Private capacity: public payment
Private business participation in government initiatives to improve access to critical health services

Report

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June 2016
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Acknowledgements:

This report presents findings from a research project called Private Business Participation in Government Initiatives to Improve Access to Critical Health Services implemented by Insight Health Advisors to study policy initiatives through which governments pay private providers to deliver health services to men and women living in poverty in Kenya, Uganda and India. The project is funded by the BEAM Exchange, which serves as a platform for sharing knowledge and learning about market systems approaches for reducing poverty and is supported by the UK Department for International Development and the Swiss Agency for Development and Cooperation.

The authors thank the BEAM Exchange, especially Jodie Thorpe, Mar Maestre and Mike Albu for their support. We also thank Meghan Bruce Kumar, who was instrumental in designing the project during its inception phase, and Dr. Nelson Gitonga from Insight Health Advisors for their inputs. We are grateful to all the advisory panel members for sparing time to review and guide our work. Last but not least, this work could not have been possible without the key informants we interviewed for the case studies. We thank them for generously sharing their views with us.
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### Abbreviations and Acronyms

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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<tr>
<td>BEAM</td>
<td>Building Effective and Accessible Markets</td>
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<td>BPL</td>
<td>Below poverty line</td>
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<tr>
<td>DFID</td>
<td>Department for International Development</td>
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<td>GHI</td>
<td>Government Health Insurance</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human immunodeficiency virus/acquired immune deficiency syndrome</td>
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<td>IFC</td>
<td>International Finance Corporation</td>
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<td>ITNS</td>
<td>Insecticide Treated Nets</td>
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<td>KW</td>
<td>The German Development Bank</td>
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<td>KRCS</td>
<td>Kenya Red Cross Society</td>
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<td>LMICs</td>
<td>Low and middle income countries</td>
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<td>M4P</td>
<td>Markets for the Poor</td>
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<td>MCH</td>
<td>Maternal child health</td>
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<td>MM4H</td>
<td>Managing Market for Health</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>NHIF</td>
<td>National Hospital Insurance Fund</td>
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<td>NHIS</td>
<td>National Health Insurance Scheme</td>
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<td>OBA</td>
<td>Output based aid</td>
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<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PPP</td>
<td>Public Private Partnerships</td>
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<td>PPP-HK</td>
<td>Public Private Partnerships in Health-Kenya</td>
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<td>RSBY</td>
<td>Rashtriya Swasthya Bima Yojana</td>
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<td>SAST</td>
<td>Suvarna Arogya Suraksha Trust</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>TOG</td>
<td>Tools of Government</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VAS</td>
<td>Vajpayee Arogyashree Scheme</td>
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<tr>
<td>VMA</td>
<td>Value for Money</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Executive summary

Private health companies often do not understand government policies designed to engage the private sector. Moreover, they often lack the skills and capacity to qualify to participate in these initiatives. This research project focuses on policy initiatives used by governments in low and middle income countries (LMICs) to pay private health providers to deliver health services to the poor. It seeks to provide new thinking on the financial opportunities available to private health care providers through such government policies, and the challenges they confront in trying to participate in these policy mechanisms. The knowledge resulting from this research programme will help private health providers in LMICs become more viable, and reach scale as well as inform governments on strategies to make their policies targeting private health practitioners more effective. Moreover, the research will guide governments on strategies to make their policies targeting private health providers more effective, and guide market practitioners on the type of market interventions that make health services more accessible to the poor.

To capture the dynamics between public and private health providers, the research team used a health markets approach to guide the selection and analysis of mechanisms or policy tools that governments use to engage private sector players. Through a detailed desk review of existing studies and databases compiling examples of market-oriented health programmes as well as interviews with experts, we developed four policy case studies:

(1) health vouchers
(2) government health insurance schemes
(3) co-location of healthcare services, and
(4) service contracting.

For each policy type, we explored country examples from Kenya, Uganda, and India using both published documents and key informant interviews. The literature review and qualitative interviews revealed several areas where government and private providers experience challenges when trying to work together. Firstly, there is an information gap resulting from government and private providers not sharing information, as well as the absence of established mechanisms or frameworks to facilitate these information flows.

Secondly, weaknesses in management capacity on both sides pose a critical challenge for formal contractual engagement. Government agencies and private providers lack technical knowledge and skills in all aspects of contracting, financial management, and performance monitoring. Moreover, ministries of health (MOH) in many LMICs often play a dual role of regulator and provider of health services, which impedes their ability to fairly regulate private providers and manage competition.

Thirdly, insecurity in the funding environment impacts the implementation of government policy mechanisms for engaging private providers. The government budget process introduces annual uncertainty and, to make matters worse, governments often under-estimate the costs of service delivery by private providers and delay reimbursements or contractual payments. Many health programmes in LMICs rely heavily on donor financing, which ebbs and flows thereby introducing additional uncertainty.

A fourth type of challenge stems from a mismatch in organisational styles and differences in priorities and motivations between government institutions and private providers. For example, the private sector finds government processes to be slow and bureaucratic. These four areas are discussed extensively in the literature.

A fifth challenge – corruption – emerged as a critical issue in the key informant interviews even though it is relatively under-emphasised in the literature. The case studies highlighted four types of corruption: fraud on the part of private providers, corrupt practices by government purchasers of services, fraud committed by beneficiaries, and finally...
collusion between any of these actors.

Based on the interviews, we offer the following recommendations to government, private providers, development partners, and market practitioners:

**Governments**

- **Consult more with the private health sector.** A lack of communication between the public and private sectors fuels mistrust and competitiveness. There is increasing evidence from other economic sectors, as well as developed country ministries of health that strategies for fostering greater dialogue and alignment between both sectors, can be more widely shared and adopted.

- **Move towards formal policy arrangements that include standard operating systems and procedures.** Governments should consider including private sector providers in policy design, creating standardised procedures and templates that will increase transparency and predictability, as well as making information on how policies operate more widely available.

- **Integrate best practices into policies and procedures.** In addition to learning the mechanics of how to implement a policy tool, it is equally important to take note of the best practices. Learned with time and experience these include designing service contracts with clear steps to resolve conflict between partners, using monitoring data to benchmark important features of a service contract, and automating key functions to decrease transaction costs. Including best practices increases the likelihood of a policy tool’s effectiveness.

- **Invest in government capacity to administer the new operating systems.** To effectively use the different tools of government, MOHs will need to invest in building skills in them. MOHs may also need to hire staff with a different skills base and technical profile.

- **Address funding insecurity.** It is critical for a government to assure private providers that they will get paid and on time or else they will struggle to attract partners to their policy mechanisms.

**Private Health Providers**

- **Actively pursue the MOH.** The private sector can seek out different opportunities to engage and interact with governments to: better understand their perspective on the private provision of health; learn about new policies that will directly affect the private health sector; and future opportunities for partnership with the government.

- **Organise into representative bodies.** Following the example of countries like Uganda, Tanzania and Kenya, private providers in developing countries should establish representative bodies that can perform important functions for their members, such as conducting market research, monitoring health markets, and negotiating terms of government contracts on behalf of their members.

- **Build organisational capacity to become effective partners.** In addition to having clinical expertise, a private provider also needs administrative and management capacity to respond to tenders and to manage government contracts. Private providers can take the initiative to strengthen financial and administrative systems, better understand and manage their costs, and train their staff in key areas related to contracting.

**Development Partners**

- **Strengthen MOH capacity to strategically purchase health services from private providers.** Development partners can provide technical assistance to developing country MOHs to establish the policies and organisational arrangements needed for contract management and build their capacity to effectively implement and manage government tools.

- **Assist private health providers to organise as a sector.** Areas of support include helping private firms form associations and organisations, building
these groups into mature entities that effectively represent the private sector in policy and planning, as well as strengthening private provider capacity in contract management.

- **Use facilitation approaches to support better communication between public and private actors.** Information gaps and poor communication were common challenges across the case studies. This can be addressed through both formal mechanisms for public-private dialogue, and support for more effective communication at different levels of the system.

- **Avoid distorting markets and creating funding uncertainty.** Market distortion is a particular risk in the health sector where the provision of goods, subsidies, and grants are common. While there are times when it is appropriate for donors to make direct interventions in order to achieve critical public health objectives, donors should understand how their programmes may impact health markets (e.g. crowding out), weigh the health benefits with the long-term sustainability consequences and include an exit strategy from the outset of the project.

- **Patience and flexibility are the keys to programme success.** Market systems programmes in other economic sectors have shown that facilitating change takes time, often more than six to ten years. Achieving short-term impacts need to be balanced with indirect interventions that take time but produce lasting benefits for the health system and men and women living in poverty.

**International Health Practitioners**

- **Support MOH to better understand private health actors.** When conducting research or providing technical assistance, take the time to gather information on private health sector activities, integrate private sector data into research and programme design, and invite and involve private sector stakeholders to technical workshops, conferences and briefing.

- **Work with promising private sector interventions to share successful business practices.** The literature identified sound practices that increase the likelihood that a private health business will succeed financially. Health practitioners can play a critical role in documenting and disseminating learnings from successful business and policy models.

- **Rethink the approach to policy tools and their implementation.** The international health community needs to think in terms of using government policy tools to strengthen the whole health system – not just public health services.
1. Introduction

Working with the private health sector has gained credence among health policymakers over the past two decades (Forsberg, et al., 2011; The World Bank, 2013), as evidenced by the World Health Assembly resolution from 2010 calling upon member states to “constructively engage the private sector in providing essential health-care services” (World Health Organization (WHO), 2010). At the same time, there are a growing number of examples of successful private for-profit companies that have reached scale while serving poor and under-served groups (The Innovation Working Group Task Force on Sustainable Business Models, n.d.), such as LifeSpring Hospitals in India and the International Medical Group in Uganda (Centre for Health Market Innovations, n.d.). Several donor programs have pioneered tools and methodologies to help private sector businesses with a social mission become commercially viable and therefore more sustainable; the World Bank’s Health in Africa program, the Strengthening Health Outcomes through the Private Sector project funded by the United States Agency for International Development (USAID), and the African Health Markets for Equity project funded by the Bill and Melinda Gates Foundation and the Department for International Development (DFID) of the United Kingdom are just some examples of such initiatives.

While developing country governments have put in place a range of mechanisms to engage the private sector to help reach the men and women living in poverty, preliminary examination shows that a market-based approach to health differs considerably from market-based approaches in other sectors. These differences include a heavy reliance on donor funds; fragmentation and diversity of private sector entities and the government providing extensive regulation, often while also being a service provider in health markets. Interviews with health market experts and practitioners (see quotes in Box 1 below) reveal that even when governments have put in place policies to harness the private sector, many private health companies are struggling to participate in them. Few studies have been undertaken to understand the private sector’s perspective on the opportunities and barriers to participating in government health schemes in low- and middle-income countries.

Against this backdrop, Insight Health Advisors initiated a research project called Private Business Participation in Government Initiatives to Improve Access to Critical Health Services to study policy initiatives through which governments pay private providers to deliver health services to the poor in Kenya, Uganda and India. This research sought to address the problem that private

Box 1. The challenge of developing effective health markets

“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, World Bank Institute.

“Our [social franchise] outlets are not very flexible… and they don’t have strong business skills. [Having] these would give them a foot in the door [in terms of] being included as a reimbursable provider by National Health Insurance.” – Key informant, Population Services Kenya.

“One of the biggest challenges is the fluidity of the health market. Conceptualizing and planning are key but it does not guarantee success. There are many players and factors involved, all of which are out of our control.” – Key informant, Fountain Trust
health companies often do not understand government schemes designed to engage them and/or lack the skills and capacity to qualify to participate in these initiatives. Its goal is to build on the work done by other projects and programs focused on public private partnerships in health to explore the financial opportunities available to private health care providers that serve the poor and under-served groups through government policies, and the challenges they confront in trying to participate in these policy mechanisms. We believe that the knowledge resulting from this research program will help the private health providers in low and middle income countries become more viable and reach scale, inform governments on strategies to make their policies targeting private health providers more effective, and guide market practitioners on the type of market interventions that make health services more accessible to men and women living in poverty.

The research focuses on government schemes or policy tools used to pay private health care providers to deliver health services to the poor men and women. Through detailed case studies of these initiatives that draw from examples in Kenya, Uganda and India, the project’s three focus countries, we explore the following topics:

• Barriers private health businesses face in learning about and participating in government schemes
• Strategies that successful private businesses have employed to participate in government initiatives to deliver health services
• Specific skills and capacities needed for private health businesses to qualify for these government programs
• The role governments can play to facilitate greater private sector participation in delivering pro-poor health services.

This technical report is organised into 6 chapters. In chapter 2, we present the theoretical framework that grounds our research approach. In chapter 3, we describe our research plan in more detail. This chapter discusses the policy tools and country examples we explored. Chapter 4 presents the key findings that emerged from our research about the kind of barriers that impede the government from harnessing private actors. In chapter 5, we present recommendations on how these challenges can be addressed. Chapter 6 offers some concluding thoughts.
2. Theoretical Framework

The traditional health policy analysis of developing country health systems focuses almost exclusively on the public sector. It does not acknowledge, despite the evidence, that there is a growing, and in many cases, unregulated private health sector operating alongside the public sector (Harding, unpublished). Most developing countries have, de facto, evolved into mix health systems but the majority of health system and policy research for developing countries do not reflect this new reality. In contrast, policy research in OECD countries acknowledges that their health systems are comprised of public and private actors and therefore include measurements of health markets and private sector activities.

To capture the dynamics between public and private sectors in health, we referred to both the Marking Markets Work for the Poor (M4P) framework as well as the Managing Markets for Health (MM4H) approach, which is an adaptation of the M4P framework, to guide the selection and analysis of mechanisms that governments use to engage private sector health providers. Below, we first discuss the reasons for governments in LMICs engaging the private sector and then describe the two aforementioned frameworks briefly.

