



# JOINT LEARNING NETWORK

For Universal Health Coverage

## ENGAGING THE PRIVATE SECTOR IN PRIMARY HEALTH CARE TO ACHIEVE UNIVERSAL HEALTH COVERAGE:

*Advice from Implementers, to Implementers*

JOINT LEARNING  
NETWORK FOR  
UNIVERSAL HEALTH  
COVERAGE  
**PRIMARY HEALTH  
CARE TECHNICAL  
INITIATIVE**





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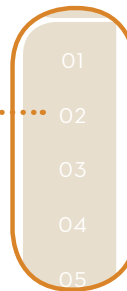
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## INTERACTIVE PDF



**INTERACTIVE FUNCTIONS  
ARE BUILT INTO THE  
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The screenshot shows a page from the manual. On the right side, there is a vertical table of contents with tabs numbered 01 to 05. Tab 04 is highlighted. Below the tabs, there is a section titled 'Box 6 list and TABLE' which is underlined. On the left side of the page, there is a section titled 'BOX 6 Why some public-private collaborations fail: Lessons from the Health in Africa Initiative'. This section contains a paragraph of text and a list of seven numbered points. The JLN logo is visible in the bottom left corner of the page, and the document title is in the bottom right corner.



Click on the tabs to **navigate between modules and steps.**

Click on the underlined text to **jump directly** to the corresponding table, figure or box.



Click on the JLN logo to return to the **front cover.**

ENGAGING THE PRIVATE SECTOR IN PRIMARY HEALTH CARE TO ACHIEVE UNIVERSAL HEALTH COVERAGE

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## ACRONYMS

<b>AKDN</b>	Aga Khan Development Network	<b>KPK</b>	Government of Khyber Pakhtunkhwa (Pakistan)
<b>AKHS,P</b>	Aga Khan Health Service, Pakistan	<b>LGA</b>	local government area
<b>ANCRE</b>	Advancing Newborn, Child and Reproductive Health Program	<b>LHV</b>	Lady Health Visitor
<b>CBS</b>	Central Bureau of Statistics	<b>MCH</b>	maternal and child health
<b>CHPS</b>	Community-based Health Planning and Services	<b>MHV</b>	mobile health vans
<b>CHW</b>	community health worker	<b>MOH</b>	Ministry of Health
<b>CME</b>	continuing medical education	<b>MOU</b>	memorandum of understanding
<b>DALY</b>	disability-adjusted life year	<b>NGO</b>	nongovernmental organization
<b>DOH</b>	Department of Health	<b>NHIA</b>	National Health Insurance Authority
<b>DOTS</b>	directly observed treatment, short-course	<b>NHIP</b>	National Health Insurance Program
<b>DQA</b>	Data Quality Assessment	<b>NHIS</b>	National Health Insurance Scheme
<b>DQRC</b>	Data Quality Report Card	<b>NTP</b>	National Tuberculosis Control Program
<b>EMR</b>	electronic medical records	<b>OOP</b>	out-of-pocket
<b>EPI</b>	Expanded Programme on Immunization	<b>PHC</b>	Primary Health Care
<b>FBO</b>	faith-based organization	<b>PhilCAT</b>	Philippine Coalition Against Tuberculosis
<b>FMOH</b>	Federal Ministry of Health	<b>PHSAG</b>	Private Health Sector Alliance of Ghana
<b>GIS</b>	geographic information system	<b>PPP</b>	Preferred Primary Care Provider
<b>GIZ</b>	German Society for International Cooperation	<b>PPP</b>	public-private partnership
<b>GPS</b>	Global Positioning System	<b>R4D</b>	Results for Development Institute
<b>HANSHEP</b>	Harnessing Non-State Actors for Better Health for the Poor	<b>RHC</b>	Rural Health Center
<b>HIA</b>	Health in Africa Initiative	<b>RSBY</b>	National Health Insurance Program (India)
<b>HIV</b>	human immunodeficiency virus	<b>SARA</b>	Service Availability and Readiness Assessment
<b>HRH</b>	human resources for health	<b>SDGs</b>	Sustainable Development Goals
<b>HSPI</b>	Health Strategy Policy Institute	<b>SDI</b>	Service Delivery Indicators
<b>ICT</b>	information and communications technology	<b>SHHS2</b>	second Sudan Household Health Survey
<b>IFC</b>	International Finance Corporation	<b>SMOH</b>	State Ministry of Health
<b>IMNCI</b>	Integrated Management of Neonatal and Childhood Illnesses	<b>TSC</b>	Technical Steering Committee
<b>KHF</b>	Kenya Health Federation	<b>TB</b>	tuberculosis
<b>JLN</b>	Joint Learning Network	<b>TNHSP</b>	Tamil Nadu Health System Project
		<b>TWG</b>	Technical Working Group
		<b>UHC</b>	universal health coverage

## ACRONYMS

- UKHSDP** Uttarakhand Health System and Development Project
- UNDP** United Nations Development Programme
- USAID** United States Agency for International  
Development
- WHO** World Health Organization

## DEFINITIONS

The Joint Learning Network for Universal Health Coverage (JLN) Primary Health Care (PHC) Technical Initiative members developed a list of definitions used in this manual based on the literature and their own experience to reflect the Initiative's common understanding of key terms.

**ENGAGEMENT:** Engagement between public and private health sectors involves “deliberate, systematic collaboration of the government and the private health sector according to national health priorities, beyond individual interventions and programs (IFC 2011).”

**ENGAGEMENT TEAM:** A team or working group with the mandate and objective of engaging the private sector. Engagement teams are small groups usually made up of key individuals from a single Ministry of Health (MOH) unit or other government office. The engagement team will likely need to conduct outreach to a wider group of public sector stakeholders (e.g., others within the MOH) even before they approach the private sector. It is important that the engagement team lead the work on behalf of the public sector, while obtaining input from their public sector colleagues.

**MAPPING TEAM:** Implementers of the mapping exercise detailed in [MODULE 2](#). The mapping team may be a subset of the engagement team or a separate group that works with or on behalf of the engagement team.

**MINI-EXCHANGE:** An innovation of the JLN PHC Technical Initiative that involves a small subset of Initiative members interested in coming together to produce a knowledge product quickly with support from international experts and technical facilitators. The accumulated experience and products from the mini-exchanges are then shared with all JLN PHC Technical Initiative members to validate and use.

**PRIMARY HEALTH CARE (PHC):** The provision of outpatient non-secondary and non-tertiary preventive, promotive, and curative care, with a particular focus on ensuring the delivery of quality health interventions prioritized by both countries and the global health community to address the highest disease burdens (Hirshon et al. 2013). PHC services are:

- **Preventive:** services that protect against illness or diseases (e.g., family planning, antenatal care, immunizations) (Starfield et al. 2008).

- **Promotive:** services that encourage well-being and healthy living (e.g., sanitation, good nutrition, smoking deterrence, mental health) (Starfield et al. 2008).
- **Curative:** services that treat and reduce the probability of disability and death due to entry-level and common high-burden diseases (e.g., deliveries, respiratory illnesses, childhood illnesses) (Hirshon et al. 2013).

**PRIVATE HEALTH SECTOR:** The private health sector is generally defined as all non-state providers, including for-profit and not-for-profit entities. These include: hospitals, doctors, pharmacies, traditional healers, faith-based organizations, private health insurance mechanisms (including community-based and employer-sponsored voluntary insurance), as well as corporate philanthropic organizations created by the private sector for social responsibility (Harding 2009; IFC 2011).

**PROVIDER MAPPING:** Usually describes the geographic location of individual providers, health facilities, and type of services provided. Often the mapping of private providers is part of a broader resource mapping exercise that includes equipment and supplies as well.

**UNIVERSAL HEALTH COVERAGE (UHC):** Ensuring that “all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.” This definition of UHC embodies three related objectives:

- **Equity** in access to health services: Those who need the services should receive them; services should not be available only to those who can pay for them.
- **Quality** of health services: Health services should be good enough to improve the health of those who receive services.
- **Financial risk protection:** The costs of health services should not put people at risk of financial hardship (WHO 2010b).



Phnom Penh, Cambodia



Hanoi, Vietnam



Malacca, Malaysia



Chennai, India



Dubai, United Arab Emirates

*Photos: Joint Learning Network*

# INTRODUCTION

**UNIVERSAL HEALTH COVERAGE (UHC) aims to reorient health system resources and utilization towards high quality, comprehensive primary health care (PHC) so that all people have reasonable geographic and financial access to services that address the greatest causes of disease burden within financial limits and in a way that does not lead to financial hardship.**<sup>1</sup> To achieve and sustain UHC and ensure access to quality PHC services for all consumers, the health systems of most countries need to engage (and aim to optimize and mobilize) both public and private sectors to provide PHC services.

## PURPOSE AND USE OF THIS MANUAL

*Advice from Implementers, to Implementers* is intended to provide implementers – such as policymakers at national- and state-level ministries of health, health financing agencies, PHC development agencies, state-level and local-level public health departments, local government, and research institutes – with practical guidance for engaging with the private sector around domains detailed by the International Finance Corporation (see box below).<sup>2</sup> *Advice from Implementers, to Implementers* also contains real world case studies to help elucidate the guidance.



Some countries have found it useful to form a team or working group with the mandate and objective of engaging the private sector, and thus we refer to the “engagement team” in this manual. Engagement teams are small groups usually made up of key individuals who are part of a single ministry of health (MOH) unit or other government office. The engagement team will likely need to conduct outreach to a wider group of public sector stakeholders (e.g., others within the MOH) even before they conduct outreach with the private sector. It is important that the engagement group lead the work on behalf of the public sector, while obtaining input from other interested public sector colleagues.

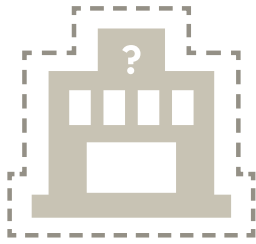
### **The International Finance Corporation (IFC) details five domains through which the private and public health sectors engage:**

1. Policy and dialogue and the degree to which the private sector is included in discussions regarding health sector policies and practice;
2. Information and data exchange;
3. Regulation;
4. Financing, which includes funding and purchasing; and
5. Public provision of services.

*(IFC 2011)*

<sup>1</sup> This statement reflects the view of JLN PHC Technical Initiative members. More information about the JLN PHC Technical Initiative’s approach to PHC-oriented UHC is described in [Appendix A](#).

<sup>2</sup> *Advice from Implementers, to Implementers* is written for public sector “engagement teams,” but it could easily be adapted for use by private sector providers who themselves wish to initiate and promote better engagement with the public sector.



## WHAT IS THE PRIVATE HEALTH SECTOR?

**The private health sector is generally defined** as all non-state providers, including for-profit and not-for-profit entities. These include: hospitals, doctors, pharmacies, traditional healers, faith-based organizations, private health insurance mechanisms (including community-based and employer-sponsored voluntary insurance), as well as corporate philanthropic organizations created by the private sector for social responsibility.

*(Harding 2009; IFC 2011)*

## WHAT IS ENGAGEMENT?

**Engagement between public and private health sectors** involves “deliberate, systematic collaboration of the government and the private health sector according to national health priorities, beyond individual interventions and programs.”

*(IFC 2011)*



Modules in this manual present and discuss a series of steps that the engagement team can take to engage and partner with the private sector in PHC service delivery. Different teams from different contexts and at different stages in the engagement process will find certain sections more salient than others. Each module includes sections describing:

- **WHY** the step or module is important (the problem statement) and
- **HOW** to implement the step or module (the process), where possible, supported by real world cases and documentation.

*Advice from Implementers, to Implementers* is also intended to function as a living document that will be updated periodically based on learnings and feedback from users.



## MOTIVATION FOR DEVELOPING THIS MANUAL

Most JLN countries have de facto mixed (public and private) health delivery systems, but government health system stewards sometimes lack essential information to engage effectively with private providers around PHC including information concerning the supply of services, the quality of those services, and the profile of their users.

As found in the application of the JLN PHC Technical Initiative Self-Assessment Tool<sup>3</sup> in several countries, private providers are often ineffectively organized and regulated, and potentially underutilized in terms of advancing national health priorities (though highly utilized by consumers). In other locations, JLN countries have begun to make progress in connecting with private providers, but still face engagement challenges (Box A). Some existing literature describes why the public sector should work with the private sector, and vice-versa, and points out the challenges associated with this engagement (see APPENDIX B for more detail). Additionally, there is a growing body of global experience and resources in determining provision roles across the public and private sectors and in contracting or

otherwise engaging private providers to advance national health goals in low- and middle-income countries (Bustreo et al. 2003; Loevinsohn et al. 2005). However, health system stewards interested in working with the private sector often lack the tools, ability, or know-how to create an effective partnership (Hozumi et al. 2008; Harding 2009). In addition, there are sometimes legal and regulatory obstacles to using public funds to contract with private providers; this prevents health system stewards from working with the private sector (Casbin 2015). Thus, there is a need to generate evidence and good practices that will help countries develop better partnerships between the public and private sector for delivery of PHC services.

### BOX A

#### JLN country challenges engaging the private sector in PHC service delivery

**In Tamil Nadu state, India, and Upper East Region, Ghana,** private providers do not typically deliver preventive or promotive services, due to perceived issues of cost and lack of adequate manpower, interest, patient compliance, and government incentives/support (Blanchet et al. 2016).

**In Malaysia,** the government is the main provider of PHC services, but private sector utilization is substantial and must be better coordinated within the country's coming health system review plans.

**In Vietnam,** engagement of the private sector in the provision of preventive and promotive services is low. The health services delivery network historically has been split between curative and preventive provision of services. Promotive and preventive services are provided through government-run district health centers, while PHC curative services are provided by government-run district hospitals and commune health stations, as well as private practices.

<sup>3</sup> The JLN PHC Technical Initiative Self-Assessment Tool is a multi-stakeholder survey that helps document and assess how health insurance or financial coverage institutions interact with other actors and programs; it identifies key areas of improvement and opportunities to align the health financing agency or other health financing policymakers with PHC goals. More information about application of the Tool in JLN countries is found in [Appendix A](#).

Based on the engagement challenges experienced by JLN PHC Technical Initiative members, as well as the lack of practical guidance for determining how countries should engage with private providers around PHC service delivery, JLN members collected country experiences and worked with leading experts in the field to jointly produce modules for *Advice from Implementers, to Implementers*.

