

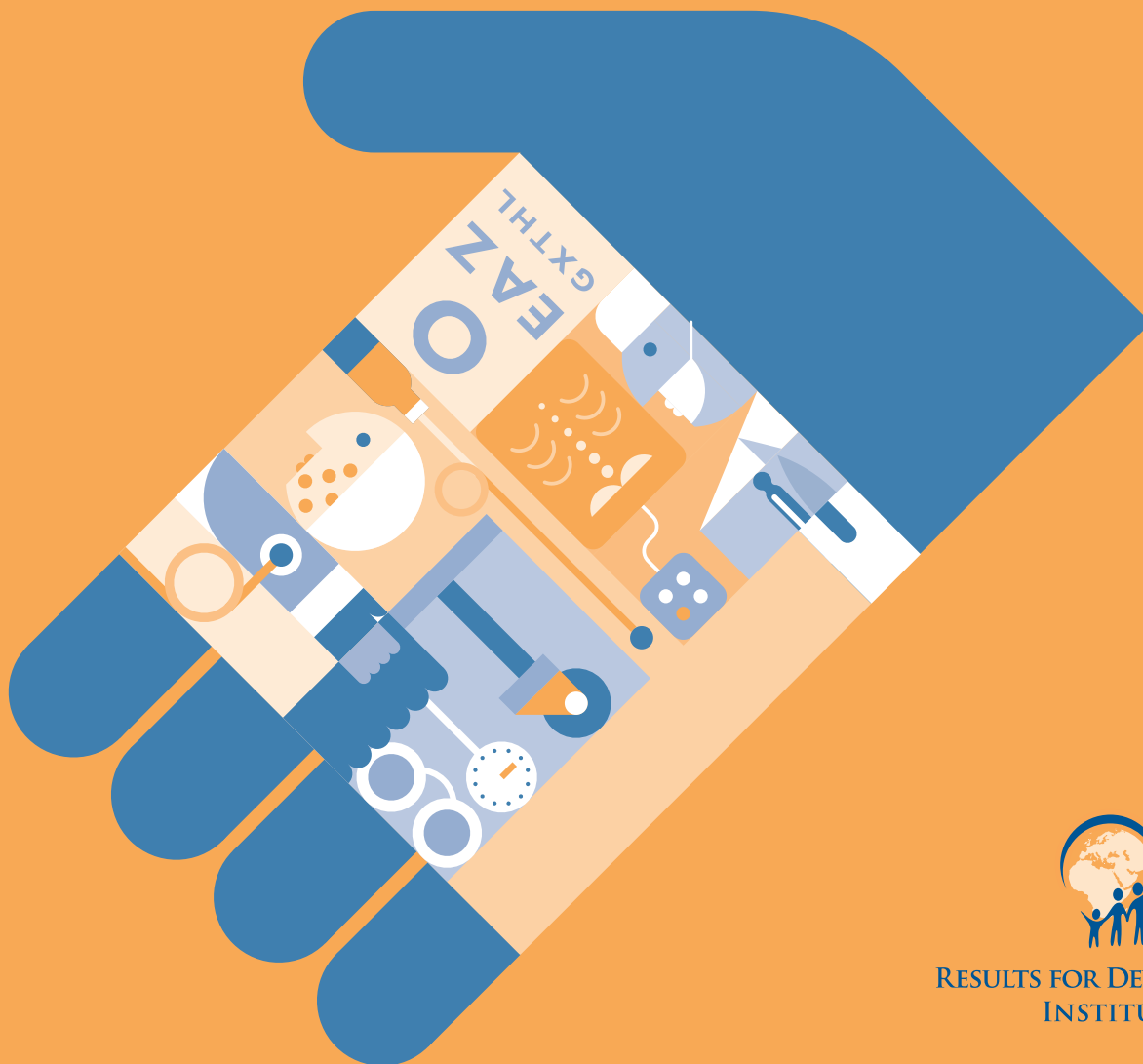
The Rockefeller Foundation–Sponsored Initiative on the Role of the Private Sector in Health Systems in Developing Countries

# Technical partner paper 9

Health Sector Governance and  
Implications for the Private Sector

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FOUNDATION

# **Health Sector Governance and Implications for the Private Sector**

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## Abstract

The private sector plays an increasingly important role in the health systems of low- and middle-income countries. Scaling up the delivery of essential interventions to achieve international health targets is dependent on working with it. The “private health sector” includes an enormous diversity of actors, including providers, funders, and suppliers of physical and knowledge inputs for the health sector. The boundaries between the public and private sectors are often unclear as many private actors operate outside the regulatory framework of the health sector on an informal basis.

The private sector has received insufficient attention from national and global policymakers because of a lack of information about its role. Public sector institutions often have a limited experience of engagement with the private sector due to suspicion compounded by a history of a lack communication, concerns about sustainability, and the complexity of interface required. They also lack the skills and competencies to engage with autonomous actors through more flexible and consensual approaches (as opposed to direct control).

This paper presents an analytical framework for conceptualizing the governance/stewardship function within health systems and the role of government in the context of an expanded role for private service provision and financing. The paper begins by reviewing the approaches to defining and identifying its main functions, drawing on recent literature. Governance is increasingly recognized by the World Health Organization and other global and national actors to be a fundamental health system function, and is a central part of their health sector and developmental strategies. Governance is a multidimensional concept, and there are normative, instrumental, and pragmatic models of stewardship. Governance failures, in health systems or in the wider society, have been perceived as obstructing progress toward international goals such as the Millennium Development Goals for health. These failures include the lack of a long-term vision and planning for essential interventions, the absence of a functional regulatory framework, failure to address corruption, and limited efforts to assess performance. However, existing governance frameworks have not always been explicit about the significant role often played by private sector actors.

The paper then explores typologies of governance, with a focus on multiple forms of engagement and relationships between major public and private sector actors in achieving public health goals. In our conceptual model, the government interacts with the private sector at three different levels: by protecting the public interest, by working with the private sector, and by learning from each other. Possible roles for government (funder, regulator, health system steward) are identified in the context of a large or growing private sector. Indicators of progress are suggested. The framework recognizes that there are multiple public and private sector actors including individual consumers, civil society, and, particularly in the context of aid-dependent low-income countries, donors. These actors are in complex interrelationships involving exchange of funding, skills, inputs, services, information, influence, and accountability. The relationships are shaped

by formal rules of engagement and informal rules, values, and attitudes. Maintaining engagement between actors—through dialogue, sharing information, and ensuring mutual accountability—is key to building and sustaining these relationships. The framework is applied to three case studies—of Afghanistan, India, Uganda—illustrating how differences in context affect the nature of the stewardship function and the approaches that have been adopted to shaping the role of government in mixed health systems. Finally, the capacities required within both the public and private sectors to establish working models for multi-actor collaboration are considered.

## **1. Introduction: Why the Private Sector Matters**

The private sector plays an increasingly important role in the health systems of low- and middle-income countries. It has received insufficient attention because of a lack of information about its role and significance, especially in the context of increasing external assistance. Public sector institutions often lack the skills and competencies to engage with non-state actors, as well as the motivation and interest to do so.

Since the 1990s, the World Bank has pioneered initiatives to draw on the private sector as a partner in reform of health financing and delivery, including proposing the introduction of user fees in public facilities in low- and middle-income countries and, more recently, reevaluating the role of the private sector in relation to contracting-out, social reinsurance, and the corporatization of public hospitals (Preker A and Harding A 2003). Historically, some bilateral governmental agencies such as the U.S. Agency for International Development have worked in close collaboration with the private sector, and have funded projects implemented by private sector organizations, both for-profit and not-for-profit. In the case of the U.S. Agency for International Development this collaboration has been a reflection of one broader aim of U.S. foreign assistance policy, which is to expand free markets (USAID).

However, it is increasingly recognized that achievement of the Millennium Development Goals for health and other international targets is dependent on a significant scaling up of essential services. In many resource-limited settings, this has involved working with the private and voluntary sectors. It is now clear that the private sector cannot be ignored, and there is a need for proactive engagement with it, alongside the conventional public sector approaches. For instance, the global health initiatives established in the late 1990s and early 2000s (e.g., Global Alliance for Vaccines Initiative and the Global Fund to Fight AIDS, Tuberculosis and Malaria) have identified mechanisms to operate through private sector organizations in an effort to improve aid effectiveness and find new ways of working with recipient countries (Brugha R and Walt G. 2001; Brugha R, Starling M et al. 2002). This has led to a growing interest in incorporating private sector models and innovations such as results-oriented management.

The existence of a large private sector has multiple effects on the health care system and on households. A high level of direct out-of-pocket payments for private health care is often the cause of catastrophic health expenditure (Das and Hammer 2007). In settings where public health systems are weak and underfunded, patients and providers may enter informal transactions (also a form of unregulated private practice), which are a commonly used coping strategy for underpaid health workers (Balabanova, McKee et al. 2004). Use of the private sector can lead to unaffordable and poor-quality care, especially for the poorest groups, who have limited alternative options (Das and Hammer 2007), although a lack of rigorous evidence makes it difficult to generalize across settings (Patouillard, Goodman et al. 2007). In many middle- and low-income countries, private sector use has been associated with an increase in multi-drug resistance for diseases requiring long-term treatment, such as TB, due to low adherence both by provider and

patient; a lack of standardized drug regimens; unregulated sales of TB treatment drugs; and insufficient patient follow-up (Shimouchi A 2001).

The nature of the private health sector in a country, and the way it has been influenced by historical patterns and changes, will determine what services are provided and the patterns of use at any particular time. For instance, in most countries of the former Soviet Union, the private sector was formalized after the political transition. However, it remains relatively limited apart from the pharmaceutical sector and outpatient care as its development is constrained by high entry costs, underdeveloped voluntary health insurance, and a lack of trust (Balabanova D and Coker R. 2008). Most recently, in the context of globalization of trade in health services, there are growing concerns about medical tourism and its effects on the public sector, if increased demand for private services translates into competition with the public sector for scarce inputs such as human resources.

Most of the literature is focused on market failures affecting the private sector and the often negative implications for affordability, socioeconomic determinants of use, and quality. However, the private sector often offers an attractive alternative where public services are geographically inaccessible, unaffordable, and of poor quality, and it is often the only option acceptable and available to users. At the same time, there may be a range of skills, ideas, capacities, and comparative advantages within the private sector that can have positive effects on health outcomes. For example, some interventions may be more effectively delivered through existing private facilities, which the population may prefer to use (due to proximity or trust). The private sector may be used as a vehicle to meet the health needs of groups that are difficult to reach by other means such as communities in geographically isolated areas, those informally employed and not eligible for formal insurance, and groups facing stigma such as sex workers.

In theory, the effectiveness of health care delivery can be enhanced with use of innovative and flexible models and performance-based provider remuneration. Public-private partnerships may promote development and marketing of pharmaceuticals, vaccines, and technologies more broadly benefiting low-income countries. A survey in 39 low- and lower-middle income countries showed that the availability of essential medicines was on average 20 percent in the public sector and 56 percent in the private sector (WHO 2007). However, realizing these potential benefits is heavily dependent on a country's context, most importantly the governance or public sector leadership. This includes the existence of appropriate legislation, regulatory capacity, safeguards, and planning processes to ensure that there are public sector alternatives to cover the poorest groups.

