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Partnership Issues in the Social Sector

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Key Messages

[¶] References are to paragraphs.

1 Partnerships are a useful way of **including stakeholders** and engaging non-government organizations, community-based organizations and the private sector in achieving the complex set of development objectives in health and education. [¶ 5, 19, 56, 63, 83]

2 Partnership arrangements in the social sector are attractive because they help ensure the most **efficient and effective use of resources,** create the opportunity to direct most resources toward the **best provider**, serve to increase provider responsiveness, and lay the foundations to greatly expand access. [¶ 8, 55,69]

3 Partnerships can be an important way to keep the government involved and to counter the excessive influence of market forces on **areas that are not suitable for commercialization.** [¶ 4, 8, 10, 21, 33, 52, 53]

4 Central to partnerships is to address upfront the extent to which the **private sector and civil societies** are allowed to be involved and in **what areas they should be involved**. [¶ 5, 8, 33, 51]

5 Partnerships need to be area specific, demand driven, need-based and people-centered.

6 A suitable **division of labor** among players should be **based on each other's strengths**. In health, for example, the private sector's role is commonly believed to be in secondary and tertiary care, as well as the production of medical and pharmaceutical technology. [¶ 6, 8]

7 The private sector including **civil society has advantages** over the government in social mobilization, awareness building and involvement of children in education and health activities. [¶ 20, 24, 59, 60]

8 Civil society and media can affect the quality of health care by **raising the awareness of consumer rights** and utilizing **consumer protection legislation** and its accompanying mechanisms to redress **medical negligence** and malpractice. [¶ 14, 23]

9 Voluntary and non-government organizations derive strengths from their **roots in village level communities,** and from their ability to introduce both innovation and flexibility at the grassroots level. These will create synergies and lead to significant gains in programs and service delivery. [¶ 20]

10 The **private school** also has a role to play in helping the poor and the most disadvantaged groups in society gain access to quality education. This function of the private sector can be reinforced when appropriate strategies and mechanisms are in place. [¶ 34, 36, 39]

11 There is a **culture dimension of partnerships.** The methods of partnerships may be different from nation to nation, from national to local cultural settings. Approaches to creating partnerships need to be carefully studied before initiating new system of partnerships. [¶ 60]

12 **Leadership** is critical in a complex partnership. The quality of top leaders affects a partnership at every phase, ranging from the conceptual, negotiation, coordination, finalizing and commencement stages. Leaders who reflect commitment to particular programs and processes may be more successful than leaders who see themselves only as a facilitator. [¶ 2, 10, 44, 45, 49, 51, 84]

13 Government leadership is the key determinant in a partnership arrangement as it occupies a unique position to

make policy transparent and set standards for making all stakeholders **accountable for their performances** and coordinating activities in areas that the private sector does not concern itself with, e.g. the fate of the poor. [¶ 19, 56]

14 The government has an important role in establishing a **legal framework for participation** of the poor in civil society, and women and minority organizations at the national level. Government's role also extends to issues of managing contracts and supervising performance in the implementation of partnership policies. [¶ 10,19]

15 **Interpersonal capabilities** are of key importance. There must be respect for others and emotions must be handled intelligently. Understanding others, empathy, and the ability to maintain the original vision are vital. [¶ 50]

16 Sustainable partnerships require the intense handling of relationships. Because in a partnership, people from different entities may have different interests, work habits giving rise to conflict. Thus successful leadership in partnerships means possessing interpersonal intelligence.

17 One of the best ways to avoid conflict is to give **conflict resolution** a high priority from the beginning, mutually agreeing on a method of conflict resolution; eliminating possible areas of conflict through negotiation; promoting a sense of understanding of each other among leaders of each side and avoiding hidden agendas. [¶ 51]

18 When introducing **competitive mechanisms,** the government might have to create a support platform that provides the know-how of promoting ideas that are put forward by grassroots education and health players themselves. [¶ 34, 75]

19 To find a balanced approach between public and private sectors, it is important that **principles and accountability** are applied to all financers and providers either public or private. [¶ 57]

20 Seeking partnerships with the private sector should not be limited to generating resources, but ideas, knowledge and skills for developing education.

21 Successful partnerships tend to consist of more than just an agreement between two sides with common goals. Rather the **process of cooperation** in itself is important, both in building confidence between the partners and **formulating common goals.** [¶ 67]

22 **Contracting** is increasingly popular in the health sector for many reasons that include improving quality, bringing in specialized expertise and additional capital, and more importantly lower costs. [¶ 35, 52, 81, 82]

23 **International partnerships** can be built at any stage of development. However, issues like an equitable distribution of benefits and brain drain need to be addressed. [¶ 42]

24 Partnerships are not easy to measure as inputs and outputs account for only part of performance. **Impact** is a **good indicator but** it is **difficult to measure.** [¶ 81]

Introduction

1. The Partnership Issues in the Social Sector workshop continued the partnership theme of several ADB Institute workshops that preceded it, the most recent being the Information and Communication Technology and Education: Potential for Partnerships workshop organized in April 2001 in Hong Kong, China (summary online at www.adbi.org/publications/). The first workshop of this series on Public-Private Partnerships in the Social Sector held in July 1999 addressed issues relating to what needs to be done for establishing and forming effective partnerships. The knowledge provided in this workshop has assisted policymakers in better understanding the necessary conditions under which partnerships could be successfully promoted for social development. Subsequent events such as the Public-Private Partnerships in Education and Health workshops conducted in 2000 provided specific country experiences and actual models of partnerships in education and health. They covered issues on how best to serve the needs of the poor and the disadvantaged in both sectors.

2. This workshop was organized by the ADB Institute from 22 to 28 August 2001 at the Institute's premises in Tokyo. It was a continuation of the effort to support improvement in the delivery of education and health services through partnerships. The focus of this workshop is on partnership issues per se. While effective partnerships are critical to improving education and health, partnerships could work in developing countries only if policymakers and government officials are fully aware of the issues and conditions that are associated with their formation as well as their effective and efficient operation. Toward this end, the workshop is designed to serve as a catalyst for discussions on partnership issues. These include issues on four key areas: policy, leadership, governance, and management.

3. Participants attending the workshop came from fifteen member countries of the ADB, namely, Bangladesh, Cambodia, India, Indonesia, Kazakhstan, Kyrgyz Republic, Mongolia, People's Republic of China (PRC), Pakistan, Papua New Guinea, Philippines, Sri Lanka, Thailand, Turkmenistan, and Uzbekistan. Many countries sent several representatives and often this included both a specialist on education and from health, which seemed appropriate given that the workshop fully covered issues related to both fields. Besides top-level personnel from ministries of education and health and Prime Ministers' Offices, representatives of municipal administrations, non-governmental organizations (NGOs), and the academia also joined the program.

Opening Remarks

4. **Dr. Masaru Yoshitomi**, **Dean, ADB Institute**, stressed the importance of human development as the core of social and economic development in any country. Yoshitomi pointed out that the Asia and Pacific region is facing severe challenges in the social sector, as many of the world's undernourished, stunted, micronutrient-deficient, and illiterate children are concentrated in Asia. An estimated six million children die here every year before reaching the age of 5. This number is more

than half of the world's total. Three quarters of the world's underweight and stunted children are in Asia. Most of them are from families with illiterate parents, live in remote areas and urban slums, and come from ethnic minorities.

5. Yoshitomi emphasized the importance of involving all stakeholders including the poor in the development process. Governments and aid workers have increasingly recognized that it is virtually impossible for any single organization to address all social sector issues. NGOs are needed to help provide the required services in the social sector. This is where partnerships come into the picture. He mentioned the importance of partnerships in achieving these goals. Yoshitomi also stressed the importance of addressing this workshop's issues, as they are crucial in building workable and effective partnerships in any country. Such policy issues as the extent to which the private sector and civil societies are involved must be addressed upfront in order for partnerships to successfully function. As a new challenge to support the ADB's overarching goal on poverty reduction, he noted that the Institute is committed to explore the effective approach to reduce poverty and that partnerships are seen as having great potential in improving education and health.

