



# Private finance and provision of health, education and water

For a number of reasons governments often finance and provide basic social services—basic health care, primary education, water and sanitation. One reason is that because such services are public goods, their market prices alone would not capture their intrinsic value and social benefits. Basic education benefits not only the individual who gains knowledge, it also benefits all members of society by improving health and hygiene behaviour and raising worker productivity.

A second reason for public financing is to ensure that basic social services are available equitably. Poor people usually lack these services, and if they have to pay for them they may not use them—making it difficult to escape poverty.

In addition, the state often plays a dominant role in the provision of these services. Provision by many suppliers (public or private) can result in duplication and higher costs. Moreover, access to basic social services is a fundamental human right—enshrined in the UN Covenant on Economic, Social and Cultural Rights—and governments have an obligation to ensure that these services are provided to their people. Government commitments to the UN Millennium Declaration and Millennium Development Goals reflect this obligation.

But public provision of social services is not always the best solution when institutions are weak and accountability for the use of public resources is low—often the case in developing countries. (Chapter 7 describes how to make governments more accountable in the use of public resources for social services.)

In rich countries private providers dominated health, education and water services in the first half of the 19th century. But these services were limited. In the second half of the century public financing and provision became dominant. Indeed, only when governments intervened did these services become universal in Canada, Western Europe and the United

States—in the last quarter of the 19th and first half of the 20th centuries.

In poor countries private health providers and schools coexisted with a growing public sector in the first few decades after the Second World War. But in the 1980s and especially the 1990s, private provision began to increase rapidly. As loss-making state-owned enterprises were privatized in productive sectors—in both industry and services—the same trend was encouraged in social services.

The experiences of rich countries suggest that the sequence for social services should be comprehensive provision by the state early on, followed by more targeted interventions and then public-private partnerships to serve different markets—depending on the nature of services in different sectors.

## WHY HAS PRIVATE PROVISION INCREASED IN POOR COUNTRIES?

In developing countries the private sector's growing role in health and education, and the push to privatize water and hospital services, have been driven by three factors: lack of government resources, low-quality public provision and pressure to liberalize the economy.

### LACK OF GOVERNMENT RESOURCES

Strapped for cash—whether domestic resources or foreign aid—many governments of poor countries cannot provide social services effectively or fund large investments in infrastructure. Privatization is often pursued with a view towards obtaining revenue, but the biggest returns to government come from eliminating subsidies to loss-making public enterprises.

In some cases, such as domestic water and sanitation (and irrigation water and energy), insufficient government funds have been

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compounded by distorted tariff structures. Under state ownership tariffs are often too low to recoup costs, and user failures to pay tariffs are often overlooked. This approach essentially subsidizes rich people—while poor people suffer from lack of access. Moreover, as urban populations increase, fiscally strapped local authorities cannot expand services to cover them. As a result water services decline in quantity and quality in middle-class neighbourhoods—and fail to reach new poor neighbourhoods.

#### LOW-QUALITY PUBLIC PROVISION

Linked to lack of resources is the weak record of public provision in many countries. Stories abound of governments failing to provide their citizens, especially poor citizens, with basic social services or with services of good quality.

In India and Pakistan poor households cited teacher absenteeism in public schools as their main reason for choosing private ones.<sup>1</sup> Poorly paid public sector doctors often supplement their incomes by selling drugs intended for free distribution.<sup>2</sup> As a result poor (and non-poor) people are forced to use private providers—because such providers are more accessible and often dispense drugs as part of their consultations (unlike government facilities, where drugs may not be available).

To access more and better water, poor people often must pay exorbitant prices for it from private tankers run by small vendors. Most residents of South Asian cities receive water for only a couple hours at a time, and not every day.<sup>3</sup> They get electricity for a few more hours a day, but interruptions increase in the hottest parts of the summer—when temperatures can rise to 48 degrees Celsius.

#### PRESSURE TO LIBERALIZE THE ECONOMY

The third push for private provision has come from donor policies advocating economic liberalization and free markets to advance growth and development. Social services are frontier issues in this move to expand the private sector's role. In the 1990s many donors supported extending private provision and financing to social services, especially urban water supply. The World Trade Organization's General Agreement on Trade in Services also encourages private entry in social services (box 5.1).

#### HEALTH

Many developing countries—in Latin America, South Asia and South-East Asia—have substantial, thriving private sectors. In addition, a

BOX 5.1

#### Social services and the General Agreement on Trade in Services

The General Agreement on Trade in Services (GATS) establishes a legal framework for international trade in services through both general trade rules and specific national commitments for accessing domestic markets. Many critics have asked if the GATS goes far enough in protecting countries' ability to decide how best to deliver social services—including determining the extent to which foreign suppliers should engage in their delivery.