2.1. Rationale for Working with the Private Health Sector

Ministries of Health in developing countries, development partners and international health practitioners engage with the private health sector for a variety of reasons. As the text box illustrates, the private sector is comprised of a diverse set of actors, who are active in all areas of the WHO’s health system building blocks including leadership and governance, service delivery, medicine supplies, human resource for health production, health financing, and health information systems.

There is no “right” or “wrong” reason for engaging the private health sector. Moreover, there is no “ideal” public-private mix in a health system. Several factors shape a government’s rationale for working with the private health sector — economic development, political institutions, MOH capacity, and social values and norms (O’Hanlon, unpublished). In short, there is no prescriptive pathway, nor an ideal set of policy solutions or institutional configuration. No matter the reason for working with the private health sector, one of the MOH’s key functions is to develop, in consultation with key stakeholders with a vested interest in the health sector, a vision for its health sector and a strategy for working with private health organisations.

In general, there are four reasons for a developing country MOH, development partner and international health practitioner to work with private health providers, which are described below (see Section 2.3 for an overview of the regulatory and financial policy tools available to implement these strategies).

- **Grow the private health sector in general or in a specific market.** For example, several middle income countries, such as in Eastern European and a few Sub-Saharan African countries, have a small private health sector coupled with growing demand for health. These governments have put into place polices to encourage private sector development with the aim to increase the size and production of the entire health sector (e.g. making the “pie bigger”). These policies try to “level the playing field” by addressing market conditions and biased regulations so as to attract new entrants into the health sector. An example of growing the private sector in a specific market is the MOH objective to establish local manufacturing capacity
for pharmaceutical and other medical supplies. These government policies not only address market barriers but also create financial incentives for the private sector focused on this specific health market.

• **Harness the private health sector in a specific market / system area.** Many LMIC MOHs struggle to deliver quality health services at an affordable price, particularly for the poor and other underserved population groups. In a few instances, it may be more cost-effective for a MOH to harness existing private health providers to fill in these service delivery gaps than to expand their own services. For example, in the state of Karnataka in India, the government realised that 90 percent of all hospital care was delivered by private facilities and so decided to contract these private facilities to provide inpatient services for the poor instead of building new hospitals. In Kenya, several county governments have decided it is more efficient to contract a private operator to run their emergency services than to purchase, equip and operate their own ambulances.

• **Correct the private health sector.** The private health sector has exploded in many LMICs, often faster than the government can put into place the policies and systems to effectively regulate them to assure patient safety. In such situations, the MOH’s goal is to influence private provider behaviour to adopt “correct” practices. For example, unlicensed traditional healers and price gouging on drugs are areas that MOHs in LMICs have tried to “correct” through social regulations and better enforcement. Similarly, the government wants to ensure there is no difference in quality of care irrespective of whether the provider works in the public or private sector.

• **Regulate the private health sector.** With a mixed health system involving both public and private sector actors, it is even more important for the MOH to become an effective regulator. In this setting, the health sector is no longer “government” nor “market”, but instead becomes a system in which the government is with, not versus the market (Colandar R. 2014). This framing acknowledges the symbiotic relationship between public and private sectors, and attempts to influence them, through a variety of regulatory and financial policy tools, to achieve the “right” balance depending on the country context as well as the quality of delivery across the sectors. Regulating the private health sector focuses not only getting the right balance between the two but ensuring key market conditions, such as access and equity, are achieved, which the market alone will not assure.

These strategies are not mutually exclusive and a government can adopt several approaches concurrently. Also, a government’s private sector approach can vary from health market to market. It is important to note that private sector strategies are dynamic, evolving over time as the health system and markets adjust. Development Partners and international health practitioners can support a MOH’s private health sector strategy through financial support and technical assistance to implement the related policy tools of government.

2.2. Markets for the Poor (M4P) Approach in Health

M4P is an approach for studying the way the poor participate in market systems more generally. As shown in Figure 1, a market system is built around many actors. At its heart are the suppliers and consumers of services and the core transaction between them that involves the latter purchasing services from the former. Surrounding them are numerous other actors such as government agencies, civil society groups, private sector actors, and professional associations that are both influencing the rules that regulate market transactions and performing a range of supportive functions (Private Sector Innovation Programme for Health (PSP4H), 2014; The Springfield Centre, 2014).
There are many similarities between health and other economic sectors. In health, there is a wide and diverse range of stakeholders engaged in private health operations (e.g. multiple levels of hospitals, diagnostics and laboratories, pharmaceutical production, supply and distribution, medical training, etc.).

Another is how fragmented and disorganised the private health sector is, with weak representative bodies and nascent membership organizations, making it difficult for the government to engage the private health sector.

However, there are some key differences when using the M4P approach in health. International donor agencies have become market players, dampening competition and crowding out the private health sector in specific health markets (Public Service Strengthening Using Market Systems Development Strategies: M4P and Health in Kenya, Presentation delivered at 9th Annual BDS Conference, Mombasa, November 2013).

In many developing countries, the rules do not create a “level playing field” between public and private providers in many health markets. Often health ministries will design a policy or regulation without actively engaging the private sector to understand reforms that potentially could have a negative impact on the market. In most instances, a LMIC MOH plays a dual role in the health sector, not only setting the rules (regulation) but also delivering health services (supplier), creating conflict of interest when governing health markets. There is also asymmetry of information, created by the fact that the government does not regularly share and exchange health and market information with private providers thereby limiting their ability to align their activities to health priorities as well as to gauge market potential. Governments play a critical role in ensuring access, affordability and quality of health services for all their citizens. MOHs have several policy tools (see next section – tools of government) to achieve these goals.

However, few developing country MOHs have the necessary systems and skills (support functions) to effectively apply these policy tools to produce both health goals and sustainable health markets. For example, many MOH in developing countries do not collect data on the size and scope of private sector activities and are unaware of or do not acknowledge the private sector’s contribution in health. Moreover, MOH staff are often selected for their medical background and may lack skills or training to understand how health markets operate.
or how to shape them. Economic and financing skills to introduce subsidies and/or grants so as not to distort health markets are also limited.

2.3. Managing Market for Health and Tools of Government

Health policymakers frequently debate the relative effectiveness of government versus private action in addressing public needs. Often they overlook the extent to which actual health systems are already solving their problems through collaborative and complementary actions by government and private actors. A MOH can effectively engage private health groups using a variety of instruments – or “tools of government” (ToG) – for public action (Harding, unpublished).

Managing Markets for Health (MM4H) builds a market based approach and focuses on the ToG that enable a MOH and private organizations to join forces to meet people’s health needs. These tools help governments structure a health market, guiding market operation in the public interest. This framework identifies eight tools of government commonly used in health policy and implementation (see Figure 2). The framework distinguishes between finance tools and regulation tools. Regulatory tools rely on government power to compel or prohibit actors to behave in a certain way. Health policymakers frequently use three different regulatory policy tools to manage a mixed health system: i) social regulation, ii) economic regulation and iii) public information. These regulatory tools differ with respect to the purposes they serve and the methods they use.

- **Social regulation** is probably the most widely understood tool in the health sector. Social regulation involves setting rules on individual or organisational behaviour. Examples ensuring food safety, medical provider qualifications, facility requirements, etc. A government administers these rules and sanctions individuals or organisations for non-compliance. In many OECD countries, the government shares this responsibility (co-regulation) with a third party or non-governmental agency such as professional associations.

- **Economic regulations** control the entry and exit of firms, prices, and/or output, aiming to address a market failure to permit market processes to operate more beneficially. These regulations influence a firm’s behaviour. Governments write regulations and deploy bureaucratic processes to influence prices or mark-ups, firm output and entry to/exit from markets. For example, a government may block a hospital’s efforts to acquire the only other hospital in a region which would give them the power to charge excessive prices.

**Figure 2: Health tools of government**
• **Public information** consists of government taking steps to collect and disseminate information that will influence consumer behaviour. Common examples include information and communication campaigns, media disclosures on provider fraudulent behaviour or malpractice.

Health policymakers in both OECD and developing countries use several finance-based policy tools, including entry and purchase contracts, tax regulations, grants and government backed loans, to guide market and/or constrain market operations to achieve health and social objectives.

• **Tax policy** can encourage or discourage certain behaviours by individuals or organisations by diminishing or increasing their tax obligation. For example, a MOH can exempt VAT and import tax on medical equipment not readily available to encourage private investment in purchasing this equipment.

• **Grants** consist of allocation of financial or in-kind benefits to organisations to support their on-going activity. Several international donors offer grant funds and donate medical commodities to faith based and non-government organisations delivering health services to under-served population groups to help them expand access.

• Governments can facilitate access to capital for specific individuals or institutions to encourage a health activity that would achieve a health benefit or build a health market by **loan guarantee** or an interest rate subsidy through a commercial bank. In Kenya, the government not only offered tax relief but also favourable credit terms to a company so they would to build a condom manufacturing plant in response to the HIV/AIDS epidemic. In Tanzania, the government offers loans at favourable terms to students who want to become health professionals.

• **An entry contract** regulates which private organisations are permitted to deliver products or services to an identified group. This mechanism allocates public funding to a target group to purchase a restricted set of services and/or goods. In India, the government sponsored health insurance schemes enters into a contract with multiple providers who are eligible to serve covered patients. This contract, however, does not guarantee each provider a specific volume. Since the money follows the beneficiary, several contracted providers compete for clients based on quality.

• Under a **purchase contract**, the government buys a package of health products and/or services to be delivered to an identified group of people. For example, Tanzania contracts one of the principle faith-based organisations to deliver health services on their behalf in rural areas where there are no public facilities.

2.4. Application of M4P and MM4H Approaches in this Study

We used a *market systems lens* to analyse policy challenges and to make recommendations. Both the M4P and MM4H approaches identify bottlenecks and constraints, to explore their root causes, and experiment as a method to discover what works. The more **traditional approach** to health policy analysis and design is presumptive rather than diagnostic. It starts with strong priors – mental models – about the nature of the problem and the appropriate policy fixes. The assumptions on the factors contributing the problem are accompanied with a long list of reforms - the proverbial “laundry list”. When the reforms fail, the typical response is to push forward rather than question the assumptions. In health, one tends to focus on “best practices”, “rules of thumb” or the latest development strategy. As a result, the recommendations tend to be poorly contextualised (Rodrik, D. 2008).

Moreover, we focused on the financial instead of regulations tools of government, in part, because developing country governments are starting to experiment with these types of policies given the limited success of regulation in governing the private sector. Although it is critical for a developing country MOH to build their capacity to regulate both public and private sector activities throughout the health system, it is a larger task than our research scope. Moreover, there is growing evidence that these
ToG have been more effective influencing private provider behaviours, such as entering into a new market and strengthening quality of care. Also, we are interested to understand how these financial tools of government can encourage private providers to deliver health services to population groups that they do not normally serve - men and women living in poverty and other hard to reach groups. Among the financial tools, we selected grants, entry and purchase contracts because they are more commonly used by governments in health markets compared to tax and loans.
3. Research Methodology

Our approach to the research, comprised of three steps, is shown in Figure 3.

Firstly, we undertook a detailed desk review to synthesise insights from the existing literature about health markets as well as to identify policy tools that developing country governments have used to engage private health actors and to find specific examples of these policies in the study’s three target countries. Secondly, we conducted qualitative interviews with key informant to gather information about the case studies. The third step entailed analysing the data, drafting the technical report, and writing a policy brief for wider, non-technical audience. The research team formed a Delphi Panel to inform and guide all three steps of the research plan. They participated actively in all three phase of the project. Each of these elements is discussed below.

Our target audiences for the research include private health providers in LMICs, government officials in LMICs, donors active in the health sectors in LMICs and practitioners – both market-based practitioners and international health experts – who work in LMICs health. The technical report contains an in-depth analysis of the literature and key informant interviews, as well as recommendations. The policy brief summarises the technical reports findings and recommendations.

3.1. Literature Review and Country Examples Selection

To synthesise existing evidence and identify case studies, the team used the following three approaches (see to annex 1 for more details):

1. Literature review: The research team used different search engines to find articles written on public-private policy initiatives in health. We searched MEDLINE, PubMed, Popline, and JSTOR databases for articles and studies published between 2005 and 2015 with the following keywords/terms: private health sector; private policy formulation; public-private dialogue; public-private partnerships; health contracting; health insurance; vouchers subsidies; primary health care; ambulatory health services; Kenya; India; Uganda; Private health business; commercial health business; sustainable health business.

Figure 3: Overview of the Analysis Plan
also included studies covering multiple countries where appropriate. We used the studies identified to both synthesise existing evidence about health markets and to identify case studies for this study.

2. **Review of the Centre for Health Market Innovation (CHMI) database**: We searched the CHMI database for specific projects showcasing a public-private partnership in the three countries selected using the following filter criteria: “public-private partnership” and “government primary funder”. We then added the three country names India, Kenya and Uganda to this combination in turn. Finally, we used “primary health care” or “maternal and child health” or “emergency response services” filter criteria individually and also in combination to obtain a list of potential projects. We selected these services because they are most relevant for the poor.

3. **Consultation with colleagues**: While the research team found a significant volume of academic literature and current public-private partnership projects in India, there were a very limited number of studies and projects in Kenya or Uganda. The results of various database queries, keyword combinations and reference list searches failed to identify sufficient cases. The research team then turned to colleagues with extensive professional experience or expertise in each country to help narrow the focus, particularly in the case of India where there was a surplus of potential case studies, or to expand the short list of case studies in both Kenya and Uganda.