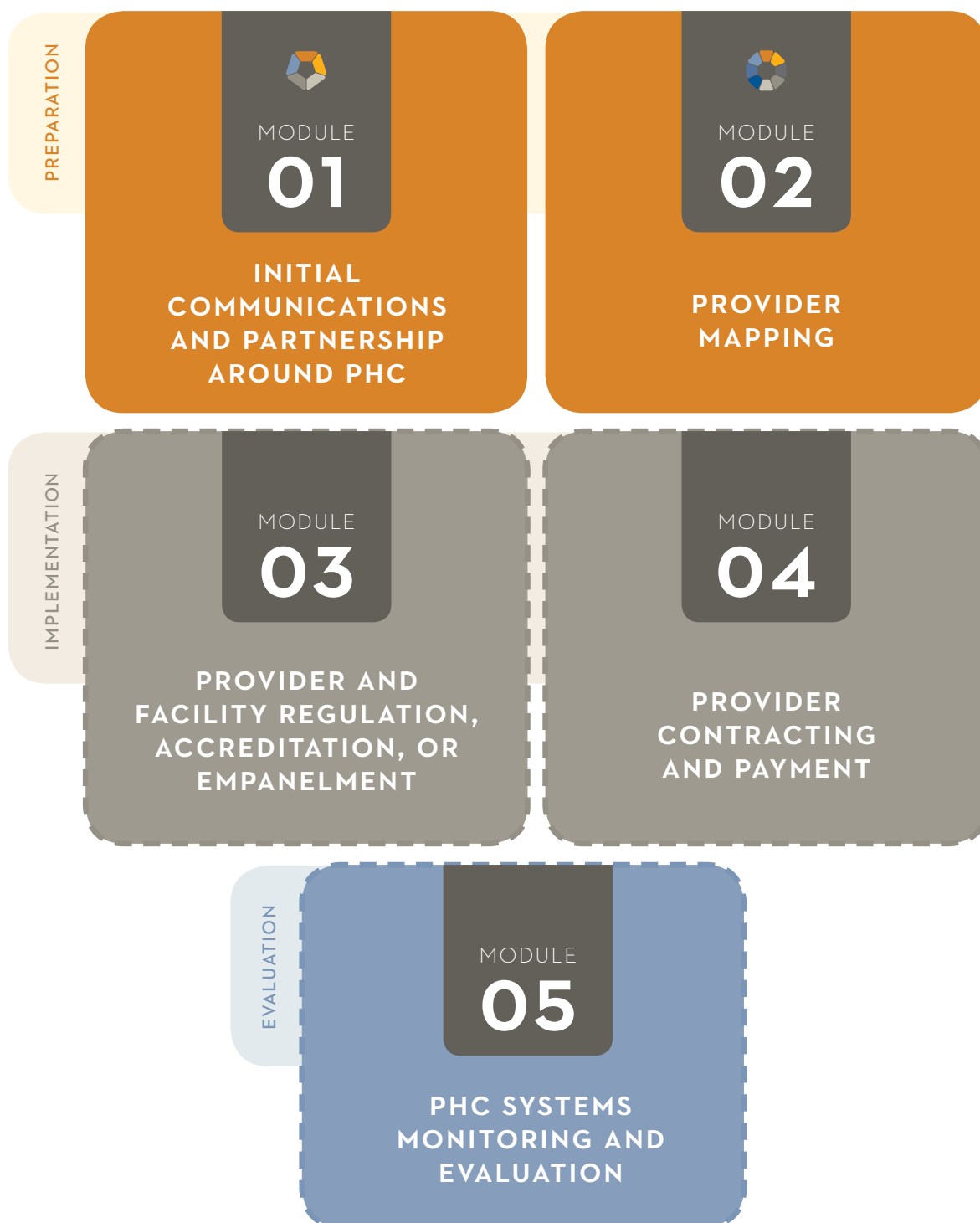
*Advice from Implementers, to Implementers* will include the following five modules about the process for public sector engagement with the private sector around PHC. The current version of this document includes the first two modules; the others will be published at a later date.

1. Initial public and private sector communications and partnership around PHC
2. Provider mapping
3. Provider and facility regulation, accreditation, or empanelment
4. Provider contracting and payment
5. PHC systems monitoring and evaluation

A visualization of this process is shown in [FIGURE A](#).



## Process for engaging public and private sectors in the provision of PHC services



----- To be published at a later date

## METHODOLOGY

Like other JLN-published products, *Advice from Implementers, to Implementers* was developed through a global practitioner-to-practitioner exchange using a collaborative approach to developing knowledge products. The approach draws on experiences and evidence from multiple JLN member and non-member countries; international experts, partners, and working groups; and published literature. The methodology complements knowledge products that describe the theory of how things should work as well as other products that focus on how things actually do work at the country level.

To lead this work, a subgroup of JLN PHC Technical Initiative members volunteered to develop *Advice from Implementers, to Implementers*. Beginning in March 2015, this smaller group of members, called a “mini-exchange,” drafted a proposal for the work and began planning an in-person kick-off meeting.<sup>4</sup> The mini-exchange members include JLN PHC Technical Initiative members from Tamil Nadu (India), Malaysia, the Philippines, and Vietnam; an international expert consultant and former Director of Health of the Aga Khan Foundation, an institutional member of the Aga Khan Development Network (AKDN); JLN partner organizations including the World Bank-Cambodia, IFC-Ghana, and GIZ-India; and Results for Development (R4D) technical facilitators. Mini-exchange members engaged in several in-person and virtual meetings and consultations to conceptualize, outline, write, and review *Advice from Implementers, to Implementers* including in May 2015 in Dubai, United Arab Emirates; in July 2015 for a virtual webinar; in September 2015 in Hanoi,

Vietnam; in November and December 2015 for virtual webinars; and in January 2016 in Tamil Nadu state, India. The participation of additional international stakeholders, as well as the inclusion of country facility site visits during in-person meetings, has helped to increase the diversity of experiences cited in the document. The JLN PHC Technical Initiative mini-exchange has also received inputs on the concept, outline, and case studies for *Advice from Implementers, to Implementers* from participants at the regional Harnessing Non-State Actors for Better Health for the Poor (HANSHEP) workshop in Nairobi, Kenya, in July 2015. HANSHEP workshop participants included public policymakers, technical advisers, and private sector representatives. In January and February 2016, the document was reviewed by a group of international experts, and in March 2016, PHC Technical Initiative members from nine JLN countries gathered in Phnom Penh, Cambodia to complete a final review of the document.

<sup>4</sup> The “mini-exchange” is an innovation of the JLN PHC Technical Initiative that involves a small subset of Initiative members interested in coming together to produce a knowledge product quickly with support from international experts and technical facilitators. The accumulated experience and products from the mini-exchanges are shared with all JLN PHC Technical Initiative members to validate and use.

# INITIAL COMMUNICATIONS AND PARTNERSHIP AROUND PHC

**FOR COUNTRIES THAT HAVE DECIDED TO ENGAGE with the private sector to advance PHC – policy, data exchange, regulation, financing, and provision of services – this module describes five steps to take to launch communications and begin institutionalizing a partnership with private sector actors.** The five steps, listed in [FIGURE 1](#), lay a strong foundation for the ensuing public-private partnership. Work discussed here also will set the stage for the topics discussed in the four later modules: provider mapping; provider and facility regulation, accreditation, or empanelment; provider contracting and payment; and PHC systems monitoring and evaluation.

FIGURE 1

## Five-step process for initial communications and partnership with the private sector





## STEP 01

# PREPARE FOR DIALOGUE WITH STAKEHOLDERS BY CONDUCTING STAKEHOLDER ANALYSES

## WHY CONDUCT STAKEHOLDER ANALYSES?

**SINCE MOST HEALTH REFORMS AND INITIATIVES involve the allocation of resources and varying ideologies about health systems, they have the potential to meet with support from certain powerful actors and opposition from others; these responses to reform often determine its success as much or more than technical inputs.** Stakeholder analysis responds to this challenge and is a vital tool for designing and implementing health reforms successfully. (See **BOX 1** for more details.) The engagement team should plan to update stakeholder analyses routinely throughout the process of public-private engagement; the step is included in all modules of this manual.

Stakeholder analysis involves much more than merely identifying and talking with relevant parties – that is, it goes beyond stakeholder dialogue. It prioritizes actors to help determine the success or failure of an activity or policy, assesses how and why the actors have influence over that particular policy, and leads to adjustments in the proposed policies or other strategies to bolster the actors' support, lessen their opposition, and thereby increase the chances of success. Stakeholder analysis helps to tease out, for example, groups who are very vocal but who do not necessarily

speak for all those involved. In addition, it may help to understand the role and voice of donors and the media. As a first step, the engagement team should prepare for both initial dialogue and future issue-specific stakeholder analyses by identifying potential stakeholders and beginning to document their positions relative to public-private engagement in PHC. More detailed resources exist for how to conduct stakeholder analyses (*Schmeer 1999; Varvasovszky et al. 2000; www.polimap.com*), but high-level steps are outlined in this module.

### BOX 1

## Definition of stakeholders; why stakeholder analysis is a vital tool for public-private engagement

**Definition: Stakeholders are defined as individuals, groups, or organizations that have an ideological and/or economic interest (stake) in a particular policy (or activity) and the potential to influence policy direction.**

Many of the activities and policy changes discussed in this manual require resource commitments and have the potential to create winners and losers among stakeholders. They



can therefore be blocked or hindered if stakeholder interests are not adequately

considered. Stakeholder analysis helps account for stakeholder interests when designing an activity, such as provider mapping, or a policy change, such as a new way to accredit or pay providers.

Stakeholder analysis evaluates stakeholders to determine their relevance to a project or policy. It involves assessing stakeholders' positions, interests, influence, interrelations, networks, and other characteristics vis-à-vis the project or policy. Results from this analysis inform strategies to increase the chance of success of the activity or policy and any follow-on system changes (*Varvasovszky et al. 2000*).

## HOW TO CONDUCT STAKEHOLDER ANALYSES?<sup>5</sup>

### STEP 1.1

**Step 1.1** is to list all potential stakeholders in actions and policies related to private sector engagement. **TABLE 1** lists potential stakeholders and some of the interests in private sector policies that each category of stakeholders might have. The list is a generic starting point for stakeholder analysis; a country's engagement team should adapt it to their situation.

TABLE 1		Interests of key stakeholders in private sector engagement
STAKEHOLDER	ILLUSTRATIVE INTERESTS	
NATIONAL HEALTH PLANNERS AND POLICYMAKERS	<ul style="list-style-type: none"> <li>• Leverage private providers for public health priorities</li> <li>• Regulate quality</li> <li>• Reduce costs through organizational and payment changes</li> <li>• Support goals of national political leaders</li> </ul>	
SUB-NATIONAL HEALTH PLANNERS	<ul style="list-style-type: none"> <li>• Same as national planners, but with a sub-national focus</li> <li>• Maintain or grow autonomy from national authorities</li> </ul>	
PUBLIC INSURERS	<ul style="list-style-type: none"> <li>• Ensure access for enrolled population</li> <li>• Reduce costs, avoid perception that private providers are “profiting” from health care</li> <li>• Improve oversight of quality of care and financial accounting among private and public providers</li> </ul>	
PRIVATE INSURERS	<ul style="list-style-type: none"> <li>• Maintain and grow market share, fending off “competition” from public sector insurance</li> <li>• Ensure access for enrolled population</li> <li>• Improve oversight of quality of care</li> </ul>	
PRIVATE SUPPLIERS OF INPUTS, REPAIRS, AND MAINTENANCE <i>(inputs include medications, supplies, contraceptives, and equipment)</i>	<ul style="list-style-type: none"> <li>• Secure or expand potential markets for their products and services</li> </ul>	
HEALTH SECTOR PROFESSIONAL BODIES <i>(for example, the national association of midwives)</i>	<ul style="list-style-type: none"> <li>• Maintain and grow provider income</li> <li>• Support provider performance and quality improvement, including contributing to guidelines and standardized protocols for treatment and diagnosis</li> <li>• Improve provider quality of professional life</li> <li>• Maintain autonomy between providers and patients, and ability to improve quality of care</li> </ul>	

*continued*

<sup>5</sup> Adapted from Schmeer 1999 and Varvasovszky et al. 2000: 338–45

TABLE 1

## Continued

STAKEHOLDER	ILLUSTRATIVE INTERESTS
PRIVATE PROVIDERS OF SERVICES	<ul style="list-style-type: none"> <li>• Maintain, increase, and expand business</li> <li>• Gain more favorable financing</li> <li>• Achieve high quality of professional life</li> <li>• Increase knowledge and skills</li> </ul>
SOCIAL FRANCHISES	<ul style="list-style-type: none"> <li>• Maintain and grow provider income</li> <li>• Maintain and increase market share</li> <li>• Streamline administration and reduce operational costs through a network model</li> <li>• Improve access to and quality of care through standardized protocols</li> <li>• Access public sources of funding</li> </ul>
ENTERPRISES <i>(private sector enterprises providing services to their employees, acting as buyers of health services)</i>	<ul style="list-style-type: none"> <li>• Maintain a healthy workforce</li> <li>• Contain or reduce costs of care and insurance programs</li> </ul>
CHARITIES	<ul style="list-style-type: none"> <li>• Improve access to quality care</li> <li>• Gain more favorable and sustainable financing</li> <li>• Achieve high quality of professional life</li> <li>• Increase knowledge and skills</li> </ul>
HEALTH ACTIVISTS	<ul style="list-style-type: none"> <li>• Improve the way private providers and consumers talk and think about health</li> <li>• Raise awareness for health causes</li> <li>• Support quality improvement and performance</li> </ul>
PATIENTS/CLIENTS	<ul style="list-style-type: none"> <li>• Access quality (safe, effective, patient-centered, timely, efficient, and equitable) health care</li> <li>• Hold providers accountable for quality care</li> </ul>
ACADEMICS	<ul style="list-style-type: none"> <li>• Collaborate on training and capacity building</li> <li>• Collaborate on research and evaluations</li> </ul>

## STEP 1.2

**Step 1.2** is to adapt the generic stakeholder interests listed in [TABLE 1](#) to the specifics of a country. One way to learn about the interests of a stakeholder group is to examine their statements of purpose, objectives, and strategy (often on the group's website) as they might relate to private sector engagement. It is useful to apply a framework to analyze stakeholder interests, such as one that examines how the proposed activity or policy might affect the stakeholder in terms of: (1) power and prestige, (2) financial position, and (3) ideological stance. In some cases, the interests of a group may not be completely transparent so early in the process; activities such as the provider mapping in [MODULE 2](#) might add a fourth aspect, related to the stakeholder's interest in controlling information or data (vital for mapping and other analyses/system diagnoses). See Step 1.5 below for more on how to gather information about the interests of the stakeholder groups.

## STEP 1.3

**Step 1.3** is to rate the stakeholders in terms of importance, typically from low to high, sometimes identifying stakeholders with “veto power” – those without whose approval an activity or policy cannot legally proceed. Generally, the more resources (financial, human resources, access to mass media, etc.) and the more motivation a stakeholder has to influence a policy, the more important it is to consider their interests when adjusting the policy and/or creating strategies to gain support.

## STEP 1.4

**Step 1.4** is to formulate and disseminate a draft concept paper (see **BOX 2**) on the proposed activity or policy that takes into account the identified interests of high-priority stakeholders and resources likely to be needed to carry out the activity. The concept paper will be used in Step 1.5.<sup>6</sup>

## BOX 2

## Writing a concept paper



**A concept paper is a document that summarizes a proposed activity or policy. It is a useful tool for stimulating discussion, and a precursor to a full proposal. A draft concept paper should:**

- Provide background information – why it is important to solve this problem, and why past efforts to address the problem have been insufficient
- State the primary and secondary objectives of the activity or policy
- Describe what the outputs of this activity or policy will be
- Anticipate questions about resource needs by detailing necessary inputs (funding, human resources, equipment, overhead, etc.)
- Cultivate buy-in by demonstrating to stakeholders how the proposed activity or policy will impact them

<sup>6</sup> This transparent documentation of initial policy ideas is advisable for straightforward activities, such as the provider mapping of **Module 2**, but in the case of controversial policies – a new payment mechanism or regulation, for example – policymakers may wish to skip this step, that is, to proceed to Step 1.5 without producing a formal, written proposal that could draw the attention – and opposition – of groups whose interests might be jeopardized by the proposed change.

**STEP 1.5**

**Step 1.5** is for the engagement team to conduct specific consultations with high-priority stakeholders (see Step 1.3). The draft concept paper (Step 1.4) can be sent to the stakeholders in advance of the consultations or described in a PowerPoint presentation at the meetings. The engagement team might meet with representatives of a single stakeholder or with representatives of multiple stakeholders at one time. The purpose of the consultations is to better understand the motivations of high-priority stakeholders (refine the results of Step 1.2), including their interests, the extent to which they agree with the primary and secondary purposes of the proposed policy, and to make initial inquiries about their willingness to contribute funds and data. It is helpful to develop a standard questionnaire to ensure that all issues are covered with each stakeholder. This will facilitate analysis of the responses.