Conceptual Framework and Overview

6. **Dr. Yidan Wang**, **Training and Learning Methods Specialist, ADB Institute**, introduced participants to "Partnership Issues in the Social Sector—An Overview". Wang is the designer and coordinator of this and previous capacity-building programs on partnerships in the social sector that have been conducted at the ADB Institute. She noted that there are different levels of challenges in the social sector today. At one level, emerging market economies in Asia give rise to the demand for better quality and more choices in the sectors' offerings. At other levels, there are immediate needs for improved access and equity to the poor and the disadvantaged population in Asia. More importantly, a special effort has to be made in order to reach the poorest and improve their conditions in education and health. From this, there comes a need to engage all players that are involved in the social sector services to form public-private partnerships in achieving the more complex set of objectives.

7. Wang noted that there are three large movements that support partnerships. Decentralization has encouraged local and community involvement in the social sector and led the state to concentrate on the role of policy and legislation. Privatization has led to growing emphasis on the market and growth of the private sector. Globalization has enabled a general climate for collaboration between the various sectors and groups with different interests.

8. The rationale for partnership stems from the will to combine the strengths of different players. Partnerships make it possible to reach the hard-to-reach and the poorest, improve management and enable effective allocation of resources, expand financial resources, and raise quality through competition. Wang mentioned that there are many experiences in Asia demonstrating the synergy of partnerships and she presented two examples in education from Nepal and the PRC, elaborating how NGOs, at national and local levels, could successfully reach the poor children, school dropouts, and women in rural and remote areas where governments could only play a limited role.

9. However, Wang cautioned that partnerships give rise to complex challenges. They comprise different concerns and interests, often address a variety of issues and purposes, and they not only incur benefits but also costs. And partnerships take place only in a country's specific economic, political, and social context.

10. A number of policy issues could be derived from this, including the questions on the extent and the areas the private sector should be involved in the health and education sectors, the incentives and the status it should receive, and the types of arrangements that should be made in a mutually beneficial way. Equally important is the leadership issue. Governments could play a leading role in partnerships to fulfill the functions of ensuring that the basic health and education needs are provided for all and overcoming possible market failures. In this context, government leadership often extends beyond policy and the legal framework to issues of coordination and areas that the private sector does not concern itself with. Finally, governments often play key roles in enforcing accountability to the pegde vis-à-vis the private sector. Other management challenges in partnerships include all issues relating to contracts, including developing contracts, and managing finance and personnel under partnership agreements. All these frequently overlapping issues need to be addressed when forming partnerships and they will be discussed further during the course of the workshop.

11. **Mr. Alok Mukhopadhyay, Chief Executive, Voluntary Health Association of India**, spoke on his specific concerns with partnership building in health under the title "Paths are Made by Walking". Starting from the World Health Organization's definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", Mukhopadhyay reviewed the current health challenges facing developing countries. The impact of the epidemiological transition creates a double burden of disease for many nations (newly emerging diseases and aging). Health-damaging industries like tobacco, alcohol and pesticides are expanding rapidly in many parts of the world.

12. Health and medical care are increasingly subject to market forces that need to be restrained or redirected. Over decades, the state has played a significant role in the health sector. With globalization and the influence of new economic policies, there is tremendous pressure to replace this arrangement and place the social sector in the market place. Health is a vital human good, and totally commercializing it—even for the sake of choice and efficiency—runs a potent risk. Submitting to the market-forces often puts the integrity of medicine itself at stake. One needs to appreciate the importance of advocacy for people-centered health from this backdrop.

13. In the developing world, a large section of the population does not have a well-defined and strong enough platform to air their frustration against inadequate social policies. This vulnerable section of the population is totally dependent on the government health sector since they do not have the financial means to buy services from the market place. Several studies show that when the public health infrastructure does

not work, the health expenditure becomes one of the major contributors for indebtedness of the poor. On the other hand, continuing with a highly subsidized health and medical care system for all is an unsustainable proposition in the long run.

14. In this complex situation, it is essential that government, private and non-profit voluntary sector collaborate. In this, the government sector ought to concentrate on adequately addressing poverty, protecting the vulnerable, creating a supportive environment for healthy living, and continuing to be a major provider of preventive and primary health care as well as epidemiological surveillance. Main concerns include optimizing the functioning of the government's infrastructure, ensuring accountability to the people, sustainability and true orientation towards the un-reached. The private sector's tasks are located in secondary and tertiary health care, as well as the production of medical and pharmaceutical technology. It will be important to regulate for quality services at reasonable cost and against market failures as well as to prevent the profit motive from dominating human concerns. The voluntary sector should proactively engage in all of the above spheres, not least in order to perform a watchdog/consumer rights role. Central to this will be strong advocacy for pro-people policies. Concerns with this sector include its sustainability, its focus on its core competencies, including the spirit of altruism. Successful examples for public-private partnerships of the kind outlined above can be found in—among others—he PRC (community-based primary health care in Nanjing) and India (Khoj projects in remote parts of the country and polio plus campaign).

15. However, the challenge in the new millennium will be to recognize that in no country in the world has the private sector alone had the answer to the health problem of the population. Even in the United States, 47 per cent of the population is without health coverage. Secondly, it is imperative to acknowledge that health improvement is less an outcome of medical technology than of living standards. Thirdly, the macroeconomic policies of globalization, liberalization and privatization that are increasing the exploitation of low-income countries and communities around the globe have had profoundly deleterious effects. Finally, it is simply not true that the world does not have the resources to pay for health for all. It is estimated that the cost of providing basic health care to the world's population will amount to $25 billion. This is a fraction of the $400 billion that the world spends on armaments annually.

16. Health policies need to grow, develop and be continually creative to meet the changing needs of the situation. Unfortunately, most states lack the sensitivity and dynamism to quickly respond to these challenges. Therefore, the most important form of public-private cooperation is perhaps sustained advocacy on health policy, to ensure that it is sustainable, people-oriented and relevant. The importance of urgent and sustained global advocacy for restoration of fundamental values of Alma Ata cannot be overstressed.

Policy Choices in the Social Sector

17. **Dr. Donald K. Adams, Professor Emeritus, University of Pittsburgh, U.S.,** spoke about "Education, Poverty Reduction, and Social Inclusion". Adams organized his comments around the key concepts associated with effective poverty reduction, examined two contrasting scenarios of programs to extend educational opportunities of the poor, identified issues concerning the knowledge base for pro-poor education programs, and outlined three core ideas that give direction to improving the pro-poor effectiveness of national educational systems. He noted that such current key concepts of development policy as poverty, good governance, and dialogue—although of heuristic value—can become treacherous as explicit guides for planning and analysis. For example, poverty measures are frequently built around quantitative indicators and take inadequate notice of the complex reality of poverty that the poor themselves recognize as being relevant to pro-poor plans and actions. Similarly, good governance, fueled by transparency and accountability, appears to imply participatory, democratic political and social institutions unfamiliar to many poor. Moreover, the poor often describe existing government institutions as largely ineffective and irrelevant to their needs. Finally, dialogue, understood as a process involving actors in shared inquiry at all levels of design and implementation of education programs—is rare in most national and international-sponsored programs of education reform.

18. Specifically for the field of education, Adams sees two contrasting scenarios for developing policies and programs to contribute to poverty reduction. Scenario 1, the minimalist approach, puts emphasis on access, inputs, and to some extent, persistence in basic education and represents only incremental change from present policies supported, at least in principle, by most Asian governments. Within the foreseeable future nearly all of the children of the poor in East and Southeast Asia will enter school. A reasonable long-term expectation for several Asian countries is that most children will persist through a cycle of basic education. This would represent a significant accomplishment and have desired employment implications and positive consequences for the quality of families and the civic society. However, these changes could take place within educational systems, which nevertheless remained fundamentally elitist at post-basic education levels. Scenario 2, the comprehensive approach, recognizes that the overall expansion of education access and general improvement of the management of the system are necessary but not sufficient achievements to level the education playing field for the poor. Scenario 2 assumes that students can be obstructed or marginalized in a number of ways at all levels of the education system. Compensatory programs for the poor would begin at the pre-school level and extend through higher education. This second scenario thus builds on many of the objectives and programs of scenario 1, but involves higher costs, major policy changes, and radically higher expectations.