In many countries, the role of the government in leading the health sector is complicated by the multiplicity of health providers, facilities, and funding streams. The role of the private sector within a pluralistic health system, in situations where the public sector has limited capacity and resources, is not fully understood. The private sector may have complex relationships with multiple actors, at the level of service delivery (for example, through contracting), at the health policy level (health sector regulation), and at the wider



government level (business watchdogs). Its role is often complementary to the public sector, filling coverage gaps (e.g. the informally employed) and responding to local needs. Even where it is large and diverse, it is often insufficiently acknowledged in the long-term strategies and policies developed by ministries of health and global health actors. In fragile states there are semi-independent parallel health systems that often offer the only available source of care (as in covering refugees, rural area, or other excluded groups) and have few linkages with the “official” health system. In such situations, it is not clear who should lead the health sector, and by what means and how interventions and policies to achieve international targets (such as the Millennium Development Goals for health) can be planned and delivered. Yet another case is where the private sector has been historically almost entirely banned, as during the communist era, and subsequently has been legalized but with limited support for its development. The private sector may also compete with the public sector for resources and scarce inputs such as staff.

The aim of this paper is to present a framework for conceptualizing the stewardship function within the health systems and the role of government in the context of an expanded role for private service provision and financing. The paper explores the concept of stewardship and seeks to offer typologies of governance, with a focus on forms of engagement with the private and voluntary sectors. It identifies the key areas in which stewardship can contribute to supporting and monitoring the private sector to maximize its public health impact. The paper draws on recent literature published in peer-reviewed journals and unpublished documents, as well as on three country examples: Afghanistan, India, and Uganda. These case studies illustrate how differences in context affect the nature of the stewardship function and the approaches that have been taken in practice to shaping the role of government in mixed health systems. Cross-cutting issues and relevant lessons are discussed.

## **2. Private and Public Sectors: Definitions**

Before identifying the barriers to effective engagement between the public and private sectors, the terms “public sector” and “private sector” should be defined. From the perspective of political science, the public sector is defined as to include “[the] kind of activities public institutions carry out and how decisions are made and implemented by these institutions” (Lane JE. 2000). The public health sector is often understood simply as the Ministry of Health, but for the purposes of this paper, it includes, at the national level, (quasi-)independent regulators that are state-funded or state-owned and public payers such as independent state insurers (e.g., social insurance funds in Eastern Europe). Other government agencies such as business regulators, ministries of labor, ministries of commerce, and the judiciary may also have authority over issues relevant to private health sector operation, through functions such as licensing of health providers if set up as businesses or settling of litigation cases through courts of justice. At the international level, the public sector also encompasses international organizations such as the United

Nations and its specialized agencies (for example, the World Health Organization) (Reich 2002). All of these have the mandate to safeguard the public interest and improve health system effectiveness and outcomes.

The “private health sector” includes an enormous diversity of actors. These can be classified in several broad categories:

- Private sector providers. This group can often be the most visible part of the private sector because they have direct contact with users. However, there is considerable heterogeneity within this category, and the configurations of providers are specific to each context (see Box 1). For example, providers range from modern practitioners and certified health care professionals to traditional healers or other lay persons.

Even in high-income country settings such as the United Kingdom, there is a wide range of practitioners providing therapeutic, clinical services, and alternative and spiritual treatments (Helman 1990). In low-income countries, private providers can provide both curative and preventive services, auxiliary services, and psycho-social support (Bennett 2005). Although such providers aim to treat physical and mental health problems or enhance health (as defined by the users), many of these fall outside the health care sector and are regulated by other institutions. Homeopaths and other alternative practitioners are examples.

Private provision also comprises a range of institutions with different status—from largely not-for-profit nongovernmental organizations (NGOs) and faith-based organizations, to for-profit health care businesses—and may be organized as an individual or group practice.

- Financers, including private insurance, community-based health insurance, employer-based insurance, or direct employer financing of care.
- Private providers of inputs, including producers, procurers, and distributors of commodities relevant to the health sector. This includes physical inputs such as infrastructure, pharmaceuticals, and supplies such as condoms (Conteh and Hanson 2003) but also knowledge production (e.g., medical training institutions, production of information).

Private sector organizations can be funded through their own sources (from investment and profit, including from user payments), through government grants or subsidies, international aid grants, international donations (in kind), or a mix of these.

The private sector can be also formal or informal, where formality is defined in terms of recognition of health care providers by a country’s legal framework. For example, there are formally and informally employed staff categories within the private sector. Informally employed staff may be recognized and sought by the clients they serve, but not by the legal framework of the country. Thus, in Uganda, while formal sector providers comprise licensed private clinics, pharmacies, and drug shops, informal sector providers include unregistered private clinics, drug shops, market or itinerant vendors,

home-based providers, and traditional healers, who are not licensed but are favored and legitimized by communities (Birungi, Mugisha et al. 2001). Similarly, in the area of private finance, there may be cases where small-scale community insurers can be informally organized and not registered with government institutions, especially in the case where state capacity to regulate them is weak.

### **Box 1: Typologies of private sector providers in India**

India has a diverse private health sector, which accounts for over 80 percent of outpatient visits (Peters D. and Muraleedharan VR. 2008 ); (Berman 2001). It can be classified according to its status (for-profit or not-for-profit, or formally or informally trained practitioners).

- Formal, medically qualified, private for-profit providers (hospitals, individual and group practices of general practitioners and specialists)
- Formal, medically qualified not-for-profit sector (hospitals, outpatient facilities, community-based programs)
- Formal providers qualified in Indian and other, non-allopathic system of medicine (hospitals, outpatient providers who have received formal training and are licensed)
- Less than fully qualified practitioners (partially qualified and experienced practitioners of allopathic medicine and other practitioners with limited or no formal training delivering mainly acute outpatient treatment and drugs)

Other classifications reflect the variable length and content of training for private providers and the qualifications obtained. Training programs last from six months to six years, and many providers lack formal qualifications (Das and Hammer 2007). The following groups can be identified:

- Those with an MBBS degree (bachelor of medicine and bachelor of surgery)
- Those with formal training in alternative medicine (Ayurvedas, homeopaths, Unani, and integrated systems doctors with degrees other than the MBBS degree)
- Those with little or no formal training (paramedics or “Registered Medical Practitioners,” generally referred to as “RMPs,” who are not registered with any recognized medical council, including the councils for alternative medicines.)

There is a third category that includes institutions that take a somewhat intermediate position between the public and the private sectors. These include organizations that share some of the characteristics of both the public and private sectors: consumer groups, NGOs, civil society, and some media organizations that are not part of government but seek to promote public interests (Reich 2002). This category also includes professional

organizations (e.g., physicians' and nurses' associations), which are often funded fully or partially from private sources and whose main objective is to safeguard their members' interests, uphold professional ethics and identity (WHO 2006), and act as a platform for expressing collective views and positions, rather than to protect the public interest in general. In the absence of a long-established code of conduct, creating effective professional associations for informal providers, for example drug sellers, as a means for promoting good practice, is likely to take a long time.

For example, the General Medical Council is an association comprising physicians working in the public and private sectors in the United Kingdom and is funded by its members' contributions. It has an extensive mandate in licensing practitioners and considering malpractice cases, which in many other countries are the prerogative of the state, and its decisions can only be challenged through the courts. In other areas, its recommendations are advisory and reflect professional hierarchies and ethical concerns (e.g., on the appropriateness of particular treatments and rationing), with the state retains ultimate decision-making power.

Establishing strict boundaries between the public and private sectors can be difficult. They are often overlapping, especially in the area of financing and provision of care. For example, traditional notions of the public sector refer to government-owned and government-operated providers that receive public finance to supply public services (Le Grand J. 2003). However, in systems where the purchasing and provision functions have been separated, governments may contract with the private sector to provide health services using public funds. Community-based insurance schemes may be used to finance care provided through the public health infrastructure (Bennett, Russell et al. 1995). Health workers can hold an appointment with a government facility and at the same time work either as independent health workers or as employees of a private practice (dual practice) (WHO 2006). They may collect informal fees from patients in public facilities or refer patients from public facilities to their private practices (McPake, Asiimwe et al. 1999). Other practices that challenge the boundaries between the two sectors include when public hospitals run private wards and charge for those services or when they allow physicians to treat private patients within public premises (Mills et al. 2002); and when commodities (drugs, condoms, and the like) purchased by the public sector are diverted into informal markets (Bennett et al. 2005). The reasons for this convergence between public and private can be sought in the weak health systems of many low and middle-income countries (due to long-term under-financing, conflict, or other reasons); traditions within the country; or societal expectations and ideologies, for example a belief that public institutions may benefit from market-oriented mechanisms and incentives (performance-related payment of providers, competition).

### **3. What Are the Barriers to Public-Private Engagement?**

Many governments have a limited track record of engagement with the private sector because of a suspicion of the private sector compounded by a lack of information and a lack of history of communication (Bennett 2005). Many developing countries have traditionally followed a model of public provision and financing whereby ministries of health are responsible for hiring doctors, building hospitals, providing supplies, and paying for care. Often, separate management procedures, patterns of care, and information systems hamper effective collaboration between the public and private sectors. There are also concerns about the opportunity cost of resources channeled through the private sector to achieve health gains and improved efficiency in the short term, which could be applied more effectively to increasing the longer term sustainability of the public system. The vision and the ethos (an important element of governance) in the public and private sectors are often seen as incompatible, leading to a reluctance to seek public-private partnerships.

Another set of barriers to public-private engagement relates to the complexity of patterns of care, which may require prevention, treatment, and follow-up. This is particularly the case for chronic communicable and non-communicable diseases where delivery of effective care requires prolonged treatment, a combination of provider skills at different levels of the health system, and access to drugs and other commodities. Over the course of their treatment, users frequently move between the public and the private sectors, for example, to use different types of clinical skills and drugs. Providing integrated and continuous care is a challenge even in high-income settings, and even more so in under-resourced and fragmented health systems in low-income countries.

As discussed earlier, with the growing investment in the health sectors in developing countries, for example through the global health initiatives, resources are increasingly channeled both through ministries of health and through private and voluntary sectors. Efforts have been made to build on the expertise and capacity of the private sector and to establish working models for multi-actor collaboration. Evidence from research on the effectiveness of public-private partnerships in this area is still somewhat limited. However, there are positive examples emerging. In Tanzania, a Global Fund grant to support a voucher scheme for insecticide-treated nets for malaria prevention was channeled through a partnership between the government, NGOs, and the private retail sector: NGOs were to be contracted to do logistics, training, and promotion of vouchers, which are distributed by the public sector and redeemed from private shops (Hanson, Nathan et al. 2008).

#### 4. Governance in the Health Systems: Definitions and Frameworks

This section examines briefly some of the definitions and frameworks used to conceptualize governance and stewardship and examines their relevance to the private sector. The concept of governance is seen as fundamental by international actors, and it forms a central part of their health sector strategies and broader developmental strategies. Health sector governance is seen to be shaped by a country's history, culture, values, institutions, and politics but also by the broader governance framework of a country. However, it is recognized that socioeconomic development does not lead to public sector development without purposeful investment, including strengthening the governance framework (Ahmad, Dreze J. et al. 1991).

##### *Governance: Definitions and dimensions*

In essence, governance influences how systems operate, what decisions are made, and what inputs are absorbed. Most frameworks incorporate a feedback loop—top-down action is followed by a response at the grass-roots level. For example, government regulations may be implemented and interpreted at the level of service delivery, and any problems should in theory feed back to the policy level and lead to revised policy. Although governance is usually analyzed in terms of the national level, it is increasingly considered in relation to the global level, reflecting political processes involving aid effectiveness and aid architecture. It has also underpinned the current debate and policy agenda on health systems strengthening.

Governance can be defined as the “action or a manner of governing,” government, the office or function of governing; or the authority, control, and steering (2006). It is a multidimensional concept related to a diverse range of ideas—systems of representation or citizen engagement, accountability, responsiveness, power and institutional authority, ownership, political stability, and the rule of law. Its dimensions include the *political*—how those in authority are elected, appointed, monitored; the *economic*—how public resources are managed and policies implemented; and the *institutional*—how citizens and the state itself relate to the society's or public institutions. It is clear that each of the common definitions used emphasizes one of these dimensions to a larger extent; while some of the definitions emphasize the role of multiple actors, others take a more institutional approach. The definition of governance used by the United Kingdom's Department for International Development explicitly includes the private sector in defining governance (see box 2).

