

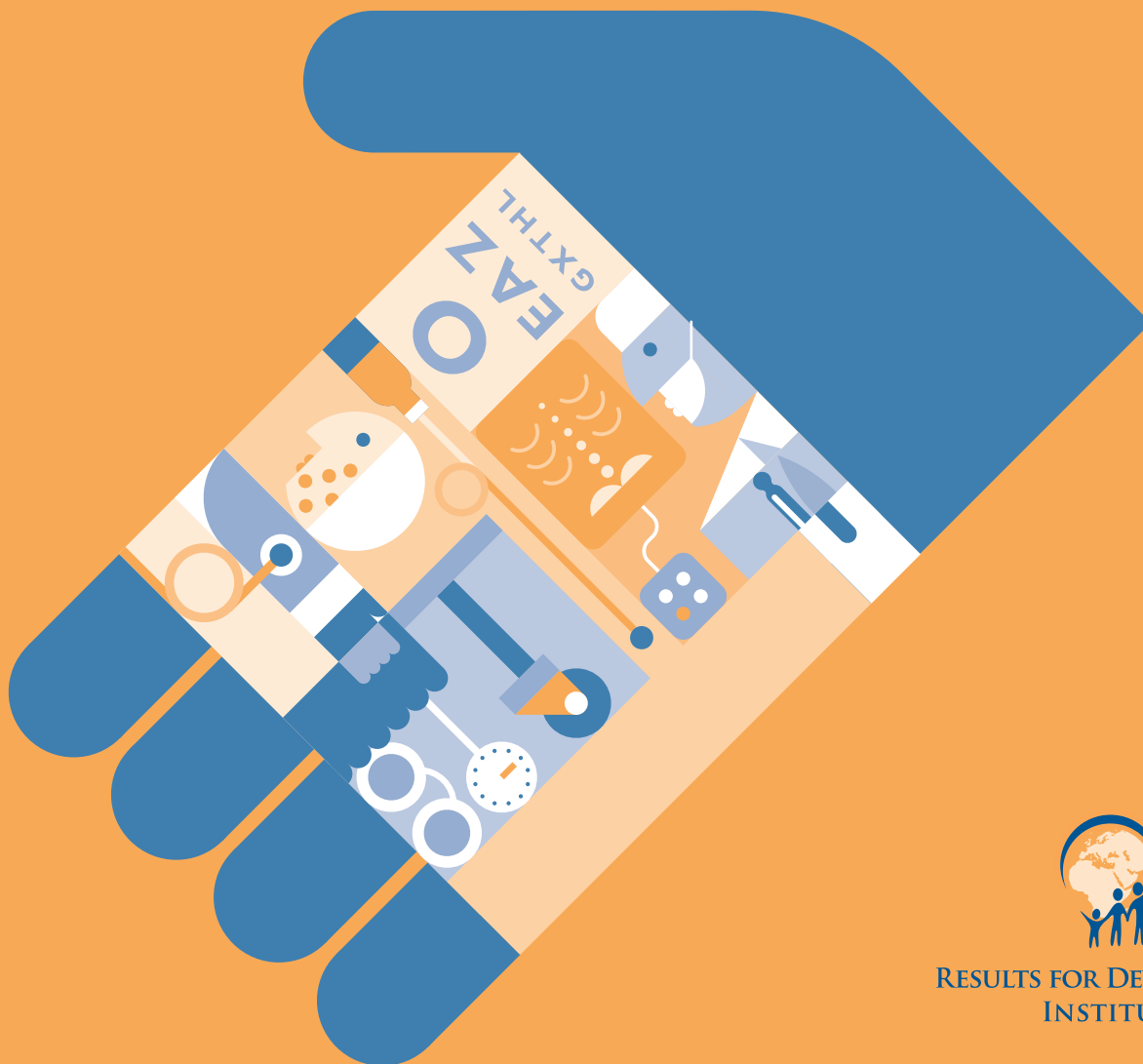
The Rockefeller Foundation–Sponsored Initiative on the Role of the Private Sector in Health Systems in Developing Countries

Technical partner paper 2

The Role of the Private Sector in Health: A Landscape Analysis of Global Players' Attitudes toward the Private Sector in Health Systems and Policy Levers That Influence These Attitudes

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RESULTS FOR DEVELOPMENT
INSTITUTE

THE
ROCKEFELLER
FOUNDATION

A Landscape Analysis of Global Players' Attitudes

October 2008

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Contents

Introduction	1
Objectives	1
Methods	2
Qualitative research	2
Quantitative research	2
Research on strategies to influence attitudes	2
Key findings	3
Summary of strategic recommendations	6
Discussion	7
Table 1: Public and private sector views on trust	7
2. Quantitative Online Survey of Attitudes toward Health Service Provision and Financing in Low- and Middle-Income Countries.....	10
Objectives and methodology	10
Respondent characteristics	10
Table 2: Primary work areas of respondents.....	11
Table 3: Types of organizations of respondents	12
Figure 1: Percentage of respondents by extent of interaction with different provider types.....	14
Key findings	15
Figure 2: Perceptions of the private sector: Percentage of respondents who entirely agreed or somewhat agreed	15
Figure 3: Perceived impact of interventions on improving availability of health services for low-income populations.....	17
Figure 4: Perceived impact of interventions on ensuring affordability of health services for low-income populations.....	18
Figure 5: Perceived impact of interventions on improving quality of health services for low-income populations.....	19
Figure 6: Identified challenges to health service provision for low-income populations, by percentage of respondents.....	20
Figure 7: Identified challenges to health service provision for low-income populations, by respondents' geographical regions	21
Table 4: Perceptions of the role of the government.....	22
Figure 8: Perceived contribution of providers to improved access to childhood immunization services.....	23
Figure 9: Perceived contribution of providers to improved access to services for child fever.....	23
Figure 10: Perceived contribution of providers to improved access to normal delivery services	24
Figure 11: Perceived contribution of providers to improved access to tertiary inpatient care	24
Figure 12: Perceived contribution of providers to improved access to diagnostic and laboratory services.....	25
Figure 13: Responses to two statements on responsibility for improving health	26
Figure 14: Responses to two statements on public-private collaboration.....	26
Figure 15: Responses to two statements on private sector involvement	27

Figure 16: Not-for-profit providers generally do not want to engage or collaborate with the government.....	28
Figure 17: For-profit individual providers generally do not want to engage or collaborate with the government	28
Figure 18: For-profit facilities generally do not want to engage or collaborate with the government	29
Figure 19: Existence of barriers to public-private collaboration for provision of health services for low-income populations by geographical work area	29
Figure 20: Barriers to public-private collaboration	31
Figure 27: The most feasible way of reducing out-of-pocket expenditures among low-income populations	36
Figure 28: The government should strictly monitor and control the quality of services provided by private for-profit health services providers, by organization type	37
Figure 29: The government does not do a good job of regulating providers, by provider type.....	38
Figure 30: Donor funding should be channeled through the government/ministry of health	38
Figure 31: Donor funding should be channeled through the government/ministry of health, by organization type	39
Figure 32: Donors should directly fund private health providers to strengthen them, by organization type	39
Figure 33: Donors should encourage governments to involve the private sector in health service provision for low-income populations	40
Figure 34: Donors should target public sector health services only	40
Discussion and recommendations	41
3. Qualitative Study of Policymakers’ Perceptions of the Private Sector.....	42
Introduction and methods	42
Table 5: Target groups and number of respondents interviewed.....	42
Table 6: Health and development indicators in Pakistan, Thailand, and Zambia.....	43
Findings	44
Conclusion	56
4. Strategies to Address Attitudinal Barriers toward the Private Sector.....	58
Introduction	58
5. Study Limitations and Conclusions	66
Study limitations	66
Conclusions	66
References	68
Appendix 1: Quantitative Online Survey	70
Appendix 2: Identification Process of Potential Respondents by the Global Health Council	79
Appendix 3: In-depth Interview Guide	80

1. Research Overview and Collective Analysis of Results

Introduction

There is a growing body of evidence that suggests that the private sector could play an important role in financing and providing health services in low- and lower-middle-income countries (Tawfik et al. 2002; Larson et al. 2006; Sauerborn 2000; Hanson and Berman 1998). This recognition has led to several international fora and working groups that focus on how the private sector can become more involved in health systems. In such settings, some participants assert that negative attitudes toward the private sector are a barrier to expanding collaboration between the public and private sectors (CDC 2005). The purpose of this study was to explore these attitudes toward the private sector and impacts on public-private collaboration.

We first conducted a literature review to explore the existing literature on attitudes toward the private sector in low- and middle-income countries. While our research focused on the low- and lower-middle income countries, we expanded the literature search criteria to include middle-income countries in general. The literature review yielded a limited number of research articles that examined attitudes or perceptions toward the private sector. These articles are limited in scope, often focusing on specific countries or specific disease interventions. However, several studies of such attitudes, in Bangladesh, India, and Uganda, have found evidence of mistrust between the public and private sectors (World Bank 2003; De Costa et al. 2008; Birungi et al. 2001).

We then assessed global and national stakeholders' attitudes toward the private sector in low- and lower-middle-income countries, with a focus on health service provision and financing for the poor, using a questionnaire survey and interviews with key informants. Finally, we explored strategies for influencing attitudes toward the role of the private sector in health systems, and we developed a set of strategic recommendations for consideration by the Rockefeller Foundation's Private Sector Initiative.

This report combines findings from three distinct studies in this research project: (1) quantitative research on attitudes toward the private sector, based on the questionnaire survey, (2) qualitative research on attitudes toward the private sector, based on key informant interviews, and (3) research on strategies to influence attitudes toward the private sector in health systems. This section of the report provides an overview of the three studies and collective analysis of findings from them. The section is followed by the three respective research reports.

Objectives

This research project had two objectives:

- To assess current attitudes of major global and national stakeholders on the role of the private sector in low- and lower-middle-income countries, with a focus on health service provision and financing for the poor.

- To develop a set of strategies to address attitudinal barriers.

Methods

To achieve the first objective, the research team employed qualitative and quantitative research methods to gather data on attitudes toward the private sector. Ethical approval for both the qualitative and quantitative research was obtained from PATH's Research Ethics Committee. To achieve the second objective, the team researched strategies that could influence attitudinal barriers toward the private sector's involvement in health systems.

Qualitative research

The qualitative research was designed to provide depth to the quantitative survey on attitudes toward the private sector. The research was exploratory and probed the roots and contexts of perceptions of different private sector actors currently and potentially involved in health service provision and financing for the poor.

The research was based on in-depth interviews with respondents at both the global and national levels in three countries (Pakistan, Thailand, and Zambia). The research involved 16 in-depth interviews at the global level and 41 interviews at the national level. The first group of global-level interviewees was selected from the list of the Global Health Council Conference in 2008, in collaboration with the Global Health Council. Subsequently, researchers used snowball sampling, by asking interviewees whom they considered in the public and private sectors to be most influential in facilitating collaboration between the two sectors. The global-level interviewees came from donors, international technical agencies, academic and research institutions, and headquarters of international nongovernmental organizations. The national-level interviewees were chosen purposively using the research team's contacts in the countries. The national level interviewees included officials of national government from health, finance, planning, and other ministries, politicians, technical staff at country offices of donor agencies, international technical organizations, nongovernmental organizations, donor-funded projects, and health professionals. A detailed description of the qualitative research methodology and findings can be found in the section 3 of this report.

Quantitative research

The quantitative research involved an online survey that was conducted by PATH and the Global Health Council. The survey sought to gather perceptions from global health communities on private sector participation in the financing and provision of health services for low- and middle-income countries. In total, 1,201 responses were received, of which 469 completed responses were included in the analysis. The detailed description of the quantitative survey along with the major findings can be found in the section 2 of this report.

Research on strategies to influence attitudes

Our second task was to explore strategic options to address attitudinal barriers toward the private sector in health systems. The research team conducted a review of public policy and public health literature and conducted discussions with issue advocates at the Technical Partners Meeting at the Rockefeller Foundation in July 2008.

Key findings

Seven themes emerged through our analysis of both the qualitative and quantitative data.

Theme 1. There was no agreement about what the “private sector” or a “public-private partnership” was.

The qualitative research findings suggest that there is no agreement among global and national respondents regarding who should be included in the definition of “private sector.” The majority of respondents understood the term to include nongovernmental organizations, faith-based organizations, and for-profit providers. A handful of respondents included other non-state actors, such as traditional healers, village midwives, and multinational companies. Respondents overwhelmingly agreed on the need to distinguish between for-profit and not-for-profit providers, and attitudes were more likely to be influenced by a respondent’s perception of the provider’s motivation than the idea of the “private sector” more generally.

The quantitative research findings also indicate that not-for-profit providers were perceived differently from their for-profit counterparts. While general views of not-for-profit providers tended to be positive, the for-profit groups were seen as profit-driven, less willing to collaborate with the public sector, less likely to contribute to health system strengthening, and more likely to create inequity in health service provision. Perceptions of the government’s ability to control private sector actors and the quality of private sector services were similar for not-for-profit and for-profit providers.

Respondents also expressed some confusion and frustration about what “public-private partnerships” are and how viable they are as a means of addressing urgent health problems that face the poor. The majority of respondents to the quantitative survey agreed with statements related to public-private collaboration, such as “the government and the private health sector should share responsibility for improving the population’s health status” and “public- and private-sector collaboration is a win-win proposition for health systems.” At the same time, respondents were unsure of the consequence of such collaboration. For example, sizeable numbers of respondents were concerned that private sector involvement might create inequity and compromise the health systems’ ability to meet the complex needs of low-income populations.

Theme 2. Most respondents gave qualified responses in their views of the private sector, although their perceptions varied depending on their personal ideology and history, type of intervention, area of focus, and country context.

Respondents’ perceptions of the private sector appear to be influenced by multiple factors such as personal ideology and experiences, career history, particular health focus, and country context (and their own definition of the private sector). Many respondents held

competing views of the private sector. On the one hand, there was ideological skepticism regarding the private sector's motivation for its involvement, a belief that the private sector is driven by economic gain, and that its participation creates inequity in health systems. On the other hand, the same respondents often held the pragmatic view that the private and public sectors need each other for a range of reasons and that the private sector can be useful in certain types of collaboration.

Perceptions varied depending on the specific public-private mechanism in question. For example, the majority of global-level respondents were skeptical about the effectiveness of insurance schemes in low-income countries but were favorable to contracting. The majority of respondents in both the quantitative and qualitative research favorably viewed government regulation of the private sector. Yet many respondents also agreed that governments often lack the capacity to implement effective regulatory mechanisms.

Theme 3. Negative views—although in the minority—were deeply rooted.

Only a small number of respondents in the qualitative research expressed strongly negative views about the private sector. These negative perceptions were based on philosophical beliefs and personal experiences. Many respondents also feared that investment in the private sector might deprive the public sector of badly needed resources. For the majority of respondents, however, these negative views did not necessarily mean that the respondent would take an obstructive stance toward public-private interactions in his or her professional capacity.

The quantitative survey found that about 15 percent of respondents strongly agreed with the following two statements: “the government should provide free services to everybody” and “the government should provide all health services free of charge.” These responses reflect this sub-group's strong preference for free government health services.

Theme 4. The public sector viewed the private sector as a means to an end.

One strong sentiment that emerged from the research was the idea that public-private interactions should be a means to accomplish public health goals, as opposed to a strategy to achieve greater privatization of services. One consensus emerging from the national-level qualitative interviews was that a privatized, “American-style” health financing and provision system was neither a feasible nor desirable model for developing countries. The quantitative survey also found that many respondents were concerned that the conversion of government facilities into autonomous facilities might affect the availability and affordability of services for low-income populations.

Thus, respondents generally viewed the private sector as a means to several different ends. Examples of the perceived benefits included the private sector's ability to:

- Stimulate the public sector to improve service quality and upgrade incentive structures.
- Provide public sector workers with opportunities to supplement their income through dual practice or supplementary employment with nongovernmental organizations.

- Decrease pressure on public sector facilities.

A number of respondents cited partnerships embedded within vertical, disease-specific programs—such as tuberculosis, malaria, and HIV/AIDS prevention and control—as positive examples of how the private sector can be mobilized in innovative ways to help achieve targeted public health outcomes.

Respondents with a pragmatic, instrumentalist view of the private sector were supportive of partnerships if they were properly regulated and controlled. A number of respondents placed responsibility for concession in public-private interactions on the shoulders of the private sector. The public sector was seen as being responsible for providing a unified, overarching, public good-focused strategy for health service provision and financing at both the national and global levels. There was a view that the private sector could not be counted on to act in a disinterested or consistent manner and, hence, should be willing to forfeit control, authority, and benefit to those in a position of “stewardship” over public health.

The results of the quantitative survey also indicated demand for strict government control and regulation over the private sector, with 86 percent of respondents entirely agreeing or somewhat agreeing with the statement that “the government should strictly monitor and control the quality of services provided by the private sector.” This result does not indicate that the government is perceived to be fulfilling its role as a regulator of the private sector. The majority of respondents also thought that government’s capacity to regulate the private sector was inadequate.

Theme 5. At the national level, the private sector feared government interference, while the public sector feared a loss of control.

Although many respondents expressed the view that the public sector is unreceptive to collaboration with the private sector (particularly for-profit providers), many also noted that the private sector was similarly apprehensive about public-private interactions. The source of distrust and fear on both sides was rooted in the unique conditions of each country and affected by diverse histories of privatization and health sector reform, differing public health priorities, and distinct political and economic circumstances.

Reasons for the apprehension included the government’s perceived inefficiency, incompetence, bureaucracy, corruption, and limited capacity. Private sector respondents also were concerned with over-regulation and interference by government. Public sector respondents expressed fear of losing control and authority when partnering with the private sector.

Similarly, there were diverse perceptions of the role of donor agencies in supporting private sector engagement. While the majority of respondents agreed that donor agencies should encourage private sector involvement, perceptions were mixed on whether donor funding should be channeled through the government or directly to the private sector.

Theme 6. There was significant experience with many different forms and models of public-private interaction.

The qualitative research found that the majority of interviewees had some experience, either direct or indirect, with public-private interactions of some kind. Based on survey results on the extent of interactions with different private sector providers, we speculate that not-for-profit providers are the dominant partners of such interactions, followed by for-profit individual providers such as private clinics. The survey results also indicate that the extent of interactions with informal sector/non-professional providers is limited.

There was no “gold standard” of public-private interaction that was referred to in the qualitative interviews of either the global- or national-level respondents, and many respondents expressed some frustration with the lack of definition or understanding of what a public-private partnership or collaboration is.

Theme 7. The evidence base on private sector involvement was not seen as sufficient.

Many respondents felt that more evidence on the private sector’s role in health systems in low-and lower-middle-income countries is needed, particularly on the following questions:

- Who uses the private sector in low-income countries?
- When and why are people using the private sector?
- What public-private interactions already exist? Do they help the poor? Do they present negative consequences to public health?

Summary of strategic recommendations

Based on these research findings, our research team developed five strategic recommendations for the Rockefeller Foundation’s Private Sector Initiative. Because stakeholder perceptions about the private sector appear to vary according to geographical region and context, we recommend that each strategy be adapted to fit the particular implementation setting.

- **Strategy 1. Reframe the “private sector” issue.** Issue framing should be based on the Rockefeller Foundation’s Private Sector Initiative Secretariat’s clear objectives and an understanding of the target groups and their views.
- **Strategy 2. Implement learning projects.** Learning projects build confidence in the possibility of collaboration between the public and private sectors. Learning projects also serve as a complementary strategy to evidence collection and dissemination.
- **Strategy 3. Consolidate and disseminate the evidence base.** The evidence base regarding the role of the private sector in health service financing and provision for the poor should be strengthened, and the documentation of experiences should be supported.
- **Strategy 4. Find champions and build trust.** Identify and support national and global champions to build a coalition on the issue to increase attention and funding.

- **Strategy 5. Shape public health education.** Encourage and support teaching on the private sector in public health schools.

Discussion

This study’s exploration of global health stakeholder attitudes toward the private sector probed views on the role of the government and the relationship between the public and private sectors. Our research found that many respondents desire effective government regulation and control of the private sector. Regulation is considered part of governments’ governance and stewardship functions in the health system strengthening framework proposed by the World Health Organization (World Bank 2003), and is one of five major policy levers to improve health system performance in a leading model (Roberts et al. 2004). Our findings indicate that there is a consensus on the importance of strengthening governments’ ability to act as stewards of health systems to improve public-private interactions.

Our research also revealed considerable distrust between the public and the private sectors. The notion of trust is inherent to the concept of stewardship. For example, Kass (1990) defined stewardship of public administration as “the administrator’s willingness and ability to earn public trust by being an effective and ethical agent in carrying out the republic’s trust.” We therefore suggest that improving trust between the public and private sectors is a critical element of success for their interactions.

Trust indicates involvement of two or more parties (trustees and trustors) and is defined as “a belief, attitude, or expectation concerning the likelihood that the actions or outcomes of another individual, group, or organization will be acceptable or will serve the actor’s interests” (Sitkin and Roth 1993). Das and Teng (2004) propose two kinds of trust in their conceptual framework of trust: “goodwill” trust and “competence” trust. “Goodwill” trust is the trustor’s belief about the trustee’s intention as well as his or her willingness to act in the interests of the trustor. “Competence” trust is the probability that the trustor believes the trustee has the necessary skills and ability to carry out certain actions and achieve desired results.

Our research found that many public sector respondents held mutually competing views of public-private interactions, often including ideological skepticism and opposition, on the one hand, and a pragmatic, instrumentalist view that acknowledges the usefulness of the private sector in achieving certain health objectives, on the other hand. As shown in table 1, we categorized the words respondents used to describe the private sector into these two types of trust. These categories help illustrate how these competing views are generated. Similarly, we also categorized descriptions of the public sector and governments by the private sector.

Table 1: Public and private sector views on trust

	Public Sector Views on the Private Sector	Private Sector Views on the Public/Government Sector
Descriptions related	• Is driven by economic gain	• Is corrupt/focused on its own gain

to goodwill trust	<ul style="list-style-type: none"> • Is unwilling to collaborate with the public sector • Competes for resources • Creates inequity • Is unregulated 	<ul style="list-style-type: none"> • Is over-regulated • Strangulates the private sector through regulation • Imposes taxes • Takes credit for collaborative successes
Descriptions related to competence trust	<ul style="list-style-type: none"> • Provides high-quality care • Brings vibrancy that can stimulate the ministry of health • Can provide innovative ways to achieve target outcomes 	<ul style="list-style-type: none"> • Is incompetent • Lacks management capacity • Is inefficient • Is overly bureaucratic

This basic categorization may oversimplify the delicate relationship between the two sectors. For example, it does not quantify the frequency with which these expressions were used for each category.

Nevertheless, the table illustrates general trends. Negative language used by the public sector to describe private sector’s intentions indicates the lack of goodwill trust. On the other hand, the positive descriptions of the capability of the private sector indicate the existence of competence trust. The negative language used by the private sector to describe the public sector in both categories indicates a lack of both types of trust by the private sector toward the public sector. Given the diversity of respondents’ opinions, further development and application of this trust framework should be performed in light of the specific public-private interactions in question.

The competing views held by the public sector toward the private sector—the simultaneous ideological skepticism and pragmatic instrumentalist view—manifest differences in qualities of these two forms of trusts. The ideological skepticism is linked to the lack of goodwill trust, while the pragmatic view is based on a comparatively positive competence trust. The existence of competing views on the private sector is not unique to low-income countries; a similar study in the United Kingdom also found that public sector managers possess pragmatic views on the private sector while holding ideological concerns toward private sector motivation (Field and Pech 2003). Another study from the United Kingdom revealed a similar pattern of perceptions toward the private sector by non-health social sector managers. However, the ideological skepticism found in the U.K. study did little to prevent managers from engaging with the private sector (Knapp et al. 2001).