19. Adams pointed out that, for developing countries, the knowledge base is inadequate to support scenario 1 and even less so for scenario 2. While there are promising research- and experience-based observations which, at a minimum, suggest directions for planning and action, there is still little knowledge about which type of interventions and the intensity of interventions that can consistently close the learning gap between the children of different social and economic backgrounds. Future studies need to reveal more about the policy, planning and implementation context at the school level, the consequences of pedagogies on different groups of students, and the

multiple ways education innovations can benefit different stakeholders. Adams suggests that there are many approaches to linking education to poverty reduction. He outlined three core ideas, which can give direction to improving the pro-poor effectiveness of the government's education system. First, a strong government education system is likely to have several important roles, including creating information on the poor and pro-poor compensatory programs, establishing a legal framework for participation of the poor in civic society and encouraging women's and minority organizations at the national level which may, in turn, assist the creation of informal and formal local affiliates. Second, listening to the voices of the poor, e.g. through Participatory Poverty Assessments (PPAs), in order to gather information on their current status, concerns, interests, and skills, and to increase their participation in, and ownership of, education decisions, plans and programs. Third, partnerships at the local level—the home, school, and community nexus—are of fundamental importance. For many countries the key partnerships for equitable development of quality education may well be the ability of central partners and community partners to communicate, learn and act. Adams concluded that given our limited knowledge we should approach pro-poor poverty interventions with appropriate humility.

20. **Mrs. Meenakshi Datta Ghosh, Joint Secretary, Ministry of Health and Family Welfare, Government of India**, spoke on "Partnerships for Community Health Development in India". After an overview of the public health structure of India, she outlined India's experience in partnerships with civil society. Civil society constituents are functioning intermediary organizations between the citizen and the state, and may include women's groups, local and national NGOs, private, nonprofit sector, professional groups and associations. Voluntary and NGOs derive strength from their roots in village level communities, and from their ability to introduce both innovation and flexibility at the grassroots level. Partnerships with these groups create synergy and lead to significant gains in programs and service delivery.

21. Over the years, increasing space has been given to the non-government sector in India's five-year plans, particularly in the years between 1985 and 2001. In the reproductive health sector in India, the government-NGO partnership is viewed as a most unique three-tier hierarchy. At the apex, there are four national NGOs originally selected on account of their long-standing commitment and pioneering work in the advocacy and provision of health care in remote areas of the country. They are partners with government at the highest levels of dialogue in the government-NGO interface. The second tier comprises of mother NGOs—so called because it is their primary responsibility to identify the most appropriate field NGOs within their jurisdiction and to train, equip, and monitor them. The third tier comprises of field NGOs.

22. In the field of health care, public-private partnerships have played key roles in several areas. Regulatory mechanisms reflect government's role as overall coordinator and regulator of the health sector. However, the effectiveness of regulation as a tool is context dependent. The government has found it necessary to supplement and support regulation by other, more cooperative strategies for working with private sector providers. Concerning the quality of care, for example, the Government of India is particularly vigilant about provisioning of supplies and services within the primary health care infrastructure. Government has therefore partnered in widespread consultation with leading gynecologists and surgeons, professional medical associations, voluntary and non-government organizations. This partnership led to the formulation of the Standards for Male and Female Sterilization in 1989. These have been updated several times and followed by several other guidelines. The government has continued stakeholder consultations since in order to ensure that there is complete comprehension of these guidelines among health care providers.

23. Another important partnership affecting quality of care has been created by the civil society consumer movement in India that has succeeded in utilizing consumer protection legislation and its accompanying mechanisms for redress on occasions when service users were victims of medical negligence or malpractice. Civil society consumer organizations and the media worked hard to raise awareness of consumer rights. A recent decision to bring private medical practice under the Consumer Protection Act (CPA) of 1986 is a significant step forward. Professional organizations and local medical associations by themselves have remained ineffective in influencing the behavior of private providers. A substantial number of doctors shared the view that the Act would make them more responsive to consumer needs.

24. Partnerships have also influenced health policy in India. From 1992 until 1994, the pre-International Conference for Population and Development (ICPD) consultations included NGOs, women activists, demographers, voluntary organizations, etc. These consultations served to clarify issues for the Government of India in its policies and programs pertaining to population, health and women's empowerment. In 1994, the year that ICPD was held, a network of voluntary organizations, researchers, activists etc. formed a civil society organization called HealthWatch. This group works with the government to do away with method-specific targets and to adopt an integrated and holistic approach. In 1996, the Government of India adopted the target-free approach first in 18 districts, then throughout the country. In January 1997, the government announced that it has decided to adopt an integrated reproductive and child health program.

25. Also active in the area of reproductive health were the partnerships that formed the "friends of the pill" movement. In 1992-1993, the National Family Health Survey had indicated that only 1.2 per cent of the women in India used the oral contraceptive pill. A campaign was launched to improve acceptability and usage by 25 per cent within two years. The campaign partnered with over 300 leading doctors, and trained 30,000 chemists as well as 22,000 practitioners of the Indian Systems of Medicine. Media workshops and health camps were held frequently in each state in partnership with Rotary and the Lions Associations. This campaign conducted with multiple partnerships won three national and international awards.

26. The private sector also made a significant contribution to the eradication of polio in India. Rotary International be-

came an active partner in the endeavor to make every resident of India polio free. Already in 1987, Rotary International's polio eradication program contributed $20 million for the purchase of oral polio vaccines, surveillance and social mobilization activities. When the Government of India launched its Polio Plus Campaign in 1995, Rotary International ensured that a large number of volunteers organized social mobilization programs to generate awareness. This was done through involvement of school children, and transporting vaccines to polio booths. Specially designed vaccine carriers were produced and distributed by members of Rotary International through the generous contribution towards the polio eradication program in India in addition to the logistics support and voluntary services provided by thousands of Rotarians.

27. The most ancient partnerships for community health development in India is the one formed with the Indian Systems of Medicine (ISM). These indigenous health traditions date back to 5000 BC in some cases. Immense experience and wisdom garnered over centuries have been transmitted in part through learned professionals, but was never restricted to them alone. After independence, the ISM did receive a measure of state support. Currently, non-government centers of excellence are organized by traditional healers dealing with bone-setting, treating polio, eye diseases, arthritis, skin diseases, etc. Against this background, the primary health care movement has begun to scrutinize these classical approaches and confirm what is sound through observation and clinical trials. Research Councils have identified more than 9,000 tribal and folk remedies by observing people in remote parts of the country and their health practices mostly based on the use of plants. Most recently, the National Population Policy 2000 provides specifically for the mainstreaming of the ISM in the provisioning of reproductive and child health services. An Expert Committee for Reproductive Health Research and Contraceptives for ISM considers projects aimed at identifying methodologies and approaches for family planning through the ISM. An operational research study funded by the Ministry of Health is soon being introduced in five states to examine the efficacy and acceptability of ISM approaches to reproductive and child health.

28. Other partnerships in the area of health, discussed by Ghosh, included examples from Tanzania, Pakistan, Bangladesh, and Sri Lanka. Recent studies recognize that although partnerships may not absorb as large a share of project resources as other components, they do need a reasonable and timely level of monetary support and management attention to succeed. Partnerships need to be area-specific, demand-driven, need-based, and people-centered. This calls for enduring changes in the legal-administrative framework accompanied by health sector reform.

29. **Dr. Ryoji Kobayashi, Professor, Metropolitan University of Tokyo, Japan**, spoke on "Development of the Public and Private Relationship in the Care of the Elderly in Japan." To facilitate understanding of the characteristics of elderly care in Japan, Kobayashi first reviewed the development of the system through three stages. The first stage of "poor relief" lasted from 1946 to 1961. During this stage, the Daily-life Assistance and the Social Welfare Services Acts shaped care for the elderly in Japan. Welfare service recipients were limited to those receiving livelihood assistance.

