Netherlands Platform for Global Health Policy and Health Systems Research

Ministerie van Buitenlandse Zaken

MARIE STOPES INTERNATIONAL

EXPERT MEETING REPORT, by Serge Heijnen

"Public-private cooperation to improve health care in low-income countries"
The Hague - The Netherlands, 25 September 2009, 09.00 – 16.00 hrs.

Introduction and purpose

On 25 September 2009, some 40 expert representatives from Dutch and international organisation covering policy-making, research, development practice and commercial industry met in The Hague upon the invitation of the Ministry of Foreign Affairs of The Netherlands, the Netherlands Platform for Global Health Policy and Health Systems Research and Marie Stopes International. *Paul van der Maas, Chairman of the expert meeting*, explained the purpose of the expert meeting: to share experience and evidence about the way the public and private sector can cooperate with the aim of contributing to the health of the population in low-income countries. Specifically, the expert meeting aimed to discuss the following critical questions with policy relevance for the Dutch development sector:

1) What types of promising public-private interactions exist that may contribute to an increase in access to and utilisation of healthcare in low income countries?
2) What is the role, capacity and the potential of the private sector to stimulate quality reproductive healthcare?
3) What is the performance of private health financing mechanisms, and is it possible to channel donor funds through private health financing mechanisms?
4) What are gaps in knowledge and possible questions for further debate and research around these themes?

Anno Galema (Ministry of Foreign Affairs of The Netherlands) in his welcome remarks mentioned the current strong policy attention to this topic internationally: Bellagio and Berlin meetings, Taskforce Innovative Financing for Health. Dutch development policy also gives importance to the role of the private sector (for-profit and not-for-profit) though funding is mostly directed at the public sector. However, most health care financing and delivery systems in low-income countries are mixed public-private models which means we have to look for opportunities in the private sector, and not get stuck in ideology.

Part 1: Public-private cooperation in healthcare delivery

April Harding (World Bank) in her keynote presentation highlighted that the private sector is large and important in most low-income countries, used by lots of people – often with quality problems, and many users may be impoverished by payment, or not get needed services or drugs due to payment barriers. But, the private sector is not engaged much, or well: the government often does not play a stewardship role vis-à-vis the private sector, and the private sector is mostly omitted from program efforts of governments and donors, with examples from recent or current child health, malaria, TB and disease surveillance programs in several low-income countries. However, there is reason to think that engagement of the private sector

would improve impact, as pointed out by recent scientific publications evaluating arrangements with the private sector such as contracting, insurance, vouchers, quality improvement (accreditation, chains, social franchising), pay-for-performance, drugs-for-performance, and hospital public-private partnerships (PPPs). So, lots can be done but actually little is happening. Why is that so? Is it because the way we fund (largely directed at the public sector)? The way international donor organizations and donor countries prepare their support (mostly public sector experts)? The way we invest (resources directed at building, equipping, training instead of support to stewardship and enabling functions and arrangements)? There is a lack of capacity on the part of low-income countries' governments about dealing with the private sector, and little support from funders and technical agencies to support them.

Finally, it is important to note that terminology about public-private partnerships is often different (e.g. result-based financing, pay-for-performance, output-based partnerships, output-based approaches etc.), but they refer to quite similar approaches and arrangements.

James Bjorkman (Institute of Social Studies) in his keynote presentation about "PPPs: lessons from India" stated that PPPs are an alternative to overcome the deficiencies of service delivery by either partner – whether public or private – but they are no panacea for the ills of public sector health systems. PPPs hold great potential if the public sector can organise itself and develop sufficient capabilities to supervise them. If a policy of PPPs is to succeed, conditions need to be understood as objective policy lessons. Field research in nine states of India during 2003-2007 has provided very valuable lessons (24 points), indicating the importance of leadership, vision, respecting and understanding each others objectives, and individuals acting as change agents. Legislation should be in place to ensure that services are adequate and reach the intended beneficiaries, while appropriate regulation about the private sector should balance accountability and innovation. PPPs must define performance indicators, incentives and penalties, mechanisms for dispute settlement, exit options, quality standards, risks etc. and should be explored empirically and scaled-up where possible, not imposed top-down. There should be adequate government capacity (managerial, technical). Critical for successful PPPs is the role of the government: policy, enabling variations (no one-size-fits all), adequate decentralisation and payment systems, Also critical are regular exchange of communication, joint planning and problem-solving, appropriate supervision, management information and monitoring as well as ability to tolerate mistakes and to learn. A first step for successful PPPs must therefore be to improve basic administrative systems. Any government that fails to deliver quality services due to lack of administrative capacity would not be able to contract either clinical or non-clinical services.

