



# Project Rationale and the Role of Public Intervention

## Alternative Project Designs

Essential at the early stage of a project analysis is a clear statement of a project's goals; that is, what aspect of health the project aims to improve. Virtually all health objectives can be met in alternative ways and it is important at the design stage to consider the feasible range of alternatives available. Cost-effectiveness analysis, discussed in detail below, is an important tool for comparison between alternatives.

Good project appraisals consider a range of alternative approaches. The range of project designs should consider the following factors:

- (i) the variation in the combination of components needed to address a particular objective;
- (ii) the range of intervention modalities, e.g., whether an intervention should be provided in health facilities or through outreach workers;
- (iii) different types of inputs, e.g., medicines, contraceptives, equipment, personnel;
- (iv) alternative institutional arrangements for the management and delivery of services including whether the services could be contracted through the private sector; and
- (v) different scenarios for the timing and phasing of the project.

The project should identify the components needed to achieve its objectives. This involves not only what will be done but also when, by whom, and how well. In terms of the combination of inputs, substitutability of inputs should be explored, especially when there are weaknesses in the delivery system. For example, if the country does not have enough qualified doctors, how then can lesser-trained medical personnel be used to achieve the same outcomes? Rather than using expensive equipment that is costly to maintain, are there simpler technologies that may require more personnel but are equally effective? Evaluation of alternative designs should consider the role of pilot projects and operational research on alternative strategies, and the process of scaling up from pilot projects to more general implementation. This is especially true for activities with limited operational and scientific evidence on implementation issues and impact. However, lack of data on impacts of specific interventions will always be a problem in certain areas. Hence, it is unrealistic to expect that the consequences of alternative designs can be specified in detail for all projects.

## **Role of Government**

The question of whether health projects should be in the public, private, NGO or traditional sectors is part of the comparison of project alternatives. Although a majority of health expenditures within the region now goes to private providers, there are still strong grounds for arguing that the public sector will continue to play a key role. In the present policy environment where private initiatives in all areas are

encouraged, the location of a project in the public sector will have to be justified as part of the appraisal procedure.

In theory, the economic rationale for intervention in the health sector can be formulated on both efficiency grounds and equity grounds. Public intervention in the health sector is justified when private markets fail to function efficiently, or when the social objectives of equity in access and improved status of women, the poor, and indigenous peoples are unlikely to be attained under given income and resource distributions. Market failures due to public goods and externalities, informational imperfections in health service markets, and informational imperfections in insurance markets have long been recognized to comprise the logical basis for public health programs and social insurance schemes directed at health care. *Public good* properties of the treatment and prevention of communicable diseases, *externalities* associated with infectious diseases, and *informational imperfections* in the markets for medical services and insurance products are all reasons why market solutions may be suboptimal. Together with equity considerations, market failures provide a rationale for health sector interventions and a motivation for ADB projects directed at health investment.

The clearest justification for public provision of health services, as opposed to subsidization of private provision, is the public good factor. Public good has two essential features. First, it is *non-rivalrous* in consumption. That is, as benefits accrue to one individual or household, the consumption of those benefits does not interfere with or detract from the consumption of those same benefits by other individuals and households. The second property of a public good is *nonexcludability*. Once the public good has been produced, for example the eradication of an infectious disease like small pox, there is no way to prevent (exclude) others from enjoying the benefits such production confers. Pure public goods are both non-rivalrous and nonexcludable while pure private goods are both rivalrous and excludable. Since it will not be able to capture user willingness-to-pay, the private sector will have no incentive to produce public goods, unless contracted by government to do so. The precise distinction between pure public and private goods is not always clear, but *Figure 2* gives an illustrative classification for health programs.

Although in principle only and not necessarily public provision, externalities or health impacts on others apart from particular individuals also justify public involvement. In the case of contagious diseases, the response of the private sector, particularly consumers of preventive care, will be insufficient to ameliorate the health risk. Private benefits from immunization are substantially less than social benefits because immunized individuals protect not only themselves but also others they come in contact with and potentially expose to risk.

