Executive Summary

Healthy Partnerships

How Governments Can Engage the Private Sector to Improve Health in Africa

THE WORLD BANK

IFC International Finance Corporation
World Bank Group

Executive Summary

Healthy Partnerships

How Governments Can Engage the Private Sector to Improve Health in Africa

THE WORLD BANK

IFC International Finance Corporation
World Bank Group

This document contains a modified Executive Summary of the published Report "Healthy Partnerships." A list of contents of the Report and the Acknowledgments are included here. The publication and copyright information on this page refers to the full-length Report. In this modified version of the Executive Summary, additional graphs from the Report have been added to illustrate the main findings. When citing the work, please refer to the full-length Report. It can be ordered from the World Bank or accessed online at **www.wbginvestmentclimate.org/health**.

1818 H Street NW
Washington DC 20433
Telephone: 202-473-1000
Internet: www.worldbank.org
E-mail: feedback@worldbank.org

1 2 3 4 14 13 12 11

ISBN: 978-0-8213-8472-5
e-ISBN: 978-0-8213-8473-2
DOI: 10/1596. 978-0-8213-8472-5

Library of Congress Cataloging-in-Publication data has been requested.

Cover images, left to right: ©Ami Vitale/World Bank, ©Trevor Samson/World Bank; ©Glenna Gordon; ©iStockimages.com, ©Glenna Gordon

Cover and text design: Naylor Design, Inc.

List of Contents in the Full-Length Report

Acknowledgments

This Report, which is part of the World Bank Group's "Health in Africa" initiative, was made possible through funding from the Bill & Melinda Gates Foundation and the International Finance Corporation (IFC). The findings and conclusions contained within are those of the authors and do not necessarily reflect positions or policies of the Gates Foundation or the IFC.

Lead author and project team leader was Connor Spreng. Senior guidance throughout the project was provided by Alexander Preker, as well as Scott Featherston, Khama Rogo, April Harding, Marie-Odile Waty, Cecile Fruman, and Pierre Guislain. External project partners were the RAND Corporation, together with the Results for Development Institute and the Economist Intelligence Unit (EIU). Cowriters were Ryan Marshall, Ifelayo Ojo, and Leo Abruzzese; as well as Dominic Montagu, Tatiana Popa, David Bishai, April Harding, and Alexander Preker. The conceptual framework underlying this Report, the additional data collection (provider survey), and the analytical work accompanying the Report in academic publications, including excerpts included in the Report, were developed jointly with the RAND Corporation, principally Neeraj Sood, Joanne Yoong, and Nicholas Burger. The provider survey was developed in consultation with the Institute for Health Metrics and Evaluation at the University of Washington, the Schaeffer Center for Health Policy and Economics at the University of Southern California, and individual outside experts.

The emerging analytical framework and the story line for the Report were discussed at a number of consultative meetings. A special thanks goes to Ke Xu and Eyob Asbu who represented the World Health Organization (headquarters and Africa region, respectively) during the Report's development. The team collecting the engagement data consisted of Jean-Baptiste Blanc, Maria Bouskela, Sandrine Kouamé-Amani, Ryan Marshall, Ifelayo Ojo, and Paula Tavares. Peer reviewers of the data collection methodology were Jishnu Das and Carolin Geginat. We are indebted to the more than 750 respondents in the 45 countries, and to the World Bank and IFC country teams, who strongly supported the data collection on the ground. We are also grateful to the validators of the coded data; they are listed on the report's website (**www.wbginvestmentclimate.org/health**)

Peer reviewers of the Report were Benjamin Loevinsohn, Philip Musgrove, and Vincent Palmade.

Project management support was provided by Therese Fergo. The Report was edited by Leo Abruzzese (EIU) and Diane Stamm. Design and typesetting were done by Naylor Design, Inc.