The text box (overleaf) outlines the criteria adopted to choose the government schemes or policy mechanisms to be the focus of the study. The application of these criteria resulted in the selection of four policy mechanisms linked to the tools of government presented in the prior chapter as well as country examples within each. These are shown in Table 1 and discussed in detail in Chapter 4.

**Table 1: Country Examples and Financial Tools of Government**

<table>
<thead>
<tr>
<th>Case Study</th>
<th>Description</th>
<th>Financial tool type</th>
<th>Country</th>
<th>Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vouchers</strong></td>
<td>A demand-side financing mechanism for transferring an earmarked subsidy to an individual or household. People can exchange the voucher for a defined package of services from designated service providers. The provider is in turn reimbursed by the voucher agency for services delivered.</td>
<td>Entry Contract</td>
<td>Uganda</td>
<td>Maternal health voucher programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Kenya</td>
<td>Output-based Aid (programme for reproductive health)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>India</td>
<td>Gujarati Chiranjeevi Yojana</td>
</tr>
<tr>
<td><strong>Government Health Insurance</strong></td>
<td>Insurance schemes wherein a public insurer contracts health providers, which are typically institutionally separate from the insurer and could be either public or private, to deliver services to scheme members. We are particularly interested in GHI schemes that have a pro-poor focus</td>
<td>Entry Contract</td>
<td>Kenya</td>
<td>National Hospital Insurance Fund</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>India</td>
<td>Rashtriya Swasthya Bima Yojana</td>
</tr>
<tr>
<td><strong>Colocation</strong></td>
<td>A private entity enters into a contractual relationship to co-locate its operations in a government health facility. The private operator refurbishes, equips, and often staffs operations and may pay &quot;rent&quot; for the space. The public facility negotiates an affordable price and/or links payment to GHI.</td>
<td>Service Contract</td>
<td>Kenya</td>
<td>Co-location of Lancet laboratory services at Moi hospital in Voi</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>India</td>
<td>Placement of dialysis equipment by B.Braun in a teaching hospital</td>
</tr>
<tr>
<td><strong>Service Agreements</strong></td>
<td>A formal agreement between the government and private provider to either provide management and/or health services</td>
<td>Grant and or Contract</td>
<td>Kenya</td>
<td>Contracting of emergency services by the County Government of Kisii</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>India</td>
<td>Suvama Arogya Suraksha Trust (SAST) in Karnataka</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Uganda</td>
<td>Government grants to faith-based organisations delivering health services</td>
</tr>
</tbody>
</table>
3.2. Qualitative Data Collection

We conducted 30 interviews with key informants to gather information about the case studies as well as expert views on health markets. Table 2 below shows the different types of key informants interviewed. The interviews were conducted either face-to-face or by phone. The interviews were semi-structured in format, where we used a discussion guide to elicit insights from the key informant.

Table 2: Qualitative Interviews Completed

<table>
<thead>
<tr>
<th>Respondent type</th>
<th>Number of Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior managers for private healthcare businesses</td>
<td>14</td>
</tr>
<tr>
<td>Government officials</td>
<td>9</td>
</tr>
<tr>
<td>Leadership of associations representing private health sector actors</td>
<td>3</td>
</tr>
<tr>
<td>Development partners (World Bank, IFC, USAID, DFID, etc.)</td>
<td>2</td>
</tr>
<tr>
<td>Market systems practitioners (e.g. Springfield, Kenya Markets Trust)</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
</tr>
</tbody>
</table>

3.3 Advisory Panel

We convened an advisory panel consisting of ten members to guide and inform our research. Although the panel members share many of the same characteristics as those of the key informants, the members were not part of the group interviewed for the research. Annex 1 contains a table that lists all the advisory panel members, their institutional affiliation and geographic location. We reached out to the panel three times in the course of the project to get their input on the research design and case selection, preliminary findings, and the draft report.

Box 2. Criteria for Case Study Selection

- The scheme represents a finance policy tool wherein government agencies like national MOHs or government health insurance agencies or subnational governments are funding PFP or PNFP organisations to deliver health services. The government may co-finance the programme with a donor or through a loan from a donor.
- The government exercises considerable control over the programme even if they have contracted third parties to perform the purchasing function or other management responsibilities.
- The policy entails the government paying private providers using grants, service contracts, or entry contracts.
- The policy targets the poor.
- The policy is in use in more than one of the three focus countries.
- The policy displays potential for application in multiple settings.
- The private organisation(s) is of medium-size and displays potential for scale-up.
At the heart of this study are government schemes or policies wherein the government pays private providers to deliver health services to the poor. This section presents the four case studies, namely voucher schemes, government health insurance schemes, co-location, and service agreements, using country examples from Kenya, Uganda and India. Vouchers and health insurance are examples of entry contracts, while co-location is a type of service contract. Service agreements take the form of service contracts or grants. The country examples are summarized in Table 3 at the end of the chapter.

4.1. Voucher Schemes

Voucher schemes are a mechanism for transferring an earmarked grant or subsidy to a specified population group (e.g. low-income households, poor women of reproductive age, the elderly etc.). Holders of the voucher can exchange it for a defined package of services from designated service providers. The four key actors in any voucher scheme are: the source funding the vouchers which could be a government or a donor, the voucher management agency (VMA), health providers, and target clients for the scheme (Meyer, et al., 2011). The provider is reimbursed by the VMA for services delivered. The VMA typically serves multiple functions including distributing the vouchers, contracting providers, negotiating the value of the voucher, and reimbursing claims. The voucher could be free or sold at a subsidised rate. Voucher schemes remove financial barriers to access faced by target groups. They also offer financial incentives to providers to deliver particular services covered by the voucher. Therefore, they stimulate both the demand and supply of services.

Voucher schemes have been used in the health sector by many countries at all levels of economic development. In the United States, for example, voucher schemes have been used to promote sexually transmitted infections (STI) services, cancer screenings, or primary health care services among low-income groups, minority populations, and migrant workers (Gorter, et al., 2003). In many LMICs across Latin America, Asia and Africa, they have focused mainly on basic health goods and services, for example insecticide treated nets (ITNs); maternal and child health services such as antenatal care (ANC) visits, deliveries, childhood immunisations; and sexual and reproductive health services like STI treatment and family planning (Meyer et al. 2011).

Health voucher schemes are currently in operation in all three focus countries for this study. The programs are summarised below (see annex 3 for more detailed descriptions of the country examples):

- **Chiranjeevi Yojana in Gujarat, India:** The Government of Gujurat (a state in India) launched the Chiranjeevi i in 2005 (wherein the government contracts private health facilities to provide free-of-charge services to poor women. Household living below the poverty line (BPL) are eligible and are issued identification cards, which they can present to access services at empanelled facilities. The government reimburses the providers for services performed.

- **Output-Based Aid (OBA) Voucher Program for Reproductive Health in Kenya:** The OBA program offers poor mothers vouchers to access safe-motherhood, family planning and gender-based violence recovery services from empanelled public and private health facilities. The program is co-financed by the German Development Bank (KfW) and the Government of Kenya. MOH provides oversight and overall leadership for the implementation of the scheme. PricewaterhouseCoopers serves as the voucher management agency (VMA). The vouchers are sold to women living in poverty at a subsidised price and can be redeemed by the women at any empanelled public and
private health provider of her choice.

- **Reproductive Health Voucher Program in Uganda**: In an effort to improve maternal health outcomes amongst the rural and poor populations of Uganda, the Global Partnership on Output-Based Aid and KfW funded the implementation of the Reproductive Health Voucher Program between 2008 and 2012. The voucher enables poor women to access safe motherhood services at enlisted private for-profit and private not-for-profit health facilities. Initially, the program was implemented in six districts, and later, extended to an additional 14 districts of south-west Uganda.

4.2. Government Health Insurance Schemes

Government health insurance (GHI) refers to insurance schemes wherein the government allocates public funds to one or more insurance agencies, which could be public or private, to cover men and women living in poverty. The insurer can enlist either public or private health providers. Several LMICs have initiated new GHI schemes or expanded existing social health insurance schemes to insure the poor (Lagomarsino et al. 2012).

Existing GHI schemes vary along multiple dimensions (Lagomarsino et al. 2012). This includes the manner in which the schemes are financed; in some countries, the new enrollees make a partial contribution and the government covers the remaining costs, while in others the entire cost of the scheme is financed by the government (e.g. Kenya). They also vary in terms of whether participation is mandatory or voluntary and the nature of risk pooling (whether the poor are in a separate scheme or linked with existing risk pools of formal-sector employees). Finally, GHI schemes vary according to who provides the services (public and/or private providers), and how they are paid (fee-for-service, capitation etc.) (Lagomarsino et al. 2012).

The study examines GHI schemes that contract private providers (either exclusively or alongside public providers) to deliver services to the poor who are enrolled in the program. The study includes the following country examples (see annex 3 for more detailed descriptions of the country examples):

- **The Rashtriya Swasthiya Bima Yojana (RSBY) in India**: RSBY is a national health insurance program that is implemented by state governments of India. The scheme covers hospital costs up to Rupees 30,000 (approximately USD 600) for a registered BPL family. The program is financed jointly by the national government and state governments, with beneficiaries paying a small, one-time registration fee at the time of enrolment. The state government contracts insurance companies (either public or private) through a competitive bidding process. The insurance companies are responsible for empanelling hospitals (both public and private), enrolling beneficiaries, claims processing etc., and often contract TPAs and other vendors to handle one or more of these responsibilities. All transactions in the program are cash-less.

- **The National Hospital Insurance Fund (NHIF) in Kenya**: NHIF operates a mandatory social health insurance scheme for Kenyans employed in the formal sector (both public and private). The NHIF package is available to informal sector households on a voluntary basis. Until 2012, NHIF only covered hospital costs. Since then, NHIF has gradually introduced an expanded benefit package that includes outpatient services to all its members. NHIF contracts both public and private providers to deliver health services to its members.

4.3. Co-location

Co-location refers to an arrangement whereby a public hospital – that is fully owned and managed by the government – contracts a private company to operate and maintain a department or a service within its facilities. The goal is to deliver services that the public hospital currently does not have and/or is struggling to deliver according to standards. The terms of the contract and the manner in which the private vendor is remunerated may differ. In some cases, the contract allows the private vendor to charge a "socially" acceptable fee for its MOH clients. Often, the contract stipulates price levels and
services that the private vendor can apply to its customers. Alternatively, the government may agree to purchase a certain volume of services from the vendor at a certain price.

A leading example of co-location is the Pelonomi-Universitas Hospital public-private partnership in South Africa, wherein the state department of health in the Bloemfontein region of the country entered into a 20-year agreement with Community Hospital Management Limited, a private company, to operate a private ward within the public facility. The private company received the use of the space and in return shares a certain portion of the revenue with the government. The study examines two examples of such schemes (see annex 3 for more detailed descriptions of the country examples):

- **Partnership between B. Braun and the Government of Andhra Pradesh in India** for co-location of dialysis equipment: B. Braun, a medical equipment manufacturer provides dialysis equipment at no cost to nephrology departments located in government hospitals in the Indian state of Andhra Pradesh. The private operator trains government facility staff in the use of the equipment and provides refresher trainings when necessary. The private operator also assumes full responsibility and costs for equipment maintenance. The government assures B. Braun a certain number of patients at price designed to allow B. Braun to amortise the upfront cost of the equipment and costs associated with installation, training, maintenance and repair. Patient numbers are enough for B. Braun to not only generate sufficient revenue to recuperate its initial investment and operating costs but to also realise a profit within a calculated time period. Since the MOH pays B. Braun for this service, dialysis treatment is free of charge to the patient.

- **Co-location of laboratory equipment by Lancet Laboratories in a public hospital in Kenya**: An international non-governmental agency called Wildlife Works Carbon, a private laboratory firm called Lancet Laboratories, and Moi District Hospital in Taita Taveta County in Kenya signed a three-way agreement to refurbish and operate a modern, state-of-the-art laboratory at the public hospital. Wildlife Works Carbon financed the renovation of Moi hospital's laboratory while Lancet, to this day, provides training, operational supervision, equipment maintenance, computers and quality assurance services. The hospital staffs and operates the laboratory. Under this partnership, Lancet collects user-fees which are below market rates for laboratory services from MOH patients. The patient pays a "socially acceptable" fee. There is sufficient volume that Lancet is able to not only generate sufficient revenue to cover its operating costs but is also to share a surplus between Lancet (60%) and the hospital (40%).

### 4.4. Service Agreements

Service agreements allow governments to contract out specific services to a private provider. The contracting out of public services originated with public service reforms in high-income countries in sectors such as water, gas, electricity and transportation. In the health sector, contracting was initially used to outsource non-clinical services such as food, laundry and cleaning services. Eventually service contracts are used for clinical services as well. Contracting private providers to deliver primary care has a long history, in some case over 100 years, in several European countries and the United States; for example, the National Health Service in the United Kingdom and the Medicaid program in the United States both use service contracts with private providers to deliver services to program beneficiaries. The service contracting model has since spread to several low and middle income countries, in part due to health reform agendas promoted by donor agencies (Liu, et al., 2004). The study examined examples in Kenya, Uganda and India (see annex 3 for more detailed descriptions of the country examples):

- **Contracting of hospital services for BPL in Karnataka, India**: The State Government of Karnataka issues eligible residents who are BPL cards and automatically enrols them into Vajpayee Arogyashree Scheme (VAS). Eligible
beneficiaries receive free tertiary care at both private and public hospitals empanelled by Suvorna Arogya Suraksha Trust (SAST) an autonomous trust created by the government. Beneficiaries pay no premiums or co-payments at the point of service. As most hospitals are in urban centres while beneficiaries are located in remote villages, empanelled hospitals were required to organise health camps in rural areas to screen patients for tertiary care and transport eligible patients to hospitals. Health camps are part of the contract agreement. Hospitals receive a fixed payment per health camp conducted.

