ties were established locally, and since many of the managers belonged to the community, project activities continued with minimal disruption.

5. **The project adopted a hub approach that decentralized management to the Rural Health Center level.** The objective was for the Rural Center to function as a hub for eight to ten Basic Health Units, to provide 24-hour emergency obstetric and neonatal care with a functional ambulance and resident male and female staff, and devolve financial and administrative powers to a Rural Center manager. Most of the medical officers were located at the Rural Centers, and each was staffed with five medical officers, including two female medical officers.
6. **The District Health Management Team met regularly to review progress and resolve specific issues.** District officials were trained in planning, budgeting, and use of information. Performance-based incentives contributed to the use of data as a management tool.

DELIVERING RESULTS

Available evidence suggests that the project objectives were met. The data point to substantial improvement in utilization of services, and the findings of the facility survey indicate increased availability of medicines, staff, and equipment, and high levels of patient satisfaction.

The project successfully revitalized primary healthcare service delivery in Battagram, with a substantial increase in utilization of preventive and curative services. The project also helped the provincial government explore options to improve the provision of primary care health services through better management of district-level health systems—mainly by testing out innovative methods through public-private partnerships. The results of the JSDF pilot were disseminated through a workshop to a wider audience of political representatives and government officials at the provincial and district level.

These results have further strengthened ownership and support within the government administration and the provincial leadership to replicate and scale up the initiative, particularly in underserved districts. The World Bank has received a request for the replication of the JSDF pilot model in an additional five districts where health services have been affected by the 2009 militancy and 2010 flood crises.

Photo © Arne Hoel/World Bank

Improving healthcare in Ghana

National Health Insurance expands access to care

By Nathaniel Otoo

In 2003, only 20 percent of Ghanaians had access to the care they required. In response, Ghana established a National Health Insurance Scheme (NHIS) to protect the population against the risk of catastrophic healthcare expenditure. As a key social protection policy, the NHIS has come to represent an important plank in Ghana's medium-term poverty reduction strategy. It is key to achieving the country's health goals.

Ghana's National Health Insurance Scheme, created to establish equitable and universal access to good quality healthcare, is a hybrid. The system leverages the strengths of the private-for-profit, private-not-for-profit, and public sectors for healthcare provision, using lessons learned from pilot community health insurance schemes that operated before its establishment to shape its successful design.

The NHIS has seen rapid growth, attributable to its reliance on this mix of resources, and in the process it has significantly contributed to poverty reduction and achievement of national health goals.

EVOLUTION OF THE NHIS

2003
- -Act 650 passed

2004
- -Legislative instrument 1809 passed
- -First actuarial study
- -First scheme established
- -Blanket accreditation granted

2005
- -Claims payment starts

2007
- -First tariff review starts
- -National Information and Communication Technology (ICT) project starts

2008
- -Free maternal program starts
- -Diagnosis Related Groups (DRGs) introduced

2009
- -First actuarial review
- -Full scale accreditation starts
- -Review of Act 650 starts

2010
- -Full scale clinical audits start
- -Claims processing center established

2011
- -Preparation for capitation pilot starts

The NHIS is regulated and supervised by the National Health Insurance Authority (the Authority), an agency of the Ministry of Health. It has established three ways to provide financial access to healthcare for the population (see below).

As of June 2011, 145 District Schemes had been set up. A further 10 satellite District Schemes are expected to be set up by the end of 2011. In 2008, the first private health insurance schemes were licensed; since then, five more schemes have been added to further increase coverage.

1 District Mutual Health Insurance Schemes

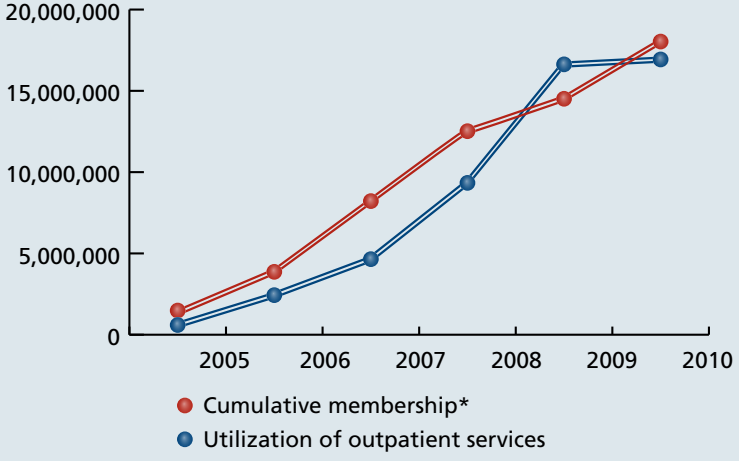
Public schemes promoted by and set up as companies (limited by guarantee) by district assemblies; the key operational arms of Ghana's decentralized governance system.

