Insight Health Advisors
Results Through Partnerships

# PRIVATE CAPACITY, PUBLIC PAYMENT:

## Private business participation in government initiatives to improve access to critical health services

Insight Health Advisors

June 22, 2016

# Overview

- Introduction
- Study design
- The case studies
- Key findings
- Recommendations

# INTRODUCTION

# Background

- Market systems approaches are gaining credence
- Many examples of successful private health businesses reaching scale while serving the poor and underserved groups
- Developing country governments have put in place a range of mechanisms to harness the private sector
- The experience has been mixed

*"There are many tools available to harness the private sector. But several governments not only the lack the skills needed to implement them but also do not have the skills to identify and engage the private sector. MoHs do a terrible job in reaching out to the private sector and promoting these government programs."*
*- Key informant from the World Bank Institute*

# Our study

- To explore **policy initiatives or mechanisms**
  - To pay private providers to deliver health services
  - Examples include contracts, subsidies or grants

- To document the experience of both the public and private actors
  - Detailed case studies of these policy mechanisms
  - Three focus countries of **Kenya, Uganda and India**

# STUDY DESIGN

# Focus areas

The case studies explored:

## Private health business perspective

- Barriers in learning about and participating in policy initiatives
- Strategies used to partake in government policy initiatives
- Specific skills and capacities needed to qualify for these government programs

## Government perspective

- Role governments can play to facilitate greater private sector participation
- Barriers in engaging private sector

# Study design

- Used a ***market systems lens***
- Focused on policy mechanisms where
  - Purchaser is a national health insurance fund, a national ministry of health, or a sub-national government
  - Payment mechanism is a contract, grant or subsidy, or health insurance
- Focused on eligible private providers
  - Both not-for-profit and for-profit entities
  - Medium-size and exhibit potential to scale
  - Serve low-income or underserved groups
- To the extent possible, focus country examples that are not dependent on donor financing

# Analysis plan

## Step 1: Literature Review

- Synthesize insights about health markets
- Identify policy mechanisms
- Identify specific examples of the initiative in target countries (India, Kenya, Uganda)

## Step 2: Key Informant Interviews

- Business managers
- Government officials
- Development partners
- Health market experts

## Step 3: Analysis & Dissemination

- Synthesize findings from interviews and literature
- Draft final report and policy brief
- Disseminate study findings

Advisory panel input

# THE CASE STUDIES

Kenya, India and Uganda

# Policy initiatives and country examples

| Policy type | Description | Country | Program |
|---|---|---|---|
| **Vouchers** | • Demand-side financing mechanism<br>• Transfers earmarked subsidy to an individual or household<br>• Voucher barer exchanges voucher for a defined package of services from designated service providers<br>• Provider is reimbursed by voucher agency for services delivered | Uganda | Maternal health voucher program |
| | | Kenya | Output-based Aid (OBA) program for reproductive health |
| | | India | Gujarat Chiranjeevi Yojana |
| **Government health insurance (GHI)** | • Public insurer contracts health providers to deliver defined package of services to scheme members<br>• Typically institutionally separate from the insurer<br>• Providers can be public or private<br>• Focused on GHI with a pro-poor focus | Kenya | National Hospital Insurance Fund |
| | | India | Rashtriya Swasthya Bima Yojana (RSBY) |

# Policy initiatives and country examples

| Policy type | Description | Country | Program |
|---|---|---|---|
| **Co-location /placement of lab and diagnostic services** | • Private entity enters into a contractual relationship with government facility<br>• Locates its operations in a government health facility<br>• Private operator refurbishes, equips, and staffs operations and pays "rent" for space<br>• Public facility negotiates an affordable price and/or links payment to GHI | Kenya | Lancet laboratories' placement of laboratory center in two public hospitals |
| | | India | B Braun PPP for dialysis equipment in Andhra Pradesh |
| **Service delivery contracting** | • Formal agreement between the government and private provider<br>• Private provider manages and/or delivers health services | Uganda | Service Level Agreement with FBOs to deliver a wide range of health services including inpatient care |
| | | India | Suvarna Arogya Suraksha Trust (SAST) in Karnataka |
| | | Kenya | Contracting of emergency services from Kenya Red Cross by Kisii County |

# KEY FINDINGS

# Key challenges faced by private providers

- Literature and case studies revealed range of challenges
- We have organized them into 4 categories
  - Information deficits
  - Weaknesses in management and business capacity
  - Insecure funding environment
  - Differences in organizational cultures
- Key informant interviews confirmed these challenges
- They also brought up one additional challenge which is underemphasized in the literature – corruption and fraud

