In this paper the author, a former senior level executive with extensive experience managing and privatizing public health and human services in the U.S., provides an overview of government policy options for the auspice and methods of health and human service delivery. Privatization of such services is examined in detail including the history, status and experience with this activity in the U.S. along with strategic considerations in considering which services are best privatized. Critical issues in implementation of a decision to privatize a particular service are identified and analyzed. The processes necessary to conduct effective privatizations are elaborated. Lessons learned and best practices are presented to assure that governments selecting privatization of public services are able to do so in a manner that maximizes the accessibility and quality of services provided, assures accountability, and contains costs at market-based, competitive levels.
Introduction

The purpose of this paper is to reflect the current United States policy and practice relative to the privatization of public human services and the experience and insights gained by a senior state-level practitioner. The aspects of privatization to be examined include underlying policy issues, inherent opportunities and constraints, strategies, methods, safeguards and controls to protect the public interest and the interests of those to be served. It is hoped that lessons learned and insights gained by examination and reflection of United States experience will assist other nations considering privatization of public services.

The paper is written from the perspective of a former senior state official and Cabinet Officer for the State of New Jersey serving in three separate gubernatorial administrations (1990-1998) with first-hand experience in this subject area. The author also served as the Executive Director of a national membership organization (1998-2000) - The American Public Human Service Association representing senior public officials from throughout the United States who dealt with these same issues.

The author had the opportunity to lead New Jersey's efforts to privatize the care of some of the state's most seriously and persistently mentally ill, and those with profound developmental disabilities, by closing state institutions and financing private organizations to care for them in community settings. During the author's tenure as Commissioner of the Department of Human Services, approximately 500,000 Medicaid (governmental insurance for low income individuals and families) recipients were enrolled in private, for profit managed health care programs, and the operation of 22 child day care centers serving hundreds of children was transferred from the auspice of the New Jersey Division of Youth and Family Services to a variety of nonprofit corporations. Based on this experience, coupled with the review of the relevant literature, the issue of privatization will be considered in the following framework:

1. An examination of the roles of government in the human services;
2. Organizational auspices for the delivery of human services - The U.S. framework;
3. Current U.S. and State of New Jersey history and trends in privatization;
4. Strategic considerations in determining the auspice of service delivery;
5. Critical issues in the implementation of privatization of public human services;
6. Summary and conclusions

The Role of Government in the Human Services - Public Policy Options

Governments maintain a broad series of options for the human services. The first and perhaps foremost is that of policy. At the most basic level, government must determine what specific services are to be provided, the form or nature of the service and the method of delivery. Further consideration must be given to who is eligible for the service and for how long, which entity can best provide the service and how it might be financed.

These options might be best illustrated in considering a specific service – say child care for working parents. The policy choices for government might include:

- A determination as to whether to directly fund child care providers, provide funding to other levels of government to do the same, and/or to give tax credits to those individuals paying privately for the service or corporations that offer it for their employees;
- A decision as to whether and to what extent to fund child care provided through centers or specially designated facilities, care provided in the home of the parent or care provided in the home of a provider;
- A choice as to the focus on the age bracket of children to served, infants, toddlers and/or school age children;
- A choice as to whether to underwrite child care offered by for-profit providers, nonprofit or non-governmental organizations or public entities; and
- A determination as to the basis of eligibility for children to receive the service such as the income of their family, whether or not the child had any special needs or issues facing them or their families; or by virtue of the geographical area in which they might reside.

Another dimension of the social policy choices relate to sources and methods of financing. For example:

- Would the child care services be financed by government and if so by through what method or tax source?
- Would recipient families be expected to contribute?
- Would provider organizations be asked to match government funds?
- Would citizens who pay for child care or organizations that provide it for their employees as a benefit
be eligible to receive deductions from the tax they might be otherwise obligated to pay to the government?