2 Private Mutual Health Insurance Schemes

Promoted and set up by private persons as companies limited by guarantee without a motive for profit.

3 Private Commercial Health Insurance Schemes

Promoted and set up by private persons as limited liability companies with a motive for profit.



** This is the total number of members eligible for ID card issuance on a cumulative basis. There is a possibility of duplicates as some members re-register rather than renew after a long lapse in membership.* Source: National Health Insurance Authority

Ghanaians who do not belong to the two types of private health insurance schemes can become members of District Scheme, and there is no restriction on citizens belonging to one type of private health insurance scheme joining the other.

The quick growth in membership of District Schemes over the years is attributable to several factors:

- Significant commitment by district assemblies to establish District Schemes as establishment of schemes was a key performance indicator for district chief executives.
- Sense of community ownership of District Schemes.
- Decoupling children from their parents for the purpose of membership in District Schemes.
- Implementation of a maternal policy that provides immediate and free coverage for pregnant women.
- Extensive public education.
- Bipartisan political support following the establishment of the NHIS.

Notwithstanding the proliferation of private health insurance schemes in the past few years, membership in District Schemes accounts for over 98 percent of the population with access to one form or the other of health insurance.

MECHANICS

District Schemes are funded from the following sources:

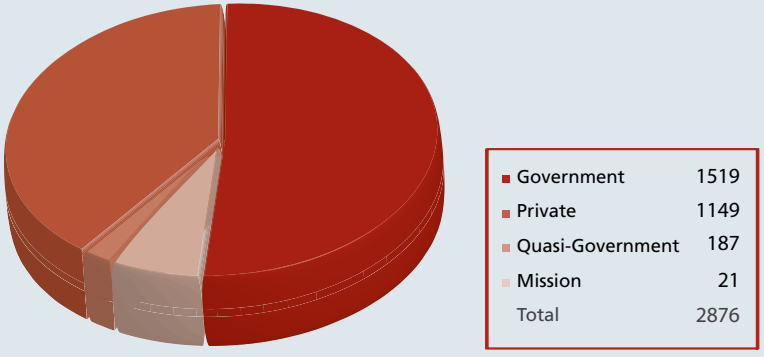
- Premiums paid by informal sector members.
- Consumption tax (2.5 percent).
- Social security contributions (transfer of 2.5 percentage points).
- Returns on investment.
- Sector budget support.

Private health insurance schemes rely solely for their funding on premiums paid by their members. They are not entitled to subsidies from the National Health Insurance Fund.

The benefit package offered by District Schemes is comprehensive, covering up to 95 percent of disease conditions in Ghana. Private health insurance schemes are free to determine their benefit packages, but require the approval of the Authority to offer such packages to their members.

Both District Schemes and Private Schemes are free to select their healthcare service providers from the public, private-not-for-profit and private-for-profit sectors. This approach proved pragmatic, considering Ghana's healthcare infrastructure, and it has also afforded schemes an opportunity to procure services in a way that engenders efficiency.

The accreditation of healthcare service providers started in 2005 with the granting of blanket accreditation to public, mission- and faith-based healthcare providers, as well as the grant of provisional accreditation to private healthcare providers based on a minimal documentation, as a means to ensure a quick roll-out of the scheme. As of December 2008, 1551 private and over 3,000 public and mission providers had been accredited.



FACILITY BY OWNERSHIP

Source: National Health Insurance Authority

In 2009, the Authority developed a set of accreditation tools which formed the basis of a full-fledged accreditation system. The tools are organized into 12 modules:

1. Range of services
2. Staffing
3. Environment and infrastructure
4. Basic equipment
5. Organization and management
6. Safety and quality
7. Outpatient services
8. Inpatient services
9. Maternity services
10. Specialized services
11. Diagnostic services
12. Pharmaceutical services

The provider payment system of choice for District Schemes at the point of establishment of the NHIS was fee-for-service. This payment system lent itself to easy use as most stakeholders were experiencing health insurance for the first time. Over time, other more complex systems of provider payment have been implemented or are being piloted. A Diagnosis Related Groups system was implemented in 2008 and a capitation system is expected to be piloted in a selected region of the country in the third quarter of 2011.

CHALLENGES

Notwithstanding the NHIS's successes since its inception, it faces significant challenges. NHIS project managers and staff have outlined pragmatic steps for addressing the issues that most threaten to derail the program. They include difficulties in identifying and covering some

categories of the poor and vulnerable; complex and unclear governance structures that sometimes make regulation, supervision and implementation difficult; inadequate capacity on key technical issues; challenges to sustainability of the scheme; increase in moral hazards; computerization of operations; and quality of care issues.