Executive Summary

Health systems across Africa are in urgent need of improvement. The public sector should not be expected to shoulder the burden of directly providing the needed services alone, nor can it, given the current realities of African health systems. Therefore to achieve necessary improvements, governments will need to rely more heavily on the private health sector.[i] Indeed, private providers already play a significant role in the health sector in Africa and are expected to continue to play a key role, and private providers serve all income levels across Sub-Saharan Africa's health systems. The World Health Organization (WHO) and others have identified improvements in the way governments interact with and make use of their private health sectors as one of the key ingredients to health systems improvements.[1] Across the African region, many ministries of health are actively seeking to increase the contributions of the private health sector. However, relatively little is known about the details of engagement; that is, the roles and responsibilities of the players, and what works and what does not. A better understanding of the ways that governments and the private health sector work together and can work together more effectively is needed. This Report is about bringing the two parts more effectively together: 'the power of two' (see figure 1).

This Report assesses and compares the ways in which African governments are engaging with their private health sectors. Engagement is defined, for the purposes of this Report, to mean the *deliberate, systematic collaboration of the government and the private health sector according to national health priorities, beyond individual interventions and programs.* With effective engagement, one of the main constraints to better private sector contributions can be addressed, which in turn should improve the performance of health systems overall.

Collaboration between the government and the private health sector is nothing new in Africa. Private providers, especially faith-based organizations (FBOs), have been serving African communities for decades, often predating political independence. But engagement between governments and self-financing or for-profit[ii] providers occurs far less often, even though the clear majority of private providers are self-financing.

FIGURE 1

The Power of Two

Seeing with two eyes—seeing the full health sector, with its public and private components

Working with two hands—both partners in the health sector, public and private, need to work together to carry the heavy load

Source: "Healthy Partnerships" team, 2011.

i. The term "private health sector," as used in this Report, includes all nonstate providers.
ii. For-profit and self-financing are used interchangeably, as discussed in the Report's introduction.

For this Report, a new framework was developed to assess the level of engagement between the public health authorities and private sector providers. A team of researchers collected data through interviews, supplemented by desk research, in 45 Sub-Saharan African countries. More than 750 in-person interviews were conducted with key stakeholders in each country: senior government officials; private sector representatives, including practicing doctors and nurses; and independent experts. The results highlight those places where public-private collaboration is working well and those where it is not. The framework and its indicators also suggest strategies to enhance contributions by the private health sector.

As stewards of the health care system, governments should be seeking ways to leverage available resources, thereby improving quality and access. Our research starts with three observations:

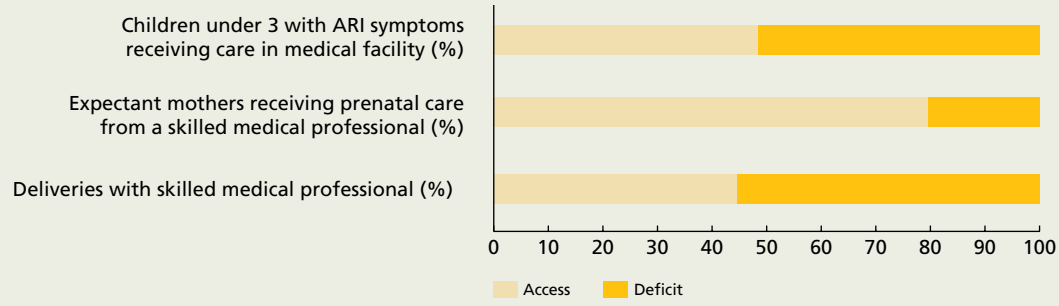
- Africa's health systems need to be improved.
- The private health sector is too large to ignore.
- Engagement can improve the use and effectiveness of existing resources.

The poor performance of many of Africa's national health care systems is sobering. Less than 50 percent of all births in the region take place in a health care facility, and only about half the children with serious infections are treated in clinics or hospitals (see figure 2).[2] These averages mask significant disparities in access: women in the top wealth quintile are nearly six times more likely to deliver their baby in a health care facility than women in the lowest quintile.[3] Where pregnant women have access to prenatal care, it is often of poor quality.

