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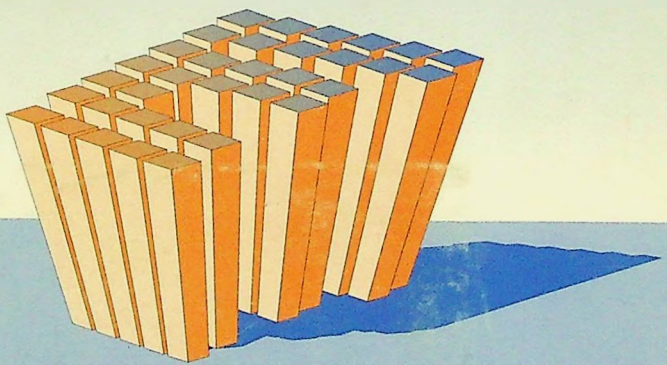
# HEALTH ECONOMICS

## TECHNICAL BRIEFING NOTE

# PRIVATIZATION IN HEALTH



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WHO TASK FORCE ON HEALTH ECONOMICS

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TECHNICAL BRIEFING NOTE

# PRIVATIZATION IN HEALTH

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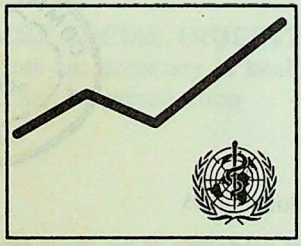

**WHO TASK FORCE ON HEALTH ECONOMICS**

June 1995

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## FOREWORD

Building upon activities already undertaken in the area of health economics, the Director-General created the Task Force on Health Economics (TFHE) in November 1993 in order to enhance WHO's support to Member States.[1] Its goal is to further the use of health economics in the formulation and implementation of health policies, giving priority to countries in greatest need.

The Task Force aims not only to strengthen the technical content of WHO programmes so that they can better adapt the tools of health economics to country needs, but also to foster cooperation among development agencies in applying health economics at country level.

A series of documents in English and French is now available (a list of which can be found at the end of this paper) to help meet the information needs of both those involved in the organization, planning and financing of the health sector and health professionals whose expertise may lie in other areas.

This paper is the first in a new series of ***Technical briefing notes***. These notes tackle subjects of concern to health policy decision-makers, particularly in developing countries. They are intended to provide readers who are not necessarily familiar with the health economics aspects of a subject, with information designed for non-specialists. Nonetheless, the notes are comprehensive and reflect the entire scope of a given topic.

The series start with this note on privatization in health, an issue which is clearly at the forefront of many discussions in ministries of health in developing countries and elsewhere, and among policy-makers worldwide.

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[1] Members of the Task Force are: J.-P. Jardel (Chairman), M. Jancloes (Vice-Chairman), G. Carrin (Secretary), S. Bertozzi, A.L. Creese, D.B. Evans, K. Janovsky, J.M. Kasonde, C.M. Kinnon, E. Lambo, P. Lowry, J.H. Perrot, B. Sabri, C. Sakellarides, Than Sein, L. Tillfors, G. Velasquez, C. Vieira, A.E. Wasunna.

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## INTRODUCTION

This technical briefing note provides an introduction to some of the key concepts associated with privatization in the health sector. Although commonly used, the term «privatization» can be a source of confusion because it is applied to several distinct types of change taking place in the health sector. This note aims to clarify the differences among these types of change and presents some of the potential consequences of a greater role for the private sector in health.

### *Structure of the briefing note*

***Section 1*** Defines privatization, identifies the components of the private sector, and provides a table depicting various combinations of public and private financing and provision of health services.

***Section 2*** Reviews the recent increase in emphasis on private financing and provision of health care services and identifies two broad categories of privatization (active and passive privatization).

***Section 3*** Provides descriptions and selected examples of three major forms of government-driven, active privatization policies, and discusses the potential impacts of each in terms of equity, efficiency and quality of care. The particular strategies reviewed are:

- Divestiture of public assets
- Public contracting with private sector providers
- Incentives and regulatory stimulation of private sector growth

***Section 4*** Discusses passive privatization, or changes in the relative balance between public and private sectors which occur because of factors that are not necessarily linked to public policy.