## Box 2: Definitions of governance

The United Kingdom Department for International Development: “We use the term governance to mean how the institutions, rules and systems of the state—the executive, legislature, judiciary and military—operate at central and local level and how the state relates to individual citizens, civil society and the private sector. We use government to mean the executive function at central and local levels. The political system or politics is the way power in the state is acquired and how people and groups inside and outside government influence the use of that power.” (DFID 2001)

The World Bank: “We define governance as the traditions and institutions by which authority in a country is exercised for the common good. This includes (i) the process by which those in authority are selected, monitored and replaced, (ii) the capacity of the government to effectively manage its resources and implement sound policies, and (iii) the respect of citizens and the state for the institutions that govern economic and social interactions among them.” (The World Bank 2008)

The International Institute of Administrative Sciences: “The structure of institutions and societal norms by which authority is exercised for everyone's benefit at all levels, from local to global.” (GWG IIAS (The Governance Working Group of the International Institute of Administrative Sciences) 1996)

Several types of models of governance and leadership can be distinguished (drawing on Brinkerhoff and Bossert 2008):(Derick W. Brinkerhoff and Thomas J. Bossert 2008).

- Normative models, drawing on core societal values and norms, usually formalized through the legal and regulatory framework of the state. However, this model takes a top-down perspective and does not sufficiently reflect the complexity of regulation (as opposed to the “command and control” models) and of the behavior and motivation of front-line actors and their interactions.
- Instrumental models, focusing on intermediate health system objectives such as efficiency, effectiveness, private sector regulation, anti-corruption and good governance (e.g., the World Bank’s Worldwide Governance Indicators and Transparency International’s country ranking in corruption indices).
- Pragmatic models, emerging as a way of managing complexity at the micro/meso level by those who implement policies. It is argued that many international agencies tend to narrow down the concept of governance in line with their programmatic objectives (adopting normative/instrumental models) and that donor agencies (and governments) need to interact with local stakeholders to better operationalize the broader concept of governance, allowing it to be adapted to country-specific realities (Hyden 2003).

### ***Governance frameworks***

Governance is identified as a core health system function by the World Health Organization in the 2000 *World Health Report* (WHO 2000), with the revised 2007 framework underlining its importance as cutting across health systems (WHO 2007). The World Health Organization considers the governance function of the health system as fundamental for all other functions (delivery, resources, financing), and has introduced the term “stewardship” (WHO 2000), later framed as “leadership” (WHO 2007). The concept of “leadership and governance” can be understood as a series of functions, both within the health system and beyond, requiring certain institutional capacities (see box 3).

#### **Box 3: Elements of leadership and governance**

- Policy guidance:
  - Formulating sector strategies and technical policies. Vision.
  - Identifying the roles of public, private and voluntary sectors
- Intelligence and oversight:
  - Generation, analysis and use of data on health systems goals and outcomes, especially for vulnerable groups
  - Monitoring the effects of policies and reforms; policy options
- Collaboration and coalition building:
  - Across sectors in government and with external actors
- Regulation and incentives—“fairly enforced”
- System design:
  - Ensuring a fit between strategy and structure and reducing duplication and fragmentation
- Accountability to the public. Transparency.

Source: WHO 2007.

In this framework, the government is responsible for system performance and achievement of policy goals. It emphasizes the “new” government roles given the complexity of actor and system design—roles in policymaking, information gathering, regulation and incentives (in the public and private sectors), and collaborative working (WHO 2000), going well beyond financing and provision of services, which have hitherto been considered main government responsibilities. The 2007 version of the framework is

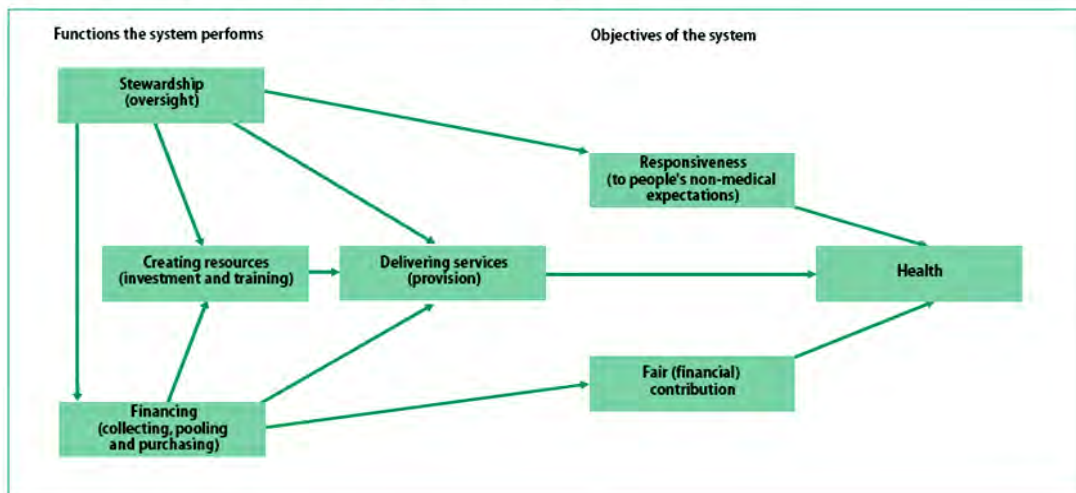


explicit about the main government responsibilities—to protect the public interest through engagement in political and technical actions—and gives added emphasis to global governance (harmonization and alignment between the multiple actors).

The World Health Organization’s view of the role of the private sector has evolved in recent years. It recognizes that governments have to reconsider their role in the health system, in relation to new stakeholders that emerge through new policy processes (as when decentralization gives a more prominent role to regional authorities and private entities). It recommends engagement, stating that “...it is clear that governments do not have all the answers. Productive relations with the private sector and voluntary groups are both possible and desirable” (WHO 2007). However, governments should take the lead because they “have a much wider range of policy levers at their disposal” (ibid.). Government adaptation to more pluralistic delivery models often implies the involvement of subnational authorities, rather than of private and voluntary actors. Although the World Health Organization’s leadership concept emphasizes the need to build coalitions with the private sector, the latter is still seen as an external actor that has to be brought on board once key national strategies are formulated. More generally, the private sector is less frequently mentioned under the other elements of governance as defined by the World Health Organization.

**Figure 1: Health system goals and functions**

Figure 2.1 Relations between functions and objectives of a health system



Source: WHO 2000.

The World Bank has defined governance in terms of six dimensions (The World Bank 2008):

- Voice and accountability
- Political stability and absence of violence
- Government effectiveness
- Regulatory quality
- Rule of law
- Control of corruption

Drawing on this framework, the most explicit linkage with health sector governance has been in the area of good governance and accountability. Good governance is seen as an essential precondition for development and as cutting across sectoral programs, including the health sector (Box 4).

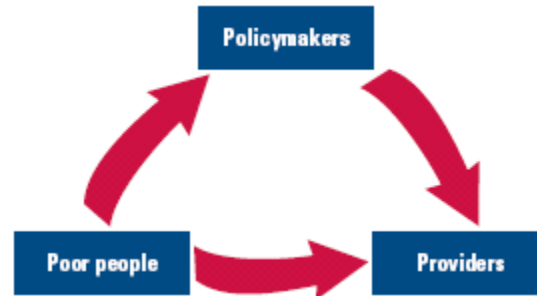
**Box 4: Principles of World Bank Group engagement on governance and anti-corruption**

- Governance and anti-corruption are key for development—a capable and accountable state can reduce poverty.
- Country ownership and leadership are more effective in the long term to improve governance. The World Bank seeks to strengthen, rather than bypass, national institutions.
- The World Bank still supports poorly governed countries/innovative approaches.
- Engaging with a broad range of government, business, and civil society is key to governance reform and development outcomes.
- Strengthening transparency, participation, third-party monitoring in its own operations.
- Harmonized approach at the global level.

The World Bank has also developed an accountability framework representing the relationships between poor people, policymakers, and providers (World Bank 2003) (Figure 2). It has been influential in informing policy and practice and in further conceptual development of the concept of governance (Bossert T 2007). Accountability is an aspect of governance, related to the health system goals of fairness and effectiveness, which can be also seen as indicators of health system performance (WHO 2000). According to the Word Bank framework, poor people have two ways to ensure that services are accountable or responsive to them—directly through their choice of providers or, indirectly, by influencing provider behavior via elected officials. In some settings, people may receive public subsidies (for example, through vouchers) to access privately provided services that are deemed beneficial. The framework does not differentiate between public and private providers, or depict how other policy actors are

accountable to the providers. It also does not show the role of donors separately, implying that they would have an advisory role to the government.

**Figure 2: The World Bank’s accountability framework**



Source: World Bank 2003.

### ***Governance failures***

Governance has often been discussed in terms of governance failures, in health systems or in the wider society. A number of these have been perceived as particularly problematic. These include a failure to effectively lead the health system with a long-term vision, and to prioritize, plan, and deliver the basic interventions required to improve outcome and make progress toward international goals such as the Millennium Development Goals for health (Travis 2002). Governance failure can also be seen in an absence of a functional regulatory framework and accountability procedures and in limited efforts to assess health system performance. Failures to address corruption—including informal payments by patients that may deter access to care, kickbacks from pharmaceutical orders, or the sale of counterfeit medications—represent an increasing concern as they may undermine effective system functioning (Vian 2008).

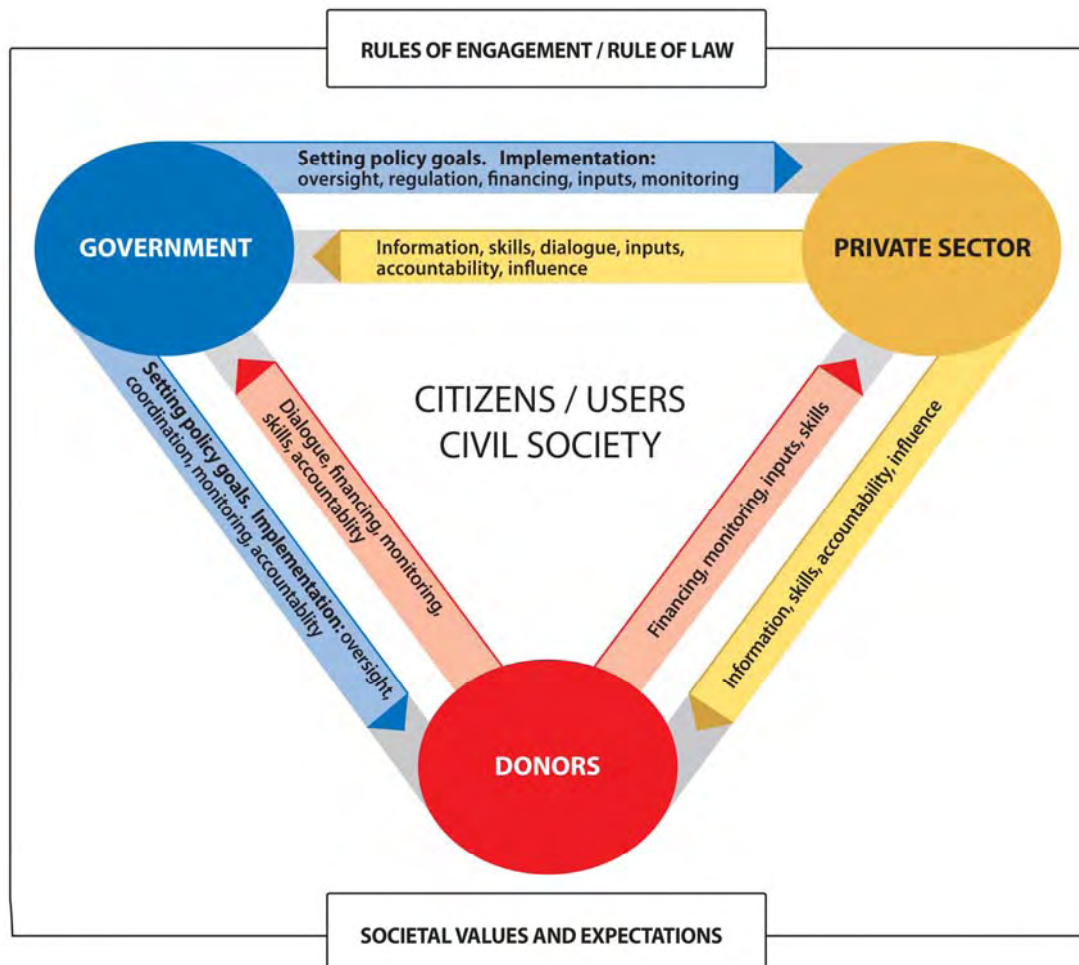
In summary, although there has been a range of frameworks seeking to represent actors involved in health sector governance and the relationships among them, these frameworks have not always explicitly demonstrated the significant role often played by the private sector. For example, the forms and mechanisms of government regulation and oversight in the private or public sector will be very different, requiring very different capacities.