The private sector is part of the answer, if only because of its size. More than half of all health care spending in Sub-Saharan Africa comes from private parties,[4] and private providers are responsible for delivering at least half the services (see figure 3).[5] This is true for the poor and the rich, and for urban and rural populations alike.[6] Many patients choose private over public providers because they prefer the care, and others do so because care is not available from public providers. Although the quality of private services can range from very poor to very good, it is comparable to what is provided by public providers, often because many doctors and nurses work in both sectors. The private health sector not only provides additional access to care, but also is a source of much-needed capital, competition among providers, management skills for operating complex systems like hospitals, and innova-

FIGURE 2

Health Services Access Deficit in Sub-Saharan Africa



Source: Demographic and Health Survey data; World Bank, *World Development Indicators,* 2010.
Note: SSA averages represented for DHS data include the countries for which data are available. WDI averages include the 45 countries coverd by this report. ARI = acute respiratory infection.

tion and flexibility in health care delivery. Harnessing these potential contributions fully is the critical challenge.

The goal of this Report is not to argue for a greater or smaller role of the private sector in health care, but for a closer collaboration between the public and private sectors and a stronger contribution of the private sector toward national health priorities. The policies and practices suggested here can improve public-private engagement. The private sector must be an integral part of any solution to providing more equitable health care to all people, since the public sector cannot solve the problem by itself. An example of a misconception about equitable health care is that it is sometimes believed that public spending on health care mostly benefits the poor. However, it is frequently the relatively wealthy, not the poor, who disproportionately benefit from public spending. The disparity is especially pronounced in Sub-Saharan Africa, where the poorest 20 percent benefit from only 13 percent of public money for health care compared to almost 29 percent of public money benefiting the richest 20 percent.[7]

When the public and private health sectors work together, outcomes tend to improve. The literature on maternal and child care shows that closer coordination between the public and private sectors has improved access to family planning and increased the participation of skilled attendants during childbirth, both of which have saved lives.[8] Contracting or purchasing services from the private sector, provided it is done well, can also be effective. Here, too, the results from maternal and neonatal programs have been particularly impressive.

Findings

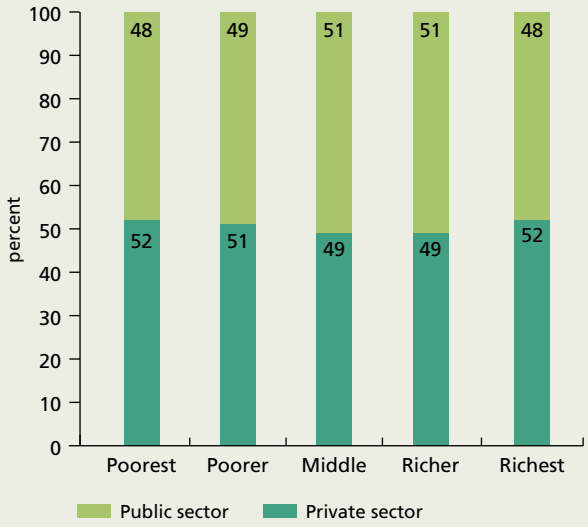
Although public-private collaboration is not a new concept, the framework used in this Report to measure it is. Based on a public economics framework, we identified five domains that collectively constitute engagement:

- Policy and dialogue
- Information exchange
- Regulation
- Financing
- Public provision of services.

There is more engagement with the nonprofit sector than with self-financing providers across all domains in all countries. Governments typically trust FBOs, the dominant form of nonprofit providers, because of their social aims and their commitment to the public good. The engagement is also high because FBOs are relatively well organized and often predate the establishment of the public health systems. In many countries, FBO facilities are indistinguishable from public facilities and some serve as public reference hospitals. The close collaboration between the public health sector and FBOs is not without its challenges, however. Shortcomings in each of the five domains frequently reduce the effectiveness of the engagement with the FBOs. The often-blurred lines between FBOs and public facilities make the standardized assessment and comparison of engage-

FIGURE 3

Source of Health Care by Wealth Quintile for Households in Sub-Saharan Africa



Source: Analysis of DHS surveys; latest survey year available included; Montagu 2010.