***Section 5*** Provides a brief discussion of internal market mechanisms.

***Section 6*** Points to the potential conflict between private financing and provision mechanisms and public health objectives, and presents strategies for public management of the privatization process.

# 1. DEFINING PRIVATIZATION AND THE PRIVATE SECTOR

## 1.1 Privatization and public market mechanisms

Privatization can be defined as a ***process in which non-government actors become increasingly involved in the financing and/or provision of health care services.*** A distinction should be made between the process of privatization and the public/private mix in the health sector. In most countries, both public and private sectors play a role in the financing and provision of health care, although the relative size and importance of each sector vary significantly from system to system. Privatization involves changes in public and private roles and responsibilities in the health sector, and generally includes changes in actual ownership of the means of financing and/or producing health care.

The term privatization is often applied less accurately to policies that are designed to establish a «public market» or an ***internal market*** *(1).* Such policies encourage competition or market-like behaviour within the public sector. Examples of internal market policies include performance-related payment mechanisms (e.g. capitation), or policies designed to encourage patient choice of provider. These strategies do not fit the precise definition of privatization cited above, since they do not necessarily involve changes in public or private responsibility for health services financing and provision.

## 1.2 Components of the private sector

The private sector encompasses both for-profit and not-for-profit (NFP) subsectors and therefore includes not only health workers in private practice but also local and international NGOs, mission organizations, voluntary associations and other groups.

It is often assumed that the objectives and motivations of the NFP subsector are similar to those of the public sector *(2).* One important similarity between the NFP subsector and for-profit providers, however, is that both subsectors are more likely to be concerned with issues of efficiency and resource management than public sector providers, mainly because the «financial survival» of both NFP and for-profit providers is not certain.

## 1.3 Combinations of public and private sector financing and provision

Different combinations of public and private responsibility for the financing and provision of health care services can be depicted as in the table below. The process of privatization can be represented as a *shift from one cell to another* (e.g. from cell A to cell C).

The table below provides a convenient means of depicting alternative financing and provision relationships between the public and private sectors. In most countries, several different financing and provision arrangements (i.e. «cells») will co-exist. A fairly serious limitation of the table is its inability to illustrate changes taking place *within* cells. For example, internal market policies cannot be depicted as a shift from one cell to another, but rather as a change taking place within cell A.

**Possible combinations of public and private sector financing and provision**

| | RESPONSIBILITY FOR PROVISION | | |
|---|---|---|---|
| **FINANCING SOURCE** | **PUBLIC** | **PRIVATE NOT-FOR-PROFIT** | **PRIVATE FOR-PROFIT** |
| **PUBLIC** | ¤ General tax revenues used for direct public provision.<br>**CELL A** | ¤ Public insurance contributions used to purchase the services of NFP providers.<br>**CELL B** | ¤ General revenues used to purchase the services of private for-profit providers.<br>**CELL C** |
| **PRIVATE** | ¤ User fees paid for private use of public facilities.<br>**CELL D** | User fees paid of NFP facilities.<br>**CELL E** | ¤ Private insurance payments paid to providers in private practice.<br>**CELL F** |

Note: Each cell provides one example of a financing/provision combination. Other combinations are possible. Specific combinations that are discussed in the text below are marked with the symbol ¤.

## 2. FACTORS INFLUENCING PRIVATIZATION STRATEGIES

Health sectors may become more «privatized» in response to a variety of pressures, both with and without the active collaboration of governments.

### 2.1 Economic assumptions and political motivations

Policy-makers are often driven to privatize the health sector because of a number of preconceived notions about the benefits of privatization. Some commonly held assumptions about privatization and the private sector in health are listed below. The extent to which these assumptions are valid is discussed in more detail in the remainder of the note.