**STEP 1.6**

**Step 1.6** is to process all the information gathered from the consultations to revise the draft concept paper. This might mean having to decide among competing interests, giving greater weight to the interests of the higher-priority stakeholders, and/or finding ways to compensate stakeholders whose preferences are not chosen in one area with benefits in another area. The revision also needs to take into account the affordability of meeting the various interests. A tool such as Policy Maker ([www.polimap.com](http://www.polimap.com)) might be used at this step (O'Brien et al. 2007; Drake et al. 2011; Lin et al. 2010).

**STEP 1.7**

**Step 1.7** is to conduct another round of consultations with key stakeholders concerning the revised concept, this time seeking endorsements and specific commitments of participation, financial resources, and/or data, along with feedback on the revised concept.



**STEP 1.8**

**Step 1.8** is to make additional modifications (if all goes well, these will be small changes to the revised concept based on the consultations in Step 1.7). This process might have to be repeated several times. The product of this step is a final concept paper.

**STEP 1.9**

**Step 1.9** is to present the final concept paper to all stakeholders, again inviting feedback, but expecting that it will be minimal from the high-priority stakeholders because they have been consulted repeatedly and their interests taken into account. Feedback from lower-priority stakeholders can be incorporated if it has merit and is doable within financial constraints, but if not, it should be acknowledged and declined.

This process is expected to generate political and financial support as well as data for the design and implementation of private sector engagement activities and policies. While the engagement team will lead this dialogue with stakeholders, it might need a neutral facilitator (e.g., from a university) to implement this process on its behalf.



## STEP 02 UNDERSTAND AND DETAIL RATIONALE FOR ENGAGING THE PRIVATE SECTOR IN PHC

### WHY DETAIL THE RATIONALE FOR ENGAGEMENT?

**ENGAGING THE PRIVATE SECTOR TO IMPROVE PHC within UHC is a complex, multi-faceted endeavor, and detailing the rationale for engaging the sector is a vital early step.** Knowing why you are doing something helps with following steps – like when, where, how, and with whom you’ll do it. In this case, an engagement team<sup>7</sup> will find it useful to decide and document why to engage the private sector (or some part of it). Team members should ask questions to help them identify and articulate reasons for working with the private sector; useful questions are listed in **BOX 3**. Next, clarifying the “why” for pursuing the private sector and high-priority objectives that the engagement team hopes to fulfill with private sector actors will enable the team to decide on concrete steps to open communications and begin forming partnerships; organizing in this way will also help avoid the paralysis that can occur if a team tries to tackle all forms of engagement with an entire, ill-defined “private sector.” These preliminary ideas can become talking points in early meetings with private providers to help motivate and facilitate cooperation.

#### BOX 3

#### Why work with the private sector?

**Answers to these and other questions will lead to different types of engagement with different segments of the private sector.**

- Is it to increase access to essential services in a particular region or for population groups that currently make heavy use of private rather than government providers?
- Are significant segments of the population using private providers for primary curative care, but missing out on preventive care?
- Are there concerns about the quality of private services that call for more effective regulation?
- Will a future health financing reform or donor transition benefit from public financing flowing to private providers for the first time?



<sup>7</sup> The guidance here is written for public sector “engagement teams,” but it could easily be adapted and conducted by private sector providers who wish to initiate and promote better engagement with the public sector themselves.

## HOW SHOULD THE PUBLIC SECTOR DETAIL THE RATIONALE FOR ENGAGEMENT?

The engagement team should hold at least one half-day internal brainstorming session with government stakeholders (MOH, health financing agency, and others) to define the public sector's rationale for seeking engagement with the private sector. During this meeting, the engagement team might also hypothesize the private sector's interests in partnering and plan a time to conduct another brainstorming session on this topic. While the brainstorming should aim to identify explicit reasons, this step does not require a great deal of time or resources.

### KEY THEMES FOR DISCUSSION DURING THIS BRAINSTORMING SESSION MIGHT INCLUDE:

- Governance of the overall health system or of a particular health agency (see [Box 4](#) for more detail on governance considerations)
- Population health priorities and concerns (e.g., stubbornly high childhood death from malaria, maternal mortality from preventable causes, a recent report on fast-rising prevalence of diabetes).
- Health system “building blocks” that concern the private sector (e.g., pharmaceutical supply chains, human resources for health (HRH) in underserved areas, data for monitoring and evaluation and decision making)
- Health system intermediate goals (e.g., access, quality, efficiency, equity)
- Upcoming reforms and transitions (e.g., proposals for national health insurance, expected “graduation” from external assistance).

### FACILITATION OF THE BRAINSTORMING SESSION CAN CHOOSE FROM SEVERAL APPROACHES THAT INCLUDE:

- Assigning one or two engagement team members to do rapid background research in which they review country surveys and studies on the government's major PHC-related health priorities, health system gaps, and major concerns; information about the role now played by the private sector relative to these priorities, gaps, and concerns; and data that provide evidence to substantiate these priorities, gaps, and concerns. Then, team members present their findings to the broader group.
- Assigning a facilitator to guide and record key take-away points from discussion about these priorities that seem to be most urgent, feasible, or easiest (the “low-hanging fruit”) for cooperation with the private sector.
- Bringing public sector stakeholders (MOH, health financing agencies, and others) together to brainstorm about how to engage with the private sector. The outputs of this meeting will be used to develop the public sector's approach for dialogue with the private sector.
- Coming to consensus on first drafts of one or two general rationales for engaging the private sector, plus three to five specific objectives for engagement, which will be documented in a table (see [TABLE 2](#)).
- Keeping note of, but not dwelling on, negative or positive biases that public sector actors may have about the private sector, and vice versa. These may color hypotheses about the rationale for engagement and may need to be mitigated or controlled by chairpersons or facilitators of the initial meetings.
- Inviting a trusted “key informant” or knowledgeable insider from the private sector to join in the brainstorming session to hypothesize and outline the private sector's interests, and offer initial feedback and guidance to the discussion. If this is not possible, assign one or more team members to role play a private sector representative to test the validity of the chosen rationale and objectives.

**Governance here refers to the roles, responsibilities, and relationships of the overall health system or an individual health agency, such as the MOH or national health insurance agency and their key partners, as well as the institutions, systems, and routine practices that shape those roles and help hold various actors accountable.**

Thinking about these roles, responsibilities, and accountability mechanisms can help illuminate where and why better public-private cooperation is needed.

Concepts like governance or stewardship are very broad, but several frameworks are available to help organize and focus discussions.\* Regardless of the framework and principles/dimensions chosen, an engagement team can begin by questioning whether the government's current relationship with the private sector (and vice versa) is satisfactory across different dimensions.

For example, the engagement team could ask the following:

- Is the MOH's ability to regulate quality in the private sector sufficient? If not, that could be a key objective of an engagement activity.
- Private providers might ask if the decision-making processes of a public health purchasing agency are consistent and transparent enough to motivate them to participate in publicly financed health initiatives. If not, improving those processes might be a step towards increasing engagement.

In sum, deliberate questioning and thinking along dimensions of governance will help identify clear rationales for engaging the private sector in PHC, which is a primary objective here.

\* Siddiqi et al. (2009) summarize frameworks for analyzing health system governance from the WHO, World Bank, United Nations Development Programme (UNDP), and Pan American Health Organization (PAHO) and propose their own 10 guiding principles: strategic vision, participation and consensus orientation, rule of law, transparency, responsiveness, equity and inclusiveness, effectiveness and efficiency, accountability, intelligence and information, and ethics. Savedoff et al. (2008) focus specifically on governance of mandatory social health insurance systems, and offer five governance dimensions: supervision and regulation, consistency and stability, coherent decision making, transparency and availability of information, and stakeholder participation.

**TABLE 2** is a tool that can be used to summarize and document the output from the brainstorming session. The ideas noted by or attributed to the private sector might turn out to be inaccurate, so it is important to review and update them in **STEP 3**, when engaging with the private sector.

TABLE 2		<b>Template for documenting rationales, objectives, and challenges for public-private collaboration in PHC</b>	
		OBJECTIVE	OUTCOMES
WHY SHOULD THE PUBLIC SECTOR WORK WITH THE PRIVATE SECTOR?	OBJECTIVE 1		Outcome 1.1
			Outcome 1.2
	OBJECTIVE 2		Outcome 2.1
			Outcome 2.2
WHY SHOULD THE PRIVATE SECTOR WORK WITH THE PUBLIC SECTOR?	HYPOTHESIZED OBJECTIVE 1		Hypothesized Outcome 1.1
			...
CHALLENGES TO COLLABORATION AND PARTNERSHIP			
POTENTIAL SOLUTIONS TO CHALLENGES			



# STEP 03 ACTIVELY LISTEN TO THE PRIVATE SECTOR

## WHY ACTIVELY LISTEN TO THE PRIVATE SECTOR?

**LISTENING TO THE PRIVATE SECTOR WILL HELP the public sector understand more about the private sector’s challenges, where the sectors’ goals differ, and especially why the private sector is reluctant to work with the public sector.** This understanding will allow the public sector to revise its hypotheses regarding the private sector’s interests in engagement in **STEP 2**.

Reasons for private sector reluctance to work with the public sector include:

- Distrust of government with respect to paying the private sector in a timely manner and delivering on contractual agreements;
- Concern that government will create burdensome and unfair regulations that constrain/control private sector operations;
- Competition with the government; and
- Belief that the government inherently distrusts the for-profit (commercial) sector’s motives in the delivery of health care.<sup>8</sup>

Hearing the private sector explain its concerns and skepticism about engagement helps the public sector formulate ways to address the concerns and allay the skepticism. There may be easy, quick fixes, such as granting private sector actors access to public health sector data, which will begin to win the private sector’s trust. This initial collaboration also will let the public sector identify key private sector actors – players and/or champions, associations, and so forth – who will foster buy-in to a sustainable relationship between sectors.

## HOW CAN THE PUBLIC SECTOR ACTIVELY LISTEN TO THE PRIVATE SECTOR?

Once the engagement team has identified reasons for engaging with the private sector (**STEP 2**), it must decide how to meet and actively listen to that sector. It can do so by meeting with private sector groups or with individuals in the private sector.

### ENGAGING WITH PRIVATE SECTOR GROUPS

In many countries, private health sector professional associations and other bodies, many of which represent private sector subgroups (e.g., pharmacists, midwives), help structure and bring a common voice to the heterogeneous sector. They organize the private health sector’s interactions with other social sectors and the government, as well as interactions within the private health sector itself for better collaboration and organization among subgroups. To the extent possible, the public sector should engage

with these private sector bodies to improve collaboration, communication, and efficient engagement with the sector. For example, Uganda and Kenya’s faith-based organizations (FBOs), which are major contributors to service delivery and health worker training, have organized themselves into interfaith groups (*GIZ 2012*). By interacting with interfaith groups, the public sector can pursue more comprehensive relationships with FBOs, moving beyond MOUs with individual organizations to partnerships that include a wide range of faith-based stakeholders. In Kenya, the private

<sup>8</sup> See [Appendix B: Making the case for engaging the private sector in PHC](#) for more information on private sector reluctance to work with the public sector.

health sector formed the Kenya Health Federation (KHF) as part of the Kenya Private Sector Alliance, bringing together all for-profit groups engaged in health: outpatient facilities, hospitals, pharmacies, and pharmaceutical manufacturers. The Federation meets directly with the Kenyan government to discuss the wide range of health sector and market conditions that affect its members.

When deciding how to approach private sector groups, the engagement team should consider how representative a group is. If it claims to speak for the entire sector, it should include members from the entire sector, including all types of providers (clinicians, pharmacists, etc.), facilities

(inpatient, outpatient, pharmacies), and ownership or affiliation (for-profit and not-for-profit or FBOs). It also must be respected by its constituents; if not, its constituents will ignore its requests and suggestions. In Ghana, for example, a private health sector organizational body was established in what was perceived as a top-down action, and it lacked a good understanding of the interests of different private sector stakeholders. As a result, its members did not see it as legitimate and many refused to cooperate with it; the organization eventually was restructured to be more representative and is working to build constituents' trust (see [Box 5](#)).

BOX 5

**Challenges in establishing coordination platforms: Lessons from Ghana**

**The Private Health Sector Alliance of Ghana (PHSAG) was one of the first private sector coordination groups established in the Africa Region.**

The MOH facilitated the establishment of PHSAG with funding from The Rockefeller Foundation and technical support from the IFC-funded Health in Africa Initiative. PHSAG's development provides useful lessons regarding structure, leadership, and stakeholder engagement in such groups.

PHSAG was established without systematic consultation having been carried out among the wide range of private sector stakeholders in order to understand their needs. As a result, the stakeholders did not have a voice in PHSAG's structure, which did not take into account existing institutional relationships. Furthermore, to take advantage of new grant funding, leadership positions in PHSAG were rapidly filled by appointment rather than by election. A constitution was drafted without consultation with different private sector stakeholders.

Perceptions that the MOH had sponsored the formation of PHSAG spurred suspicion among its constituencies and created a legitimacy challenge for PHSAG leaders, who were unable to effectively convene or represent the stakeholders. Several provider associations refused to sign the constitution. PHSAG has since been restructured, and has an elected, representative executive and a new constitution. The work of rebuilding trust among stakeholders is ongoing.



Other process options for the team to consider when engaging with private sector groups include the following:

- In countries where private sector professional groups do not exist, the public sector should incentivize and motivate their formation. However, how the public sector does this is important. For a group to be effective, private sector members must feel ownership of it. To achieve this, the engagement team needs to work deliberately, first engaging with a small number of private sector “key informants” who will work on the team’s behalf to gather private sector support to form the group.
- Identify a representative from an existing private sector group to be a point of contact with the public sector. The representative should be chosen by the private sector group.
- Sometimes it is advisable for a neutral third party (e.g., someone from a university or policy research institute) to facilitate discussion among public and private sector stakeholders, to help build trust and to ensure that no one subset of private providers speaks for all.
- Hold a workshop for stakeholders from across the public and private sectors. [STEP 5](#) provides guidance on a potential workshop agenda, and [APPENDIX C](#) describes a successful engagement workshop held in Ghana to discuss a World Bank private sector assessment.
- Engage around national and international health events, such as World Health Day and World Diabetes Day.

### ENGAGING WITH INDIVIDUALS IN THE PRIVATE SECTOR

When working with a private sector group is not possible, the engagement team should meet with individual stakeholders to learn more about the sector. When choosing individuals with whom to meet, the team should keep in mind the potential conflict of interest that dual providers present. The term “dual providers” refers to health professionals who may, for example, act as a state employee during the day and as a private provider in the evenings (so-called “moonlighting”). If the team meets with such individuals, it should take the dual position into consideration when analyzing findings.

The engagement team can use the following processes for engaging with individuals in the private sector:

- Conduct interviews or focus groups with these individuals.
- Analyze and synthesize findings from the interviews, identifying aspects of engagement about which the individuals are unclear, as well as differences and opportunities discussed.
- Host a workshop with key public and private stakeholders to validate and debate the interview findings. An example of what a workshop can achieve comes from Benin, where the public sector began engagement with the private health sector through interviews and focus groups to better understand the benefits of and constraints to regulating the private sector; the MOH hosted a workshop with private sector representatives to discuss the findings and work together to determine the best way forward (see [APPENDIX C](#) for more details).

Actively listening to the private sector will help the engagement team validate and/or revise their hypothesized rationales from [STEP 2](#). It will also help the team to identify common interests on which the sectors can base their first collaborations (see [STEP 4](#)).