The concept of trust usually includes the risk concept (Das and Teng 2004), in which trust becomes critical in the presence of perceived risk. Applying this concept, it follows that trust in public-private collaboration in health systems would improve if the risk of interactions could be reduced, or if the risk of non-interactions becomes prohibitive. For example, communication on successes resulting from a government’s improved capability might help increase the private sector’s trust of government competence. Similarly, donor communities’ assurance that private sector involvement would not

reduce public sector resources could help reduce the perceived risk of government engagement. Finally, in the U.K. context, where public sector managers are constantly reminded to reduce service costs, the perceived risk of non-engagement is higher than the risk associated with the engagement (Field and Pech 2003). This is partly because public health managers generally hold strong competence trust in the private sector regarding its cost-effectiveness.

Certain attitudes held by the public sector—such as the belief that the private sector should shoulder the responsibility of concession—must be changed to increase goodwill trust of the private sector. However, goodwill trust can be difficult to influence over a short period of time, largely because it is ideologically based. Thus, the initial focus of trust-building efforts should be on building competence trust by strengthening the government’s ability to complete tasks required for public-private interventions while simultaneously strengthening the private sector’s ability to provide required services in health systems. This focus would not downgrade the importance of efforts to build goodwill trust through increased communications.

The strategic recommendations described above reflect the findings of our qualitative and quantitative research. These recommendations would require additional analysis and elaboration to become operational.

In addition, our research identified several information gaps that must be filled. In particular, we recommend additional research on the following:

- Perspectives of the private sector, especially for-profit providers and non-professional providers, on engagement with the public sector
- The policy processes, enabling environments, or intervention mechanisms that can facilitate collaboration across actors and services
- Regulation as a potent intervention mechanism or medium of collaboration
- Trust-building activities for public and private sectors at the local, national, and global levels

2. Quantitative Online Survey of Attitudes toward Health Service Provision and Financing in Low- and Middle-Income Countries

Objectives and methodology

We conducted a quantitative online survey to gather perceptions from global health communities on private sector participation in the financing and provision of health care for low-income populations in low- and middle-income countries (appendix 1). PATH designed and tested the instrument in consultation with the Initiative Secretariat and the Global Health Council. We piloted the instrument with a convenient sample of 10 people on the clarity of questions and choices, ease of responding to questions, length of the content, and the response time. PATH's Research Ethics Committee provided ethical approval of this work.

We conducted the survey through Survey Gizmo (www.surveygizmo.com) from May 27, 2008, to July 2, 2008. The team disseminated the URL for the online survey in flyers distributed at the Global Health Council Conference in May 2008. We also sent individual e-mails to the following:

- The participant list for the Global Health Metrics and Evaluation Conference (310 contacts)
- The participant list for the Wilton Park Conference on Public-Private Investment Partnerships in Health Systems Strengthening (59 contacts)
- PATH staff based in our Kenya and Vietnam offices and their partners (approximately 50 contacts)
- Staff at John Snow, Inc., the faculty at the University of Washington School of Public Health, and former fellows of the Harvard School of Public Health Takemi Fellowship Program in International Health (approximately 50 contacts)
- Global Health Council members. A total of 3,901 of 4,084 potential respondents received an invitation to participate in the survey. (Appendix 2 describes the Global Health Council identification process.)

An incentive—a random drawing for one of ten \$50 amazon.com gift cards—was offered to respondents to encourage them to fill out the survey.

Respondent characteristics

The team received 1,201 responses to the survey, yielding a response rate of 24 percent of approximately 5,000 e-mails and flyers distributed. A total of 469 respondents completed the survey.

Primary work areas. As shown in table 2, the 10 most frequently reported primary work areas were community health/nongovernmental organization development (15.7 percent), HIV/AIDS (13.4 percent), reproductive health/family planning (9.6 percent), health systems management (8.1 percent), infectious disease (6.0 percent), health policy (5.7

percent), child health and development (5.7 percent), health and human rights (4.7 percent), health education/social marketing (4.5 percent) and health care financing/insurance (3.8 percent).

Table 2: Primary work areas of respondents

	Number of Respondents	Percentage of Samples
Community health/nongovernmental organization development	74	15.7
HIV/AIDS	63	13.4
Reproductive health/family planning	45	9.6
Health systems management	38	8.1
Infectious disease	28	6.0
Health policy	27	5.7
Child health and development	27	5.7
Health and human rights	22	4.7
Health education/social marketing	21	4.5
Health care financing/insurance	18	3.8
Health care reform	12	2.6
Information systems	11	2.3
Maternal health	10	2.1
Environmental health and sanitation	9	1.9
Adolescent health	6	1.3
Chronic/degenerative disease	6	1.3
Disaster/refugee health	6	1.3
Tobacco/substance abuse	6	1.3
Hospital/clinic administration	5	1.1
Communication/advocacy	5	1.1
Nutrition	4	.9
Drug policy and management	3	.6
Other	23	4.9
Total	469	100.0

Organization type. Table 3 shows the type of organization that respondents reported working for. About 19 percent of respondents worked at research/academic institutions. Almost one-third of respondents (32.6 percent) worked in organizations providing technical assistance, 13.8 percent were governmental agencies or officials, and 11.3 percent worked for funding-related organizations.

Table 3: Types of organizations of respondents

	Number of Respondents	Percentage of Samples
Research/academic institution	90	19.1
International private voluntary organization (technical assistance)	68	14.5
Domestic private voluntary organization (health service provision)	57	12.1
International organization (technical)	52	11.1
Ministry of health/population (or similar government department)	33	7.0
International private voluntary organization (health service provision)	33	7.0
Domestic private voluntary organization (technical assistance)	33	7.0
Governmental donor agency/overseas development assistance agency	16	3.4
International organization (funding)	15	3.2
Other governmental agency	14	3.0
International private voluntary organization (funding/donor)	13	2.8
Pharmaceutical or medical device industry	11	2.3
Domestic private voluntary organization (funding/donor)	9	1.9
Ministry of finance/planning (or similar governmental department)	2	0.4
Other	24	5.1
Total	469	100.0

Location. Respondents were asked to identify the country or region of the developing world with which they were most familiar and to respond to the survey questions with that region in mind. In all, respondents identified 6 regions and 61 countries. The research team excluded surveys for which respondents answered “developed countries”¹ or provided no response to this question. After this adjustment, 425 of 469 samples remained for further analysis.

Using the World Health Organization’s regional classification, approximately 22 percent of responses represented the Africa region, 5.2 percent represented the Southeast Asia region, 4.7 percent represented the Americas, 1.2 percent represented the Eastern Mediterranean, 0.9 percent represented Europe, and 0.5 percent represented the Western Pacific.

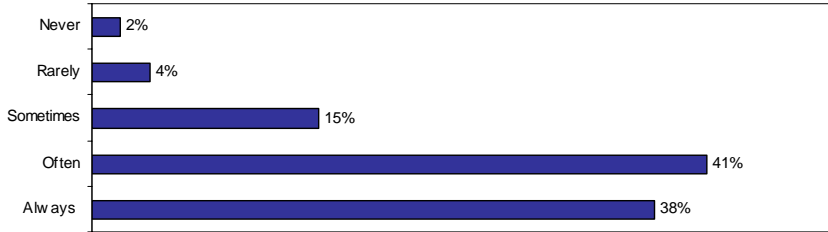
With respect to countries, India was the most common location of survey respondents (12 percent). Other countries with relatively high responses included Nigeria (7.8 percent), Pakistan (5.6 percent), and Kenya (3.8 percent).

¹According to the list classified by the *CIA World Factbook*.

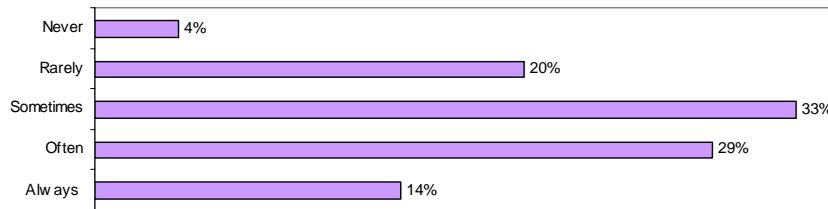
Interaction with service providers. The extent of respondents' interactions with different types of health service providers in a professional context varied. The majority of respondents often or always interacted with public sector providers and not-for-profit organizations (figure 1). Half of respondents rarely or never interacted with nonprofessional providers.

Figure 1: Percentage of respondents by extent of interaction with different provider types

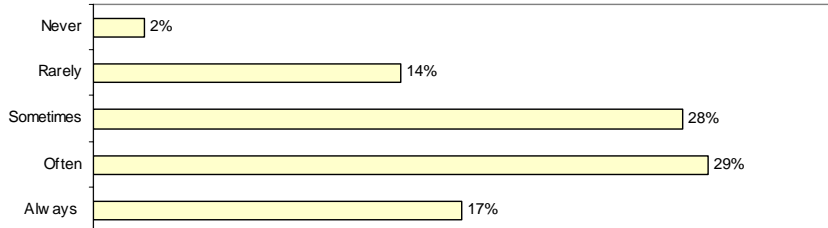
Not-for-profit organizations (415 samples)



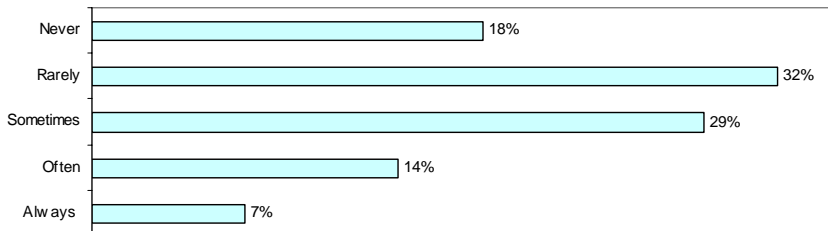
For-profit, private sector facilities (384 samples)



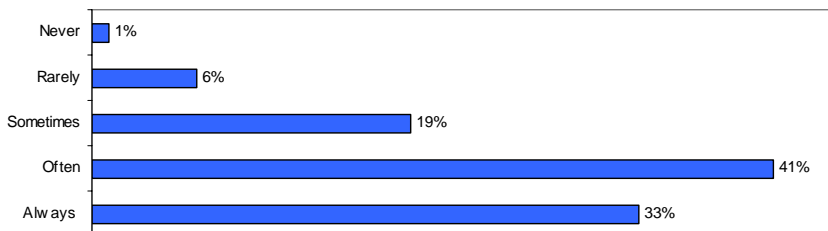
Individual practitioners (383 samples)



Non-professional providers (378 samples)



Public sector providers (397 samples)

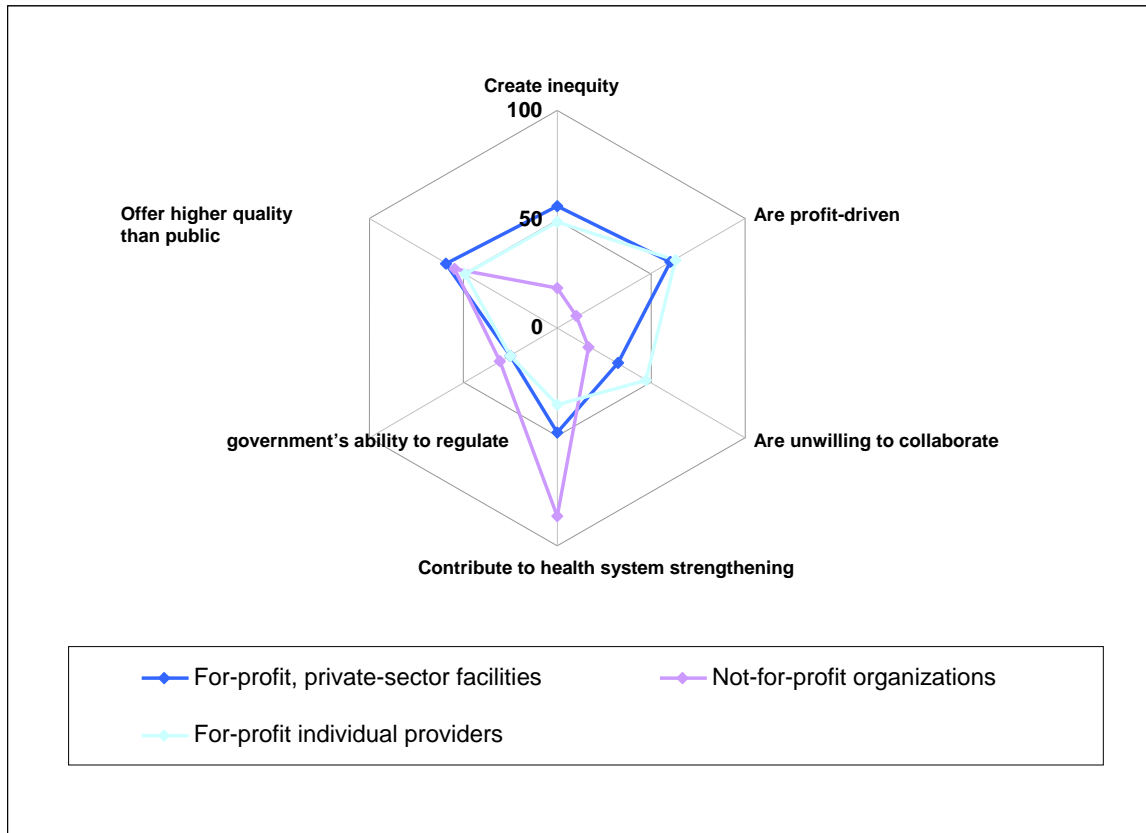


Key findings

1. There is a spectrum of perspectives on the private sector.

The survey results revealed a range of perspectives on the private sector’s involvement in the provision of health services. Figure 2 plots the proportion of respondents who entirely agreed or somewhat agreed on six aspects of private sector involvement: that private sector entities create inequity, have a for-profit motive, are unwilling to collaborate with the government, contribute to health system strengthening, the government’s ability to regulate, and offer better quality health services.

Figure 2: Perceptions of the private sector: Percentage of respondents who entirely agreed or somewhat agreed



Overall, attitudes toward “not-for-profit providers” were more positive than those toward “for-profit providers and facilities.” Perspectives on for-profit private facilities (such as hospitals, clinics, and large pharmacy chains) and for-profit individual providers (physicians, nurses, and drugstores) did not show marked differences. Respondents tended to consider for-profit facilities as relatively more willing to collaborate with the government and contribute to the provision of health services for low-income populations than the for-profit individual provider group.

The perceived impact of selected public-private interventions on the availability, affordability, and quality of health services also ranged widely. Interventions that involved contracting primary care to private providers, strengthening government's regulatory mechanisms, national health insurance, or social marketing were perceived to have a high impact on improving the availability of health services (figure 3). In contrast, voucher schemes, national health insurance, and community-based insurance had a greater perceived impact on ensuring the affordability of health services (figure 4). The majority of respondents (63 percent) perceived that an intervention to strengthen regulatory mechanisms would have a high/very high impact on the quality of health services (figure 5).

Figure 3: Perceived impact of interventions on improving availability of health services for low-income populations

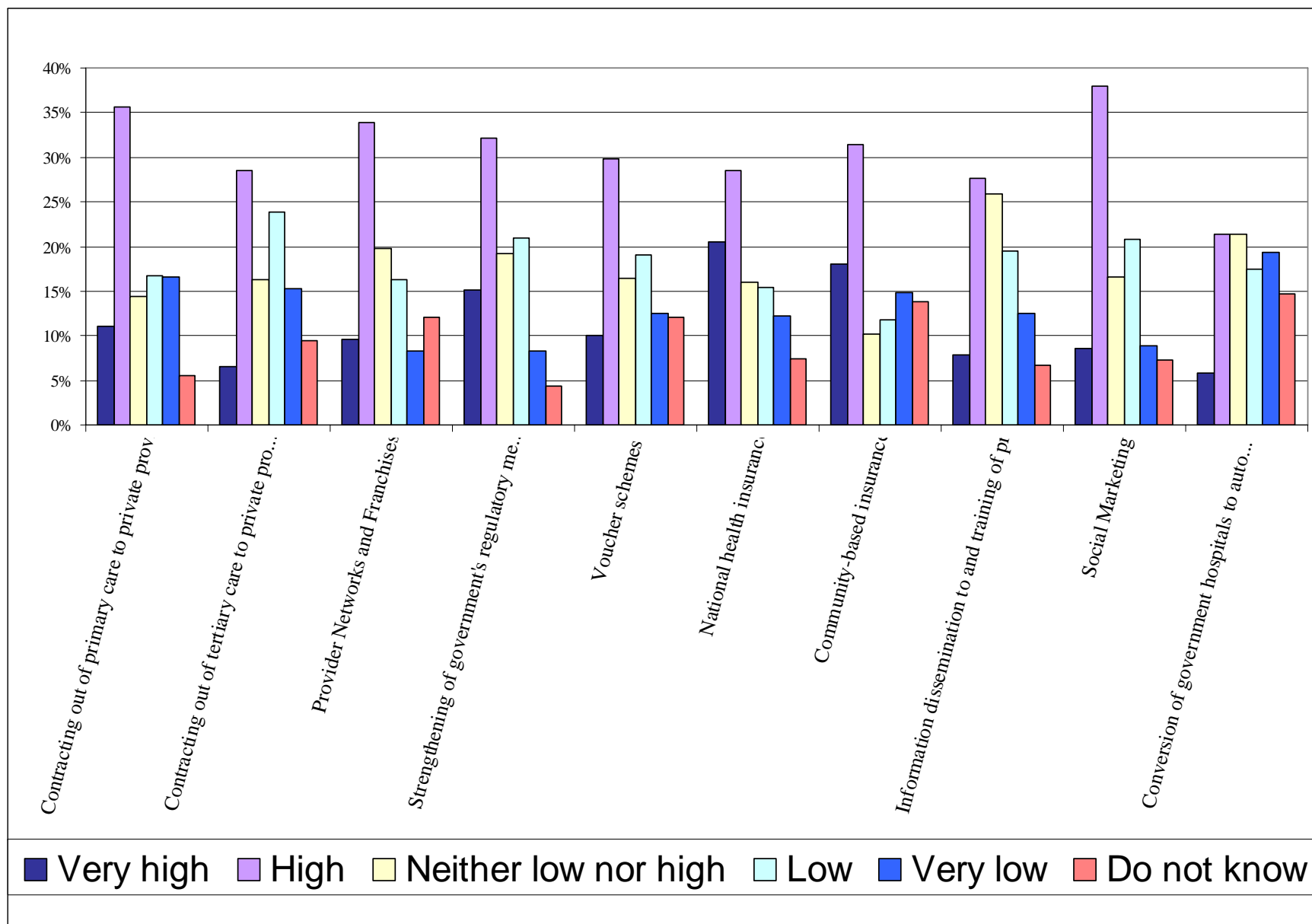


Figure 4: Perceived impact of interventions on ensuring affordability of health services for low-income populations

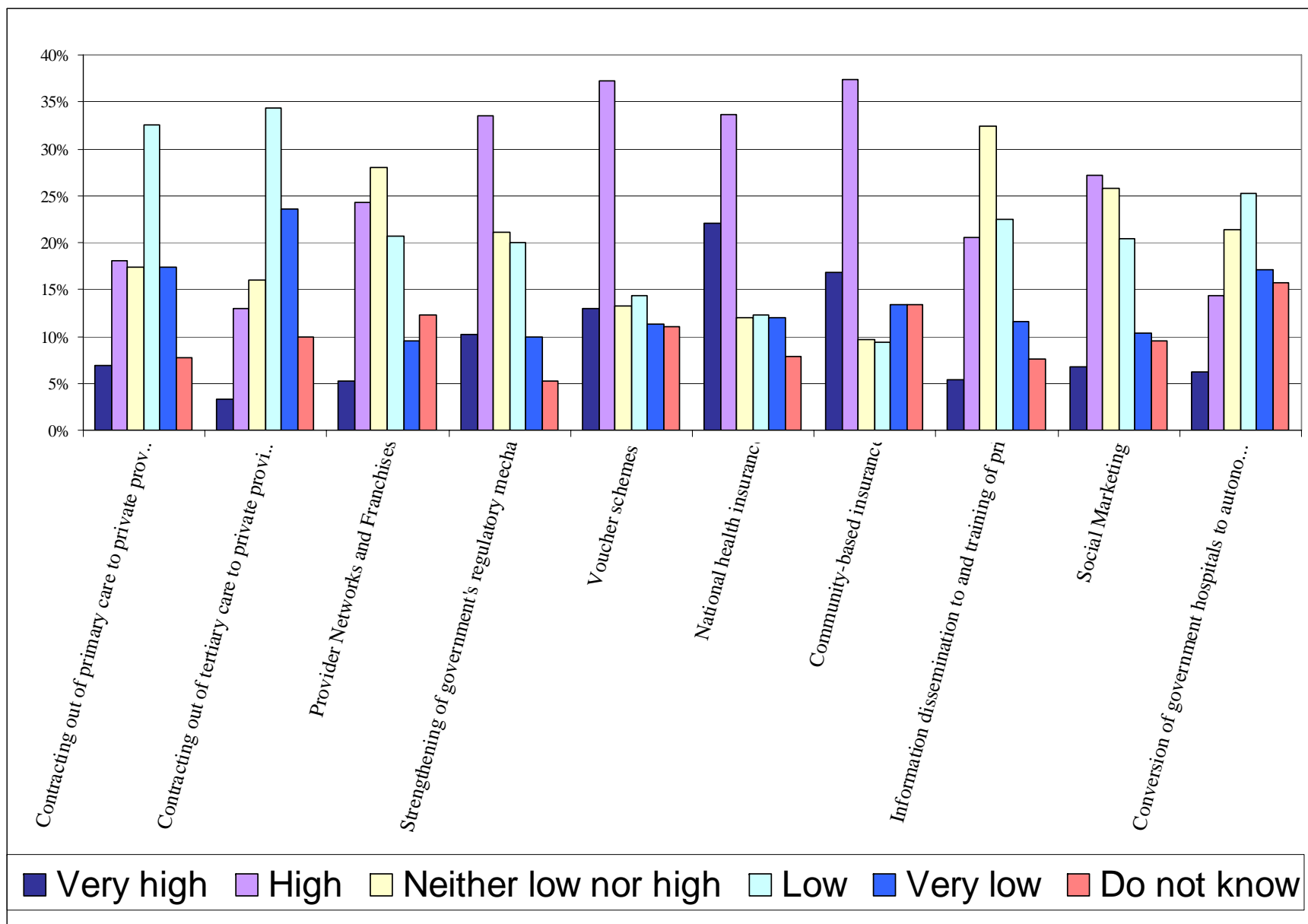
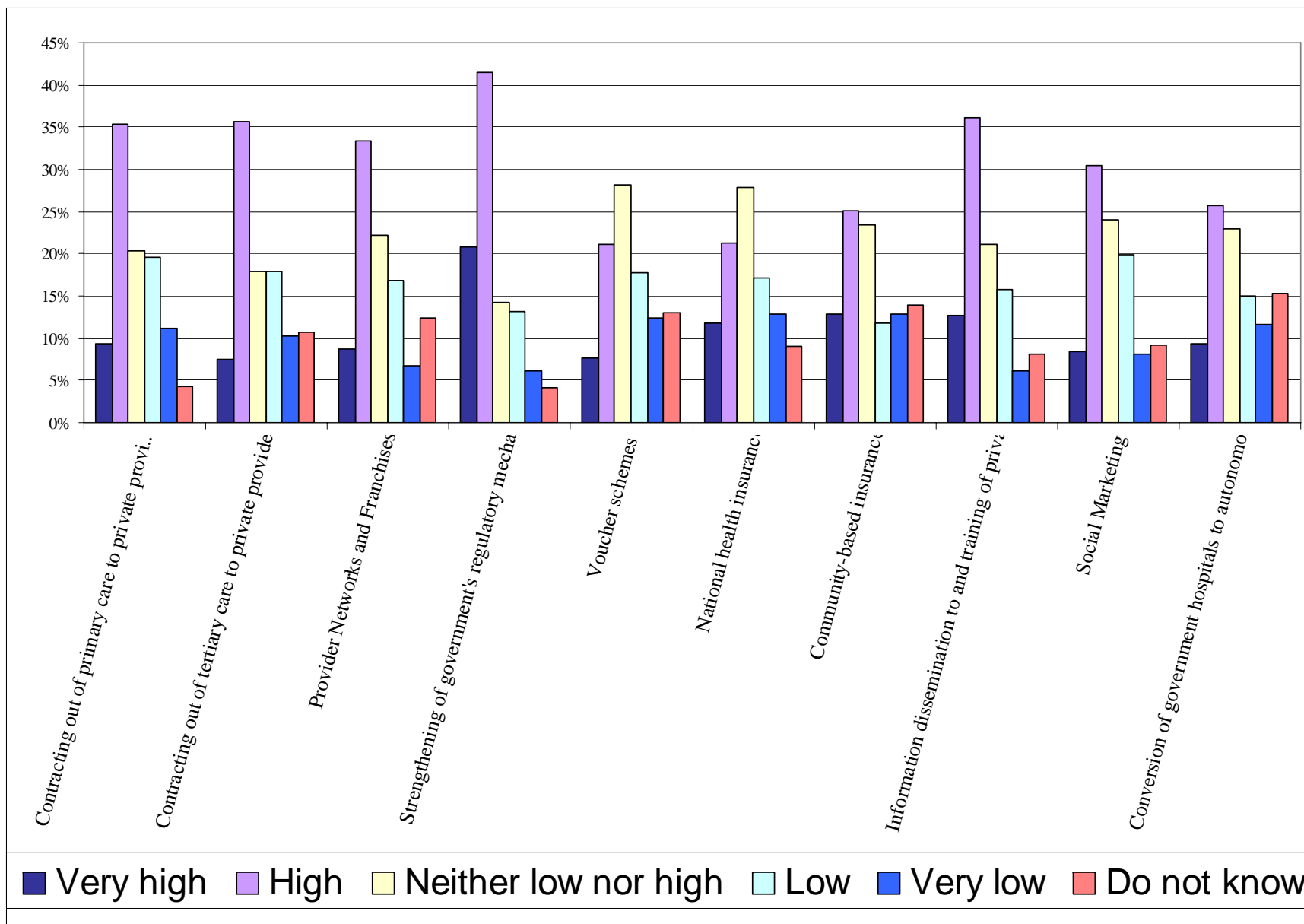