On the one hand, the agreement gives governments considerable discretion in deciding how, when and whether to open services to international trade. No country is required to open any specific sector to foreign competition, and countries can set conditions on the nature and pace of such liberalization. Governments can also, with adequate compensation, suspend or modify existing commitments to liberalization. In

addition, the agreement includes a "governmental authority" exclusion, which defines services covered by the GATS as "any service in any sector except services supplied in the exercise of governmental authority". Finally, countries can invoke general exceptions to protect public interests, including national security and public health.

On the other hand, the GATS commits members to "successive rounds of negotiations...with a view to achieving progressively higher levels of liberalization", and countries will come under increased pressure to liberalize new areas of service delivery. More worrisome, undefined terms in the agreement could negate the above safeguards.

The governmental authority exclusion applies only to services provided on neither a commercial nor a competitive basis. Governments, however, rarely deliver social services exclu-

sively, but through an evolving mix of public-private actors that compete for clients. And the precise scope of services fitting the exclusion criteria remains ambiguous. If not covered by the exclusion, legislation used by governments to ensure equitable and efficient delivery of these services could conceivably conflict with the GATS. State aid offered exclusively to non-governmental organizations operating schools and clinics in underserved areas could be challenged if a government liberalized its health and education sectors and these market conditions were not officially registered.

The GATS could be strengthened by eliminating the governmental authority exclusion or by rewording the text to ensure that services provided in the "exercise of governmental authority" is understood relative to function, not means of delivery.

Source: Mehrotra and Delamonica forthcoming; Save the Children 2001; Canadian Centre for Policy Alternatives 2003; UNHCHR 2003; WTO 2003.

large portion of health spending is private in all regions,<sup>4</sup> with more than half of basic health services provided by private providers in low-income countries.<sup>5</sup> In Asia and Latin America a significant share of hospitals and health facilities are privately owned, though preventive measures are largely the responsibility of the public sector.<sup>6</sup>

More than any other developing region, Latin America has experienced a huge shift towards private care since opening the management of its health sector to international companies in the 1990s. Several multinational corporations (Aetna, CIGNA, Prudential, American Insurance Group—all US-based) are providing health insurance and services in the region. And they intend to assume administrative responsibilities for public health institutions and to secure access to social security funds for medical care. These companies invest by:

- Purchasing established companies that sell indemnity insurance or prepaid health plans.
- Associating with other companies in joint ventures.
- Agreeing to manage social security and public health institutions.<sup>7</sup>

About 270 million Latin Americans—60% of the population—receive cash benefits and health care services paid for by (and often delivered by employees of) social security funds. Penetration by multinational corporations in social security funds is most advanced in Argentina and Chile but is growing in Brazil and starting in Ecuador.<sup>8</sup>

#### *IMPACT OF MANAGED CARE*

All citizens should have access to basic health services. And private provision can help meet different needs. But is equity ignored in the process?

Latin America has long relied on public social security funds to provide health services. But in the 1990s the management of many funds was offered to foreign health insurance firms. As a result more funding is used to cover higher administrative costs and returns to investors, reducing access for vulnerable groups and spending on clinical services. In Chile in the late 1990s about a quarter of patients under private managed care opted for care from public

clinics, citing as their main reason the high co-payments required under managed care.<sup>9</sup>

In Argentina public hospitals that have not converted to managed care face an influx of patients covered by privatized social security funds. These patients have had to resort to public hospitals because they cannot afford their co-payments or because private practitioners have refused to see them (due to non-payment by the social security funds).

Argentina and Brazil's public hospitals now require reimbursements from social security funds and from private insurance, as well as co-payments. To receive free care at public institutions, poor patients must undergo lengthy means testing—with rejection rates averaging 30–40% in some hospitals.<sup>10</sup> And because managed care organizations attract healthier patients, sicker patients are being shifted to the public sector. This two-tier system undercuts the pooling of health risks and undermines cross-subsidies between healthier and more vulnerable groups.

#### *APPROPRIATENESS OF HEALTH CARE AND REGULATION*

The supposed benefits of privatizing social services are elusive, with inconclusive evidence on efficiency and quality standards in the private relative to the public sector.<sup>11</sup> Meanwhile, examples of market failures in private provisioning abound.