## **5. Health Sector Governance and the Private Sector: An Analytical Framework**

To deal with the considerable complexity of creating a governance framework that incorporates the role and significance of the private sector, we have first sought to identify the key actors and the relationships between them. The approach we take is normative, as with other similar frameworks, because it is extremely difficult to identify actors and relationships that are constant over time and across different contexts. This is even more so in low- and middle-income countries where capacity to maintain formal relationships may be limited.

It is now recognized that the main goals of health systems include health attainment for individuals and families, fairness, and responsiveness and that health systems are only effective to the extent they meet these objectives (WHO 2007). This implies that citizens and, specifically, health care users are central to any framework of health sector governance (Figure 3).

**Figure 3: Health sector governance and the private sector: An analytical framework**



However, it is important to distinguish analytically between users as citizens and civil society (NGOs, patient groups, media, and so forth). Although the interests of citizens and the civil society may overlap (as when an NGO represents citizens or patient groups), this may not always be the case (as when an NGO's main interests are to sustain its activities rather than to respond to need, which may involve scaling down some services). Both citizens and civil society actors have multiple relationships with each of the other major actors, relevant to the health sector—and these relationships are likely to be different for the two groups. For example, civil society may receive funding from donors and be accountable for it, and can also collectively monitor certain elements of the health system, while users can only submit individual complaints through government about the private sector. For simplicity, we designate the central place for the two types of actor but cannot graphically represent all possible linkages as they are different in each context.

For example, one possible way for the government to seek to improve health system accountability to citizens and users is by regulating the behavior of the private sector (see the India case study, in appendix 1). However, government's limited ability to regulate private providers disadvantages users and also hampers the effective functioning of the health insurance market. Because providers can charge rates as they wish and because out-of-pocket is still the predominant mode of payment for hospital services, the ability of insurers to influence pricing by providers has been restricted. In Afghanistan, there has been a major shift in the government role from service provider to steward/financer contracting with NGOs to deliver essential health care (appendix 3). The attention to accountability and quality ensured through comprehensive monitoring and evaluation procedures (using a facility-based score card tool) has considerably improved access to basic health services in many areas (apart from remote areas or parts of the country with continued security concerns).

The other major actors include the government (which includes the Ministry of Health and other institutions with relevance to the health sector), the private sector (including the private and voluntary sectors), and in many low- and middle-income countries that are recipients of international assistance for health, donors.

All of these actors operate within the broader governance framework in a given country. It is based on the rule of law and the "rules of engagement"—which set the overall context for the way political processes work and different actors relate to each other (power, accountability, regulation). These rules determine how the health sector and other sectors operate, and how the health system is set up. However, there is also a set of informal rules (Bossert T 2007), values, and expectations within each society that govern the behavior of all actors. The laws, the "rules of engagement," and the institutions need to have legitimacy and be respected by the citizens in order to be observed and effectively enforced. Both formal and informal rules influence and frame all interactions between the actors. Over time, the informal rules and popular expectations change and influence the rules of engagement and rule of law through the political system; there is therefore a constant cycle of adaptation.

When describing the relationship between the different actors, we take as a starting point the role of government, which is often seen as the steward (WHO 2000) or the leader of the health system (WHO 2007), having a central role in ensuring good governance (Kaufman, Kraay et al. 1999). There is a recognition, mainly through the work of the World Health Organization and other global actors, that the government has the extensive responsibility for (a) defining the policy goals, (b) implementing the policies to meet these objectives, and (c) monitoring. However, we recognize that in practice this is not always the case—especially in countries where institutional capacity and financial resources in the public sector are severely limited (fragile states, post-conflict states, and the like). There may be situations where there is a well-developed and long-dominant private sector, and the government has only relatively recently sought to steer the health care system (India). In other cases, where the government is weak or nonexistent, it is the private and voluntary sectors (sometimes supported by donors) that are setting the rules for the government. While recognizing that the private sector may continue to be

influential and important in many settings, global actors have sought to invest the government with the role of key leader and actor shaping the health sector. The expectation is that most countries will eventually move toward a model in which government plays the stewardship role and, at a minimum, seeks to protect the public interest.

Policy goals may be set in consultation with the private sector, donors, and civil society (as in sector-wide approaches, also called “SWAps” or discussions of national strategic plans), but the government leads the process. This involves gathering information on needs and possible outcomes, setting priorities, and planning. Once the policy objectives are set, the government ensures that these are implemented through strategic oversight and monitoring. In cases where there is significant private sector involvement, donor involvement, or both, the role of government in monitoring implementation and outcomes is even more important, through collecting information about the activities of the private sector and donors, mortality and morbidity patterns, and health service utilization. The government is also responsible for regulating the private sector according to the legal and regulatory framework, both within the health sector and beyond. In cases where public funds are used to finance care provided by the voluntary or private sectors (as in contracting out services, or provision of direct subsidies), there is a need for clear financial accountability. In mixed public-private models, the government can provide other inputs such as infrastructure, staff, and guidelines (e.g., for community-based health insurance).

It is important to emphasize that the relationship between the government and the private sector is two-way— the public sector and donors may draw on skills available in the private sector such as management capacity, drug distribution systems, and access to marginalized groups. The private sector may benefit from publicly funded inputs (drugs, a trained workforce working in both the private and public sectors, physical infrastructure of health facilities) that can ultimately benefit the population and those accessing the health system.

The role of government in relation to donors includes accountability, particularly where donors have provided funding and technical skills. An important function of government in relation to donors is its responsibility for coordinating activities and ensuring that these are in keeping with national strategies and plans. On the other hand, donors can hold the government accountable (if they have provided funding) by obtaining information on the health sector and monitoring progress toward mutually agreed indicators. Another aspect of the relationship between government and donors within this framework is the willingness of donors as a group to harmonize their policies and procedures, and align these with the nationally agreed plans of the government, as applied to the private sector and the civil society. Donors often can contribute technical skills, to benefit both the public and private sectors. Donors can also channel international assistance for health (monetary and in-kind) directly to the private sector and civil society, to provide a wide range of services.

The private sector is accountable to the government in terms of regulatory requirements and other specific agreements, including being legally registered, maintaining quality standards, ensuring safeguards against abuse are in place, and the like. It can be also accountable to donors where the donor is providing the funding and technical assistance. As discussed above, the private sector, ideally, provides information about its activities to the government and to donors if relevant (e.g., population served, outcomes, utilization data disaggregated according to pre-agreed criteria, user characteristics) that could feed into national data collection systems, to help identify gaps in coverage and plan for the scaling-up of services. The private sector can also provide other inputs that can benefit the public sector, for example personnel trained by NGOs or private educational establishments who can then be employed in the state sector, or certain skill sets not available in the public sector such as management expertise.

A critical role that is specific to the private sector is its ability to influence the other actors through lobbying and participation in the policy process, for instance by gaining favorable public exposure in the media: this is often played out in the relationship with the government, with donors, and, to a lesser extent, with civil society.

As noted earlier in this section, citizens may have multiple relationships with any of these health system actors, depending on the setting, health system setup, and formal and informal rules. In relation to citizens, the government ensures that policy goals are formulated and met, through oversight and monitoring. This involves health system-specific goals such as providing responsive services (in terms of patient health needs, demand) but also enforcing wider legal rights such as the right to redress in cases of discrimination or malpractice. In most cases, citizens can hold the government accountable through the political system (voice/vote) or through regulatory channels (complaints, exiting the system). The private sector offers services to the population (financial, treatment, inputs such as drugs). When deciding to access the health system, users exercise choice in relation to which private facility they attend and what services they pay for.

As discussed above, civil society may have interests that closely overlap with the interests of individual users and their families, or in other cases, it may have characteristics similar to voluntary sector entities that are part of the private sector. Certainly, it is agreed that the government must ensure a fair democratic process and create an enabling environment for the existence of civil society organizations, even provide funding (e.g., national press, watchdogs). Civil society organizations may receive information, funding, and other inputs from the private sector and donors, which can then demand feedback and accountability. On the other hand, civil society can provide skills and information to the other actors in the framework and act as an independent monitor of governance issues in the health sector (specifically in relation to non-state actors), and thus have considerable influence over the policy agenda and public accountability.

Figure 3 above shows that, in most relationships, the key element of governance is maintaining engagement—through dialogue, the sharing of information, and accountability by actors for their actions. Thus, it is important that all actors, but most of



all the government, create and maintain spaces for this dialogue and make sure that flows of communication are sustained.

## **6. Forms of Engagement between the Public and the Private Sectors**

Having discussed the main building blocks of the health sector governance framework, we now examine the forms of engagement and the functions for the public sector that these forms of engagement require. The framework helps to define the role of the government in health sector governance vis-à-vis other actors involved, and identify the range of actions required.

In our conceptual model, the government interacts with the private sector at three different levels: by protecting the public interest, by working with the private sector, and by learning from each other (see the table below). The relationship between the government and private sector actors can be placed on a continuum moving from a minimum level of interaction to a higher degree of engagement between the two sectors.

Protecting the public interest represents the minimum level. At this level, the government defines and enforces the rules of engagement; and ensures an overall good governance environment. Within this context, it sets the policy goals in the health sector with a view to ensuring that basic services are available to the population; it establishes mechanisms of risk protection for the poor and vulnerable; and it ensures that required resources are generated and allocated. Finally, the government stewards the health sector toward achieving the policy goals that have been set. At this level, there are minimum forms of engagement with the private sector that the government needs to accomplish to protect the public interest. These are regulating and stewarding. When regulating the private sector, the government must set minimum standards for quality of services and medical education, enforce these standards through monitoring and sanctions, and legislate against malpractice. As part of its stewardship role, the government is likely to require data from the private sector (e.g., utilization statistics, some process and outcome indicators) for monitoring of the sector as a whole.

As government interaction with the private sector expands toward working to increase coverage through affordable mechanisms and reducing fragmentation, additional forms of engagement may take place. In relation to financing, the government may consider contracting with private organizations to provide specific health services (for example, the recently launched National Rural Health Mission in India provides for contracting with private practitioners to fill the vacant posts in public facilities). Alternatively, it may provide tax credits to reduce health care costs for small employers (Hess C., Schwartz S. et al. 2008). As leader of the sector, the government can involve the private sector in making decisions on health policy objectives and strategic plans; provide information to providers (e.g., treatment guidelines) and users (e.g., health information and promotion); and promote an effective balance between preventive and treatment services.

A higher degree of interaction takes place when both sectors learn from each other's experiences by collaborating on common activities. In its stewardship role, the government can foster greater interaction by creating spaces for communication and exchange that can allow for the development of joint activities. These can lead to opportunities for both sectors to learn from each other (e.g., in relation to management models, service delivery approaches).