Ingvar Olsen (Norad) briefly provided the perspective of Norway as donor country. ODA for health has been steadily increasing, particularly multi-lateral funding while MDGs are at the centre of policy attention. Norway has launched an MDG 4/5 Initiatives which is also supported by The Netherlands, among others. As part of this initiative, a multilateral trust fund on Result-Based Financing is set up at the World Bank which now supports RBF health pilots in some 7-8 countries. In addition, Norway sponsors bilateral programmes focusing on maternal and child health in India, Tanzania, Pakistan and Nigeria. There are very different definitions and various types of interaction in public and private delivery and financing. One should also realise that there are different approaches facing the question on public or private provision of services, such as ideology, pragmatism and knowledge/evidence-based. GAVI is seen as a promising public-private interaction at global level, while for example Malawi CHAM and Afghanistan offer insight about contracting models at country level. Nonetheless

the important role of the private sector in healthcare delivery and the increased avenues for funding - through global health initiatives (GHI), direct private partners and private insurance - the public sector is (still) dominant as beneficiary for donor funding and Norway is no exception.

Willem van de Put (HealthNet TPO) as referent mentioned the importance of clarifying concepts and definitions to create some common ground for communication and understanding. He explained the specific context of fragile states where there is no public sector and the government (or lack of it) is the problem. In addition, one cannot speak of a private sector; there are only very diverse entrepreneurs but no framework or arrangements. In addition, mostly the same people or providers operate in both the public and the private sector. However, as there are no laws or rules, it is the perfect starting position as it is easy to think 'out of the box' when there is no box. It is important to avoid unrealistic expectations about the public service while simultaneously one should prevent a derailed private sector to grow. Strategies in this context are: to start with the stewardship role of the government, rather than provision; to develop models for provision from the outset, avoiding the non-productive distinction public-private, and to build sustainable financing mechanisms.

During the *discussion* the question was raised whether governments/donors should not first make a favourable climate for the private sector and appropriate frameworks for spending rather than developing direct financial stimuli and approaches to work with the private sector. There was agreement that both elements are an important part of a 'holistic' picture but alone do not suffice in the health sector. In addition, the notion was raised that we should involve more the Ministries of Finance in the discussions, as they are the principal receivers of budget support. This is true, but is also important to strengthen the position of the health sector by earmarked funding and by offering evidence about what has been or can be done with the money (result-based financing is important tool to help this discussion). A point was raised that it is difficult to talk about shared objectives between the public and private sector. This is true, but one can have win-win situations if you have different prime objectives, but want to see the same outputs. Appropriate incentives are crucial.

Part 2: Role of the private sector to stimulate quality reproductive healthcare

Corinne Grainger (Options) in her keynote presentation about "public-private cooperation for sexual and reproductive health (SRH) service delivery; evidence and challenges for scaling-up" mentioned that a large proportion of SRH services in developing countries are delivered through the private sector, including for the poorest, while governments are struggling to reach the MDG targets. 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?" Most recently, output-based partnerships (OBPs) are used as a tool to link outputs with payment using contract. Governments want to work with the private sector for purposes of increased accessibility, financial risk-sharing, quality and efficiency purposes. Forms of OBPs are contracting-out (incl. social franchising), contracting-in, vouchers and insurance. There is strong evidence and examples were given from donor-funded programs in 1) Gujarat, India Chiranjeevi Safe Delivery Voucher Scheme, 2) Kenya RH-OBA voucher program for family planning and safe delivery, 3) Nicaragua adolescent sexual health voucher program, and 4) Afghanistan basic health services contracting-out of reproductive health services. As outputs and outcomes these programs have shown significant increases in institutional delivery rates,