An additional role a government might choose to take relates to regulatory oversight. These choices would include:

- Whether or not the government would set and/or enforce standards for the facilities and actual care offered by privately operated child care facilities;
- Provide direct financing to non-governmental entities to provide the service;
- Transfer current governmentally operated child care services to the auspices of non-governmental entities; and,
- Determine the mix of approaches outlined above that best fits the vision and values of the role of government and that of non-governmental entities in the particular jurisdiction.

Finally, a government would need to decide whether or not to:

- Directly operate the service with government employees and public facilities;
- Whether or not a government issued license would be required to operate specific child care services;
- Whether or not the government might impose penalties for violation of standards; and,
- Whether the government might offer resources to assist private providers in remedying deficiencies.

This last item relating to considerations in determining the auspice of actual service delivery along with issues associated with the implementation of decisions in this regard is the primary focus of this paper.

**Organizational Auspices for the Delivery of Health and Human Services**

**The United States Framework**

The United States employs three basic structures for the delivery of human services. These include the public sector, consisting of units of federal, state, regional and local government. The second sector would be that of non-profit or what might be referred to as non-governmental organizations, and, the third would be private for profit corporations.

The federal government in the United States predominately finances the broad array of health and human services that constitute the safety net for its citizens. These programs include those directed to income insurance which provides benefits to retirees and those who become disabled to work based on their payments into a special fund; income maintenance which provides cash benefits to low income families as well as the aged, blind and disabled; child welfare which is directed to the safety and well being of children; health care services to the aged, disabled and individuals and families with low income; and, a variety of services for individuals and families with special needs relating to such conditions as mental illness, addiction to substances, developmental disabilities, and other medical diagnoses. The federal government directly operates several of the major income and health care insurance programs (Social Security and Medicare) along with the income maintenance program for the elderly, blind and disabled (the Supplemental Security Income (SSI) program and allocates funds to state governments to operate the others under federally established guidelines and requirements. Each state must develop and submit a plan to the federal government to receive such funds which must detail the methods and means by which a specific program will be operated.

Units of government have three fundamental options by which a particular service may be delivered reflecting the choices outlined above. As noted, the
responsibility for delivery may be delegated to a nonprofit or non-governmental organization. In the United States, these latter organizations have the following characteristics and requirements:

- They are registered with the federal and state governments with a stated charitable, educational or religious purpose or mission;
- They are granted exemption from taxes for income received relative to the charitable, educational, or religious activities in which they are engaged;
- Individuals or private entities receive deductions from taxes they would otherwise be required to pay for any donations made to these organizations;
- Limits are imposed on nonprofits as to political activities and lobbying with lawmakers and other elected officials;
- They are governed by an independent board of individuals who are essentially volunteers and not compensated for their service;
- The governance board or board has a self generated membership and thus selects its own members, defines lengths of terms and leadership responsibilities; and,
- Periodic public reporting relative to financial activities, status, board membership and other activities is required at regular intervals.

Religious or faith based organizations have special restrictions on the receipt and use of public funds. The U.S. constitution requires a separation of church and state and generally speaking such funds may not be used by such organizations for proselytizing individuals to a particular faith or to serve or hire only individuals of that faith in the course of providing a designated service.

Another choice would be to delegate the operation of a specific service to a proprietary or for profit organization. Such entities are organized to provide a financial return on investment for owners or investors, are not exempt from taxes, can retain or distribute profits made from the delivery of delegated services to owners or investors, are self governed by a Board and chief executive officer or owner, do not have the same limitations on political activity or lobbying as nonprofits, but are subject to governmental regulations in other spheres of their activities.

U.S. History and Trends in the Auspice of Delivery of Human Services

The U.S. has enjoyed a long history and culture of private charitable giving and the organization and delivery of human services by nonprofit and faith based organizations. A major change occurred during the administration of U.S. president Franklin Delano Roosevelt in the 1930s with the passage of the Social Security Act. This law, as amended through the years, shifted the focus to public or governmental leadership in the organization, financing and delivery of a broad swath of health and human services. This Act continues to serve as the anchor, statutory basis and financing vehicle for the health and social welfare safety net for U.S. citizens including Medicare, Medicaid, Supplemental Security Income, child support enforcement, child welfare and other critical services and benefits.