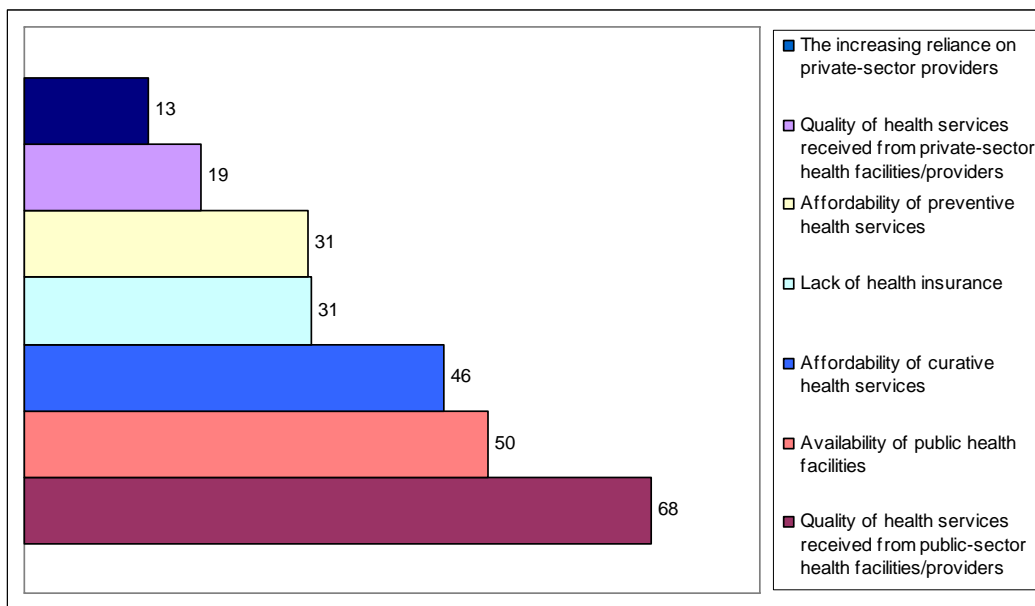
Figure 5: Perceived impact of interventions on improving quality of health services for low-income populations



2. Concerns about the private sector vary by geographical region and type of private sector players.

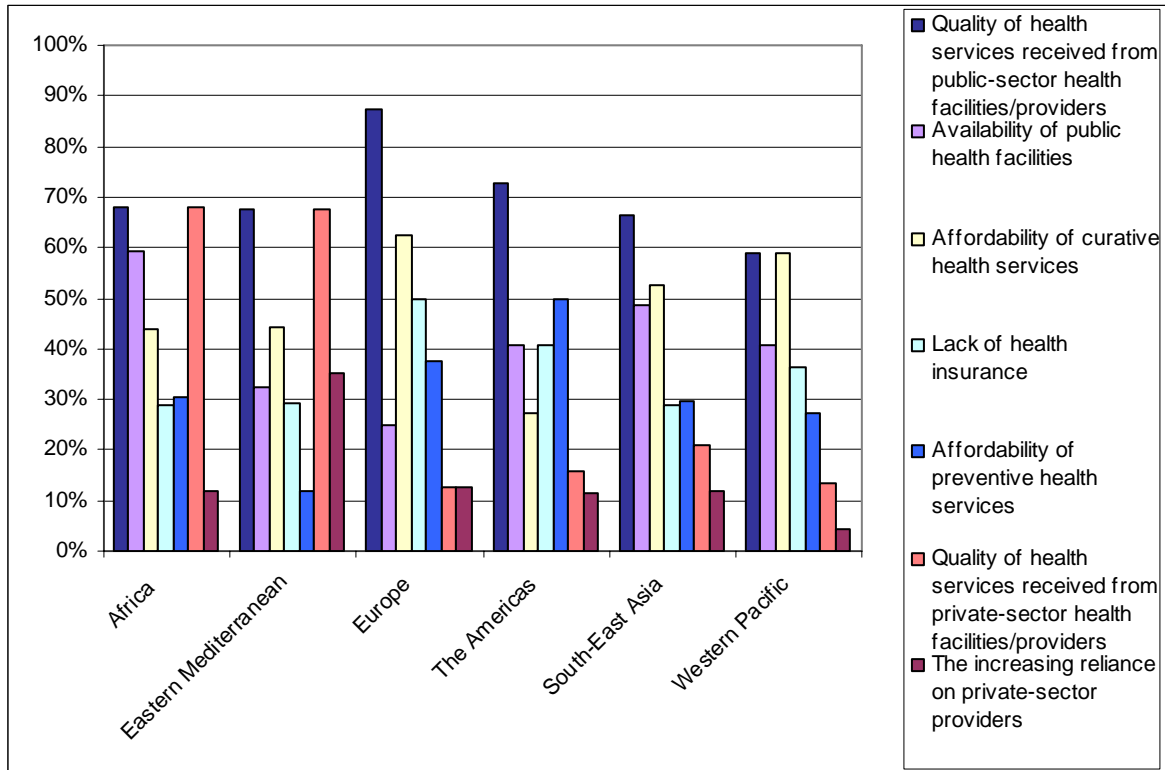
Respondents were asked to identify three of seven challenges to health service provision for low-income populations. The questionnaire listed seven challenges: availability of public health facilities, affordability of curative health services, affordability of preventative health services, quality of health services received from public sector health services, quality of health services received from private sector providers, increasing use of private sector providers, and lack of health insurance. The five most frequently identified challenges were associated with the public sector (figure 6).

Figure 6: Identified challenges to health service provision for low-income populations, by percentage of respondents



Although the quality of private sector health service and the increasing reliance on private sector providers received the lowest response (19 and 13 percent, respectively), the regional-level analysis revealed that the private sector's service quality received the same level of concern as the public sector's and ranked as the highest challenge in Africa and East Mediterranean regions (figure 7).

Figure 7: Identified challenges to health service provision for low-income populations, by respondents' geographical regions



About 86 percent of respondents somewhat agreed or entirely agreed that the government should strictly monitor and control the quality of services provided by private for-profit health services providers and (table 4).

Table 4: Perceptions of the role of the government

	Number of Respondents (percentage) ^a					Total
	Entirely agree	Some-what agree	Neutral	Some-what disagree	Entirely disagree	
The government should provide health services to everyone free of charge.	109 (26)	117 (28)	29 (7)	86 (21)	72 (17)	413
The government should charge everyone for health services, regardless of their income level.	19 (5)	53 (13)	15 (4)	83 (20)	240 (58)	410
The government should concentrate its resources for health service provision on low-income populations.	187 (45)	157 (38)	23 (6)	30 (7)	16 (4)	413
The government should provide only preventive health services, such as immunization and health education.	39 (10)	61 (15)	22 (5)	101 (25)	187 (46)	410
The government should strictly monitor and control the quality of services provided by private for-profit health services providers.	238 (58)	114 (28)	24 (6)	16 (4)	20 (5)	412
The government should prohibit private practices by public sector health care providers (dual practices).	57 (14)	83 (20)	68 (17)	96 (23)	105 (26)	409
The government should collaborate with the private sector to provide health services to low-income populations.	283 (70)	84 (21)	17 (4)	9 (2)	14 (3)	407

^a Percentages may not add up to 100 percent due to rounding.

Respondents were also asked to rate the perceived contribution of each type of provider to improved access to five types of health services (childhood immunization services, child fever, non-emergency obstetric care, tertiary inpatient care, and diagnostic and laboratory services). The contribution of nonprofessional providers to all types of services was rated as minimal

(figures 8 through 12). Health services associated with child fever ranked high for not-for-profit private providers and individual practitioners. For-profit private institutions were perceived as helping improve access to diagnostic and laboratory services and to tertiary inpatient care.

Figure 8: Perceived contribution of providers to improved access to childhood immunization services

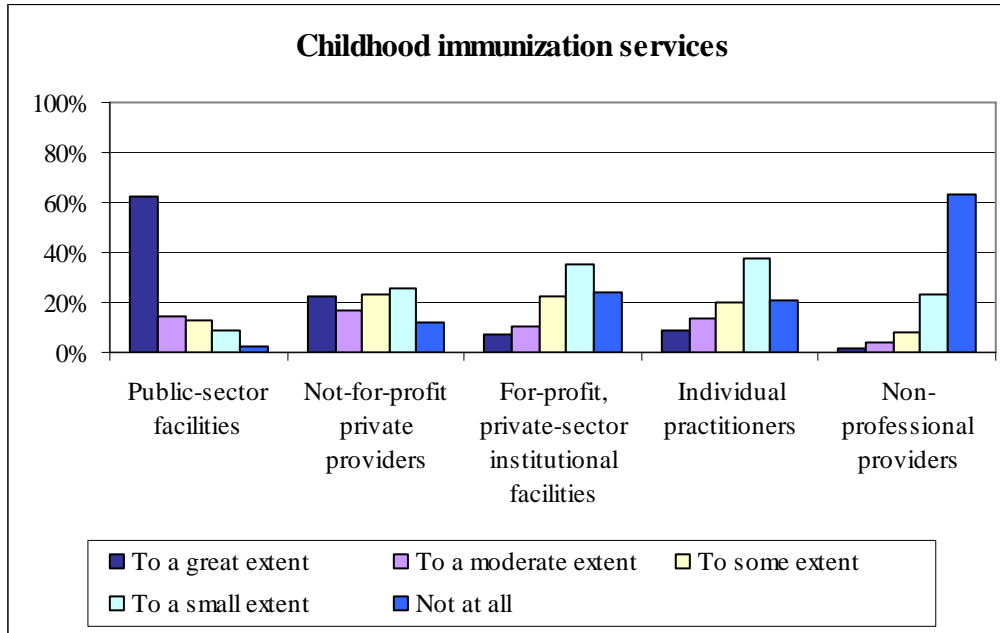


Figure 9: Perceived contribution of providers to improved access to services for child fever

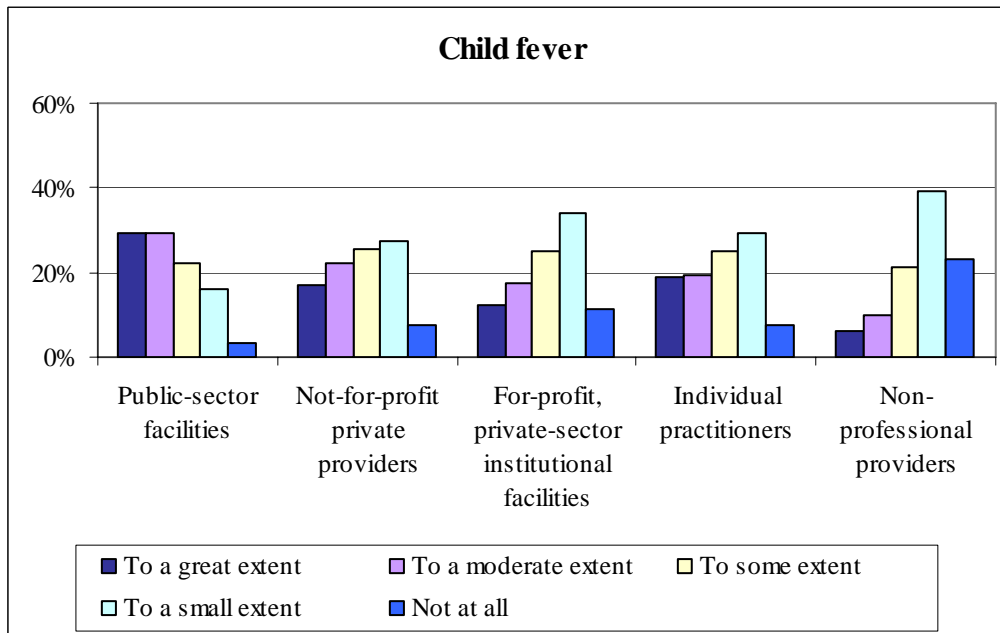


Figure 10: Perceived contribution of providers to improved access to normal delivery services

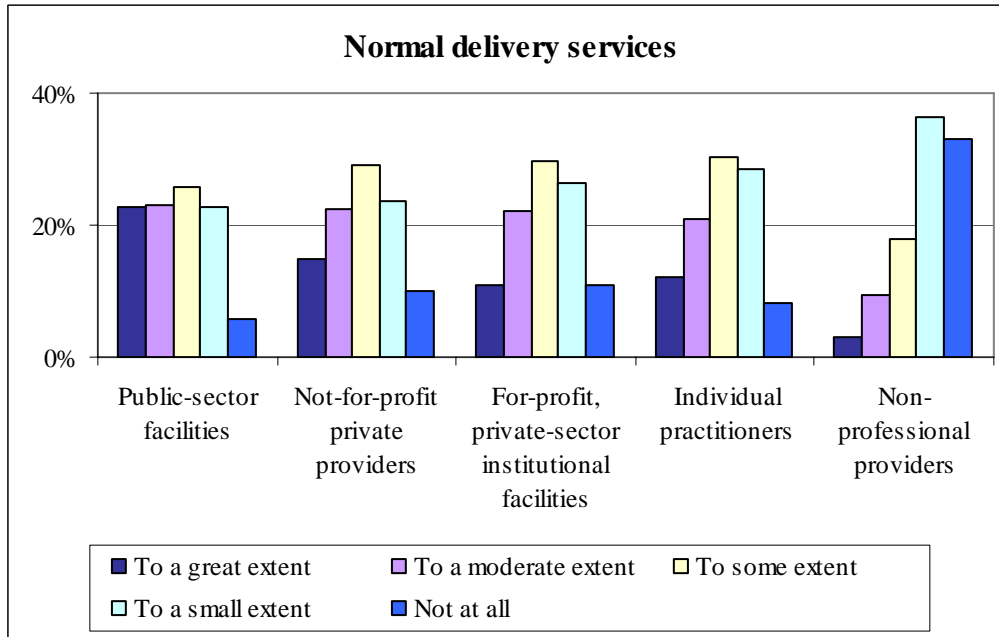


Figure 11: Perceived contribution of providers to improved access to tertiary inpatient care

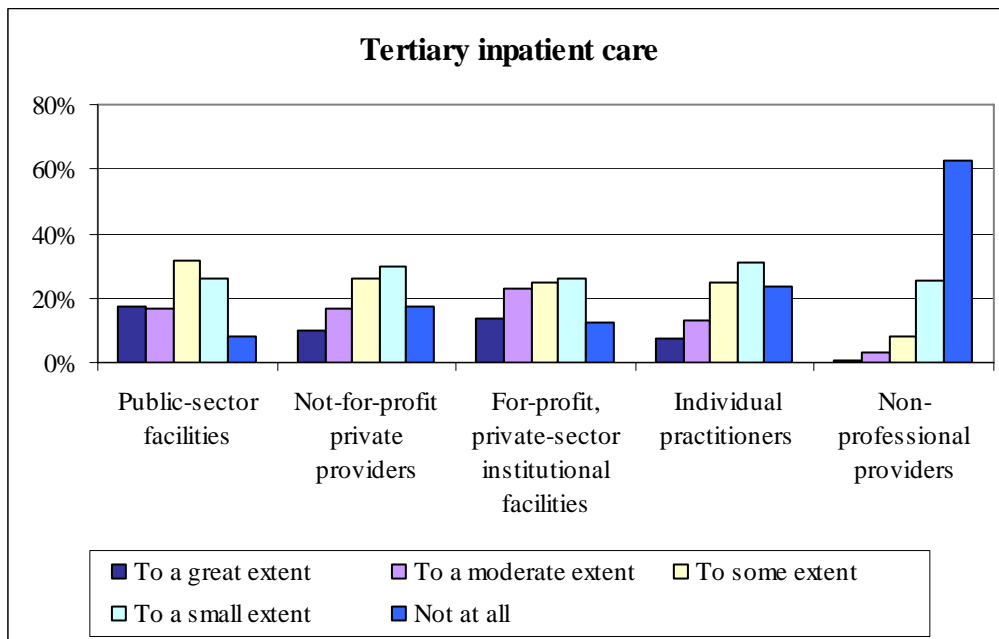
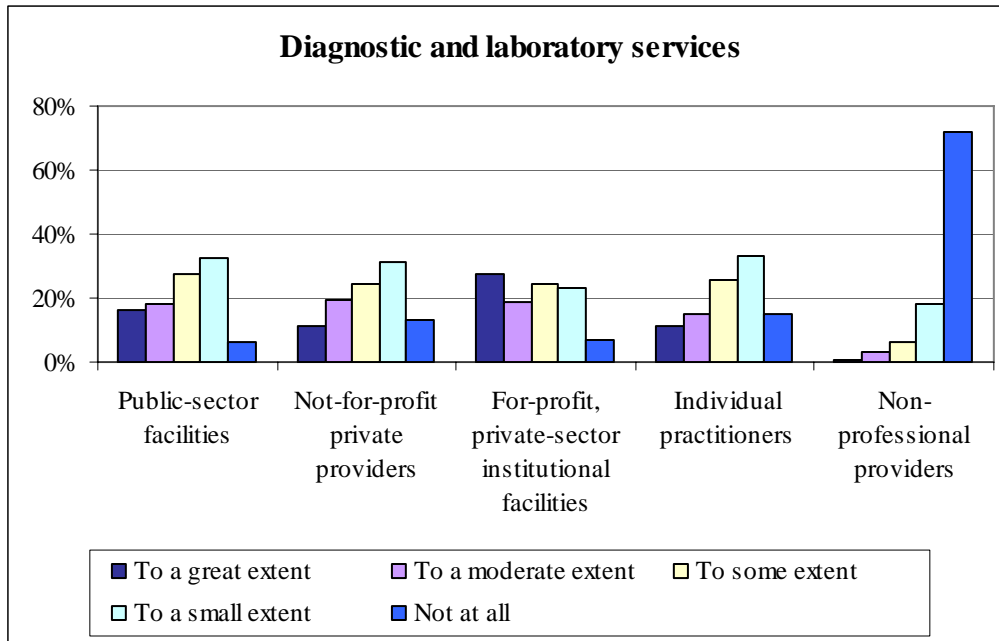


Figure 12: Perceived contribution of providers to improved access to diagnostic and laboratory services



3. Views on public-private collaboration are largely positive, but significant concerns remain.

When respondents were presented with a set of extreme opinions on public-private collaboration and asked to select the opinion that was closest to their own views, a complex set of issues emerged. The majority of respondents (63 percent) generally agreed with the idea that the government and the private sector should share responsibility for improving the population’s health (figure 13) and that public-private collaboration is a win-win proposition for health systems (64 percent) (figure 14). But a sizeable number of respondents also expressed discomfort with the idea of private sector participation; 19 percent agreed that the private sector, especially the for-profit sector, takes advantage of the public sector.

Figure 13: Responses to two statements on responsibility for improving health

- Statement 1: The government and the private health sector should share responsibility for improving the population’s health status.
- Statement 2: Responsibility for improving the population’s health status lies with the government.