Note: All data are drawn from the sum of all Population-Weighted Sub-Saharan Africa Demographic and Health Surveys conducted after 2000. Source of treatment is a summary of respondents with children under 5 years of age reporting treatment in the prior two weeks for diarrhea and fever/cough.

ment impractical. Therefore, the key findings and conclusions for each domain, described below, refer to the engagement between the government and the for-profit or self-financing providers—the clear majority of the private health sector.

Policy and dialogue

The policy and dialogue domain concerns the private sector policy framework on paper and in practice, as well as the level of dialogue between the public and private sectors. Policy and dialogue between the government and the private health sector are the foundations of effective engagement; they set out roles and responsibilities of the different actors. A functioning dialogue with private providers is a sign that the government is aware of their presence, takes them into account, and views them as partners.

While more than 85 percent of the countries we studied have an official policy of working with the private health sector, the majority of Sub-Saharan African countries do not actually implement the policy. The level of dialogue between the government and the private health sector is low across the region. However, there are a growing number of countries in which a dialogue is being (re-)initiated as a necessary first step in improving engagement. In Ghana, for example, the level of engagement between the government and the private health sector has greatly improved since the existing private health sector policy was revived through a new forum for dialogue. The private sector, in turn, has responded by forming an umbrella organization of private providers, a critical step. Indeed, beyond Ghana, the organization of the private sector itself is critical in establishing a dialogue, but is lacking in most countries.

See figure 4 for highlights of the results in policy and dialogue. For more details on the individual indicators, refer to Appendix 4 of the Report.

FIGURE 4

Policy and Dialogue: Low Implementation

Source: "Healthy Partnerships" data, 2011.

Information exchange

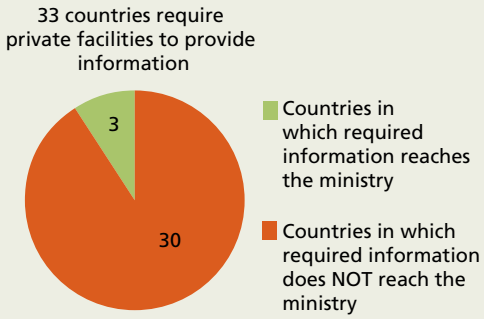
The information exchange domain concerns information flows between the public and private sectors, and private sector inclusion in national health management information systems and disease surveillance. Accurate information about the scale and scope of privately provided care is a key ingredient of engagement. Information systems remain incomplete if they do not include the private health sector. This is especially pertinent if the private health sector is providing a large proportion of health services. Having separate or designated information systems for the private health sector on its own is neither necessary nor more effective.

Information exchange is weak in most countries, with a majority of countries lacking basic elements of a well-functioning system. Despite existing legal requirements for the private sector to provide data to the Ministry of Health, the data seldom reach the government (see figure 5). There are somewhat higher levels of inclusion of the private health sector in disease surveillance programs. Particularly during severe disease outbreaks, governments often reach out aggressively to private health providers and include them in official programs.

The few countries that do relatively well in this domain, such as Burkina Faso and Rwanda, keep the private sector well informed and include private providers in existing public health sector information channels, such as for health management information systems data.

FIGURE 5

Information Exchange: Too Low in Practice



Source: "Healthy Partnerships" data, 2011.

Regulation

The regulation domain focuses on the ability of the government to design and implement a regulatory framework for the private health sector. The registration of private health facilities, as a basic precondition for effective planning in the health system, falls under regulation. Among the five domains, governments tend to overemphasize regulation, without properly accounting for the lacking enforcement capacity.

The registration of private providers is poor in most countries, which leaves a critical gap in the understanding of "who does what" in the health system. In addition, regulations are often inappropriate or outdated and enforcement is weak across the region. Overly complex frameworks that are contradictory or that cannot be implemented as intended create uncertainty and opportunities for arbitrary enforcement. Even private providers complain about the lack of consistent regulatory oversight, which allows low-quality providers to continue to operate. It is critical for governments, but also for the private health sector, to understand that self-regulation can substitute for enforcement by the government.

