

Service level agreements for primary healthcare in Malawi

Secondary Case Study

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Context

In its bid to achieve Universal Health Coverage (UHC), the Government of Malawi (GoM) has sought innovative ways to increase population coverage for essential health services, especially in rural areas which populations may not always have easy access to clinics or other health facilities.

To achieve this goal, GoM decided to partner with an existing network of health facilities run by the Christian Health Association of Malawi (CHAM). CHAM is an umbrella organization for most Christian faith-based health facilities in Malawi, which oversees about 35% of all health centers in the country (Chirwa et al. 2013). CHAM facilities are generally concentrated in some of the poorest areas of Malawi, often in rural regions, and operate independently according to a fee-for-service model.

The health system in Malawi is decentralized, with districts responsible for their own policy decisions. Beginning in 2004, the central GoM began to encourage District Health Offices (DHOs) to engage with CHAM facilities in their catchment areas through the implementation of a national policy encouraging Service Level Agreements (SLAs) between public and private sectors. The goal was to increase geographic coverage of essential health services by removing user fees at CHAM facilities, while also ensuring sustainability of CHAM operations by connecting them with a steady base of patients.

The national MOH and the CHAM Secretariat signed a broad memorandum of understanding, with SLAs administered through a decentralized structure at the district level and with the relevant DHO taking charge of the implementation process (Chirwa et al. 2013). The MOH delegated implementation of the SLAs to each DHO, which were responsible for funding local SLA services and health worker salaries. The DHOs were also tasked with procurement of essential drugs, equipment, medical supplies, and for transport for referrals and other resources to be used by participating CHAM facilities (Chirwa, et al. 2013). By 2011, 75 of the total 172 CHAM facilities in Malawi were engaging with district governments in SLAs (Chirwa et al. 2013).

This case study explores the implementation and results of this partnership, including whether and how it achieved its intended outcomes and the factors that may have helped or hindered the success of this public-private engagement. The remainder of the case study is organized into the following sections: Methods; Results; Key Success Factors; and Discussion.

Methods

This case study is one of six developed for the Strengthening Mixed Health Systems (SMHS) project that presents analysis from existing evaluations of public-private engagements for health and new interviews and review of the data. The secondary case data collection and analysis for all six cases uses both existing research and supplemental primary data collection to answer the questions: (1) is there evidence that this public private engagement (PPE) is associated with improved outcomes, and (2) what factors are associated with helping and/or hindering the success of the engagement. After identifying the PPEs for these case studies, we undertook a structured search of the literature to compile existing peer-reviewed and grey literature about the PPE that would help us to answer the above questions. In addition, we attempted to interview researchers of PPE evaluations and PPE implementers/partners, when they could be identified, to collect supplementary data on the two questions. The resulting documents and transcripts were then coded and analyzed using a set of closed codes centering on four themes: PPE context and background, process evaluation results (activities, outputs, and outcomes), and helping/hindering factors. The qualitative analysis of the process evaluation results and factors coding is presented in the Results section of the case study. For the factor coding specifically, we utilized a set of codes designed based on the PPE Factor Ecosystem that was developed as part of the SMHS project; a description of the ten factors is included in Box 1.

Box 1. PPE Factor Ecosystem

The factors presented in the Results were developed as part of a systematic evidence review conducted by the research team. This review surfaced common factors in the published literature that were cited as playing a role in either helping or hurting the success of PPEs, resulting in the development of a new ecosystem framework. The factors in the ecosystem include Environmental, Structural, and Engagement factors, specifically:

- Environmental – shaping the environment in which a PPE operates (including political, financial, legal and organizational).
- Structural – defining the architecture of a PPE (including engagement models, formality, and resources for engagement).
- Will to engage - the intention, interest, or commitment of individual PPE actor and their institutions to enter and sustain the engagement.
- Trust - the belief that the opposite sector is acting in good faith and has the goodwill and integrity to effectively participate in an engagement.
- Mutual understanding – the understanding of the opposite sector’s capacities, motivations, resources, and role in the health system.
- Communication – the process and approach used by sector partners to exchange information and participate in dialogue.
- Engagement rationale – the basis of and motivation for the engagement.
- Technical and managerial capacities – the capacities of PPE actors related to the technical area of PPE focus as well as project management and joint leadership.
- Accountability – the process and approach used by sector partners to hold one another accountable for carrying out their roles and responsibilities in the PPE.
- Other – while the above types represent factors that emerged from the literature, we allowed for open coding of factors that arose in evaluations, documentation or interviews of the focus PPE that did not otherwise fit into the above categories.