Clinical services and drugs are essentially private goods, and there is much evidence of failures in markets for them. Limited regulatory capacity compounds the problem. For example, in many developing countries overtreatment is a major problem in private health care. In Brazil caesarean sections are more common among private patients because doctors are paid more for operations than for normal births.<sup>12</sup> In Mumbai, India, private providers engage in unnecessary referrals and tests—with referring providers getting a cut of referred providers' fees.<sup>13</sup> By contrast, even though most Canadian and US and many European physicians are private, strong professional regulation ensures that there is no crisis of overtreatment.

In developing countries unregulated private pharmacists also overtreat illnesses or overprescribe expensive drugs. Such inappropriate

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use of medicines leads to dangerous treatment practices, higher health care costs and growing drug resistance. Drugs account for 30–50% of health care spending in poor countries, compared with 15% in rich.<sup>14</sup> People who cannot afford professional services must go to pharmacies, which often do not follow prescribing regulations—especially in China, South Asia and parts of Africa. In India more than half of out-of-pocket health spending and nearly three-quarters of inpatient spending go to medicines and consultation fees.<sup>15</sup>

#### *COSTS*

In many developing countries costs are rising and technology is accumulating in the private health care sector. Thailand's private health sector has as much or more of some high-technology equipment as the private sectors in most European countries, even though Thailand's per capita income is much lower and its disease burden is much different.<sup>16</sup>

In China a shift in focus from preventive to curative services has significantly increased drug sales since economic reforms began. Foreigners have invested in about 1,500 drug manufacturing ventures across the country.<sup>17</sup> With limited access to professional services and aggressive drug production in an unregulated market, the result is irrational drug use—particularly among poor people. In 1993 drugs accounted for 52% of China's health spending, compared with 15–40% in most developing countries.<sup>18</sup> In some rural areas Chinese farmers spend two to five times the average daily per capita income on a typical prescription. Apart from contributing to unnecessarily high medical costs, excessive and inappropriate prescribing of drugs in poor rural areas exposes patients to the risk of ineffective treatment and adverse side effects.<sup>19</sup>

As noted, in Latin America managed care organizations have taken over the administration of public health institutions—diverting funds from clinical services to cover higher administrative costs. To attract patients with private insurance and social security plans, public hospitals in Buenos Aires, Argentina, have hired management firms that receive a fixed percentage of billings, increasing administrative

costs to 20% of health spending.<sup>20</sup> In Chile administrative and promotional costs account for 19% of managed care spending.<sup>21</sup>

#### *BRAIN DRAIN*

In developing countries growth in private health care often draws badly needed human resources away from fragile public systems—as in Thailand in the 1980s and 1990s.<sup>22</sup> Public clinics are left to care for the most vulnerable groups—the poor, the elderly, the disabled—with fewer well-trained physicians.

#### *EDUCATION*

In most OECD countries about 10% of students attend private primary schools (both independent and government-dependent). That share tends to be higher in developing countries. In Latin America private schools account for more than 14% of primary enrolments, though in high-performing Costa Rica the share is just 7%.<sup>23</sup> Among 22 Sub-Saharan African countries with data the private share in 10 is 10–40%—in the other 12, less than 10%.<sup>24</sup> In India the share of private schools is highest in states with the lowest primary enrolments (Bihar, Uttar Pradesh), indicating that the private sector is the escape route for a poorly performing public sector.<sup>25</sup>

In many (though not most) developing countries private enrolments rise with the level of education.<sup>26</sup> Yet for a large number of countries in all regions, recent data are lacking on private enrolments at all levels—making this an area deserving attention from governments and donors.

Three issues are crucial in the private financing and provision of education. The first affects demand: high household costs compromise universal access to basic education. The other two are related to supply, affecting equity and efficiency. One relates to the comparative performance of public and private schools, the other to public subsidies for private schools.

#### *HIGH FEES, LOWER ENROLMENTS*

Requiring poor households to pay for schooling (private or public) is not conducive to achieving

universal primary education and so is unlikely to help achieve the Millennium Development Goals. In Ghana two-thirds of rural families cannot afford to send their children to school consistently, and for three-quarters of street children in Accra (the capital) the inability to pay school fees was their main reason for dropping out.<sup>27</sup> Where school fees have been removed in Africa, children have flooded into schools.

#### QUALITY ISSUES

Many proponents of private education claim that private schools outperform public ones, are inherently more accountable and help students develop stronger cognitive skills and feel a greater sense of ownership for their education.<sup>28</sup> But little evidence substantiates these claims.<sup>29</sup> Private schools do not systematically outperform public schools with comparable resources. In Peru students in private primary schools outperform their public counterparts—but pay up to 10 times more for their education.<sup>30</sup>

In Brazil achievement scores in maths and language favour private school students to the same degree as in several OECD countries (Greece, Ireland, Spain).<sup>31</sup> But this advantage is linked to the students in each type of school. In every country studied, students in private secondary schools come from wealthier households than do students in public schools.