- **Government budget support to faith-based organisations (FBOs) to deliver health services in Uganda:** In recognition of the significant contribution that faith-based organisations FBOs operating health facilities make to the overall health system in Uganda, the Ugandan MOH agreed to support the FBOs' ongoing health activities through a “block grant” called the Primary Health Care (PHC) basket fund. Initially, the MOH allocated 5% of its total budget to support FBOs. Through advocacy and negotiation, this percentage has increased to 17% in 2016. The PHC basket funds guidelines sets clear rules on how the funds are to be allocated according to facility level and geographic location as well as budget line item.

- **Contracting of Kenya Red Cross Society (KRCS) to deliver ambulance services by Kisii County, Kenya:** The County Government of Kisii has contracted KRCS to provide ambulance services to county residents. As per the contract, KRCS supplied and operates a fleet of 9 ambulances, one per sub-county of Kisii. The county pays Ksh. 600,000 per month per ambulance. For that amount, KRCS provides a fully equipped ambulance, which is operated by a trained Emergency Medical Technician (EMT) and a paramedic. KRCS is responsible for fuel and maintenance of the vehicle, and also covers the costs of any medication or consumables used by patients while in the ambulance.
<table>
<thead>
<tr>
<th>Case Study</th>
<th>Country Example</th>
<th>Country</th>
<th>Public Partner(s)</th>
<th>Private Partner(s)</th>
<th>Description of the programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vouchers (entry contract)</td>
<td>Maternal health voucher programme</td>
<td>Uganda</td>
<td>MOH</td>
<td>Marie Stopes International as voucher management agency (VMA); private health providers</td>
<td>The programme sold vouchers for safe motherhood, family planning and STI treatment at a subsidised rate to poor households. The vouchers gave access to services at enlisted private facilities (public facilities were not included). Marie Stopes International, served as the VMA, reimbursing providers based on submission of claims and the voucher.</td>
</tr>
<tr>
<td></td>
<td>Output -based Approach for reproductive health</td>
<td>Kenya</td>
<td>MOH</td>
<td>PwC as VMA; IPA Global to provider quality assurance; enlisted private health providers</td>
<td>The programme offers poor women vouchers to access safe-birth, family planning and gender-based violence recovery services. The aim is to increase access to quality reproductive health services by giving women choice over where to seek services. MOH provides oversight and overall leadership, while PwC manages the programme. The vouchers are sold to women living in poverty at a subsidised price and can be redeemed at enlisted public and private health providers.</td>
</tr>
<tr>
<td>Govt Health Insurance (entry contract)</td>
<td>Gujarat Chiranjeevi Yojana</td>
<td>India</td>
<td>Gujarat govt/ district health depts</td>
<td>Enlisted private providers</td>
<td>The Gujarat Government decided to engage private obstetricians to expand coverage of maternal health services. Below poverty line mothers can enrol for the programme. Contracted practitioners provide free-of-charge deliveries to these women who present documentation of eligibility at the time of service.</td>
</tr>
<tr>
<td>Co-location Services (service contract)</td>
<td>National Hospital Insurance Fund (NHIF)</td>
<td>Kenya</td>
<td>NHIF</td>
<td>Contracted private hospitals and clinics</td>
<td>Kenyans employed in the formal sector (both public and private) make mandatory contributions to the NHIF through automatic payroll deductions. The NHIF package is available to informal sector households on a voluntary basis. The government is currently piloting a health insurance subsidy scheme wherein MOH pays the premium for very marginalised men and women. NHIF contracts both public and private providers to deliver services to its members.</td>
</tr>
<tr>
<td></td>
<td>Co-location of Lancet laboratory services at Moi hospital in Voi</td>
<td>Kenya</td>
<td>Moi District Hospital in Voi</td>
<td>Lancet Laboratories; Wildlife Works Carbon (WWC)</td>
<td>WWC, an international development partner, financed the renovation of the hospital laboratory and the leasing of laboratory equipment from Lancet Kenya. Lancet provides training, operational supervision, equipment maintenance, computers and quality assurance services. The hospital staffs and operates the laboratory. User-fees are split Lancet (60%) and the hospital (40%).</td>
</tr>
<tr>
<td></td>
<td>Dialysis equipment by Braun in a teaching hospital</td>
<td>India</td>
<td>Public Hospitals</td>
<td>B. Braun Medical Equipment</td>
<td>B. Braun provides free dialysis equipment to government hospitals. The company buys, installs and maintains a set number of dialysis machines and is responsible for all consumables at a pre-determined price. It also trains government facility staff to use the equipment and provides refresher trainings. After the contract elapses, the equipment is either replaced or ownership is transferred to the facility.</td>
</tr>
<tr>
<td>Service Agreements (Service Contracts or Grants)</td>
<td>Contracting of emergency services by Kisii County Government</td>
<td>Kenya</td>
<td>County Government of Kisii</td>
<td>Kenya Red Cross Society (KRCS)</td>
<td>KRCS was contracted to deliver ambulance services in Kisii through a fleet of 9 ambulances (one per sub-county). The county pays Ksh. 600,000 per month (US$5930) per ambulance. In return, KRCS provides a fully equipped ambulance, operated by a trained Emergency Medical Technician (EMT) and a paramedic. KRCS is responsible for fuel and maintenance and the costs of any on-board medication.</td>
</tr>
<tr>
<td></td>
<td>Suvama Arogya Suraksha Trust (SAST) in Karnataka</td>
<td>India</td>
<td>SAST</td>
<td>Eligible private hospitals</td>
<td>Eligible beneficiaries receive free tertiary care at both private and public hospitals contracted by SAST, which also runs health camps in rural areas to screen patients for tertiary care and transports eligible patients to hospitals. Health camps are part of the contract agreement. Hospitals receive a fixed payment per health camp conducted.</td>
</tr>
<tr>
<td></td>
<td>Govt grants to faith-based groups</td>
<td>Uganda</td>
<td>MOH</td>
<td>Faith based organisations (FBO)</td>
<td>The Ugandan MOH agreed to support several FBOs ongoing health activities through a “block grant” called the Primary Health Care (PHC) fund. Initially, the MOH allocated 5% of its total budget to support FBOs, increasing this to 17% in 2016. The PHC funds guidelines sets clear rules on how the funds are to be allocated.</td>
</tr>
</tbody>
</table>
5. Key Findings: Challenges to Public and Private Sectors Working Together

Even as governments in LMICs put in place policies to harness the private sector to deliver affordable, quality health services to poor and hard to reach groups, many private providers struggle to learn about these initiatives and are often not in a position to take advantage of them. The literature review and case studies highlighted four key types of challenges: 1) information deficit, 2) weakness in management capacity, 3) insecure funding environment, and 4) mismatch in organisational cultures. Table 4 illustrates how these challenges link to key components of the M4P and Tools of Government in the MM4H approach (see Table 4).

The case studies highlighted one additional area that is relatively under-emphasised in the literature: corruption. This chapter discusses the key challenges that have resulted in this “gap” between the intention of these policies to engage the private sector and private provider participation in the schemes.

5.1. Information Deficits

Information is critical to engaging the private sector and designing effective policies that harness private sector activities in different health markets. The literature and the case studies highlight several challenges in this area, which can be broadly categorised into two types: poor flow of information between the government and the private sector, and the lack of mechanisms to foster and regulate this interchange.

The first challenge – that of government and private sector actors not sharing information with one another – is widespread. Many country governments in LMICs lack basic data on the size and scope of the private health sector (Akhtar, 2011; Tangcharoensathien et al., 2008). A multiple country review found that many MOH only collect service delivery statistics on government facilities and lack basic data on the number and type of private health facilities, making it difficult to engage private providers effectively.

Table 4: Key Challenges

<table>
<thead>
<tr>
<th>Information Deficit</th>
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<tbody>
<tr>
<td>Supporting function - Information</td>
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<table>
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<tr>
<th>Weaknesses in Management capacity</th>
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<tbody>
<tr>
<td>Supporting Function-Skills and Capacity</td>
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<tr>
<th>Insecure Funding Environment</th>
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<td>Financing Tools of Government</td>
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<tr>
<th>Different Ethos / Organisational Cultures</th>
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<tr>
<td>Regulation – Rules and Norms</td>
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</table>
difficult to know who may be a potential private sector partner to deliver critical health services and products (Palmer, N. 2006).

In a few examples, such as contracting for primary healthcare in Estonia, national legislation prevented the state from collecting data on private providers, which hampered the Ministry of Social Affair’s ability to monitor the implementation of contracts and evaluate provider performance (Atun, R. 2004). Furthermore, there is no standard or consensus on what data is to be collected on the private health sector and how it is to be collected (Sabri et al., 2007; England, R. 2008). The lack of information is also common in OECD countries; a review of the UK’s experience in contracting shows that governments need greater local market intelligence (Macmillan, R. 2010).

The flow of information from the government to private actors also presents challenges. The literature shows that many MOHs are inconsistent in disseminating information, particularly about policy reforms, regulatory changes and service delivery goals, to private health providers (Palmer, N. 2006). For example, a study of cooperation between service purchasers and private elderly care and primary health care providers in Finland found that short notice about service changes makes it difficult for the private health sector to plan for resource and staffing needs (Tynkkynen et al., 2011).

Although the MOH may not regularly share information with the private health sector, it is also important to note, that private providers in LMICs are reluctant to share information for fear of increased taxation and other forms of state scrutiny. Another reason often cited why private sector organisations do not report to government is the lack of trust and understanding between them (Hozumi, D. 2009).

Donors and international health experts at times perpetuate the problem of lack of information, albeit inadvertently. When designing donor programs and health, they frequently focus on supporting the public sector, with little regard to the program’s impact on other health stakeholders like private for-profit and not-for-profit providers engaged in a specific health area. The gap analyses they conduct often do not involve information on the private health sector, resulting in interventions only targeting public sector activities. The classic example in the health domain is the condom market. PEPFAR and GAVI donate condoms to many LMIC to battle HIV/AIDS. These donation programs do not take into account the social marketing and private sector products already in the marketplace; the free product “crowds out” these products.

The second common problem related to information is the absence or poor functioning of institutionalised mechanisms through which MOHs and non-state health actors can communicate regularly (Batley and Mcloughlin, 2010; The World Bank 2011). Formal dialogue usually takes place at “set-piece-events” that are one time occurrences associated with policy design and strategy development rather than continuous interactions about policy implementation (Batley, R. and Mcloughlin, C. 2010). For example, in Afghanistan’s contracting-out for Basic Public Health Services, a lack of communication between provincial health directorates and non-profit private providers undermined the Ministry’s efforts to integrate health services and risked inefficient use of critical resources due to overlaps in service provision planning (Siddiqi et al., 2006). And efforts to regularly involve the private sector in decision-making and policy implementation are often stymied by logistical difficulties (Palmer, N. 2006). A report by the World Bank (2011) focusing on African countries found that while nearly half have such mechanisms in place, actual levels of dialogue are low in many places.

These challenges are echoed by the case studies. Key informants in all three countries mentioned the poor flow of information between MOH and private players and vice versa as a problem. Many of the private providers interviewed expressed frustration at the lack of communication from MOH and other government agencies. Even in instances where a MOH has set up a PPP unit, which is the case in all three countries, they have not been effective at channelling information about PPP legislation, partnership opportunities and other government policies designed to involve
private providers in service delivery.

On the flip side, government agencies interviewed struggle with collecting information from private providers even when reporting is stipulated in the contract. The NHIF in Kenya contracts private providers to deliver outpatient services and pays them on a capitation basis. Consequently, providers do not need to submit claims to get reimbursed. However, NHIF would like to collect information on patient volumes, service utilisation etc. in order to monitor implementation of the scheme. The providers view this as an unnecessary burden and NHIF is currently not penalising any for failing to report the information despite the contract requirement. The sole exception is in Uganda where the FBO Bureaus consistently report to the MOH and indeed, the MOH has fully integrated all FBO service statistics into all of their policy and planning initiatives whereas data on the private health providers are not included. Trust and aligned missions are a few of the reasons given why FBOs do not hesitate to report to the MOH. (see Table 5)

Often government schemes paying private providers to deliver services involve a third party, which further complicates the information flow. In the case of the voucher program in Kenya and the health insurance scheme in India, the government contracted out the purchasing function to third parties. In such a structure, the providers expressed concern about the government being disengaged from the management of the program and that they did not have direct channels to the government communicate problems they experienced in working with the third parties related to contracting or the claims.

With support from development partners, many countries especially in Africa, have instituted formal mechanisms for public and private actors to dialogue with each other. For example, key public and private sector stakeholders in Kenya established the Public Private Health Kenya (PPP-HK) as a forum for the government and the private sector to dialogue on health issues. Although PPP-HK has gone a long way in facilitating greater dialogue, it struggles to consistently and regularly bring together key public and private actors to interact together. These kind of information flows are necessary for effective interactions between government agencies and private providers participating in government initiated health financing schemes. First, to be effective, these bodies have to meet regularly which has been a challenge. Second, these fora often tackle high-level policy issues but do not wade into the details of particular schemes or policies that may interest and affect only a small subset of members. Ultimately, creating a single, national-level platform for high-level dialogue between public and private sector stakeholders is necessary but not sufficient to ensure effective communication between the two sectors.