For this case study on SLAs in Malawi, a total of two articles were identified, reviewed, and coded. While these evaluations provide important insight into the question of helping and hindering factors, it is important to note the limitation that existing studies may not have sought to explicitly measure factors; as such, those identified through the coding of existing evaluations may not provide a fully representative view of the factors that influenced the effectiveness or lack thereof of the engagement.

Results

There is evidence that the introduction of SLAs in Malawi increased access to healthcare services for the poor and for those in rural areas, though this increase was not sustained over time as SLA agreements disintegrated.

SLAs succeeded in increasing population coverage, which was one of the main goals in the partnership between GoM and CHAM. SLAs also succeeded in reducing or eliminating user fees for the poorest populations. Chirwa et al. (2013) found that participants in their qualitative evaluation agreed that SLAs were a positive initiative, helping to compensate for geographical barriers, increase coverage of health services, improve universal access to health care among poor populations, and improve equity of access to health services.

SLAs also improved health-seeking behavior among patients living within CHAM catchment areas, though other factors such as sustained distance from CHAM facilities and associated transport, food and accommodation required in traveling for services remained deterrents from seeking care (Chirwa et al., 2013).

Although there was an increase in the proportion of people utilizing health services after SLAs were introduced, this improvement in utilization was not sustained over time (Chirwa et al. 2013). Some challenges identified include that there was not additional procurement of drugs, recruitment of health personnel or expansion of infrastructure alongside the removal of user fees under the SLAs. Subsequently, CHAM facilities were often not capacitated to deal with the large influx of patients (Mpakati Gama et al. 2013).

Another key outcome that the SLA program sought to achieve was improved quality of care. In exit interviews, patients expressed satisfaction with improvements in the quality of health services over time. In a client exit survey, Chirwa et al. (2013) learned that patients used health services more often after introduction of SLAs because the services at CHAM facilities were generally free, which was a large factor in patient health-seeking behavior. Additionally, most clients surveyed were happy with the quality of health they received at SLA facilities (Chirwa et al., 2013).

However, while patients were happy with the quality of health services they were receiving, health care workers were not always satisfied with their own capacities to provide high-quality care under the new SLA agreements. Chirwa et al. (2013) carried out a Front Line Providers survey, which identified substantial increase in workload after SLA implementation. Employees generally expressed that their workload increased after implementation of SLAs because the significant decrease in user fees was accompanied by a large influx of new patients. Chirwa et al. (2013) spoke with facility level managers, who reported that the increased workload was a barrier to providing high-quality care, because there was not an associated increase in resources.

Key Success Factors

A number of factors were identified in this analysis that contributed to the mixed performance of CHAM SLAs in Malawi. These include structural factors, communication, trust and will to engage. In interpreting these findings, it is important to acknowledge that the assessment of these factors was drawn from only two studies; the authors of these case studies were unable to find additional research on this program. As such, the results presented on factors are limited in terms of their sources.

Structural factors and capacities. Chirwa, et al. (2013) found that SLAs were put into place relatively rapidly, and while a MOU was signed at the national policy level, no such formal agreements were signed at the district policy levels. This quick decision-making process to implement SLAs did not include consultations with district stakeholders, which prevented providers, institutions and stakeholders from adequately preparing the systems and structures necessary to successfully launch an ambitious new initiative. Additionally, DHOs, CHAM facility managers, civil society stakeholders, and health care providers were not oriented on their expected roles (Mpakati Gama et al., 2013). No overarching structural frameworks, policies or guidelines were put in place to shape the creation of contracts between individual DHOs and CHAM facilities or to clarify roles and responsibilities within the arrangements (Mpakati Gama et al., 2013)

In the national-level MOU, the MOH and CHAM Secretariat drew up an original list of service prices that was then communicated to DHOs and CHAM facilities, but the decentralized actors did not have a say in creating or validating the price lists. Additionally, while the price lists were provided to the parties within the SLA engagements, the central-level actors did not provide guidelines alongside the lists (Chirwa et al., 2013). This led to conflicting views on whether SLAs had existing policies for the billing prices of services. This lack of clear central guidance engendered a laissez-faire attitude toward reimbursements, claims, and procurement, with each individual SLA partnership managing individual arrangements differently and leading to confusion and lack of cohesion across the broader PPE (Chirwa et al. 2013).