30. The second "welfare" stage began with the National Pension and the National Health Insurance Acts of 1961. It included the Law of Welfare for the Aged (1963), Free Medical Care for the Aged (1973), the Law of Health Care for the Aged (1983), and the Basic Pension Plan of 1986. During this stage, eligibility for welfare services was expanded first to low-income households, then to all people with care needs. However, the latter ones were required to participate in the cost of services according to their ability to pay. The third stage saw the expansion of care services, beginning in 1989 with the 10-year Plan for Promoting Health and Welfare for the Elderly (Gold Plan). It was soon followed by the reorganization of welfare services of 1990. The Long-term Care Insurance Act (1997) introducing the principle of social insurance to services for the elderly and the Social Welfare Act (2000) crowned this period. Under this scheme, persons above a certain age pay insurance premiums in exchange for receiving care services in times of need.

31. This flurry of legislative activity in the field of social services for the elderly in recent years is caused by profound demographic and social changes in Japanese society. The percentage of elderly in the population has grown steadily; it exceeded 7 per cent in 1970 and 14 per cent in 1994. The percentage of the "old-old" population aged 75 and more soared to 5.4 per cent in 1991 and 7 per cent in 2000. This rapid population aging is partly caused by the extension of the life expectancy to 84 years for women and 77.1 years for men. As a result, the estimated population of dependent elderly has risen to 120,000 bedridden, 20,000 demented, and 130,000 frail elderly who require intensive medical and personal care. At the same time, family structure has changed. The average number of family members shrank from 4.97 in 1950 to 2.97 in 1997, while the percentage of elderly and elderly couples living by themselves increased from 10.7 per cent and 16.2 per cent in 1980 to 20.1 per cent and 21.6 per cent in 1997, respectively.

32. Historically, family members provided services for the elderly. In 1929, institutional care for the elderly started on a very limited scale as part of the public poor-relief program. This continued until well after World War II, when homes for the elderly were operated under the National Assistance Law. In 1963, the government created Special Care Homes (SCH) to provide care for handicapped elderly who cannot receive family care. About 280,000 beds were created in such homes by 1998, but still many elderly had to be kept on the waiting lists. This caused many elderly to stay for long periods in hospitals even after acute treatment was completed, thus raising health insurance expenditures greatly. Community care services were introduced in Japan in the 1960s, but their expansion only began in the 1980s. The central government, prefectures, and local governments in conjunction with various degrees of private co-payments financed all of these services.

33. The recent introduction of Long-term Care Insurance gave the private sector a much greater role in service provision for the elderly. Government now limits its role to managing the new scheme's finances and to regulating and supervising—including complaint procedures, quality assurance and information provision—the services market that Long-term Care Insurance has created. Private providers can now join this mar-

ket freely in areas where they identify needs and thus economic opportunities. In particular, many for-profit enterprises are now offering ambulatory care services, the supply of which had been insufficient under the earlier government-provided scheme. On the other hand, non-profit organizations that have been active in ambulatory care since the 1980s are not able to enter the market for long-term care services to the degree that it was hoped. Weak financial and organizational structures—often due to the lack of substantial support from public authorities—do not allow them to compete successfully with the more agile and aggressive for-profit enterprises. The slower-than-expected expansion of the long-term care market as a whole, however, appears not to be caused by a lack of interest either on the part of for-profit or non-profit providers, but by the fact that Japanese consumers do not necessarily welcome service providers' intrusion into the privacy of their homes.

34. **Dr. James Tooley, Professor of Education Policy, University of Newcastle, England**, gave a presentation on "Accountability, Quality and Equality: Public versus Private Provision of Basic Education for the Poor", giving insights into policies on the role of private schools in basic education. Tooley questioned the discourse that the public sector should be responsible for all aspects of education on four grounds. First, there have been doubts about the effectiveness and efficiency of public education. Second, there are doubts about the equity, or fairness, of public education, and its accountability, especially to the poor. Third, there is an increasing awareness of initiatives by educational entrepreneurs, and evidence to suggest that competitive pressures can lead to significant educational improvement. Fourth, a practical consideration is the need to restrain public expenditure, in order to reduce budget deficits and external debts, and the consequent need to find alternative sources of educational funding.

35. According to Tooley the private sector has impressed many governments, looking to improve the quality and efficiency of public schooling. The British government is currently in the process of contracting out failing schools and local education authorities to the private sector. However, this process is not confined to developed countries. In India, for example, the government looks to contract out the software and hardware to private companies. Thus, he suggested deeper private sector involvement as a suitable way to help the most disadvantaged groups in society gain access to education.

36. He presented two types of private schools, or "budget schools," for the poor in India based on seven case study in Andhra Pradesh. The first type of school charges about $20 and the second $54 per year, which account for 5-11 per cent of family income. Among the different objections raised against these budget private schools is the issue of whether such schools would be concerned with education, rather than simply featuring businessmen employing the poor. It was found that a significant proportion of teachers in each of the case study was trained—and in all but one school a majority of teachers was also of graduate level. Teachers were in general paid less than those in government schools, usually in the range of 25 to 40 per cent of government salaries. The great majority of teachers was female. The explanations given are that some teachers do not wish to work at government schools, where there are discipline problems and a general lack of educational concern. But most would be unable to get such jobs because of corruption and cronyism in government appointments. In addition, teachers' pay, while low, was often higher than in other jobs that would be available, including unskilled clerical work.

37. A further objection against these budget schools is that they are for the better off financially and better-motivated parents, and hence promote inequity. Against this, the research found, first, that each of the schools provided free and subsidized places in the school—sometimes over 1/3 of places—to the 'less blessed' children in the neighborhood. Second, the majority of the parents who sent their children to the $20 schools were from some of the very poorest groups in society—rickshaw pullers, market vendors and the like. The budget schools would therefore seem to have the potential to reduce inequality within the society as a whole rather than exacerbate it.

38. An alternative answer to the inequity issues is to consider ways in which the numbers of free places at such schools can be extended, and the number of higher quality budget schools can be increased. He noted that outside assistance could play a valuable role. One obvious way is to create private scholarship scheme, funded by philanthropy, from which parents could draw from to pay a large proportion of school fees. Fees could only be spent at schools that satisfied certain quality standards. This would not have the effect of increasing either the schools' or the company's profits, rather it would increase the proportion of the poorest parents who send their children to quality budget schools.

39. In conclusion, Tooley suggested a possible business model—a formation of an Education, Management and Investment Company—as a "chain" of budget private schools. The company would have the mission of helping educationists who provide places for low-income families to better assist the children they serve, in both educational and financial terms. The company would develop its educational model for 'Partner' schools, including the development of an appropriate curriculum, assessment system, and teacher training, etc. directly relevant to the context of serving slum and low-income families. The company would also create the management and business model for partner schools to adopt in terms of a contract. The company would also invest in the school's infrastructure and subject the school to quality control. He noted that this model would create a win-win situation for all and would be one of educational community self-help, not of educational dependency.

Leadership Issues in Partnerships

40. **Mrs. Carol Fimmen, Director, Global Education, College of Business and Technology**, **Western Illinois University, United States**, spoke on "Partnerships in the Training of Future Business Leaders—The North American Experiences". At the center of her presentation was the issue of internationalization, "a process which integrates an international/intercultural dimension into the teaching, research and service functions of higher education institutions." Internationalization is of particular importance as it is the basis for expanding partnerships, strengthening schools' abilities to carry out their missions, and expanding students' understanding of other cultures and languages.

41. In the United States, the concern with internationalization has led to a number of partnerships across boarders. The North American Consortium for International Advancement (NACIA) includes not only universities from the United States, Canada and Mexico, but also from Brazil, Argentina, Chile, and Costa Rica. Under this consortium, an international MBA program has been developed that requires spending one term in each country and one term implementing a joint research project with team members from all three countries. Another program that has arisen from NACIA is implemented with the Mexican Development Bank and allows students to work with small businesses.

42. A number of new challenges for international partnerships in business and education are receiving increasing attention. First, there is an uneven distribution of benefits often caused by scientific and cultural discrepancies and "haves" and "have-nots" between exchange participants. Second, international cooperation has proven to be a complex process. While it is promoted by new information and communication technology, it should be shaped in such a way that it promotes cross-border solidarity among academics, institutions, and students. Third, brain drain from developing countries to economically more affluent countries needs to be eliminated. Developing countries need to develop and maintain their own highly skilled experts. Programs need to provide the unique information and knowledge that developing countries require. In turn, these countries have to offer adequate compensation and benefits in order to be an attractive location for highly skilled personnel.