#### PUBLIC FINANCING FOR PRIVATE SCHOOLS— POTENTIAL DRAWBACKS AND BENEFITS

The main rationale for government support is that private education meets excess demand for education. But in most cases fee-based private education responds to different demand, not excess demand—particularly in low-income countries, where poor households have limited capacity to pay even public school fees. Thus government support for private education can be inequitable if it is not targeted to poor households. In OECD countries direct support for private primary and secondary schools averages about 10% of government spending on education. By contrast, in India nearly a third of direct education spending supports private

institutions—yet the country is home to more than a third of the world's children of primary school age not in school.<sup>32</sup> In Indonesia most rural private schools are as dependent as public ones on state subsidies.<sup>33</sup>

Many developing country governments also pay the salaries of private school teachers, making them less accountable to parents and principals.<sup>34</sup> Such subsidies place even greater stress on already weak public systems, which must provide services for the most vulnerable groups with fewer human and financial resources.

A study of 16 developing countries found that those with the highest private upper secondary enrolments also have the lowest overall upper secondary enrolments (India, Indonesia, Zimbabwe).<sup>35</sup> But in China, Jamaica, Malaysia and Thailand—which have relatively high enrolments—more than 90% of direct public spending on education reaches public schools.

#### MAKING PRIVATE PROVISION WORK FOR POOR PEOPLE

Despite its potential drawbacks, public funding of private schools can help in certain circumstances—particularly if governments have trouble paying the full costs (building schools, paying teacher salaries) required to achieve universal primary schooling. In some countries a shortage of public schools has led to expansion in private schools. To ensure that children from poor families unable to pay school fees are able to attend private schools, governments could finance their education through vouchers.

Colombia, for example, introduced a voucher system in response to a shortage of public secondary schools. This approach to public funding of private education can help expand schooling at lower cost for the government, because the only cost the government bears is the voucher. This is slightly different from a voucher system that enables families to enrol their children in the school of their choice, public or private. To avoid giving windfall gains to the middle class that customarily purchase private education, vouchers should be restricted to poor families—as in Bangladesh, Chile, Colombia, Puerto Rico and the United Kingdom.<sup>36</sup>

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## WATER AND SANITATION

Only about 5% of the world's people (about 300 million) receive their water from private companies. Most privatization of water and sanitation services has occurred through public-private partnerships in urban areas, with almost all occurring in the 1990s in highly urbanized countries (table 5.1).

Private companies are unlikely to be interested in providing water services in rural areas in low-income countries—because rural areas are generally considered unprofitable. In sanitation, public-private partnerships sometimes also view poor people as being unprofitable. Reflecting such biases, some private water companies have found ways of excluding poor people from service even in urban areas. In Cartagena, Colombia, a large shantytown did not receive water services because the company considered it outside the city area.<sup>37</sup> Moreover, in some countries the extension of connections has been limited. In Dakar, Senegal, about 80% of the population had access to safe drinking water in 1994. Four years after the service was privatized, only 82% had access.<sup>38</sup>

International private sector involvement in water and sanitation remains limited in the urban areas of low-income countries. Even in middle-income countries, where most people live in urban areas, international private firms may be discouraged by the scale of investments required. Sustained service provision is best achieved through the efforts of local communities and firms (private and public), and building this capacity is an important role for government.

### MIXED PERFORMANCE, UNCERTAIN FINANCING

Public-private partnerships in water and sanitation—which have grown from almost none in the early 1990s to more than 2,350 today—have a mixed record of performance. One of the main arguments for privatization is that it provides new capital, enabling public-private partnerships to mobilize additional resources for basic services. But since peaking in 1996, international private financing for water and sanitation has declined. And that decline is expected to continue.<sup>39</sup>

TABLE 5.1  
Investments in water and sanitation projects involving private participation, various countries, 1990–94 and 1995–2000 (millions of US dollars)

Country	1990–94	1995–2000
Argentina	4,075	4,173
Brazil	3	2,891
Chile	128	3,720
Czech Republic	16	37
Indonesia	4	883
Malaysia	3,977	1,116
Mali	0	697
Mexico	295	277
Philippines	n.a.	5,820
Romania	n.a.	1,025
South Africa	n.a.	209

Source: World Bank 2002j.