Over time, and at an uneven pace, the pendulum has swung back in the other direction. The federal government still directly operates several of the critical programs but has delegated or devolved responsibility and authority for major programs to the state level. The states in turn have delegated the responsibilities associated with operating a number of major programs and services to the private sector – both to nonprofit and for profit organizations. In addition, as a matter of public policy, the nonprofit role has emerged to be a complementary partnership relationship with government. The view of this role holds that nonprofits meet the health and human services needs of citizens not provided for by government and serve as a viable entity to
deliver government services. Economic and workforce trends have driven this arrangement as public sector workers unionized at a far greater rate than those in other sectors; and, negotiated enhanced salary and benefits to the point that the costs of providing services and benefits could be accomplished for considerably less cost by the nonprofit sector.

In addition, political thinking and values in the U.S. focused on crafting “a smaller and smarter government” which fueled an expansion of privatizing public services. A former U.S. President, George W.H. Bush, for example, spoke of his vision of “one thousand points of light” or an array of private and religious organizations to meet the needs of citizens outside of government intervention. Influential authors such as Osborne and Gaebler suggested the role of government as “steering the ship of state” and suggested that “rowing the ship” (or actually delivering health and human services) should be the role of the private sector. Finally, the second President Bush pressed successfully for the expansion of faith based services permitting the greater entry of religious organizations, with fewer restrictions, into the provision of basic governmentally funded services. The practice was called “charitable choice” and required if a government were to use such an organization for such services, they would be required to offer citizens a non-faith based alternative for the same service. Such services include drug and alcohol use counseling and treatment, housing development, job placement and others.

During this same period foundations and umbrella fundraising organizations developed further and continue to fund health and human services. Umbrella fundraising entities such as the United Ways, Associated Health Charities, and Jewish Federations have regional organizations throughout the United States, raise money directly from private sources, and uses a volunteer based planning and allocation system to distribute funds to nonprofit organizations to meet the ongoing and emerging needs of area residents. Foundations, another form of nonprofit organization, have grown in significance as funders of the health and human services as well. Major donors will create such entities for the purpose of carrying out the donor’s social welfare agenda by providing grants to nonprofit organizations in a manner that provides significant tax advantages to the donor.

In the more recent past, and particularly as the economy has become more service oriented, for profit organizations have greatly expanded their role in the delivery of public health and human services. For example, many states have contracted out the operations of correctional facilities to for-profit organizations. In a growing number of states – and now recently in New Jersey – for profit corporations are expanding their role in the ownership of hospitals and related health care facilities. Many states have privatized significant components of their safety net programs: child welfare, child support enforcement, mental health, developmental disabilities, public assistance and others. Medicaid, the largest health care program serving the nation’s poor, has been contracted out in the vast majority of states to private, for-profit, managed care corporations.

A relatively new development is the creation of groups of interlocking corporations (overlapping management and/or governance) some of which are organized as nonprofits and others of which are incorporated as for profit. In some of these instances, government may contract with a nonprofit to deliver specific services. The nonprofit, in turn, may subcontract certain aspects of contracted work (financial management, real estate services, transportation, etc.) to the interlocking or subsidiary corporations. It appears that new forms and variations on the traditional nonprofit and for profit forms are rapidly evolving. The benefits of these forms permit a profit making venture to donate earned profits to a nonprofit entity under the same umbrella of corporations thus minimizing or eliminating any tax obligation.

As a former senior state official as noted above, I gained firsthand experience in the privatization of formerly governmentally operated services. My experience in these matters has led me to conclude that privatization is not inherently good or inherently bad. The critical factors of distinction relate to what specific services are selected for privatization, how the transition from public to private auspice is managed, what forms of performance management and accountability are employed, and what controls are put in place and exercised to safeguard the public treasury and those that are most needy and vulnerable who require the privatized service.