Figure 2  
Illustration of Public and Private Goods

	RIVALROUS	NON-RIVALROUS
EXCLUDABLE	<b>Private Good</b> <ul style="list-style-type: none"> <li>• Cancer Therapy</li> <li>• Kidney Transplant</li> <li>• Dialysis Treatment</li> </ul>	<b>Mixed Good</b> <ul style="list-style-type: none"> <li>• Medical Research</li> </ul>
NON-EXCLUDABLE	<b>Mixed Good</b> <ul style="list-style-type: none"> <li>• Fresh Water</li> </ul>	<b>Public Good</b> <ul style="list-style-type: none"> <li>• Health Sanitation</li> <li>• Vector Control</li> <li>• Immunization Programs</li> </ul>

In the extreme case, if all individuals in an area except one person were immunized against a contagious disease, that one would have no incentive to be immunized as there would be no private benefit from doing so. A similar phenomenon categorized under the general rubric of *externalities* is dramatically and tragically evident in the case of the AIDS epidemic. Once an individual has contracted the HIV virus, private incentives for prevention are substantially diminished with the spread of the virus as a possible consequence. Additionally, lack of treatment causes the spread of communicable diseases and improper use of antibiotics gives rise to resistant strains of bacteria.

Lack of information is also an important concern of the health sector. Markets work best when information about goods and services are readily available and producers and consumers are equally well informed. Health care is a particularly complex service and is not easily understood or cheaply sampled, unlike many consumer goods. The users of health services have difficulty gauging the quality and the appropriateness of the care they receive and rely heavily on advice from health service providers. As a result, there is a tremendous asymmetry of information between the users of health care, who are drawn largely from the general population, and the providers of health care, many of whom are highly-trained professionals. This asymmetry exists within the health care systems of all societies but is particularly acute in DMCs where many users of care are poorly educated. Under these conditions, private proprietary providers may be tempted to provide a low quality of service,

such as inappropriate or non-*efficacious* care, and to charge prices too high for the services provided. Furthermore, even the more obviously private good elements of the health sector, such as hospital treatment for noncommunicable diseases like cancer or kidney failure, may require significant public sector support, either through the training of medical staff or basic research on forms of treatment.

Given the impossibility of operating the health sector on a purely commercial basis, various forms of intervention have been used by DMCs in the region. Project analyses should consider which is most appropriate for the objective at hand.

### **Direct Public Provision of Health Services and Products**

Direct public provision of health services is an intervention favored by many developing countries because it affords control of the quality, type of care, and geographical distribution of facilities. Importantly, it allows public health to be provided either free of charge or at low cost to target groups, thus meeting an important equity objective, particularly in rural and low-income areas where effective demand is insufficient to stimulate private provision. Where private providers are poorly developed or nonexistent, equity in health services may be achieved only through direct government delivery, at least in the short run. This approach, however, involves public funding and raising additional public finance may entail macro economic costs through deficit financing or higher taxation. Hence, it should not be automatically assumed that public provision is preferable to the other alternatives. The impact of a project on private sector health providers should also be considered. If some are crowded out, the health benefit of the project will be its net effect (allowing for any displacement of private provision) rather than its direct impact. Further, there may be an area for collaboration between public and private sectors in the contracting out aspects of health provision to private providers.

### **Promotion of Voluntary Non-Profit Providers and NGOs**

Voluntary nonprofit providers and other NGOs came about partly in response to the failure of the private sector to fully meet the social need for health services. NGOs have different objectives than proprietary health care providers. Although the private for-profit sector has incentives that encourage the efficient production of services, these same incentives also lead to lower quality of services and even inadequate service for low-income clientele. In the attempt to meet the needs of clientele not served or not served well by the private for-profit sector, NGOs have an advantage over government because their internal organization and structure lead to the efficient production of services much like that of the private for-profit sector.

Unlike those of the for-profit private sector, however, the objectives of NGOs tend towards quality service and care for the underprivileged. Where government regulation is weak and monitoring of the private sector difficult, NGOs may be particularly well suited to provide high-quality care.

## **Contracting Out to Private Providers**

An increasing amount of experience has accumulated internationally on the issue of the public sector contracting out various health services to private or nongovernment provision. Although this process has not been carried to many of the DMCs, it nevertheless has a number of potential advantages. For example, it focuses on tangible outcomes with financial reward linked directly to achievement; it draws on the experience of NGO or other non-public sector suppliers; it allows governments to focus on financing and regulation rather than on day to day management of health services. On the other hand, its disadvantage is that for its success, a competent public bureaucracy is required to ensure the adequate regulation and monitoring of the private contractors involved so that appropriate national standards of health coverage are assured. As part of on-going health sector reform initiatives, ADB is encouraging DMCs to look into ways of involving private providers in the sector. *Box 2* describes the introduction of an experimental contracting out system in Cambodia.