A notable exception to the weak regulatory frameworks across the region can be found in South Africa, where the private health sector is considered one of the best performing in the world and operates in a highly regulated environment, including strict enforcement. Aside from the fact that the capacity of both government and private health organizations is high, the private sector is primarily funded through insurance. This builds in a strong incentive for compliance with rules and regulations. See figure 6 for highlights of the results in regulation.

Financing

The financing domain covers the revenues that are actually or potentially available to the private health sector and the government's influence of such funds through various mechanisms. The key to financing is to ensure that there is a mechanism that allows poor people to have access to services, and that public funds buy value for money from either public or private services that compete on a level playing field. This principle of strategic purchasing (buying services from the best providers regardless of ownership) is especially important in countries where the private sector is large.

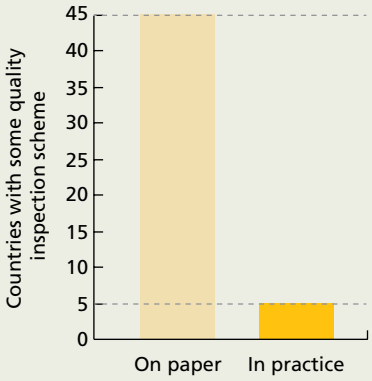
As a proxy for whether governments are committed to improving the effectiveness of public funds, the existence of any ongoing contracts to pay private providers is used. The existence of any financial incentives specific to private health sector facilities serves as a proxy for whether the government seeks to improve the investment climate for the private health sector. Finally, and perhaps most important, the level of private provider coverage by health insurance is used as a proxy to assess whether a significant part of the population can access the private health sector without having to pay out-of-pocket.

The Report finds that a third of Sub-Saharan Africa governments contract with self-financing providers for services, and half of those governments also offer financial incentives. Seven countries offer financial incentives but no contracts. The level of health insurance coverage that would allow reimbursement for treatment received in a private facility is low; in most African countries, it is available to less than 15 percent of the population. But the levels of health

FIGURE 6

Regulation: Lack of Prioritization

Comprehensive registry of private facilities exists in only **6** out of **45** countries



Source: "Healthy Partnerships" data, 2011.

insurance coverage are growing. There is a strong interest in expanding such coverage and a clear momentum to do so. In several countries, for example, Ethiopia, Kenya, Nigeria, and Uganda, the introduction of an expanded (public) insurance scheme is at an advanced stage. See figure 7 for highlights of the results in financing and public provision of services.

Public provision of services

The public provision of services domain focuses on how governments use the direct production of health care inputs and health services to collaborate with the private health sector. Through strategic allocation of resources, governments can use public production to complement, crowd out, or build a supporting environment for private health care markets. In addition, the public sector can ensure the availability of basic services and institutional support. Like the private sector in general, the private health sector also depends on infrastructure services such as water, electricity, and good roads.

In many countries, there is some evidence that governments and the private sector can collaborate relatively well on disease and immunization programs. In addition, there is some form of patient referral between the private and public sectors in most countries. These instances of collaboration, sometimes prompted by the requirements of donor programs (for example, requirements to make donated medicine also available to patients in the private health sector), on narrow issues hold some promise for engagement at the systems level.

Action plan

While this Report focuses on the technical aspects of engagement, the importance of the political process cannot be overstated. Sophisticated and technically appropriate solutions are useless if they are not translated into concrete action by the stakeholders. Indeed, the application of the framework proposed here, and the implementation of changes in policy and practice, is a political challenge rather than a technical one. All stakeholders—governments, the private health sector, but also donor and third-party organizations—are impacted by such reform.

Key actions needed include the following:

- For governments, a first step in the short term is to avoid interventions that are unnecessarily burdensome for the private health sector. Beyond that basic step, an ongoing dialogue with the private sector is needed, as is a basic understanding of its size and activities: who is in business, which services they are providing, and where they are located. A better understanding of what type of private providers are serving the poor, for example, is critical for the success of public health programs. In the longer term, review and reform of the key policy instruments are needed, particularly of regulation. Often it will be a matter of simplifying the rules and bringing them into alignment with what can be enforced. Especially for instruments that are technically and politically difficult, such as financing, it is advisable to start with relatively simple, but concrete, steps. That way the necessary capacity and experience can be developed over time.