Strategic Considerations in Determining the Auspice of Service Delivery

The first step in any privatization process would be to review the relevant research literature. There is a growing body of research that relates to the efficacy of specific types of health and human services and factors that affect successful implementation, access and quality of service. The process of ana-
lyzing whether or not to privatize provides the opportunity also to modify the service in content and delivery in ways that comport with research findings.

Another key task is to determine the core competencies of the government in a particular jurisdiction. What are the government’s history and strengths in service delivery? What type of workforce does it historically attract and what types of tasks and activities are done well and which ones are problematic?

For example, in the U.S. government entities have a long history of determining the eligibility of individuals and families for a wide array of services and benefits. Whether eligibility is determined by a means test (level of applicant income and/or assets compared to an established standard), medical diagnosis, or membership in a particular group, this activity or task has long been within the province of government. In addition, specific services that involve elements of social control such as child protection, child support enforcement, services to the seriously and persistently mentally ill, services to individuals with profound developmental disabilities, child support enforcement and custodial services for residents of certain residential and correctional institutions have also been traditionally operated by government. Conversely, services involving complex or specialized technology and related competencies may often be in the exclusive domain of the private sector.

Despite the fact that many entry and mid-level governmental employees often receive greater total compensation than their counterparts in the private sector, there are high skill areas requiring advanced levels of education for which market forces drive compensation levels for such positions above what government might accommodate. These include services requiring advanced specialty area education and expertise in fields such as engineering, architecture, medicine, law, information technology and others.

Simply because a governmental jurisdiction has a history of performing a certain function, this does not necessarily mean the competence does not exist or could not be developed in the private sector and the reverse is true as well. A decision on this issue requires a strategic assessment of both sectors.

Another factor that should be examined relates to what would be the specific advantages of engaging the private sector in delivering a specific service. In today’s economy, relative cost usually emerges as a primary consideration. As noted, the unionization of public employees in the U.S. has driven up the costs of delivering services in the public sector. Public employees generally in many states earn higher salaries and enjoy a richer package of fringe or ancillary benefits than the private organizations would provide or support. Some would argue that when government retains a monopoly on certain services, the lack of competition allows cost to rise inordinately and stifles innovation and creativity.

Measuring the relative difference in costs in weighing privatizing a specific service should include all related current and future costs. For example, using the example of a child care program again, let us say that that it costs the government $200 per week to provide child care for each toddler in a state operated program. A review of proposals reveals that a private organization has offered to provide this same service at $150 per week per child served. The savings to government might be then calculated as $50 for week for each child. If the program serves 50 children, that would represent an annual savings of $130,000.

What the preceding calculation misses however is the social welfare benefits that might consequentially be necessary for those public employees who would lose their jobs as a result of the privatization. In the U.S., for example, this could include the cost of unemployment insurance benefits, Medicaid health insurance, public cash assistance, supplemental nutritional assistance and others for affected workers. Further, the processes required for downsizing in the public sector often have high morale and productivity costs for non-affected employees. Thus, given the preceding, the cost analysis underlying a decision to privatize a public service should consider the full and true cost of each alternative.

Cost over time is also a significant factor. Experience in numerous jurisdictions has revealed that private organizations may initially propose and accept a very low reimbursement rate to attract government to enter into an agreement to privatize a specific service. Over time, the governmental jurisdiction may become dependent on the private organization for the specific service thus creating an opportunity for the private provider to take advantage of this dependency and raise rates for services to excessive levels. In addition, there may be additional services or adjustments in contract services required that may not have been envisioned at the initiation of the relationship, thus creating a situation in which the private organization could charge excessive rates for service modifications or additions. The best protection here for government would be to anticipate as many possible vari-
lations or supplemental services that might be necessary prior to any agreement and include the negotiated cost for these within the final agreement.