lower costs per delivery and impact on maternal mortality rate (Gujarat); increased treatment of obstetric emergencies, quality improvements and increased accessibility of institutional deliveries, also to the poor (Kenya); higher use of SRH services and greater knowledge about contraceptives of providers and users, and increased up-take of modern family planning (Nicaragua). Importantly, 2 out of these 3 donor-funded programs (Kenya and Gujarat) were continued by the government after completion, while the Nicaragua program was not. This is very likely due to the involvement of the government already in the planning stage of the donor-funded programs, which was the case in Kenya and Gujarat and which did not happen in Nicaragua. Finally, the Afghanistan scheme showed significant increases in institutional delivery, antenatal control, family planning as well as higher coverage of services and trained staff. Key challenges in working with the private sector are: political commitment & stewardship, accreditation and quality assurance, contracting arrangements, price-setting, adequate and fair disbursement of funds, and monitoring and evaluation. In general, there is still a marked lack of capacity by governments to work with the private sector and an important lack of evidence to show that these approaches work.

Maaike van Min (Marie Stopes International) in her presentation indicated that the lack of progress towards MDGs (particularly MDG 5) combined with the lack of public resources for health should force us to rethink the public/donor approach more towards providing assistance and facilitating private initiatives (for-profit and not-for-profit) or individuals and organizations. For MSI this means working in innovative ways to provide reproductive health to as many people as possible, with a special focus on vulnerable groups: different forms of output-based partnerships. MSI has seen an increase in the number of clients taking up reproductive healthcare through these PPPs. MSI's own capacity is still growing by better learning, experiencing and documenting while MSI also advocates for this approach to governments and donors by showing examples and evidence. Challenges are to give an appropriate role to output-based partnerships in country health systems and in aid structures. Also, implementation challenges need to be overcome, such as fraud and other factors influencing access (e.g. adequate roads and transportation).

Christopher Purdy (DKT International) started his presentation with the important remark that it is not only the public sector that has requirements, but that actually the demands of the private sector are equally important. What is needed on that side is a positive business environment, where it is possible for entrepreneurs to efficiently register a (new) business or (new) products, where tax and import laws are appropriate and where opportunities for business are created. The private sector can create demand for (public) reproductive health services or goods, e.g. by educating women or informing the general public, can train health professionals and can support in building capacity or infrastructure. Competition has the advantages of offering more choice to consumers and increasing chances for improved quality of government services. Question still is how to serve the poorest of the poor as the strict commercial approach is, at its core, profit-oriented. As a show-case the "Andalan Health Program" of DKT Indonesia was presented, providing a range of products while being a consumer-oriented service as well as catalyst for the government and private sector. The program has trained large numbers of doctors and nurses in IUD insertion and removal, put in place a social franchise of 15.000 midwives delivering a range of maternal and child health services. On outcomes, DKT claims to have protected 5.1 million couples with significant impact on prevention of maternal and infant deaths, as well as averted pregnancies, abortions and primary HIV infections.

Jurrien Toonen (KIT Amsterdam) as referent indicated that the private sector has been a blind spot for policy-makers for a long time. There is no unity in direction and no shared values, while the relationship is marked by distrust from both sides. Therefore we should not speak of partnerships but contractual relations. Donors should bring policy, practice and science together to challenge the mistrust and to discuss how private sector objectives can be combined with public health goals. It is important to find out what works better in what context, and keep a strong focus also on quality of services – not only access – because that is one of the most important shortcomings of the private sector. Donors should stimulate operational research as well as allowing innovations sufficient time to reach their full potential.