STEP  
**04** FIND AREAS OF COMMON GROUND,  
AND AGREE ON FIRST STEPS FOR  
COLLABORATION TO BUILD TRUST

**WHY FIND AREAS OF COMMON GROUND AND AGREE ON EASY FIRST STEPS?**

AS STEP 3 JUST NOTED, active listening enables the engagement team to understand the differences between public and private sectors but also to identify commonalities and areas of agreement across the sectors on which collaboration can be based. The two sides share many reasons for working in the health field: for example, providing for the common good, helping their community to be as healthy as possible, and maintaining expert standards in the field. They may also seek to improve the same health care priorities, such as preventive and PHC services, quality, referral systems, and the pre-service training that provides human resources for both sectors.

Initial areas of collaboration should be the “low hanging fruit” – outcomes that are relatively easy to achieve – because early success builds confidence in the process and encourages both sides to grow their relationship. By

starting with activities that are too complex to achieve, the partnership may lose momentum. [Box 6](#) lists reasons for public-private partnership failure, and [Table 3](#) sets forth low-cost first steps towards collaboration.

BOX 6

**Why some public-private collaborations fail: Lessons from the Health in Africa Initiative**

**The Health in Africa (HIA) Initiative of the World Bank Group operates in nine African countries and has extensive experience in promoting public-private collaboration.**



HIA has established a number of forums for public-private dialogue, and in the process noted challenges that can result in “failed” public-private collaboration. Implementing agencies can be ambivalent about private sector engagement, believing that the sector’s profit motivations lead to poor service at high prices. More specifically, challenges include:

1. The absence of a clear policy direction and framework for public-private collaboration;
2. A lack of clarity within implementing agencies on the goals and objectives to be achieved;
3. Inconsistent messaging on the benefits of private sector participation in health service delivery, particularly for universal coverage;

4. Inappropriate labeling of the private sector (including pharmaceutical and logistics sectors) as having a non-core service delivery function;
5. The absence of both a public-private sector policy dialogue platform, and an effective system for mainstreaming private sector commitments into the health sector strategy;
6. An absence of the necessary capacity and technical know-how to manage private public collaboration; and
7. A lack of resources within an MOH’s public-private partnership unit to promote public-private collaboration and to help support implementing agencies in developing and engaging the private sector.

TABLE 3

## Examples of easy, low-cost first steps for public-private sector collaboration

ACTION	DESCRIPTION
RECOGNIZING THE PRIVATE SECTOR'S CONTRIBUTIONS	<p>Publicly recognize private sector providers and/or clinics that deliver PHC services to motivate the private sector and garner its support for collaboration and coordination. The recognition program could award a prize or certificate when a facility effectively promotes PHC (e.g., collaborates with other providers to improve referral processes or introduces new preventive services like systematic screening for diabetes and hypertension).</p>
SHARING DIAGNOSTIC EQUIPMENT	<p>Achieve efficiencies by sharing diagnostic equipment. Diagnostic equipment involves large investment costs that if shared across the sectors become more manageable. Examples where this has been successful include:</p> <ul style="list-style-type: none"> <li>• In Andhra Pradesh, India, the government engaged with the state's network of private providers to improve diagnostic service capabilities at medical college hospitals in four towns, thereby containing costs and improving the health of the poor (<i>IFC 2010</i>).</li> <li>• In The Republic of Congo, the public and private sectors discussed collaborating to make hemodialysis more widely available. The public sector, which did not have equipment for hemodialysis, explored the possibility of sending their patients to private clinics in Pointe Noire for these services (<i>Makinen et al. 2012</i>).</li> </ul>
CO-DEFINING QUALITY INDICATORS	<p>Collaborate on the definition of quality indicators, measurement methods, and participation in monitoring and evaluation of quality for each actor in health service delivery. This will enable the private sector actors to share their perspective on the importance and feasibility of collecting specific quality indicators, the recommended methods to collect these indicators, and the frequency of collection. For example, in Benin, both sectors collaborated to define quality indicators that public and private providers would employ through a joint workshop conducted with assistance from a USAID-sponsored project.</p>
CO-SPONSORING CONTINUING MEDICAL EDUCATION (CME) AND TRAINING UPDATES	<p>It is in the interest of both the public and private sectors to have well-trained and up-to-date providers to ensure better quality of services. Government support for training updates is often available to the public sector, but the private sector is rarely included. Moreover, many countries do not require CME for nongovernment employees. This results in many private providers using out-of-date practices either because they cannot access trainings, or are not required to complete CME. Country examples of co-sponsoring CME:</p> <ul style="list-style-type: none"> <li>• India is exploring options to expand and regulate CME. In 2014, the Global Alliance for Medical Education hosted a meeting with public and private sector stakeholders to discuss national obstacles to implementing federal regulation and explore solutions for expanding and regulating CME. The meeting started a dialogue process that could solve an important issue in training and regulation (<i>Srivastava et al. 2015</i>).</li> <li>• Central health authorities in China and Indonesia have created national credit systems for CME, applied to all health professionals. In Indonesia, CME is mandatory for re-licensure; in China, it is necessary for career advancement and re-registration. While commercial entities are not permitted to provide CME in either country, private institutions approved by the government routinely deliver CME programs (<i>Miller 2015</i>).</li> </ul>

<p>SHARING DATA TO IMPROVE HEALTH SERVICE DELIVERY</p>	<p>Share data for specific health areas between both the private and public sectors, including, but not limited to: (a) infectious disease reporting, (b) quality, and (c) service volume data. Sharing data for these purposes can help improve the responsiveness of health services to infectious diseases across sectors, drive improved quality of services through increased competition, redistribute health services and health inputs based on utilization data, and monitor results over time.</p>
<p>INCREASING PRIVATE SECTOR ACCESS TO PUBLIC COMMODITIES</p>	<p>Grant the private sector access to public commodities such as basic essential medicines, vaccines, and contraceptives available at favorable prices from a government store. This helps to enable private providers to deliver those services and increase PHC service coverage (e.g., Benin).</p>

## HOW TO FIND AREAS OF COMMON GROUND AND AGREE ON EASY FIRST STEPS?

During the initial stakeholder workshop (see **STEP 3**), the engagement team can use the following questions to guide the discussion about finding common ground and agreeing on easy, low-cost areas for initial collaboration, as detailed in **TABLE 3** above.

It is helpful to start with some broad questions:

- Why are we in the health field?
- How can our ideals be realized?

- How can prevention be compatible with earning payments for curative care?

Based on responses to those questions, ask questions like the following to identify more specific areas for collaboration:

- How have the public and private sectors collaborated (formally or informally) in the past?
- How can we share costly diagnostic equipment?
- How can we ensure that all providers are using up-to-date methods?
- How can we ensure adequate quality of care for users of all services?
- Does the private sector serve target populations (extreme poor, rural populations, etc.) unserved or underserved by the public sector? If not, what would it take to serve these populations in the future?

Instead of, or in addition to, these questions, the engagement team might consider using strategic planning tools to help determine priority efforts:

- Use the *JLN PHC Technical Initiative's UHC-PHC Self-Assessment Tool* to assess how health insurance schemes or other financial coverage institutions interact with PHC actors and programs (including private sector) and identify opportunities for the health financing agency or other health financing policymakers to improve alignment with PHC goals and actors.
- Conduct a needs analysis, or contract an independent research firm to conduct the analysis, to understand private sector needs.



# STEP 05 ESTABLISH A REGULAR CONSULTATIVE PROCESS WITH JOINT AGENDA SETTING

## WHY ESTABLISH A REGULAR CONSULTATIVE PROCESS WITH JOINT AGENDA SETTING?

**ESTABLISHING A REGULAR CONSULTATIVE PROCESS with the private sector will reinforce and sustain collaboration between the public and private sectors.** Ensuring the process is practical for both sectors and includes collaborative agenda setting that reflects public and private sector interests will ensure that both sectors deem the partnership worthwhile. Like **STEP 4**, the regular consultative process will strengthen the cross-sector relationship, increasing the likelihood for a successful and sustained partnership.

## HOW TO ESTABLISH A REGULAR CONSULTATIVE PROCESS WITH JOINT AGENDA SETTING?

Many countries have protocols for regular joint meetings to discuss topics of shared interest, such as identifying ways to reduce the spread of communicable diseases and maternal deaths; these help to unite the sectors on a specific issue. The public sector might consider building on these meetings, or establishing a separate, regular consultative process.

The engagement team's first meeting with the private sector should focus on setting norms for the consultative process. These include decisions about meeting frequency, participation, structure, and where and when meetings should be held. The norms should reflect the needs of the group. **Box 7** lists core meeting principles that regular consultative processes should follow including meeting frequency and schedule, participants, location, and agenda.

BOX 7	<b>Core meeting principles that the regular consultative process should follow</b>
<ul style="list-style-type: none"> <li>• Meeting frequency determined by purpose</li> <li>• Regular participation by core members (e.g., relevant stakeholders, senior individuals with decision-making power, junior members to act on decisions)</li> <li>• Structured agenda set and agreed upon by all stakeholders</li> <li>• Meetings held:             <ul style="list-style-type: none"> <li>+ On nights or weekends (if likely to increase participation)</li> <li>+ With consistent dates and times</li> <li>+ With time limits on length</li> </ul> </li> </ul>	



BOX 8

## Case study: Engaging the private sector at the tertiary level in Tamil Nadu, India

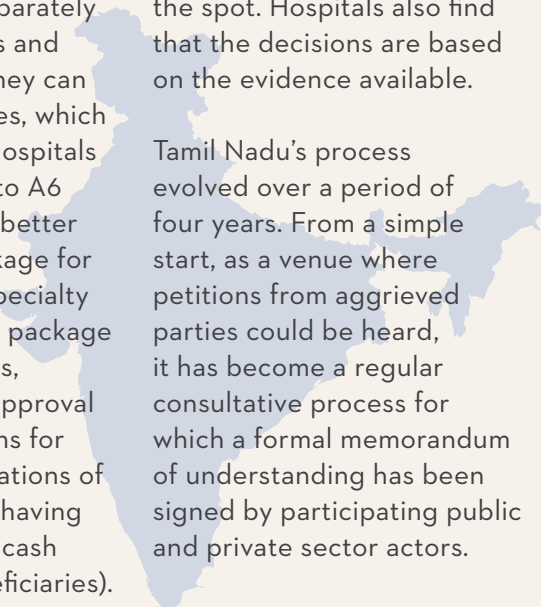
### Tamil Nadu holds weekly “grievance” meetings for private hospitals empanelled under the Chief Minister’s Health Insurance Scheme.

They are held every Monday at 3 p.m. IST at the Tamil Nadu Health System Project Office (TNHSP). Participants in the meetings are officials at the decision-making level from the three partners implementing the insurance scheme: government or TNHSP, the insurance actors, and the Third Party Administrator (TPA). With all three implementing partners at each meeting,

private hospitals find the meetings highly valuable. They do not need to wait to meet the officials separately at different locations and at different times. They can voice their grievances, which vary from grading (hospitals are graded from A1 to A6 with A1s receiving a better reimbursement package for the same service), specialty certifications, health package costs, pending claims, denied or reduced approval of claims, suspensions for negligence, and violations of scheme norms (e.g., having collected additional cash from insurance beneficiaries).

Attending hospitals are ensured of some practical solutions to the grievances on the spot. Hospitals also find that the decisions are based on the evidence available.

Tamil Nadu’s process evolved over a period of four years. From a simple start, as a venue where petitions from aggrieved parties could be heard, it has become a regular consultative process for which a formal memorandum of understanding has been signed by participating public and private sector actors.



Generally, the purpose of the meetings will determine their frequency. For example, in Ghana the private sector holds bi-monthly meetings at the national level to discuss policy issues related to public-private sector engagement. These meetings are also attended by public sector representatives including the Head of the Private Health Sector Unit at the MOH. During these meetings the group identifies topics to share at the National Health Sector Quarterly Business Meetings, which brings together all actors in the health sector. In contrast, in Tamil Nadu, India, public-private meetings on the day-to-day running of a hospital are held weekly (see [Box 8](#)). In Vietnam, MOH holds an annual national meeting with private health sector stakeholders to review and discuss a wide array of topics of interest to the public and private sectors, while Malaysia’s MOH shares information with private providers by email and virtually determines if they need to hold a meeting, and if so, when. In some places, meetings may be held frequently at first; once the main tasks have been completed, meetings might be held less frequently but often enough to maintain momentum.

Who participates is integral to the success of the consultative process. Participants are determined by the subject and purpose of the consultations. Regular participation by the same key stakeholders helps ensure progress and consistency. In Tamil Nadu ([Box 8](#)), meeting participants learned that having the same attendees – and particularly persons responsible for implementing any changes decided on at the meetings – is important to the success of the meetings. These persons should include both senior-level staff with significant decision-making authority and junior-level staff to help brief senior staff (who do not attend) and execute the next steps.

When deciding when and where meetings will be held, it is important to consider private provider schedules. For example, it might be most convenient for meetings to be held on weekends or evenings when private providers are not seeing patients. Meeting agendas and times should be limited to maintain focus and not take attendees away from other activities; regular meeting dates and times should be set and maintained; and agendas should be agreed upon and distributed before the meeting starts.

Public and private sector actors should develop a joint meeting agenda with shared goals. As has been noted, agenda items that are important to both the public and private sector, and represent easy, low-cost first areas for collaboration, can help sustain engagement. Public and private sectors should also determine the level of commitment necessary to achieve the goals and clarify this to stakeholders early in the collaboration to ensure that everyone has the same understanding of the partnership.

Finally, each meeting should identify important agenda items for future meetings; these should be:

- Important and high-priority issues for both parties;
- Discussed and mutually agreed upon issues and activities for collaboration (e.g., low-hanging fruit efforts)

To sustain the interest of the private sector in this dialogue, it is critical that the group identify opportunities early on for the private sector to increase its business and/or recognition.

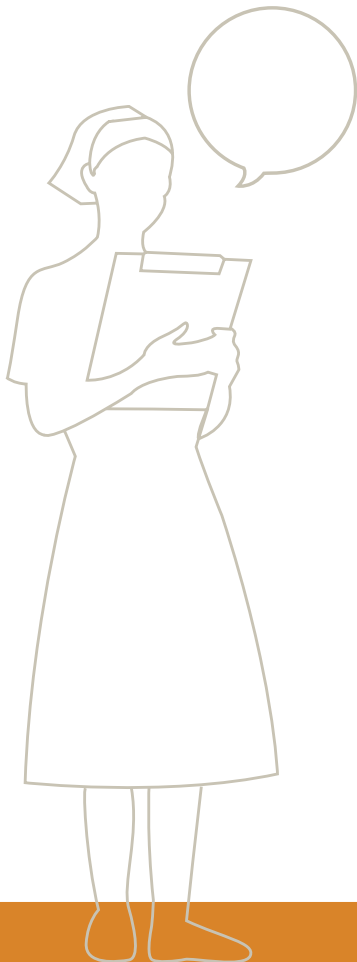
## MODULE 01 SUMMARY

**MODULE 1 HAS COVERED STEPS FOR initial public-private health sector engagement around PHC.** The advice provided is based on experiences and views shared by JLN PHC Technical Initiative country members, to help public sector engagement teams communicate effectively with the private sector. While the steps in this module are presented linearly, the process is iterative; certain steps might have to be repeated. Engagement teams adopting this manual may find themselves in the middle of the engagement process but having to go back and complete a missed step. A team also might consider some steps more important than others and thus focus on them more than on others. The engagement team can use the following Module 1 checklist to ensure successful initial engagement with the private sector, as well as the list of “dos” and “don’ts” reflective of this module.

# INITIAL COMMUNICATIONS AND PARTNERSHIP AROUND PHC

## CHECKLIST

- **PREPARE** for dialogue by conducting stakeholder analyses.
- **UNDERSTAND AND DETAIL** the rationale for public and private sectors to work together in PHC delivery.
- **ACTIVELY LISTEN** to the private sector.
- **FIND AREAS** of common ground, and agree on easy, low-cost first steps for collaboration to build trust.
- **ESTABLISH** a regular consultative process with joint agenda setting.