The Authority is in the process of finalizing a plan to directly address these challenges, and to evolve an agency that meets the original policy objectives. The plan aims to enhance the financial sustainability through additional sources of funding, cost containment strategies, prudent fund management and a mix of payment mechanisms as well as:

- Increase membership by effectively identifying and covering the poor and vulnerable and increasing enrollment within the informal sector.
- Contribute to securing universal access to healthcare through implementation of a mandatory basic health insurance scheme.
- Review the legal framework for the implementation of the NHIS to ensure improvement in governance and implementation.
- Improve computerization of operations through better specification, improved project management, and effective Information and Communication Technology governance.
- Improve quality of healthcare services through an update of accreditation tools, post accreditation monitoring, and strategic health sector investments.
- Shorten claims processing and payment turnaround time.
- Strengthen audit and risk management systems as well as reward and sanctions regimes to reduce incidents of fraud and abuse.
- Increase capacity in key technical areas.

REPLICABILITY

In Africa and other developing regions of the world where healthcare reforms have become top priority for governments, Ghana's experiences implementing a national health insurance scheme could hold valuable lessons. Not only has Ghana's approach resulted in significant improvements in access to healthcare, it has also helped strengthen quality assurance systems and a provided a space for the development of a fledgling private sector in the healthcare industry.

Ghana's success is attributable to political commitment, innovation, attention to local context, and experiential learning. The United Nations Development Program recognized this in 2010 when it cited Ghana's health insurance scheme as a model for south-south cooperation, citing its attributes of being demand-driven, country-owned, innovative, efficient, sustainable, scalable and for possessing in-country leadership.

Protecting the uninsured

How Mexico's tripartite scheme ensures universal coverage for its citizens

Mexico's decade-old Seguro Popular finances healthcare through a broad package of care that extends coverage to citizens not eligible for social security

By Claudia Macias

In 2003, Mexico was among the lowest spenders on health (only 5.8 percent of GDP), and out-of-pocket payments for health were high. Mexican families already vulnerable to poverty were offered few options for healthcare, especially those that covered catastrophic expenses. That changed with the introduction of the Social Protection System in Health (SPSS) and its Seguro Popular (Popular Insurance), a policy for financial and health protection for the uninsured. The goal is to extend healthcare coverage to citizens not eligible for social security.

Through SPSS, the Mexican government has incrementally expanded coverage for the uninsured. Seguro Popular now covers around 48.5 million individuals, or almost 95 percent of citizens without social security. The budget for SPSS has increased alongside recognition of its success: in 2004, it was approximately $385.6 million, and in 2010 it reached almost $4,160.0 million, according to the Results Report of the National Commission of Social Protection in Health (June 2011). In the plan's first decade, it has already reduced out-of-pocket and catastrophic health expenditures for the poorest segments of the population, provided greater incentives for the efficiency of the system, promoted a more equitable allocation of the financial resources in health, and offered a better quality of care.

FINANCING

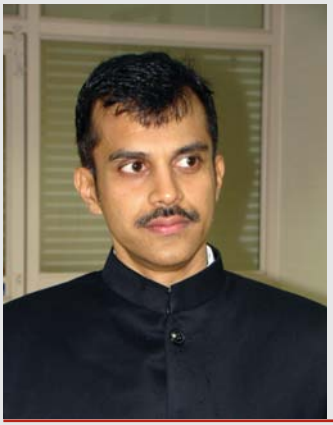
The financial model of the SPSS is a tripartite scheme with federal and state government contributions as well as contributions by patients in accordance with their ability to pay. However, federal and state financing constitutes the principal source of resources to ensure equitable coverage. A benefit package includes the interventions and medicines associated with first and second level care at no cost to the patient.

ENROLLMENT AND RENEWAL RATES

Enrollment began in 2002 in five pilot states and was already in place in 24 states two years later. Since then, there has been a notable increase in coverage. By the end of 2004, 5.3 million people were insured, and of that number, 94 percent belonged to the lowest two income deciles. By mid-2005, all Mexican states had joined the plan. By the end of 2009, more than 31 million individuals were enrolled, and by the end of June 2011, this number reached 48.5 million. This most recent figure represents 94.5 percent of the federal target of universal health coverage.

Extending coverage within indigenous communities has been a special priority for the government. As of the first half of 2011, 4.4 million people have enrolled from localities with 40 percent or more speaking an indigenous language. The states with the highest number of insured in indigenous communities include Oaxaca, Chiapas, Veracruz, Puebla, Yucatán, and Guerrero. Of the total enrollment, 17.3 million people live in rural areas (35.6 percent of the total) and 31.2 in urban areas (64.4 percent).