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### SERVICE CHARGES

The private sector's reluctance to fund less profitable investments in poor rural areas hurts users. But public-private partnerships often do the same, even more directly—through charges that hit poor people disproportionately more. This fact has to be balanced against the even higher prices that poor people previously paid for water from small vendors.

Public-private partnerships are based on the assumption that customers pay for services. Privatization in water and sanitation has led to much higher fees, sometimes overnight—and sometimes with disastrous consequences (box 5.2). But if success requires higher tariffs, state water companies have shown that it is possible to use the additional revenue to improve services and expand coverage.

### POSITIVE PRIVATE PROVISION

Not all privatizations of water and sanitation have been failures. In Sub-Saharan Africa, for instance, public-private partnerships have improved water quality.<sup>40</sup> More generally, success in privatizing water services largely depends on government regulation, investor interest and the initial state of the enterprise.<sup>41</sup> Countries with decent services before privatization often continue to do well after.

Where poor people have reaped the benefits of privatized water services, it has been due to political will. In Bolivia water and sanitation concessions in La Paz and El Alto were

### User fees in South Africa and Bolivia

Privatization of water services has often led to increased tariffs largely unaffordable to poor households. Under some public systems, households enjoyed low water bills—well below the rate needed to recoup costs—and non-payment of bills was largely overlooked. This approach is undesirable because cash-strapped public companies essentially subsidize both rich and poor people. But an overnight jump from exceptionally low to excessively high water bills also has disastrous consequences for poor households.

#### South Africa

South Africa has made incredible progress in providing water supplies to its people, though managing fee structures has been a challenge. In August 2000, however, a cholera epidemic broke out in the province of KwaZuluNatal—infected nearly 14,000 people and claiming more than 250 lives. The epidemic started after local authorities cut water supplies to people living in an informal settlement who were unable to afford new user fees. The minister of water affairs and forestry admitted that the policy of cost recovery

exacerbated the cholera epidemic, forcing households to seek alternative water sources.

In the build-up to privatizing water services, South Africa reversed its policy of keeping tariffs low and overlooking non-payment. But this reversal occurred overnight—and without concurrent measures to ease the financial burden on poor people.

#### Bolivia

In early 2000 protests broke out in Cochabamba, Bolivia, largely in response to the tripling and quadrupling of household water costs. This price hike came only weeks after Aguas del Tunari, a London-based private company, took over the city's water system. The protests effectively shut down the city for four days. And as protests spread throughout Bolivia, 50 people were detained, dozens injured and 6 died from the violence.

Many analysts agree that the significant increase in water tariffs was driven by the cost of an expensive construction project that households were obliged to pay for up-front. The Misticuni Project, one of the most complex en-

gineering projects in South America, involves building a \$130 million dam, a hydroelectric power station and a \$70 million, 20-kilometre tunnel used to transport water from the Misticuni River to Cochabamba.

User fees have great potential for impoverishing users and deterring people from using badly needed services. When user fees for basic social services have to be increased, governments must ensure that they are tailored to users. First, governments should be open with citizens about why increases are needed. There should be clear communication between service providers and users in this regard. Second, governments should strategically fix tariffs so that wealthier households can subsidize poorer. Other means of subsidizing poor people should also be sought. For instance, many campaigners in South Africa asked that the government provide 50 litres of water a day free of charge to poor households—the World Health Organization minimum for maintaining health and hygiene. Third, increases in water bills should be instituted progressively, not overnight.

Sources: ICIJ 2003c; Lobina 2000; Sidley 2001, p. 71.

awarded to the bidder that promised to make the most new connections in poor neighbourhoods. The winning bidder was then obliged to connect 72,000 families to piped water and 38,000 to sanitation over a five-year period.

In addition to contractually obliging private providers to expand services, governments have used revenue from privatization towards that end. Financial incentives, such as capital grants, have been offered to providers that service poor neighbourhoods. In addition, the high tariffs that tend to accompany privatization can be offset with subsidies targeting poor people. In Chile government subsidies ensured that no household spent more than 5% of its income on water.<sup>42</sup>

#### PROMISING APPROACHES

Government programmes have registered many successes in delivering basic social services to all citizens. Thus privatization need not be seen as the only option for reforming poorly run public services.

#### RELYING ON EFFECTIVE GOVERNMENT SYSTEMS

Many activities in the social sectors produce public goods or have many externalities, requiring state involvement to provide basic services to all. The recent push to privatize basic social services has ignored the past experiences of rich countries—as well as of many developing countries today—which relied on state systems to provide basic social services to most (if not all) of their people when they were developing. Private actors played only a limited role.