We are considering here the scenario of a benevolent government that is interested in improving the health and well-being of its citizens and that has the basic resources at its disposal to do this. However, as mentioned earlier, there are situations in which the private and voluntary sectors can form alliances and choose not to engage with the government in order to protect public interest (failed states, war zones, areas with a high level of corruption in the public domain); this collaboration is also accommodated by our framework (figure 3 above—relationships between the private sector, donors, and NGOs). It could be argued that this form of alliance does not preclude efforts to build government capacity in the medium or long run.

## The role of the government in relation to the private sector

Levels of Public Engagement with the Private Sector			
<b>PROTECTING</b> the public interest  To define and enforce the “rules of engagement” and uphold the rule of law To ensure good governance To set health policy goals: To ensure basic services are available and equitably distributed To establish risk protection mechanisms To ensure resource generation To be an effective steward of the health system To ensure responsiveness to the population To be accountable for health system performance (policy implementation and service delivery)		<b>WORKING</b> with the private sector  To scale up interventions and improve quality  To reduce fragmentation and achieve synergies  To foster collaboration and coalition building between the public and private sectors  To recognize professional organizations or self-regulatory bodies to facilitate the progress toward common policy goals	<b>LEARNING</b> from each other  To ensure that the public and private sectors, as well as the civil society, collaborate and learn from each other’s experience
↓		↓	↓
Forms of Public Engagement with the Private Sector			
<b>Regulation</b> - Law enforcement (ensuring compliance, e.g., compliance with international health regulations) - Setting minimum standards for quality/legislation against malpractice - Setting minimum standards for medical education—including the public and the	<b>Financing</b> - Subsidies (through tax, grants, in-kind, investment, credit, loans, concessions) - Obtaining credit from the private sector to expand public health infrastructure (e.g., Private	<b>Stewardship</b> - Formulating and appraising sectoral strategies and technical policies involving the private sector - Involving non-state actors in making decisions to achieve overall health policy objectives (e.g., priority setting, planning, service delivery configurations) with clearly defined roles - Monitoring and assessment (generation, analysis, and use of data on health system goals, needs,	 - Provision of information: (Harding A and Preker A 2003) - to users: on consumers' rights and health information and promotion, on private sector performance (quality and patient safety data) to allow greater consumer choice (Hess C., Schwartz S. et al. 2008) - to providers: treatment guidelines/protocols, recommended drugs, evidence-based information - Coordination of epidemic and emergency preparedness and response, and surveillance for diseases of epidemic potential - Promotion of an effective balance of services (e.g., between treatment and prevention) and reduction of incentives toward non-essential treatment - Provision of resources/commodities (staff secondment and dual practice, drug packages, subsidies for purchase of equipment) - Delegation from the public to the private sector (e.g., the state delegates

private sectors - Strengthening public accountability and citizens' voices, transparency, e.g., through: - Use of intermediaries to introduce consumer safeguards (such as the Consumer Protection ACT (COPRA) in India) (Kaufman et al. 1999) - Licensing - Accreditation (mandatory) - Creating a legal basis for the existence of self-regulatory bodies in the private sector	Finance Initiative) - Contracting out - Social marketing - Use of vouchers - Franchise	and outcomes; monitoring system's performance and the effects of policies, both in the public and private sectors); knowledge generation and translation into policies - Anti-corruption measures - Preventing the public interest from being captured through lobbying etc. (e.g., government's ability to resist pressure from the private sector)	responsibilities for workforce regulation to medical associations) - Training of health workers (continuous education, supervision) - Learning from innovative models of service delivery, financing, management, manufacturing, procurement - Frequent communication, supervision, and feedback mechanisms between government, private sector, and civil society - Facilitating change through the use of policy advocates: participative, bottom-up approaches involving community, managers, and staff - Participation at global-level initiatives, including a focus on the private sector
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Indicators of Progress			
- Regulatory framework for operation of a private health sector (existence of legal instruments—specific to the health sector or via general business regulation, trade, commerce) - Dedicated	- Mechanisms for private sector finance (e.g., established public-private partnerships) - Levels of financing	- Platforms for effective public-private collaboration (within the policy process, e.g., annual joint review meetings) - Joint initiatives in place (e.g., training) - National strategic plans and technical policy documents - Health Management Information Systems - National Health Accounts - Annual performance reports - Research and studies - Treatment protocols and guidelines - Participation of private providers in government training schemes	

<p>court/justice system (e.g., health consumer forums, tribunals)</p> <ul style="list-style-type: none"> <li>- Medical audits</li> <li>- Medical malpractice insurance schemes</li> <li>- Consumer redress mechanisms at the facility level (e.g., complaints boxes)</li> <li>- Consumers' charter</li> <li>- Information, education and communication materials</li> </ul>		
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Clear boundaries between the different levels of public engagement with the private sector are unlikely to be found in real country contexts. Governments may be working with the private sector, for example by providing subsidies to NGOs, without achieving a minimum level of effective enforcement of rules and regulations (as in Afghanistan). The problem of non-compliance with existing rules may prompt governments to seek alternative mechanisms to regulate the private sector, which could be seen as an expanded form of engagement. But these may also be limited in their scope to contribute to improvements. In India, for example, in spite of there being several and comprehensive legal instruments to regulate the private health sector, including a dedicated court system (Consumer Forums) that offers faster processing of cases through the Consumer Protection Act as compared with the regular courts, the ability of the government to enforce the law and deal with increased public demand for legal services is weak—as exemplified by the experience of Consumer Forums, which struggle with insufficient staff and lack of infrastructure (Peters D. and Muraleedharan VR. 2008 ). In addition, the Consumer Forums address only the areas where consumers complain against a deficiency in service by the health providers, and do not address failure to comply with government regulations, limiting their utility to regulate the private health sector.

### *Examples of country experiences*

More detailed examples of country-level experiences in how government engages (as a regulator, funder, and steward) with the private sector are discussed in this section, based on case studies of India, Uganda, and Afghanistan. The Indian case study, in appendix 1, focuses on regulation and the development initiatives of a fast-growing private insurance market. Public-private partnership with the government providing subsidies for faith-based NGO service providers is the theme for the Ugandan case study in appendix 2. Finally, the Afghan experience of contracting with NGOs to provide health services is illustrated in appendix 3.

The country examples indicate that governments can successfully engage with the private sector in a number of ways and in a range of different contexts. As a steward and funder, in each setting government collaborated with private sector organizations to increase coverage and improve the geographical spread of services. This was possible in India as state governments acted as buyers of health insurance packages covering vulnerable population groups. In Uganda and Afghanistan, private providers received government subsidies or were contracted to provide services in remote and under-served areas.

Governments used innovative models such as contracting to outsource service delivery or administrative capacity. In India, the government contracted out expert services from third-party administrators to support its insurance activities in the health sector. In Uganda and Afghanistan, where the governments lacked sufficient financial resources, donors were influential in supporting government efforts to strengthen the policy process and capacity to collaborate with private providers. In addition to providing financial resources, donor support for country-level aid coordination mechanisms was also beneficial in fostering a synergizing environment for government and private sector interaction, as was the case in Uganda. In Afghanistan, donor funding enabled integration

of what was a fragmented system of private providers. Contracting with NGOs resulted in coverage of 77 percent of the population in all regions of the country.

These country examples also show that there are a number of challenges with regard to government engagement with the private sector. For example, a common problem included the lack of sufficiently developed information systems that allow the inclusion of private sector data. Although the data repository (created from the insurance perspective) in India provides some demographic information on insured persons and claims processing data, it does not include information on quality of care provided to the insured, or on outputs and outcomes. In Uganda, the exclusion of private for-profit providers from routine information systems hinders the scope of government planning and efforts to evaluate the health sector as a whole. When directly financing the sector—for example, by contracting with private providers—governments have greater leverage and can require reporting from the private sector to include various types of information, including quality measures (Hess C., Schwartz S. et al. 2008), and it can also build in financial rewards for improvements.

When introducing regulatory measures and developing financial and other initiatives involving the private sector, it is important to pay close attention to the whole cycle and not only the design phase—including management (with clear administrative responsibilities) and close monitoring. For example, cost control mechanisms need to be built into the design and implementation of insurance plans, which prevent misuse or overutilization of benefits with implications for the long-term sustainability of the plans.

A possibility is that governments establish legal requirements for public reporting to support consumer choice by allowing open access to standardized performance measures for private providers. Such a requirement may work as an incentive mechanism for providers to increase quality and efficiency (lower costs) because they are at risk of competition from other providers with higher ratings who can attract more consumers (Galvin 2003). However, these require strong government capacity to develop standardized measures and make these available to the public in a way that is both accessible to consumers and useful for clinicians; their development involves an intensive process of expert consultations on the choice of measures and on how best to package the information for consumers, and an intensive process of agreement with private providers.

Other challenges that can be seen in the country examples:

- Lack of skills at subnational levels of government to work with private providers (e.g., the inability of district politicians to recognize the role of private providers in Uganda, and insufficient stewardship capacity in Afghanistan)
- Unpredictability of external funds (e.g., risk of decreased aid levels in Afghanistan as conflict subsides and maintenance of budgetary ceilings by the government in Uganda preventing an increase in donor funding)
- Effects of competition (changes in the nature and structure of the health care market, including the possibility of greater use of public facilities).

### *Examples of global actors' efforts to strengthen the private sector*

Globally, there has been considerable experience in collaborating with the private sector. For example, the U.S. Agency for International Development works with more than 300 private voluntary organizations based in the United States that operate in various developing countries. The supplies (commodities, services) used by agency-funded projects, however, tend to be earmarked for American contractors (over 3,500 American companies work with the agency). This is often criticized for not allowing the strengthening of local markets but instead reverting as benefits to the American economy (Azfar O. 2002).

More recently, a number of global health initiatives that provide grants to developing countries have made deliberate efforts to engage the private sector in their decision-making processes. In the case of the Global Fund to Fight AIDS, Tuberculosis and Malaria involvement of the private sector is demonstrated by membership of private sector organizations (for-profit and not-for-profit organizations) on the board of the fund (GFATM n.d.). In addition, fund recipients are required to have established a Country Coordinating Mechanism which should include private sector representatives.

Other global health initiatives involving collaboration between the public and the private sectors have been created with the aim of fostering the development and distribution and sometimes the donation of health or health-related products (e.g., drugs, vaccines, and diagnostic tools). Both types of global health initiatives (grants or commodities oriented) have contributed to international health by bringing what were “neglected” health problems into the national and international agendas; raising new funds for these health issues, fostering research and development, enhancing access to health interventions among the poor, improving health services capacity, and creating norms and standards at the international level (Buse K and Harmer A 2007). However, the authors also point to negative effects exerted by these initiatives, namely, distorting the national priorities by imposing their own agendas onto recipient countries, allowing some stakeholders greater say than others within decision-making structures, failing to abide by governance principles such as transparency and dealing with conflict of interest, decreasing the “public” nature of global health initiatives, and failing to compare systematically the costs and benefits of public or private models.

Another example of international donor engagement with the private sector but operating at the country level is the experience of Output Based Aid run by KfW (German Development Bank). In Kenya, KfW supports a voucher scheme that is considered to have achieved good targeting of the poor, produced a good health impact (in terms of maternal mortality and contraceptive prevalence), supported the private sector (by including independent midwives), and created competition between public and private facilities. It is, however, a vertical approach in that it covers only safe motherhood and family planning, and up-scaling to other services is technically problematic. The management of the voucher scheme is set up as a parallel structure to the existing government structures because of fears that efficiency and transparency of resource management by government institutions are lacking. Nevertheless, there is a long-term



plan to integrate the voucher schemes into the National Hospital Insurance Fund (Schickinger C. 2008).