### 5.2. Weak Management Capacity

Irrespective of the tool of government, the

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<th>Table 5: Information gaps</th>
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<td><strong>Gaps discussed in the literature</strong></td>
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<td>MOH and private providers do not widely share information with each other.</td>
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<tr>
<td><strong>What we heard from the key informants</strong></td>
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<td>“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).</td>
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<td>“The insurer sometimes rejects cases for reasons that are not made clear to the provider.” (Private health provider, India)</td>
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<tr>
<td>Mechanisms/fora to facilitate greater communication between government counterparts and private actors are either absent or weak.</td>
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<td>“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.” (Health markets practitioner, Kenya)</td>
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public sector – or in this case a MOH – needs the necessary technical skills and institutional systems in place to effectively design and implement them. At the heart of all the policy instruments under review in this study – vouchers, health insurance, co-location and contracting – is a contract. The success of these financial policy tools hinges on the contracting parties – both public and private – being able to manage the contractual relationship. Weak management capacity on the part of government and private providers manifests itself in many ways.

First, MOHs and other government health agencies in both high and income countries often lack the institutional capacity and technical expertise necessary to manage the contracting process. For example, when New Zealand introduced reform for contracting-out health services in the 1990s, the four regional purchasing bodies had very little technical expertise in generating contracts and were given very little guidance on how to develop contracts (Tynkynnen et al., 2013). Each regional body adopted a different approach that often emulated commercial models. Unfortunately, the inefficient process of determining how to draft the contract extended the time to create a draft to two years in some instances. (Ashton et al, 2004). The governments of both the United Kingdom (UK) and the United States (US) have struggled to institutionalise government capacity to manage contracting (or commissioning) of third party organisations to deliver social services despite such schemes being in operation for many years. Government reports cite a lack of staff with the requisite skills to prepare and negotiate contracts with specific goals against which contractors can be held accountable, monitor compliance with statutes, regulations, and the terms of the agreement, and evaluate contractors’ performance in delivering services, achieving desired program goals, and avoiding unintended negative results (GAO, 1997; Macmillan, R. 2010).

In the same vein, LMICs often lack strong contracting agencies with the basic knowledge, tools and understanding of health service needs, local health markets and sound contracting practices that are prerequisites to successful purchasing. A study examining Estonia’s experience in contracting Emergency Medical Services (EMS) noted one of the key reasons contributing to failure in the first round of contracting was the government’s lack of basic capacity for contracting. Consequently, the government did not perform the necessary analyses to specify realistic goals and estimate true costs for delivering EMS services, nor did they have a clear set of criteria by which to assess the tenders (Lember et al, 2013). In the case of South Africa, lack of technical skills in contracting have often resulted in a complete re-draw of the contract design, effectively doubling the amount of work time (Poole et al, 2015; Palmer and Millis, 2006; Kula and Fryatt, 2013). Some studies indicate that even after substantial time contracting through South Africa’s National Health Insurance, the public sector still has management weaknesses and would benefit from the contracting-in of private sector expertise (Kula and Fryatt, 2013). Similarly, in Afghanistan, evaluation of the government’s large contracting program in health revealed that the MOH was dealing with several overlapping challenges with private providers because of limited exposure to the formal project management processes inherent to contracting (Siddiqi et al. 2006).

While some donors have invested in improving government systems for purchasing services in the context of specific donor-financed programs such as health vouchers, overall capacity for strategic purchasing remains weak. It is worth recognising that badly done contracts can serve the interest of some within government, and consequently there can be resistance to change.

Secondly, the lack of management capacity is not limited to government alone; private sector organisations also lack the skills needed to manage and deliver public social services contracts. Many private providers do not have capacity to submit successful tenders: they are unable to effectively communicate their technical approach; often do not have sufficient staff capacity in terms of number and skills; and, do not demonstrate a knowledge of tender’s outcomes or have mechanisms to measure results (Macmillan, R. 2010). Also, both government and private providers of health and other social services report that overly complex commissioning
and procurement process can overwhelm inexperienced and resource strapped private organisations (Macq et al., 2009; Rohloff et al., 2011; Cristia et al., 2015; Heard et al., 2013; Tynkynnen, L. 2013). Moreover, some private organisations do not have the resources or capacity for undertaking key functions like strategic planning or cost accounting which are necessary to successfully manage public sector contracts (Macmillan, R. 2010). As governments move away from contracting based on relationships and informal cooperative practices to more formal, business-oriented and competitive contracting (GAO, 1997; Macmillan, R. 2010), private organisations also need to create capacity to compete for and manage such contracts.

Although the donor community is increasingly interested in working with the private health sector to address health system gaps or priority health areas, few donors offer technical and financial support to strengthen either the public and private health sectors’ capacity to manage (MOH) or implement (private sector) effective services contracts. Donor funds focus almost exclusively on donating commodities and strengthening the quality of private providers in key health services. In the case of Uganda PEPFAR project, even prohibit the principal private sector partner, the FBOs, to charge an administration fee to manage large sums of funds going to their health network. Although many LMICs, including those in the study, “purchase” health services from private health providers using informal mechanisms, such as a letter of intent, Memorandum of Understanding, service agreement or grant, donors do not include much needed technical assistance to MOHs to strengthen their contracting capacity, in their programmes. Gaps in management capacity came up repeatedly in the case studies. In Kenya for example, the NHIF has launched programs to expand its benefit package to include outpatient services and provide subsidised insurance coverage to the poor. However, they have been slow in enlisting facilities to cater to the needs of these new programs, principally because the departments that handle the contracting do not have the staff needed to handle the increased volume of contracts. In the case of the voucher programs, many small- to medium-sized facilities in both India and Kenya are keen to participate in these schemes, but do not have the internal systems to manage contract requirements. Although the India case studies also demonstrated management weaknesses, both examples show the positive consequences when a government invests in building the systems and staff skill to manage its policy tools. In both the voucher and contracting cases, the state governments invested heavily to design and document contracting policies and procedures, build the contracting management systems, and train government staff in contracting skills.

A third challenge relates to government as a purchasing agent failing to apply smart purchasing practices, which has significant implications on how non-state providers are selected (Keovathanak et al., 2010; Khim and Annear, 2013; Soeters and Griffiths, 2003; Sabri et al., 2007; Waldman et al., 2006; Kemmer, W. 2005; Zaidi et al, 2012; Zaidi et al, 2011). For example, locating the contracting authority closest to the beneficiaries and providers is considered good practice. In Finland, the government has contracted both for-profit and not-for-profit private providers since the early 1990s to deliver primary health care (PHC) and specialty services. Initially, the Finnish government delegated contracting authority to municipality regional health authorities as is common practice in other OECD countries. After over a decade of pressuring small municipalities to merge into larger purchaser agency, the government instituted a formal project in 2005 to restructure the contracting processes and to consolidate purchasing activities to help standardise processes in an attempt to create greater efficiency (Tynkynnen et al., 2013). Making purchasing bodies larger made it more difficult for small prospective bidders to learn about potential contracts. In time, the large contracts have resulted in some provider groups becoming monopolies. (Tynkynnen, L. 2013; Tynkynnen et al., 2013).

Getting “smart purchasing” right has been a key challenge in the outpatient scheme introduced by NHIF in Kenya. While the insurer opted to use capitation to pay providers
following global evidence showing that it is a good way to contain costs, they have struggled to arrive at rates that are acceptable to private providers or to educate the private providers about how capitation works. The voucher programs across the three focus countries for this project have had varying degrees of success in terms of mitigating perverse incentives for private providers to opt for more expensive procedures (specifically, performing caesarian sections rather than normal deliveries because the former has a higher reimbursement rate). While the voucher scheme in India has used bulk purchasing to address this problem (wherein they pay for 100 deliveries at a time and assume a fixed rate of caesarian sections), the voucher schemes in both Kenya and Uganda are still paying for each unit of service delivered and are therefore more susceptible to this problem.

There are several factors contributing to why it is difficult to apply international best practices to strategic purchasing. The first is political: many MOHs are not interested in splitting the provider and purchasing function and want to retain their role as service provider. The second is donor orientation. As mentioned previously, donors are still reluctant to provide the technical experts who can offer MOHs the international perspective and guidance on best practices in contracting. Third, these experts are usually lawyers who daily rates far exceed donor salary caps and as a result, the MOHs hire a different skill base that may not have the wide ranging experience needed. Finally, the two sides rarely see eye to eye on the costs of the services being purchased.

A fourth challenge relates to governments knowing how to regulate a market, especially when they are also playing a service delivery function. A key tenet of using market-based policy approaches is to create competition between multiple providers in order to drive price down and quality up, yet many governments struggle to manage competition effectively (GAO, 1997). Competition can occur when private sector organisations compete among themselves or public sector organisations compete with the private sector to conduct public sector business. Several factors make it difficult to establish and maintain competitive markets with contractors. Government reports from both the UK and the US cite the lack of large numbers of social service providers with sufficiently skilled labour to respond to government bids (GAO, 1997; Macmillan, R. 2010), resulting in the same small number of contractors chasing after government business which can lead to a monopsony. Another factor is the inherent tension between fair, open competition and long-standing links between government officials and contractors which have previously held government contracts (Macmillan, R. 2010). Unfair competition between public and private sector healthcare providers still exist, particularly in LMICs. For example, in Tanzania, the Ministry of Health and Social Welfare introduced contracting through service level agreements and decided to make all public providers automatically eligible, while private providers had to compete for public contracts for health services. Many private providers stated that this practice has created a double standard favouring public health providers over private ones (England, R. 2008).

Creating a level playing field for public and private providers has proved to be challenge in some of the schemes we studied as part of this project. When governments purchase services from both public and private providers, as is the case with the voucher scheme and GHI program in Kenya, the payment schedule has to reflect the fact that public providers receive input-based subsidies from the government (in the form of staff salaries and drugs), while the private providers have to recover all their costs. This balance has not been easy to achieve, leaving many private providers with the perception that they are receiving insufficient compensation. There is also the feeling that while private providers are subjected to inspections before enlistment, public providers are automatically included in the schemes. In the case of the SAST, the Fund managers were clear that their policy objective is not to level the playing field in order to grow the private health sector but instead to supplement government services. In light of these challenges, several private providers emphasised the need to have an independent regulatory body to hold both public and private providers to the same standards. In the most recent round of expansion, the voucher program in Uganda
has put in places measures to mitigate some of these challenges, including using an independent costing exercise to set prices as well as instituting comparable vetting for both public and private providers before they join the scheme.

The final challenge in this area is performance monitoring. These policy initiatives require the government to assess a private provider’s compliance with the terms of the contract, existing policies and regulations, and to evaluate the private provider’s performance in delivering services, achieving desired program goals, and avoiding unintended negative results. Several studies revealed that monitoring performance is the weakest link in public-private interactions as a growing number of governments try to make their private partners accountable for results (Akum, F. 2014; GAO, 1997; Lember et al, 2013; Macmillan, R. 2010). Monitoring the effectiveness of social services programs poses special challenges because social services in general, and health services in particular, have poor performance measurements and indicators. In the absence of a framework specifying program results, US state and local government found it difficult to identify desired results (outcomes) for social services programs and to move beyond a summary of program activities (output) (GAO, 1997).

New Zealand is an example of how a government has successfully created a performance monitoring system that improved performance and fostered “friendly” competition among private health providers (Ashton, et al., 2005). The primary healthcare market was restructured to encourage PHP to organise into Primary Health Operators (PHOs) – a private, third party organisation. PHOs become the unit for performance monitoring. A Health District’s success depended on how well they managed their PHOs’ performance. Each quarter the MOH publishes all the PHC indicators by district. All stakeholders, District Health management, PHOs and the private health providers all knew that their performance was closely monitored. Other OECD are using third parties to monitor health sector performance.

Tracking the flow of funds is one of the most reliable mechanisms to monitor performance as well as ensure accountability (Salamon, L. 2002). The money trail helps determine who is doing what to whom, when and how. It also tells policymakers what they are getting for their money. But capacity to conduct financial analysis on expenditures, revenue, profits and losses is weak. Collecting cost data from publicly provided services is not available while cost data from private providers is not always adequate, making it difficult to compare publicly and privately provided services (GAO, 1997). Moreover, often the amount allocated to service contracts and or new policy initiatives are guided primarily by budget pressures and cost-cutting imperatives instead of a comprehensive analysis of the true cost to deliver a defined package of health services and products (Macmillan, R. 2010).

The case studies further emphasised the challenge of monitoring quality. While schemes where payment follows the patients, like insurance and vouchers, are geared towards tracking the volume of services delivered, assessing the quality of that delivery is much more challenging. In the case of the Kenya voucher program, a private partner was contracted with the sole purpose of monitoring service quality and assisting providers improve over time. While it is a more expensive solution, it is one of the more effective ways of addressing the challenge of quality assurance. Many of the other programs that do not have such an explicit quality monitoring system have instead relied on existing government structures for supervision at the local level or competition between providers to improve quality, which have proven to be less effective. Local government officials in India have numerous responsibilities, and are not able to provide the kind of quality checks that are needed. In many areas where voucher and health insurance schemes operate in Kenya and Uganda, beneficiaries have to choose between two or three empanelled providers. This limits the extent to which consumers can “vote with their feet” and drive providers to improve their services.

Despite the challenges, two country cases were able to set up effective quality assurance mechanisms. In the case of Uganda, the
Bureaus established quality systems that ensured all their facilities complied with government quality standards and regulations. Moreover, they conducted joint supportive supervision with MOH officials. However, the block grants did not adequately fund this critical management function. In the case of Karnataka, SAST developed sophisticated management systems that linked performance to payments. It is important to note that it took years for SAST to design these systems. Moreover, the quality/payment system was initially paper-based and riddled with error and fraud. Once they managed to move to a web-based system, both issues were addressed as well as effective reporting on quality performance of all their contracted providers. In fact, quality performance is one of the key considerations before renewing a private hospital’s service contract.