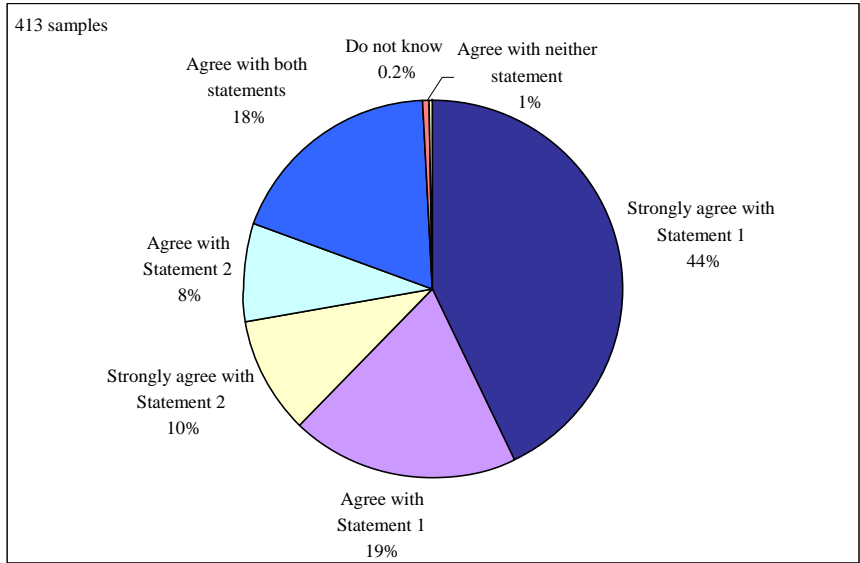
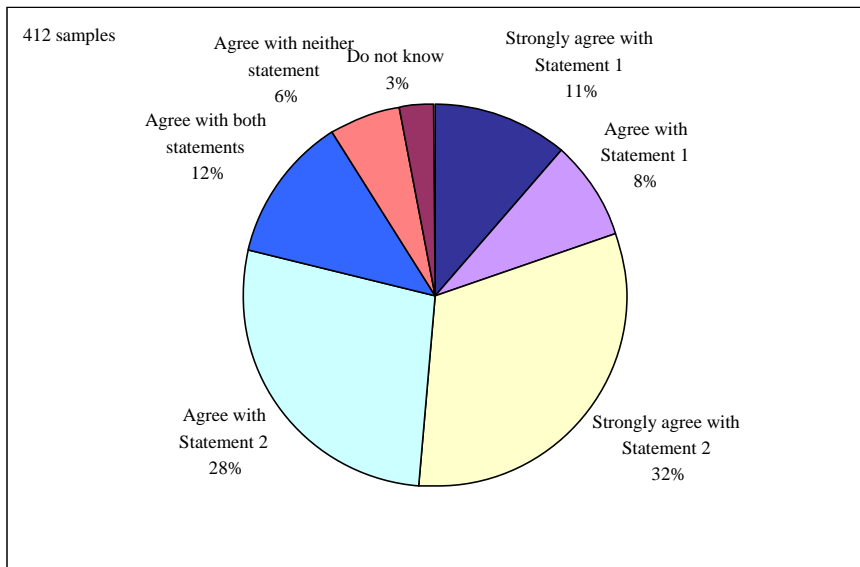


Figure 14: Responses to two statements on public-private collaboration

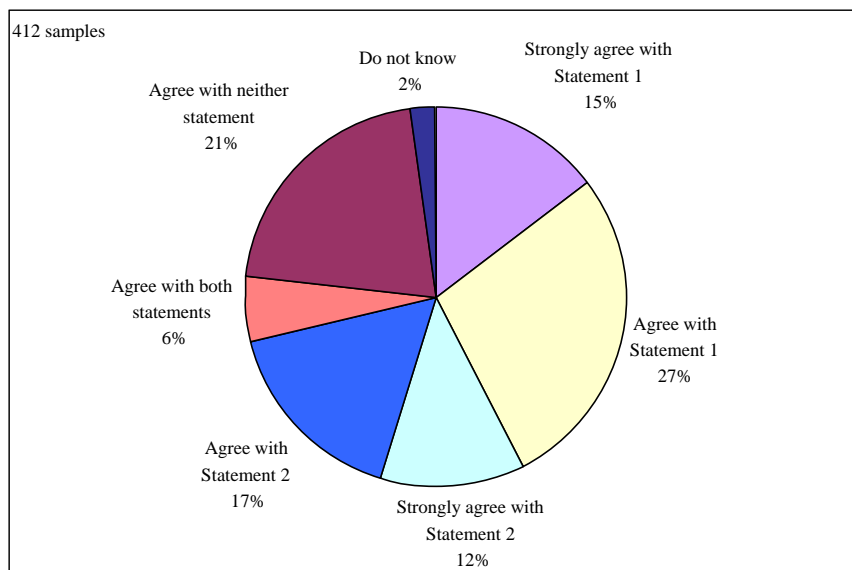
- Statement 1: The private sector, especially the for-profit sector, takes advantage of the public sector.
- Statement 2: Public and private sector collaboration is a win-win proposition for health systems.



Forty-two percent of respondents agreed with the statement that the private sector and/or market mechanisms will bring in more resources and better quality services to low-income populations, while 29 percent thought that the involvement of the private sector would create inequity without improving the quality of services to low-income populations (figure 15).

Figure 15: Responses to two statements on private sector involvement

- Statement 1: The private sector and/or market mechanisms will bring in more resources and better quality services to low-income people.
- Statement 2: Private sector involvement in the delivery of health services will create inequality without improving the quality of health service provision to low-income populations.



Approximately 75 percent, 55 percent, and 36 percent of respondents somewhat disagreed or entirely disagreed that not-for-profit providers, for-profit private facilities, and for-profit individual providers, respectively, do not want to engage or collaborate with the government (figures 16 through 18).

Figure 16: Not-for-profit providers generally do not want to engage or collaborate with the government

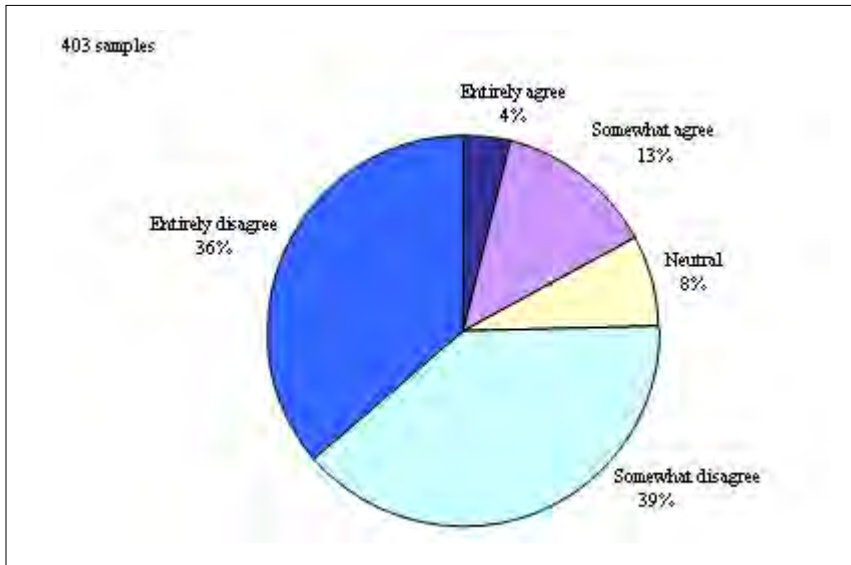


Figure 17: For-profit individual providers generally do not want to engage or collaborate with the government

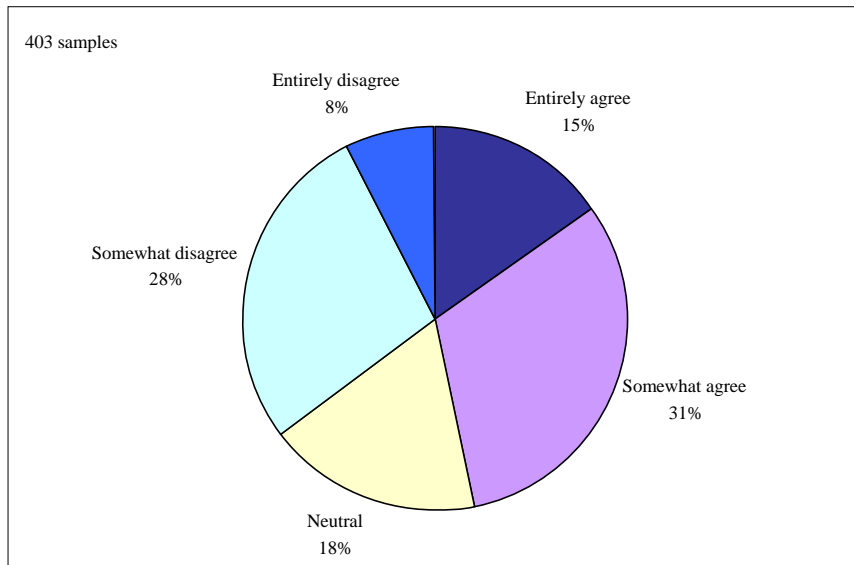
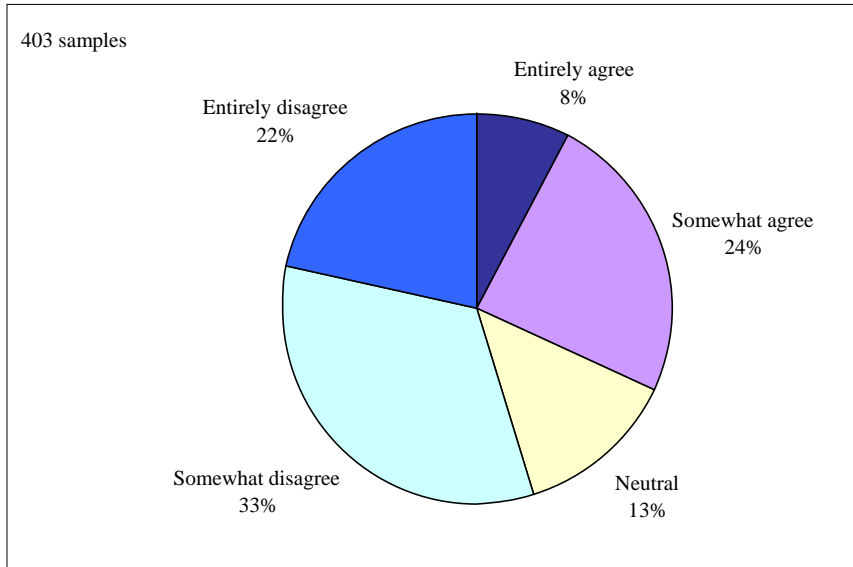
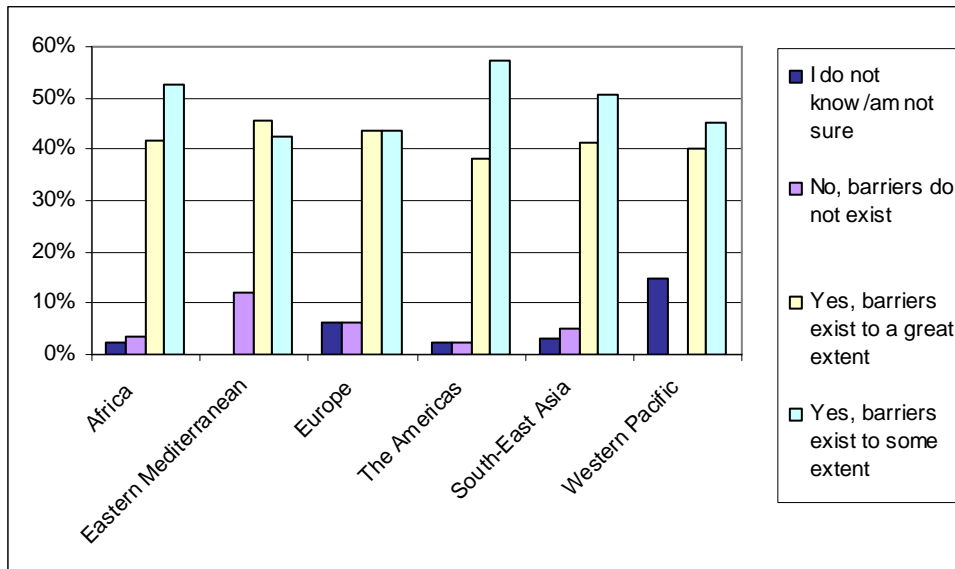


Figure 18: For-profit facilities generally do not want to engage or collaborate with the government



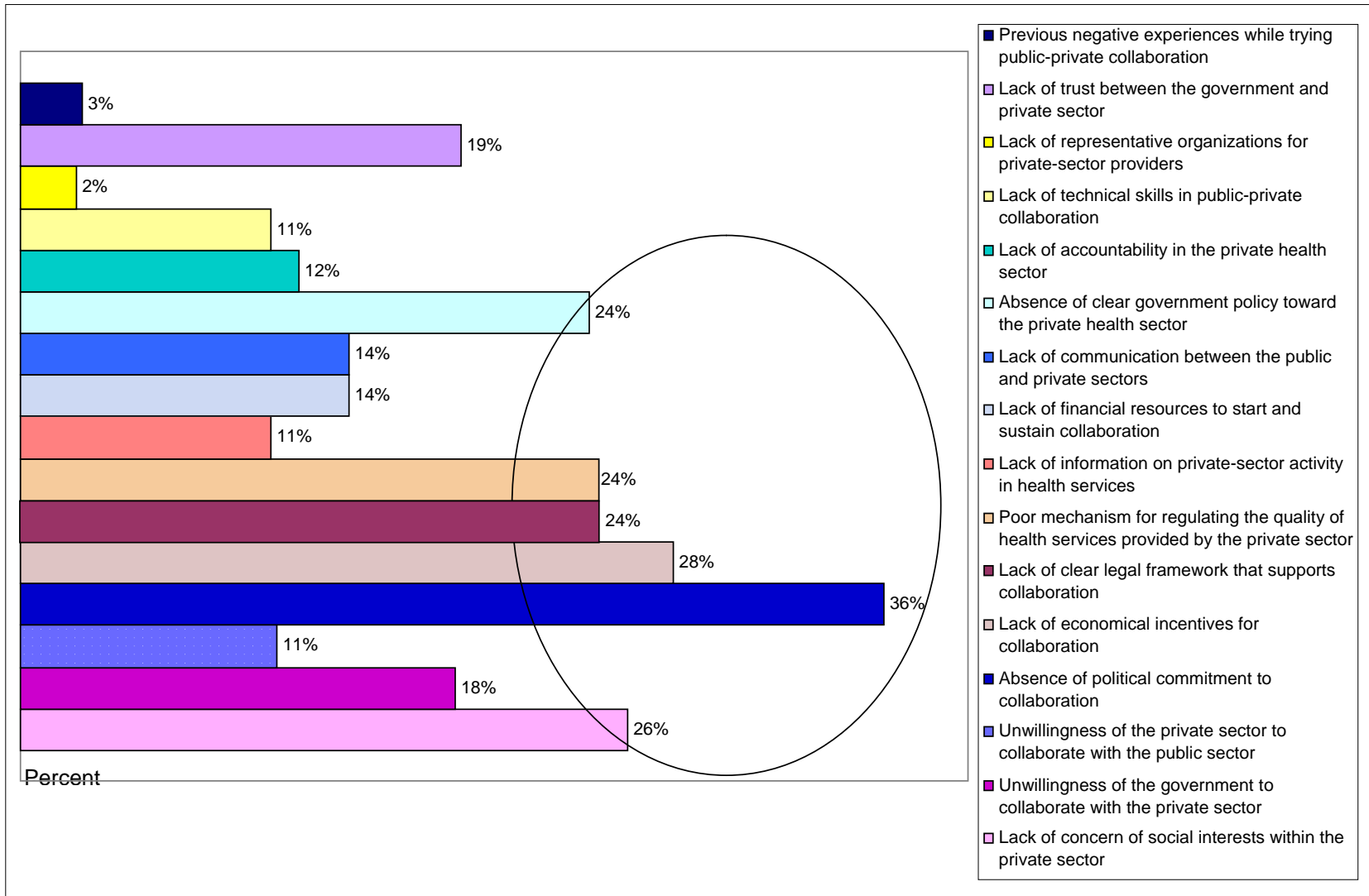
About 51 and 42 percent of respondents thought that barriers to public-private collaboration for provision of health services to low-income populations existed to some extent and to a great extent, respectively. The findings were consistent across regions (figure 19).

Figure 19: Existence of barriers to public-private collaboration for provision of health services for low-income populations by geographical work area



Common barriers were identified as a lack of accountability in the private sector, a lack of economical incentives for collaboration, an absence of clear government policy toward the private health sector, poor mechanisms for regulating the quality of health services provided by the private sector, and a lack of a clear legal framework that supports collaboration (figure 20).

Figure 20: Barriers to public-private collaboration



The barriers that most contributed to a lack of public-private collaboration, however, varied by region (figures 21 through 26). The absence of political commitment to collaboration was the top-ranked barrier reported in Africa (figure 21), the Americas (figure 22), Southeast Asia (figure 25), and the Western Pacific (figure 26) regions.

Figure 21. Most common barriers to public-private collaboration in the Africa region

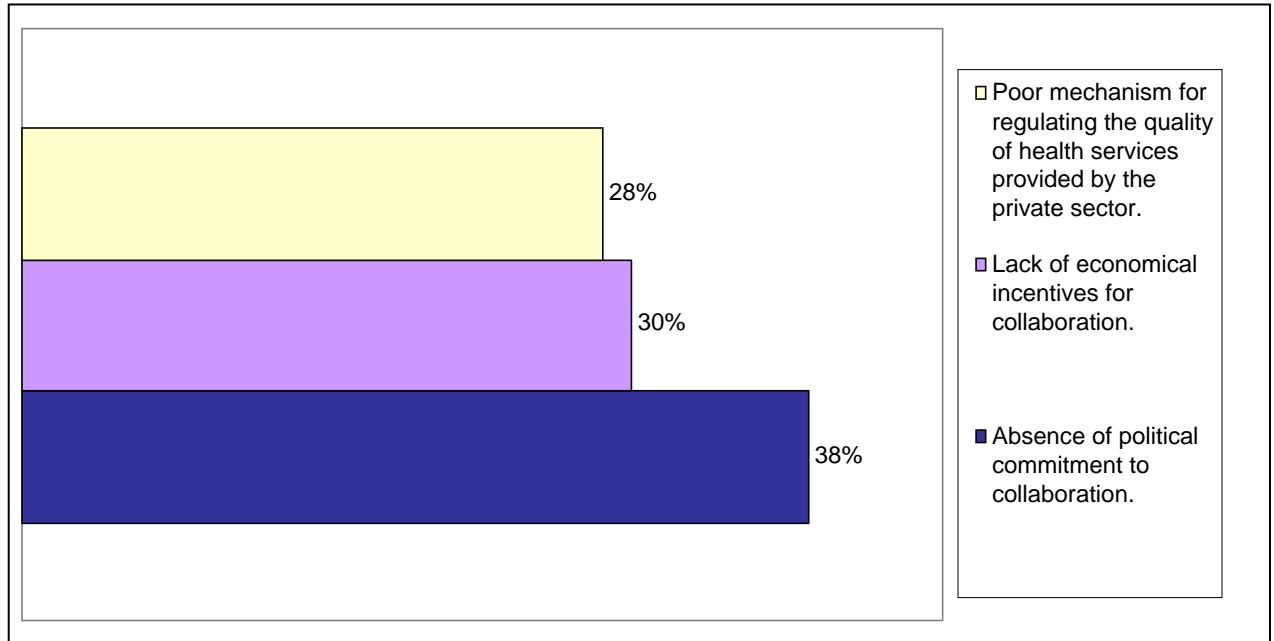


Figure 22. Most common barriers to public-private collaboration in the Eastern Mediterranean region

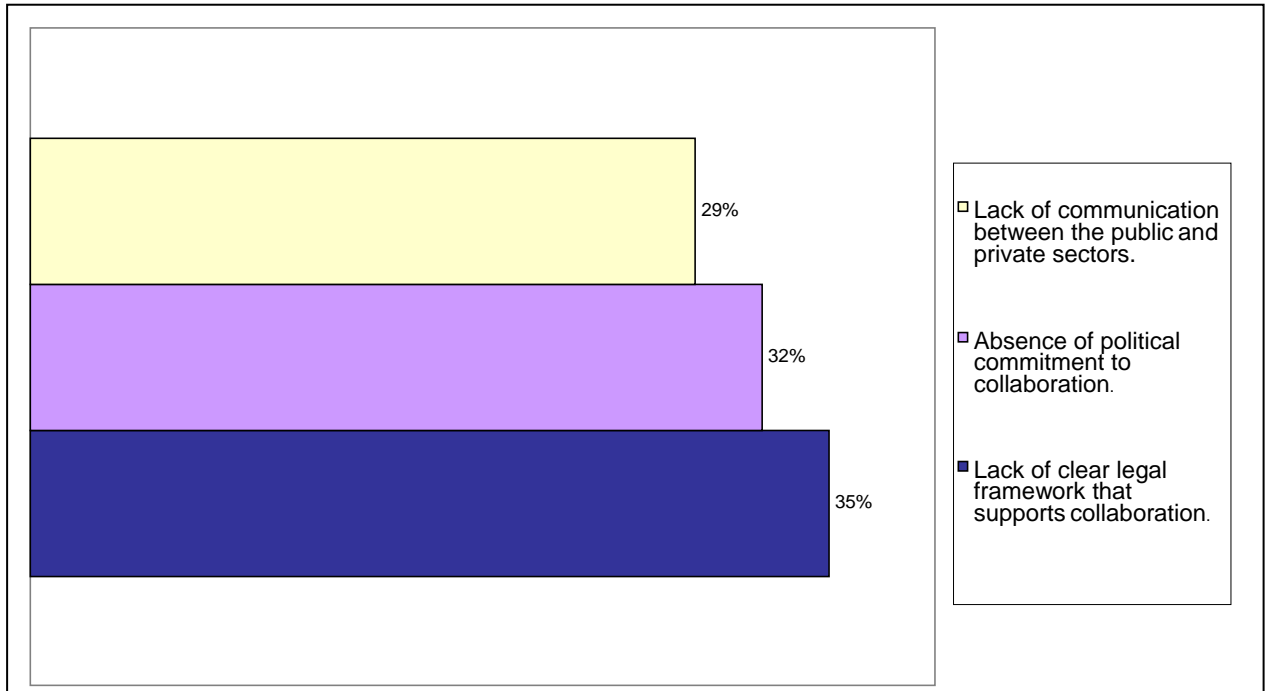


Figure 23. Most common barriers to public-private collaboration in the European region

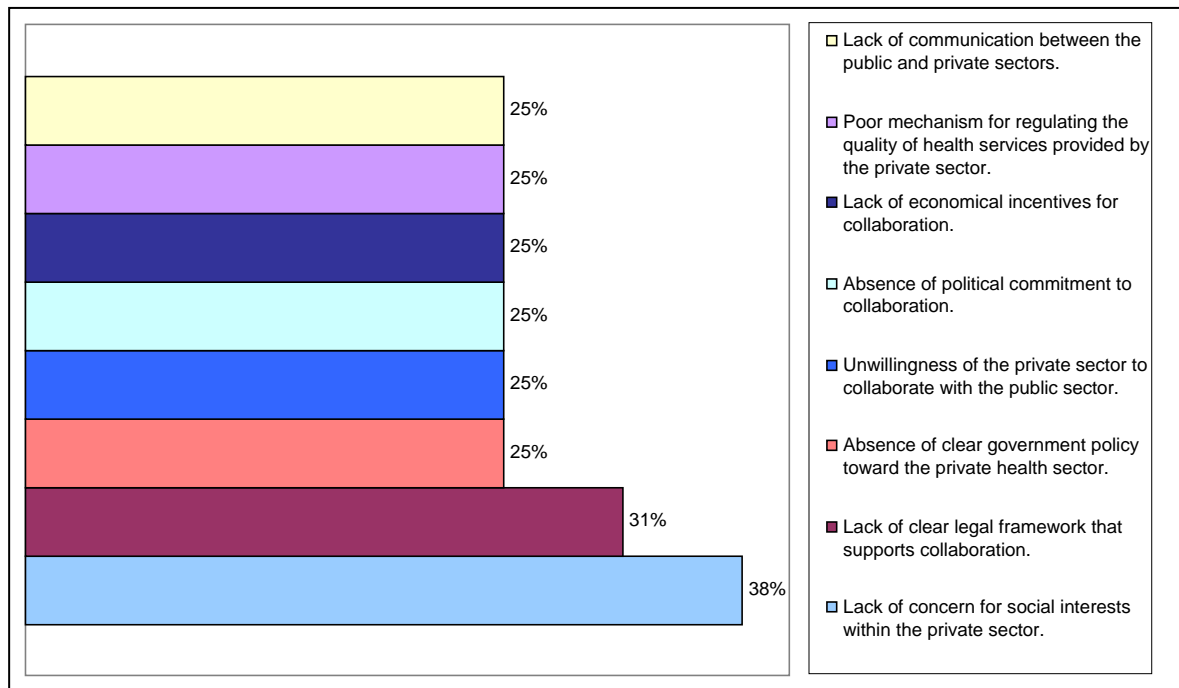


Figure 24. Most common barriers to public-private collaboration in the Americas region