## **7. Strengthening Public-Private Engagement: What Capacities Are Needed?**

This section examines the capacities, structures, and institutions needed for successful public-private engagement, overcoming existing barriers and strengthening governance. It draws on the capacity frameworks by Mills et al. (Mills A., Bennett S. et al. 2001) and Hilderbrand and Grindle (Hilderbrand and Grindle 1997), distinguishing between internal and external capacity. *Internal* capacity comprises finance, management and information systems, human resources, and task networks (communications and coordination between actors implementing a certain task), while *external* capacity includes public sector institutional context (policies and management practices, rules and regulations, formal and informal power relationships) and the broader environment (the economic, political, and social context).

### ***Public sector capacities***

In terms of internal capacity, successful engagement with private sector providers and other actors requires capacities and skills in the area of regulation, management, and implementation of flexible financing mechanisms. For example, there are significant public sector (organizational and institutional) capacities required to effectively contract out services. These include the capacity to design (contract writing skills including specification of services and performance measures), the capacity to manage (setting up of administrative and financial systems), and the capacity to monitor (time and resources to visit contractor facilities) the contracts (Palmer and Mills 2005).

In the public health sector, there is also a shortage of trained personnel who can lead and manage a meaningful collaboration between the public and private sector. In addition to skilled staff, as part of the task network, the government in its engagement with the private sector needs to foster regular communication and coordination, which requires a specific structure (e.g. a unit and or an advisory board within the Ministry of Health dedicated to public-private partnerships). Such an institutional space should serve to support and sustain the policy dialogue with private entities. For example, the Mission Secretariats and Health Societies established at the central, state and district levels under India's National Rural Health Mission form an institutional space that could augment the managerial and communication capacity with the various stakeholders in the health sector.

In addition, management and information systems in the public sector are often rigid and hierarchical, making it difficult to draw on the strengths of the private sector (which exercises greater autonomy to test different options such as payment mechanisms to providers) and absorb innovative models. However, programs like Rajiv Aarogyasri, the

state-funded health insurance plan for the poor in the state of Andhra Pradesh in India, attempt to draw on the strengths of the private insurer in providing appropriate management and information systems, thus enhancing the capacity of the state to provide coverage for surgical procedures through a network of private hospitals at a pre-negotiated cost. Another example of this problem is the case of Uganda, where donors have relied on the Joint Medical Stores in Uganda as a “safety valve” to ensure constant drug supplies in view of the National Medical Stores’ limited management capacity in procurement and distribution. Examples of successful transfers of innovative private sector models to government institutions and procedures in low- and middle-income countries remain rare. This is a challenge even in developed countries, but some experiences show there is scope in the public sector for greater learning from private sector innovations:

In California the Pacific Business Group on Health is working with the NCQA and the Integrated Healthcare Association to develop rewards for providers based on various aspects of quality. General Electric, Ford, United Parcel Service (UPS), and others have developed a pay-for-performance model that will be piloted in Cincinnati and Louisville in 2003. This approach uses an actuarial model to estimate savings from treating diabetics according to evidence-based guidelines and then shares the savings equally between employers and providers. Clinicians who follow the guidelines, verified through certification sponsored by the NCQA and the American Diabetes Association, will receive an extra \$100 for each diabetic covered by one of the participating employers. If all purchasers [including government purchasers] participated, a clinician with 150 diabetics in his or her practice would earn an additional \$15,000 per year, and purchasers would save approximately \$2.5 billion annually (Galvin 2003).

Finally, in relation to internal capacity, governments often lack financial resources to regulate, finance, and steward the health sector effectively. A number of low-income countries rely on international donors to complement their financial capacities. This is not without problems, as donor funding tends to be unpredictable and is not always aligned to the recipient country’s priorities and policies.

External capacities required include the existence of institutions that can effectively regulate and enforce the rules in the public and private spheres (e.g. regulators and watchdogs). Such institutions should have sufficient power and legitimacy, clearly defined procedures and scope of regulatory functions, and operate at national or subnational levels. There is also a need for sufficient transparent procedures, safeguards against corruption, and ability to resist targeted lobbying in favor of narrow private commercial interests.

When health systems are being decentralized, which changes the balance of power and accountability channels between the central and district levels of government, regulating the non-state sector may require specific capacities at each level of the government. Thus, the NGOs or voluntary sector organizations involved in health system financing or front-line service delivery may be seen as accountable and responsive to local needs by the

district-level authorities, but less so by the central-level administration, which may be seeking to achieve complementarity among a range of actors providing services within national-level strategies. For example, when considering the feasibility of scaling up voluntary community-financing plans in Armenia, the national health authorities had a very limited understanding of the advantages of these plans (covering remote rural populations, accessible first-line service responsive to local needs and preferences) and their potential to contribute to extending coverage (Poletti, Balabanova et al. 2007). They were reluctant to incorporate the plans into national strategies for the financing and delivery of primary health care, instead opting to keep them parallel to the state-funded public sector.

More broadly, effective regulation of and collaboration with the private and voluntary sectors is dependent on functioning democratic institutions and processes, which allow a dialogue between different policy actors within a stable political context. A high level of corruption in the formal public sector or political interference can prevent the scaling up of successful small-scale initiatives (often in the non-state sector) and undermine trust among beneficiaries (Bennett 2004).

Political stability will play a crucial role in enabling a country's government to engage with the private sector. In settings where there is severe political conflict, donors operating humanitarian aid may be the only actors in a position to work with non-state providers.

In low-income settings, some of these capacities need to be developed over time as reform or other public-private interactions occur. However, when planning radical reforms (e.g. extension of insurance coverage or financing infrastructure), some of these safeguards need to be set up in advance to prevent a capture of resources or power by the private sector, for example following the contracting out or privatization of health system elements (Balabanova, McKee et al. 2004).

### ***Private sector capacities***

In terms of internal capacities, there is a range of managerial, professional, and technical capacities required within the private sector to allow a good level of engagement with the rest of the health system. In many cases, these will depend on whether the private sector in a country is consolidated or fragmented. In the former case, where there is high level of self-regulation (as in the General Medical Council in the United Kingdom), private providers may be able to influence policies in the public sector (e.g. formulate clinical guidelines, working conditions). In the latter case, the problem of fragmentation will require strong leadership and organizational capacity from the private sector to establish coordinating bodies. This was the case in Uganda, where part of the private sector (the private not-for-profit providers) was able to set up coordination bureaus to facilitate dialogue with the government. But the coordinating structures (bureaus) also served to strengthen their internal networking capacity, supporting the development of a central database system, procurement, and so forth (box 5). The levels of trained staff,

management and clinical capacity, and financial resources can be extremely diverse and, where it is lacking, may reduce the incentives to create linkages with the public sector.

**Box 5: Private not-for-profit coordination structures and dialogue with government in Uganda**

Effective dialogue is critical in the realization of the goals of the partnership. The dialogue is influenced by the governance arrangements in place for both public and private actors. How are decisions made? Who is at the negotiation table? Whom are they representing? What is the mechanism for feedback to the constituencies? How is consensus built? In whose interest is the agenda? Within the government sector, the answers to the questions are thought to be obvious. The structures within government, though often weak and at times dependent on personalities rather than institutions, are well defined at the local, district, and central levels. Within the private sector, there are differences in governance structures such that sub-groups within the private sector such as private not-for-profit providers, private health practitioners, NGOs and other civil society, and traditional medicine practitioners do not all share one common vision. This creates a tendency to compete for recognition as well as for resource inputs within the private sector. Competition between the private entities weakens the quality of the engagement with the public sector. The private not-for-profit providers overcame this by setting up the medical bureaus. Although independent and administratively autonomous, the bureaus have a sense of belonging created around shared values and an organizational culture that constitutes their identity.

The private sector could be engaged in areas where it has a clear comparative advantage, for example in developing and distributing new drugs or in scaling up essential services to reach marginalized groups. In Uganda, it did so by demonstrating its ability to cope with shocks and recoveries over the years and brought lessons that the public sector is being able to draw from. For example, “task shifting” was pioneered by private not-for-profit providers through the use of Nursing Aides. With minimal training, this cadre was able to fill the human resource gaps experienced by the private not-for-profit providers. The issue of the quality of care delivered by this cadre has been debated, and in time Nursing Aides have been replaced by Nursing Assistants, who are formally trained and recruited within the national health system.

But the private sector could acquire broader and more sustainable strategic capacities to engage in wider health system strengthening efforts with overall long-term benefits. For instance, disease-specific projects often delivered through private sector organizations in a vertical approach (not in an integrated mode with the public health system) are criticized for disrupting service delivery, such as taking away government staff for training purposes, with negative consequences for users. In the Gambia, “it was observed that in a typical month health teams had only a few days for routine activities because so

much time was allocated to programme workshops” (Conn, Jenkins et al. 1996). This would also be true in India, where, for example, the Pulse Polio immunization campaign (initially catalyzed by bodies like Rotary International) would require considerable time inputs from public health system personnel for training, manning of vaccination booths, and “mop-up rounds.”

Generally, in terms of external capacities, the private sector is influenced by a country’s overall institutional and broader environment as determined by the rules of engagement and rule of law and by societal values and expectations. More specifically, the private sector may be hampered by high entry costs, bureaucratic hurdles when setting up private entities, an unstable business environment, and unpredictable changes in regulatory mechanisms, creating insecurity and a focus on short-term objectives. The existence of dual practice may also have a considerable influence over the incentives and behavior of private practitioners and the type of care provided.

## **8. Conclusion**

The global health community would benefit from an exploration of new models for integrating public and private health resources to create comprehensive health systems better equipped to improve health outcomes and that are more responsive. However, in this paper we argue that an effective public-private partnership requires reexamining governance (both formal rules of engagement and informal societal rules and values), and this poses considerable challenges in terms of the capacities for engagement required in both the public and private sectors. The situation is further exacerbated by the complexity of relationships among multiple actors, at the subnational, national, and global levels, many of which are informal.

The analysis raises a range of questions that can be used to guide further investigations. While our framework identifies three main forms of engagement—regulation, financing, and stewardship—these may not encompass the variety of relationships between the public and the private sector that may exist in low-income settings.

Different contexts imply different types and mixes of private sector actors (e.g. NGOs versus for-profit insurance) and different forms of engagement with them. Expanding our set of case studies to consider a broader range of situations (e.g. in middle-income countries) may be valuable in identifying different forms of engagement and in testing and adapting the framework. Further analysis may also help to create a typology of the different types of governance functions needed to deal with the different constellations of private sector actors.

We identify the main capacities needed to strengthen governance. However, further analysis of effective interventions that have strengthened capacity in the public and private sectors is needed. This could take a case study approach, looking at specific capacity strengthening measures or a historical one, for example, tracing the evolution over time of governance structures in settings that have seen an expansion in the size and role of the private sector.

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## **Appendix 1: How the Public Sector Engages with the Private Insurance Market in**

### **India**

#### **Background**

While commercial health insurance constituted only 0.7 percent of private spending in 2001–2002 and barely covered 1 percent of the population, its importance in India is rising quickly. Health has been the fastest growing segment in the insurance industry in India in recent years, and it grew 60 percent in 2007–2008 to command a market of about \$1.2 billion (in U.S. dollars) and now constitutes 18 percent of all business of non-life insurers, second only to motor insurance, which is statutorily mandated. The rapid growth and vast potential of private health insurance is increasingly attracting more insurers to offer innovative health insurance products and also to market their health products at a higher decibel level than has ever been the case in the past. It is estimated that about one-tenth of the country's population has access to any form of health insurance, including social health insurance and government-financed health insurance.