43. Global leadership training aimed at fostering individuals who challenge processes, inspire shared visions, and enable others to act is at the heart of global business education. Such programs are often funded jointly by the private and the public sector, implemented as a stand-alone curriculum, integrating humanity studies, research activities, language training and spans international geographic areas. Developing such programs raises numerous issues such as funding, public and private sector involvement, curriculum, and student career development. Cross-border partnerships under such programs may include not only higher education institutions, but also businesses and community services.

44. In developing such global leadership programs with many partners, it is critical to build common understanding of principles and values, set up goals, make international "connections", and decide who carries out required tasks. This is to address the concern of diversity, culture, implementation, and sustainability. Important additional options include "horizontal" cooperation with regional and multilateral organizations or with civil society. Information Technology (IT) offers opportunities to make increased use of government services and to gather information online.

45. **Mr. Lalith Chandrakumar Weeratunga, Additional Secretary, Ministry of Education, Government of Sri Lanka**, spoke on "Leadership Issues in Public-Private Partnerships in Education and Training". Weeratunga based his talk on several specific experiences, including the partnerships between the Ministry of Education and the Ceylon Chamber of Commerce and the Round Table on Education that contributes to policy development as well as specific projects. These are aimed at strengthening English education through collaborative activities, promoting IT education through setting up school-based training centers, subsidizing teacher training programs and furthering management development in schools.

46. Under the Development of Schools by Division (DSD) Project, 341 schools throughout the island nation were selected. About 25 per cent of these schools are linked with private sector organizations that contribute management development of the principal and the school's management team through the private sector, provision of some physical infrastructure, library development, and provision of teachers in science, mathematics, English and IT. For example, Lions International has introduced the Lions Quest program to 134 DSD schools that focus on imparting life skills and building character in students. A private bank purchased the learning materials and Lions Quest of India trained the teachers.

47. Sri Lanka's National Apprenticeship Scheme is also featured by a public-private partnership. It is implemented by a government organization, the National Apprentice and Industrial Training Authority (NAITA). It offers both institution-based training and Enterprise Based Apprenticeship (EBA) with 73 per cent of trainees full-time attendees of the latter program. While apprenticeships in industry are widely popular among youths, industrial and commercial enterprises also require timely skill formation continuously. But such enterprises cannot afford to run full-time training programs for new employees. Since NAITA pays allowances to the apprentices during the period of apprenticeship, it is attractive to employers. These apprenticeships are offered through formal contracts. NAITA provides supplementary theoretical instruction. About 14 per cent of the trainees spend 50 per cent of their training time in enterprises. The results of this program are encouraging: about 88 per cent of those who complete their apprenticeship report that their training was very relevant to their present employment; 62 per cent find wage employment upon completion of the program; 38.7 per cent find employment in the same establishment where they were trained; and 9.6 per cent are self-employed.

48. Another important program that draws extensively on a public-private partnership is the Vocational Training Authority (VTA) that was set up by an act of parliament. VTA runs training centers to provide youth with skills in different trades. It actively seeks the support of the private sector for on-the-job training and final placement in employment. With the help of leading industrialists, it provides craftsmen with opportunities to upgrade their skills. VTA also cooperates with NGOs. Training centers are established in Buddhist temples and church-based organizations that also shoulder the responsibility for the management of the centers. While VTA covers the cost of training materials and payment of instructor salaries, trainees are recruited jointly by VTA and the NGOs.

49. Drawing on his experiences with the above projects and programs, Weeratunga shared a number of lessons that he had learned. He noted that leadership is critical in a complex partnership. Leaders who reflect commitment to particular programs and processes may be more successful than leaders who see themselves only as facilitators. The quality of the leadership affects a partnership at every phase, ranging from

the conceptual, negotiating, finalization to the commencement stage. At the initiation of the partnership, the quality of the top leadership of the partners determines the fate of the partnership. The vision of these leaders must have large intersections for consistent implementation to continue at the working level. Here, establishing ground rules is crucial to avoid conflict later.

50. When the partnership is mid-course, interpersonal capabilities become important. Because in public-private partnerships, people from different entities work together, they may have different work habits giving rise to conflict. In such situations, there must be respect for others and emotions must be handled intelligently. Understanding others, empathy, and the ability to maintain the original vision become even more important, when the partnership is in danger of dissolving.

51. Successful leadership in partnership therefore means possessing interpersonal intelligence. Thomas Hatch and Howard Gardner have identified four components of interpersonal intelligence: organizing groups, negotiating solutions, personal connection, and social analysis. In partnerships, all these abilities come into play because a good partnership requires the intense handling of relationships. Therefore, it is becoming evident that different knowledge, skills, and attitudes—particularly in the area of relationship management—are required in managing partnerships and run-of-the-mill managers cannot necessarily address these issues successfully. Partnerships should thus be managed by emotionally intelligent people. Important ways to avoid conflict include: giving conflict resolution a high priority from the beginning; mutually agreeing on a method of conflict resolution; eliminating possible areas of conflict through negotiation when the partnership is conceptualized; promoting a sense of understanding of each other among the leaders of each side; and avoiding hidden agendas.

Governance and Management

52. **Ms. Maryse Dugue, Project Economist, Office of Pacific Operations (OPO), ADB**, in her paper "Governance and Management in Contracting Services to the Private Sector: A Case from Papua New Guinea" outlined the extent and nature of the role of churches in Papua New Guinea in providing health services, particularly in rural areas, and discussed key issues arising from the involvement of private providers in the delivery of such services.

53. Papua New Guinea has 5.1 million inhabitants, 85 per cent of which live in rural areas. Most communities remain fragmented and isolated because there are about 700 languages in use and the limited physical infrastructure is deteriorating. The National Department of Health (NDOH), the Department of Personnel Management (DPM), and the Department of Finance lead the health sector at the national level. The administration extends down through 20 provinces to the level of 89 districts that are responsible for rural health services in their jurisdiction. Health services are provided under different arrangements: publicly provided are services in government facilities, either free of charge (publicly financed) or with user charge (privately financed). Privately provided are services in mission or NGO facilities where salaries are paid by the government (publicly financed) and in private practices where the customer has to pay for them (privately financed). Major current challenges for the health systems are under-funding, a need for decentralization, a need for coverage extension, and equity of access. Difficulties in all these areas combine to produce poor outcomes.

54. The public-private partnership between the government and 20 church agencies strongly shapes the health services provision. The church currently provides 45 per cent of total health services and 49 per cent of rural ones. These agencies also carry out 60 per cent of general nurse training and all of community health worker training. The partnership in itself is therefore not questionable; it is a necessity. The contract between the government and the Church Medical Council (CMC), the central representation of the churches' medical agencies, can therefore be characterized as a non-competitive contract with voluntary agencies. It has its foundation in the National Health Administration Act and the National Health Plan 2001-2010 and provides for public funding of salaries and recurrent expenditures.

55. In more general terms, partnership arrangements are attractive for several reasons. First, it helps ensure the most efficient and effective use of public resources in terms of health outcomes. Second, they create the opportunity to direct most resources toward the best provider. This, in turn, can serve to increase provider responsiveness on the whole and lay the foundation to improve coverage. Such partnerships are particularly attractive when they lead to demonstrable cost savings or improved benefit to users. One important prerequisite is that outputs can be clearly specified. Other requirements include proper incentives, regulatory frameworks and institutional capacity: that is the capacity of the public administration to negotiate favorable contracts and to monitor their proper execution. In practice, this last point frequently poses the main problem.

56. Thus good governance is of key importance to successfully managing partnerships. Predictability of government decisions and consistent application of the rules by civil servants are essential in order to give private sector partners security. Internal and external accountability and transparency of information, e.g. audit results, are vital. More importantly, participation should include all stakeholders. Public participation should be promoted on different levels. Consumer awareness can be strengthened e.g. through report cards or the display of service prices. Community participation can be mobilized through audits. User fees, on the other hand, have proven to be of limited value in increasing vigilance among consumers. For-profit and non-profit partners have different objectives and behave according to different management constraints.