Ongoing challenges include ways to create the right balance of incentives, accountability, and innovation at the level of the decentralized entities. However, universal health coverage is expected by the end of 2011, and reaching that milestone signifies real progress for citizens of Mexico.



Insuring Andhra Pradesh's poor

An Indian State Trust transforms access to care

Mr. Srikant Nagulapalli is the CEO of the Aarogyasri Health Care Trust, the government body in charge of implementing the Rajiv Aarogyasri Health Insurance Scheme in the state of Andhra Pradesh (AP). He began his career with the government of AP and is now responsible for implementing this flagship health insurance scheme covering 20.4 million below poverty line (BPL) families across 23 districts of the state.

The Aarogyasri Health Care Trust was founded in 2007 to address the issue of catastrophic health expenditure among the poor and uninsured families of AP. At the provider level, it gives the patient the choice of network facilities and service providers by empanelling both private and government facilities through rigorous infrastructure and services quality criteria and periodic renewal; at the level of administration and claims management, the scheme is built around a contracting arrangement with private insurance firms. These firms manage subscription/marketing, pre-authorizations, claims and fund disbursements, and absorb some of the underlying health insurance risks through a payment mechanism based on a capitated premium. Mr. Srikant Nagulapalli talked to *Handshake* about what makes it successful.

Interview by Alison Buckholtz

Four years from inception, the Aarogyasri Trust manages the healthcare needs of over 80 million people in Andhra Pradesh who are below the poverty line. How did you publicize your offerings?

We reached out to patients, rather than waiting for patients to come to us. We held large-scale health camps [screenings] in every sub-district and at the village level. This resulted in a lot of cases being detected that required tertiary care procedures. All of these people were immediately taken to a network hospital and operated on. Once they were operated on free of cost, immediately word spread around and gave publicity to the scheme. It's all word of mouth.

How did they manage their healthcare before they found out about your Trust?

Before this scheme, they never had any options for tertiary care. Most of these hospitals were located in Hyderabad or state headquarters [far from the village]. So people were either suffering without treatment, or borrowing money from the local moneylender and paying money to a private hospital at exorbitant rates. The scheme helps finance their catastrophic healthcare costs, which were ruining them financially.

From the patient's point of view, how does the process work?

Let's say a man has a heart condition. He would consult his nearest public healthcare doctors, and if he is advised to take tertiary care, he would be referred to a network hospital empaneled with us. Our representative located in the primary health center takes his details and he's then escorted to the nearest hospital. Once he reaches the network hospital he is registered by one of our health facilitators at the reception center, who are available around the clock. We have a reception center at all of our 350 network hospitals. The patient is registered online, then examined by a specialist, who conducts the appropriate diagnostic tests. The results are uploaded online. Our doctors at the head office take a look at the documents and medical

We are bargaining with the network hospitals on behalf of the poor people, so instead of a patient buying the services individually, they now have bargaining power.

records. If he is in need of a particular tertiary care procedure, the approval is given within 12 hours of registration, the patient is operated upon or the therapy given. The patient is discharged and payment made to him to cover travel charges to go back to his home. Once he is home, another of our health facilitators attached to our primary health centers follows up the case at periodic intervals.

How are the costs covered?

Andhra Pradesh's government provides budgetary support to the Aarogyasri Trust. The Trust pays the premia on behalf of the beneficiaries to an insurance company selected to administer the scheme in a group of districts. The insurance company in turn reimburses the network service hospitals for eligible procedures performed on the beneficiaries. The Trust also runs a self-administered scheme, under which the Trust funds, built up through government grants, are used to reimburse for procedures not covered under the Aarogyasri plan. Payments are made directly to the network hospital based on the cost negotiated with them, keeping in view the large-scale volumes needed.

Commitment from the government has been quite phenomenal. That's what has made this a success.

What has been the biggest impact on the doctors at the network hospitals?

We are bargaining with the network hospitals on behalf of the poor people. So instead of an individual poor patient buying the services individually, they have a bargaining power in the form of the Trust. This has caused doctors to change their mindset.

How do you communicate with the doctors at the network hospitals?

We have monthly meetings with doctors on the kinds of standards that we enforce on various procedures, be it angioplasty or long bone fracture. All the protocols we enforce are a result of continuous brainstorming sessions. We keep training these doctors and they give us their inputs, based upon which we act periodically. With doctors' feedback, the scheme can continually evolve and be responsive. We see it as a way to continually strengthen these institutions.

How are network hospitals certified?