The engagement structure also failed to include clear procedures, communication channels, or monitoring and evaluation systems to guide and support the implementation of SLAs. In addition to this overall lack of structure, stakeholders were not provided with clear information about their respective roles, which was reported by interview participants to have negatively impacted SLA performance (Chirwa et al. 2013). The issues with structure extended to health records documentation systems; a lack of validation built into CHAM's systems contributed to decreased efficiency, which was exacerbated by lack of supportive supervision by DHOs (Chirwa et al., 2013).

There were also a number of financial challenges in the system's structure, eventually resulting in delays or non-payment of bills. Chirwa et al. (2013) note that there were frequent delayed cash transfers to the DHO, with resulting delayed payments downstream at the CHAM facility level.

The government lacked the managerial and supervisory capacities needed to adequately facilitate timely procurement, contracting and information/resource flows. As an example, DHOs were responsible for supplying drugs, but in many places these responsibilities were not realized. In these cases, CHAM facilities were forced to procure supplies from private suppliers at a higher cost, which DHOs were then reluctant to reimburse (Mpakati Gama et al. 2013). Chirwa et al. (2013) also note that the CHAM facilities may have purposely escalated their costs in order to compensate for delays in government payments. Additionally, CHAM facilities

alleged that DHOs did not have the capacities to provide the resources laid out in the contracts, including health commodities and referral systems/transportation.

Due to weak monitoring and evaluation structures and capacities, DHO personnel were unable to clarify the allegations of 'ghost' patients in some facilities – patients who may not have actually needed the services for which the facility charged the government (Mpakati Gama et al. 2013).

Ultimately, these weak or nonexistent engagement structures increasingly led to mistrust between DHOs and CHAM facilities, a factor that is explored more below.

Communication. As noted by Chirwa et al. (2013), DHOs and CHAM facilities were not consulted during the rapid process of SLA policy creation between the MoH and the CHAM Secretariat. This lack of communication was a challenge from the beginning and did not improve throughout the course of the engagement. Because private facilities were not adequately involved in early discussions on the implementation of SLAs, the engagement had outdated price lists, poor communication channels, and unclear roles/responsibilities (Chirwa et al. 2013).

These communication challenges are illustrated in a major conflict between parties centered on the price lists. The lists had been drawn up at the beginning of the engagement without input or validation from local-level stakeholders, and they were not revised throughout the first five years of the engagement, even to adjust for inflation or other increases in facility costs. CHAM facilities, which had become increasingly unhappy with the price lists, claimed to have raised their concerns with DHOs, but alleged that they did not receive a response. With no cooperation from their government counterparts, facilities decided to revise the prices unilaterally (Chirwa et al., 2013) As laid out in the signed memorandum of understanding between the parties, the DHO was not allowed to reimburse CHAM for invoices beyond a certain cost ceiling. CHAM's unilateral revision of the price list (and resulting higher invoices) eventually led to accumulation and non-payment of bills by the DHOs who were not allowed to reimburse beyond the agreed-upon amount, hindering provision of services under SLAs (Chirwa et al., 2013).

Included in the overall lack of structures and guidelines was a lack of clear procedures for communication between parties, from the outset of SLA implementation. This led to ad hoc, infrequent communication between parties, resulting in information imbalances between the partners and contributing to the degradation of trust referenced above (Chirwa et al., 2013).

Trust. There was initially strong trust between parties due to the common objectives between partners (Chirwa et al., 2013). The MOH and DHOs saw the SLAs as an opportunity to expand the reach of their health service coverage, and the CHAM facilities saw the potential to have consistent guaranteed income flow. Additionally, both parties were interested in improving health in Malawi and working toward UHC (Chirwa et al. 2013). Unfortunately, the trust present at the beginning of the engagement disintegrated over time as the partners experienced breakdowns in accountability, communication, financial structures and capacities. This was especially exacerbated by broken promises on both sides and "*information-based power dynamics*" resulting from poor communication (Chirwa et al. 2013).

Due to unclear expectations and poor accountability, both partners began to engage in opportunistic behaviors, further degrading the already weakened trust. Mpakati Gama et al. (2013) note that the government consistently accused CHAM facilities of misconduct, including inappropriate claims fueled by inflated utilization figures and over-prescribing of medication. This misconduct also included alleged ghost patients (mentioned previously) and claims that CHAM regularly overcharged the DHOs for transport. The government was also perceived to have partaken in opportunistic behaviors, mostly manifesting in the delay and non-payment of SLA bills even in cases of facilities that had already provided services and needed to be reimbursed (Mpakati Gama et al. 2013).