- For the private health sector, forming credible associations or representative organizations is an essential first step. Too often, such an organization does not exist (see figure 8). Being well represented will enable a productive dialogue with the government, including the identification of priorities and capacities. An especially important area for collaboration in the longer term is quality of care. Provider networks, improvements of internal quality control in clinical practice, and business management training are all effective ways for the private sector to improve the quality of their services.
- Donors are asked to support engagement at all levels and to include the private health sector in intervention programs, where appropriate. Donor funding and project designs should not be based on preconceived notions of the size, ability, and motivations of the private health sector.
- Third-party organizations, such as insurance agencies and civil society organizations, can play an important role in facilitating and supporting engagement and providing support to the private health sector to upgrade its operations.

FIGURE 7

Financing: a Key Instrument

- In **18** countries, there are contracts with private providers and in **16** countries financial incentives are offered
- Coverage of health insurance is very low across the region; expansion of coverage is a "game changer"

Public Provision of Services: Frequent Use

- Frequent inclusion of private providers, often in donor supported disease programs
- Much room for improvement and expansion of these currently limited partnerships

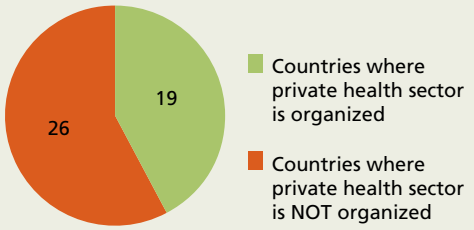
Source: "Healthy Partnerships" team, 2011.

FIGURE 8

Private Health Sector: Better Organization Needed

Government needs a counterpart to engage with that is

- Credible
- Capable
- Representative



Source: "Healthy Partnerships" data, 2011.

With respect to the analytical work, the action plan going forward is to build on this important first step in understanding engagement in a more systematic way. What lies ahead is the further development of the framework for assessing engagement and its application in areas that were beyond the scope of this Report. Further work toward how public-private engagement can be improved will benefit African health systems and their patients.

Designated resources are available for stakeholders interested in taking an active role in the improvement of public-private engagement. A toolkit with detailed information on approaches and practical steps to reforms can be found at **www.wbginvestmentclimate.org/health.**

In conjunction with the other available resources and with the expertise at the country level, this Report should be used as an advocacy tool in the reform process. The framework developed here and used to assess engagement across Sub-Saharan Africa provides a starting point for developing a country-specific reform agenda, and better engagement can lead to reforms in the health sector more broadly.

Even though the challenges are enormous and improvements in African health systems are urgent, the willingness—and even demand—to look at health systems in a new way is reason to hope. When public and private sectors work in partnership, improved access to affordable, high-quality care is achievable in Africa.

Notes

1. WHO 2010a; IFC 2008; Lagomarsino, Nachuk, and Kundra 2009.
2. Data obtained from Demographic and Health Surveys (DHS); latest available year included. RAND analysis. For a complete list of countries and years included in the RAND DHS analysis, see Appendix 2.
3. Data obtained from DHS; latest available year included. RAND analysis.
4. IFC 2008.
5. Data obtained from sum of all Population-Weighted Sub-Saharan Africa Demographic and Health Surveys conducted after 2000. Analysis by Dominic Montagu, 2010. For a complete list of countries and years included in the DHS analysis, see www.ps4h.org/globalhealthdata.
6. See Section 1 for details on use of health care services by wealth quintiles.
7. Davoodi, Tiongson, and Asawanuchit 2010.
8. See literature review in Section 1, under Observation 3, of main report.

For a complete list of references, please refer to the full-length report.

The full-length Report can be ordered from the World Bank or accessed online at www.wbginvestmentclimate.org/health.

Economist Intelligence Unit

The Economist

THE WORLD BANK

SKU 32575