We have statutory requirements for all the private medical hospitals to conform to certain minimum standards from an infrastructure, manpower, equipment, and service delivery point of view. We follow the statutory require-

ments of the government, plus certain additional requirements that we enforce for the purpose of this program. We have a very systematic empanelment procedure where all applications are made online. A team of doctors randomly visits the hospital and inspects the premises, based on the application submitted, and the standards required for our purpose. Qualified hospitals are automatically empanelled.

Do you work with public hospitals as well?

Yes. We do not differentiate between a private hospital and a public hospital. We look at all of them on par. The public hospitals have a lot of infrastructure, so they do qualify quite easily.

Has the scheme brought change to public hospitals?

It has provided the public hospitals with a lot of financial resources to upgrade their infrastructure, and this program has also provided an incentive for better services in public hospitals.

What makes your program successful while others face problems?

It has to do with the way we identify beneficiaries. With other public insurance schemes, there is no disease coverage prior to the insurance. We cover pre-insurance diseases also.

Also, we don't have a system of smartcards. We identify beneficiaries, based on their poverty card status, whose data is available online. If they have that card, they are automatically eligible for the scheme, and they need not undergo another enrollment for this program. They can walk into any hospital and use the services. They don't need anything else.

Are other plans copying the successful elements of your program? Can it be replicated?

Other governments are interested in our scheme, but each government has its own requirements, so implementation depends on the policy the government intends to pursue. Infrastructure, availability of doctors, everything varies from state to state. Certainly other states and regions can learn from our experience. Overall, the commitment of the AP government toward this scheme has been quite phenomenal in terms of the funding and administrative support. That's what has made this scheme a success.

How do you measure progress?

It is a bit difficult to link up the scheme immediately with various health indicators, like life expectancy, infant/maternal mortality rates, or a reduction in morbidity/mortality rates. On the whole it's about an increase in the productivity of the population. As long as the productivity of the population in terms of their working hours increases, we feel that the scheme is a success.

Photo © Manu Dias/AGECOM

Hospital do Subúrbio

A project in pictures

For more than a decade, the government of Bahia has been at the forefront of innovative approaches to healthcare. In the 1990s, the State of Bahia contracted with several not-for-profit companies to manage new hospitals built and equipped by the State, under contracts not exceeding five years. While this model delivered good results, the legal restrictions on longer-term contracting precluded any private sector investment for new public facilities or equipment. The establishment in 2004 of a PPP legal framework at the federal level (followed by the state level) allowed for longer-term PPP contracts. As a result, Bahia's government launched Brazil's first health PPP—the Hospital do Subúrbio. IFC advised the government on the transaction, in partnership with the Brazilian Development Bank (BNDES), and the Inter-American Development Bank.

08/2009

Hospital do Subúrbio is located in a poor area of Salvador, the capital of Bahia State in northeast Brazil. Since 1988, the Brazilian constitution has guaranteed access to medical care for all citizens. To fulfill this mandate, the Government of Bahia engaged IFC to implement a pilot public-private partnership for the hospital, which is under construction. Under the PPP, the private operator will be responsible for equipping and managing the 298-bed hospital, which also includes a surgical center, clinic, medical laboratories, physical therapy unit, and a pharmacy.

02/2010

For the first time in Brazil, a health PPP is bid on a stock exchange. The auction was held at Bovespa on February 26, 2010 at the Sao Paulo stock exchange, ensuring transparency. The Promedica & Dalkia consortium (Prodal), composed of a leading Brazilian healthcare company and a French firm specializing in facilities management and non-medical services, is declared the winner. Prodal is expected to invest $32 million in hospital equipment.

07/2010

Construction of the hospital is completed in July 2010 and the facilities are handed over to Prodal, the private partner, which takes responsibility for equipment and operations. This is the first hospital in Brazil to be equipped and managed through a PPP arrangement. The hospital represents the biggest investment in health in the country in 20 years and creates a new business model for providing high-quality healthcare services to Brazil's poorest citizens.

EARLY 09/2010

The Development Agency of the State of Bahia and Prodal sign the financing contract for the purchase of equipment for Subúrbio Hospital. The value is estimated at R$31 million, comprising all equipment and furnishings required for the smooth operation of the hospital.

MID 09/2010

Subúrbio Hospital opens its doors to the public. During the first month of operations, the hospital functions at a 50 percent capacity to ensure that all systems are working properly. In addition to traditional emergency care, the hospital provides specialized treatment for trauma, orthopedic emergencies, and other complex injuries.

03/2011

Six months after it opened its doors, Subúrbio Hospital is working at full capacity and has provided medical services to over 47,000 patients, including over 138,000 emergency room and outpatient visits—an average of three procedures per patient.