# Information gaps

| Gaps discussed in the literature | What we heard from the key informants |
|---|---|
| MOH and private providers do not widely share information with each other | *"The challenge is that the [PPP] Act has not been widely disseminated and is not accessible, which has led many to view it as mysterious. In some cases, it is completely misunderstood and misinterpreted by both government and private sector players."* (Manager of a private health business, Kenya).<br><br>*"The insurer sometimes rejects cases for reasons that are not made clear to the provider."* (Private health provider, India) |
| Mechanisms / fora to facilitate communication between government and private actors are either absent or weak | *"For a partnership to work, there is a need to invest in the process right from the start, by setting clear expectations from all the partners, and establish a communication process that is easy, accessible and agreeable to all partners."* (Health markets practitioner, Kenya) |

# Management challenges (1)

| Gaps discussed in the literature | What we heard from the key informants |
|---|---|
| Government lacks institutional capacity and technical expertise to manage the contracting process | *"There are too many layers of protocol…"* (Private health business manager, Kenya)<br>*"It took [the national insurer] a while to contract facilities because it did not have sufficient number of staff to go through the paperwork."* (Government official health insurance agency, Kenya) |
| Private providers lack technical knowledge and skills, particularly contracting and financial management | *"There were many, many facilities…but lots of them did not even meet the minimum standard [for contracting]."* (Voucher Management Agency officer, Uganda)<br>*"Capitation is new to many of the providers. They need to improve their financial management systems."* (Government official health insurance agency, Kenya) |
| MOH fails to apply good practices from prior experiences in contracting of social services | *"Capitation is a good idea…but it has been difficult to implement."* (Government official in health insurance agency, Kenya)<br>*"Government leadership in terms of incorporating PPP into policy frameworks is still lacking. It doesn't seem to recognize that 80% of healthcare is consumed in the private sector..."* (Private sector umbrella body representative, India) |

# Management Challenges (2)

| Gaps discussed in the literature | What we heard from the key informants |
|---|---|
| MOH unable to create and manage competition in health markets<br><br>Difficult to create level playing field when gov't is both regulator and provider of health services | *"Private sector players felt the program was unfair. The reimbursement levels were the same at first. Private players felt they were investing more and spending more, while public sector [facilities] get input-based subsidies."* (Private provider, Kenya)<br><br>*"Regulation is often used to subdue the private sector. The district medical officer is supposed to supervise private providers; but there is a conflict of interest here since he represents the interest of the public providers. We need an independent body."* (Representative of a private sector umbrella body, India) |
| Performance monitoring by MOH the weakest link in the partnership. | *"We need to learn how to use clinical audits better in management and quality improvements."* (Government official, India)<br><br>*"Service providers were serving ghost clients, providing ghost services and thus necessitated [the PMU] to have very tight and elaborate systems to track service provision. This is labor intensive."* (Officer from the Voucher Management Agency, Uganda) |

# Insecure funding environment

| Gaps discussed in the literature | What we heard from the key informants |
|---|---|
| Gov't under-estimates costs for service delivery by private providers | *"The reimbursement [were] not high enough to attract large private providers."* (Private health provider, Kenya)<br>*"Rate revision ought to be frequent, but that is not so easy to do."* (Government official managing voucher program in Gujarat, India) |
| MOH does not comply with contract terms and fails to consistently pay on time | *"Some providers have lost enthusiasm for the program because of the payment delays. Half have dropped off."* (Private provider participating in voucher scheme, India) |
| Donor financing can be unpredictable | *"Related to the uncertainty of contracts is the perception that donor funds are not guaranteed after each contract period."* (Private provider participating in voucher scheme, Kenya) |
| High transaction costs<br>• For gov't to ensure compliance<br>• For private providers to establish systems and procedures to manage contracts | *"Voucher programming is laborious to manage – resource and time wise."* (Official from VMA, Uganda)<br>*"[In selecting private partners, the government actor] has constant dialogue with the providers. This does add to the workload… In subsequent schemes, we have opted for a Third Party Administrator to ease this burden."* (Government official involved in voucher program in India) |

