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Public – Private Cooperation for SRH Service Delivery

Evidence and Challenges for Scaling-up

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Why work with the private sector?

- **A large proportion of SRH services in developing countries are delivered through the private sector, including for the poorest**
- **Governments are struggling to meet their national and international targets for SRH delivery (MDGs)**

So the key question is…

How can governments leverage private sector capacity for SRH service delivery so that this both benefits the poor and other vulnerable groups, and supports efforts to reach national and international targets for SRH (MDGs)?

What types of Approach are we talking about?

Formal PPPs

- Examples include BOOT, PFI, divesting, leasing
- Large scale, long-term investments
- Usually infrastructure and utility projects (incl. hospitals, bridges etc.)
- Not a common approach for specific SRH services

What types of Approach are we talking about?

Traditionally…

- **A wide variety of private sector actors in SRH – this is a highly heterogeneous group**
- **Mostly input-based approaches (funding training, salaries, etc.)**
- **Influencing providers behaviour (through regulation, incentives, training, pre-packaging)**
- **Influencing client behaviour (social marketing & IEC)**
- **Difficult to look at value for money or cost effectiveness**
- **Limited success in scaling-up**

What types of Approach are we talking about?

More recently …

- **Governments experimenting with Output-based Approaches (OBA) or Output-based Partnerships (OBP)**
- **These are "*partnerships between the public and private sectors, which link outputs with payment using contracts*"**
- **OPBs supports health sector reform efforts, since they require:**
  - **Contracts to regulate the partnership**
  - **Stewardship by the government** (*the ability/capacity to bring the private sector under the regulatory umbrella of the state*

Output-based Partnerships

"Partnerships between the public and private sectors, which link outputs with payment using contracts"

Private Sector Cooperation

Forms of OBP

- **Contracting out (incl social franchising)**
- **Contracting in**
- **Vouchers**
- **Insurance**

Why do Governments want to work with the private sector?

- To expand access to services, to target specific populations and to provide specific services in specific areas
- To share (financial) risk with the private sector
- To limit the damage from unregulated, poor quality private providers
- To use the efficiency of the private sector to improve services and service delivery

What is the evidence that these objectives are achieved?

Summary of Selected Evidence on…

- **Chiranjeevi Scheme (Gujarat, India): vouchers for safe delivery**
- **Kenya RH-OBA Programme: vouchers for FP and safe delivery**
- **Vouchers for Adolescent Sexual Health in Managua, Nicaragua**
- **Contracting out of basic health services in Afghanistan**

Chiranjeevi Scheme – Scaling-up Services for Poor Pregnant Women through OBP

- Started as one-year pilot – since **extended to whole state** (scaling-up)
- **Targeting was accurate** – 94 percent of beneficiaries fell into the BPL category
- **Significant increase in institutional delivery rates**
- **Significantly lower costs than market rate** through bulk purchasing of services by Govt
- Beneficiaries saved av USD 82 per delivery
- **Est. impact on MMR** showed **maternal deaths less than a tenth of expected figure**

Poor Kenyan women access good quality maternal health and FP through OPB

- Accredited 54 public, private (for profit and non-profit providers)
- In first 2 ½ years > 60,000 women delivered using a SM voucher and number of obstetric emergencies treated increased significantly
- Up-take of SM vouchers represented over half of all deliveries at contracted facilities
- Targeting of the poor worked well using locally relevant tools
- Evidence of a supply-side response $\Rightarrow$ improved quality

Sexual Health Services for Young People in Nicaragua (2000 – 2005)

- Mass targeting of vouchers to all adolescents in poor areas (markets, poor barrios, transport points) (2000 – 2005)
- High uptake of vouchers (25% among female and 13% among male adolescents)
- Much higher use of SRH services and greater knowledge of contraceptives and STIs among users compared with non-users
- Doctors' knowledge of contraceptives and STIs increased significantly
- Use of modern FP increased significantly, shared decision-making and condom promotion remained significantly higher after programme ended

Afghanistan: Evidence and Impact of contracting out PHC

- Antenatal control increased from 5% to 41% for the EC provinces
- Institutional deliveries increased from 3% in 2004 to 23% in 2007 for the EC provinces
- Family Planning (FP) increased from 5% in 2003 to 16% in 2006
- The coverage of BPHS has steadily been increasing to the current 66% and still rising
- The proportion of health facilities with at least one trained female health worker increased from 25% in 2002 to 76% in 2007.

Key Challenges

…to working with the private sector

- **Political Commitment & Stewardship**
- **Accreditation & QA**
- **Contracting**
- **Setting prices**
- **Funds flow**
- **Monitoring and evaluation**

Don’t Neglect the Policy Level

- Efficient and effective working with the private sector necessitates:
  - Demonstrable, clear long-term political will
  - A good understanding at the policy level of what the different modalities are, where they are appropriate, and how to use them
- Most successful OBP programmes we have examined have demonstrable political commitment to working with the private sector and clear rationale for doing so

Stewardship

- The stewardship role of the government is essential – in terms of regulating the private sector, contacting with private providers, ensuring that objectives and targets are met
- Need to build capacity for stewardship – build into HSR efforts

Accreditation & Quality

- Accreditation is key to defining quality of service provision
- Balance – don’t set the bar too high or too low
- Poor accreditation and quality lead to loss of trust
- Knowledge of, and capacity to develop good accreditation systems rare

Contracting

- Ministries of Health often lack contracting know-how
- Contracts often lack
  - Specificity (time & place, services & quality standards)
  - Definitions of quality
  - Monitoring
  - Sanctions
  - Detailed description of processes

Funds flow

- **Payment systems do not work**
  - **Mode of payment to private partner and contingencies in case of delays often not clearly defined - scope for corruption and unethical practices**
  - **There can be long delays in release of funds leading to poor services and loss of interest by partners (providers & clients)**

Setting Prices

- Avoid perverse incentives
- Market segmentation needed
- More innovation in terms of setting reimbursement rates (marginal pricing)

Monitoring & Evaluation

Measuring performance is weak

- OBPs facilitate the gathering of data – but still very poorly done
- Insufficient attention given to measuring results/outputs e.g. performance & outcome indicators, health impact, monitoring quality, etc
- Need more evidence on whether public-private sector cooperation can reach the poor and other vulnerable groups and at what cost

The question…

- **We believe there is a marked lack of capacity by govt to work with private providers effectively and efficiently – and an important lack of evidence to show these approaches work**

- **How can this best be addressed?**

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Thank you