09/2011

The hospital has now been in operation for over one year. Indicators from the first and second trimester demonstrate that the population has wide access to healthcare services, achieving the government's goals for the period. The hospital has had 45,000 emergency visits, 90,000 outpatient consultations, and has conducted 115,000 therapeutic diagnostics; the occupancy rate is 95% with low rates of nosocomial infection.

Four takeaways: The Subúrbio PPP

By Dr. Jorge Solla, Health Secretary, State of Bahia

1. **Select your consultants carefully**. In this case, three factors were relevant: sector expertise, availability of the consultants to dedicate adequate time to the project, and their credibility in the market.
2. **Select a cohesive technical team** that is available, interested, and has balanced knowledge of the issues both from a technical and political perspective.
3. **Have clearly defined policies and instruments** for the project to be implemented.
4. Most important, **provide adequate support for the team and involve the public representatives** in areas such as finance, health, civil affairs, as well as and the top-level public representative, be it the mayor, governor or president.

Photo © Hoong Wei Long

Singapore's secret to healthcare

Public-private collaboration for cost-efficient, high-quality healthcare

By Meng-Kin Lim

Singapore's unique health financing system combines medical savings accounts, supplementary public catastrophic insurance, supplementary private insurance, government-funded subsidies for the majority who utilize public healthcare, and special grants for the poor and elderly. It includes a complementary health provider system, as well as periodic changes in incentives to encourage patients, providers, and insurers to adapt to changing needs. The results have been impressive, and although the approach is not easily replicable, aspects of it can pave the way for public-private collaboration in other countries.

Is it possible for a nation to enjoy universal access to top-quality healthcare on a shoestring budget? Probably not, but Singapore comes close. Among developing as well as developed economies, Singapore is gaining attention for a healthcare system that costs so little, yet achieves so much.

This tiny island republic was once a British colonial outpost in the backwaters of Southeast Asia, and has grown into a bustling city-state with per capita GDP of $57,200 (PPP, 2010), exceeding that of Britain, Japan, and Korea. In 2010, average life expectancy was 81.4 years, up from 62 years in 1957 (the earliest statistic available) and infant mortality was 2.2 per 1,000 live births, down from an appalling 82 per 1,000 live births in 1950. The World Health Statistics 2010 ranked Singapore second-lowest for infant mortality in the world and ninth-highest for life expectancy at birth.

On the financial front, national health expenditure has remained between three to four percent of GDP in the past four decades, compared to OECD's average of nine percent of GDP in 2009. The WHO 2000 report also gave Singapore high marks, ranking it sixth best in the world for "overall efficiency." And Singapore holds the world record for the highest concentration of Joint Commission International (JCI) accredited hospitals.

SINGAPORE'S "SECRET"

Singapore's success in the healthcare sector is tied to an integrated system where the public and private sectors play critical and intersecting roles in healthcare financing and healthcare provisioning. At independence in 1965, half of national health expenditure was from government coffers; now, it is less than one-third. Coverage then was patchy; now, there is universal coverage. The state guarantees "needed healthcare" to those unable to afford the co-payment levied on all, regardless of income status. In 1960, there were fewer than 50 doctors in the whole country with any higher qualifications, and standards in the decrepit and poorly equipped government hospitals were low. Now, 800,000 foreign patients flock each year to this thriving medical hub to pay for world-class medical care.

Singapore's approach to healthcare holds useful lessons for other countries struggling to balance the roles of the public and private sectors in search of better performing healthcare systems. Like other countries, Singapore faces the multiple challenges of a rapidly aging population, the escalating cost of increasingly sophisticated and high-tech medical treatment, and rising consumer demand in the face of finite resources. However, there are reasons to believe that Singapore is better situated than most to surmount these challenges. Among its advantages: a government willing to make hard-nosed decisions; a population conditioned to cost-sharing; and an incentives regime that encourages demand-side responsibility while discouraging supply-side waste.

The relative ease with which health policies are introduced and implemented in Singapore (even when it comes to interventions aimed at lifestyle or behavior change as in the case of smoking, drug addiction and HIV/AIDS) is not easily replicable elsewhere. Singapore's great advantage is that its democratically elected government

has been in continuous power since 1959 and is thus able to pursue pragmatic policies with the longer term "good" in mind, while also garnering continuous public support.

In addition, because there has not been a tradition of state largesse in Singapore, the government did not find it difficult to make the case that free healthcare in the face of potentially insatiable demand was illusory and potentially ruinous. Instead, it convincingly argued that whether the burden falls on taxes, Medisave, employer benefits, or insurance, it is ultimately Singaporeans themselves who must pay. Taxes are paid by taxpayers, insurance premiums are ultimately paid by the people, and employee medical benefits form part of wage costs. In the end, overburdening the state or employers would affect the competitiveness of Singapore's externally-oriented economy as well as individual livelihoods. Citizens understand that, and act accordingly.