The *discussion* focused first on the question why we think the private sector is successful: creating demand, client-driven, innovating, finding niches in markets and ability to offer targeted services were mentioned. Also, the question about how to overcome distrust between the public and private sector was asked, and appropriate information, communication, training and evidence were seen as important tools. An important question was also asked how long donors are still going to continue funding large programs focused (almost) exclusively on the public sector while knowing that a large majority of clients/patients are actually served by the private sector. Difficult barriers have to be overcome, for example how to find the private sector (very heterogeneous consisting of thousands/millions of people/organisations), new platforms or systems have to be devised for this. In this light, the question was also raised if large institutional donors are working on making their procurement and disbursement rules and regulations more adept to private sector needs (e.g. faster payment of invoices, opportunity to actually make a profit, complexity of procurement procedures and documentation etc.). Unfortunately, this continues to be a major barrier for better cooperation of the public and private sector.

Part 3: Public funding and private financing mechanisms

Leon Bijlmakers (ETC Crystal) in his keynote presentation on "performance criteria for health financing mechanisms" started his arguments by saying that the often-used 2 X 2 matrix on public-private service delivery and financing should actually be extended to a 3 x 2 matrix. External /donor funding for either private or public service providers has to be included given the evidence and the discussions about the importance of donors on country health financing and delivery systems. There is indeed great diversity in health expenditure levels among countries in sub-Saharan Africa as measured in e.g. per capita health expenditures, financial development assistance to health, private expenditures as % of total health expenditures, or out-of-pocket expenses as % of private health expenditures. There is no "one size fits all" and this should be an important lesson for health system interventions by governments and donors.

Multiple factors co-determine whether (poor) people get the services they require and whether national targets & MDGs will be met. He argued that increased health financing or introducing a new financing mechanism will not make the difference if other critical issues are not taken into consideration as well, for example on quality standards, health workers retention, procurement systems and protection of vulnerable groups. According to WHO, there are 6 building blocks of health systems (stewardship, workforce, financing, supply, service delivery and information). Any initiative that claims to strengthen health systems should support one or more of these building blocks, while not undermining any of the others.

Hence, new/alternative health financing mechanisms would need to be appraised not only to: raising resources fairly and equitably; protecting people from catastrophic health expenditure and/or allocating resources efficiently and equitably, but also on their impact on the other building blocks of the health system. His final statement was that "national health systems, even though they may be weak, should be the first option for any external agency to channel money, procure drugs and supplies, technical assistance, and report on performance and the use of resources". This includes both public and private actors, as long as they have a legitimate function in the system.

Onno Schellekens (PharmAccess) in his presentation on "Public funding and private financing mechanisms: the role of voluntary private health insurance in Africa" started by painting a picture of the under funded health sector in Africa, the large proportion of out-of-pocket expenses, the absence of investments in the private health sector in Africa, and the increased reliance of health systems on donor funding. The current situation is very insufficient, as risk pooling is underdeveloped, the bulk of donor funding is channelled through the public sector, healthcare delivery is inefficient, while African health insurance companies' abilities are inadequate by all means (data, risk equalization, IT support etc.). There are very good reasons to involve government in health care, unfortunately the preconditions for state-led models to work are not met in Africa - for example the ability of the state to raise taxes or to actually deliver services nationwide. There is no other solution than involvement of the private sector. The meaning of the word private to PharmAccess is "not for everybody". However, donors take public-private dimensions insufficiently into consideration and have a number of policies in place that discriminate the private sector. There are 2 main issues to a private-sector-friendly policy: How can donor funding be used 1) to avoid crowding out of private finance, and 2) to improve efficiency of the healthcare value chain (incl. cost reduction, quality improvement, establishing group-based voluntary private health insurance schemes and willingness to pay voluntarily). One has also to realize that there is a tight relationship between income and health expenditure with little room for policy variables. Despite, the challenge should be to increase overall resources without crowding-out the existing private resources. PharmAccess claims that the risk equalization scheme in Namibia has led to additional voluntarily prepaid resources for health paid by those who could contribute: the avoidance of crowding out is worth many times the original premium subsidy (to be published in Health Affairs November/December 2009). Another challenge is the reduction of out-of-pocket expenses through risk pooling mechanisms, which requires making of explicit choices on the demand side (voluntary contribution meaning segmentation of the healthcare/insurance market) and supply side: adequate supply is needed to generate this willingness to pay.