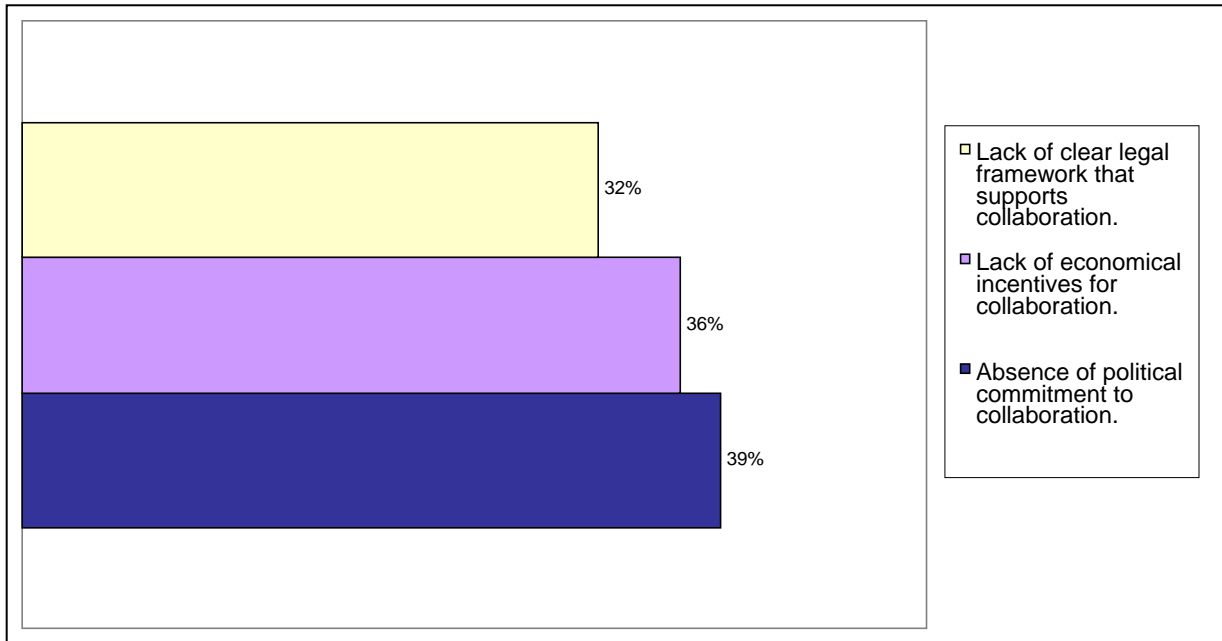


Figure 25. Most common barriers to public-private collaboration in the Southeast Asia region

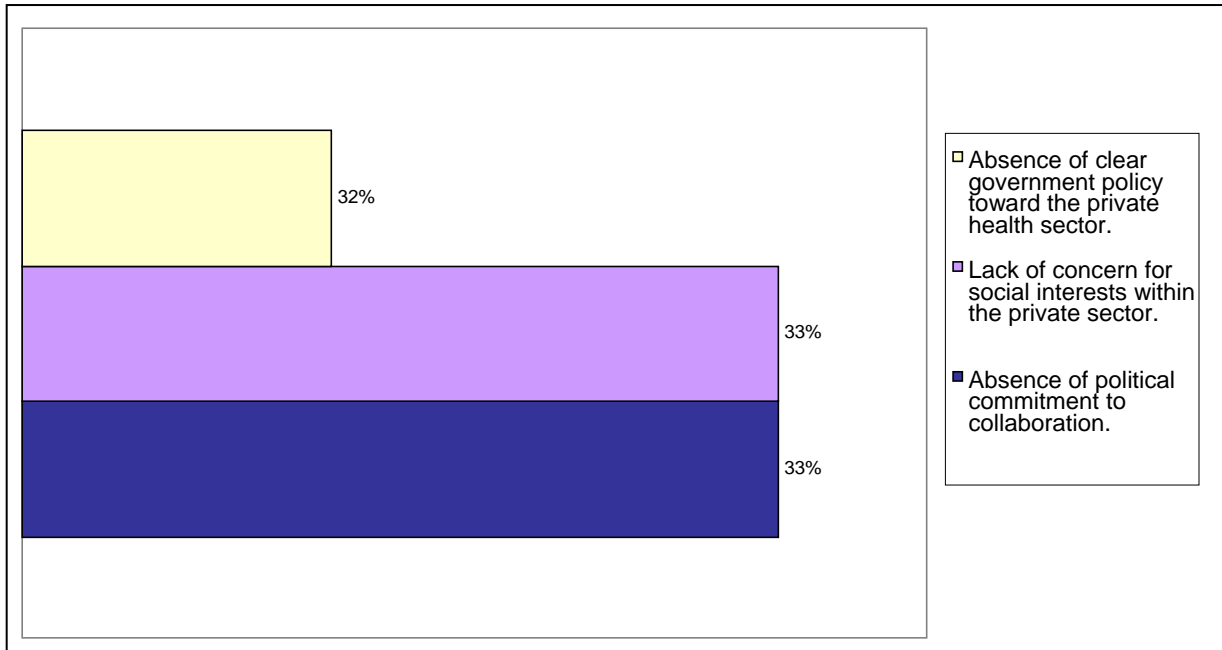
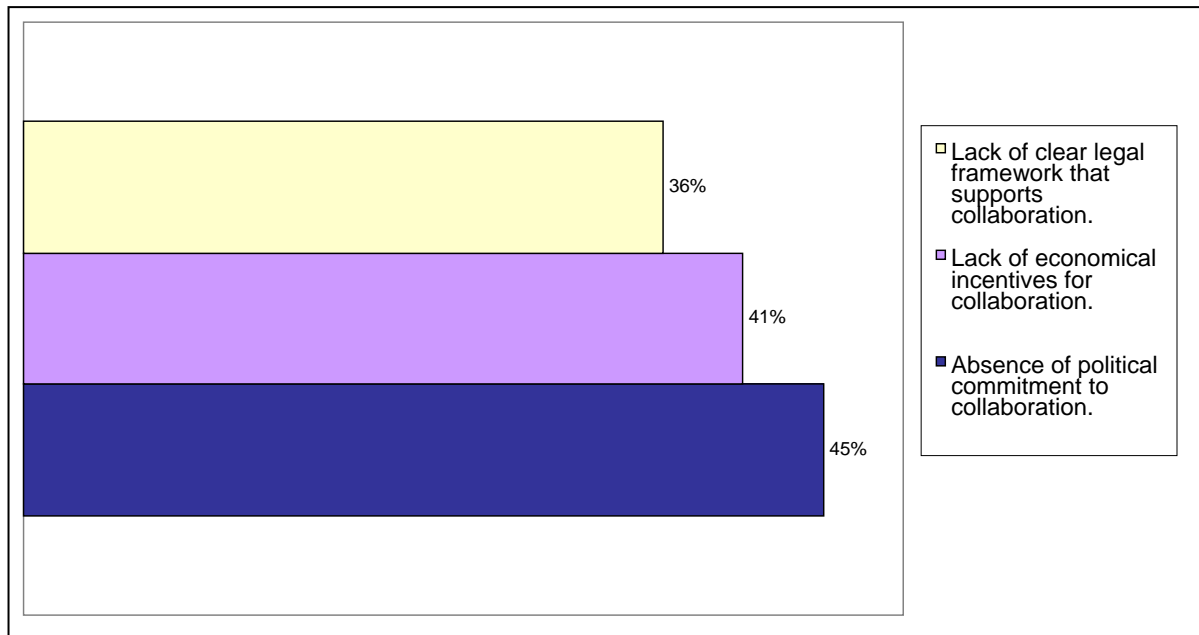


Figure 26. Most common barriers to public-private collaboration in the Western Pacific region

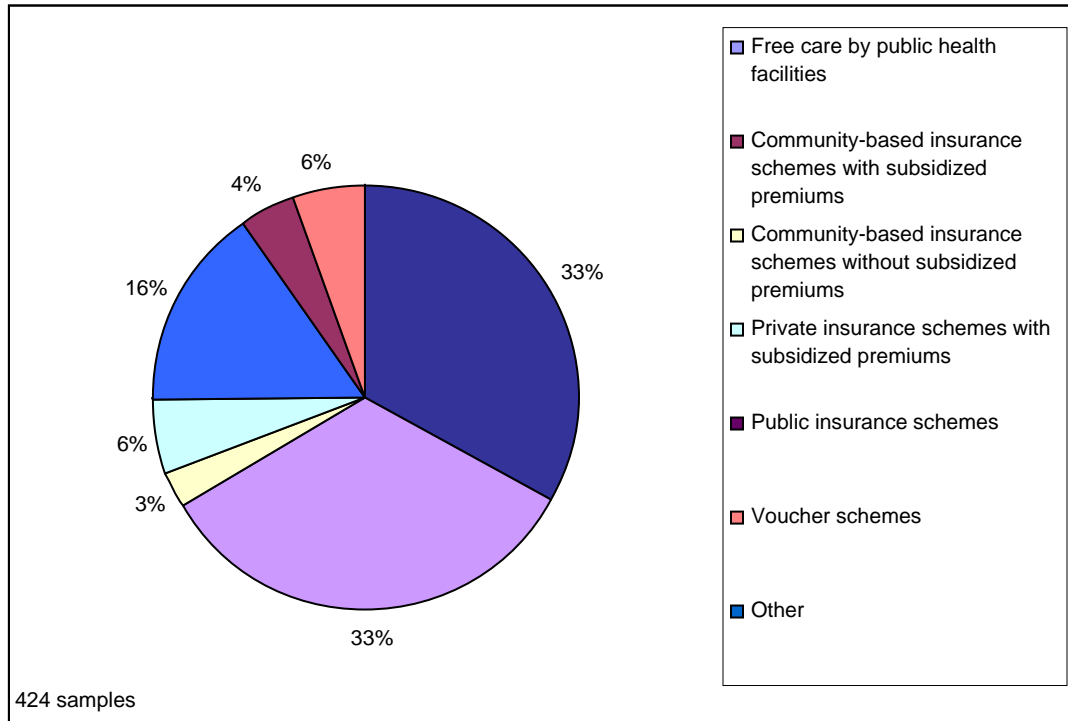


4. The government should take the lead.

The study findings suggest that the public and private sectors could significantly contribute to health service provision and that the government's role in regulation and control would need to be expanded and strengthened. Respondents identified the most common challenges to health services as being the quality of health services received from public sector health facilities or providers (68 percent) and the availability of public health facilities (50 percent) (figure 6 above).

The most frequently chosen ways of reducing out-of-pocket expenditures among low-income populations were identified as free care by public health facilities (33 percent) and community-based insurance schemes with subsidized premiums (33 percent) (figure 27).

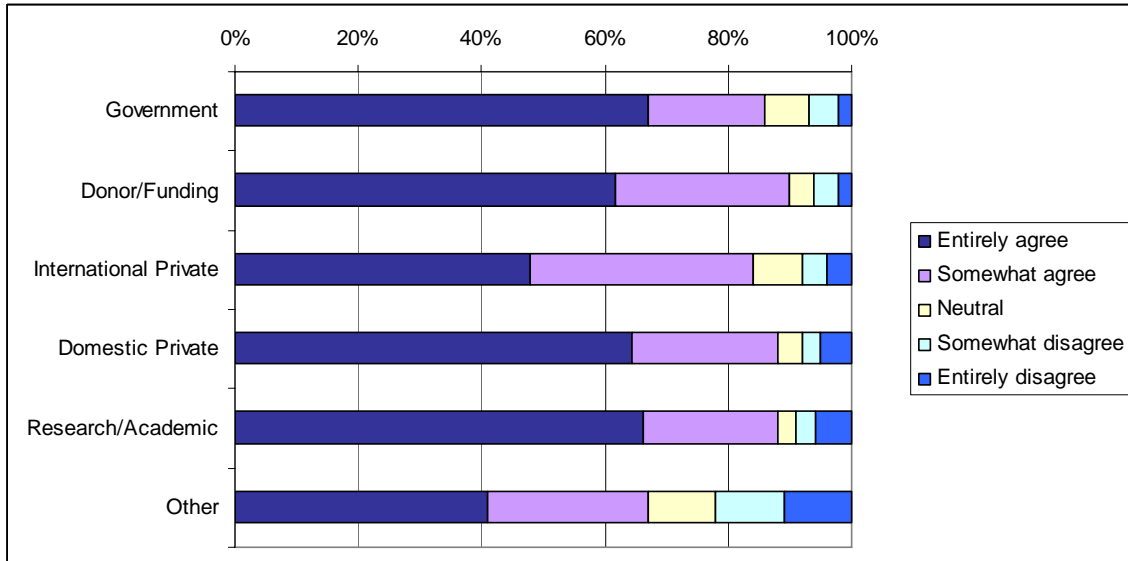
Figure 27: The most feasible way of reducing out-of-pocket expenditures among low-income populations



Although 83 percent of respondents somewhat agreed or entirely agreed that the government should concentrate its resources for health service provision on low-income populations (table 4 above), non-public providers were also seen as helping improve access to health services (such as child fever and diagnostic and laboratory services) among low-income populations (figures 8 through 12 above).

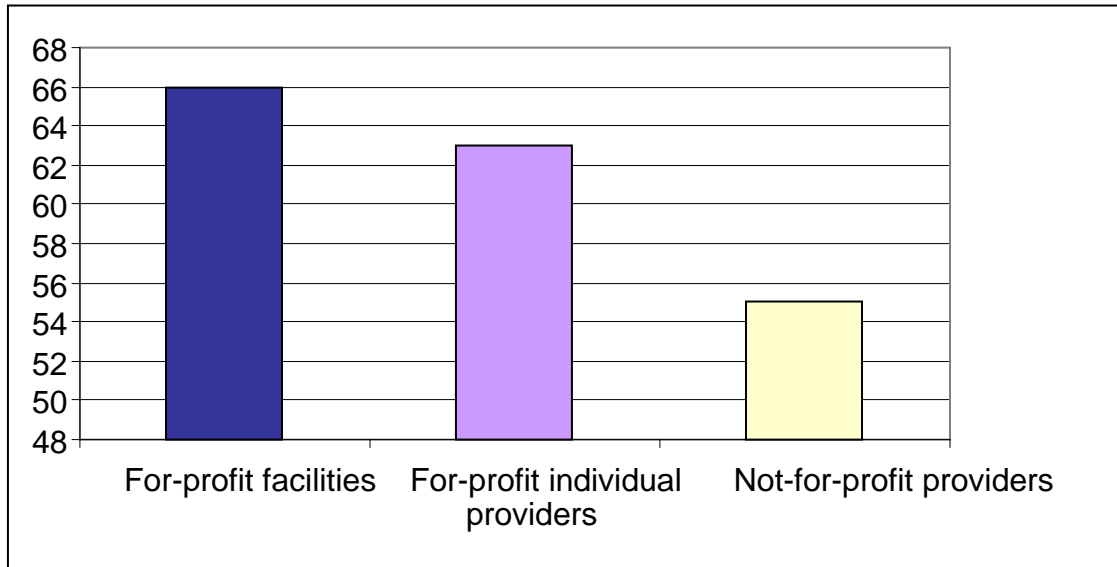
Seventy percent of respondents entirely agreed that the government should collaborate with the private sector to provide health services to low-income populations (table 4 above). Classifying respondents by their organization type, the analysis shows that the majority of respondents who worked for a government (67 percent), a donor/funding agency (61 percent), domestic private organization (65 percent), or research/academic institute (67 percent) entirely agreed with the statement that “the government should strictly monitor and control the quality of services provided by private for-profit health service providers” (figure 28).

Figure 28: The government should strictly monitor and control the quality of services provided by private for-profit health services providers, by organization type



Respondents viewed that strengthening government’s regulatory mechanisms would improve the availability, affordability, and quality of health services to low-income populations (figures 3 through 5 above). On the other hand, a majority of the respondents perceived that the government does not do a good job in regulating for-profit private sector facilities (66 percent) and for-profit individual providers (63 percent). Respondents seemed to think that the government does a relatively better job of regulating nonprofit providers compared with other private sector providers (figure 29).

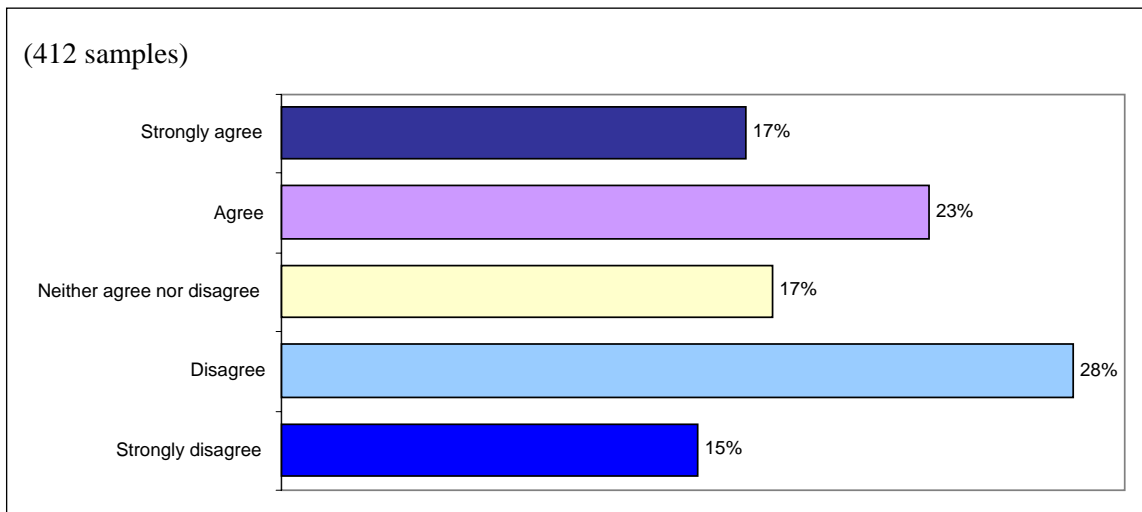
Figure 29: The government does not do a good job of regulating providers, by provider type



5. Donors should encourage public-private sector collaboration, but the funding channels should be carefully determined.

Perceptions on whether donors’ funding should be channeled through either the government/ministry of health or private sector were mixed. The proportion of respondents who disagreed or strongly disagreed that donor funding should be channeled through the government/ministry of health was slightly higher than those who agreed or strongly agreed (43 percent versus 40 percent) (figure 30).

Figure 30: Donor funding should be channeled through the government/ministry of health



About half of respondents agreed or strongly agreed that donors should directly fund the private health sector. Analysis by type of respondent organization reveals that respondents who work for a government (56 percent) or research/academic institute (60 percent) favored channeling funding through government, while those who work for an international (48 percent) or domestic (72 percent) private organization or donor/funding agency (50 percent) favored funding through the private sector (figures 31 and 32).

Figure 31: Donor funding should be channeled through the government/ministry of health, by organization type

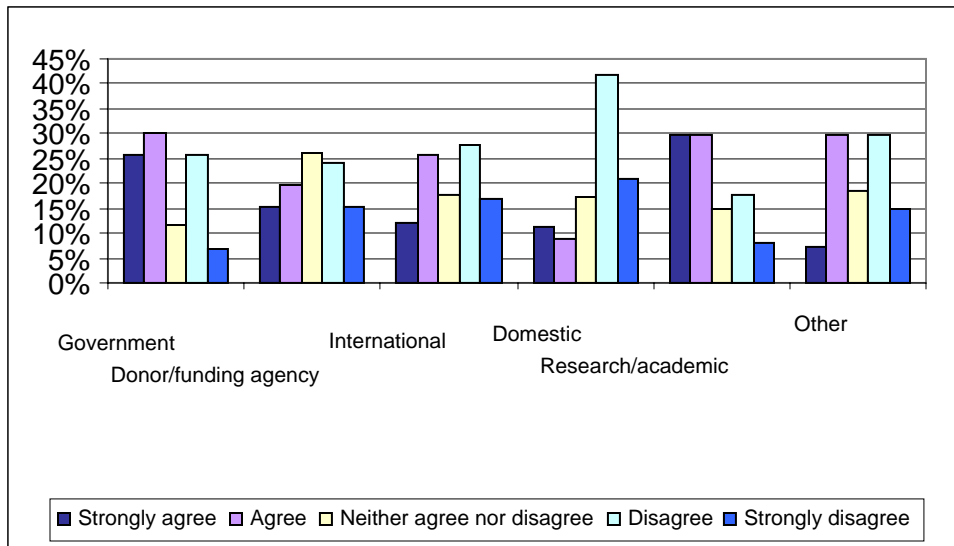
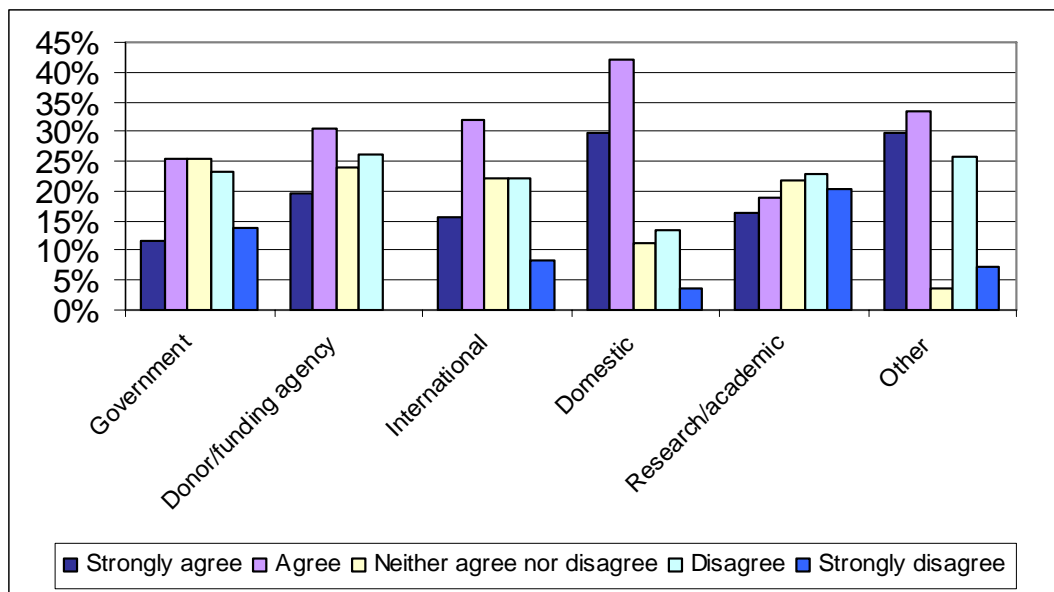


Figure 32: Donors should directly fund private health providers to strengthen them, by organization type



A high proportion of respondents (85 percent) supported the role of donors as encouraging governments to involve the private health sector in health service provision for low-income populations; 63 percent of respondents were not in favor of donors targeting public sector health services only (figures 33 and 34).