A key strategic consideration is whether or not there is a robust and competitive private market for the service considered for privatization. Competition among many eligible and appropriate providers will contain costs, provide alternatives to government and give more control in contract management and negotiations. With this in mind, many public hospitals and residential institutions have privatized food service for patients and residents. Preparing and distributing meals is not necessarily a core competence in government in the U.S. and there is a competitive private and robust market for this purpose.

Government must also consider initially and over time developments in the marketplace relating to mergers and acquisitions of firms providing the types of services under review for privatization and other market factors that reduce competition. Consolidations of vendors may reduce marketplace competition and limit the power and control government can exercise over the private provider. There may be other regulatory authority government may exercise to prevent excessive consolidation and market control by any single provider.

An example of the above referenced problem was experienced by the state of Tennessee in the U.S. Tennessee was an earlier innovator in the provision of health care insurance and bid out the management of its Medicaid and allied programs to private managed healthcare insurance companies. A number of companies initially participated giving service recipients the choice as to which health insurance plan to join and providing a competitive market enabling the state to better control costs and services. Over time, due to market forces, the field of providers narrowed to a single one thus reducing the state’s control over both program costs and the range of services available to participants. This latter factor rendered the state vulnerable to litigation enforcing the rights of recipients to receive certain services.

Another key factor to consider is the capacity of the state to successfully execute and manage the privatization of a specific service. The latter activity requires the strategic planning, assessment and business skills necessary for this effort to succeed such as:
- The ability to create and manage a competitive process among providers in a manner that results in competitive price and quality of the privatized service;
- The need to create and successfully negotiate a legally binding contractual agreement that requires the provider to provide the service at the levels of quality and comprehensiveness specified;
- The capacity to effectively monitor performance of the provider, ensure accountability and require corrective action when necessary and appropriate; and,
- The ability to critically analyze contract outcomes and incorporate what is learned into successor contracts with providers to improve future services and results.

**Critical Issues in the Implementation of Privatizing Public Services**

**Selecting the Method**

An initial determination must be made as to method by which the government will organize and finance the privatized health or human service. For example, in the U.S., government utilizes four primary methods for this purpose. These include (1) cost reimbursement, (2) unit cost, (3) managed care and (4) payment for performance and/or outcomes. The choice to be made has critical implications for the cost, quality and accessibility of the services to be provided.

Cost reimbursement (1) is an arrangement in which the government and the provider structure reimbursement for services provided based upon the costs the provider can document as necessary and appropriate to deliver the services. This would include the creation of an agreement containing a budget reflecting the unique and specific costs for employee compensation, occupancy of facilities, equipment, furniture, travel, training, consumable supplies and related items necessary and attributable to the delivery of the specific services. Once the services are initiated the provider would then send periodic invoices to the government seeking reimbursement for the costs incurred for that period consistent with the referenced budget. This type of agreement has been the historical basis by which government has secured many human services for its citizens. The advantage of cost reimbursement relate to the predictability of costs, expenses and reimbursements for both government and the provider. The disadvantages are the labor intensity of management (reporting requirements, modifications, etc.), and the lack recipient choice (usually in this format a particular provider has a defined geographic area and population).

Unit cost (2) arrangements are ones in which the government conducts market research and fixes a standard cost for a particular service. Approved pro-
Providers are only reimbursed when they can document that a specific service was provided to an eligible recipient. There is no guarantee as to a total or aggregate amount of payments to any provider over a given period of time. The advantage here is that with a sufficient amount of participating providers, service recipients are empowered with choice in the market thereby driving competition and quality. With certain forms of service, recipients may require training and information to assist them in navigating the market and making choices as to providers that are in their best interests. From the provider standpoint, unit cost competition introduces an element of financial risk. For example, if a provider does not attract a sufficient number of recipients to serve, the reimbursements from government may not be sufficient to cover costs thus rendering them unable to meet financial obligations. In this system, providers thus need to focus on marketing their services and satisfying their customers. Government correspondingly needs to focus on establishing adequate, market-based reimbursement rates that are periodically reviewed and adjusted as necessary; and, to assure that an adequate numbers of providers are engaged so that access to the service is maintained in all covered geographic areas.