57. In Papua New Guinea, minimum standards have been set for district health services. The same indicators will be applied to church, as well as to government health facilities. These include outcome indicators, i.e. immunization coverage, percentage of deliveries supervised, and structure indicators, i.e. water and electricity at the facility, radio communication, etc. Enforcement of these standards is attempted through inspection (difficult because of harsh travel conditions), price and payment mechanisms, third party audits (expensive) and the very powerful tool of consumer edu-

cation. Concluding from her experiences in Papua New Guinea, Dugue emphasized that the private sector is neither the panacea nor the devil in the health care system. In finding a balanced approach, it is important that principles and accountability are applied to all financers and providers – public and private. The ultimate rule for decision-making needs to be "value for money".

58. **Dr. Emily Vargas-Baron, Co-Director of Education, Institute for Reconstruction and International Security through Education** (the RISE Institute), reported on "Successful Partnerships: Lessons Learned from Public-Private Partnerships for Educational Development". Vargas-Baron saw public-private partnerships as an essential part of good governance for systems of formal and non-formal education. As such, they are necessary to achieve effective, sustained educational reform and development. However, fundamental responsibility for providing universal basic education must lie with the public sector. Only this sector—government at all levels from communal to provincial to national levels—can guarantee that all groups, both dominant and subordinate, will be given equitable educational opportunities. All nations that have achieved high levels of economic and educational development have provided universal, compulsory and free primary education, and most of them have also provided universal access to lower secondary, if not also upper secondary education. Therefore, Vargas-Barron considered it to be unwise to recommend that less developed nations de-emphasize the public sector and depend more heavily upon private sector programs.

59. However, the private sector has critical roles to play in all phases of educational policy, planning, and program development. The private sector can play instrumental roles in educational development especially by helping to raise educational quality through its universities and teacher training colleges, to lead curricular reforms and textbook development, to improve lifelong access to learning through non-formal education programs, and to help ensure accountability through continuous monitoring, evaluation, and assessment. The role of the private sector in educational planning is particularly sensitive to the civil society in ensuring equitable education of high quality for all children, youths, and adults. In those countries where public-private partnerships were not created to help design and carry out educational reforms, the reforms have failed or had only a very short period of impact. To ensure the sustainability of a national or provincial educational plan, public-private partnerships must be developed and nurtured. These partnerships will help to maintain the vision, content, and momentum of education plans from one political administration to another.

60. Vargas-Baron noted the cultural dimension of partnerships. She observed that the national culture determines partnership methods and public vs. private initiations. For example, the methods for establishing these complex partnerships differ from country to country. In some countries, such as Japan, partnerships tend to be initiated mainly by representatives of the public sector, while in the US, Mexico and Egypt, they tend to be inspired by civil society institutions. This culture dimension needs to be carefully studied before initiating any new system of partnerships.

61. There are many examples of successful public-private partnerships in different cultural settings. In Columbia, for example, the Non-Formal Education Movement, drawing on the traditional Columbian system of *tertulia*, led to the development of hundreds of effective, long-lasting public-private partnerships. Similarly, in Pakistan the Primary Education Development Program of Baluchistan, drawing support from the government, NGOs, parents, and teachers, has dramatically improved girls' education. The higher education projects of Chengdu, PRC, and of Arizona, US have improved educational development and training capacities of all institutions involved. Another important example of partnerships for education and training has been the establishment of Semi-Autonomous Institutes, created in certain countries to meet specific needs in education. They exemplify the union of both government and the private sector and they bridge two sectors. These institutions ensure a strong base and have a better chance of being well supported over time.

62. How public-private partnerships are designed, developed and nurtured is critical to their eventual success. The conditions associated with successful partnerships and the elements for success are now quite clearly understood. While it is important that the cultural context of partnerships at both local and national levels should be well reflected, a certain set of strategies, policies, plans, and funding approaches is required for a nation that decides to help establish public-private partnerships. At a minimum, these should encompass the following areas: the identification and convening of potential partners with a focus on the greatest level of inclusiveness possible; specification of methods for providing equitable support in terms of financial resources, goods and services; shared vision, expectations, roles and objectives; recommendations regarding the best modes for designing and implementing partnerships; and the development of a system for monitoring and evaluating partnership to ensure accountability, transparency and the measurement of results.

63. **Mr. Ian Whitman, Principal Administrator, Directorate for Education Employment, Labor and Social Affairs (DEELSA), OECD**, spoke of the experiences in the OECD on partnerships with business, parents, and other stakeholders in relation to education management. Whitman first outlined the changing context of school management at the turn of the century. School management is an invention of the 20th century, growing out of a trend towards full-time professional management of financial, instructional, human resources and facilities within a central bureaucracy delivering universal public education. However towards the end of the 20th century, central authorities began devolving some of these responsibilities to local municipalities and individual schools. Challenges thus include managing educational change at a time when the character and mission of schools are being redefined; having an understanding about new trends in public management with a less bureaucratic and institution-led approach that is moving towards a performance driven public sector; and finding new and effective ways of managing knowledge in organizations that need themselves to learn continuously.

64. As public management is changing with increased emphasis on setting objectives and allocations for government actions, rewards and sanctions for performance, etc., schools also have to change the way they operate. While schools are allowed to make decisions more locally, governments have

simultaneously become more demanding on schools in terms of achieving measurable outcomes. Communities are encouraged to participate in rebuilding schools from the bottom up. Finally, there is a move to provide some services on contract rather than directly by the government. One of the ways in which schools have reacted to these challenges is partnership. This again has increased the demand for managing relationships outside the school with business, consumers, and parents.

65. For the business sector, severe economic constraints have hampered the creation of partnerships with the education sector in many transition countries. The forms of business-education cooperation cover a wide range. Most involve simple forms of cooperation: work-experience placements are the most common activity in European countries, if only because these are often required by governments or are part of the system. Reinforcing this link with the workplace, visits to companies by pupils and teachers, work-shadowing (observation of a worker's daily routine) and teacher secondment have become increasingly popular. But much activity also goes on within schools, notably curriculum development projects, and the establishment of mini-enterprises. Emphasis has been given to direct help from companies to schools and students—such as one-to-one mentorship of pupils by company employees, adopt-a-school initiatives and donations of equipment.

66. Partnerships that go beyond a specific activity based on a company's relationship with a school are even harder to classify. Coalitions have been set up to change education in a variety of ways. The most coherent model is the compact, where employers in an area agree to give jobs to pupils who meet certain education objectives. The most famous is the Boston Compact founded in 1982 that was replicated in France, Germany, and other countries. More one-sided business coalitions have been common in North America and large corporations have become more inclined to launch their own programs that reward innovation across entire school systems. Other coalitions are formed around programs originated by public, semi-public or other non-profit bodies. Such schemes may aim to promote enterprise in schools, improve career guidance or retrain teachers with business cooperation. Such programs and partnerships in general tend to be concentrated on upper secondary, and designed in particular for those in vocational studies.

67. Whitman noted that a successful partnership tends to consist of more than just an agreement between two sides with common goals. Rather, the process of cooperation in itself is important, both in building confidence between the partners and formulating common goals. Partnerships change in character and content, and improve their abilities to bring about significant changes in education as they mature. Partnerships succeed best where they go with the grain of initiatives being taken within public schooling systems and have been useful catalysts for such changes. Other important criteria for success are the context of the school system, specific cultural factors, the national economy and the character of the local community.

68. Perhaps the most important general feature is that partnerships evolve over time. The first stage usually emphasizes getting to know each other and promoting contacts. At this stage, there may be no concerted effort to use partnerships to change methods or content of education. Such links with little or no tangible education benefit have been dubbed 'feel-good partnerships'. Most partnerships begin this way and then move beyond to something more influential. Coalitions extend partnerships beyond a simple school-business link. As well as bringing together a number of businesses and schools, they may also bring in others with an interest in education. Commonly agreed directions can bring about more effective change than when the partners are pursuing their own goals. First experiences can help to develop understanding of what needs to be done. System change can be clearly distinguished from change that applies only within the limits of a particular project. Movement towards new ways of doing things is perhaps the most important way in which the impact of partnerships can grow.