#### **Public-private engagement**

Today, the participation of the government in the Indian health insurance sector itself is multifaceted. Within the overall framework of government institutions is the statutory regulatory authority for insurance set up by a parliamentary act in 1999, christened the Insurance Regulatory and Development Authority (IRDA), which is entrusted with laying down the regulations and the rules of the game for health insurance, and which also has a prominent development agenda for health insurance. In addition, the Ministry of Finance provides tax concessions under the Income Tax Act for purchasing health insurance policies up to specified limits<sup>1</sup> while also subsidizing a voluntary health insurance plan sold through the public sector insurance companies, called the Universal Health Insurance Scheme (UHIS), aimed at those who live below the poverty line. Yet another public player in promoting private health insurance is the Ministry of Health, which, under the National Rural Health Mission, promotes health insurance products and also has provisions to subsidize the sale of such products.<sup>2</sup>

The government also owns the largest players in the sector (together accounting for 61 percent of the health insurance business volumes in 2007–2008<sup>3</sup>), which continue to be substantially larger than their newer private sector counterparts, although the pace of growth of private insurers is faster, and they have been gaining market share in health insurance by virtue of their higher growth.

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<sup>1</sup> [www.incometaxindia.gov.in](http://www.incometaxindia.gov.in)

<sup>2</sup> <http://mohfw.nic.in/NRHM.htm>

<sup>3</sup> IRDA Journal, June-July 2008 at [www.irdaindia.org](http://www.irdaindia.org)

Finally, the government is also an increasingly important buyer in the competitive insurance market, particularly in areas such as agricultural and health insurance. As buyers of services, various state governments are now buying large group health insurance coverage from commercial insurers for their vulnerable groups (very often those who live below the poverty line). The recently announced Rashtriya Swasthya Bima Yojana (RSBY, literally translated as the National Health Insurance Plan) aims to cover 60 million poor households (300 million people) over the next five years, starting in April 2008, and is almost entirely subsidized by the federal and state governments in a 3:1 ratio, with the insured only paying \$0.70 per year. This plan is being implemented through commercial insurance companies, which are selected and contracted by the government after an open bidding process. A similar program, Aarogyasree, was launched by the state government of Andhra Pradesh in 2007 and covers over 18 million beneficiaries, entirely at state cost.

Regulatory interventions in this context include:

- Regulations for third-party administrators (TPAs—Health): The state-run insurers were general insurers and did not have much specific expertise in health claims or in managing a contracted network of hospitals for providing cashless services to policyholders. TPAs have provided this capacity over the past six years and undertook the functions of contracting hospitals, issuing identity cards to insured persons which could be used by hospitals to provide cashless service (that is, at no charge to the insured, and to be billed to the TPA/insurer directly), managing pre-authorizations, processing claims, and sending claim payments to the insured persons. These functions were outsourced to TPAs at a negotiated cost calculated as a percentage of the premium (5.5 to 6 percent). As a consequence, TPAs invested in information technology capacity and became good sources of data for the insurers and subsequently the regulator. Regulations for TPAs set out the requirements for licensing and conduct of TPAs.
- Regulations on micro-insurance, which enable low-priced policies with lower sum insured. This has facilitated distribution of such products through non-conventional media—nongovernmental organizations (NGOs), self-help groups, and so on, which could become micro-insurance agents. Life insurers could join forces with non-life insurers, and vice versa, to offer products that could be combined at the point of sale and offer life, property, and health coverage in a single policy.
- Protection of policyholders' interests: The IRDA Protection of Policyholders' Interests regulations, 2002, are aimed at safeguarding the consumers' interests and prescribe service standards for insurers (including transparency, disclosures, and timelines for various services) and grievance redress mechanisms for the insured. The Insurance Ombudsman mechanism was created in 1998 for the purposes of quickly disposing of the grievances of the insured customers and of mitigating the problems involved in redressal of those grievances. This institution has proved to be of great relevance for the protection of interests of policyholders and also in building their confidence in the system.

Below are some developmental initiatives in the health insurance market spearheaded by the IRDA:

- **Health Insurance Working Group:** The group was set up by the regulator in 2003, and it has established sub-groups and subcommittees addressing specific areas for development of health insurance (such as stand-alone health insurance companies, product innovations, and health insurance data) and gave its recommendations to the regulator and to other stakeholders in the system. Membership included industry, government, and professionals. Later in 2007, the regulator supported the activities of four industry chambers within which health insurance groups with multi-stakeholder representation were initiated. These groups contributed to a consultative process for policy formulation and development of the sector.
- **Data repository:** One of the outcomes of the Health Insurance Working Group was the constitution of a Health Insurance Data Repository. The standardized submission of health insurance data from the TPAs has resulted in a large database of relevant information over the last four years, which could provide useful inputs for regulatory interventions, pricing and underwriting by insurers, and management of claims.

## **Challenges**

- **Access:** Proximity to services, zero or low co-payments and low opportunity costs of seeking care, and the availability of a cashless facility are some of the factors that influence use of benefits offered by health insurance. Thus, if a poor rural family is covered against hospitalization, but the nearest eligible hospital is too far, or if the family is expected to pay first and seek reimbursement later, such factors act as a strong deterrent against use of health care. New programs such as the RSBY seek to reduce these barriers by, for example, offering cashless services.
- **Consumer awareness:** To derive greater benefits from mass health insurance plans purchased by governments, there is a need to ensure adequate awareness among those who are covered. In many cases, premiums are paid by the government as a lump-sum amount or deducted by a cooperative from members' accounts, but the intended beneficiary may never be aware of being part of a health insurance plan. This naturally has an impact on use, and use in initial periods remains low. One way to ensure awareness of such plans could be to collect a nominal contribution (bearing in mind the administrative costs of such collection). In RSBY, for example, the amount of 30 rupees paid by each family will certainly help ensure that beneficiaries are aware that they are covered by the plan.
- **Design and monitoring:** There should be a system of checks and balances for adverse selection (in cases where the coverage is voluntary), cost escalation, moral hazard by the insured or the provider, and malpractice, which need to be carefully addressed as much at the design stage as through subsequent monitoring and modifications of the plan. A poorly designed insurance plan could lead to cost escalation in the health system, which will not only make the insurance plan unviable but may also have the secondary effect of raising costs for the uninsured.

- **Competition:** Although many states enlisted their public facilities as providers under their health insurance plans, use of public facilities under the insurance plan has remained low, as the insured may prefer a private provider when both are available. Greater initial efforts may be needed to ensure a level playing field to the public hospitals, which could include, for example, co-payments for using private hospitals or alternative remuneration mechanisms for public sector facilities, so that use of public health infrastructure also improves along with improvement in access for the citizens. Insurance funds reimbursing public facilities could help improve the infrastructure and could also contribute to motivating those employed in the public health system.
- **Cost control:** Mechanisms that prevent misuse or overutilization of the benefits may be needed to ensure the long-term sustainability of these health security measures. This could also include careful negotiation and contracting with providers to ensure quality, access, and affordability.

Source: Singh Nagpal P., and S. Nagpal. India case study.

## **Appendix 2: How the Public Sector Engages in Partnerships with the Private Sector in Uganda**

### **Background**

The history of public-private partnerships in Uganda dates back to the pre-independence period when voluntary health providers, mainly faith based, provided health services alongside the formal government system. The introduction of government subsidies (grants-in-aid) to these organizations was implemented from 1956 onward.<sup>4</sup> However, as the country struggled through the economic and political downturn of the 1970s and 1980s and the National Health Service collapsed (including losses of critical human resources, deterioration of infrastructure, decline in health investment, and weakening of governance systems), the government subsidy stopped altogether after a period of decline. This resulted in uncontrolled and unregulated growth in the private health sector, in particular private not-for-profit providers, nongovernmental organizations (NGOs), clinics, drug shops, and informal health providers. International charitable support emerged to assist the mission health services to expand and fill the vacuum created by the collapse of National Health Service at the time. New mission health services were established, especially in the remote and under-served areas of the country. However, by the early 1990s, most western charitable support to the mission health facilities had started to dwindle. This coincided with the channeling of a larger proportion of development aid directly to government systems through the Sector-Wide Approach (SWAp) launched in the late 1990s, resulting in a loss of revenue for some of the nongovernmental actors, particularly the not-for-profit sector. To survive, the mission health sector introduced or expanded user charges to generate income and sustain their services. Given the poverty levels in the communities, this strategy was not able to generate sufficient resources to run the sector and had negative effects on service utilization.

### **Renewed public-private engagement**

In the mid-1990s, the mission health services rebranded themselves as “private not-for-profit” providers to emphasize the charitable nature of their health services. The high level of user charges was perceived as a political tool for negotiating government subsidies. Electoral politics was also taking root at the time, which allowed some political voices to support the private not-for-profit facilities that were faced with closure due to “double jeopardy”—poor revenues and exorbitant user charges. The government’s rationale for strengthening the partnership with the private not-for-profit sector was to support and complement an already existing system with a sizable infrastructure, particularly in the rural areas, and health training capacity.

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<sup>4</sup> General Notices of Government, 1957, 1959, 1961. Uganda Gazette.

Given the fragmented nature of the private not-for-profit sector, the efforts to mobilize government support were diffused and not well coordinated. In attempts to coordinate their voices, three medical bureaus<sup>5</sup> (Catholic, Protestant, and Muslim) were established to engage the central government and district local governments. The new bureaus were active in the overall policy development process, and this led to the offshoot of a specific public-private partnership policy development process. These two processes provided the space for institutionalization of the collaboration between government and the facility-based private not-for-profits represented by the three bureaus. The private for-profit and traditional health sector were left behind in these policy developments, mostly due to the lack of institutions to represent them.

Three contextual factors synergized the public-private partnership engagement in Uganda: (1) the Health Policy development process in the late 1990s; (2) the HIPC (Highly Indebted Poor Countries) initiative of the World Bank; (3) the SWAp in 2000. The Health Policy development process provided the space for discussion of health service packages and coverage, recognized the role played by the private not-for-profit sector, and reaffirmed the public-private partnership principle, while HIPC provided the opportunity to expand the resources available for social development. With HIPC funds, the government was able to allocate more funds to the health budget, including grants to the private not-for-profit sector. The move to SWAp to finance the health sector engendered the pooling of donor resources, channeling donor funds through the national budget and strengthening Ministry of Health leadership for the sector. The SWAp process provided the *institutional* mechanisms and structures for public-private partnership engagement.

### **Benefits of engagement**

- Grants to private not-for-profit providers expanded from 1 billion Ugandan shillings in 1997 to 20 billion in 2006 in real terms. The grants expanded from private not-for-profit hospitals to cover all private not-for-profit health facilities, including smaller health centers. In 2005–2006, about 5 percent of the total health sector budget was allocated to private not-for-profits.
- As grants to private not-for-profit providers increased and as government rescinded cost sharing in all public facilities in 2001, the private not-for-profits were subjected to government pressure to reduce user charges at their facilities. This process led to reduced and flat-fee structures in most private not-for-profit facilities.
- Sector planning and monitoring under SWAp actively involved private not-for-profit bureaus. A public-private partnership working group was formed as an institutionalized arrangement for direct private not-for-profit engagement in the sector planning and monitoring under SWAp. The private not-for-profit bureaus also participate in policy dialogue through other SWAp working groups (among them, budget, medicines, and human resources).

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<sup>5</sup> The bureaus' main functions are to represent and coordinate the different health providers in the private not-for-profit sector, coordinate and promote professional development and ethics, provide support services, and accredit the member facilities.