DO

- Form an “engagement team” or committee that can coordinate input from various public sector colleagues and lead the effort to engage the private sector on behalf of government.
- Start preparing right away to analyze stakeholders’ interests in public-private cooperation on PHC, and leverage existing stakeholder analysis tools to do so. Strategies to gain support from a changing array of stakeholders will be essential at every step.
- Be explicit and detailed about why the public sector wants to engage the private sector in PHC and, perhaps even more importantly, understand clearly why the private sector can be expected to engage with the public sector. Build on “low-hanging” common goals, while acknowledging areas of disagreement.
- Consider and validate the perspectives of the private sector.
- Choose a small, concrete issue to start working on with a few private sector parties sooner rather than later, such as data sharing or defining quality indicators. This is especially important where little precedent exists for public-private collaboration.
- Commit to a series of consultations or meetings with representatives of the private sector that take place at meeting times that are convenient for all.



DON'T

- Approach private providers as mere instruments to carry out the public sector’s will. Failing to identify shared goals and “win-wins” is a recipe for stalling and protest.
- Assume the public sector understands the private sector’s interests. For example, don’t assume the private sector is only interested in making more money.
- Let the *perfect* (comprehensive public-private agreement or dialogue platforms on strategy and means of cooperation for PHC) be the enemy of the *good* (start collaboration on smaller, shared, concrete needs, despite disagreement on other goals and policies).
- Confuse a few one-off stakeholder “meetings” with the ongoing process detailed in **STEP 3** and **STEP 5** of active listening, issue-tailored analysis, smart strategizing for how to work best with private providers, and establishing a regular consultative process.





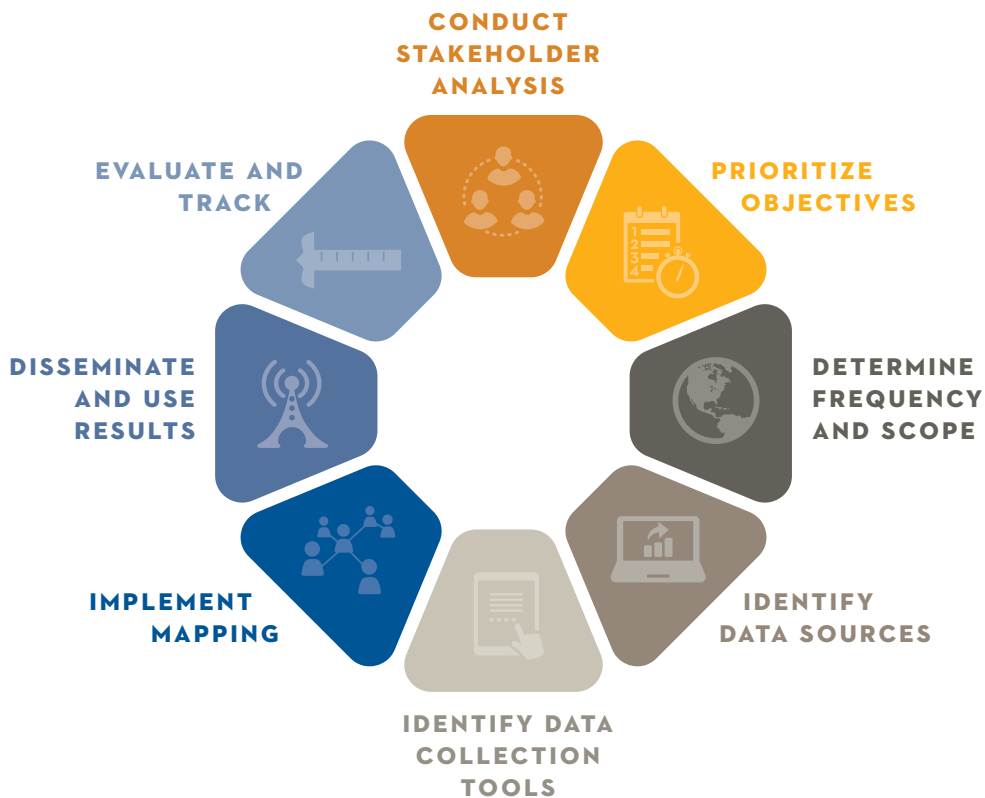
MODULE  
**02**

# PROVIDER MAPPING

**MODULE 2 IS ABOUT PROVIDER MAPPING. Provider mapping indicates where private providers are located and what services they provide.** Establishing a mutually beneficial partnership (the focus of [MODULE 1](#)) combined with mapping PHC providers sets the foundation for work with the private sector that can facilitate the processes of provider and facility regulation, accreditation, or empanelment; provider contracting and payment; and PHC systems monitoring and evaluation, which will be covered in three subsequent modules.

FIGURE 2

**Eight-step process for provider mapping**



## WHAT IS PROVIDER MAPPING?

Provider mapping usually describes the geographic location of providers, health facilities, and types of services provided. Often it is part of a broader resource mapping exercise that also covers equipment, supplies, and HRH. Depending on its objectives and funding, provider mapping may be a one-time exercise or an ongoing or recurrent process.

## WHY DO PROVIDER MAPPING?

Health care policymakers and planners often must make key decisions without having evidence to adequately inform those decisions. For example, they often lack information on the spatial distribution of health providers and facilities, especially private providers, and how the distribution relates to populations, sub-populations of interest (e.g., women of reproductive age, children), epidemiological patterns, health care needs, and sources of input supply and referral. In many countries, specific health-related data are collected by individual agencies for their own purposes; the data are not shared or compiled or widely available to inform decision making. Consequently, policymakers make key decisions “in the dark” and in ways that may be inefficient or even in conflict with key health goals.

Many countries, recognizing the need for data-based decisions, have conducted various types of provider mapping. Malaysia did provider mapping as part of a major system review, so that strategic decisions would be backed by facts about the spatial distribution of health system actors (see [Box 12](#)). Fifteen Pacific island countries mapped their HRH to resolve deficiencies in their human resources information systems (*University of New South Wales 2009*). The African Center for Global Health and Social Transformation (ACHEST) mapped health policy and strategy organizations in five African countries to examine how the organizations could work together to support health system stewardship and governance functions of their ministries of health (*ACHEST 2012*).

Provider mapping is appropriate in a variety of country conditions and situations, including when the country is trying to re-orient care towards PHC in order to achieve UHC. The mapping can identify PHC provider and facility spatial distribution compared to population catchment areas (and socioeconomic makeup of those areas) and provider and facility capacity to deliver comprehensive (preventive, promotive, and curative) PHC. The findings help countries determine how to provide comprehensive PHC to the entire population. For example, a mapping exercise might reveal gaps in geographic access to PHC for the poor due to a lack of public facilities in an area. At the same time it may show that the same area has private facilities that provide PHC

services but are unaffordable for the target population. In such a situation, policymakers could encourage the private facilities to join government-run health insurance schemes, thereby giving the target population both geographic and financial access. Similarly, if the exercise identifies facilities that lack capacity to provide comprehensive PHC, policymakers might expand capacity and quality at those facilities or they might restructure the local delivery system by networking facilities to provide comprehensive PHC. For example, Ghana's National Health Insurance Authority (NHIA) recently conducted a provider mapping exercise in regions where they will be rolling out capitation to determine which facilities will be able to provide the capitated packages of services and thus also act as the contracting entity for capitation (see [Box 13](#)).

Additionally, mapping of providers, linked to information on patient populations, demographic profiles, and other PHC resources, is useful for several reasons. It can inform planning of interventions for targeted populations at national and local levels, as well as decisions about locating new facilities and outsourcing services. It can also be useful for writing regulations for reporting and licensing; improving monitoring of standards and quality of services; evaluating change resulting from health interventions; contributing to epidemiological studies; managing risk; and informing strategic health marketing.

## HOW TO DO PROVIDER MAPPING?

Provider mapping consists of the eight-step process outlined in this module. The steps should be adapted to the specific country context – few countries will follow every step in exactly this sequence, and steps should be considered iterative. **BOX 13** walks readers through the entire process as it was implemented for a provider mapping exercise in Ghana.

This module refers to the implementers of a mapping exercise as the “mapping team.” The mapping team may be a subset of the engagement team (see DEFINITIONS and INTRODUCTION), or a separate public-sector group established to work with or on behalf of the engagement team.<sup>9</sup> Policymakers and planners are the primary users and consumers of the mapping exercise findings, but

other stakeholders will also find the information useful, including government agencies, local or international health partners, academic institutions, professional associations, and the private sector.

<sup>9</sup> In the event that the public sector entity does not have the capacity (time or skills) to conduct a provider mapping exercise, this module could be used as a terms of reference for contracting the work out.



# STEP 01 CONDUCT PROVIDER MAPPING-SPECIFIC STAKEHOLDER ANALYSIS

AS IN MODULE 1, THE FIRST RECOMMENDED step is to conduct a stakeholder analysis, this one specific to provider mapping. This is to ensure that: (1) there is financial and political support for the mapping, (2) financial resources can be mobilized for it, and (3) access to critical data can be obtained. MODULE 1, STEP 1 outlines a nine-step process for stakeholder analyses. Building on these nine steps, TABLE 4 and TABLE 5 provide more details to consider for a mapping-specific stakeholder analysis – including potential stakeholders and their interests in mapping, and types of providers and other organizations that are typically the primary and secondary foci of mapping exercises. A mapping-specific analysis should consider, and adjust to, stakeholder positions on the inputs required for and the outputs generated through the mapping, including which entities have what kind of access to the outputs and which entities will be most supportive and interested in the outputs.

In conducting a stakeholder analysis, it is advisable to produce a draft concept paper that details the provider mapping process and that can be shared and used to guide discussions with stakeholders. This concept paper should include all steps planned for the mapping, including dissemination of the findings. Sample contents of a

mapping concept paper are listed in Box 9. If time does not allow for drafting and discussing a concept paper, even a rapid analysis of a small number of key stakeholders will be useful and better than no analysis at all.

BOX 9

### Contents of a mapping concept paper for stakeholder analysis

**The following items might be considered for inclusion in a concept paper for provider mapping:**

- Purpose and objectives of mapping in the specific country context
- Frequency planned for mapping (one-off, repeated at specific intervals)
- Expected access to data
- Expected outputs of mapping
- Roles of participating agencies and units in the mapping, including the institutional home for the mapping
- Cost and sources of financing for the mapping
- Benefits of mapping to different stakeholder groups
- Logistics of conducting the mapping
- Dissemination of mapping findings

TABLE 4

## Common key stakeholder interests in provider mapping

STAKEHOLDER	ILLUSTRATIVE INTERESTS IN MAPPING
POLICYMAKERS	<ul style="list-style-type: none"> <li>• Advancing health system goals while supporting political imperatives of the government</li> <li>• Making strategic decisions concerning new initiatives (e.g., what investments to propose, such as new facilities, new equipment, new staffing)</li> <li>• Tracking changes in supply (from mapping) and demand (from other sources) for services over time</li> </ul>
NATIONAL HEALTH PLANNERS	<ul style="list-style-type: none"> <li>• Improving health, access, and quality, while minimizing costs and financial risks to the government</li> <li>• Proposing/planning for new providers to expand access</li> <li>• Proposing changes in services offered by providers (new equipment, new types of personnel) for quality improvement or cost containment</li> <li>• Proposing public-private partnerships (e.g., sharing of diagnostic equipment)</li> <li>• Tracking changes in supply of services over time</li> <li>• Matching services to epidemiological information</li> </ul>
SUB-NATIONAL HEALTH PLANNERS	<ul style="list-style-type: none"> <li>• Same as national planners, but with a sub-national focus</li> </ul>
EPIDEMIOLOGISTS AND OTHER RESEARCHERS	<ul style="list-style-type: none"> <li>• Expanding volume, quality, and accessibility of data for research and publications</li> <li>• Matching epidemiological information to service supply</li> <li>• Expanding potential of service providers to respond to disease outbreaks or disasters</li> <li>• Doing analyses of health markets</li> <li>• Informing sampling frames for surveys of providers</li> </ul>
PUBLIC AND PRIVATE INSURERS	<ul style="list-style-type: none"> <li>• Maintaining or increasing enrollment while minimizing costs</li> <li>• Expanding coverage of insured populations by service supply</li> <li>• Accrediting or empaneling a sufficient quantity of quality providers to meet demand</li> </ul>
PRIVATE SUPPLIERS OF INPUTS, REPAIRS, AND MAINTENANCE <i>(inputs include medications, supplies, contraceptives, equipment)</i>	<ul style="list-style-type: none"> <li>• Locating potential markets for their products and services</li> </ul>
HEALTH SECTOR PROFESSIONAL BODIES <i>(for example, the national association of midwives)</i>	<ul style="list-style-type: none"> <li>• Advocating for professional development and compensation of members, as well as investment in the health sector</li> <li>• Locating potential new members</li> <li>• Developing provider networks for referral</li> </ul>
CONSUMERS/CLIENTS	<ul style="list-style-type: none"> <li>• Advocating for improved services, infrastructure, and quality of care</li> <li>• Making informed choices about where to obtain health care</li> </ul>
FOR-PROFIT COMPANIES	<ul style="list-style-type: none"> <li>• Identifying providers to sell information to pharmaceutical companies</li> </ul>

TABLE 5

## Illustrative lists of health providers and other organizations to consider in a mapping-specific stakeholder analysis

### PRIMARY FOCUS FOR MAPPING: *PHC providers*

- Physicians
- Nursing personnel and associations
- Midwifery personnel and associations
- Dentists
- Dental technicians/assistants
- Pharmacists
- Pharmaceutical technicians/assistants
- Laboratory scientists
- Laboratory technicians/assistants
- Radiographers
- Environmental health workers
- Public health workers
- Community health workers
- Medical assistants
- Personal care workers
- Other health workers
- Health management workers
- Traditional and complementary practitioners
- Occupational health services

*Source: Hensey 2012*

### SECONDARY FOCUS FOR MAPPING: *other agencies and organizations that affect PHC*

- Hospitals, emergency medical services, rural health, community health, midwife and birth centers
- Mental health facilities, substance and alcohol abuse services
- Insurance providers, employer health benefits/services
- Chiropractic services
- Linkages to facilities outside county (regional-state)
- School health services
- Pharmacies (retail and wholesale), X-ray, other diagnostic services (e.g., scanners), laboratory services, medical/health transportation, medical and health equipment suppliers (including spare parts and maintenance services)
- Nursing, medical, dental, and related school services
- Institutional health
- Dental providers
- Nursing homes, adult homes, health and respite care
- Volunteer/private medical centers, free clinics and pharmacies
- Foundations (national, state and local)
- Pre-service training institutions
- Research units



## STEP 02 PRIORITIZE OBJECTIVES

IT IS IMPORTANT TO PRIORITIZE THE OBJECTIVES of provider mapping to ensure that the most important objectives are met if resources and time are limited. The prioritization process will, as an extension of **STEP 1**, involve negotiation with and among stakeholders who may have competing interests in the provider mapping. It often is helpful to classify all possible objectives as primary (high-priority, essential) and secondary (lower-priority, useful if resources permit). Even after determining the highest-priority objectives, it is important to consider the costs of and time needed to implement a provider mapping – implementers may have to adjust their methodology or priorities based on costs and timeline. Stakeholder analysis should also obtain and adapt to stakeholders’ positions on mapping objectives. **TABLE 6** and **BOX 10** give examples of countries’ mappings and objectives and a typical list of key questions to answer. Often the “where are the providers” objective is of highest priority.