Additionally, government agencies had significant power within the engagement and took advantage of CHAM's reliance on government contracts to operate. They began to cap prices and delay payments, knowing that it would not damage their contracts with CHAM facilities as there were few alternative purchasers of CHAM services (Mpakati Gama et al. 2013). After some of the CHAM facilities had invested resources in facility capacity-building to better engage with DHOs, the government threatened to discontinue SLA contracts with them unless they agreed to government price lists. The DHOs knew that CHAM facilities could not easily repurpose their newly built capacities to alternative uses, leaving facilities with little negotiating room to increase service prices beyond the initial price list (Mpakati Gama et al. 2013).

Chirwa et al. (2013) found that these issues with transparency, dishonesty, failure to follow guidelines and overcharging of SLA services had a negative impact on the performance of SLAs. Breaches of trust occurred on both sides: the government did not always supply finances and medications as needed, and CHAM facilities did not always remove user fees. In response to these challenges, neither CHAM nor DHOs sought curative actions and the potential for conflict, fearing economic and political repercussions. Because both parties were hesitant to address the problems in the relationship, the challenges continued to fester and negatively impact PPE outcomes (Mpakati Gama et al. 2013).

Will to engage. Initial motivations for partnership were well-aligned on the surface, as both partners claimed they wished to improve access to and affordability of healthcare services, but each side may have had ulterior motives for participating in the partnership. The stated common objective for the SLA partnerships focused on the need to increase coverage and affordability in order to improve health and UHC (Mpakati Gama et al. 2013).

Consequently, some contradictions between stated and revealed objectives began to emerge. Mpakati Gama et al. (2013) note that CHAM facilities' primary goal may have been to generate financial resources that could be used to pursue and promote their missionary activities, and not strengthen the health system. Similarly, there were indications that the government had underlying political objectives in engaging with the private sector, rather than to improve population health for its own sake. Mpakati Gama et al. (2013) add that challenges in will to engage were exacerbated by the numerous public sector stakeholders involved in the partnership, all of whom may have had different motives for engagement.

Mpakati Gama et al. (2013) explain that the underlying ulterior motives for engagement may have hindered overall efforts to institutionalize SLAs. Some DHOs were resistant to enter into SLA agreements, despite central level endorsement of the policy. Mpakati Gama et al. (2013) hypothesize that this may have occurred in instances where partners at the implementation level feared that partnership with the private sector may erode their authority within the health system. This was observed in the reluctance of some government agencies to engage with CHAM facilities, in favor of concentrating on growing public service provision and therefore expand their influence (Mpakati Gama et al. 2013).

Overall enthusiasm for SLAs and will to engage on both sides decreased over time due to delayed payments and review of contracts, unresolved misunderstandings, lack of trust, and perceived opportunistic behaviors.

Discussion

Analyses by Chirwa et al. (2013) and Mpakati Gama et al. (2013) indicate that, while SLA agreements between GoM and CHAM were initially well-received and did initially succeed in improving accessibility to health services, their long-term performance was undermined by mistrust.

While we cannot establish any type of causal relationships between these factors based on the evidence, there are some interesting trends in the temporal relationships between events that indicate there may be some linkages between factors. Initially, the engagements between GoM and CHAM were characterized by trust due to strong alignment in perceived engagement rationale. However, the SLA initiative was put in place rapidly and without input or validation from a number of key parties. This, in addition to a lack of structural frameworks or guidelines from the very beginning, immediately undermined the engagement's goals by failing to create mechanisms for financial transfers, communication, accountability, or feedback.

Additionally, the contracts did not clearly lay out roles and responsibilities of each partner and stakeholders were not oriented on their roles within the engagements. Without these types of structures in place, both parties operated under self-identified guidelines and policies in absence of formalized rules. These ad hoc decisions led to misunderstandings, information inequities, delayed transfers, and unilateral decision-making.

As a result of these negative factors within the engagement, trust steadily disintegrated over the course of the SLA initiative and went unresolved as both partners were reluctant to address the challenges through direct communication. As trust decreased over time, so did the will to engage by both parties. Both DOHs and CHAM facilities involved in the engagement initially showed will to work together, but gradually lost interest in collaboration as misunderstandings and negative feelings built up between them. Eventually, these became insurmountable and the internal struggles led to non-continuation of SLA agreements. Though the SLAs were successful in many ways, there is strong evidence that their long-term sustainability was ultimately undermined by a buildup of hindering factors.

References

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This case study is one of a series of six secondary cases written for the Strengthening Mixed Health Systems program, analyzing the factors helping and hindering the effectiveness of public-private engagements for health in low- and middle-income countries. All case studies, as well as a report presenting cross-cutting findings, can be found on the Strengthening Mixed Health Systems project website.

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