- ***Assumption:*** The private sector is free from the administrative and political constraints commonly associated with public bureaucracies *(3)*. From this perspective, privatization is seen as a way to improve resource management and thus lead to more efficient and effective health services delivery.

- ***Assumption:*** Scarce government resources will be «freed up» to provide services for the poor to the extent that those individuals who are willing and able to pay for health services seek care outside the public sector.

- ***Assumption:*** The infusion of «market forces» (e.g. in public market policies), such as competition and incentives, will lead to improvements in service quality.

Privatization has also been driven by changes in social organization and political structures. Countries in all regions have sought to move from centrally planned economic decision-making toward an acceptance of market economics. One consequence of this trend has been a shrinking government presence in sectors previously dominated by government.

While privatization has been a policy focus in many countries, some governments - including several of the countries in the Eastern Mediterranean Region - have not developed explicit policies toward privatization.[2] In these cases, the relative role of the private sector in health has not yet become a major concern.

### 2.2 Active vs. passive privatization

Although privatization often occurs as a direct result of government policy changes, it can occur even without specific policies targeted at the health sector. For this reason, it is useful to distinguish two broad categories of privatization processes.

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[2] Countries such as Bahrain, Kuwait, Oman, Saudi Arabia and the United Arab Emirates have been able to continue providing free services of good quality to their populations, although resource constraints have emerged as an important policy concern. Source: EMRO communication.

- ***Active privatization:*** the government actively encourages changes in the public/ private mix.

- ***Passive privatization:*** the private sector grows on its own accord, without any related changes in government policy.

Within the broad category of active privatization, there are a variety of strategies that serve to increase the involvement of private sector actors in health services financing and provision, several of which are discussed in section 3 below.

## 3. APPROACHES TO ACTIVE PRIVATIZATION

Policies designed to actively increase private sector involvement in health care financing and provision can result in complex, often blurred relationships between public and private sectors. Sometimes the same people are engaged in both sectors, and health facilities may be used for both public and private service provision. Because of the inherent complexity of privatization strategies, the implications for the role of government are difficult to predict, and will vary from strategy to strategy and from setting to setting.

From a practical viewpoint, it is extremely difficult to assess the ultimate impact of privatization strategies on health status. An alternative is to evaluate the impact of privatization on a set of ***interim policy objectives*** such as equitable access to health services, efficient use of resources, and quality of care.

### 3.1 Divestiture of public assets

#### Description and selected examples

In the strictest sense, privatization involves a ***transfer of ownership***, in which the State divests itself of public assets to private owners. The primary objective of divestiture is to reduce the scale of government commitments.

In the Czech Republic, for example, the government plans to transfer 70% of existing hospital beds to both NFP and for-profit subsectors by 1996. Private sector financing of health care is also being encouraged through the development of private for-profit health insurance schemes *(4)*. In China, health reforms begun in the 1980s fueled a rapid rise in the role of the private sector in both health financing and provision. Many village health centres were sold and converted into private clinics *(5)*.

#### Potential impacts of divestiture

- ***Equitable access to care:*** Too much reliance on private sector financing mechanisms may result in inequities in access to care. In the Czech Republic, private insurance companies are beginning to compete on the basis of patient selection, which may serve to diminish equity *(4)*. Some observers suggest that adverse equity effects may result from a failure to recognize the importance of maintaining financial «safety nets» for health systems, particularly in poor rural areas *(6)*.

- ***Efficient use of resources:*** While divestiture of public assets will undoubtedly reduce the burden of public sector financing, there is a risk that higher health care costs may be associated with uncontrolled privatization, as private providers seek to maximize revenue. Efficiency may be diminished further if providers have incentives to provide unnecessary and expensive care (e.g. unneeded tests, excessive reliance on costly equipment). Such incentives

are common in private for-profit insurance schemes, in which a third party (the insurance company) reimburses providers on a fee-for-service basis.