Figure 33: Donors should encourage governments to involve the private sector in health service provision for low-income populations

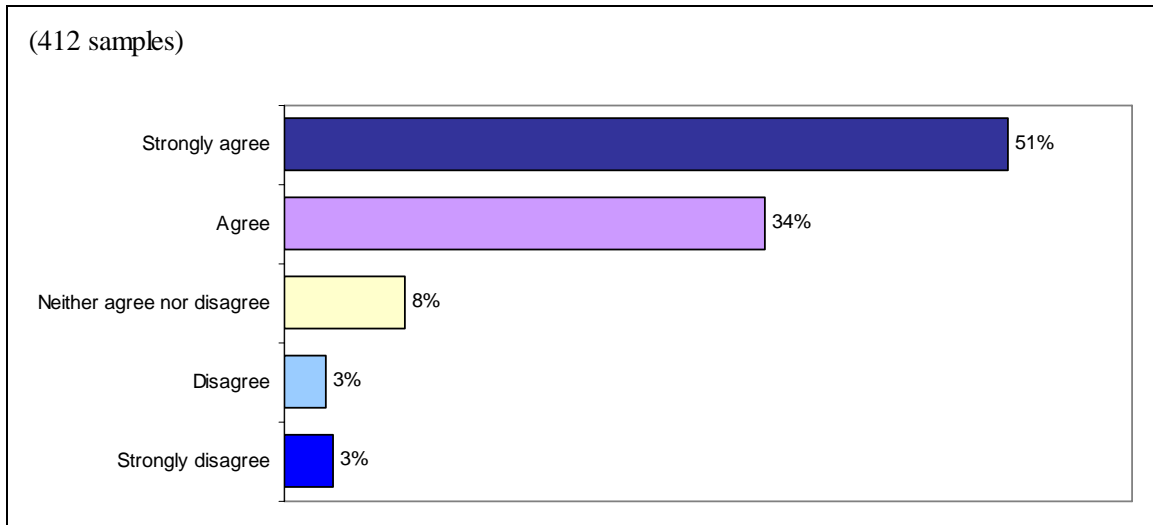
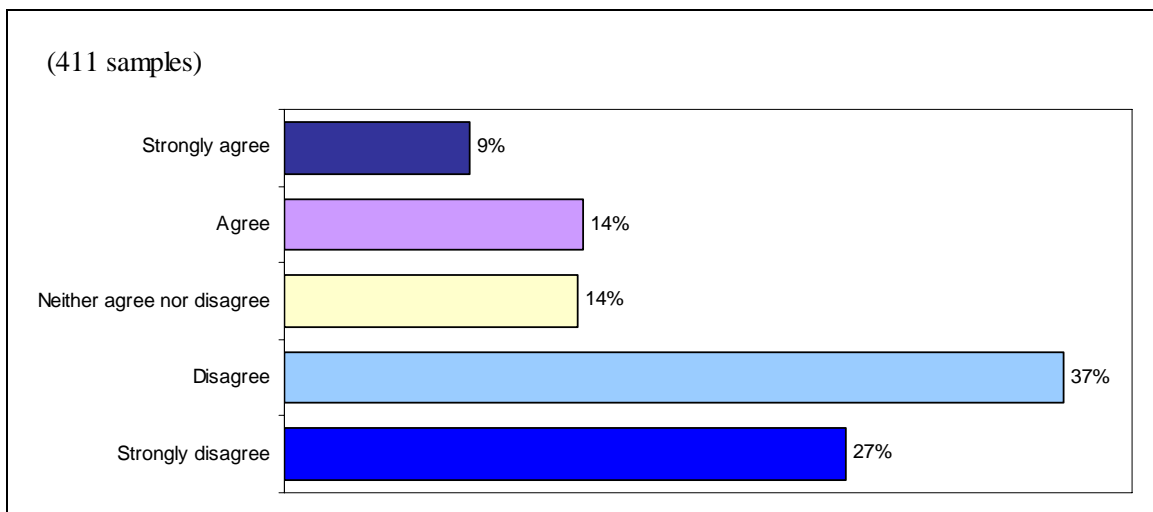


Figure 34: Donors should target public sector health services only



Discussion and recommendations

These findings suggest that the private sector is generally perceived by the global health community as having a crucial and complementary role in the provision of health services. The most commonly identified challenges to health service provision for low-income populations were related to public sector performance. The perceived performance of private sector involvement was more subject to geographical variations, type of private sector group, and type of services provided. Perceptions toward public-private collaboration were generally positive, but the findings also indicate a certain level of discomfort with private sector participation.

In terms of engaging the private sector, no “one-size-fits-all” approach emerged during this research. Each collaborative intervention was perceived with different degrees of impact on the availability, affordability, and quality of health services. The survey results also indicate that respondents are favorably inclined toward establishing a framework for the government to collaborate with the private sector and strengthen its regulatory role. Donor involvement in encouraging the government to involve the private sector was seen as acceptable. However, as there is little consensus on how donors should channel their funding, this involvement could create an adversarial reaction from stakeholders.

Potential areas for further work include the following:

- Reviewing the roles and practices of nonprofessional private sector groups in health service provision in low-income populations
- Facilitating a policy process to engage segments of the private sector and assisting the government in developing a framework for this engagement
- Reviewing regulatory systems on the private health sector and identifying potential interventions to strengthen them
- Defining who private sector providers are (rather than simply addressing them as the “private sector”) and framing and designing the initiative’s scope according to the strategic focus of the initiative
- Understanding the perspectives of the private sector on these issues as well (This survey focused on the perspective of public sector stakeholders.)

3. Qualitative Study of Policymakers' Perceptions of the Private Sector

Introduction and methods

This qualitative study sought to assess the perceptions that selected national and global health policymakers have of the private sector's role in health systems in low- and lower-middle-income countries, with a focus on service provision and financing for the poor. The exploratory research probed the roots and contexts of people's views on various private sector actors currently and potentially involved in health service provision and financing.

The qualitative research involved 57 in-depth interviews with policymakers at two levels: the global level and the national level (in three countries). Researchers conducted 16 interviews with global-level respondents representing four target groups and 41 interviews with national-level respondents from seven groups (table 5).

Table 5: Target groups and number of respondents interviewed

Respondent groups	Number of respondents interviewed
Global-level respondents	
Donors	3
International technical agencies (health and financing)	3
Academic and research institutions	1
Headquarters of international nongovernmental organizations	9
National-level respondents	
National government officials from health, finance, planning, and other ministries	9
Politicians	1
Technical health staff in donor organization country offices	9
Country technical staff in international agencies	3
Donor-funded project offices	1
Health professionals (medical clinic staff, pharmacy staff, nurses, midwives) from health service provider organizations/trade unions	9
Technical staff from nongovernmental organization country offices (local and international)	9
Total number of respondents	57

The in-depth interviews conducted at the national level took place in Pakistan, Thailand, and Zambia. We selected these countries to ensure diversity in geographical location, income group, levels of private health expenditure, and involvement of the private sector in health service provision and financing (table 6).

Table 6: Health and development indicators in Pakistan, Thailand, and Zambia

	Pakistan	Thailand	Zambia
Population*	152 million	63.7 million	11.5 million
Life expectancy*	65 years	71 years	38 years
Income group*	Low income	Lower-middle income	Low income
GDP per capita*	\$566	\$2,356	\$336
Government expenditure on health as a percentage of <u>total</u> expenditure of health**	27.7%	61.6%	51.4%
Private expenditure on health as a percentage of <u>total</u> expenditure on health**	72.3%	38.4%	48.6%
Out-of-pocket expenditure as a percentage of <u>private</u> expenditure on health**	98.0%	74.8%	68.2%

* World Bank 2006.

** WHO 2006.

The researchers conducted 12 interviews in Pakistan, 17 interviews in Thailand, and 12 interviews in Zambia. Interviewees were chosen purposively to represent seven target groups at the national level (table 5 above).

The researchers used an open-ended interview guide, based on a series of 10 questions, to conduct the interviews (appendix 3). The instrument enabled the researchers to keep the interviews semi-structured but allowed respondents to explore issues that were important to them. The interviews focused on perceptions of the private health sector and its role in health provision and financing for the poor (as compared with the public sector’s role), how these perceptions were formed, and specific experiences with different categories of private sector actors. The interviews were not recorded, but the researchers kept detailed notes of each interview. Interview data have been kept confidential, and interviewee names are not used in the study reports.

The researchers analyzed the qualitative data using thematic analysis in two stages. In the first stage, each researcher analyzed his or her interview transcripts and identified emerging themes. For the second stage, the research team met in Seattle in June 2008 and reviewed the data as a group, agreed on common themes, coded the data based on these themes, and discussed overall findings.

During the data coding, the researchers looked for positive, negative, or qualified responses to private sector involvement in health provision and financing. The researchers defined a “negative response” as one that opposes public-private interactions under any circumstance, a “positive response” as one that strongly advocates for public-

private interactions as a primary means to providing and financing health care, and a “qualified response” as one that recognizes a role and place for public-private interactions within specific, well-defined contexts.

Findings

The team categorized the findings into seven themes, as described below.

Theme 1. There was no agreement about what the “private sector” or a “public-private partnership” was.

There is no agreement among global and national respondents regarding who should be included in the definition of “private sector.” The majority of respondents asked the researchers early on in the interview what was meant by the term “private sector.” Several respondents preferred using the term “non-state sector” throughout the interview. The researchers encouraged respondents to provide their own definition of the private sector and explain why and how it differed from the public sector category. This resulted in a range of definitions. One respondent from a major donor agency, for instance, included all non-state actors who have a direct or indirect impact on the provision and financing of health services in his definition of the private sector. This included groups ranging from traditional healers and village midwives to multinational companies running corporate social-responsibility programs.

Most respondents, however, had a more restrictive understanding of the private sector that included only nongovernmental organizations, faith-based organizations, and for-profit providers such as solo practitioners, pharmacists, private clinics, and hospitals. In Thailand, almost every respondent, even those in nongovernmental organizations, assumed that the private sector refers to “private for-profit hospitals and pharmacies.” Many Zambian respondents referred to not-for-profit actors as “civil society,” or “community-based.” The majority of respondents at the global level and in Thailand did not include providers in the informal sector—such as traditional healers and village midwives—in their definition of the private sector. However, in Pakistan many respondents included traditional healers as part of the private sector because many citizens go to *hakeems* or homeopaths as part of their out-of-pocket health expenditure. In Zambia, too, where use of traditional healers is quite high, several respondents mentioned their role in health care provision.

Respondents overwhelmingly agreed on the need to distinguish between for-profit and not-for-profit providers, and attitudes were more likely to be influenced by the respondent’s perception of a provider’s motivation than by the idea of the “private sector” more generally. For example, many respondents viewed for-profit providers as purely driven by profit motives with no adherence to professional standards and ethics. One global respondent from an international development agency specifically drew a line between for-profit and not-for-profit agencies, noting that nongovernmental organizations and faith-based organizations resembled the public sector more than for-profit entities in terms of their accountability and broader emphasis on the public good. Another global respondent, a health economist from a donor agency, suggested that for-profit providers

should be carefully distinguished from their nongovernmental organization and faith-based organization counterparts on the premise that for-profit providers are mainly driven by profit motives and therefore do not provide services to people who they know cannot pay, while the not-for-profit organizations are driven by passion and a greater sense of commitment to performance and serving the poor.

Similarly, some respondents expressed some confusion and frustration about what public-private partnerships (PPPs) are and how viable they are as means of addressing urgent health problems that the poor face. For instance, in Pakistan, some donors seemed wary of the range and number of different public-private interactions and were skeptical about their replicability. One donor agency representative in Pakistan explained that there “is much more rhetoric about PPPs than actual partnerships. I have not seen much of that. There is very little on the ground.”

One global-level respondent openly criticized the health community for putting too much credence and emphasis on an already tried and failed idea:

...PPP's won't solve the problem. In the 1970s I was employed at some sort of a missionary hospital in Tanzania. And my salary was paid by the government. So, it was a PPP too. PPP is not a new concept. It has long existed. But they won't solve the problem. They have a limited potential. It is silly to put too much credence into a single model or solution.... People are looking for buzzwords. This is not a new trend. And certainly it is not a panacea. Professionals, international agencies, and donors should stop searching for buzzwords but solutions.

The term “private sector,” therefore, means different things to different people. The lack of a consistent understanding about what constitutes private provision and financing influences people’s willingness to accept and interact with non-state actors.

Theme 2. Most respondents gave qualified responses in their views of the private sector, although their perceptions varied depending on their personal ideology and history, type of intervention, area of focus, and country context.

Given the range of respondents and diversity of country settings, it is perhaps not surprising that a variety of perceptions about the private sector appeared in the interviews. Although it is difficult to generalize, it appears that respondents’ perceptions of the private sector were more polarized in Thailand and Pakistan, while many respondents in Zambia and at the global level reflected a more mixed perspective.

Particular views about the private sector often seemed to be individualized—that is, they were based on personal ideologies and experiences and the individual respondent’s career history. For example, many national-level respondents have worked in the public sector as well as in the private sector, either in nongovernmental organizations or private practice (sometimes simultaneously). These professional experiences contributed to a more nuanced perspective of the private sector. Furthermore, views of the private sector also depended on the respondents’ particular health focus. For example, respondents

working in primary health care delivery seemed more skeptical of private sector involvement, whereas respondents involved in the delivery of higher level services tended to be more positive.

Perceptions also varied depending on the specific public-private mechanism in question. Some respondents were favorable to insurance schemes, while others were negative about the idea. The majority of respondents at the global level were very skeptical about whether insurance schemes could work in low-income countries and particularly whether schemes could effectively include the poor. Global respondents were generally favorable to contracting. At the national level, respondents tended to support contracting too, although their enthusiasm varied depending on the nature of services and the profit motives of the providers in question. Proposals to outsource auxiliary services, such as vehicle maintenance or janitorial work, were rarely controversial. There were mixed reactions, however, to proposals to contract out preventive and clinical care, especially to for-profit providers.

As for regulation, most respondents agreed that ministries of health need to establish a strong regulatory environment by monitoring, certifying, accrediting, supervising, and setting up a code of ethics for private sector providers. Yet, a number of global and national respondents felt that many developing-country governments lack the necessary institutional capacity and know-how to set up such regulatory institutions without help from international agencies and donors, while others pointed to a lack of evidence that accreditation and other regulatory systems work well in developing countries. Most respondents favored some degree of “regulated market” in the health sector rather than a purely open-market economy in which for-profit and not-for-profit providers freely compete along with public sector providers.

A variety of opinions was also evident across the national examples. Only two interviews in Zambia represented polarized positions, such as “the government should provide everything” or “the more private sector involvement the better.” Between these extremes were varying opinions about the public-private mix. Most respondents in Zambia were able to come up with a variety of creative ways in which the private sector, whether for-profit or not-for-profit, could be engaged by donors and government to increase efficiency, expand access to care, and improve equity.

For example, some respondents in Zambia felt that the government should provide the bulk of medical services, with missions, trusts, and nongovernmental organizations complementing the government by stepping in to meet neglected populations. In this model, for-profit providers exist only at the margins of the health system and are left largely on their own to target high-income clientele. Others argued that the private for-profit sector should play a major role in the health system—but only for outsourced auxiliary services such as drug supply-chain maintenance, and not for clinical care. In this model, for-profit private companies would be actively solicited by the public sector for contracts, but for-profit private providers would, again, be left at the margins. Still other respondents felt that not-for-profit providers and missions should provide critical services—but only in areas of the health systems that add value to the public sector (such

as laboratory services and specialist services), while the public sector should be strengthened to focus on preventive and primary care. This model would allow for the public sector to be strengthened and the not-for-profit sector to be more closely controlled and engaged in targeted interventions. Finally, several respondents asserted that for-profit providers should be actively encouraged to focus on services for the middle class and rich, while nongovernmental organizations and the public sector should focus on the Essential Package of Services for the poor. Respondents with this view emphasized that there is nothing wrong with a two-tiered system as long as the poor receive an essential package.

In Thailand, respondents' views were far more polarized, with provider associations often representing one view, government/civil society representing the other view, and public sector financing agencies falling somewhere in the middle. Respondents from the government and consumer affairs referred to the private sector as "rapacious," "profiteering," "unregulated," "uncaring about public service," and "unwilling to work with poor people in poor areas." Within provider associations, on the other hand, the perception was that the public sector does not address provider incentives or professional satisfaction because it is caught up in its own institutional inefficiencies and bureaucratic culture. Respondents from the public financing agencies echoed both views, describing private sector providers as caring mainly about profit and dealing mainly in curative rather than preventive care, while characterizing the public sector as inefficient, of poor quality, and as more concerned about its own institutional financial viability than patients' needs. Despite these strong views, almost all respondents in Thailand recognized that both sectors need each other, at the very least because competition between them can be a positive thing, as it can raise standards in both sectors.

There was also a polarized response to the private sector in Pakistan. The private sector was generally seen as completely unregulated and therefore providing a variable quality of health care at fees that can impoverish poor families. The public sector was almost universally viewed as poorly managed with no incentives or no monitoring system for performance.

While each country example and respondent provided a unique perspective, the majority of respondents gave qualified responses in discussing their views on the private sector. Expressed in the majority of interviews was the view that the for-profit private sector is unregulated and driven by economic gain. There was also a general perception that the government has poor management capacity, is unwilling to give up control of service provision, and wants to get the credit for any positive results that might occur from engaging with the private sector. At the same time, most respondents recognized that the private and public sectors need each other for a range of reasons. For example, the private sector can fill gaps in public sector activities and provide an incentive for public facilities to improve quality, while the public sector can regulate and oversee the private sector to ensure quality of care. Thus, many respondents, while not wholly enthusiastic about for-profit provision and financing of health services, can see the usefulness of certain types of partnership with private sector actors.

Theme 3: Negative views—though in the minority—were deeply rooted.

Only a small group of respondents expressed particularly negative views about the private sector. These negative perceptions are based on deeply rooted philosophical beliefs and personal experiences. For example, one respondent pointed to “social justice” as informing her views, while another said that “practical experience in the field” was the root of her beliefs. Another respondent explained that his personal experience working in the private sector formed his negative perception of the sector:

I worked in the private sector and did oil trading. I learned about the inefficiency of the private sector. Efficiency of the private sector is a myth. I was bored and the work was value-less. So I became a management trainee at a public hospital instead. People had low salaries, but they worked hard and were efficient.

Further probing in the interviews also showed that negative views were more complex and did not always match what the respondents were doing in practice. Some respondents pointed to certain circumstances in which working with the private sector was appropriate (often involving contracting with not-for-profit providers). Others went on to describe their past or current involvement in public-private interactions, with generally qualified or positive views of the experiences. Only one respondent at the global level remained consistently negative about the private sector throughout the interview.

Global-level respondents with negative views felt that, instead of investing resources in the private sector, more funding should go into the public sector. For example,

It is B.S. that the growing power of the private sector can solve the health problems of the poor. The private sector cannot take care of the poor. It is not the knight on the white horse. It is just a fantasy. They exist because there is no public sector. If there is a public sector which provides affordable, high-quality services, people won't go to the private sector.

The argument that because the private sector is so big, we should invest in it, is wrong. Instead of running down the public sector, when it has so few resources, why don't we invest in the public sector and see what it can do?

For these global-level respondents, a major concern is that a new donor and international agency focus on the private sector will mean that resources, which they feel are desperately needed by the public sector, will be diverted to private sector projects with negative consequences for public health. Negative views, then, while not in the majority, are often based on deeply rooted fears and are therefore difficult to counter. At the same time, our research found that negative views toward the private sector did not necessarily mean that a respondent was acting in an obstructive way toward public-private interactions in his or her professional capacity.

Theme 4. The public sector viewed the private sector as a means to an end.

One strong sentiment that emerged from the interviews is the idea that public-private interactions should be a means to accomplishing public health goals, as opposed to a strategy to achieving greater privatization of services. In general, few respondents openly advocated for an unrestricted, market-based health system. One consensus that emerged from the national-level interviews was the sense that a privatized, “American-style” health financing and provision system was neither a feasible nor desirable model for developing countries. Many respondents pointed to the health insurance crisis in the United States as a prime example of the risks of privatizing health provision and financing. At the same time, many also believed that the private sector could and should be strategically deployed to achieve specific objectives. Thus, most respondents took an instrumentalist approach to the private sector—viewing collaboration as an instrument to bring about positive health outcomes—as opposed to advocating for a more general ideology of privatization.

Respondents viewed the private sector as a means to several different ends. For instance, respondents at all levels repeatedly emphasized the interdependence and interconnectedness of the public and private sectors, especially in terms of service provision. The existence of a vibrant private hospital or clinic system can stimulate ministries of health to improve the quality of services, upgrade the incentive structure for public sector providers, tighten up regulation and accreditation systems, and take a more patient-oriented approach toward health care delivery. One representative of the public sector in Zambia argued:

It is an issue of competency. The private sector can be more efficient and influence us to be more efficient. It can act as a catalyst.

The private sector, according to these respondents, pushes the public sector to compete and become more responsive to the idea of the patient as someone who is not simply a recipient of free services, but a consumer of care—that is, someone who, even in the absence of user fees, pays for their health care through taxation and thus has a right to expect the highest quality.

Other respondents pointed out that the private sector also helps by providing poorly paid public sector health workers with an opportunity to supplement their income, either through dual practice in private clinics or supplementary employment from nongovernmental organizations. Surprisingly, many public sector respondents supported dual practice, provided that measures were enacted to control conflicts of interest and to discourage a drain of public sector employees to full-time private work.

For example, many respondents in both Thailand and Zambia viewed the existence of dual practice as a mechanism to prevent brain drain, although they acknowledged that there were problems with dual practitioners leaving work early or attempting to divert public sector patients toward their personal private practices. For many of the Thai public sector respondents, the problem was less an issue of part-time dual practice than an issue of doctors leaving the public sector for full-time work in private hospitals. Similarly, in

Zambia, one government representative said that he did not have a problem with providers working for profit after hours, but he did have a problem with them abandoning the medical services altogether to work with nongovernmental organizations or donor organizations. In Zambia, respondents noted repeatedly that many of the most energetic, talented, and qualified doctors have been poached by nongovernmental organizations, international agencies, and better-funded, not-for-profit mission hospitals. While dual practice was not specifically mentioned as a mechanism to prevent brain drain in Pakistan, it was generally accepted as a necessary fact of life to ensure a monetary incentive for public sector health professionals. One government official suggested that there be more organized mechanisms for private sector practitioners to take advantage of public sector facilities. He provided the example of “institutionalized practice” in which doctors can use public sector facilities during off hours to collect fees that are then distributed to the doctor (50 percent), the institution (25 percent), and the attendants (25 percent).

In addition, although respondents repeatedly noted the danger of creating a two-tiered health system, many also saw private sector provision as a means of decreasing the pressure on public sector facilities. When the “private sector” was understood as “for-profit private clinics and hospitals,” such as in Thailand, respondents described a scenario in which middle-class clients were able to bypass unreasonably long queues so that time and resources were freed up for poor patients. When “private sector” meant primarily “not-for-profit” faith-based or trust-based facilities, like in Zambia, respondents envisioned decreasing public sector pressure by broadening the mix of low-cost services available to the poor. This was less of an issue in Pakistan where, particularly in rural areas, public sector facilities are underutilized often because of a lack of supplies and health personnel. However, several respondents in Pakistan mentioned using regulation of the private sector as an incentive for the public sector to improve the quality of services offered in its existing facilities.

A number of respondents cited partnerships embedded within vertical, disease-specific programs as positive examples of how the private sector can be mobilized in innovative ways to achieve targeted outcomes, such as those spelled out by the Millennium Development Goals. Tuberculosis, malaria, and HIV/AIDS prevention and control were highlighted as areas in which for-profit companies, nongovernmental organizations, not-for-profit foundations and trusts, public sector financing agencies, and national governments have made productive alliances. For example, respondents in Pakistan and at the global level mentioned the failure of many national governments to meet tuberculosis detection and treatment targets as a primary stimulus for successfully engaging private sector actors. In Zambia and Thailand, a similar point was raised with regard to HIV/AIDS control and prevention, with a variety of private sector actors engaged in everything from advocacy and lab testing to drug procurement and supply-chain management. These targeted partnerships, formed as a means toward a specific end, were relationships that even those respondents with serious reservations about the motivations of private sector actors could see as potentially useful. In the case of tuberculosis control in particular, the ability to provide examples of fruitful models of past collaboration served as a critical tool in program development. Respondents also gave administratively and financially pragmatic reasons for public-private interactions. In

Pakistan several respondents mentioned that the Global Fund proposal process requires that both public and private providers be included in proposals to obtain funding. For example, a donor agency representative in Pakistan noted that:

The Global Fund is urging every proposal made to have a public and a private sector partner. It is on the basis of a prime and sub relationship, and they expect a dual proposal with a public prime [relationship] and a private prime [relationship]... In the area of HIV/AIDS, you have to have private partners, especially when you don't have a generalized epidemic and there is a certain amount of stigma associated with the disease.... There is a considerable amount of money in the Global Fund.