BOX 10	Questions the provider mapping might answer		
<ul style="list-style-type: none"> <li>• <b>Where are the providers?</b> Can produce a report with GIS interactive mapping of the location of provider and related facilities, indicating distances between them, zoning, and area characteristics (e.g., urban-rural)</li> <li>• <b>What services are delivered, what HRH are employed, and what equipment is available?</b> What is the service package offered by each facility and how does it compare with a desired service package, service, and resource mapping for optimal use and potential for sharing across facilities?</li> </ul>	<ul style="list-style-type: none"> <li>• <b>What is the capacity of providers to deliver priority health services (actual and potential)?</b> Determine actual capacity and needs for capacity building and training, and possibilities for service outsourcing.</li> <li>• <b>What is the status of registration, licensing, and accreditation of the facilities mapped?</b> To what extent are the facilities meeting professional standards and legal requirements?</li> </ul>	<ul style="list-style-type: none"> <li>• <b>What are the financing options?</b> Are facilities eligible for receiving reimbursements from a national health insurance scheme in addition to OOP payments?</li> <li>• <b>What are the quality and safety levels of delivered health services?</b> Do the facilities meet standards of clinical practice, and do they use standard protocols?</li> </ul> <p style="text-align: right;"><i>continued</i></p>	

- **What are the referral relationships with other providers, both public and private?**

Map formal and informal networks and public-private partnerships in service delivery to examine continuity and access to care.

- **What are the sources of supplies?**

What are the sources of input supplies (e.g., medications, reagents, equipment, parts, maintenance, outsourced diagnostics, etc.) used and available to providers? Are

the supplies paid for at market prices or available at subsidized prices? Are the sources centralized or local? What transportation is needed to obtain the supplies, or are they delivered to the providers?

- **What is the socioeconomic status of facilities' clientele?**

What is the population in the vicinity of the providers? What are the targeted populations (e.g., women of reproductive age, children, elderly, and people below the poverty line)? What is

the morbidity pattern? Socioeconomic status? Financial (insurance) coverage?

- **What community links to the facilities exist, and do the facilities participate in any community activities?**

Are there organized forms of community participation (e.g., village or neighborhood health committees)? Outreach programs? Community health workers?





TABLE 6

**Primary objectives of example mapping exercises**

MAPPING EFFORT	PRIMARY OBJECTIVE
MALAYSIA	Spatial location of public and private providers to inform design of a health system review
PACIFIC ISLAND COUNTRIES	Location of HRH
FIVE AFRICAN COUNTRIES	Existence, functions, and characteristics of policy and strategy organizations in each country
GHANA MINISTRY OF HEALTH, GHANA NATIONAL HEALTH INSURANCE AUTHORITY, AND GHANA HEALTH SERVICES	Locations and capacities of providers to deliver (or form networks to deliver) a package of PHC services under a new capitation payment mechanism
GHANA PRIVATE SECTOR ASSESSMENT	Spatial location of private and public providers
VIETNAM	Spatial location and size of hospitals, compared to the socioeconomic status of the catchment area
BAHRAIN	Supply-side readiness of health service delivery infrastructure to respond to insurance implementation; business capacity to transact with outside insurance



# STEP 03 DETERMINE FREQUENCY AND GEOGRAPHIC SCOPE OF MAPPING

PLANNERS SHOULD NEXT DETERMINE the estimated frequency and geographic scope of a mapping exercise (or exercises), considering prioritized objectives, costs, and timeframe.

## 03

### SHOULD THIS BE A ONE-TIME MAPPING OR ROUTINE?

Some mappings are one-time activities for a particular purpose at one point in time. Others are done at regular intervals to keep information updated. One advantage of a one-time mapping is its one-time cost. But to be able to follow trends in health care provision and need, it might be important to repeat the mapping at regular intervals. To minimize costs, follow-up mapping could be focused on high-priority items rather than all aspects of the initial mapping.

For example, a country could do a one-time geographic mapping of all facilities, and at the same time institutionalize a protocol for follow-up mapping to add new or newly approved facilities and to remove closed facilities.

If a country has experienced population shifts – out- or in-migration, changes in the socioeconomic profile of particular regions or districts – it could conduct provider mapping in only those areas to better understand provider changes in response to the population trends there.

Deciding before any mapping is done to make the mapping one-off or repeated (and how frequently) is important. It will allow the organization doing the mapping to obtain data sets one time or to set up a process to obtain data at the specified intervals. It also will signal if funding for the mapping needs to be found once or if mapping should be made a regular line item in the budget.

### SHOULD THE MAPPING COVER THE WHOLE COUNTRY OR SPECIFIC COUNTRY REGIONS OR DISTRICTS?

In addition to frequency, it is important to identify the geographic scope of a mapping exercise. In some cases, a nationwide provider mapping is needed, while in other cases it is not. For example, if a specific intervention is being implemented in a subset of country regions, the mapping may only need to cover those regions. Ghana’s NHIA conducted provider mappings in regions where capitation is being rolled out to better understand facility capacity

for receiving capitated payments and providing all the care included in the capitated package (see [Box 13](#) for more details). Also in Ghana, an IFC-supported private sector assessment included mapping a seven-district sample to gain an understanding of private provider characteristics. The survey team recommended that Ghana’s MOH periodically re-survey providers in a subset of districts to track trends in the development of the private sector.



STEP  
**04**

**IDENTIFY EXISTING DATA SOURCES**

TO AVOID DUPLICATION OF EFFORT and to keep costs low, it is wise to identify sources of secondary data that can inform the mapping exercise. This minimizes the need to do costly primary data collection. **TABLE 7** lists some potential sources of existing data. After identifying potential existing sources of data, the mapping team must evaluate the extent to which the secondary data satisfy the mapping objectives; they may have to balance the utility of the secondary data against the cost of collecting new data. If primary data collection is needed, the mapping team will need to identify and consider different data collection tools and processes for collecting the data, as discussed in **STEP 5**.

TABLE 7		Potential sources of secondary data
DATA TYPE	DATA SOURCE	
SPATIAL DISTRIBUTION OF PROVIDERS AND RELATED UNITS	Ministry of Commerce or local governments that oversee and register private businesses (for private providers and related units only); MOH	
EQUIPMENT AND SUPPLIES OF PROVIDERS	Equipment sellers' sales records; facility registration data; pharmaceutical industry	
HRH	MOH or Ministry of Civil Service payroll (public sector HRH only); professional associations of health workers	
EPIDEMIOLOGICAL DATA	Epidemiological unit of the MOH or disease control agency; Demographic and Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS) data; electronic medical records; health insurance claims data	
POPULATION DATA	Statistics office; census bureau; local governments	
SOCIOECONOMIC STATUS DATA	Living standards household surveys; poverty mapping surveys	
HEALTH INSURANCE COVERAGE	Health insurer membership databases	
UTILIZATION DATA	Health management information systems	
ROADS AND MEANS OF TRANSPORT	Ministry of Transport	

*Note: Data may be available at a cost from private companies that collect the data for profit. However, private entities may be reluctant to share proprietary information, and it is worth noting that private sector data may be biased toward urban markets.*



# STEP 05 IDENTIFY DATA COLLECTION TOOLS AND ALIGN WITH ICT CONSIDERATIONS

**ONCE THE MAPPING TEAM HAS DECIDED what secondary data can be used for the mapping and what primary data need to be collected, it should identify and evaluate tools available for the data collection.** The team should consider the functions and limitations of each tool identified (such as interoperability with existing health management information systems), the associated financial costs (initial investment costs and the amount needed over time), and the time needed to train, modify, and use the tool. For example, the mapping team might consider the tools’ spatial location functionality/ Geographic Information System (GIS), as this can be particularly helpful for identifying and mapping the locations of private providers. (See **BOX 11** for uses of GIS mapping software.) Next, the team can compare these functions and limitations and evaluate the advantages and disadvantages (particularly with respect to outcome) of each tool.

TABLE 8 lists some existing “global” data collection tools that could be used in mapping exercises, along with their objectives, functions, and limitations. All the tools listed are open source, and some have spatial location functionality/ GIS. As noted in the table, a challenge that mapping teams encounter in trying to use these tools is the absence of a master provider list or census to survey – many developing countries do not have such a list, so mapping teams need

to first conduct a census as part of their data collection. For example, researchers assessing the quality of public and private health care in Madhya Pradesh, India, had to first develop a list of all providers in the health care market in the villages in their sample (*Das et al. 2015*). They did this by conducting a household census asking respondents for the names and locations of all providers from whom they had sought primary care in the previous 30 days.

BOX 11

**GIS mapping software**

**Some GIS mapping software is designed specifically for health care mapping and enables users to enter data about health facilities, health care provider personnel, and at-risk populations.**



**It can also be used to:**

- Map specific health variables
  - Understand the overall health and morbidity of a population
  - Look for clustering or locally elevated risks
  - Analyze health care coverage to identify gaps and inefficiencies
  - Examine patterns of health care utilization and/or access to care
- Match a network of health care specialists and providers to the needs of the population
  - Help to locate and select health care providers
  - Choose optimal locations for new hospitals and outpatient clinics
  - Deliver in-home services more efficiently

Source: *GIS Mapping Software for Health Care, public health and epidemiology* <http://www.caliper.com/Maptitude/PublicHealth>

TABLE 9 shows several tools used in actual country mapping exercises and summarizes their content, methods, strengths, and weaknesses. Using these tools, countries can assess: (1) the ability of a health system to deliver the full set of services, (2) the quality of health services, (3) the performance or achievements of the health system, and (4) the quality of data reporting.

Additional examples of GIS used for health system mapping are found in:

- Eastern Indonesia, where global positioning system (GPS)-enabled personal digital assistant phones were used to conduct rapid field collection of health infrastructure data; open-source GIS software was used to map health indicators; and a free modeling tool was used to assess and map service availability (*Fisher and Myers 2011*).
- Malaysia, where the MOH commissioned a provider mapping using GIS. There is more information about Malaysia's use of GIS in the discussion of STEP 6; details of the mapping exercise are in BOX 12 and visualizations created based on mapping findings are in FIGURE 3.

TABLE 8

## Global tools used in country provider mapping exercises

TOOL NAME	OBJECTIVES	
<p><b>SERVICE DELIVERY INDICATORS (SDI) SURVEY</b></p> <p><i>(WORLD BANK 2013)</i></p>	<ul style="list-style-type: none"> <li>• Provide decision makers with citizen perspectives about health service performance and quality</li> <li>• Track progress over time and hold public accountable for public spending</li> </ul>	
<p><b>PRIMARY CARE ASSESSMENT TOOLS (PCAT)</b></p> <p><i>(JOHNS HOPKINS UNIVERSITY)</i> <i>(SHI ET AL. 2011; STARFIELD 2011)</i></p>	<ul style="list-style-type: none"> <li>• Assess PHC achievements from point of view of community, patients, and health professionals and managers</li> </ul>	

HOW TOOL FUNCTIONS	LIMITATIONS
<ul style="list-style-type: none"> <li>• SDI surveys are conducted at schools and health facilities across Africa to measure the performance and quality of services. SDI implementation also builds the capacity of local organizations in research, policy, and analysis, as well as in communication of the information.</li> <li>• The SDI Initiative is a partnership of the World Bank, the African Economic Research Consortium, and the African Development Bank. The World Bank is the implementing partner of this Initiative for the first five years of this 10-year program that started in 2012.</li> <li>• The SDI Initiative collects and analyzes new data every two years in each country involved. Thus far, it has collected data in Kenya, Mozambique, Niger, Nigeria, Senegal, Tanzania, Togo, and Uganda.</li> <li>• Surveys are standardized, allowing for data comparison across countries as well as across country regions.</li> <li>• The tool measures:             <ul style="list-style-type: none"> <li>• Provider competence and knowledge (e.g., adherence to clinical guidelines), including consumer/citizen opinions and inputs</li> <li>• Proxies for effort (e.g., case load per clinician)</li> <li>• Availability of key infrastructure and inputs (e.g., medicines, equipment)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Data are subjective and rely in part on respondent views, making them subject to bias.</li> </ul>
<ul style="list-style-type: none"> <li>• The tool contains the following instruments:             <ul style="list-style-type: none"> <li>• Consumer-client surveys</li> <li>• Facility surveys</li> <li>• Provider surveys</li> <li>• Health system survey</li> </ul> </li> <li>• The tool also includes a manual to help researchers administer the surveys.</li> <li>• The surveys collect data on both structural and process elements of PHC including:             <ul style="list-style-type: none"> <li>• Accessibility; range of services; definition of patient population and/or patient characteristics; patient-provider perspectives on the experiences of care received; continuity of care; utilization; and health problem recognition.</li> </ul> </li> <li>• These surveys have been implemented in Brazil, Canada, China, Spain, South Korea, Taiwan, and the United States.</li> </ul>	<ul style="list-style-type: none"> <li>• The questionnaire is long and therefore potentially burdensome to respondents leading to incomplete responses.</li> <li>• Based on self-reporting, which is subject to recall bias.</li> </ul>

*continued*

TABLE 8

Continued

TOOL NAME	OBJECTIVES	
<p><b>SERVICE AVAILABILITY AND READINESS ASSESSMENT (SARA)</b></p> <p><i>(WHO 2015)</i></p>	<ul style="list-style-type: none"> <li>• Assess and monitor the service availability and readiness of facilities that in aggregate show the readiness of the health sector</li> <li>• Generate reliable and regular evidence to support the planning and managing of a health system</li> </ul>	
<p><b>SERVICE PROVISION ASSESSMENT (SPA)</b></p> <p><i>(DEMOGRAPHIC AND HEALTH SURVEY 2016)</i></p>	<ul style="list-style-type: none"> <li>• Assess and monitor the overall availability of different facility-based health services in a country and their readiness to provide those services</li> </ul>	
<p><b>DATA QUALITY REPORT CARD (DQRC)</b></p> <p><i>(WHO N.D.)</i></p>	<ul style="list-style-type: none"> <li>• Ensure systematic assessment of completeness and internal and external consistency of health system reported data and intervention coverage rates and identifies data quality problems that need to be addressed</li> </ul>	

Note: [Table 8](#) lists open source tools available to the public at no cost. Policymakers may also wish to consider proprietary tools, which often have more advanced functionalities, are upgraded more frequently, and may include technical support resources, albeit at a higher financial cost.