Many of today's high-performing developing countries managed to improve health indicators early in their development—providing universal health care paid out of government revenues. In many (Botswana, Costa Rica, Zimbabwe) better-off citizens opted out by taking private health insurance.<sup>43</sup> Or, if private insurance was not available (Sri Lanka and Kerala, India), they paid private providers directly.<sup>44</sup> But for most of these countries' populations, better health was the result of universal and affordable

care—financed by government revenues and made effective by allocating resources to the lower levels of the health system.<sup>45</sup>

High-performing developing countries also began pursuing universal primary education early in their development, when their incomes were lower. Countries with literacy rates above those of their neighbours in 1980 also had smaller shares of students in private schools in the 15 years leading to 1980. In South Asia, for example, Sri Lanka's literacy rate in 1980 was 85%—while the regional average was an extraordinarily low 38%.<sup>46</sup> And Sri Lanka's proportion of students in private primary and secondary education was low in the 15 years to 1980.

In water and sanitation there is ample evidence of inefficient, oversized, corrupt state-owned companies. But there are also successful public systems largely ignored by proponents of privatization. Chile, for example, made safe water available to 97% of its urban population by 1990, and sanitation to 80%. And in Bogota, Colombia, municipal water services were threatened with privatization—but, completely reformed, they have expanded coverage (box 5.3).

In Debrecen, Hungary, the state-run water company required considerable investment in the mid-1990s. Attempts were made to contract

the service to one transnational water company, then another—but both attempts failed. In 1995 the city council decided that local water managers had the expertise to carry out the work. A new local public company made the needed investments at much lower costs than the bids by the private companies, partly by sourcing supplies locally instead of importing them. As a result prices are 75% lower than predicted by the private companies.

#### STRENGTHENING THE STATE

Regulatory capacity in developing countries has to be built up so that public and private provision works for all services and users. A key policy recommendation is to retrain government staff. This does not necessarily mean rich countries providing more technical assistance or technical cooperation—it means them paying for transfers of skills and exchanges of experience among poor countries.

In health the need for regulation applies to both privatized companies and existing private services, both to protect consumers and contain costs. Most health ministries in developing countries have extremely weak information systems, undermining their ability (or perhaps indicating their unwillingness) to regulate private

#### BOX 5.3

##### Successful state-run water systems

Efforts by the Chilean government in water and sanitation show that state-run systems can achieve positive results. By 1990, 97% of Chile's urban population had access to safe water, and 80% had access to sanitation. The cornerstones of the country's success:

- Separating central regulation and regional operation.
- Increasing financial investments in the sector.
- Developing a system for fixing tariffs objectively.
- Introducing incentives for efficiency.

Between 1988 and 1990 Chilean authorities established a new system for fixing tariffs objectively—essential to revitalize the industry. The regulator established a maximum tariff based on a model efficient provider, and any differences of opinion between the company holding the concession and the regulator were to be resolved by a tripartite commission of experts. The reform permitted the gradual adjustment of tariffs to new, higher levels. Objective tariff

fixing was a main contributor to the success achieved in the management of water and sanitation services since 1990.

The private sector played a role in Chile's water and sanitation sector, but this role was limited and strictly regulated by the central government. There was a big increase in the contracting out of many activities by all companies, including operation, management and capital investment of entire systems, as well as maintenance of all aspects of the networks, meter reading and billing. Contracting out reduced the number of workers per connection. And in 1995 the average level of unaccounted-for water was 31%, far less than the Latin American norm of 40–60%.

In Colombia's capital, Bogotá, privatization was rejected in the late 1990s. The city refused World Bank money and transformed its public utility into the most successful in Colombia.

Source: ICIJ 2003a; Mehrotra and Delamonica forthcoming.



providers. In South Asia, despite widespread private provision and high private spending, regulation has failed abysmally to ensure quality care for most users of private providers.<sup>47</sup>

Regulation of clinical health services, for instance, requires tackling the proliferation of private providers—often untrained, unlicensed and unregulated. Governments must bring these actors into the public domain, which will require licensing and regular training to improve knowledge and skills. Training has increased provision of antimalaria drugs in Kenya and improved management of acute respiratory infections and diarrhoea in Mexico.<sup>48</sup> In addition, the Rural Medical Association of West Bengal has adopted the World Health Organization's list of 40 essential medicines for recommended use by its members. Getting practitioners to restrict their use of these drugs will improve quality and control. Other measures for regulating providers include developing consumer protection legislation, promoting professional ethics and providing non-financial incentives, such as enhanced prestige.