Onno Schellekens argues for a new model which is based-upon 9 principles: acknowledge that healthcare is a service industry; channel private resources through bottom-up voluntary private risk pooling schemes; include risk equalization to manage crowding-out effects, involve the private health sector, use donor funding to subsidize premiums; use long-term donor commitments to reduce the investment risk; enforce quality of care through performance-based contracts; initial segmentation of the market; generate actuarial data. Risk pooling spurs a virtuous circle of health care where the cost of insurance can be substantially reduced and the quality of care can improved by supporting investments in the health sector (e.g. by creating investment funds where suppliers can take loans, this is also very problematic in Africa.

Arthur ten Have (Ecorys) as referent commented on performance criteria that the diversity of health systems requires country specific approaches, that the health financing system is a sub-

system that cannot be held/made responsible for the whole system, that specific performance criteria for health financing are available and that existing and new financing mechanisms should be measured against the same yardstick. On the PharmAccess presentation he acknowledged the existing difficulties of predominant focus on government health systems, and the importance of private payments & private provision in LICs, also for the poor. He agreed with the proposition towards a more institutional and economic understanding of the health sector as an industry, and the presented results seem encouraging. A question is how much subsidy the concept can "bear" if it is to be scaled up? He concluded that financing mechanisms should take into account financial sustainability and be based on the historic development of health (financing) systems. No global solutions exist but GLOCAL knowledge is needed, but expertise on health financing (insurance) for developing countries is thin. Given current shortcomings, the existing systems must be challenged and new experiment need to be nurtured to show their potential. They should be well-documented and judged upon their results.

In the discussion the question was asked "Who should experiment?" This should be policy-makers and implementers at the local and global levels. Government health systems should be used if this is the dominant model or when capacity has been built in the public sector (for example in Ghana health insurance). But the private sector should be included as well, and experiments in and with the private sector should be considered particularly when the role of the private sector in delivery and financing is proportionally large. A very important question focussed on the short duration of donor-funded projects vis-à-vis the time it takes for local processes to lead to tangible outcomes: projects should lead to fast results while the reality of implementation is usually very complex and it often takes years and years to build capacity and supporting systems. Donors should not immediately stop if no results are seen in 3-4 years and should also realise that working with the private sector is even more difficult than working with the pubic sector (where to start?, with whom?). These projects take time to mature, but at the end could potentially be very rewarding.

Part 4: Agenda for research and debate

Serge Heijnen (Netherlands Platform for Global Health Policy and Health Systems Research) informed the audience of the aims, sessions and evidence presented and questions raised at the IHEA pre-congress symposium "The role of the private sector in health", held at 11 July 2009 in Beijing, China. This event was a milestone as it was the first global meeting bringing together researchers interested in the private sector with the aim to map out what is known and promoting greater research interest and knowledge generation in this area for the benefit of health systems development. In total some 28 abstracts and 18 posters were presented which is in fact not a lot. The abstract book and the presentations are available at www.ps4h.org/ihea. Research indeed indicates a large and expanding private sector in several African and Asian countries, particularly in the ambulatory and pharmaceutical sectors, less prevalent in the in-patient sector. Technical quality of private providers in absolute terms and compared to public providers is usually problematic. There are few studies on the role of the private sector in disease management (in immunization & child health, HIV/AIDS, STI management). Regarding funding a recent research to be published by Abt Associates acknowledges the worrying trend that crowding-out of the private sector (and the government investments) takes place because of donor funding for HIV/AIDS services in Sub-Saharan Africa. The authors conclude that in order to sustain those services, continued and greater involvement of the private sector is required. Research also acknowledges that most health