- ***Quality of care:*** There is sufficient evidence, particularly from non-health sectors, that competition and private initiative can lead to better quality goods and services. In the private provision of health services, however, quality of care is often in delicate balance with competing objectives of efficiency, equity and resource generation. In China, the rural health care system eroded during the recent period of rapid privatization, and there is considerable debate about the extent to which privatization policies may have led to a deterioration in the health status of the rural poor.[3] It is conceivable, therefore, that cost containment strategies and/or profitability objectives could compromise efforts to improve service quality.[4]

## 3.2 Public contracting for private sector service provision

Contracting involves shifting partial or complete responsibility for the ***provision*** of clinical or non-clinical services to the private sector, while the responsibility for financing remains with the public sector. Contracting arrangements are diverse and are evolving rapidly. A selection of some of the most recent developments in contracting is discussed below.

### 3.2.1 Contracting with the private for-profit subsector

#### Description and selected examples

Past contracting arrangements are fairly common for intermediate health care inputs (e.g. non-clinical services such as laundry and catering, hospital billing, etc.).[5] Recently, contracts with for-profit providers for the provision of preventive and curative health care services have become more prevalent.

Contracting can take a variety of forms, and can be adapted to meet the needs of individual countries. In Namibia, surgical care in rural areas is often carried out by teams of GPs in private practice, under contract with the Ministry of Health. Contracts can also be developed with specific institutions; Zimbabwe has had some experience developing contracts with mine hospitals for the provision of services to eligible populations *(2)*. And in the UK, as many as 30 different clinical services have been contracted to the for-profit subsector; many contractors are foreign companies *(7)*.

[3] The Government of China has in recent years taken steps to improve the health status of the rural poor.

[4] In the Western Pacific Region, a private for-profit hospital in Papua New Guinea has had difficulties in maintaining quality of care, and is experiencing related problems with utilization and, thus, profitability. Source: WPRO communication.

[5] At the Mulago hospital in Uganda, for example, meals for staff, elevator services and the management and maintenance of steam facilities are contracted out. In Zimbabwe, the maintenance of instruments and electronics, provision of laundry services, and the supplies of certain drugs are based on contractual agreements. Source: AFRO communication.

Some countries use social security funding to pay for-profit providers, which represents a variant on the contracting strategy. In Chile, health care is provided through three separate institutions, two of which allow the use of public funds to pay for private sector treatment *(8)*. Sometimes social security institutions contract with private providers to deliver health care services on a fee-for-service basis. This is done in Brazil - through the National Social Security Institute of Medical Care - and in the Islamic Republic of Iran, where the Ministry of Health and the Social Security Health Services negotiate with private providers to design fee schedules for the provision of curative services *(9, 10)*.

#### *Potential impacts of contracting with the for-profit subsector*

- ***Equity:*** Developing contracts with the private for-profit subsector has the potential to increase access to health services for disadvantaged groups, to the extent that contracts encourage an increase in the *availability* of services. Unfortunately, there is little evidence that contracting with the for-profit subsector has led to improvements in access to care.

- ***Efficiency:*** Contracting is a strategy aimed at improving the productivity of public resources by taking advantage of efficiency gains that are perceived to exist in the private sector *(11)*. In the case of Namibia, for example, the contracting arrangement for surgical care has been reasonably successful in containing costs, but there is evidence that GPs often give priority to their own private patients over patients covered under the contracts.

  The requirements of public sector monitoring and management may also reduce the efficiency gains that might be realized through a greater private sector role. As an example, a country might wish to develop contracts with private sector providers in order to encourage more efficient use of public resources. But capacity-building for effective management of the contracts (to ensure compliance and protect against fraud or abuse) may require the investment of yet more public resources. In such a case, use of public funds by private providers creates a new need for public supervision.

- ***Quality:*** It has also been suggested that contracting may lead to quality improvements *(12)*. The potential for quality improvement (and cost containment) through contracting is maximized in an environment of *competition* for contracts. Countries with poorly developed private provider markets are therefore unlikely to realize the full potential of service contracting *(11)*.