Managed care (3) approaches represent one of the more recent developments in the arena of privatized public services. This form of care and financing originated in the healthcare industry and is being applied to a number of other types of services including child welfare, developmental disabilities, behavioral health and others. The basic concept involves organizing a key field of services such as health care by engaging managed care organizations (MCOs) to offer eligible recipients a full array of services in a coordinated or managed framework deemed necessary in that field to achieve the desired outcomes for recipients and control costs at the same time. Thus, a participating MCO, with government oversight, would be required to:

- Enlist and engage a broad array or network of individual provider organizations;
- Define the length, scope, content and duration of services to be provided;
- Establish market-based rates to compensate participating providers; and,
- Designate a single locus or authority for the coordination and management of recipient services often referred to as a case manager to assure recipients receive just the services they need to achieve the desired outcome.

Managed care may be provided on what is referred to as a “risk basis”. This means that the MCO would be provided a uniform and recurring flat payment or capitated rate for each eligible recipient enrolled in their program. The MCO receives that same payment irrespective of the actual costs in serving a particular recipient. If the group of enrolled recipients incurs more costs than the aggregate of capitated payments received, the MCO suffers a financial loss. Conversely, if less cost is incurred than the aggregate payment the MCO received, a profit is realized. The financial or business dynamic of this form of organization that is believed to be advantageous in healthcare, for example, is that effective MCO’s can both maximize the health of the recipients and be profitable at the same time. MCO’s that effectively arrange for the delivery of primary and preventive healthcare services to recipients may thus avoid the greater expense associated with more serious illness and hospital care. Also, management of services is viewed as necessary to prevent duplication of service and the provision of unnecessary services and procedures.

An effective application of managed care requires an actuarial assessment for the establishment of the individual capitation rate to be paid the MCO. This rate should encourage economies and efficiencies not discourage needed care; and, in fact, provide the financial incentive to provide the most effective range of services. Managed care provides the advantage to government of predictability of expenditures, cost control and not needing to deal individually with engaging and monitoring the performance of the scores of organizations that make up the partici-
pating MCO’s provider network. It also provides a market base for provider rate setting by taking this activity out of the sphere of government which could be affected by political considerations.

For MCO’s, there is the financial risk described above but also an enhanced opportunity for profit. Providers will likely be subject to the collective power of the MCOs as regards the establishment of reimbursement rates and the course of treatment for recipients. They may well control of pricing their services and face serious competition and pressure to join MCO networks. Managed care has the advantage for consumers of facilitating access to individual services they require in a coordinated manner in an otherwise highly complex and fragmented marketplace. Critics would state that the emphasis is more on managing costs than managing care. Consumer or recipient choice is limited in many cases to those providers that are in the network of the MCO. Practices such as requiring “prior authorization” to access more costly services also serve to constrain choice and access in certain instances.

Managed care is attractive to government as it provides elements of predictability and control over costs and delegates to MCO’s the sometimes contentious and labor intensive process of provider engagement, rate setting, monitoring performance and managing recipient relations.

The last general format (4) is that of paying for performance or outcomes. In this arrangement, the government only pays the private contractor when agreed upon outcomes are achieved. Thus the provider receives no payment for work done that did not achieve the identified outcome regardless of any costs that may have been incurred.

One of the traditional criticisms of social welfare programs is that they measure process rather than outcomes. For example, an organization may get paid for providing 15 hours of counseling to 100 individuals with substance use disorders and that payment is made without regard to the effect or outcome of that counseling.

An example of pay for performance or outcome would be a national company in the U.S. that specializes in placing public welfare recipients in unsubsidized employment. They will agree to the arrangement that the government refer welfare recipients and only pay the provider when referred recipients become employed and pay again at the six and 12 month intervals subsequent to employment if the former recipient maintains the job for those periods of time. Thus the provider is responsible for any and all training, placement and support services associated with the defined outcome.