Accreditation can be used to inform consumers about which private medical providers are registered. A professional body that offers accreditation and training to unregistered providers would benefit both providers and the public. It would build on the desire of providers for social recognition and prestige. And it would help promote the use of essential medicines through public campaigns.

Improving consumer behaviour is also important for health care regulation. This can involve improving consumer knowledge or providing subsidies to make quality services more affordable. Governments can also create institutions that enable consumers to challenge private providers who offer poor care.

Regulation of education and water services is often equally weak. In water privatizations public water authorities often assume the role of regulator. But international private providers rarely adhere to their agreements with host governments (box 5.4).<sup>49</sup> Much more international support is needed to build regulatory capacity in these and other infrastructure areas if the private sector is to do more in achieving the Millennium Development Goals.

BOX 5.4

### Metropolitan Manila and Buenos Aires: mixed record of experience with water privatization

#### Manila

In 1995 the Philippines declared a water crisis. The public water utility had left 3.6 million people unconnected to a water supply. And for those with connections, service was often erratic. In 1997 two private water companies won concessions to take over Manila's water system, dividing the metropolitan area into eastern and western zones. Within five years the companies had connected roughly 2 million more people to the network and service had improved significantly. During this time new service connections tripled from 17,040 a year (before privatization) to 53,921 (after).

Yet six years after privatization the water companies have performed below their targets—and are even asking to withdraw from the concessions. By 2001 one company had supplied water to 85% of its population, slightly below its projection of 87%, while the other company surpassed its target. But much debate surrounds the calculation of these figures, possibly leading to the dampening of reported success rates. Although one private water company saw no decline in the number of leaking pipes and water thefts, the other saw these figures increase. And by January 2003 water tariffs had risen by two to five times 1997 rates in both zones. Indeed, a 2000 survey of residents in 100 districts revealed a mixed perception of

privatization, with 33% of respondents noticing better service, 55% noticing no change and 12% noticing deterioration.

#### Buenos Aires

In 1993 Argentina's government privatized the Buenos Aires water utility, and service quality and expansion subsequently increased. Company figures indicate that it connected roughly 1 million new users to the water system. And in the first year the company reduced water rates by 27%. But this drop simply rolled back significant rate hikes instituted by the public utility prior to privatization. In subsequent years the company repeatedly raised water rates, and in 1996 protests against high water bills occurred in Buenos Aires.

Furthermore, a government review found that by 1997 the company had built only about one-third of the pumping stations and underground mains it had promised to complete by then. And investments in sewerage networks totalled just \$9.4 million—one-fifth the level promised. According to recent estimates, the picture is quite different when the country is considered as a whole. In the second half of the 1990s municipalities with privately managed water services have worked better than those publicly managed, particularly in poor areas, contributing to faster reductions in child mortality.

Source: ICIJ 2003b; Galiani, Gertler, and Scharfrodsky 2002; ICIJ 2003d.

#### INVOLVING NON-GOVERNMENTAL ORGANIZATIONS

Social service provision by non-governmental organizations (NGOs) has been viewed as the "middle way" between market and state provision. For some analysts it provides a rationale for increasing the role of civil society organizations in providing these services. NGOs are often quite successful at filling gaps left by the public system (as with the primary schools set up by the Bangladesh Rural Advancement Committee). They are also useful in articulating community concerns, especially for poor people, to make institutions perform better. In water and sanitation, rural areas have been best served through user committees supported by NGOs.

But NGOs should be a complement to, not substitute for, state activities.

NGOs have also joined partnerships among governments, businesses and civil society organizations. When private firms win long-term concessions for urban water and sanitation services, the contracts usually require significantly increasing coverage. Doing so may require skills and resources beyond the scope of private firms, especially foreign ones. NGO partners can improve a firm's understanding of its poor customers (expanding the customer base, improving project design), reducing capital and operation and maintenance costs, as with the water concessions in La Paz and El Alto, Bolivia.

BOX 5.5

### **The Bamako Initiative: pooling community resources for health care**

The Bamako Initiative is an initiative that pools community resources to finance local health care. The initiative has been implemented to a varying degree in more than 40 low-income countries, with half in Sub-Saharan Africa. It has not only protected households from catastrophic health costs, but has also organized communities to help strengthen and sustain local public health services. These communities contribute financial resources to local health clinics and have a voice in the management of these services.