COMPETITION IS ENCOURAGED

Singapore's economy thrives on global trade and financial services; its formula for success includes a strong commitment to open markets, minimal regulation, and rule of law. So it is not surprising that Singapore's healthcare sector is highly competitive. Singaporeans enjoy freedom of choice among providers, and the freedom to own shares of the private healthcare providers listed on the Singapore Exchange. The private sector, accounting for 80 percent of daily outpatient attendances and 20 percent of hospital admissions, takes a significant load off the government's back.

At the same time, private providers have to fend off competition from a stable of well-equipped and highly-regarded public sector hospitals and national specialist medical centers for its own share of the high-end, personalized, medical services market. This competition forces both the public and private sectors to deliver more efficient services. The government publishes price and quality indicators of both public and private hospitals on its website to facilitate informed patient choices.

3Ms: MEDISAVE, MEDISHIELD, MEDIFUND

The foundation for Singapore's health financing system—Medisave, Medishield, and Medifund ("3M")—was laid over two decades ago, with the introduction of medical saving accounts in 1984. The underlying policy premise of healthcare financing in Singapore is that healthcare (along with housing and education) should not be provided free of charge. Singapore's unique cost-sharing and risk-spreading system of healthcare financing treats the majority of healthcare consumers as co-paying partners while making special provisions for the minority who cannot afford the co-payment. Such an approach avoids providing the rich with healthcare handouts, as would be the case under a universal coverage system that ignores income status. It also counters the "moral hazard" generally associated with fee-for-service, third-party reimbursement.

THE MAIN ELEMENTS OF THE 3M HEALTH FINANCING SYSTEM

MEDISAVE 

- Compulsory individual medical savings account for employees or self-employed citizens or permanent residents; tax exempt and interest-yielding.
- Funded by employee payroll deductions from 6.5 to 9 percent (depending on age).
- Can be used for hospitalization, day surgery and certain outpatient expenses.
- Eight out of 10 Singaporeans admitted to hospitals pay their bills with Medisave.
- Combined Medisave accounts of all Singaporeans amounted to S$42 billion in 2008, six times Singapore's annual national healthcare expenditure.

MEDISHIELD 

- Voluntary low-cost insurance plan to protect households from large and unexpected financial losses due to illness.
- Coverage for catastrophic illnesses for which Medisave is unlikely to be adequate.
- Singaporeans who want more benefits or amenities such as nicer hospital rooms are free to purchase enhanced "shield" plans offered by private insurers.
- In 2002, Eldershield was set up to provide supplementary, severe-disability insurance for long-term care.
- In 2008, 84 percent of Singaporeans were covered under the Medishield and related shield plans.

MEDIFUND 

- State-funded, administratively decentralized, safety net for the poor.
- Created in 1993 with an initial capital of $200 million; now stands at $1.7 billion.
- Interest is distributed to both public and non-profit hospitals run by voluntary welfare organizations, covering the costs of patients unable to pay their hospital bills.
- In 2000, the ElderCare Fund was initiated for subsidizing voluntary care organizations that offer care to the elderly.
- In 2007, Medifund Silver was set up to provide even more targeted support for Singaporeans over 65 who are unable to pay their bills in public sector hospitals.

CORPORATIZATION OF PUBLIC HOSPITALS

Singapore's patients are well-served by 29 hospitals and specialty centers. Seven public hospitals and six national specialty centers account for 72 percent of the beds, while 16 private hospitals account for the rest. About 12 percent of daily outpatients are seen by traditional Chinese practitioners in the private sector.

Public-sector hospitals and specialist medical institutions were restructured over a 15-year period, between 1985 and 2000, which resulted in their gaining greater autonomy in operational and fiduciary matters. Government ownership was retained through a fully government-owned holding company. Matters such as recruitment and remuneration of staff are decentralized, while more sensitive issues such as increases in ward charges require government approval. In 2000, the restructured institutions were reorganized and consolidated into two "clusters" —Singapore Healthcare Services and National Healthcare Group—each with its own tertiary hospital, supported by specialist medical centers and regional hospitals. Simultaneously, all government polyclinics providing outpatient primary healthcare came under the management of either of the two clusters. Thus, in one fell swoop, horizontal and vertical integration of all the public sector healthcare providers was achieved.

The private sector compares favorably to the public sector in quality of expertise and facilities, and is perceived to be better in terms of responsiveness. Prices are not regulated, and in such a competitive environment, leading physicians and surgeons typically earn considerably more than their public sector counterparts. This differential pay gradient has resulted in a steady flow of talent from the public sector, concerning the government, which has moved to make careers in the public sector more rewarding and satisfying.