This format has not yet proliferated in the U.S. Often times it is difficult to define or a single appropriate outcome for a broad group of individuals. For example, the goal in serving individuals with serious and persistent mental illness is to provide services and supports in the least restrictive living arrangements in which the individual can maintain wellness and recovery. This often means independent community living. Yet for reasons not always under the control of the provider, the recipient may decompensate and become a danger to self and others. If providers were only paid for the desired outcome (unrestricted community living) a negative financial dynamic might evolve that may enhance the risk to recipients – providers might not seek or delay hospitalization of the recipient when necessary to increase or extend payments. The concept has never widely been implemented in its broadest form as discussed above, but in a number of contracts, bonus payments are made if providers achieve certain pre-determined performance benchmarks. Performance benchmarks here might refer to numbers of individuals served, timeliness of service or other agreed upon outcomes that are believed to be hallmarks of quality services.

The pay for performance or outcomes approach is attractive to government as payment is in fact linked to outcomes providing far greater clarity around performance and return on investment. Payment levels must be carefully developed to help organizations offset the cost of unsuccessful interventions and significant thought must be given to develop and define outcomes to be achieved and the pricing or payment structure to employ.

There are some special risks for recipients in the above described model. There are clear financial disincentives for providers in serving those individuals with the greatest needs and requiring the highest investment of services and support. From the provider standpoint, why invest time and resources with an individual whose “success” is questionable? Why not just skim out those who have already made some level of success on their own and just need modest support to succeed? Using the example of the organization placing welfare recipients in employment, the concern might be referrals of individuals with some modicum of education and work experience would be prioritized and those without would not be served.

**Protecting the Interests of the Most Needy Recipients**

Recipients that have the greatest need,
whose problems or issues are acute, whose required services may be the most expensive or labor intensive, or who present other difficulties to providers, may often be at great risk of not receiving what they require and what the contractual arrangement with the provider may stipulate. In addition to how and why that may occur in pay for performance arrangements as noted above, it is also a problem in managed care settings as well. The practice of “adverse risk avoidance” in the managed healthcare domain is one in which eligible recipients with chronic health conditions which are expensive to treat may be actively discouraged from enrolling in a particular MCO. Further, abuse of prior authorization for more costly services may occur so that the process of receiving authorization to obtain the required service may be made onerous to the point of effectively discouraging the recipient. Cost reimbursement providers may similarly avoid such eligible recipients and unit cost providers may not be given an adjusted rate to accommodate additional costs for service. Using child care as an example, if a unit rate cost is established for the service, a family with a child with a disability may find difficulty in locating a provider willing to incur the extra work and possible expense of serving the child and meeting any special needs without some sort of additional support. Government entities need to address this issue in any and all agreements with private organizations for the delivery of health and human services and employ effective monitoring of services to prevent or minimize this problem.

**Rate Setting and Payments to Private Organizations to Deliver Public Services**

In order to protect public funds and the recipients of public services, governments must assure that funds paid to private entities for the delivery of public services are sufficient in amount to assure quality, are based on market research, and are not excessive so that unreasonable profits accrue to provider organizations. Market research is essential to determine fair rates and payments for these purposes and monitoring of rates and contracts is also necessary to achieve this end. Inflationary costs must be accommodated on a periodic basis to prevent deterioration of the content and quality and the numbers of recipients served.

Establishing and overseeing at risk, capitated managed care services with MCOs represents a special challenge. It is essential in this instance to carefully and judiciously establish capitation rates and adjust them over time as costs vary due to factors beyond the control of the government or the provider. For healthcare contracts, the utilization of consultant actuarial services is highly recommended. Further, to prevent excess profiteering by MCO’s, a number of governments have employed what are called medical loss ratios which limit the percentage of payments received by the MCO from the government that may be used for profit and administrative expense. Anything above that designated percentage is required to be either reinvested in recipient services or returned to the government. On the other hand, some governments have incorporated what are referred to as stop loss provisions into MCO contracts to provide for additional payments to the MCO under certain conditions if the magnitude of financial loss for the MCO exceeds a pre-established level. These contractual limitations can provide reasonable limits to profit and losses to protect both government and private providers in this financial risk-based context.