## **Regulation of Services and Licensure of Private Providers**

Poor quality of service from private providers is a serious issue and public licensure and regulation are a possible response. In DMCs, non-efficacious counterfeit pharmaceuticals pose a quality-control problem within the private sector.

Unqualified physicians and other health providers are other sources of ineffective care and inefficiency in the system. Regulation and licensure will likely improve quality, or at least assure minimal levels of it. Regulation, however, will generate a new set of direct and indirect costs. Moreover, licensure and regulation tend to reduce competition and may lead to the accrual of economic rents by the regulated sector.

## **Health Education and Information Dissemination**

The public sector can provide direct education and information to compensate for informational imperfections in the private sector and the existence of external effects associated with contagious diseases. The government can maintain a health

## Box 2

**Contracting out Health Services: Cambodia Basic Health Services Project**

The ADB project will support the testing of the contracting out of basic health services to NGOs and other private providers in five districts with five other districts monitored as comparator areas. The Government will define the standards of service delivery the contractor must meet and will incorporate these in tender documents. For example, the successful bidder will be required to immunize 90 percent of children, ensure that 80 percent of children receive vitamin A supplements, and ensure that 95 percent of pregnant women obtain prenatal care. Tender documents will state which districts are to be covered and what inputs the government will supply. Bids are to be evaluated on both costs and scope of services offered and the winning bidder will be given a four-year contract. The performance of the contractor will be monitored annually or bi-annually by the provincial health office, the Government through the Ministry of Health, and an independent consultant appointed by the Project. Performance bonuses will be given to the contractor if substantial improvements in health services are achieved. If minimum standards are not met, the contract will be cancelled. As part of the comparison to establish the impact of management improvements alone resulting from contracting out rather than simply using additional financial inputs, the comparator areas will be given additional funds from the Ministry of Health if they submit a plan of action of acceptable quality.

Source: Loan 1447-CAM: *Basic Health Services Project*, 1996.

information system that reports on training and professionalism of physicians and the quality of care provided by hospitals and clinics. This, in turn, can provide consumers of medical services with some of the information they need to make more efficient choices.

## Public Health Insurance

Health insurance provides protection against the risk of medical expenses by allowing the insured to share that risk with other members of the group. The financial pool is supported by all members of the group through taxes or premium contributions. With subgroups placing claims on the group's financial resources in a more or less random fashion, the risk is spread over many individuals, becoming substantially lower than that faced by an individual in financial isolation. Although most public insurance and some private insurance perform a redistributive function as well, risk-sharing is considered the fundamental function of insurance. This risk-sharing function is particularly important in DMCs where the financial burden of ill health can have a catastrophic effect on the well-being of households. The greatest underlying

demand for health insurance is the protection against large, catastrophic expenses that are unpredictable. Unfortunately, the same characteristics that create the need, namely large expenses and lack of predictability, also make insurance against catastrophes the most difficult to underwrite and the least attractive for the private sector to supply. Private insurance markets may also fail to spread risks properly due to informational imperfections. Because the financial risk of ill-health can have a devastating impact on family welfare particularly in poor households, many DMCs look to public health insurance as a potential intervention. Motivations for interventionist policies are further strengthened by the recognition of private market failures due to moral hazard and adverse selection.

Adverse selection, a classic asymmetric information problem, results from unobservability of the risks by the insurer. It occurs when high-risk patient-consumers self-select a favorable insurance coverage, thereby driving up insurance premiums and driving out low-risk patient-consumers, causing in turn a further increase in premiums. Eventually, the insurance market shrinks, leaving some individuals and households uninsured or with less than full coverage. If private insurers can screen out high-risk patients, those patients may be uninsured. But screening of patients by insurers for the purpose of exclusion uses valuable resources and may result in a misallocation. In either case, some segment of the population is left uninsured or underinsured in response to adverse selection problems. With universal coverage as a remedy, all members of a society or community can be covered by health insurance. This is typically accomplished by mandatory participation in a public health insurance program, requiring everyone to purchase private insurance, or a combination of the two. The main advantage of universal coverage is that it eliminates the adverse selection problem by preventing individuals from self-selecting and insurers from screening. Within the region, however, public insurance schemes still remain poorly developed, covering no more than 10–15 percent of public health financing. Carefully designed schemes may, in the future, provide a significant means of increasing health care finance; but as yet, their role is minor.