systems world-wide are now mixed systems in terms of financing, delivery and utilisation. Referral patterns between public and private providers are highly complex and depending on the local circumstances: sometimes referral patterns from the private to the public sector dominate – which seems logical given that hospitals are usually public facilities – but in some countries and/or sub-systems public to private referrals dominate for a number of reasons (usually related to provider incentives, quality and culture). The statement that the private sector is under-represented in national policy-making was also verified by a recent study which showed large variety in the extent to which national health plans mention private sector related items and data. It leads to conclusions that health systems in LMI countries are very pluralistic. Planners have to develop first a view on this reality and then a vision on how to handle it. There is still a long way to go before health sector plans reflect the reality and significance of the private health markets. On the other hand, in financing there would always need to be some social mechanisms at place (based on solidarity, ability to pay) to allow for funding of minimum services for the poor and vulnerable. This does not necessarily bite with private insurance models: it can exist within private insurance through vouchers and subsidies and both models can co-exist in pluralistic health systems. Given the generally-speaking poor quality of private providers the government would need to improve its governance function to deal with this situation. Research is still in its infancy and opportunities are huge, but priority questions need to be well-formulated and allow for context-specific dimensions.

April Harding (World Bank) in her concluding remarks stated that "knowledge silos" exist in global health (e.g. TB, HIV/AIDS, malaria, reproductive health, health systems, health financing etc.). Malaria programs, for example, could engage private pharmacies and bed net distributors and retailers using many of the strategies developed to mobilize the private sector in reproductive health programs – but programs rarely reflect insights from this knowledge base. There would be much benefit to get these people talking to each other. Countries also can learn a great deal from each other. Hence the importance of this and similar meetings. Capacity-building at global and local levels is important, as there are not enough people who are expert in contracting, franchising, accreditation, voucher systems etc, and countries have a hard time accessing the help they need in this regard. Donors should be critical to their own policies and mechanisms (who we talk with, how we transfer money etc.): which can inadvertently exclude mechanisms to engage the private health sector. Finally, there are still large operational problems in working with the private sector: it is very big and diverse and a more organised private sector will help on all accounts. However, there are also regulatory policies that keep the private sector fragmented. For example, many countries have one pharmacy-one pharmacist regulations that block the development of multi-pharmacy chains. In some instances, removing regulatory barriers can be an important step to bring about positive changes in private sector markets (e.g. chains usually provide higher quality and lower costs, as well as being easier to regulate than individual units). In addition, both financing and supply-side measures are needed. Institutionalized forums for dialogue between the public and private sector at country level are often missing and could help to create understanding and win-win situations for private organizations and health.

David de Ferranti (Results for Development Institute) made a number of points:

- The continuing debate about the role of the private sector in health needs to move on from being heavily ideological to being more focused on evidence-building. More attention needs to be given to assessing what works and what doesn't – and what works best and least well. Question about <u>why</u> things have worked or not need to be understood better. So do issues about the sequencing and pace of the steps required to

implement changes, the risks involved, the impact on the health system, and how to get more health for money (not just how to get more money for health).

- We also need to think more carefully about research topics are worth investigating and which not, and about how much – and what kind of – effort we should devote to a topic, given that resources (including time and human energy, not just money) are limited. We should be constantly asking ourselves: what questions are we seeking to answer, and how much and what sort of evidence is needed to carry the day with whoever we're trying to convince. Research that tries to answer questions at a very aggregate level – e.g., how many more health workers are needed globally – is often less illuminating in the end than research that builds up from country-level investigations.

- There is a values-driven debate underlying a lot of the dialogue about public and private roles. Pro-public vs. pro-private viewpoints vy with each other, but there is a third option as well, the pragmatic viewpoint, that argues for focusing on whatever works and whatever produces the best health outcomes at the least cost, regardless of whether it's public or private. This values-driven debate is important, and shouldn't be underestimated. It is the source of huge challenges in getting people to understand each other, and in getting clarity on what to do.