5.3. Insecure Funding Environment

As the MM4H approach shows, favourable

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<th>Gaps discussed in the literature</th>
<th>What we heard from the key informants</th>
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<td>Government lacks the institutional capacity and technical expertise necessary to manage the contracting process.</td>
<td>“There are too many layers of protocol to navigate for private partners to engage with government. Similar layers exist with regulatory bodies as well.” (Manager of private health business, Kenya)</td>
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<td>Private providers lack technical knowledge and skills in all aspects of policy instrument, particularly contracting and financial management.</td>
<td>“There were many, many facilities…but lots of them did not even meet the minimum standard [for contracting].” (Official from Voucher Management Agency, Uganda)</td>
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<td>MOH fails to apply good practices learned from prior experiences in contracting social services.</td>
<td>“Capitation is a good idea…but it has been difficult to implement.” (Official in the government health insurance agency, Kenya) “Government leadership in terms of incorporating PPP into the policy frameworks is still lacking. It doesn’t seem to recognise that 80% of healthcare is consumed in the private sector. It plans as though government facilities are providing all the care.” (Representative of a private sector umbrella body, India)</td>
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<td>MOH unable to create and manage competition in health markets. Difficult for MOH to create level playing field when government is both the regulator and runs public healthcare facilities.</td>
<td>“Private sector players felt the programme 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) “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)</td>
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<td>Performance monitoring by MOH the weakest link in the partnership.</td>
<td>“We need to learn how to use clinical audits better in management and quality improvements.” (Government official, India) “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 labour intensive.” (Officer from the Voucher Management Agency, Uganda)</td>
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market conditions – including supportive regulations governing market entry, competition and price as well as realistic health regulations fairly implemented across public and private health sectors – are critical. However, financial resources have an even greater significance on a private sector organisation’s ability and interest in participating in policy initiatives, particularly when the government wants to influence private sector behaviour to improve quality and/or serve certain segments of the population such as the poor. Funding certainty has a direct bearing on provider motivation to work with the public health sector. Yet the government flow of funds to private providers suffers from several challenges.

Firstly, despite willingness to undertake new policy initiatives, some governments experience resource constraints and uncertainty in funding, which induces financial insecurity for both the MOH and private healthcare providers (GAO, 1997; Macmillan, R. 2010; Palmer and Millis, 2015; Palmer, N. 2006). For example, the Health Care Board in Estonia initiated the tender process without knowing the size of the budget. Parliament had not passed the state budget and there was no guarantee of funds for the EMS contract. As a result, the government had to cancel the tender when faced with the possibility of cutting the number of ambulances or lowering the quality of care with uncertain funding (Lember et al. 2013). In our case study of service agreements in Uganda, we found that the vagaries of the annual budget process pose a challenge to service agreements.

Secondly, governments or purchasing agents often under-estimate the true costs of the service they are purchasing. In the case of Malawi, the MOH has partnered with the Christian Health Association in Malawi (CHAM) under a Memorandum of Understanding (MOU) since 2002 to deliver key primary health care services in many locations (Palmer, N. 2006). Initially, the government of Malawi directly funded CHAM with a budget line item to pay for CHAM staff. Subsequently, the MOH has moved to service level agreements (SLAs) complemented with free inputs (such as medicines, test kits, etc.) (Ergo et al., 2010). The SLA budgets did not cover the true cost for CHAM to deliver the complete health services package, resulting in annual budget deficits. As a result, CHAM had to find other strategies to address the underfunding that ran contrary to the spirit of the contract. CHAM did not remove user fees, an expected outcome of signing SLAs, and raised drug prices to compensate for having to purchase drugs in the retail market (Chirwa et al., 2013).

Complaints about low reimbursement rates are ubiquitous in the voucher schemes as well as the health insurance schemes we studied. According to the key government informants, this partly reflects the absence of reliable and timely data on the costs of private service provision. In the absence of such cost data, governments or their agents purchasing services are often prone to underestimate the cost in order to conserve budgets. Governments are also slow to revise rates as inflation and other market forces drive up the costs of service delivery.

SAST in Karnataka is trying to address reimbursement rates. They have asked private sector providers to present their costs and negotiate “reasonable” fees. They have also compared their reimbursement rates with neighbouring states to determine if they are under or overpaying for services. Moreover, this year, they are undertaking exhaustive cost studies in both the public and private sectors. Private providers acknowledge that the reimbursement rates are low but have agreed to them because they consider it their social responsibility to serve the BLP at a cost affordable to government. However, the private providers are not willing to use the same reimbursement levels for BLP for the other two insurance programs and are demanding market rates.

The PHC grant to the Uganda FBOs is the most notable case of funding levels not reflecting the true cost of services. By the time the 17% of the MOH budget has been allocated among the four bureaus and across all facilities, the supplementary funds amount to only 5% of a facilities operating costs. As result, the FBOs have had to resort to user fees to recuperate their costs, a policy that runs contrary to their mission and government intention in funding FBOs.
Thirdly, a common financial obstacle for private healthcare providers is late payments. Ghana introduced a National Health Insurance System in 2003, which relies heavily on private healthcare providers to deliver the basic benefits package. Although the law stipulates that healthcare providers should be reimbursed four weeks after claims have been submitted, the NHIS has been notoriously late in paying providers—on average 8 months (Akum, F. 2014). Delays in reimbursement have prompted private providers to take only paying clients and turning away NHIS ones, to send insured clients to pharmacies to pay out of pocket for drugs covered by NHIS (Akum, F. 2014).

Private providers participating in all the voucher and insurance schemes studied mentioned delays in payment being a key challenge for them. In the voucher programs in all three countries, private providers interviewed complained about having to wait for long periods to get reimbursed. These waiting periods far exceed the time stipulated in the contracts and memoranda of agreement that they sign. The introduction of provider payment mechanisms like capitation wherein the provider receives payment in advance has alleviated this challenge in the case of NHIF in Kenya.

Fourthly, international development assistance—a critical source of health financing in many LMICs—suffers from uncertainty and can have distortionary effects on the market. For example, the Afghan government had difficulties in securing long-term contracts with non-profit private providers. During the war, all health service delivery was both funded by international donors and often delivered by international actors, leading to short-term planning and contracting. After the war, local NGOs were unsure of the long-term funding prospects (England, R. 2008). Also, donor funding created competition between externally funded non-profit private providers and publicly funded non-profit providers. The MOH was unable to coordinate services delivered by all non-profit private providers and to grow the private sector capacity to provide sustainable health services (Siddiqi et al. 2006).

Another challenge arising from donor funds is “mission drift”. International donor funds come with a specific health focus (e.g. the United States President’s Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis, and Malaria, two of the largest donors in health, focus on very specific health conditions and fund related interventions), which can reorient an entire program away from the original government motivation for the policy initiative (Palmer, N. 2006).

The voucher programs in both Kenya and Uganda are heavily reliant on donor financing. This has made private providers wary of the schemes. Providers in the Kenya program invested in growing their capacity as a result of receiving heavy volumes of patients from the voucher program. They are now worried about how they will sustain their business once donor financing ends since it is likely that the Government of Kenya will not continue financing the voucher scheme. In the case of Uganda, the medical bureaus have turned to donor funds because the MOH direct budget support is not adequate to help cover their costs. In a few cases, certain donors have stipulated that their funds are not allowed to cover the Bureau’s management and administrative costs and can only go towards specific services. Although helpful, the donor funds do not contribute to the bureaus’ long-term sustainability.
### Table 7: Challenges related to insecure funding

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<th>Gaps discussed in the literature</th>
<th>What we heard from the key informants</th>
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<td>Governments often under-estimate the costs for service delivery by private providers</td>
<td>“The reimbursement [were] not high enough to attract large private providers.” (Private health provider, Kenya)</td>
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<td>“Rate revision ought to be frequent, but that is not so easy to do.” (Government official managing voucher programme in Gujarat, India)</td>
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<td>“[Providers] are always complaining about the rebate rates or the capitation amount [being too low].” (Official from government health insurance agency, Kenya)</td>
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<td>MOH does not comply with remuneration terms of contract and fails to consistently pay on time.</td>
<td>“Some providers have lost enthusiasm for the programme because of the payment delays. Half have dropped off.” (Private provider participating in voucher scheme, India)</td>
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<td>“While payment times have improved over the years, it can still take 2 months even though MOU says 15 days.” (Private provider participating in voucher scheme, India)</td>
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<td>Donor financing can be unpredictable.</td>
<td>“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)</td>
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<td>High transaction costs associated with government having to ensure compliance and for private providers to establish systems and procedures to manage contract.</td>
<td>“Voucher programming is laborious to manage – resource and time wise.” (Official from VMA, Uganda)</td>
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<td>“[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 programme in India)</td>
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<td>“Contract enforcement is difficult at the service level. Some partners do not comply with contract terms as stipulated, requiring NHIF to invest heavily in supervision and partner management activities.” (Government health insurance agency, Kenya)</td>
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<td>“…and we need to learn how to use clinical audits better in management and quality improvements.” (Government official, India)</td>
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Fifthly, both government and private providers experience high transaction costs to participate in the policy initiatives under review. While governments may realise savings from contracting private organisations to deliver social services, these savings may be offset by administrative burdens and additional costs incurred by contractor transitions (e.g. start-up and close-out costs), monitoring contractor compliance and evaluating performance and value for money (GAO, 1997). On the other side, private providers delivering social services also experience “hidden costs” to invest in creating and establishing systems and procedures to manage public contracts (Macmillian, R. 2010).

Private providers also experience transaction costs in participating in public contracts that they do not incur while delivering services directly to patients. In Estonia’s primary health care reform, the MOH’s cumbersome administrative processes and reporting requirements created excessive delays and management costs, limiting the time private provider staff could dedicate to delivering services to patients (Atun, R. 2004). In New Zealand, when the government introduced public contracts, the cost to compete and the delays related to prolonged negotiations made participation by small healthcare providers infeasible (Ashton et al., 2004).

In Uganda, the Medical Bureaus discussed the costs for them to manage a network of hospitals, clinics and health facilities – many of them located in remote areas. Despite the government subsidies and added revenues from development partners, they are still not able to cover their administrative costs to perform many of the functions that make them attractive as PHPs, such as compliance, quality assurance, trained health staff, well-stocked pharmacies, and supportive supervision. In fact, the providers interviewed complained that donors frequently do not acknowledge the administrative costs entailed in running these networks, even as their reporting requirements create additional administrative burdens and costs.

5.4. Organisational Cultures Differences

In as much as public and private sectors are keen to partner, differences in organisational culture as well as a lack of trust often hampers their ability to do so.

Firstly, the two parties have different priorities. Contracting primary health care services in Finland demonstrated the mismatch in the motivations and interests. On the one hand, private providers worry that public contracts inherently reduce competition, limiting their ability to adapt to market changes and earn a profit while on the other hand, government wants to protect beneficiaries’ rights (Tynkynnen et al. 2009). In Ghana, private health providers were initially unwilling to participate in negotiations with NHIS because the contracts failed to incorporate the interests and motivations of both parties (England, R. 2008). Contracting experiences in both Malawi (Chirwa et al. 2013) and Italy (Capellaro et al. 2011) demonstrated the difficulties encountered during the implementation of contracts when each partner fails to comprehend the interests and motivations of the other, often resulting in conflict and partnership failures.

Many LMIC governments are reluctant to work with private – particularly for-profit – healthcare providers because they are distrustful of the profit motive (Hozumi et al. 2008). Various stakeholder groups, such as consumer groups, unions and advocacy groups, raise concerns about the private sector performing social services traditionally viewed as the government’s responsibility (GAO, 1997). In fact, several OECD countries prefer to partner only with non-profit organisations, regardless of capacity or quality, because they perceive their motive to be more aligned with those of the government’s (Palmer, N. 2006). In the US, experts in social service privatisation have expressed concern that contractors, especially when motivated by profit-making goals and priorities, may be less inclined to provide equal access to services for all eligible beneficiaries. Instead, they first provide services to the clients that are easiest to serve, a practice commonly referred to as “creaming,” leaving the more difficult cases to the government to serve or leaving them undeserved (GAO, 1997).
When the Kenya OBA was first being designed, there was considerable opposition within government circles to the idea of contracting private providers. While some within the MOH recognised the importance of partnering with private providers given that they account for nearly 50% of health facilities in the country, others felt that government resources should be used to extend the reach and improve the quality of public facilities. Stakeholders interviewed in India mentioned that there is considerable mistrust of private businesses amongst civil society groups and the media. They do not view PPPs in a positive light but instead cite them as evidence that the government is failing to deliver on its promises and diverting public resources to private actors seeking to maximise profits.

Secondly, government and private providers have different operating styles and organisational cultures. When Estonia decided to contract out emergency medical services, the Ministry of Social Affairs restricted competition to state-owned enterprises. The government wanted to retain significant control over the contract. However, state-owned enterprise staff did not agree to the level of government supervision over day-to-day operations and this may have contributed to the ultimate failure of the first attempt to competitively contract out EMS (Lember et al. 2013). In Guatemala, the government managed its contract with healthcare NGOs as though they were MOH facilities. The NGOs lost much of their autonomy and decision-making ability to change contracted services to better respond to the needs of local populations. Eventually, the NGOs

<table>
<thead>
<tr>
<th>Gaps discussed in the literature</th>
<th>What we heard from the key informants</th>
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<tbody>
<tr>
<td>Mutual distrust and suspicion arising from differences in interests and motivations</td>
<td>“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)</td>
</tr>
<tr>
<td>Differences in working style</td>
<td>“People within the ministry have different perceptions of working with private providers. Some recognise that private providers account for 50% of total provision 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)</td>
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<tr>
<td></td>
<td>“We still have issues with partner hospitals denying treatment to programme beneficiaries. Charitable hospitals and of course public and medical colleges are obliged to take all patients. However, the private for-profit partners refuse to perform certain procedures—although they are not allowed to do this—and send them to public hospitals.” (Government official, India)</td>
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<td></td>
<td>“Working with government takes time.” (Private health provider, Kenya)</td>
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<td></td>
<td>“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)</td>
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lost interest in remaining partners with the government and did not compete when the MOH tendered follow on projects (Macq et al., 2009; Cristia et al., 2015).