The initiative's strategy is to revitalize public health systems by decentralizing decision-making from the national to the district level, instituting community financing and co-management of a minimum package of essential services at the level of basic health units. The aim is to improve services by generating sufficient income to cover some local operating costs, such as supplies of essential drugs, salaries of some support staff and incentives for health workers. Funds generated by community financing do not revert to the central treasury but remain in the community and are controlled by it through a locally elected health committee. From mere recipients of health care, consumers become active partners whose voices count.

After 10 years of implementation of the initiative, community action in most rural health centres in Benin and Guinea has enabled nearly half the population to be regular users of the services. It has also raised

and sustained immunization levels close to health for all targets for 2000. Charging modest fees to users is seen in some cases as the most affordable option for the poorest people, who otherwise have to use more expensive alternatives—though it is less clear whether mechanisms exist to protect indigent members of the community.

Much of the success has been in ensuring that affordable essential drugs are readily available in health centres, under the scrutiny of committees. Another factor has been the improved attitude of health workers—traditionally one reason for people, especially women, not to use health services.

This experience suggests that in the absence of adequate government financing of health care, pooling of community resources, with some prepayment by the poor, is a fair and efficient mechanism for providing health services to poor people. Health systems that require individuals to pay out of pocket for many of the costs of health services restrict access to those who can afford to pay, and most likely exclude the poorest people. Fairness of financial risk protection thus requires the highest possible separation between contributions and use. There is consensus on the central role of public financing in public health. But for personal health care it is not the public-private dichotomy that is most important in determining health system performance—but the difference between prepayment and out-of-pocket spending.

Source: Mehrotra and Delamonica forthcoming.

NGOs can also lend credibility and outreach to education and awareness campaigns. Vivendi, the French water company, initiated a partnership with an NGO in its Kwazulu-Natal project to better understand the needs of poor communities in South Africa.<sup>50</sup>

Through the politics of pressure and engagement, NGOs are creating new agendas for businesses. A continuum of protests and partnerships between businesses and NGOs is creating a new form of regulation for global business—civil regulation.<sup>51</sup>

### *IDENTIFYING BETTER WAYS OF FINANCING SERVICES*

Aside from increasing government tax revenues, there are ways of improving service tariffs and charges to make them more rational and equitable. In health sudden, steep out-of-pocket costs can drive patients into (or further into) poverty. Surveys from 60 countries show that among poor groups, a larger proportion of households has high levels of health spending.<sup>52</sup> In the absence of public financing, prepayment schemes—which contain high health costs by spreading risks among pools of individuals—can help deal with this problem. Such schemes have not only helped protect poor households from catastrophic health costs, they have also helped organize communities to sustain local public health systems (box 5.5).

In public education there is scope for much greater cost recovery at higher levels in most developing countries. In the 1990s Africa and India increased cost recovery in public universities.<sup>53</sup> Still, it is nowhere near its potential: higher education provides enormous private benefits, and most people who can access it are not poor. Thus there is scope for much greater cost recovery (combined with exemptions for poor people).

In water and sanitation strategic tariff fixing (whether the provider is public or private) that raises user fees in line with higher use—coupled with targeted subsidies—is a good way to provide water services to more people. Targeting that is geographic (to places that poor people reside), rather than based on income, is more likely to succeed.

International institutions promoting privatization of social services need to provide much more advance support to build regulatory capacity. The World Bank has some initiatives in this area, such as the International Forum for Utility Regulation, created in 1996 as an umbrella structure for learning and networking initiatives for utility regulators. But international agencies should do more than offer advice. They should also enable field visits of developing country regulators to other countries more experienced in private sector regulation. There is also a need to prepare model clauses for public-private partnerships in water. Such clauses would draw on the lessons discussed in this chapter, so that future contracts can avoid the pitfalls of past ones.

In water all revenues come in local currency, so servicing foreign loans involves an exchange risk for both borrowers and investors. This became a problem in Argentina, Indonesia and the Philippines after devaluations,

putting pressure on water subsidiaries to raise tariffs to water users to service the loans. Thus central governments should encourage local authorities, which are usually responsible for water services, to borrow domestically—from national development banks.

Too often it is assumed that private sector involvement in water implies the involvement of foreign multinational companies. In many developing country cities small providers cover significant sections of the population: in Delhi, India, 6%; in Dhaka, Bangladesh, 10%; in Ho Chi Minh City, Viet Nam, 19%; and in Jakarta, Indonesia, 44%.<sup>54</sup>

In all sectors regulatory capacity should be built up before privatization. Otherwise, the private sector may merely respond to different demand, not to excess demand, whether in education, clinical health care or water and sanitation. With better information on the private sector and stronger regulatory capacity, the state can ensure that the private sector plays a complementary role in providing and financing these basic social services.