69. Parents and families want to support their children's learning more effectively at home, to work in partnerships with teachers, and to have more choice in selecting schools. At the same time, many countries are adopting policies to involve parents closely in the education of their children. For governments that seek to maximize the positive effects of parents-school partnerships there are several key messages, including (i) publicizing and disseminating examples of successful practice, (ii) developing methods of replicating successful strategies so that parents, students, and teachers across the country can benefit from them, (iii) promoting mutual respect among the different partners and a recognition of what each can bring to the collaboration, and (iv) clearly identifying the parental agenda in order to make the best use of the energy and the resources of parents.

70. **Dr. Christian Oberlander, Visiting Scholar, University of Tokyo, Japan**, presented on "Public-Private Partnership for Universal Health Insurance Coverage: Government and Private Health Care Providers in Developing Japan". In this case study, Oberlander examined the central instrument in the organization of ambulatory personal health services in Japan, the public-private partnership between the Japanese government and the Japan Medical Association (JMA) that represented private providers of ambulatory personal health services.

71. This partnership was initially formed in 1927 to expand access to personal health services through the introduction of statutory health insurance for industrial workers. Health insurance had been legislated in Japan in 1922, however, because of the Kanto Earthquake of 1923, its implementation was delayed until 1927. The health insurance law required providing the insured with health services in kind. This forced the government to search for options to organize service provision. After intensive research and negotiation with the Japan Medical Association, the responsible Ministry of the Interior decided to conclude a group contract with the association allowing all private practitioners to function as insurance doctors. A formal contract spelling out the terms of the partnership was signed in late 1926 by representatives from the association and the ministry. Under this arrangement, the medical association shouldered the responsibility for provision of treatment under the health insurance. The association's member doctors provided the actual services while the medical association supervised them.

72. The creation and subsequent management of the partnership between the Japanese government and the Japan Medical Association gave rise to many innovations that shaped important features of the Japanese health care system until today, ranging from the separation of public health financing and private service provision, the linking of the two through a standardized fee schedule for health services provision, and emphasizing primary health care to issues of professional autonomy, and setting of clinical standards and quality control. After World War II, this partnership was formally embodied in the Central Social Insurance Medical Care Council (CSIMCC), the advisory body guiding decisions on core issues of the Japanese health care system until the present.

73. This partnership between the Japanese government and the Japan Medical Association is particularly instructive because it likely contributed to at least three key features in the development of the Japanese health care system. First, the partnership, in part, enabled Japan to stepwise expand access to personal health services through health insurance at an early stage of its development when it had—by some of today's standards—the world's worst health system. While Japan was suffering first from the recession following the end of World War I and then from the Great Depression and its consequences in the 1930s, health insurance was meant to prevent the further spread of poverty. Second, the partnership paved the way for the Japanese to come close to realizing universal health insurance coverage in 1944—only seventeen years after its first introduction of statutory health insurance—and, after suffering severe damages at the end of World War II, formally to achieve this goal in 1961. At this time, Japan was still recognized as a developing country and many "advanced" countries like France and Germany had not yet reached this level. Third, even while universal coverage had been achieved, personal health services had become available to the entire population, and Japan achieved excellent health outcomes, the partnership helped Japan to keep health care expenditures comparatively low during the subsequent decades. Long-term observers of Japanese health care system have concluded that "Japan's health care system... helps to keep its population healthy at an exceptionally low cost".

74. Oberlander concluded that the creation of a public-private partnership between the Japanese government and the Japan Medical Association at the introduction of statutory health insurance in Japan in 1927 thus had a crucial impact on the mobilization of resources, expansion of access, the management of costs, and quality control. The partnership (i) allowed the quick mobilization of the existing health service providers for health insurance patients, (ii) created an important model that was frequently referred to when expanding health insurance coverage, (iii) allowed the management of costs through global budgeting and the national fee schedule, and (iv) promoted quality control first through the self-regulation of JMA, then through the development of quality standards.

75. **Dr. Philip Kwok-fai Hui, Lecturer, Hong Kong Institute of Education (HKIED), Hong Kong, China,** presented a paper on "Improving Educational Quality in Hong Kong: Management of Public-Private Partnerships". The Government of the Hong Kong Special Administrative Region (HKSAR) has taken measures to enhance intellectual capital in order for Hong Kong, China to remain competitive in an increasingly technology-based global economy. Hui examined the nature of the partnerships that have evolved as a result of the Quality Education Fund (QEF) that was set up by the HKSAR to flexibly subsidize education improvement projects. The fund functions through a consultative committee to distribute government funding and to promote private sector investment in education. The fund provides money for financing school as well as non-school sector projects, which include NGOs, tertiary education institutions, private enterprises, etc. Most of the resources have been earmarked for secondary education.

76. Hui presented four cases of partnerships initiated under the QEF. The first is the Hong Kong Education City.Net, which was established in March 2000 by the Education Department to further enhance Information and Communications Technology (ICT) learning, bring education onto the Internet platform, and better utilize other education resources. The key partner in the project is the Education Department that owns the HK Education City Project and its intellectual property rights. The project attracts many private companies as partners that provide online products and information to as many as 1 million students and 50,000 teachers. The second case is the partnership between the government and the NGO, Pegasus Social Service Christian Organization (Pegasus). Funded primarily by QEF, Pegasus is to provide comprehensive ICT education for all in Hong Kong, China with the aim to overcome inequalities between those who are well versed in ICT and those who are not. Through its five vehicles that are redesigned as mobile ICT education centers, the company started its services around outlying schools where there is limited ICT resources and skills with teachers. Since its operations began in 1999, the bus had visited more than 142 schools and had served more than 106,000 people in 2000.

77. The third case is the partnership between the government and higher education institutions. For instance, the HKIED has provided professional expertise in large QEF funded projects. HKIED, with its expertise in basic education, has played a critical role in teacher training and assisting schools to prepare proposals for QEF, based on sound academic rationale and experience, leading to successful biddings. The QEF has also stimulated the involvement of unconventional types of private organizations to work with the government. An example is the Ming Ri Theatre Company Ltd. that comprises people in the field of performing arts and that focuses on drama and education. With an aim of bringing integrated art courses into the formal curriculum of primary education, the Hong Kong Council of Early Childhood Education and Service contracted the service to the Ming Ri Theatre through QEF by introducing the Edu-Drama Project into schools. All projects are subject to strict cost control and quality assurance that was reviewed by an external reviewer.

78. While traditionally the benefits of public-private partnerships are to tap into private-sector resources to support ever increasing costs of education, Hui commented that QEF is different in that the government provides a large amount of funds while seeking other partners to provide ideas, knowledge, and skills to develop quality education. He also pointed out the need for further research concerning cost and effec-

tiveness of the QEF-sponsored projects. This needs to include the costs to schools that submit project applications but fail to win funding. In order to truly strengthen bottom-up initiatives, the QEF might have to create a support platform that not only supplies funding after a process of bidding and negotiating, but that also provides the know-how of promoting ideas that are put forward by the schools themselves.

79. **Dr. Marc Mitchell, Lecturer, Harvard School of Public Health, US,** provided fresh insights into "Management Issues in Partnerships". Based on the understanding that a partnership is a "relationship based upon agreements, reflecting mutual responsibilities in furtherance of shared interests", Mitchell identified four central management issues in partnerships: conflicting objectives, contracts, measurement of outcomes, and pricing.

80. Objectives of the private sector include regularly increasing profits. This leads the private sector to focus its activities on profitable services and to reduce costs through efficiency and innovation. The public sector, on the other hand, frequently aims for equity and achieving certain national priorities. It often does so by setting safety standards, creating safety nets for marginal populations, and regulating cost. The situation is further complicated by the fact that both sectors tend to have fixed perceptions about each other. People in the public sector perceive those in the private sector as only interested in money, willing to cheat to make more profits, and not interested in the fate of the poor. The private sector often views the public sector as inefficient or bureaucratic at best, corrupt and difficult at worst, and its work as of poor quality. These perceptions lead to distrust and burden potential partnerships.