Several private businesses interviewed for the case studies cited delays inherent with government procedures and processes as a key challenge. This is in part a result of government procurement rules and procedures that take time. But it also reflects a disconnect in terms of working styles. While public counterparts often prioritise due process and consultation, the private sector is more concerned with efficiency and not divulging too much information to the competition.

5.5. Alleged Corruption

The four sets of challenges presented so far were discussed extensively in the existing literature and mentioned by key informants the team interviewed for this study. There was one additional area that presents a challenge to governments and private actors working together in the health sector, which came up repeatedly in the interviews but was barely discussed in the literature: alleged corruption. The case studies highlighted four types of corruption: fraud on the part of the private providers, corrupt practices on the part of government purchasers of services, fraud committed by beneficiaries, and finally any of these actors colluding to defraud the system.

Key informants interviewed for the health insurance and voucher case studies brought

Table 9: Corruption-related challenges

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<thead>
<tr>
<th>Gaps discussed in the literature</th>
<th>What we heard from the key informants</th>
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<tbody>
<tr>
<td>None</td>
<td>Fraud on the part of the providers:</td>
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<td></td>
<td>“Some providers were charging under the table.” (Government official, India)</td>
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<td></td>
<td>“Ghost claims are a problem” (VMA official, Uganda)</td>
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<td></td>
<td>“We are trying to clamp down on hospitals extracting additional funds – ‘co-payments’ from programme beneficiaries even though they are not supposed to pay anything out of pocket.” (Government official, India)</td>
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<td></td>
<td>“Private providers have a greater incentive to cheat. They often fudge the records to make it seem like certain patients were hospitalised when they weren’t.” (Official, government health insurance agency, Kenya)</td>
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<tr>
<td></td>
<td>Fraud on the part of the beneficiaries:</td>
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<td></td>
<td>“Some rich families are wrongly benefitting from subsidies for the poor” (Government official, India)</td>
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<td></td>
<td>Alleged corrupt practices on the part of the government:</td>
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<td></td>
<td>“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)</td>
</tr>
<tr>
<td></td>
<td>Collusion between government officials and providers to submit fraudulent claims:</td>
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<tr>
<td></td>
<td>“Local branch officials collude to bypass the quality requirements, as well as inflate claims for services provided.” (Official from government health insurance agency, Kenya)</td>
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</table>
up all four forms of alleged corruption. Specifically, they mentioned private providers submitting fraudulent claims. Specifically, they mentioned private providers submitting fraudulent claims. In programs that are meant to target the poor, beneficiaries who are not poor cheat the system by registering as the poor. Government purchasers have been known to ask for bribes or kick-backs to contract facilities or register beneficiaries for schemes. Finally, we heard about collusion between all these sets of actors, for example local officials from the insurance agency and providers. While this study sheds some light on these different forms of corruption affecting health financing schemes, further research is needed into this topic, which is by no means limited to LMICs alone.
6. Recommendations

In the previous chapter, we discussed the challenges that government and private providers face when working together through government-financed schemes to deliver health services to men and women living in poverty. Despite these challenges, it is worthwhile to address them so that LMICs ministries can collaborate with the private health sector to achieve universal health coverage. There is growing evidence that under certain conditions, private health providers can deliver affordable quality health services to poor and under-served population groups (Bhattaacharyya et al., 2010; Tung and Bennett, 2014). Moreover, the government and ministry officials interviewed expressed a commitment and willingness to engage the private health sector. This in part reflects the fact that ongoing discussions in the global health community around universal health coverage has emphasised the need for ensuring that there is a purchaser-provider split within the health system as well as the importance of strategic purchasing to increase efficiency and improve quality. Hence, the time is ripe for health sector stakeholders to address some of the challenges discussed previously in order to pave the way for greater collaboration between public purchasers and private health businesses.

In this chapter we turn to existing and proposed solutions that emerged from the key informant interviews. We have organised them into sets of recommendations for governments, private providers, development partners and health practitioners. Included are references linking the recommendations back to the market systems approach (see italics). In any market system — including health — there are three main sets of functions (listed in text Box 3). In essence, all of these recommendations build all market actors’ skills and capacity to fulfil their respective roles in a health market system.

6.1. Developing Country Governments and Ministries of Health

The study reveals that sound policy design is insufficient to ensure that private sector actors will participate in its implementation. There are several steps that government entities can take to increase the success of their policy initiatives that engage the private health sector.

- **Engage and interact more with the private health sector.** Strengthening dialogue and interactions will address critical bottlenecks in a health system such as information, informal rules and practices and overall buy-in to implement policy and regulations. Private providers interviewed for this study unanimously agreed that there is not enough communication and

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**Box 3. The three main sets of market functions**

- **Market dynamics influencing the supply and demand of health goods and services.** The exchange between supply and demand is conventionally a transaction with money but can also occur through informal payments and/or government subsidies.
- **Rules** set the terms by which all the players participate in a specific market as well as shape market performance. Rules include informal rules and norms, formal regulations, guidelines and laws, and practice and are essentially the domain of government agencies and/or representative bodies (which can also be a non-state entity). Their capacity to enforce the rules is as important as the rules themselves.
- **Supporting functions** are a range of tasks, such as coordination between the sectors, sufficient financing and subsidies, adequate infrastructure, research and development, skills and capacity and information, required to develop and grow a health market system.

(Source: Bruce, 2014)
interaction between the public and private health sectors. The lack of communication, scarce opportunities to meet and discuss health sector issues, and the need for both sectors to share information continues to fuel mistrust and competitiveness between the public and private sector. There is increasing evidence from other sectors as well as developing country ministries of health on how to foster better relations, to encourage dialogue and align both sectors to work towards national health goals. Best practices common to effective public-private dialogue platforms include:

1. Create a formalised, consensus-driven mandate and align public and private institutions with it.
2. Build an organisational structure with technical and political capacity.
3. Create a balanced representation between the sectors so that actively cooperate together.
4. Foster leadership by a core group of public and private champions who "own" and "drive" the PPD process.
5. Create a learning partnership that uses data to make decisions, inform the dialogue process and demonstrate visible results (IUCN, 2012; Tennyson, 2005; Herzberg, B. 2006).

Many European countries have established formal consultative relationships between the government and non-profit sectors to help build trust, mutual understanding and shared values on the health system. In many cases, this takes the shape of formal channels of consultation and joint policy development. A good example is the German health system which is based on the principle of solidarity, resulting in “sector neutral” policies in hospital markets. Social Health Insurance managers meet regularly with private provider representative organisations to review standards, permitted rates for reimbursements and negotiate modifications (Busse and Blumel, 2014). While mechanisms for dialogue exist in LMICs, they remain weak and need to be bolstered to achieve their intended purpose (World Bank 2011). Additionally, existing fora for dialogue have been dominated by a few influential private providers, typically in urban centres, as a result of which the views of smaller private providers, typically in rural areas, are under-represented.

- **Move towards formal policy arrangements** that include standard operating systems and procedures. Formalising policy arrangements creates market predictability for private sector providers, influencing the supply of health services and goods. The country examples demonstrate that despite good intentions and efforts to design a sound, rationale policy, government efforts often fall short during implementation. One reason why is because policymakers do not invest enough time to understand the systems needed to implement policy. Another is that they do not involve those responsible for implementation, in this case private health providers, in policy design so the policy does not reflect their perspective or reality. Another contributing factor is the lack of government experience and expertise in new policy tools, such as contracting or health insurance. To address these potential pitfalls, a government can take several steps such as 1) include private sector providers in policy design, 2) create standardised systems and templates that will increase transparency and predictability for the private health sector, and 3) document and make widely available the policy and information on how the systems works.

- **Integrate best practices into policies and procedures.** Examining other country experience in key tools of government can help address government capacity challenges. Although many developing countries are beginning to experiment with a wide range of policy mechanisms that engage the private health sector, these tools of government are not new. Indeed, many developed countries and an increasing number of middle-income countries, such as Brazil, China and South Africa, have experiences and lessons to share. Following the Finnish example of primary care contracting, it is important to not re-invent the wheel and to instead examine how other countries have implemented similar policies to
learn from their experience while adapting it to the individual country context.

In addition to mastering the mechanics of implementing a policy tool, it is equally important to take note of the best practices learned with time and experience to ensure they are included in the policy design and its implementation operating systems. For example: 1) designing service contracts to include clear steps to resolve conflict between partners, 2) applying new approaches to costing and setting reimbursement levels, 3) using monitoring data to benchmark important features of a service contract such as cost, performance and prices, and 4) automating as many functions (e.g. enrolment, claims, payment, etc.) as possible to reduce fraud and error.

• Reduce transactions costs. Lower transactions costs makes market participation more attractive to private providers thereby influencing supply. Introducing a new way of purchasing healthcare from private health providers comes with both new and hidden costs. Governments therefore need to balance the cost of introducing a new policy and system with that of keeping health delivery systems the same. There are, however, different strategies to help reduce a MOH’s transaction cost to contract health services, such as 1) outsource key functions (e.g. claims processing), 2) standardizing operations to encourage task shifting, and 3) automating key contract tasks on-line (web-based enrolment, claims processing, payments, etc.). The state government of Gujarat made strategic decisions when designing the provider payment mechanism for the Chiranjeevi Yojana scheme to keep it simple in order to keep transaction costs low and administrative burdens manageable. For example, they used simple forms to keep information loads to a minimum and did not request detailed information from contracted services providers (Bhat, 2007).

• Invest in government capacity to administer the new operating systems can address public capacity to implement sound contracts and other tools of government. Both the literature and the country case studies show that most MOHs do not have the skills and capacity to purchase health services and to contract private providers. To effectively use the different tools of government, MOHs will need to invest in building their staff skill in these new tools. MOHs may also need to hire staff with a different skill base and technical profile (e.g. contract law, contract management, health finance, health economics).

Two examples demonstrate the range of skills and capacity building needed to effectively implement ToG like contracting. The State of Sao Paolo invested in creating the MOH’s contracting system and building its purchasing capacity to contract non-for-profits to deliver hospital care for poor communities living in favelas. The state’s investments yielded efficiencies and cost savings but also desired health outcomes. The private operators under state contracts were more efficient than public hospitals in terms of lower bed turnover rates, bed substitutions, average length of stay, discharges per bed and expenditure per discharge. They also had better quality outcomes measured by decreased mortality rates (La Forgia, 2010). While the state government of Gujarat invested in building district health managers and other public health officials’ skills in negotiation, networking and consultation so they could become better prepared to interact and collaborate with the contracted private providers. Increased trust through dialogue helped the government scale the Chiranjeevi Yojana Scheme state-wide (Bhat, 2007).

• Address funding insecurity. Ensuring market predictability will motivate private providers to enter into new markets and potentially increase supply in under-served health areas. Many health insurance schemes and service delivery contracts have failed because of insufficient funds and late payments. It is critical for a governments to assure private providers that they will get paid and on time or else they will struggle to attract partners to their policy mechanisms. Steps to create
a more predictable funding environment include: 1) conducting costing studies to better understand the funding levels needed, 2) setting aside sufficient budget, 3) developing a pricing strategy to keep prices affordable but also to reimburse private provider costs, and 4) automating claims and payments to ensure providers are reimbursed regularly and on time. The India SAST case showed how streamlining several key procedures as well making the system more accessible through a web-based platform not only helped reduce government and private sector transaction costs in contracting services but also funding certainty. SAST was able to increase payment reliability while at the same time reduce payment time. With greater predictability, the number of private providers contracted by SAST tripled.

6.2. Private Healthcare Providers

Private health providers also have a role to play in becoming eligible partners under these new tools of government. Private healthcare businesses, as individual providers and/or as a group, can get organised and prepare to become partners by:

- **Actively pursue the MOH.** *Strengthening dialogue and interactions will address barriers to information, informal rules and of practices and overcome the lack of trust that exists between the sectors.* As one of the PPP advisors stated during the interview, “the private sector does not have to wait for an invitation to meet with me.” The stakeholder interviews and literature revealed many of the reasons why private sector organisations are reluctant to partner with the MOH: 1) competition with the public health sector, 2) mistrust and suspicion, 3) delays in government decision-making, 4) discriminatory implementation of rules and regulations and 5) funding uncertainty.

Reasons for the rapprochement between the public and private health sectors in developing countries are similar to those in industrialised countries: neither public nor private health organisations are capable of resolving the challenges confronting health systems today by themselves. There is some, albeit limited, evidence that formal public-private dialogue in health can improve the use and effectiveness of existing resources in developing country health sectors (Healthy Partnerships, 2011). But there are more fundamental reasons why the private health sector should actively engage the MOH to overcome these obstacles, such as greater access to government officials to influence their perspective of the private health sector, shaping policy design that will directly affect the private health sector, and future opportunities for partnership with the government.

- **Organise into representative bodies.** *Structuring private providers into representative organisations helps strengthen market system functions like coordination and information sharing.* Developing country policymakers commonly express frustration on how to identify potential private partners in health because they remain fragmented and disorganised. In contrast, the private health sector in OECD countries is organised into associations or newly created structures in response to tools of government. Learning from this experience, private providers in developing countries are establishing representative bodies, like the Healthcare Federations in Kenya, Uganda, Rwanda and Tanzania. These industry associations perform important functions for their members, such as 1) conducting market research in key health markets, 2) monitoring health markets, 3) negotiating terms of government contract on behalf of their members, 4) helping small and medium-sized providers access capital and build business skills, 5) tracking changes in the policy environment, and 6) representing private sector perspective in health policy and planning.