Respondents with the instrumentalist view of the private sector were supportive of partnerships if the partnerships were properly regulated and controlled. However, a number of respondents (especially from the public sector) placed the responsibility for concession squarely on the shoulders of the private sector, believing that private sector providers or companies should willingly adapt to the requirements of either government or global public health agencies. The public sector, to these respondents, was responsible for providing a unified, overarching, public good-focused strategy for health-service provision and financing at both the national and global levels. The private sector, driven by profit or competition for donor funds, could not be counted on to act in a disinterested or consistent manner and, hence, should be willing to forfeit control, authority, and benefit to those better placed to serve in a position of "stewardship" over public health. In this instrumentalist approach, where it is believed that the public sector should tightly control private sector actors, public-private interactions are not partnerships with equal actors and shared visions. This bias has likely implications for performance.

There was also a lack of recognition among respondents of the value of investing in public-private interactions for long-term strengthening of the health system. Thus, an instrumentalist approach to public-private interactions raises the question of what becomes of partnership once "the ends" are achieved. For example, in Zambia, a number of people noted that the HIV/AIDS crisis in the country has generated much creative thinking on the subject of the private sector, which has mobilized people to develop strong working relationships among groups that might not otherwise cooperate amicably. However, only one respondent brought up the issue of what will happen to these relationships once the AIDS crisis is brought under control and the Millennium Development Goals are met. Few respondents spoke about the building of enduring capacity for public-private linkages as an important and worthy end in itself, independent of the specific public health outcomes such linkages may achieve.

Instrumentalism, therefore, would allow for global and national policymakers to engage the private sector in strategic and targeted ways. At the same time, it also can shift the responsibility for concession onto private sector actors, lead to an interaction that is not an equal partnership (with implications for performance), and inhibit creative and long-term thinking about partnership.

Theme 5. At the national level, the private sector feared government interference, while the public sector feared a loss of control.

Although many respondents expressed the view that the public sector is unreceptive to collaboration with private sector actors (particularly for-profit providers), many also noted that the private sector was similarly apprehensive about public-private interactions. Health ministries in low- and lower-middle-income countries were frequently characterized as inefficient, incompetent, overly bureaucratic, corrupt, and lacking the capacity to manage their own affairs well, let alone partnerships of any kind. At the national level, private sector representatives in all three countries were unanimous in their concern about over-regulation and interference by government. One respondent in Pakistan, where the sector is almost completely unregulated, stated that the government sought to “strangulate,” rather than regulate, private sector activities. Respondents in Thailand and Zambia cited similar concerns.

In Pakistan, private sector actors—many of whom represented not-for-profit services—asserted that the government frequently took credit for the success of public-private interactions and mentioned the public sector’s inability to share commendation as an obstacle to future partnership. Some expressed fears that the public sector would use private sector “collaboration” as an excuse to generate revenue by imposing taxes on the sector or, on a more personal level, to expand rent-seeking opportunities.

In Zambia, respondents noted a lack of enthusiasm among private sector providers to collaborate with the public sector. As one provider representative said pointedly:

Because the government has not been involved at all, the private sector has largely developed on its own.... And this has been a good thing. The minute the government starts to intervene, there will be problems.

While several respondents in Zambia pointed to the government’s contracting of Crown Agents to manage the Central Medical Stores as a primary example of successful and creative public-private interactions, at least one respondent was able to cite other instances of international private sector businesses turning down outsourcing opportunities offered by the government.

In contrast, respondents characterized the public sector’s unwillingness to collaborate as due mainly to the fear of a loss of control and authority (particularly in regard to service provision). The context of this fear differed depending on each country’s history of health sector reforms. In Thailand, for example, health financing reforms shifted the Ministry of Public Health’s financing activities to the National Health Securities Office, an autonomous public agency. Provision, regulation, and medical education remained with the Ministry of Public Health. A number of respondents portrayed the situation in Thailand as a turf war between the Ministry of Public Health and private hospitals, with the former seeking to protect the handful of responsibilities left to them.

In Pakistan, respondents believed that the public sector was hesitant to acknowledge the role of the private sector, fearing that it would expose the public sector's inadequacies and weaknesses. One donor agency representative said:

They fear it will open them up to comparison, and there is an ingrained sense that the government should provide services.... They fear that even less people will go to the public sector and that they will lose their power.... There is a sense that discussion about the private sector will undermine their role.

In Pakistan, then, the private sector was portrayed as threatening the legitimacy of the public services and, by extension, their authority.

In Zambia, the HIV/AIDS crisis has forced the public sector to begin experimenting with innovative models of partnership. Respondents' views on collaboration were generally more enthusiastic here than they were in either Pakistan or Thailand. Still, a number of representatives portrayed the public sector in Zambia as having grown used to a status quo that, for many years, preferred statist management of many economic and social activities.

Thus, in all three countries, private sector representatives characterized lack of trust and fear of control as primary barriers to collaboration with the public sector, while public sector representatives expressed a fear of losing control through partnering with the private sector. The source of distrust on both sides was rooted in the unique conditions of each country and affected by diverse histories of privatization and health sector reform, differing public health priorities, and distinct political and economic circumstances.

Theme 6. There was significant experience with many different forms and models of public-private interaction.

When considering all of the global and national responses obtained through this research, a broad range of experiences with and forms of public-private interactions emerge. While no single model or definition of a public-private interaction was expressed, several global respondents referred to the example of health insurance in Rwanda, which will be discussed later. At the national level, there was reference to a broader array of examples and situations in which the respondents perceived that public-private interactions had taken place. In Zambia, these ranged from nongovernmental organizations that were contracted by the Zambian government to run lab activities for HIV/AIDS anti-retroviral programs in southern Zambia to the contracting out of the Churches Health Association mission hospitals in rural areas. In Thailand, private hospitals are included in the National Health Security Office (universal coverage) scheme and the Social Security Office health benefit scheme. Also in Thailand, civil society organizations and the Ministry of Public Health are collaborating to bring about health system change, such as agreement on universal coverage and creating universal standards and guidelines across public and private sector providers. In Pakistan, a range of examples were cited, but the most frequently mentioned example was the contracting-out of government Basic Health Units to an nongovernmental organization in one district of the country.

Many respondents provided specific examples of ideas for future public-private interactions. For example, in Zambia there has been some discussion of outsourcing logistical aspects of district drug supply to a private company. In Thailand, there has been some suggestion of allowing private sector specialists to make use of public facilities, such as surgical theaters and labs, for a fee to better integrate public-private management of patients and to raise revenue for public hospitals.

Many global-level respondents mentioned the importance of corporate social-responsibility programs as a way to think about the future of public-private interactions. For example, one respondent noted that:

Corporate social-responsibility programs are very important for public-private and NGO partnerships. In Bangladesh some companies provide facilities, equipment to hospitals, build wings for them, give money etc...

The majority of respondents had some experience, either direct or indirect, with public-private interactions of some kind. There was no “gold standard” that was referred to at either the global or national level, and many respondents expressed some frustration with the lack of definition or understanding of public-private partnership, collaboration, or interaction. The overwhelming response was that public-private interactions are necessary for achieving specific public health goals, but their construct will vary based on the health intervention and the particular individuals involved.

Theme 7. The evidence base on private sector involvement was not seen as sufficient.

Many of the national and global respondents felt that more evidence is needed on the private sector’s role in health systems in poor countries, particularly in three areas. First, respondents felt they needed more information on who uses the private sector in poor countries. This topic emerged in interviews at the global level, as some respondents were confused about which populations are served by the private sector. Some people stated clearly that the poor use the private sector, while others argued that the private sector serves mainly middle- and upper-class clientele. Even at the national level, there was confusion as to the extent to which poor people will bypass free or low-cost primary care to access private clinics and hospitals. This was especially evident in Thailand, where provider associations, nongovernmental organizations, and other private sector representatives insisted that poor people regularly use private providers, while many government representatives were adamant that private hospitals were mainly frequented by the wealthy.

The second area for which respondents wanted more evidence is when and why people use the private sector. At both the global and national levels, respondents were unclear as to whether private sector care was being used by poor people at the primary health care level or whether they also sought private providers for tertiary, hospital-based services. Similarly, there was a general uncertainty in Thailand and Zambia about whether private providers were contacted mainly for one-off, acute cases of illness and not for chronic problems like diabetes or heart disease. Many respondents wanted more evidence to

confirm that the poor and middle classes turn to the public sector for long-term, chronic illnesses and to assess the financial burden such use places on public facilities. Respondents in Pakistan also wanted to know whether people go to the private sector because of poor quality in the public sector or because of a lack of physical access to public sector facilities.

Finally, respondents sought evidence on what public-private interactions already exist in their countries. Many cited a lack of documentation of existing projects and therefore an absence of ongoing lessons learned or best practice examples. For example, respondents in Zambia felt that there were gaps in the data as to what public-private projects were being planned and implemented. While centralized donor and government coordination of the health sector is generally strong in Zambia (compared with other sectors and countries), many respondents felt that they were learning about new public-private initiatives after the fact, with little chance to learn from and build upon the work of others as projects unfolded in real time. Many global and national respondents were also particularly concerned about whether these models are helping the poor, and they wanted more evidence on this issue.

In addition to discussing gaps in the evidence base, some respondents also pointed out problems with the existing evidence. One person from an international nongovernmental organization stated that:

A lot of the research on this topic is a bit myopic, and there is not enough attention to the negative consequences. In some of the research on the private sector, it is clear that they are looking for positive outcomes instead of negative consequences—for example, how these mechanisms might derail political efforts to attain universal health coverage in poor countries.

Although the majority of respondents discussed the weakness of the current evidence base on the private sector's role in health, many respondents simultaneously cited "evidence" to back their perceptions. This was particularly the case among global respondents who held negative views about public-private interactions. For example, one donor respondent stated that:

In financing, public financing is best. All the evidence shows that it is more effective, efficient, and equitable. I think the onus is on the private sector to prove that it can work better than the public sector.

In sum, respondents perceived gaps and weaknesses in the existing evidence base, but they were also willing to cite "evidence" to back their views of the private sector's role in health provision and financing for the poor. In fact, this apparent desire and need for evidence, especially among global respondents, has led to the creation of popular narratives that are commonly shared and reproduced as "success stories." For example, during our interviews, the majority of global-level respondents pointed to Rwanda's health insurance scheme (the *mutuelle* system) as a successful model of donor-sponsored public-private partnership. One respondent argued that:

The governments must give resources and choices to the poor by providing an insurance scheme. Yet, it does not have to be a universal or a national program. It could be a community-based selective system just like that of Rwanda. Rwanda has 77 percent coverage. They exempt the poor from paying the premium. International agencies like the Global Fund can help governments to fund such programs.

Similarly, another respondent named Rwanda as a great example of a country that successfully scaled up its community-based insurance scheme and provided coverage to the majority of its citizens at a relatively low cost.

In most cases, however, these oft-repeated narratives were not based on personal experiences or firmly connected to the existing evidence base. With the exception of a single person from an international development agency, none of the respondents who mentioned Rwanda as a success story had direct working experience with the *mutuelle* program. The respondents seemed to acquire these narratives through their colleagues and other professional circles and reproduce them without direct personal experience. The only person who had first-hand experience with Rwanda's insurance program noted that the Rwandan case should be viewed with caution rather than seen as an outright success. He also argued that, given the country's socioeconomic conditions and the unusual confluence of international and domestic political factors that uniquely contributed to the "success" of the *mutuelle* program, it was highly doubtful that other countries could easily replicate the Rwandan model.

In sum, there is a need for evidence on the effectiveness, efficiency, and equity outcomes of private sector initiatives that go beyond simple repetition of "success stories" or "received wisdom." Our respondents wanted more reliable, more thorough, and more compelling data to assist them with decision making. Barring evidence, most respondents, though open-minded, remain cautious about the benefits of more extensive public-private interactions for public health.

Conclusion

This qualitative research found that most respondents, while skeptical about the motives of for-profit private providers and financing bodies, generally gave qualified responses about the potential for strategic partnership with private sector actors. One of the most notable aspects of the qualitative research was the number of examples cited by respondents of both ongoing and proposed public-private interactions for health.

However, the team did identify general confusion over what constitutes the "private sector," with respondents using different terms (such as "civil society" or "non-state actors") to refer to different forms of non-public provision and financing. This confusion affected people's attitudes toward the private sector, with more negative views being expressed toward for-profit companies than toward not-for-profit organizations or trusts. These negative views tended to be strongly held, but they did not necessarily affect

individual or institutional willingness to engage in targeted interactions to achieve specific ends.

Other barriers to public-private interactions that were pointed out by respondents include (1) a perceived lack of evidence on the effectiveness of public-private interactions in achieving positive public health outcomes for the poor and (2) an instrumentalist approach in which the private sector was expected to give concessions to the public sector while receiving little in return. Interviews with private sector actors revealed that the private sector itself is often unwilling to enter into partnership for fear of over-regulation and interference. More research on private sector views is warranted to better understand these fears. Negative attitudes toward the public sector are just as pervasive as negative attitudes toward the private sector, and they form a formidable barrier to public-private interactions.

4. Strategies to Address Attitudinal Barriers toward the Private Sector

Introduction

Our research identified a spectrum of perceptions among global and national policymakers about the role of the private sector in health service provision and financing for the poor in low- and lower-middle-income countries. Overall, we found that views in Thailand and Pakistan were polarized (negative and positive), while views at the global level and in Zambia were more qualified.

In this section, we identify a number of strategies that have potential for influencing negative and qualified perspectives at the national and global levels. We derived these strategies from our research findings, our review of public policy and public health literature, and discussions with issue advocates at the Rockefeller Foundation's Technical Partners Meeting in July 2008. We believe that issue advocates can employ these strategies to address attitudinal barriers to collaboration, as they promote public-private interactions for making health services more accessible and affordable to the poor.

In discussing each strategy, we draw on examples in which issue advocates have successfully influenced views about particular public health and public policy issues. We also provide specific policy recommendations to the Initiative Secretariat for how to proceed with each strategy. We propose strategies for influencing views at the global and national levels and, because our research has shown that policymakers' perceptions about the private sector vary according to geographical region, we also recommend that specific strategies be designed in the context of the particular implementation setting. In some settings, engaging with the private sector may not lead to health improvements for the poor. We therefore advocate paying careful attention to specific contexts before designing interventions.

We propose five medium- and long-term strategies that could address negative and qualified views of the private sector's role in health service provision and financing for the poor. There is no panacea or quick fix. Each strategy must be carefully planned and patiently executed to achieve its objectives. When it comes to implementation, each strategy should be considered as an integral part of a broader strategy. In terms of sequencing, issue framing should be treated as the first and foremost strategy, while the other four strategies should be understood as complementary and therefore implemented simultaneously for maximum impact.

Strategy 1. Reframe the “private sector” issue

We found little agreement and varying perceptions about who should be included in the definition of “private sector” as well as varying perceptions of the “private sector” depending on how the respondent defined the term. These findings suggest a need to reframe the private sector issue. Issue framing should be the first and foremost strategy because it can help clear up the widespread confusion on the role and definition of “private sector,” and it directly relates to other strategies proposed in this paper.

The FrameWorks Institute, a Washington, DC–based think tank, describes “frames” as:

a small set of internalized concepts and values that allow us to accord meaning to unfolding events and new information. These frames can be triggered by various elements, such as language choices and different messengers or images. These communications elements, therefore, have a profound influence on decision outcomes (FrameWorks 2002).

The manner in which an issue is framed can determine the success or failure of issue advocates’ work. Issue framing does not mean merely providing a new name to an issue (for example, changing the term “private sector” to “non-state sector”) or choosing a slogan for a communications campaign. Issue framing involves building a conceptual construct or a set of interrelated stories or narratives that connect with deeply held core values (Andresen and Agrawala 2002).

One of our research findings is that global health policymakers use popular narratives and images (such as the *mutuelle* system in Rwanda) to describe how public-private interactions can be successful. These oft-repeated narratives are not based on personal experiences but are acquired through colleagues and other professional circles. Popular narratives provide policymakers with “success stories” and give them confidence in public-private interaction. Issue reframing, therefore, must relate to such narratives and stories. Moreover, the language used in issue framing must be specifically tailored to the needs and interests of the target audience of agenda-setting efforts so it can effectively communicate the desired messages.

The approach to framing an issue depends on the internal and external objectives of the issue advocates. Issue advocates must first identify the problem, points of controversy, and the message to be conveyed, and then decide on the target population and the level of analysis (global, national). For example, do issue advocates believe that the private sector is the *problem* of health provision and financing for the poor in low- and lower-middle-income countries, or do they believe the private sector is the *solution*? Furthermore, is placing the private sector issue higher on the global agenda the key objection of issue advocates? Or is fundraising the main objective?

Once the issue advocates’ objectives are clarified and the target audience is identified, the issue framing process may begin. Research on the target audience may be required. For example, if issue advocates’ main objective is to place the private sector issue higher on the global agenda, advocates must first identify policy characteristics and conduct stakeholder analyses. Research on policy characteristics will help advocates better understand existing policy issues and points of agreement and disagreement, while stakeholder analysis will identify policy actors and venues that set the global agenda in public health (Brinkerhoff and Crosby 2002). Framing can then be performed in a manner that addresses the views of the stakeholders who hold power in global health agenda-setting. For example, the research may show that powerful stakeholders are more receptive to private sector issues when they are reframed in terms of non-communicable diseases or the Millennium Development Goals. Alternatively, the research may find that

the target audience responds more positively to messages reframed from a health systems perspective.

Decisions about how to frame an issue have important consequences, as the World Health Organization discovered in regard to tuberculosis (TB) control efforts in the 1990s. In 1993, the agency hired an advocacy expert who changed the TB focus from technical concerns to concentrated advocacy by declaring TB a “global emergency” (Ogden et al. 2003). The advocacy effort targeted donors and policymakers and sought to develop a simple message that these target groups could understand and rally around. As Ogden and colleagues point out, “distanced from local realities, and with multiple responsibilities, these organizations require simple messages with which to convince their own constituencies to prioritize resources on programs, which may make a difference.” A new policy—DOTS—was designed and marketed. The advocacy effort was highly successful in raising funds and bringing attention to TB control, even though it also led to some disagreements among scientists, academics, and policymakers, who objected to the simplistic claims of the advocacy messages. In the final analysis, however, the DOTS example demonstrates that despite some risks involved in the process, issue framing can be a potent advocacy tool, especially in the hands of advocates who are highly familiar with the characteristics of the issue, local settings, and cultural and ideological sensibilities of the stakeholders.

A second example is the U.S. Agency for International Development’s Basic Health Services Project in Yemen. The project aims to improve child and maternal health in the five poorest governorates in the country. In this devoutly religious and conservative society, where Islamic leaders hold positions of extreme influence and are often approached for advice and guidance on family and personal matters, project leaders for the Basic Health Services Project framed issues of reproductive health and family planning in terms of individual and communal health. They also employed a religious message that would easily resonate with community leaders, politicians, and average Yemenites. The program has so far trained more than 100 Islamic religious leaders throughout the country who in turn train other religious functionaries to preach about the importance of reproductive health by drawing on Islamic sources such as the Quran and *Hadith* (sayings of Prophet Muhammad).²

Recommendations

We recommend that the Initiative Secretariat work with issue advocates to frame the private sector issue. The first step will be identifying the Initiative Secretariat’s internal objectives for this work. Activities to identify the problem definition, points of controversy, the message to be conveyed, target population, and the level of analysis can then proceed. The framing process may need to be supported by further research, including analyses of stakeholder and policy characteristics, that can help identify current

² For further information, see:

www.pathfind.org/site/PageServer?pagename=Programs_Yemen_Stories_Religious_Leaders and www.mophp-ye.org/english/news.html (accessed on September 24, 2008).

policy images, influential policy actors, and the venues in which actors articulate these images and ultimately set the global health agenda.

Strategy 2. Implement learning projects

One way to build confidence between the public and private sectors is to support pilot or learning projects that show officials in both sectors that it is possible to collaborate. In TB control, STOP TB supported the establishment of “learning projects” involving public-private interaction (Uplekar 2003). Another successful example is the Hygeia Community Health Plan project, which provides collective health insurance for 115,000 low-income people in Nigeria’s Lagos and Kwara states, based on risk pooling, donor support, co-payments, and utilization of local private and public health infrastructure (IFC 2008). The pilot project has become a successful example for risk-pooling arrangements and has drawn the interest of private and public officials in Nigeria and beyond. In fact, the Netherlands-based PharmAccess, the main sponsor of the Hygeia project, recently announced that it will soon launch similar community insurance schemes in Sub-Saharan Africa with support from the World Bank and host-country governments.³

Recommendations

We recommend that the Initiative Secretariat support the implementation of learning projects as a complementary strategy to evidence collection and dissemination. Both strategies can be conducted simultaneously. One evidence-gathering activity—evaluation—should be built into learning projects from the beginning of implementation.

Learning projects are particularly important for public-private mechanisms that suffer from a lack of evidence on effectiveness and feasibility. The most important aspect of a learning project is its trust-building function, as it helps stakeholders from different sectors overcome mistrust and be able to collaborate. Therefore, the Initiative Secretariat should support learning projects that serve its internal objectives and build trust.

Strategy 3. Consolidate and disseminate the evidence base

Our research found that policymakers observe gaps and weaknesses in the evidence base for private sector involvement in health. Some policymakers are confused about who uses the private sector in poor countries and are reluctant to engage in public-private interactions unless they are sure the poor are using private health services. Our research also showed that many policymakers questioned whether public-private interactions help the poor; these policymakers want more evidence on this issue before engaging in these models. Their views can be influenced through evidence gathering and dissemination.

³ For additional information, see www.pharmaccess.org/Default.asp?Page=156 and www.hifund.nl/index2.php?page=country&idsubmenu=7&naam=Nigeria (accessed on September 25, 2008).

Evidence-gathering activities, if carefully planned, can support issue advocates' case for more attention to a public health or public policy issue. This was the case for climate change. Mostafa Tolba, executive director of the United Nations Environment Programme, used evidence gathering on the societal impacts of climate variability to shift the focus to the policy relevance of climate research. The evidence-gathering activity was a five-year international study on the causes and consequences of greenhouse warming (which the United Nations Environment Programme was instrumental in supporting). At the meeting where the study results were presented, experts decided that climate change might be twice as urgent as they originally believed, and they decided to signal the issue as a policy concern and to begin advocacy for international policy responses to climate change (Andresen and Agrawala 2002).

One way to structure evidence gathering is to ensure that evaluations are built into public-private interactions from the beginning of implementation. Such evaluations have influenced stakeholder views in other areas of public health and public policy. For example, building evaluations into early conditional cash transfer (CCT) programs in Latin America and the Caribbean generated persuasive empirical data and influenced the place of CCTs on the global development agenda (Glassman et al. 2007). Similarly, in the 1980s, the World Health Organization organized a three-country evaluation of Karel Styblo's strategy on short-course regimens for TB control. The outcome showed that the strategy could be implemented successfully in developing countries, which gave the World Health Organization empirical evidence for moving ahead with DOTS (Ogden et al. 2003). In the case of the private health sector in poor countries, all evidence-gathering activities should be performed in the context of how advocates have chosen to frame the issue.