**Conducting an Effective Procurement Process**

Governments strive to obtain the highest quality of public services for the lowest possible cost from highly qualified provider organizations. In order to achieve this end, governments must administer a competitive, effective and disciplined procurement process. This process should incorporate the following:

- The development of a detailed document representing a solicitation of proposals for the quantity, quality, scope and duration of the precisely defined services desired to be procured on behalf of service recipients;
- A process that distributes and communicates that document to potential providers;
- Establishment of standards for eligible providers—specific requirements for demonstrated financial and service capacity, history of providing the solicited service, etc.
- Standards and expected outcomes for service delivery;
- The submission of detailed proposals by eligible providers incorporating the means and methods by which services would be delivered and any all costs to be reimbursed;
- A process to review proposals that effectively compared likely quality and costs associated with each application submitted by provider organizations;
- An objective decision to be made for provider selection based upon demonstrated capacity of the applicant organization, responsiveness of the proposal to the solicitation issued by the government, history of the organization in de-
Subsequent to the execution of an agreement or contract for the privatized service, responsibility and authority must be clearly vested in the unit of government and a specific governmental employee responsible for monitoring the implementation and performance of the private organization. This unit and individual should:

- Receive and examine any and all fiscal and programmatic reports generated by the provider relevant to the privatized service;
- Visit and examine any facilities utilized by the provider for service delivery;
- Obtain feedback on an organized basis on private provider performance from stakeholders such as service recipients, other governmental employees overseeing or conducting allied forms of service and any organizations serving the same recipients for other purposes;
- Analyze the diversity of provider employees and service recipients to assure nondiscrimination by the service provider;
- Identify and address any problems or issues in service delivery especially involving recipient access to services and service quality;
- Require the provider to take corrective action as may be necessary;
- Review and approve provider invoices for payment;
- Periodically brief higher level employees of the governmental unit of provider performance and issues; and,
- Recommend whether or not the contract or agreement with the private provider should be renewed at the expiration of the initial specified term.

Individuals charged with the above responsibilities should have the training, experience and expertise necessary to perform the specified responsibilities. Approaching this work with an attitude or approach of teamwork and problem solving rather than authority and enforcement is often more successful. Maintaining open communication with the provider, other stakeholders, service recipients and allied professionals and organizations is essential as is carefully reviewing and analyzing all reports relating to contract performance especially including those relating to contract deliverables and invoices for payment.

**Summary and Conclusion**

There is no general rule as to which public services might be best operated by either public or private organizations. The answer in each case requires a strategic analysis and individualized determination based upon the content of the service, the capacity and history of public and private entities in its delivery, the relative costs of delivery of the relevant public and private entities; and, the culture, tradition and values of the people of the governmental jurisdiction.

Experience has shown that introducing marketplace competition and applying controlled market forces in managing public and private health and human services enhances quality of services and helps contain costs. Empowering recipients with choice of provider can achieve these same ends. Unregulated and unaccountable monopolies of health and human services operated in either the public or private sectors have the opposite effects. Further, there are no inherent reasons why not to utilize for profit providers as well as nonprofit or nongovernmental organizations. Government can utilize either type of organization and effectively control cost and quality using the tools and processes described above.

Effective privatizations involve relatively sophisticated strategic and business planning activities. In addition, governments must develop the business management capacities to effectively implement privatizations in a manner that assures quality and controls cost. Serious thought should be given to independent evaluation of service impact on a periodic basis. Such efforts should obtain and utilize the voice of service recipients as to their direct experience with the service and the provider organization.

Successful privatizations of health and human services can result in higher quality services at lower cost, further the tradition of public/private partnerships; and strengthen civil society. It is hoped that policies and procedures outlined in this paper will hope both governments and private providers achieve these ends.
References