HOW TOOL FUNCTIONS	LIMITATIONS
<ul style="list-style-type: none"> <li>• SARA is used to generate a set of tracer indicators of service availability and readiness.</li> <li>• The tool examines:               <ul style="list-style-type: none"> <li>• Service delivery</li> <li>• Availability of basic equipment, basic amenities, essential medicines, and diagnostic capacities</li> <li>• Readiness of health facilities to provide basic health care relating to family planning, child health, basic and comprehensive emergency obstetric care, HIV, tuberculosis, malaria, and non-communicable diseases</li> </ul> </li> <li>• Has been implemented in Albania, Benin, Burkina Faso, Ghana, Honduras, Kenya, Mauritania, Rwanda, Togo, Uganda, Tanzania, Sierra Leone, and Zambia among other locations.</li> </ul>	<ul style="list-style-type: none"> <li>• Survey success depends in part on the existence of a master facility list, which SARA uses to draw a sample of facilities. Many countries do not have a “master list” of facilities, particularly of private ones. However, not having a “master list” does not mean that SARA cannot be used, but rather, that some form of list must be created as a part of the process.</li> </ul>
<ul style="list-style-type: none"> <li>• SPAs are surveys that include facility inventory, observation protocols, client exit interviews, and health worker interviews.</li> <li>• The tool examines:               <ul style="list-style-type: none"> <li>• Availability of different health services in a country</li> <li>• The extent to which facilities are prepared to provide health services: infrastructure, resources, and support systems available</li> <li>• The extent to which the service delivery process follows generally accepted standards of care</li> <li>• The extent to which clients and service providers are satisfied with the service delivery environment</li> </ul> </li> <li>• Has been implemented in 15 countries, most recently in Ethiopia, Haiti, Kenya, Malawi, Nepal, Senegal, and Tanzania.</li> </ul>	<ul style="list-style-type: none"> <li>• Survey success depends in part on the existence of a master facility list, which SPA uses to draw a sample of facilities. Many countries do not have a “master list” of facilities, particularly of private ones. However, not having a “master list” does not mean that SPA cannot be used, but rather, that some form of a list must be created as part of the process.</li> </ul>
<ul style="list-style-type: none"> <li>• The tool has two components: (1) a desk review to assess quality of health facility data, and (2) a data verification component.</li> <li>• Desk review uses WHO’s Data Quality Assessment (DQA) Tool, an Excel-based tool, to assess the quality of health facility data and looks at four core tracer indicators: antenatal care first visit, facility deliveries, DTP3, and outpatient department visits</li> <li>• The data verification component:               <ul style="list-style-type: none"> <li>• Compares health facility records to health information system reported data</li> <li>• Should be implemented alongside SARA</li> </ul> </li> <li>• Has been used in Cambodia and Uganda, among other countries.</li> </ul>	<ul style="list-style-type: none"> <li>• Needs WHO DQA Tool to complete assessment <i>(Chen et al. 2014).</i></li> </ul>

TABLE 9

## Country-specific tools used in provider mapping exercises

TOOL	MAPPING TIME	CONTENT AREAS COVERED
<b>TOOL TO ASSESS FACILITY-LEVEL READINESS IN BAHRAIN</b>	2 months (total)	<p><b>Health infrastructure</b></p> <ul style="list-style-type: none"> <li>• Location/GIS/GPS coordinates</li> <li>• Number of consulting rooms and beds</li> <li>• Facility ownership</li> <li>• Doctor information (number of physicians by specialty and availability)</li> <li>• Service availability (emergency, maternal, operation theaters, pharmacy, diagnostic by type)</li> <li>• Inpatient and outpatient data (including number of referrals, bed occupancy)</li> </ul> <p><b>Business functions</b></p> <ul style="list-style-type: none"> <li>• Information systems (coding, costing, contracting, clinical/financial management)</li> </ul> <p><b>Decision rights</b></p> <ul style="list-style-type: none"> <li>• Autonomy over HRH, budget allocation, retention of earnings, market exposure</li> </ul>
<b>TOOL FOR GIS MAPPING OF HEALTH FACILITIES AND THEIR ATTRIBUTES IN UTTARAKHAND, INDIA<sup>10</sup></b>	3-4 months (total)	<ul style="list-style-type: none"> <li>• Location/GIS coordinates</li> <li>• Facility type, staffing figures</li> <li>• Accreditation/empanelment</li> <li>• Doctor info (including specialization and availability)</li> <li>• Specialty and diagnostic procedures available and “functional”</li> <li>• Inpatient and outpatient data (including fees)</li> <li>• Patient referral information/transportation</li> <li>• General infrastructure and electricity data</li> </ul>

<sup>10</sup> Cost of mapping 1,500 facilities across the state was approximately US\$25,000 for the survey agency alone (excluding costs for developing the tool, monitoring, and analytics). Costing data for the other tools were not available.

METHODS	STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> <li>Self-administered by hospitals after being distributed through the MOH</li> </ul>	<ul style="list-style-type: none"> <li>Short, quick, easy to administer</li> <li>Cheaper to administer than other mapping tools</li> <li>Also assessed readiness for reform and autonomy level (therefore adding questions well beyond the usual SARA-style assessment)</li> </ul>	<ul style="list-style-type: none"> <li>Missing responses from hospitals due to self-administration and limited follow-up by MOH</li> <li>Purpose limited based on identified use</li> <li>Potentially useful information for the future not collected</li> </ul>
<ul style="list-style-type: none"> <li>Administered through a survey agency</li> <li>Sent teams into field with existing administrative and field research data for a better idea of where to find facilities</li> </ul>	<ul style="list-style-type: none"> <li>Short, quick, easy to administer</li> <li>Only questions that were “absolutely essential” were covered</li> </ul>	<ul style="list-style-type: none"> <li>May have missed some newer or unknown facilities</li> <li>Purpose was limited based on use identified</li> <li>Potentially useful information for the future not collected</li> </ul>

*continued*

TABLE 9

**Continued**

TOOL	MAPPING TIME	CONTENT AREAS COVERED	
<b>KENYA MASTER HEALTH FACILITY LIST</b>	N/A	<ul style="list-style-type: none"> <li>• Unique identifiers for each facility</li> <li>• Location/GPS coordinates</li> <li>• Facility type and ownership</li> <li>• Number of beds</li> <li>• Available services (e.g., HIV testing)</li> <li>• Information on hours of operation</li> </ul>	
<b>NIGERIA MASTER HEALTH FACILITY LIST</b>	N/A	<ul style="list-style-type: none"> <li>• Unique identifiers for each facility incorporating state code, local government areas (LGA) code, facility type and ownership</li> </ul>	

METHODS	STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> <li>• Created Master Facility Working Group: MOH, local research institutions, and international partners</li> <li>• Examined existing facility lists</li> <li>• Derived primarily from national distribution of antimalarial and antiretroviral commodities since 2006 (NOOR ET AL. 2009).</li> <li>• Verified by two USAID projects and later District Health Management Teams</li> <li>• Used GPS-mapped providers</li> </ul>	<ul style="list-style-type: none"> <li>• Draws from existing mapping information</li> <li>• Unique identifiers for each facility lowers updating costs, prevents duplication/omission of facilities</li> <li>• Prerequisite for more detailed assessments (e.g., SARA tool)</li> </ul>	<ul style="list-style-type: none"> <li>• Does not provide as much information as other mapping exercises</li> </ul>
<ul style="list-style-type: none"> <li>• Consultations held on how to develop a national provider identifier</li> <li>• Bottom-top facility collation approach: states compiled and sent comprehensive list to MOH</li> <li>• Done in template that already had state and LGA codes</li> </ul>	<ul style="list-style-type: none"> <li>• Draws from existing mapping information</li> <li>• Unique identifiers for each facility lowers updating costs, prevents duplication/omission of facilities</li> <li>• Prerequisite for more detailed assessments (e.g., SARA tool)</li> </ul>	<ul style="list-style-type: none"> <li>• Provides minimal information beyond location and level of facility</li> <li>• Additional information needed for meaningful analysis and/or planning</li> </ul>

STEP  
06

## IMPLEMENT PROVIDER MAPPING

THE IMPLEMENTATION STAGE OF PROVIDER MAPPING will differ for each country, according to the purpose set out by mapping stakeholders, available data, and other characteristics.

The following are four implementation steps that are likely to be required or useful for a variety of implementation contexts:

**Form an implementation team** that fulfills the distinct roles and responsibilities for mapping. In addition to health sector agencies, implementation teams might include representatives from national statistics and research institutions—[APPENDIX C](#) describes one such collaboration in Sudan. Likely roles include:

- Stakeholder outreach and communications (see [STEP 1](#));
- Research design to match mapping’s objectives (see [STEP 2](#) and [STEP 3](#));
- Alignment of research design with existing or planned ICT infrastructure and norms and logistics (see [STEP 4](#) and [STEP 5](#));
- Data collection and analysis (see [STEP 4](#) and [STEP 5](#));
- Drafting of final reports and presentations (see [STEP 7](#)); and
- Final dissemination of results (see [STEP 7](#)).

During this stage, the mapping team should decide whether team members will: (1) conduct tasks themselves, (2) contract out to consultants for certain tasks, or (3) rely on non-team members to integrate tasks into their regular duties (e.g., tasking a facility manager to collect and report data independently).

**Create an implementation plan** listing major tasks, assignment of responsibilities, and timeline. This step is critical for effective execution of the provider mapping exercise.

**Conduct data collection.** Specific tasks might include aggregating secondary data, collecting primary data, entering information into a database, as well as processing and cleaning the data.

**Analyze data and synthesize findings**, including development of data visualizations for dissemination. As part of this analysis, the mapping team should consider whether the objectives of the mapping have been met.

[BOX 12](#) details Malaysia’s provider mapping exercise including objectives, implementation experience, findings, implications, and some limitations and challenges of provider mapping. The description provides implementers with a practical and real-life implementation example.

FIGURE 3

## Provider mapping visualizations from Malaysia



HEALTH FACILITIES	TOTAL		
	TOTAL	LOCATED	%
Government (MOH) Hospital	132	132	100.0
Other Gov. (Non MOH) Hospital	7	7	100.0
Special Medical Institution	18	18	100.0
Private Hospital	215	215	100.0
Maternity Centre	23	23	100.0
Government Health Clinic	879	879	100.0
Government Dental Clinic (Standalone)	51	51	100.0
MCH Clinic	105	105	100.0
Rural Clinic (Klinik Desa)	1864	1864	100.0
Malaysia Clinic	234	234	100.0
Private Clinic	6621	6621	100.0
Private Dental Clinic	1606	1606	100.0
State Health Office	15	15	100.0
District Health Office	141	141	100.0
Hospital Day-care (Government)	58	58	100.0
Ambulatory Care (Private)	28	28	100.0
Blood Centre	6	6	100.0
Pharmacy Centre	1740	1740	100.0
Traditional & Complementary Medicine	337	337	100.0
Dialysis Centre (Gov., Private & NGO)	387	387	100.0
Radiology	26	26	100.0
Nursing Home (Private)	16	16	100.0
Medical Lab (Private)	143	143	100.0
Rehabilitation Centre (Private)	24	24	100.0
<b>Total</b>	<b>14676</b>	<b>14676</b>	<b>100.0</b>

## STATEMENT OF THE PROBLEM

**Primary care in Malaysia is provided in both the public and private sectors, with differences in types of services, provider capacity, physical setting, and geographic distribution between the two sectors. In its health system review, Malaysia recognized that the two sectors providing primary care services in partnership will make for more efficient use of health resources, and improve access to towards PHC to achieve UHC.**

## OBJECTIVES OF PROVIDER MAPPING

1. Determine where health care providers are located in the country, especially private sector providers, and
2. Provide evidence for policy making and health planning, including better integrating private providers into delivery of PHC.

## IMPLEMENTATION OF PROVIDER MAPPING

The MOH conducted a provider mapping exercise using GIS technology to establish a spatial database of the existing health facilities inclusive of provider profiles and available services nationwide. Malaysia's mapping included an implementation team of 10 researchers from the Institute of Public Health, Malaysia. The mapping was funded by UNDP, and cost approximately US\$150,000 including the cost of training the 10 researchers, consultancy fees, allowances, travel costs, the purchase of required GIS software and ICT hardware (one server, four workstations, and four computers). The mapping process, initiated in 2011, was completed within two years.

Malaysia's provider mapping work plan comprised the following steps:

1. Identification of sources and relevant agencies for primary and secondary data
2. Collection of two types of data:
  - Spatial data for the health care facilities coordinates were located via GPS and handheld and digital maps were obtained from the Malaysia Centre for Geospatial Data Infrastructure.
  - Non-spatial data on topography information, population profile, and health care profiles (facilities, providers, and services):
    - Population profiles were collected from the most recent census data for population characteristic and from the Department of Statistics for density by district.
    - Information on health care facilities, providers, and services was obtained from public and private providers themselves using a self-administered questionnaire.
3. Data entry, processing, and editing using ArcGIS 10.0 software single-user license, Microsoft Excel, and World Geodetic System
4. Verification and validation
5. Data analysis using ArcGIS 10.0 software
6. Development of user-friendly application



7. Specification/definition of outputs including:

- Interactive digital Map of Health Facilities, a database for each type of health facilities using ArcView 10.x software. The map has four modules that allow users to view, search, analyze, and use several tools to produce tables, graphs, and maps that can be stored and printed (see **FIGURE 3** for examples). This digital map shows: distribution of health facilities by state and district; distribution of services available in health facilities; and distribution of health providers.
- Coverage area of health facilities by population; database for health facilities containing a unique ID linked with the GIS spatial data including contact information and services.

8. Stakeholder engagement and feedback

9. Dissemination

10. Updating data and maintaining the system

PHC providers will be encouraged for more efficient use of health resources in urban area.

**LIMITATIONS AND CHALLENGES**

- More complete health provider and service profile data, especially from the private sector, are crucial to improve validity and reliability of the mapping process. It was challenging for the MOH to get data from private providers when there was no perceived incentive for private providers to participate in this mapping. Early engagement at the planning stage and letting private providers know what they could expect in return for their investment may increase their participation in future.
- Accuracy of the GIS data. Verification of location points, calibration of GPS apparatus, technical knowledge on how to handle GPS, strength of satellite signals, and selection of a base map could affect the accuracy of the collected data. Adjustment or validation is always needed.
- Maintenance of the GIS database. The database must be updated and feedback needs to be managed appropriately. Thus, any staff member who is assigned to this job must have sufficient knowledge of GIS database management.

**FINDINGS**

The mapping exercise found a significant difference in the spatial pattern of public health clinics and private clinics in Malaysia – public PHC clinics were dispersed whereas private clinics were clustered in urban areas.

**IMPLICATIONS**

To improve access to the PHC service network, especially in rural areas, more participation from the private PHC providers is needed. Integration of service delivery between public and private



*Adapted from Hazrin et al. 2013 by Dr. Mohd Safiee Ismail*

Mapping teams may face challenges implementing provider mapping and will need to develop creative solutions. For example, mapping teams might find official facility lists that are out of date. Ways to mitigate this challenge are to: (1) work with local governments, which usually know where facilities are located even if they are not on the list; (2) work with pharmacies/medicine sellers that fill prescriptions and supply commodities; and (3) work with taxi drivers,

who frequently know where all facilities in the area are located, including those that may be unregistered or housed in traditional locations. **TABLE 10** presents a collection of specific country challenges and lessons learned. Examining these in advance of implementing provider mapping efforts will help to strengthen the planning and implementation process.

TABLE 10

**Country experiences with provider mapping**

COUNTRY	CHALLENGES AND LESSONS LEARNED
VIETNAM	<ul style="list-style-type: none"> <li>• Data sources for mapping private hospitals were available, but very limited for private practitioners and clinics.</li> <li>• Private hospitals routinely report performance and financial data to MOH each year. However, the mechanism for collecting information from private practitioners and clinics is weak.</li> </ul>
GHANA	<ul style="list-style-type: none"> <li>• Private providers will not necessarily understand why you are collecting data or that the data are meant to ultimately help them and improve health service provision; for this reason, they might perceive the effort negatively and resist cooperating. It is important that the implementation team engages with them to explain mapping and its benefits for them. It may be useful to work with private sector associations to help facilitate this discussion and keep costs down by localizing the assessment.</li> </ul>
MALAYSIA	<ul style="list-style-type: none"> <li>• <b>Lack of up-to-date and complete data.</b> This is due in part to low survey response rates among private providers. The high financial cost of mapping software also hinders the availability of data.</li> <li>• <b>Availability of human resources for maintenance of GIS database.</b> The database must be updated and feedback managed appropriately. Thus, any staff assigned to this job must have sufficient knowledge of GIS database management. However, due to competing priorities and limited funds, dedicated and adequately trained teams are not always available.</li> <li>• <b>Dissemination of mapping results.</b> In order for findings to result in policy changes, a provider mapping exercise must envision, design, and create an effective channel for dissemination of mapping results.</li> <li>• <b>Financial and political will to apply lessons learned.</b> In order to make provider mapping exercises impactful, research must be translated into practice.</li> <li>• <b>Harmonization of provider mapping data with other available data sources.</b> Facilities currently receive registration forms every year, but they do not request GIS information. To overcome this challenge, Malaysia simply added a column for GIS coordinates to the form. This enabled easy harmonization of provider mapping information and registration data.</li> <li>• <b>Accuracy of the GIS data.</b> Many factors affect the accuracy of GIS data, including the verification of location points, calibration of GPS apparatuses, technical knowledge on how to handle GPS, strength of satellite signals, and selection of a base map. Adjustment or validation is always needed.</li> </ul>

STEP  
07DISSEMINATE AND USE  
PROVIDER MAPPING RESULTS

ONCE THE MAPPING TEAM HAS ANALYZED and synthesized the provider mapping data, the next step is disseminating the results. A dissemination plan should be drafted from the earliest engagements with stakeholders and refined during the implementation phase of mapping. Mapping output can be used by the MOH, other government agencies, local or international health partners, academic institutions, professional associations, and the private sector. For the widest impact, output should be made available in the public domain to encourage wide use and sharing of information among stakeholders, including private sector providers and members of the public who may want to know the location of the nearest provider offering PHC services.