Another evidence-gathering activity is case documentation. In our research, we found that many respondents already had significant experience in public-private interactions in the countries they work in but that most of these projects are poorly documented. Documentation can be used as an important leverage point to show reluctant stakeholders that collaboration is already occurring successfully. Officials in TB control used documentation as a strategy for this purpose. STOP TB staff members have found that documentation of existing public-private projects within countries helps build confidence between public and private sector actors at the national level. Specifically, documentation can show reluctant groups that individuals working in the public and private sectors are willing to work together for a shared purpose despite "teething" problems (Uplekar 2003).

A focus on evidence gathering is insufficient without significant effort for disseminating the findings. Specific evidence-disseminating activities include creating a network (or harnessing existing networks) to share and disseminate evidence, hosting meetings to share evidence, and hosting a Web site with links to data or information related to private sector data (as there is increasing interest in public access to data).

The effectiveness of evidence gathering depends heavily upon the flexibility and suitability of particular dissemination methods. Evidence-gathering activities for the

private sector issue should be disseminated through channels specifically designed to meet the needs and interests of target audiences without threatening or directly challenging their status or professional knowledge.

Recommendations

As part of a broader issue-framing effort, the Initiative Secretariat should support evidence gathering on the size and impact of the private sector in low- and lower-middle-income countries' health systems and its impact on the poor. Evidence-gathering activities can strengthen the work of issue advocates and build trust between public and private sector actors. The activities can be built into public-private learning projects from the beginning of implementation.

For evidence dissemination, we recommend that the Initiative Secretariat launch a Web site that serves as a global clearinghouse on successful examples of private-public partnerships and their positive impact on the poor's ability to access and benefit from health services. A Web-based dissemination strategy should be complemented by other proactive dissemination methods (such as meetings, pamphlets, trainings, newsletters, and networks) that are specifically tailored to the needs and interests of different audience segments.

Strategy 4: Find champions and build trust

Champions are individuals who are dedicated to a particular issue and able to commit their resources—time, reputation, and financial support—at the global, national, and/or local levels to bring more attention or funding to the issue. Champions are key actors in getting public health or public policy issues on the global agenda.

Years ago, the climate change issue was not on the global agenda because neither the carbon cycle nor climate modeling fit into the Cold War frame of national security. Through issue framing, well-placed champions worked creatively to make these linkages within a national security context. They also sought government funding and set up institutions to further these research agendas (Andresen and Agrawala 2002). Many other individuals and institutions have championed global health causes and interventions and successfully placed them on the global health agenda. Paul Farmer, for example, is a well-known global health champion who has effectively promoted community-based treatment strategies for HIV/AIDS and multidrug-resistant tuberculosis.

Champions' most important function is to serve as potential power brokers and mediators among stakeholders. The issue of the private sector's role in health service provision and financing is both an ideologically charged and ethically sensitive topic that leads to disagreements and mistrust among stakeholders. Our interviews in three countries found a serious lack of trust between public and private sector officials. To bridge differences and help parties reduce barriers to collaboration, champions who are trusted by both the public and private sectors could play a vital role as brokers and intermediaries. In TB control, for example, institutional champions such as nongovernmental organizations, international research institutions, and medical associations have actively played an

intermediary role to build mutual trust between the two sectors by facilitating discussion and helping actors meet on neutral ground (Uplekar 2003; Lonroth et al. 2004; Hurtig et al. 2002).

With respect to the private sector issue, champions can advocate at the global and national levels, work for global declarations or targets (such as a World Health Assembly recommendation, which has already been initiated by the Thai government), and seek funding from donors for implementation of public-private interactions. Champions can play an instrumental role in framing the private sector issue by conveying the importance of the issue and articulating new policy ideas and narratives of successful public-private projects around the world.

Our findings from the survey research indicate that most respondents held positive views about the role of issue advocates as intermediaries who can encourage governments to engage the private sector. This finding should be interpreted with caution, however. The champions' institutional affiliations (past and present) and ideological stance will be critical to their ability to advocate for the private sector. Therefore, potential champions must be viewed by both parties as neutral and impartial players. Moreover, champions should also possess extensive trust-building and negotiation skills to mediate between public and private sector officials.

Recommendations

We recommend that the Initiative Secretariat find and support new champions at the global, national, and local levels. Individual and institutional champions for public policy and public health issues emerge from hard work, moral commitment, intellectual dedication, strong and farsighted leadership, and considerable sums of financial investment. Thus, identification, cultivation, and support of champions should be carefully planned and adopted as one of the Initiative Secretariat's priorities. Individuals identified at the local and national levels should be prepared as global-level players who can internationally champion the cause of public-private interactions, create donor coalitions, build cross-sector alliances between the private and public sectors, and increase the attention given to the issue on the global agenda.

As part of a broader strategy to prepare a new generation of public health champions, the Initiative Secretariat could also partner with international agencies or donors to conduct programs to identify promising individuals and organizations. Once identified, these individuals and organizations should be provided with the necessary technical and financial assistance to grow and become global champions. Incentives should include a combination of fellowships, research grants, travel assistance, mentoring, training programs, and subsidies that allow them to learn more about the issue at hand and devote more time to advocacy, fundraising, and coalition building.

Because neutrality and the trust it generates are essential to the champion's effectiveness, the Initiative Secretariat should also provide resources for developing such skills of potential champions through training programs.

Strategy 5: Shape public health education

Today's public health graduate students will influence the issues that appear on the global health agenda in the future. Formal education on the private sector's role in service delivery and financing in poor countries could influence the manner in which the issue is perceived by public health's future leaders. The majority of public health schools in the United States do not offer courses on the role of the private sector in health service provision or financing in the developing world, however. There is therefore an opportunity for the Initiative Secretariat to initiate and encourage public health programs to include courses that will allow future public health leaders to learn about and debate the private sector's role in serving the world's poor.

Recommendations

The Initiative Secretariat should encourage public health schools to offer courses on the private sector and provide financial support for the schools to do so. These courses can be carefully planned in terms of issue framing and the Initiative Secretariat's internal objectives. Syllabi, reading packets, and textbooks addressing the history and development of the private sector's involvement in health provision and financing could be produced and made available to faculty members and students at selected public health programs. Selected faculty members and promising graduate students could be trained and sent on study trips to visit learning projects and observe the public-private projects in action. Similarly, partnerships and exchange programs between public health schools in developed and developing countries could be initiated to encourage intellectual exchanges and allow faculty and students to freely debate the health problems of poor nations and the role of the private sector.

5. Study Limitations and Conclusions

Study limitations

This study has a number of limitations. Several information gaps must be filled before a complete picture of the private sector's role and policymakers' views of this role can be developed. For example, our study examined the issue of the private sector primarily through the lens of public and not-for-profit actors. Apart from a few interviews in Pakistan, Thailand, and Zambia, the perspectives of for-profit actors are mostly absent from the analysis. There is a need to better understand the views of these for-profit players.

Moreover, the perspectives of informal private sector actors (such as traditional healers) are also missing from our study. Considering their significant market share in the health sectors of many low- and lower-middle-income countries, there is a need to learn more about how such providers are organized and the best mechanisms for collaborating and integrating them into national health systems. A related issue that needs more examination is the environments, ecosystems, or intervention mechanisms that can facilitate collaboration across sectors.

Finally, the interdependent or symbiotic nature of public-private interactions requires further investigation. More than 60 percent of the online survey respondents indicated that strengthening government regulatory mechanisms would have a positive impact on improving the quality of services provided by the private sector, and an overwhelming majority of respondents viewed the government's regulatory performance as inadequate. The issue of regulation as a potent intervention mechanism or medium of collaboration should therefore be addressed in future research supported by the Rockefeller Foundation and the Initiative Secretariat.

Conclusions

This report presents a set of strategies for addressing the attitudinal barriers to expanding public-private interactions for health service provision and financing in low- and lower-middle-income countries. The recommended strategies are proposals that will require additional analysis and elaboration to become operational. The particular focus of each strategy depends upon the internal and external objectives of the Initiative Secretariat on the private sector issue. Once these objectives are determined, the Initiative Secretariat can use the report to strategize and determine the action to be taken for addressing negative and qualified attitudes toward the private sector.

Overall, we believe that the Rockefeller Foundation and Initiative Secretariat should take the role of *instrumental leader* (that is, an individual or institution that seeks action based on ideas on how to remove barriers to collaboration between private and public sectors) instead of *intellectual leader* (an individual or institution that refrains from further action but points to ideas and direction to be taken) for these private sector issues (Andresen and

Agrawala 2002). Once a strategic plan is prepared, adopted, and implemented, activities should be monitored to ensure they are achieving the intended results.

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Appendix 1: Quantitative Online Survey

Thank you for participating in this survey. Its purpose is to assess the global health community's attitudes on financing and provision of health services in **low- and middle-income countries**. The survey should take about 20 minutes to complete. Surveys will be completely anonymous; we will not collect personal identifiers such as IP addresses. All responses will be kept strictly confidential, and the information you provide will not be used for any other purposes. When you are ready to participate in the survey, please proceed.

Part I. Respondent's characteristics

1. Which of the following best describes your main work area?

- Adolescent health
- Child health and development
- Chronic/degenerative disease
- Community health/NGO development
- Disaster/refugee health
- Drug policy and management
- Environmental health and sanitation
- Health and human rights
- Health care reform
- Health care financing/insurance
- Health policy
- Health systems management
- Health education/social marketing
- HIV/AIDS
- Hospital/clinic administration
- Infectious disease
- Information systems
- Maternal health
- Nutrition
- Reproductive health/family planning
- Tobacco/substance abuse
- Travel medicine
- Other, please specify

2. Which of the following best describes the type of organization for which you work?

- Ministry of health/population (or similar government department)
- Ministry of finance/planning (or similar government department)
- Governmental donor agency/oversees development assistance agency
- Other governmental agency
- International organization (funding)
- International organization (technical)
- International private voluntary organization (health service provision)
- International private voluntary organization (funding/donor)
- International private voluntary organization (technical assistance)
- Domestic private voluntary organizations (health service provision)
- Domestic private voluntary organization (funding/donor)
- Domestic private voluntary organization (technical assistance)
- Research/academic institution
- Pharmaceutical or medical device industry
- Other, please specify

3. **This survey includes a number of questions about your perceptions of health care provision. Please select the country or region of the developing world with which you are most familiar and respond to the questions with that region in mind.**

Pull down menu of countries and WHO regions as follows: Africa, Eastern Mediterranean, Europe, The Americas, Southeast Asia, Western Pacific

4. **Please indicate to what extent you interact with the following health service providers in a professional context:**

	Always	Often	Sometimes	Rarely	Never
Not-for-profit organizations (e.g., non-governmental and faith-based organizations)					
For-profit, private-sector facilities (e.g., hospitals, clinics, pharmacies)					
Individual practitioners (e.g., doctors, nurses, pharmacists)					
Non-professional providers (e.g., traditional healers, drug sellers)					
Public-sector providers					

PART II. Health financing

1. **Which of the following issues do you view as the biggest challenges to health service provision for low-income populations in your geographical work area? (Please check three issues that apply.)**
- Availability of public health facilities
 - Affordability of curative health services
 - Affordability of preventative health services
 - Quality of health services received from public-sector health facilities/providers
 - Quality of health services received from private-sector health facilities/providers
 - The increasing reliance on private-sector providers
 - Lack of health insurance
2. **What do you believe is the most feasible way of reducing out-of-pocket expenditures among low-income populations?**
- Free care by public health facilities
 - Community-based insurance schemes with subsidized premiums
 - Community-based insurance schemes without subsidized premiums
 - Private insurance schemes with subsidized premiums
 - Public insurance schemes
 - Voucher schemes
 - Other

PART III. Health service provision

1. How strongly do you agree or disagree with the following statements about the government's role?

The government should provide health services to everyone free of charge.
Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

The government should charge everyone for health services, regardless of their income level.
Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

The government should concentrate its resources for health service provision on low-income populations.
Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

The government should provide only preventive health services, such as immunization and health education.
Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

The government should strictly monitor and control the quality of services provided by private for-profit health service providers.
Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

The government should prohibit private practices by public sector health care providers (dual practices).
Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

The government should collaborate with the private-sector to provide health services to low-income populations.
Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

2. How strongly do you agree or disagree with the following statements about for-profit, private-sector facilities?

(For-profit, private-sector facilities include hospitals, clinics, and large pharmacy chains.)

For-profit, private-sector facilities create inequity in health services provision.
Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

For-profit, private-sector facilities are only interested in making a profit.
Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

For-profit, private-sector facilities do not want to engage or collaborate with the government.
Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

For-profit, private-sector facilities help strengthen health systems by improving access to services for the poor.
Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

The government usually sees *for-profit, private-sector facilities* as adversarial toward the public sector.
Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

The government usually does a good job in regulating *for-profit, private-sector facilities*.
Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

The quality of health services provided by *for-profit, private-sector facilities* is better than that of the public sector providers.

Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

3. How strongly do you agree or disagree with the following statements about not-for-profit organizations?

(Not-for-profit providers include non-governmental organizations and faith-based organizations)

Not-for-profit providers create inequity in health services provision.

Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

The government usually sees *not-for-profit providers* as adversarial toward the public sector.

Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

Not-for-profit providers do not want to engage or collaborate with the government.

Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

The quality of health services provided by *not-for-profit providers* is better than that of public sector providers.

Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

Not-for-profit providers help strengthen health systems by improving access to services for the poor.

Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

Not-for-profit providers are only interested in making a profit.

Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

The government usually does a good job regulating *not-for-profit providers*.

Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

4. How strongly do you agree or disagree with the following statements about for-profit individual providers?

(For-profit individual providers include doctors, nurses, and pharmacist/drug stores.)

For-profit individual providers are only interested in making a profit.

Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

The quality of health services provided by *for-profit individual providers* is better than that of public sector providers.

Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

For-profit individual providers create inequity in health service provision.

Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

For-profit individual providers help strengthen health systems by improving access to services for the poor.

Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

The government usually does a good job regulating *for-profit individual providers*.

Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

For-profit individual providers generally do not want to engage or collaborate with the government.

Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

The government usually sees *for-profit individual providers* as adversarial to the public sector.

Entirely agree; Somewhat agree; Neutral; Somewhat Disagree; Entirely Disagree

5. Thinking about the role of provision of health services in your geographical work area, which of the following statements is closest to your view?

(For each pair of statements (Statement 1 and Statement 2), please use the following numbers to rate your response: 1= Strongly agree with S1; 2 = Agree with S1, 3 = Strongly agree with S2; 4 = Agree with S2; 5= Agree with both; 6 = Agree with neither; 7 = Do not know)

Statement 1: The government should provide all health services free of charge.
Statement 2: Health care should be market-based and the government should have a limited role in direct provision of health services.

Statement 1: The government and the private health sector should share responsibility for improving the population's health status.
Statement 2: Responsibility for improving the population's health status lies with the government.

Statement 1: The private sector and/or market mechanisms will bring in more resources and better quality services to low-income people.
Statement 2: Private-sector involvement in the delivery of health services will create inequality without improving the quality of health service provision to low-income populations.

Statement 1: Government-provided health services are typically inefficient; involving the private sector and/or market mechanisms will increase efficiency.
Statement 2: Private sector involvement in the delivery of health services will focus on efficiency at the expense of meeting the complex needs of low-income populations.

Statement 1: The private-sector, especially the for-profit sector, takes advantage of the public sector.
Statement 2: Public- and private-sector collaboration is a win-win proposition for health systems.

6. Do you think there are barriers to public-private collaboration for provision of health services for low-income populations in your geographical work area?

Yes, barriers exist to a great extent
Yes, barriers exist to some extent
No, barriers do not exist
Do not know/not sure

7. Which of the following do you feel best describes barriers for public-private collaboration in your geographical work area? (Please check three that apply.)

Lack of concern for social interests within the private sector
Unwillingness of the government to collaborate with the private sector
Unwillingness of the private sector to collaborate with the public sector
Absence of political commitment to collaboration
Lack of economical incentives for collaboration

- Lack of clear legal framework that supports collaboration
- Poor mechanism for regulating the quality of health services provided by the private sector
- Lack of information on private-sector activity in health services
- Lack of financial resources to start and sustain collaboration
- Lack of communication between the public and private sectors
- Absence of clear government policy toward the private health sector
- Lack of accountability in the private health sector
- Lack of technical skills in public-private collaboration
- Lack of representative organizations for private-sector providers
- Lack of trust between the government and private sector
- Previous negative experiences while trying public-private collaboration

8. With regard to low-income populations in your geographical work area, please indicate your perception of the following interventions.*

Please use the following scale to rate your responses: 1 = Very low; 2 = Low; 3 = Neither low nor high; 4 = High; 5 = Very High; 6=Do not know

Intervention	Perceived impact on improving availability of health services	Perceived impact on ensuring affordability of health services	Perceived impact of improving quality of health services
Contracting out of primary care (Governments contract with private providers [both not-for-profit and for-profit] to deliver individual or a bundle of primary care services)			
Contracting out of tertiary care			
Provider Networks and Franchises (Networks and franchises are an affiliation of health services providers grouped together under an umbrella structure or parent organization)			
Strengthening of government's regulatory mechanism			
Voucher schemes (Vouchers have been used to subsidize the price of health services and products to target populations with the goal of improving access to and use of those services and products)			

National Health Insurance			
Community-based insurance			
Information dissemination to and training of private sector providers			

Social Marketing (Social marketing is the use of commercial marketing techniques to achieve a social objective)			
Conversion of government hospitals to autonomous hospitals			

* Definitions of individual interventions are from: Islam, M., ed. 2007. *Health Systems Assessment Approach: A How-To Manual*. Submitted to the U.S. Agency for International Development in collaboration with Health Systems 20/20, Partners for HealthReformplus, Quality Assurance Project, and Rational Pharmaceutical Management Plus. Arlington, VA: Management Science for Health.

9. In your view, to what extent have the following types of providers helped improve access to each type of health services among the low-income population in your geographical work area?

(Please use the following scale to answer: 1 = Not at all; 2 = To a small extent; 3 = To some extent; 4 = To a moderate extent; 5 = To a great extent)

Public sector facilities

- a. Childhood immunization services
- b. Child fever
- c. Non-emergency obstetric care
- d. Tertiary inpatient care
- e. Diagnostic and laboratory services

Not-for-profit private providers, such as non-governmental organizations and faith based organizations

- a. Childhood immunization services
- b. Child fever
- c. Non-emergency obstetric care
- d. Tertiary inpatient care
- e. Diagnostic and laboratory services

For-profit, private-sector institutional facilities, such as hospitals, clinics, and pharmacies

- a. Childhood immunization services
- b. Child fever
- c. Non-emergency obstetric care
- d. Tertiary inpatient care
- e. Diagnostic and laboratory services

Individual practitioners, such as doctors, nurses, and pharmacists

- a. Childhood immunization services
- b. Child fever
- c. Non-emergency obstetric care
- d. Tertiary inpatient care
- e. Diagnostic and laboratory services

Non-professional providers, such as traditional healers and drug sellers

- a. Childhood immunization services
- b. Child fever
- c. Non-emergency obstetric care
- d. Tertiary inpatient care
- e. Diagnostic and laboratory services

PART IV. Role of external funding for health service strengthening

1. Thinking about improving the quality, availability, and affordability of health services, please indicate how strongly you agree or disagree with the following statements.

(Please use the following numbers to rate your response: 1 = Strongly agree; 2 = Agree; 3 =Neither agree or disagree; 4 =Disagree; 5=Strongly disagree).

Donor funding should be channeled through the government/ministry of health

1 2 3 4 5

Donors should directly fund private health sectors to strengthen them.

1 2 3 4 5

Donors should encourage governments to involve the private health sector in health service provision for low-income populations.

1 2 3 4 5

Donors should only target public-sector health services.

1 2 3 4 5

Thank you for participating in the survey.

As a token of appreciation for your participation, we will randomly select 10 respondents to receive a US \$50 Amazon.com gift card. If you want to be included in the drawing, please enter your email address below. Only one entry per participant is allowed. Winners will be notified through email on July 15, 2008. E-mail address will only be used for the purpose of the drawing.

E-mail: _____

Appendix 2: Identification Process of Potential Respondents by the Global Health Council

The Global Health Council (GHC) comprises about 500 member organizations, including multilateral organizations, nongovernmental organizations, direct-service provider organizations, corporations, foundations, and academic institutions. More than 200 of these organizations are in 23 low-income and 17 middle-income countries. In addition, GHC has about 5,000 individual members, many of whom live in low- and middle-income countries.

GHC's database was used to identify 4,084 potential respondents. This list was generated by combining several searches and culling duplicate names or organizations that appeared on multiple lists. Students were also excluded from the sample to ensure that the respondents had hands-on professional experience in the health system.

A total of 3,901 received an invitation to participate in the survey (179 e-mails were not deliverable, and 4 recipients requested to be removed from the list) on June 6, 2008. The survey request targeted:

- Organizational and individual GHC members based in low- or middle-income countries. Nongovernmental organizations include civil society organizations, service providers, corporations, foundations, academic institutions, and other private organizations.
- Organizational and individual GHC members who work in or whose work focuses on low- or middle-income countries, but who are based in the United States or other high-income countries.
- GHC partners or colleagues based in low- or middle-income countries. Partners and colleagues include speakers at GHC's annual conferences or other events, nonmember organizations that partner with GHC on events or publications, and individuals with whom GHC has an acquaintance or friendship.

The terms *executive*, *director*, and *manager* were used in selecting individuals to receive the survey invitation.

The first reminder was sent on June 24, 2008, to the 3,901 addresses that received the initial invitation. A second reminder was sent on June 27, 2008, and targeted non-U.S.-based organizations and individuals. Also on June 27, the invitation was posted on a non-GHC blog (<http://www.webhostingreality.com/heres-your-chance-to-get-free-50-gift-card/>). This action was not initiated by GHC or PATH.

Appendix 3: In-depth Interview Guide

1) What do you think the role of government should be in ensuring health services for the poor in your country? Does government have a moral commitment to provide free/affordable healthcare to the poor?

2) What do you think are the problems with the existing healthcare system in your country, in terms of the poor's access to health services? Do you think there is a healthcare "crisis" for the poor in the country?

Probe on the respondent's view of problems in terms of a) health service provision and b) financing for the poor

3) What do you think needs to be done to improve the situation?

4) Do you think non-state actors in the health sector could help ease the problem?

Probe on the respondent's definition of the non-state, or private, sector in health – possible actors in this sector could be modern practitioners, traditional healers, NGOs, faith based groups, for-profit businesses

Probe on what respondents think their organization's view is on this question

5) If non-state health sector actors can help, how should they be involved? How can the government facilitate this process?

Probe on the respondent's view of the level of involvement such as service provision, policy making, financing

Probe on whether there is a policy in the country on public-private collaboration in health

Probe on the respondent's view of specific mechanisms such as risk-pooling/health insurance, provider purchasing and contracting, provider regulation, franchising, social marketing, vouchers, training, procurement and distribution

6) What is your view of what is already happening in the country (and in your organization) in terms of public-private collaboration? (The goal of this question is to elicit perceptions rather than in-depth descriptions of ongoing collaborations).

7) What would your biggest worry or concern be if the non-state sector becomes involved in health service provision for the poor? What would your biggest worry or concern be if the non-state sector becomes involved in health financing for the poor?

8) In your view, how would greater non-state sector involvement in the health sector change your current job situation? Would you be willing to work for an employer in the private sector? What would induce such a move (better work conditions, salary etc.)?

9) What considerations might people have if non-state actors begin to provide basic healthcare services for the poor (affordability, accessibility, etc.)? Do you think the majority of people will be more dis/satisfied with the involvement of non-state actors in the health sector?

10) How would further non-state sector involvement in health for the poor affect most people's perceptions of public services? How do you think further non-state sector involvement in health for the poor would affect people's perceptions of government?