- Given the shortage of staff in the health sector and the high cost of salaries for cadres such as doctors, the government seconded over 100 medical doctors to private not-for-profit hospitals as a contribution (wage subvention).
- Coordination between the government, donors, and numerous private not-for-profits was made more efficient by working with three bureaus. It is the work of the bureaus to amplify and coordinate the activities of their members. The bureaus provide institutions that enable capacity building among private not-for-profits. They also provide a system of accreditation that supports the regulating capacity of government.
- The Joint Medical Store (JMS), a drug procurement service created by the three bureaus, is now a major player in the procurement and supply of medicines for the whole country, offering autonomy and leverage for private not-for-profits. It supplements the National Medical Store (NMS), which is a public agency. JMS currently handles 69 percent of the primary health care medicines budget for the districts, compared with 31 percent handled by NMS. Being nongovernmental, JMS enjoys flexibility and higher efficiency in procurement than NMS. For some donor-financed procurement, JMS has provided the “safety valve” to avoid shortfalls in the supply of essential medicines.
- At the decentralized level, structures such as the District Health Management Team, District Private Not-For-Profit Coordination Committees, Health Sub-District Management Committees, and the Village Health Teams all include private not-for-profit members and are critical in the identification of health needs, prioritization, planning of appropriate response, coordination of service delivery, and monitoring and evaluation of health system performance.
- Currently, 29 private not-for-profit health facilities, representing 13.5 percent of the 214 sub-districts, are executing the function of Health Sub-District referral and management unit. This reflects the government objective of seeking to establish an appropriate and efficiently functioning referral system through use of both public and private health facilities to ensure a continuum of care.
- The private not-for-profit sector contributes to the production of human resources for health through a network of 20 health training institutions (out of 48 in the country).
- The government Health Sector Annual Performance Reports show that the private not-for-profit sector provides about 40 percent of the total volume of health services (utilization data from private not-for-profit facilities is incorporated quarterly and annually into the government’s Health Management Information System). In terms of infrastructure, private not-for-profit providers have about 34 percent of the health facilities in the country (with 86 percent of these located in rural areas). Given their share of the health budget (5 percent), the private not-for-profit providers demonstrate good value for money in their contribution to national service provision.

## Challenges

The health sector in general has not benefited from an increase in the resource envelope from the government allocation, despite the growing demands of increasing cost of health

services, population growth, and inflation. This has resulted in a stagnation of the government subsidy to the private not-for-profit sector. The government subsidy as a percentage of the total private not-for-profit budget peaked at 36 percent in fiscal year 2002–2003 and now stands at 22 percent for fiscal year 2006–2007.<sup>6</sup>

The government subsidy is not formalized under a contractual relationship. This is partly due to the complexities associated with directly linking inputs of money to outputs of service delivery, the weak capacity to formulate and enforce contractual agreements, and limited understanding of the implications of contractual agreements. Contractual agreements may require full disclosure of accounts by the private not-for-profit providers and thus infringe on the principle of autonomy for these providers as set forth in the public-private partnership policy.

Despite the limited government subsidy, the private not-for-profit providers are expected to deliver on all the health interventions according to the Ministry of Health's technical guidelines. The health technologies and treatment guidelines are continually updated, and the private not-for-profit providers are constrained in keeping up with these changes in terms of capacity and skills, for example in the expansion of services for HIV/AIDS. Another challenge relates to the “value set” of Catholic private not-for-profit providers, which opposes the provision of family planning services.

Understanding and appreciation of the partnership are not universal. Support for the partnership varies between districts with some districts convinced that the private not-for-profit providers are not entitled to a government subsidy because they are able to mobilize adequate resources from user fees and other partners. In such cases, the level of dialogue and collaboration is less than optimal.

Finally, the presence of the global health initiatives has been regarded by some as creating perverse incentives for the private sector, particularly for those struggling to raise funds for delivery of services. Others have modified their agenda in line with the global health initiatives in order to benefit from the resources available.

Source: Seengooba F., J. Bataringaya, and C. Kirunga Tashobya. Uganda case study.

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<sup>6</sup> Annual Health Sector Performance Report FY 2006/07.

### **Appendix 3: How the Public Sector Engages with Private Providers in Afghanistan**

#### **Context**

By the end of 2001, events in Afghanistan led to the removal of the Taliban regime and the establishment of a new, internationally recognized government. The ensuing re-engagement of the international community sparked off efforts to stabilize the country, including reconstruction of virtually all institutions across all sectors.

Until then, public sector health services had been primarily urban and hospital based, and were provided by the government. During the more than 20 years of war prior to 2001, these health services were dilapidated and were partly replaced by health provision through nongovernmental organizations (NGOs), with an emphasis on primary care services to the rural populations. Although the NGOs are not-for-profit private entities, they typically aim to substitute for and restore public sector provision. Local authorities need to approve their activities; they often use preexisting governmental health facilities; and their funds come from external governmental donor agencies supplemented by private donations from citizens in the NGO's home country.

Apart from these “public sector” health services, there is substantial health provision through a largely unregulated private sector consisting of a multitude of providers with varying degrees of medical training. A national survey in 2006 showed that 55 percent of the population use such private providers as their first port of call in case of illness.

By early 2002, over 80 percent of available public health services in Afghanistan were provided by a few dozen NGOs, some quite large, including a number of new, but well-established national NGOs. However, this health care “system” was highly fragmented, without common standards, and haphazardly distributed across the country. All senior and mid-level management of the new Ministry of Public Health (MoPH) were new to the job and inexperienced in public health, management, and policy processes.

#### **Donors and government engagement**

Against this background and extremely poor population health status, the international community suggested that Afghanistan build on previously successful experiments with contracting out health services in Cambodia, and apply these on a large scale. The idea was that the MoPH would set policy and contract with third parties in the private sector to provide a Basic Package of Health Services (BPHS) to all Afghans. International donors would fund these contracts, directly or—increasingly—through the ministry. Within a short period, all stakeholders bought into this idea, with the MoPH formulating the BPHS (a set of services to be provided through defined health care infrastructure and staff) and setting up a Grant and Contract Management Unit within the MoH. Key donors such as the World Bank, the U.S. Agency for International Development, and the European Commission started to issue calls for proposals in a number of bidding rounds. NGOs

proved highly responsive, with the calls attracting both preexisting international and national NGOs as well as a number of newly arriving international and newly established national NGOs.

In terms of regulation, the roll out of the BPHS meant that the government (the MoPH) directly engaged with these NGOs through contracts. The contracts stipulate what the NGOs are expected to deliver, including some benchmarks, and the amount of pay to be received, in some cases with a potential bonus for good performance. All contracts were also subjected to approval by one of the three major donors. MoPH and donors are jointly responsible for monitoring and evaluating NGO performance using a score card, partly based on objective assessments by an independent third party, a consortium of international agencies (Johns Hopkins University and the Indian Institute for Health Management Research). NGOs provide data to the government Health Management Information System and to the independent evaluator, and also provide regular reports to donors. Based on this, ill-performing NGOs may be replaced, as happened in a few cases, if a warning does not lead to improvement. NGOs can launch a formal appeal against such a decision.

## **Benefits**

By the end of 2005, this process had resulted in 55 different contracts signed, with a total value of \$155 million (in U.S. dollars), covering 16 million people (77 percent of population) across all provinces. Funds awarded averaged around \$5 per capita per year. The number of contracts and population coverage has increased since then. Results became visible, particularly in the less security-affected northern parts of the country, in the form of increases in health facilities, numbers of female staff, vaccination coverage, and other indicators. This has improved access to essential primary care for many population groups that would otherwise not have access to services, with the exception of areas with continued security concerns or remote areas.

The NGOs demonstrated a capacity to run health services during the war and also proved to have the capacity and flexibility to scale up these services during these early years of reconstruction. NGOs now act under the guidance of a central policy set by the MoPH and with much increased accountability, both to the MoPH and the donors, with much more scrutiny of actual performance. The three key donors in the health sector in Afghanistan (the European Union, World Bank, and U.S. Agency for International Development) aligned behind the agreed contracting policy, a major factor contributing to the relative success of the program. They use different mechanisms for the disbursement of funds—directly from donor to NGO or through the government—and the responsibility for managing the contracts is shared between donors and the government unit. In effect, contracting has shown to be an effective mechanism to ensure payments to the NGOs.

The introduction of a new financing relationship through contracting out the BPHS to NGOs in Afghanistan meant a substantial reshuffling of relationships between the government (MoPH), the private sector (the national and international NGO providers),

donors, and the users of the health services. The government had to give up its traditional role of service provider and strengthen its new role as steward. Once the contracting policy was accepted by the MoPH, energy was freed up because the ministry no longer had to deal with the day-to-day running of health services and could focus on setting policy, regulating, and managing the contracts in terms of procurement and monitoring and evaluation.

All health facilities are required to have community health committees ensuring that user concerns are addressed. However, actual responsiveness of health services to community-felt needs will need to be assessed.

On the whole, over the past few years, this system proved to have good checks and balances, as shown by assessments.

## **Challenges**

Many observers agree that contracting has been highly instrumental in the relative success of the rapid roll out of the BPHS. The MoPH, through its Grant and Contract Management Unit, rapidly built up the capacity to manage the contracts and has relatively good resources to do so. However, although it is part of the MoPH within the Department for Policy and Planning, the unit is relatively autonomous and relatively isolated from the process of policy and strategy formulation. The implication is that services that are contracted out may not be fully aligned with public health priorities.

The current emphasis, within the given serious constraints (finances, human resources), is very much on the relatively rigid implementation of the rationally chosen minimum services within the basic package, with primary accountability of the NGO providers to the MoPH and the donors. The contracts cover all health services at the primary care and district hospital level for the whole country, but tertiary hospital care, some vertical programs, and MoPH costs are not included—thus leading to fragmentation of care. Afghanistan is not expected to raise its own resources in the foreseeable future to cover the costs of these contracts, and there is dependency on external aid to fund further levels of services.

There are concerns about the sustainability of services in the long term and ensuring that there is investment in the health system given the competition for contracts, potential high turnover of service providers, and short contracts (two to three years in duration). Introducing longer contracts (five years in duration) has been considered but is hampered by donors' own internal accountability procedures.

Although the relationships between the MoPH and the other actors involved in financing and providing care is relatively established, shaping the new role of institutions at the subnational level is still in progress. In time, provincial health authorities may start playing a crucial mediating role, but shaping the role of the provincial health authorities, away from the role of provider and toward the role of regulator and steward, is still in progress. Clarification of the new roles, together with extensive capacity building at the

provincial level amid rapidly evolving new developments, has proven to be a major challenge, and its success is to be assessed at a later stage.

In terms of stewardship, the emphasis on implementing a basic benefits package through contracted private providers led to a focus on specific stewardship elements. The MoPH, no longer tasked with direct health care provision, could relatively rapidly develop capacity to manage contracts and improve its monitoring and evaluation function, followed by a slower process to build stewardship capacity at the provincial level. The relation between MoPH and the NGOs is primarily governed by the (perceived) adherence to the contracts. To some extent, this may hamper lesson learning on health care delivery in the harsh Afghan environment, which is also not helped by the limited contacts among NGOs involving knowledge generation.

There are also issues concerning harmonization of donor policies, as the major donors are working within the MoPH structure but are still using their own procedures in terms of procurement, and monitoring and evaluation. NGOs are in competition for contracts, and there are no incentives for self-regulation or for building alliances. There is relatively limited NGO participation in policymaking or in policy dialogue on policy goals or strategies in the health sector, and no formal mechanisms for feedback from the field about the lessons learned. Similarly, the influence of the private sector on policy is mainly through informal channels, although the larger NGOs are becoming more influential.

The feasibility of contracting as a longer term strategy still needs to be determined. In future years, the role of the donors can be expected to diminish when they will increasingly provide funds through basket funding and be less directly engaged with individual contracts. There are indications that, gradually, the MoPH and donors will seek to create a sector-wide-approach (or SWAp) type of arrangement. Key factors may be the predictability of external aid, transaction costs, further development of appropriate monitoring and evaluation systems, building up of stewardship capacity at provincial levels, and the effects of continued competition on the viability and nature of the non-state providers, such as the current NGOs. Another interesting feature to observe over the longer term will be the tension between the logic of replacing one NGO at the end of the contract period by another NGO, if the latter promises higher quality of care or a lower price, and the possible wish of the community to retain an NGO provider it trusts.

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