### *3.2.2 Contracting with the private not-for-profit subsector*

#### *Description and selected examples*

The private NFP subsector provides both curative and preventive services in a large number of countries, particularly in sub-Saharan Africa. Government support for the NFP subsector may include payment of lump sum subsidies, secondment of health personnel or subventions for staff salaries. Incentives are also frequently provided

in the form of tax-free imports of equipment and drugs, purchase rights from government stores, or the payment of retirement benefits for employees of NFP provider organizations *(2)*.

The use of more formal contract arrangements between governments and NFP providers has been suggested as a way of ensuring that the activities of these providers correspond more closely with government policy objectives. To date, there is very little experience with this form of contracting, although some examples do exist.

Limited contracts with NFP providers for the provision of specific technical services have been negotiated as part of donor project agreements in both Uganda and Zambia *(2)*. In Poland, the Government is developing contracts with NGOs to conduct public health campaigns *(13)*.

#### *Potential impacts of contracting with the NFP subsector*

- ***Equity:*** There is a distinct potential to realize equity gains with this strategy. Not-for-profit providers, usually NGOs, frequently establish health facilities in areas where government facilities do not exist *(11)*, providing access to health services for populations with otherwise limited alternatives for care. Contracts with NFP providers can ensure that disadvantaged groups have access to a minimum set of essential services.

- ***Efficiency:*** Efficiency gains are feasible with this strategy, to the extent that the financial survival of NFP providers is dependent on their ability to manage resource use. Better policy coordination between the public sector and NFP providers on such issues as the location, size and staffing patterns of health facilities should lead to improvements in the overall efficiency of the health sector.

- ***Quality:*** Services provided by the NFP subsector are often perceived to be of higher quality than those available in public sector facilities. Quality differences have been linked to more consistent availability of drugs in NGO facilities and in some cases to better technical skills of NGO staff *(14)*.

### *3.3 Incentives and regulatory stimulation to private sector growth*

#### *Description and selected examples*

Contracting with the private sector - and the development of internal markets - are ways in which *public financing* can be used to draw upon the most potentially useful aspects of market behaviour. Some countries have encouraged a greater role for the private sector in ***both financing and provision*** of health services. Examples include the repeal of legislation and regulation banning or restricting private practice (as has happened in Tanzania and Mozambique), and a rethinking of incentives to encourage private initiatives complementary to public policy objectives.

Some of these strategies involve allowing «private sector activity» to take place within public sector facilities. Innovations such as these enable private funding sources to pay for some health services that might otherwise be covered by public funds.[6] In Mozambique, for example, medical staff are allowed to run special private clinics in government facilities outside normal working hours. The countries of Indonesia, Mexico, Tanzania and Zimbabwe have private pay beds in government hospitals *(15)*.

Other methods used to encourage the growth of the private sector have included tax breaks, such as allowing the importation of specific medical supplies duty-free, or bonus incentives to encourage physicians to locate in underserved areas. In Ethiopia, private providers can purchase drugs and some medical supplies from government sources, allowing providers to take advantage of lower prices available through government bulk purchasing power *(2)*. Indonesia, Nigeria and Zimbabwe all offer tax relief to not-for-profit providers, while Mexico provides tax relief for some private health expenditures *(16)*.

Measures such as these stimulate the growth of private provision capacity and encourage increases in private expenditures for health care. Relatedly, user charges for public sector health services tend to stimulate private sector growth by a) shifting financing responsibility (at least partially) to private sources, and b) establishing price competition between public and private sectors. Policies designed to encourage the development of private health insurance mechanisms can also shift financing toward the private sector and may encourage people to use private providers.

### *Potential impacts of incentive strategies*

- ***Equity:*** When health workers are allowed to supplement their income by offering private services in public facilities, there is a risk that equity (and the quality of care provided to public patients) may diminish, as clinicians give preference to the more lucrative private services. (A related problem - and an interesting form of subsidy to the private sector - arises when health workers trained at the public's expense move into private practice.) In addition, such incentives rarely expand access to care for the very poor because of limited mobility.