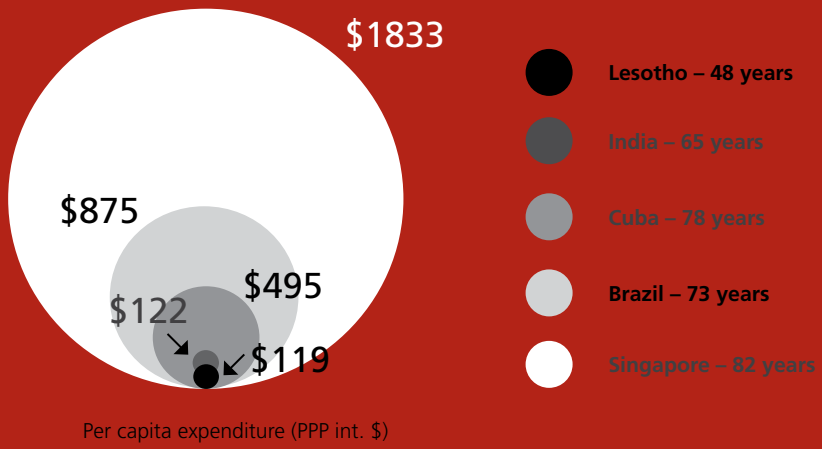
GOVERNMENT BY EXPERTISE

Singapore's proclivity to "government by expertise" is relevant to any serious discussion about the long-term success of its healthcare policies; it is an important reason why the country's approach remains cohesive and consistent despite its ongoing evolution. Often, the Ministry of Health forms committees of experts to study policy issues, and takes these inputs seriously. Typically, these committees also involve the participation of academics, community groups, and the private sector. In recent years, the process has become more consultative, and feedback from the general public is also invited.

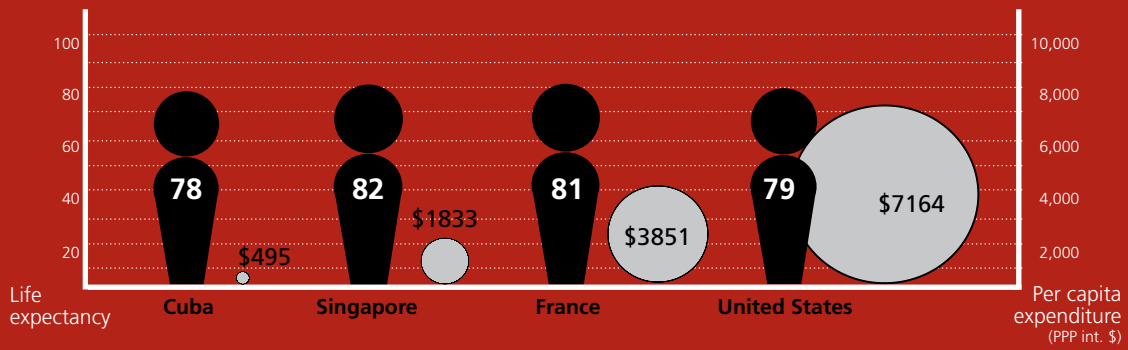
There is also an increasing realization of the need to buttress the policymaking process with a credible evidentiary base, resulting in increasing investments in policy analysis. Singapore's government understands it must play a lead role in finding the solutions to the big problems of the day, but that it cannot succeed alone—an excellent milieu for strengthening collaboration between the public and private sectors.

Challenges in health

Usually more money spent means longer lives lived....



....but not always



FAST FACTS

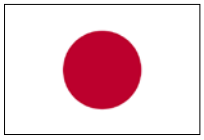
there is a global shortage of

4,300,000

doctors, nurses, midwives, and support workers

1/3 of the global population lacks regular access to essential medicines

LIFE EXPECTANCY RANGE



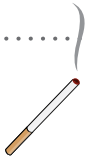
JAPAN
83 years

SWAZILAND
40 years

925,000,000 people went hungry in 2010

700,000,000 people will be obese by 2015

5,000,000+ people die prematurely from tobacco use annually



80% of non-communicable disease deaths worldwide occur in low and middle-income countries.

for every **1** child that dies in childbirth in Sweden,
1,000 die in Afghanistan.

Sources: Facing the Future, USAID, WHO, World Bank, World Hunger.

“In just the past decade, the international community has come face-to-face with the urgent need to strengthen health systems. As we all learned, commodities and the cash to buy them will not improve health outcomes in the absence of efficient, and sustainable, system for service delivery. The investment is worthwhile.”

—Dr. Margaret Chan,
Director-General
World Health Organization

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