81. Once a partnership has overcome the initial psychological hurdles and has come to the point that it is formalized, contracting becomes an essential skill. A contract can be understood as an agreement between two or more parties for the provision of specified goods or services for an agreed upon price. While, at the minimum, a contract has to cover certain basic elements that need to be spelled out clearly, there are some aspects to contracting in health care settings that have proven particularly difficult. In the health sector, it is often difficult to specify things unambiguously. While inputs and outputs are relatively easy to measure, they account only in part for performance. Impact, on the other hand, is a good measure of performance, but it is difficult to measure. Another difficulty is the public sector's limited ability to set prices because of asymmetric information, i.e. the private sector is more experienced in costing and setting prices. This often provides the private sector with opportunities to "game" the system, e.g. by selecting patients or manipulating utilization. Finally, many developing countries lack a functioning legal and regulatory framework to ensure that contracts are equitably and quickly enforced.

82. Nonetheless, contracting for services is increasingly done in the health sector for many reasons that include improving quality, bringing in specialized expertise, and additional capital, etc. The most frequent reason, however, is lowering cost. An example of this is the case study "Management Issues in PPP in Health: the Case of Hobokan" through which Mitchell steered the participants. Hobokan is a hypothetical country that is planning major reforms in its health sector. An intense discussion of the case revealed several problems with the reform proposals such as the autonomy of hospitals on the relatively small provincial level may jeopardize the effective working of this sector. Complete privatization could induce these hospitals to treat only those patients who can afford to pay. This would exacerbate the difference in access to health care between the rich and the poor. The proposed national health insurance, too, is bound to run into difficulties because the source of the premiums is largely divorced from the beneficiaries. The discussion of the implications of the case left the strong impression with participants that in dealing with the private sector, 'the devil is in the details'.

Country Presentations

83. During the workshop participants were also encouraged to share their country experiences. Dr. Sambath Youk, Deputy Director, Budget and Finance Department, Ministry of Health, Cambodia, outlined the situation of health care in her country. Although most major frameworks for health development are already in place and significant progress has been made, the health status of the Cambodian people remains among the lowest in the region. Recently, the Cambodian Ministry of Health has initiated a comprehensive health sector reform based on the concept of Sector Wide Management trying to involve all stakeholders in an overarching partnership. Mr. M. A. Muktadir Mazumder, Joint Chief, Ministry of Health and Family Welfare, Bangladesh, gave a presentation on "Partnership in Health Care: Bangladesh". The partnership approach in Bangladesh comprises incorporating stakeholders in the management of public sector health facilities, public sector-NGO partnerships in health care delivery, commissioning of services through private providers and NGOs, and improving the stewardship role through regulation of private providers. Mr. Matiullah Khan, Senior Joint Secretary, Ministry of Health, Pakistan and Dr. Dilmurad Rasulev, Head of the General Department of International Cooperation, Ministry of Higher and Secondary Specialized Education, Uzbekistan gave presentations on their experience in their own countries.

Conclusion

84. Toward the end of the workshop, participants were divided into two groups—education and health—to sort out their ideas based on their own experiences and the issues that had surfaced during the workshop. Given the presentations and discussions during the workshop, participants recommended the following points in the Annex that are of particular concern when planning effective and sustainable partnerships. The workshop ended after brief closing remarks by **Dr. Yidan Wang** of ADB Institute. **Dr. Yoshitomi, the Dean of ADB Institute** gave certificates to the participants and he also requested the participants to comment on this capacity-building program and possible future programs of its kind. Upon this request, participants expressed their strong desire for ADB Institute to continue its leadership role in this area by conducting more programs at the regional and sub-regional levels. The workshop was concluded with a cordial atmosphere among organizers and participants.

ANNEX: Action Agenda for Effective and Sustainable Partnerships in the Social Sector

The education group identified the following as issues:

Policy Issues

- Government's support is essential.
- Need to involve the stakeholders from the beginning.
- Clear and purposeful policy within the government.
- Formulation of educational reform policy requires partnerships.
- Policy creation in the traditional sense at the central level.
- Need to have annual grassroots meetings in some countries.
- Reality sometimes is not in line with policies.
- When partnerships involving community are developed, there must be coherence with the national policy.
- Unless partnerships can be sustained, they should not be initiated.
- Partnerships can be government agencies as well as those at national, provincial, and grassroots levels.
- Longer-term strategy should be built into funding arrangements.
- Making available all the resources upfront of policy formulation as they could be used during implementation.
- Centrally formulated policy must respond to the demands at the local and provincial levels.
- Typology/classification of partnerships:
  - ❑ Private-private
  - ❑ Private-public
  - ❑ Public-public
  - ❑ Local community partnership

Management and Leadership Issues

- Know exactly the terms of the "contract".
- Government should not treat the other partner merely as a contractor.
- Roles and responsibilities should be clear.
- Cost sharing system is a must. (If government. wants to save money as its primary purpose, then partnerships would not work).
- Opportunity should be afforded to partnerships to flourish despite initial clarity and clear focus being absent.
- School and community partnerships is becoming successful and sustainable.
- Many local, community and provincial partnerships are private-private. They could be used as networks.
- International partnerships do last long.
- When parents get involved in the education process, they establish very strong private-private partnerships.
- Endowment funds as well as other facilities and incentives should be provided to non-government education foundations.
- Professional partnerships in education are necessary.
- Initial funding should come from the state.
- Leadership at different levels is important.
- Autonomy should be granted to foundations created by the government for advancement of education.
- Fully transparent arrangements should be established.
- Mutually accountable systems are important too.
- Regional specific needs are to be given emphasis in national partnership policy implementation and coordination.

The health group listed the following as issues:

Policies and Governance

- Government to take the lead in defining its role and the private sector in working together (PNG—church participates in health services; Cambodia—NGOs also participate in formulation of role of government).
- What is the role of the government in partnerships?
  - ❑ Govern.
  - ❑ Define standards (e.g. India—sterilization, contraception; PNG—minimum standards for district health services; Philippines and Thailand—clinical practice guidelines and hospital accreditation).
  - ❑ Mobilize and allocate resources.
  - ❑ Ensure safety net (e.g. Bangladesh essential services package for health, Indonesia, PRC, Pakistan).
  - ❑ Provide appropriate essential health package and other health needs to all people with involvement of community.
- Government to asses how (and whether) partnerships will advance health goals:
  - ❑ In-depth analysis of what will be implications of partnerships, use of NGOs, etc.
- Consideration of demographic diversity and regional disparities in country.
- Combination of government and non-government activities is essential to expand services to all who need them.
- Need to provide legislative and regulatory framework that provides for legal status of NGOs and all participating stakeholders.
- Involvement of all stakeholders in defining policy especially in areas such as HIV/AIDS that are multi-sectoral.
- Need for transparency of budget, appropriations, and spending for health.
- Need for consistency from year to year, government to government in spending, programs, and policies.
- Control of corruption.
- Local level planning together with local level mobilization of funds.

Management

- Realistic costing of health packages and of where funds will come from.
- Training and motivation of health providers in management and in how best to deliver services and go to underserved areas.
- Management of funding and expenditures of both government and the private sector.
- Role of a government in pharmaceutical management—use of generic drugs and resistance against unnecessary expensive drugs.
- Supply management, control of excessive profits and equitable distribution of health supplies.
- Involvement of communities in supply management at local level.
- Social marketing as partnerships to make commodities more widely available.

- Mobilization of media in terms of public education and advocacy.
- Huge management burden on countries with increase in priority health issues, decentralization, integration, partnerships in the face of cutbacks on health management staff.
- Role of international agencies in terms of management and leadership requirements.
- Concern about increasing involvement in micro-management of programs by donors under SWAPs.
- Partnerships to include shared agenda and mutual responsibilities.
- Need for effective package of monitoring and evaluation of partnerships involved in projects and programs.

Leadership

- Strong leadership and well-defined agenda on part of government.
- Need for self-organization of private sector.
- Strong leadership with commitment for health at the local level.
- Leadership and ownership for partnership is needed.
- Mobilizing public awareness about the role of civil society in developing partnerships.

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