  Tax relief policies often constitute direct public subsidies to the beneficiaries. In the case of tax relief for private insurance contributions or for private health expenditures, inequities may result if the tax policies represent subsidies to those most able to pay *(16)*.

- ***Efficiency:*** Inappropriate incentives may encourage private providers to overservice patients. Providers may order unnecessary procedures or they may resort to polypharmacy if their incomes are tied to the volume of services

[6] In Sri Lanka, the Government plans to implement several policies designed to stimulate private sector growth. In government hospitals with improved hotel facilities, 10% of hospital beds will be allocated to private patients. Private nursing services have been allowed. The Government has also taken steps to reduce public training subsidies to the private sector by sanctioning the creation of private nursing schools. Source: SEARO communication.

provided or to drug sales. In situations where providers work in both sectors, providers may use their «public time» to identify clients for their private practices, patients who might be served just as effectively in less expensive public facilities.

- ***Quality***: Rapid increases in the numbers of health workers in private practice requires monitoring to ensure that the standards of care remain acceptable.

These and other potential problems indicate that privatization policies designed to spur the growth of the private sector may not result in a diminished role for government. Its role may instead need to ***shift toward one of greater regulatory and monitoring responsibility***.

## 4. PASSIVE PRIVATIZATION

In addition to the forms of active privatization described above, some countries have experienced recent rapid growth in private practice with no detectable shift in government policy. Passive privatization may occur in countries where rapid economic growth is causing the demand for health services to outstrip the quantity and/or quality of the services provided in the public sector. Passive privatization is also common in situations where a tolerant regulatory environment co-exists with tight budget constraints in the public sector. In such settings, countries may experience migration of skilled health workers to the private sector. Another possible consequence of passive privatization is rapid growth in the informal health sector, making it increasingly difficult to monitor the costs and quality of health care provision.

Passive privatization has occurred in many major urban areas in India and China, where there has been a rapid growth in private pharmacies, maternity clinics, specialized clinics and (typically small) private hospitals. The relative shares of public and private financing and service provision are shifting towards a larger private share in these contexts. Clearly, quality of care is a major concern is such cases, particularly if the growth in public monitoring and regulatory capacity does not keep pace with changes in the relative size of the private sector.

## 5. PUBLIC (OR INTERNAL) MARKET MECHANISMS

### *Description and selected examples*

The creation of ***internal markets*** within the public sector is often misleadingly referred to as privatization. With public market strategies, public financing and provision responsibilities remain largely unchanged. ***Public providers are encouraged to compete for patients*** through policies which link contract-based provider payment with the patient's choice of provider. The objectives of these strategies are twofold: 1) to stimulate efficient use of resources, and 2) to encourage providers to offer better quality of care.

In Sweden, most municipalities and county councils are operating contract payment systems for public hospitals and specialist physicians. Hospitals and primary health centres are essentially «public firms» under this approach, and support themselves partially or entirely on the revenues they are able to generate *(11)*. In other words, public resources are tied to the consumer, not to the health care facility.

In the UK, large GP practices are allowed to «hold» or manage funds for the provision of certain hospital services for their patients. The GP «fundholders» are expected to arrange and pay for the provision of hospital services on behalf of their patients *(17)*. Most public hospitals have also been transformed into self-governing trusts. Although trust hospitals are financed primarily through public funds, they have control over employment decisions, the raising and deployment of capital, and the range of services offered.

### *Potential impacts of internal market mechanisms*

- ***Equity:*** As implemented in the UK, trust hospitals are expected to compete with other hospitals for contracts. There have been suggestions that competitive pressures may force self-governing trusts to behave more like their for-profit competitors.[7] The result may be a shifting of resources toward more profitable services and away from the provision of services based on community needs.

- ***Efficiency:*** As with contracting arrangements, there are potential efficiency gains to be realized with internal market mechanisms. Indeed, internal market strategies may become indistinguishable from contracting with the private sector, since part of the idea behind contracting is to encourage existing providers such as hospitals or primary care practitioners to think of themselves as independent contractors and not necessarily public sector employees.