- A major issue around extending financial protection to the poor arises from the emergence of community-based or other sub-national level plans (aka insurance). Such schemes, if they are designed to be financially self-sustaining, cannot afford to have benefit packages that are of much consequence for participants, given how little they can afford to pay. Or if they are designed to have adequately attractive benefits at an affordable price for participants, they cannot be financially self-sustaining. This challenge needs to be confronted squarely.

- The developing world will see substantial GDP increases in the years to come according the consensus estimates. This will lead to even greater percentage increases in total health spending as well, since there is empirically a very strong relationship between GDP increases and total health spending increases. There will thus be major opportunities to improve health services, reduce out-of-pocket spending, increase insurance coverage, improve health outcomes, and curtain health expenses that are financially catastrophic for households. But will these opportunities be realized? That depends on whether the coming increase in health spending is used well or not.

Finally, *Catherine Hodgkin* (KIT Amsterdam) was asked to summarize the day's discussions. Reflecting on the 4 main questions for today's meeting she concluded that we have discussed many promising public-private interactions. The role and potential of the private sector to stimulate quality reproductive healthcare is substantial, that it is possible to channel donor funds through private health financing mechanisms, but that the same criteria should apply and accessibility to the poor should not be forgotten, and that there are huge gaps in knowledge.

Sometimes the evidence is there but it is not good enough, or not shared enough. Also, we have to be more explicit about the terminology used and the distinction between public and private sector: there are private entrepreneurs, faith-based organisations, ngo's, small-scale,

large-scale organizations etc. Also we have to try to understand each others language and nomenclature better. The discussion about sustainability and the limited time given to projects and programmes is very important as we cannot expect miracles to happen in the short-time. However, we do need to do better on information gathering, documenting and analysing. Particularly when dealing with the private sector.

Closure

Paul van der Maas (Netherlands Platform for Global Health Policy and Health Systems Research) thanked the speakers, organizers and participants and closed a highly successful and informative meeting at 16.00 hrs.

Programme

09.00 – 09.30	**Registration**
09.30 – 09.45	**Welcome and introductions** *Paul van der Maas, Chairman* *Anno Galema, Ministry of Foreign Affairs*
09.45 – 11.30	**Part 1: Public-private cooperation in healthcare delivery**
09.45 – 10.45	**Presentations related to Question 1:** *April Harding (World Bank): overview of evidence and experience* *James Bjorkman (ISS): PPPs; lessons from India* *Ingvar Olsen (Norad): perspective of a donor* *Willem van de Put (HealthNet TPO): referent*
10.45 – 11.15	Questions/discussion
11.15 – 11.30	**Coffee/tea**
11.30 – 13.00	**Part 2: Public-private cooperation to stimulate quality reproductive health care**
11.30 – 12.30	**Presentations related to Question 2:** *Corinne Grainger (Options): overview of evidence and experience* *Maaike van Min (Marie Stopes International): work and perspective of MSI* *Christopher Purdy (DKT International): work and perspective of DKT* *Jurrien Toonen (KIT): referent*
12.30 – 13.00	Questions/discussion
13.00 – 14.00	**Lunch**
14.00 – 15.15	**Part 3: Public funding and private financing mechanisms**
14.00 – 14.45	**Presentations related to Question 3:** *Leon Bijlmakers (ETC Crystal): performance measurement criteria for health financing mechanisms* *Onno Schellekens (PharmAccess): options for channelling public funds through private funding mechanisms* *Arthur ten Have (Ecorys): referent*
14.45 – 15.15	Questions/discussion
15.15 – 16.00	**Agenda for research and debate** *Serge Heijnen (Platform), report from IHEA congress (Platform)* *April Harding (World Bank) & David de Ferranti: reflections on future avenues and agenda* *Catherine Hodgkin (KIT), today's lessons*
16.00	**Closure**
16.00 – 17.00	**Informal drinks**

Location of the Expert Meeting
De Idazaal
Juffrouw Idastraat 2, The Hague
www.idazaal.nl