# Differences in organizational culture

| Gaps discussed in the literature | What we heard from the key informants |
|---|---|
| Mutual distrust and suspicion arising from differences in interests and motivations | *"Many activists oppose PPPs. They argue that government is reneging on its responsibility and public money is being diverted to private providers. They often cite malpractice examples to discredit the private providers. But malpractice – and poor quality – is a problem at public facilities too." (Private provider, India)*<br><br>*"People within the ministry have different perceptions of working with private providers. Some recognize that private providers account for 50% of total providers in the country. Hence they want to partner with the private sector. Others feel like public facilities are not as good as their private counterparts, and government should be investing public funds to improve the public facilities so they are at par." (Government official, Kenya)* |
| Differences in working style | *"Working with government takes time."* (Private health provider, Kenya)<br><br>*"There are too many layers of protocol to navigate for private partners to engage with government. Similar layers exist with regulatory bodies as well."* (Private health business manager, Kenya) |

# Corruption and fraud

| Types of fraud | What we heard from the key informants |
|---|---|
| Fraud on the part of the providers | *"Some providers were charging under the table."* (Government official, India)<br><br>*"Ghost claims are a problem."* (VMA official, Uganda)<br><br>*"We are trying to clamp down on hospitals extracting additional funds – 'co-payments' from program beneficiaries even though they are not supposed to pay anything out of pocket."* (Government official, India) |
| Fraud on the part of the beneficiaries | "Some rich families are wrongly benefitting from subsidies for the poor" (Government official, India) |
| Alleged corrupt practices on the part of the government | *"The engagement process was made more difficult by the greed by individuals to benefit from the project. The attitude is widespread across all levels – government officials at national and sub-national level, fellow professionals, and health facilities."* (Private health business manager, Kenya) |
| Collusion between government officials and providers to submit fraudulent claims | *"Local branch officials collude to bypass the quality requirements, as well as inflate claims for services provided."* (Official from government health insurance agency, Kenya) |

# RECOMMENDATIONS

# Governments

- **Consult more with the private health sector**
  - Increasing evidence on benefits of public-private dialogue
  - Proven strategies to foster dialogue and align public and private sectors
  - Widely share and adopt PPD best practices
- **Move towards *formal* policy arrangements**
  - Include private sector providers in policy design and implementation
  - Create standardized procedures to increase transparency and predictability
  - Make information on how policies work more widely available
- **Adopt best practices in designing/managing service contracts**
  - Include clear steps to resolve conflict between partners
  - Use monitoring data to benchmark features of a service contract
- **Invest in gov't capacity to administer the new policy tools**
  - Build MOH staff skill in these new tools
  - Hire new staff with a different skill base and technical profile
- **Address funding insecurity**
  - Conduct costing studies to understand funding levels needed
  - Set aside sufficient funds
  - Automate claims processing

# Private Providers

- **Actively pursue the MOH**
  - Seek opportunities to dialogue and interact with the government
  - Learn about government's perspective on private sector's role in the health
  - Ask about MOH about new policies and future partnership opportunities
- **Organize into representative bodies**
  - Follow countries examples and establish representative bodies
  - Perform important functions such as market research, monitor health markets, and negotiate terms of a government contracts
- **Build organizational capacity to become an effective partner**
  - Private provider also need administrative and management capacity
  - Strengthen financial and administrative systems
  - Better understand own costs and how to manage them
  - Train their staff in key areas related to contracting

# Development Partners

- **Strengthen MOH capacity to strategically purchase health services from private providers**
  - Provide technical assistance to MOHs to establish the policies and organizational arrangements needed for contract management
  - Build MOH capacity to implement and manage the tools of government
- **Assist the private health sector get organized as a sector**
  - Help private providers form associations and organizations
  - Building these groups to become mature associations
  - Strengthen private provider capacity for contract management
- **Implement a market systems approach to TA**
  - Approach differs from traditional donor programming
  - Is less a directive and more facilitative role
  - Occasionally requires “priming” the market
  - But is temporary with goal of exiting the market to foster long-term self-sustainability

# International health practitioners

- **Support MOH to better understand the private health actors**
  - Integrate private sector data into research and program design
  - Include private sector when providing technical assistance
  - Invite and involve private sector stakeholders to technical workshops, conferences and briefings
- **Work with promising private sector interventions**
  - Learn about sound practices increasing likelihood private business financial success
  - Contribute to growing knowledge by documenting examples of successful business models and policy approaches that reach the poor
  - Disseminate learnings from country examples
- **Retool one's thinking on policy tools and implementation**
  - Embrace public/private mix as a vision for the health sector
  - Understand the differences between policies to manage a public health network and stewarding a public/private mixed system
  - Learn about other country successes in ToG (e.g. contracting, vouchers, health insurance) integrating and strengthening the ***whole*** health system – not just public health services

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## Thank You!

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