The German and New Zealand examples demonstrate the benefit of the private sector organising themselves into representative membership groups. In Germany, all physicians are required by law to be members of their professional association that represents them on behalf
of all regulations governing their profession (social regulation), continuing education requirements (social regulation) and salary levels (economic regulations) (Busse and Blumel, 2014). Non-profit hospitals are members of trade associations which represent their interests while negotiating with Social Health Insurance providers on key issues such as quality management systems, quality reporting and accreditation (social regulation). In the case of New Zealand, the government requires all general practitioners to join a Primary Health Organisation in order to become qualified as a government provider of PHC (entry contract and service contract). These PHOs not only negotiate the terms under which they become eligible providers but also key economic issues such as reimbursement levels.

- **Build systems and organisational capacity to create sustainable businesses.** Developing business and financial skills to stay in a market and to respond to ToG shaping a health market can influence supply, helping build an implementation network of qualified private providers. In addition to having clinical expertise, a private provider also needs administrative and management skills to respond to tenders and to manage government contracts. As the desk review demonstrated, many private providers do not sufficiently invest in the business side of their private practice. Private providers can take the initiative to: 1) create financial and administrative systems (e.g. quality, accreditation, billing, etc.), 2) better understand their costs and how to manage them, and 3) learn how to manage costs under new financial reimbursement schemes such as performance based payments, capitation and price bundling. Private health providers will also have to build their staff’s understanding on how to operate these new government mechanisms as well as train them in new skills needed (e.g. accounting, billing, contracts, etc.).

6.3. Development Partners

As the study reveals, development partners have an important role to play in supporting both public and private health sectors so they can reach their full potential to deliver affordable, quality health for all. Donors are already heavily involved in promoting health reform agendas and funding specific schemes like vouchers. However, a key learning from emerging market-based health programs is the need to focus much greater effort on system strengthening and long-term sustainability. Without more attention paid to the systems underpinning health services, these services struggle to reach their full potential (e.g. quality PHC but no drugs, affordable drugs but no health insurance). As international donors increasingly becoming more open to funding private health sector activities, there is also an urgent need to invest in systems that enable the tools of government that directly engage the private health sector. Specifically, donors can:

- **Strengthen MOH systems to strategically purchase health services from private providers** by 1) Helping developing country MOHs to establish the policies and organisational arrangement needed for contract management, 2) Offering technical assistance to create the organisational structure, functions and standardised operating systems, and 3) Investing in MOH capacity and skills to effectively implement and manage the tools of government.

- **Assist the private health sector to organise as a sector so that MOH have an entity and/or collective group with which to partner** thereby reducing government transaction costs to contract with private health providers. Areas of support include: 1) help private providers form associations and organisations that group them into larger units that can interact directly with MOHs, 2) invest in building these groups to become mature associations and organisations that effectively represent the private sector in policy and planning, and 3) strengthen private provider capacity not only in clinical areas but also in business skills so they can manage and implement government contracts and/or participate in health insurance schemes.

- **Use facilitation approaches to support**
better communication between public and private sectors. Information gaps and poor communication between system actors was a common challenge across the case studies. While development partners have already played a positive role in instituting formal mechanisms for public-private dialogue, donors could place more emphasis on supporting processes or mechanisms that go beyond a national level platform to ensure effective communication at different levels of the system.

- Avoid distorting markets and creating funding uncertainty. While avoiding market distortions is important in any sector, it is a particular risk in the health sector where the provision of goods, subsidies, and grants are common, driven in part by the critical nature of many health challenges. Donors should avoid distorting the market through creating funding uncertainty that will leave private providers wary of engaging with public financing schemes. While there are times when it is appropriate for donors to make direct interventions in order to achieve critical public health objectives, there must be an exit strategy in place from the start of the project.

- Be patient and flexible for a program to yield success. M4P programs in other economic sectors have demonstrated that facilitating change takes time, often more than six to ten years. As the successful example of setting up effective quality assurance in Karnataka showed, the health sector is no different in this respect. It took several years and some trial and adaptation to develop this successful management system, demonstrating the need for flexibility and a balancing of short-term impact with indirect interventions that take time but produce lasting benefits for the health system and men and women living in poverty.

6.4. International Health Practitioners

The focus of technical assistance offered to developing country ministries is changing as health sectors become increasingly mixed with different types of non-government health care providers. In the past, technical assistance focused on strengthening the quality of MOH health services while simultaneously improving their efficiency in resource allocation. However, MOHs need a different tool box and skill set that can help all market actors fulfill their respective roles and responsibilities in a mixed health system. The community of international health experts can assist in the following ways:

- **Work with promising private sector interventions to share successful business practices.** There are specific health markets that are more conducive to market forces compared to those that are more regulated. Health products, such as retail drugs and distribution, are the easiest markets to enter due to low entry barriers and fewer regulations. Moreover, low cost products (e.g. medicines) are easier compared to higher-end treatments (e.g. oncology therapy) and equipment (e.g. laboratory and radiology equipment, cancer and other high-end diagnostic equipment) because of cost and capital needs. And simpler (e.g. outpatient, some curative) and predictable (e.g. clinical outcomes more likely) health services are more market-oriented because they can be standardised compared to more complicated (e.g. in-patient care) and rely on medical specialties, sophisticated diagnostics and treatment. It is interesting to note that many of these markets do not necessarily correspond to donor priorities. “Winning” private sector interventions share common characteristics. Key conditions that increase the likelihood of an intervention’s success: 1) target the “working poor” who have demonstrated demand for and willingness to pay for private services and products, 2) focus on geographic areas with a critical concentration of PFP providers with existing networks and demonstrated clientele, 3) stay out of donor-funded health and geographic areas to avoid “overcrowding”, and 4) work in underserved health areas identified by poor consumers that are of interest to the PFP sector.

1 Discussions summarized from MOOC course on managing markets for health. http://www.sps.ed.ac.uk/mm4h
that increase the likelihood that a private health business will succeed financially. They include: 1) concentrating in urban locations, including as peri-urban areas and smaller towns, 2) carrying out non-traditional marketing techniques designed to reach the working poor, 3) delivering better customer service than government facilities, 4) offering flexible terms of payment in response to the working poor’s purchasing habits, 5) emphasising high volume by specialising on relatively simple, low-cost services, 6) consistently looking for ways to cut costs, and 7) keeping a narrow clinical/technical focus (Tung and Bennet, 2014 and Bhattacharyya et al, 2014).

• **Re-think the approach to policy tools and their implementation.** Historically, health practitioners have focused on policy reforms as a way to strengthen MOH delivery of health services. The time has arrived whereby the international health community needs to think of using government policy tools to strengthen the whole health system – not just public health services.

One area to retool is health policy research and program design. When conducting research, or providing technical assistance, or interacting with ministry counterparts, take the time to gather information not only public sector activities but also private ones. Integrate private sector data into research and program design, and invite to, and involve in, private sector stakeholders to technical workshops, conferences and briefings. There are examples of market savvy research approaches (MM4H course: Policy Management and Implementation Section).

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**Box 4. Health Official and Policy Manager’s New Job Functions in Mixed Health Delivery System**

- Set strategic direction and policy goals that guide and encompass collective action among public and private actors in health
- Act as a buyer of health goods and services
- Monitor and manage public funds to ensure value for money
- Manage competition and monitor health markets
- Gather and share information so public and private sector actors have the market intelligence needed to make informed decisions
- Hold public and private implementation partners accountable for their responsibilities
- Build bridges between government agencies and between public and private partners so all are working toward a common purpose

(Source: MM4H Course: Policy Management and Implementation Section)

Another issue is to understand what are a policymaker’s new job functions and the policy tools needed to govern a mixed health system. Clearly the tasks for a policymaker managing both public and private health providers differ from one who is only administering MOH staff. Not only does a MOH official need to be proficient in skills needed as a public administrator – planning, budgeting, HR management, etc. – but he/she also needs new skills and policy tools to manage private providers outside a MOH bureaucracy such as contracting, managing competition and markets, and facilitating partnerships (see below). The case studies clearly revealed these skills gaps. So for international health practitioner to be effective, s/he will need to also need to learn these new skills and new ToG so they can transfer this knowledge to their counterparts in both the public and private sectors.
7. Conclusions

In this research project, we set out to understand the experience of government institutions and private health sector actors as they engage via financing schemes wherein governments pay private providers to deliver services to the poor and/or other underserved population groups in low- and middle-income countries. We used a health markets lens to both select the schemes and country examples from Kenya, Uganda, and India that we would explore through detailed case studies, and synthesise the evidence from the existing literature and qualitative interviews we conducted in the three countries.

The information we gathered highlighted several areas where public and private sector actors struggle to find a way to work together. Some of the challenges were not surprising. For example, market systems practitioners have always emphasised the need for greater information sharing between governments and private health actors to address information asymmetry. What was perhaps surprising was that despite the ongoing efforts to set up policy frameworks and institutional mechanisms to foster greater dialogue and flow of information, all sides continue to view this as a problem. This calls for greater self-reflection on the part of all actors about the methods and measures that they have been attempting already, as well as honest dialogue about why they may have failed and what needs to happen differently.

Other challenges that emerged from the literature and qualitative research, such as weakness in management capacity, insecure funding environment, and differences in organisational cultures between public and private sector providers, while not unknown or unsurprising, are not areas that have featured prominently in ongoing discussions between governments, private health sector actors, and development partners. These are areas where we need to test potential solutions, including some from other sectors, and learn from them.

Another problem that plagues policy initiatives is corruption. In the qualitative interviews we conducted, we heard repeatedly about corrupt practices on the part of all actors, public and private alike. Corruption is relatively under-emphasised in the existing literature, which may in part be due to a bias in publications towards positive results. Moreover, the sensitive nature of corruption charges may lead all parties - including development partners and market practitioners - to shy away from talking about it openly. While there are no easy solutions to the problem of corruption, more research and documentation about practices that have made it harder for actors to “game the system” can facilitate faster and wider diffusion of best practices.

Finally, all the case studies emphasised the need to build the capacity of ministries of health to be strategic purchasers of services. WHO recommends that LMICs ministries assume a greater stewardship role in a mixed health delivery system, and promotes a split in MOH provider and purchasing functions. Although many development partners are investing in programs to help strengthen health systems, the technical assistance, expertise and financial support does not focus on creating the systems to and build capacity in strategic purchasing. As MOHs struggle to deliver universal health coverage, it is incumbent on the donor community to help ministries harness private sector resources and to strategically purchase the services needed by providing technical assistance in these critical areas.


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Siddiqi S, Masud T I, Sabri B. 2006. “Contracting but not without caution: experience with outsourcing


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Annex 1: Process to Select the Case Studies

Using the keywords and terms listed in the main research report, the research team identified 491 studies and articles on public-private partnerships or related policy initiatives in India, Kenya and Uganda.

Of these, the team removed 46 duplicates, leaving 445 articles. After screening the abstracts and articles using the selection criteria, the team further whittled down the number to 344 studies. The research team referred to potential case studies identified through the CHMI search (see below) to further limit the number of articles to be used both in the literature review and country case selection. Consequently, the research team conducted full-text assessments of the remaining 101 articles to develop a framework by which to discuss the case studies and to provide background information. It is important to note that the majority of articles focused on examples of public-private policy initiatives in India.

The CHMI search yielded 113 projects using search terms such as “public-private partnership”, “government primary funder”, “India”, “Kenya” and “Uganda”. The research team removed 85 projects that either overlapped with the literature review or that the research team had prior knowledge of and knew they would not meet the selection criteria. As a result, only 28 projects remained.

Since the research team was experiencing difficulties in finding eligible cases for Uganda and Kenya, they decided to contact professional colleagues as well as Delphi Panel members to assist in the selection process. The interview objectives included narrowing the number of potential cases in India, to validate comparability of the Uganda and Kenyan cases with those in India and to add new ones that both CHMI and the existing literature may not have uncovered for Uganda and Kenya. The Uganda interviews yielded two strong cases while the Uganda one produced three. And the India interviews successfully reduced the type and number of cases to a manageable number.
### Annex 2: Advisory panel members

<table>
<thead>
<tr>
<th>Name</th>
<th>Country</th>
<th>Organisation</th>
</tr>
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<tbody>
<tr>
<td>Sofi Bergvist</td>
<td>India</td>
<td>Access Health International</td>
</tr>
<tr>
<td>Noemie DeLaBrosse</td>
<td>Kenya</td>
<td>Practical Action</td>
</tr>
<tr>
<td>Cynthia Eldridge</td>
<td>Canada</td>
<td>Independent/Former MSI East Africa Regional Coordinator</td>
</tr>
<tr>
<td>Maxwell Kolawole</td>
<td>Nigeria</td>
<td>SUNMAP/Malaria Consortium</td>
</tr>
<tr>
<td>Yasmin Madan</td>
<td>USA</td>
<td>PSI</td>
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<tr>
<td>Dominic Montagu</td>
<td>USA</td>
<td>UCSF</td>
</tr>
<tr>
<td>Timothy Musila</td>
<td>Uganda</td>
<td>Ministry of Health/PPP Health Node</td>
</tr>
<tr>
<td>Sunil Nandraj</td>
<td>India</td>
<td>Consultant, New Delhi Ministry of Health World Bank Group</td>
</tr>
<tr>
<td>Bernard Olayo</td>
<td>Kenya</td>
<td>World Bank Group</td>
</tr>
<tr>
<td>A Venkat Raman</td>
<td>India</td>
<td>University of Delhi</td>
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