[7] Source: EURO communication

- ***Quality:*** Quality improvements resulting from competition for patients could be realized with internal markets, although an implicit assumption behind provider choice provisions is that enough providers exist for patients to make an informed choice. While this may be true for urban areas, it is unlikely to be the case in sparsely populated rural areas.

# 6. PRIVATIZATION: ARE SOCIAL OBJECTIVES AT RISK?

During periods of change in public and private roles in health, it is important for governments to ensure that social objectives are not compromised, regardless of the modalities of health financing and provision. This requires developing innovative and practical relationships with the private sector.

As mentioned in section 2.1, there are a number of ways in which the private sector may contribute to the achievement of social goals. This does not mean, however, that governments should necessarily have a reduced role in the health sector. Indeed, as privatization proceeds, governments will need to evolve toward a position of greater strength, skill and sophistication to manage and monitor privatization initiatives.

## 6.1 Why governments are necessary in health

A government role in health is needed to ensure that market-oriented solutions do not jeopardize the attainment of social goals like equity. The production and distribution of goods and services in a pure private market is based on the prevailing distribution of income; those who are not willing or able to engage in market transactions will not do so. For this reason, the market, left to itself, will not allocate health resources equitably. If there is no monitoring of health services pricing, and if competition between providers fails to keep prices down (or quality high), poor and vulnerable populations will be denied affordable and equitable access to appropriate care.

A private market for health care is also subject to special forms of market failure that are not found in other markets. Providers of health care exercise unusual power: they prescribe treatment and medication for their patients and simultaneously provide the services they have recommended. In some instances, the disproportionate power of providers can work against the interests of the patient, in part because most patients are not able to assess the validity or usefulness of the provider's recommendations.

There is also an element of externality, or third party benefit, in the production and consumption of certain health services. Immunizations, for example, are beneficial even to those who are not immunized. Private (for-profit) providers of immunization services would not include «external benefits» in their production decisions, and would therefore produce less than the *socially optimal* level of immunization services.

Thus, while privatization efforts may lead to better efficiency in the use of health care resources, there is also a risk that an increased reliance on the private sector may lead to diminished equity. It should be noted that some health systems with significant private sector elements - such as Canada and some of the European systems - are regarded as highly equitable. But those systems operate within a framework of public responsibility and oversight. Problems with equity are likely to be greatest when the

relative importance of the private for-profit sector increases in the absence of a government regulatory and monitoring role.

Strategies to accelerate privatization, therefore, require a government role in order to ensure that health services remain accessible to all population groups. This is particularly important in situations where private sector providers choose to concentrate on the most lucrative services, leaving the government to provide emergency care, training and services for the poor.[8]

### 6.2 Public management of privatization

What should governments do to improve their capacities to plan and manage the evolution of new public/private relationships? The formation of well-planned policies toward the private sector requires the development of an enabling environment for effective public management of privatization, including:

- investments in information, and in information systems capable of generating relevant data about resource flows and performance in both public and private sectors *(11)*;

- strengthening of public sector capacity to set performance standards, and to monitor and enforce those standards;

- strengthening of management skills, particularly skills in establishing and supervising contracts. The development of contractual arrangements may be impeded in many countries where funding or managerial expertise is limited;

- flexible and responsive organizational structures - and the institutional capacity - to adequately monitor and motivate the private sector to achieve social goals.

Recent experience in managing the reform process in industrialized countries has shown that the ultimate success of government efforts to manage changes in the relative roles of public and private sectors in health will depend on the existence of political and legislative frameworks that clearly spell out the goals and objectives of privatization policies. This represents a broader public requirement that is to a large extent outside the direct control of the health sector *(18)*. The management of the public and private sector balance is likely to be untenable without such a framework, and without clear policy objectives and sensitive and specific regulatory mechanisms.

[8] Source: AMRO communication

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