In addition to making the mapping product available on the Internet, there are other options for dissemination. The extent to which the options are used depends on

how elaborate the mapping is and the specific desire to take a low-key or bigger “splash” approach to the mapping. TABLE 11 describes some options for dissemination.

TABLE 11

## Options for dissemination of provider mapping results

METHOD	PURPOSE
POST ON PUBLIC INTERNET SITE	Make mapping available to all potential users.
PRINTED PUBLICATIONS	Make mapping available to users who prefer printed publications.
SPECIFIC LAUNCH EVENT	Let all interested parties (invite all stakeholders) and the general public (invite the media) know about the mapping, what its key findings are, and that it is available.
PRE- AND POST-COMMUNICATION	Engage with the subjects of the mapping before and after conducting mapping to: elicit input on mapping design and plan; encourage buy-in and participation and assist in mapping facilitation; and share findings and discuss implications.
DISCUSSION FORUMS	Stimulate interest in mapping findings and doing more with mapping information. Discussion forums might be held in places where there are likely to be audiences interested in discussing the substance of the mapping (such as in the offices of key stakeholders, academic institutions, and think tanks). The forums might include a description of the mapping and then a presentation of some of the findings from analyses performed using it (to stimulate discussion by the audience).
SPEECHES BY KEY STAKEHOLDERS	Demonstrate the importance and ownership of the mapping. A speech by high-level leadership of the primary stakeholder (e.g., Minister of Health, key advisor) might be used to launch the mapping's availability. The leadership of other key stakeholders might be encouraged to make their own speeches or to mention the mapping in broader speeches by providing them with "talking points" about the main points of the mapping (what it is, what its purpose is, what it shows, and how it will be used in the future).
COMPREHENSIVE CAMPAIGN	Stimulate media interest and create news via an orchestrated campaign, including a launch event, press releases, media briefings, speeches by key stakeholders, and discussion forums. Through one-on-one events like briefings with the media, representatives can ask questions and conduct interviews, as well as receive supportive materials describing the mapping. These activities will give the media a full understanding of the mapping and hopefully facilitate the use of this data throughout the country.



STEP  
08

EVALUATE PROCESS AND TRACK  
USE OF MAPPING

**THE FINAL STEP IN PROVIDER MAPPING is to evaluate the mapping process to understand the challenges faced and lessons learned during implementation.** If the team has determined that the provider mapping will be a routine exercise (STEP 3), findings from the mapping process review can be used to refine and improve the process for the next round. For example, if the team encountered problems with availability of a specific data element, the team might consider harmonizing and institutionalizing collection of that data element going forward. In Malaysia, the mapping team conducted primary data collection of GIS coordinates because there were no existing data sources available. After a review of the mapping process, the team determined that going forward facilities could routinely collect GIS coordinates on the facility registration forms that are currently completed on a yearly basis.

In addition to conducting a review of the mapping process, it is important for the team to track the extent to which mapping results are used for decision making and action planning. The team might consider conducting a re-review

with MOH counterparts (and others targeted during dissemination) to determine whether follow-up actions have been taken one or several months after dissemination.

## Mapping of health service providers in Ghana's Upper East, Upper West, and Volta Regions

**Ghana's National Health Insurance Authority (NHIA) is currently scaling up a capitation payment system for PHC, with the threefold objective of: (1) cost containment; (2) improving the efficiency and effectiveness of health services; and (3) simplifying claims processing. Under capitation in Ghana, all NHIS subscribers select a Preferred Primary Care Provider (PPP). The PPP is then paid a fixed amount to provide a defined package of basic primary care services to enrolled beneficiaries for a fixed period of time. A fundamental component of a capitation payment system, therefore, is the PPP.**

Capitation was first introduced in Ashanti Region in 2012. The Ashanti pilot revealed several challenges, including the highly variable capacity of providers, both public and private, to deliver the package of services. For capitation to work properly, all participating providers must be able to deliver the full package of services. NHIA and other health sector agencies agreed that they needed more information about the capacity of providers to deliver capitation services. Thus, provider mapping was conducted with support from USAID's Health Finance and Governance (HFG) Project.

Below, Ghana's provider mapping is described according to the eight-step process laid out in this module.

### STEP 1: STAKEHOLDER ANALYSIS

The provider mapping was carried out by the NHIA in collaboration with the Ministry of Health and Ghana Health Service. All three agencies participated in the Capitation Technical Steering Committee (TSC). See Step 6 for details on how the TSC ensured broad buy-in and participation.

### STEP 2: PRIORITIZE OBJECTIVES

The TSC agreed that the purpose of the provider mapping exercise was to:

- Provide information on the capacity of providers to serve as PPPs to deliver the capitation package of services.
- Identify capacity gaps and suggest options for closing them.
- Serve as a benchmark to adequately monitor progress.

### STEP 3: DETERMINE FREQUENCY AND GEOGRAPHIC SCOPE OF MAPPING

The TSC began provider mapping in the three regions slated for the next phase of capitation scale-up. The NHIA plans to institutionalize routine provider mapping going forward, and has since conducted a mapping in one more region. The next two regions for mapping are under discussion.

### STEP 4: IDENTIFY EXISTING DATA SOURCES

The TSC developed criteria considered essential for delivering the capitation package (see [TABLE 12](#)). After assessing existing data sources, the TSC determined that while some data could be collected from district health insurance offices, it was also necessary to collect primary data.

**STEP 5: IDENTIFY DATA COLLECTION TOOLS AND ALIGN WITH ICT CONSIDERATIONS**

The TSC decided that the provider mapping should focus mainly on staffing capacity. Based on the capacity criteria, a data collection instrument (outlined in [TABLE 13](#)) was developed to compile information on:

- The ownership status and basic characteristics of providers;
- The capacity of each provider to deliver services (staff, equipment, hours of operation);
- Interest in and potential to form networks/partnerships across providers; and
- The GIS coordinates of each health facility, so that maps could be created showing health facility characteristics and capacity, and displaying proximity and populations served.

**STEP 6: IMPLEMENT PROVIDER MAPPING**

The NHIA worked with local consultants to coordinate data collection and analysis. Regional Health Directors and District Health Management Teams took on the main responsibility for data collection, with support from the district health insurance offices. The TSC implemented the following measures to ensure broad participation in the exercise:

- Established a close working relationship with the Regional Health Directors and jointly developed the data collection plan;
- Established a working relationship with district health insurance offices and collected membership data by districts and sub-districts;
- Carried out informational and sensitization activities;

- Collected as much information as possible from the district health offices and directly visited a sample of potential PPPs to verify district level information;
- Supervised the design and development of a facility mapping software application; and
- Conducted return visits to the health facilities in all the regions as needed to verify data after data entry.

As the mapping team analyzed initial data, it became clear that a second tier of staffing criteria would be needed. The TSC thus developed a more realistic set of Level 2 criteria, in addition to the ideal staffing scenario articulated through the Level 1 criteria (see [TABLE 12](#)). Both sets of criteria were then used to analyze staffing capacity gaps and to present the findings.

**STEP 7: DISSEMINATE AND USE PROVIDER MAPPING RESULTS**

The provider mapping captured information for 899 health facilities, 23 pharmacies, and 308 chemical shops. This represented a census of all public, private, and mission health facilities, including health facilities that do not appear on other health facility lists. The results were published in a 2015 report.

There are several implications of these results for scale-up of capitation, and development of the PHC sector in Ghana in general:

1. It is not possible to exclude Community-based Health Planning and Services (CHPS) facilities from capitation. Otherwise, many people would not have access to primary care services.

*continued*

2. A multi-pronged approach is likely needed to close the capacity gaps for an essential package of prevention and primary care services to be accessible and equitable, including:

- Bringing the services offered by CHPS and the package of services covered by capitation into alignment;
- Redistributing human resources;
- Investing in and upgrading services, particularly CHPS compounds; and
- Bringing providers together into partnerships or networks (including public-private partnerships).

Health sector agencies in Ghana are using these findings to inform capitation scale-up and improve primary health care. For example, the data is being used by a multi-stakeholder working group to inform the design of a PPP network pilot.

#### **STEP 8: EVALUATE PROCESS AND TRACK USE OF MAPPING**

As provider mapping is scaled up in additional regions and institutionalized as a routine exercise, the mapping team is making process improvements based on lessons learned from the first phase of implementation. For example, despite successful collaboration among the institutional stakeholders, provider mapping was met with skepticism from private providers, who did not fully understand the objectives of the mapping and how the results could help them (see Step 1). Reflecting on this experience, the mapping team notes that it might be beneficial to work with private sector associations to help facilitate this understanding.

*Source: Anthony Gingong, Philip Akanzing, Joseph Annor, Elizabeth Novi, Cheryl Cashin, and Surabhi Bhatt (2015). Mapping of Health Service Providers: Upper East, Upper West, and Volta Regions. Accra, Ghana: NHIA/GHS/MOH*



TABLE 12

**Capacity criteria developed for Ghana's provider mapping**

CAPACITY AREA	CRITERIA
<b>STAFFING FUNCTIONS</b> <i>The TSC determined five key functions required to deliver the capitation package</i>	<ol style="list-style-type: none"> <li>1. Make a diagnosis;</li> <li>2. Stabilize a patient;</li> <li>3. Prescribe medication;</li> <li>4. Refer patients with complicated cases to higher level facilities; and</li> <li>5. Conduct outreach related to prevention, maternal and child health services, etc.</li> </ol>
<b>STAFFING—LEVEL 1</b> <i>The TSC articulated a complement of staff necessary to fulfill the five functions above</i>	<ol style="list-style-type: none"> <li>1. Physician and/or medical assistant</li> <li>2. Staff nurse and/or midwife</li> <li>3. Dispensing technician and/or dispensing assistant</li> <li>4. Community Health Nurse/Community Health Officer</li> </ol>
<b>STAFFING—LEVEL 2</b> <i>Based on initial analysis of the provider mapping data, the TSC revised the staffing criteria as follows to align with the reality of Ghana's current HRH situation</i>	<ol style="list-style-type: none"> <li>1. Physician and/or Medical Assistant and/or Staff Nurse and/or Midwife</li> <li>2. Community Health Nurse/Community Health Officer</li> </ol>
<b>EQUIPMENT</b> <i>The TSC specified a list of equipment that would be required to deliver the services in the capitation package</i>	<ol style="list-style-type: none"> <li>1. BP apparatus</li> <li>2. Thermometer</li> <li>3. Screen</li> <li>4. Weighing scale</li> <li>5. Running water/Veronica bucket</li> <li>6. Examination couch</li> <li>7. Suction machine</li> <li>8. Stethoscope</li> <li>9. Fetal stethoscope</li> <li>10. Patient trolley</li> </ol>
<b>HOURS OF OPERATION</b>	<p>The provider should be able to dispense care to its enrolled population 24 hours per day and seven days per week</p>

TABLE 13

## Outline of data collection instrument used in Ghana provider mapping

CATEGORY	SECTIONS
STAFFING	<ul style="list-style-type: none"> <li>• What is the staff capacity of the facility and how many subscribers can be served?</li> <li>• What is the size of the population it currently serves?</li> <li>• What is the number of visits per day (by insured and uninsured patients)?</li> </ul>
EQUIPMENT	<ul style="list-style-type: none"> <li>• Which equipment does the health facility have currently in working order?</li> </ul>
HOURS OF OPERATION	<ul style="list-style-type: none"> <li>• Is the health facility open and operating?</li> <li>• Is the health facility able to serve patients 24 hours per day and seven days per week?</li> <li>• If not, what resources would it take for the health facility to have the capacity to be opened and accessible for 24/7?</li> </ul>
PROXIMITY	<ul style="list-style-type: none"> <li>• How many potential PPPs exist in each region (by regional center, district, and sub-district)?</li> <li>• What is the radius in kilometers of the population served by each PPP?</li> <li>• What is the nearest referral point and how far is it from the PPP?</li> </ul>
POTENTIAL FOR PROVIDER GROUPS/ NETWORKS	<ul style="list-style-type: none"> <li>• What is the administrative, financial, and clinical relationship of the health facility with other providers in the district and the district health administration?</li> <li>• Are the PPPs willing to work in groups? Would private-private or public-private group practices or networks be feasible? What are the obstacles that would have to be overcome?</li> <li>• Does the PPP and each affiliated CHPS compound have its own bank account?</li> <li>• Does the PPP and each affiliated CHPS compound currently manage its own budget?</li> <li>• Does the PPP CHPS compound currently manage its own internally generated funds?</li> </ul>

## MODULE 02 SUMMARY

**MODULE 2 HAS DISCUSSED WHY PROVIDER mapping is an important part of the process of engaging the private sector in PHC, and outlined steps for how to conduct provider mapping.** Provider mapping findings and results enable the engagement team to identify PHC providers more precisely, in particular private sector providers, and to engage in discussions about how to work with private providers to deliver PHC.

## PROVIDER MAPPING

## CHECKLIST

- ❑ **CONDUCT** provider mapping-specific stakeholder analysis.
- ❑ **PRIORITIZE** objectives.
- ❑ **DETERMINE** frequency and geographic scope of mapping.
- ❑ **IDENTIFY** existing data sources and new data requiring primary collection.
- ❑ **IDENTIFY** data collection tools and align with ICT considerations.
- ❑ **IMPLEMENT** provider mapping.
- ❑ **DISSEMINATE** and use findings.
- ❑ **EVALUATE** process and **TRACK** use of findings.



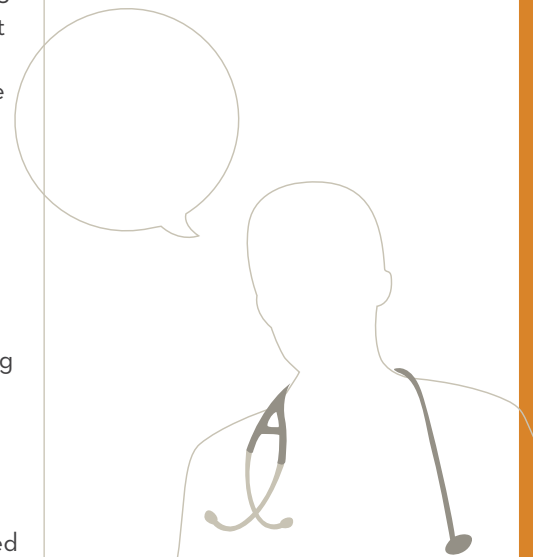
DO

- Conduct a stakeholder analysis specific to the provider mapping exercise. Why might private providers NOT want to participate, and what can be done to gain their support and participation?
- Identify the highest priority questions to answer with provider mapping, and align those with available budget, human resources, and time. Some secondary “nice to have” information may need to wait.
- Plan from the beginning for multiple, periodic mapping exercises, except in occasional cases where a one-time specialized mapping is required.
- Use existing data sources where available and relevant to minimize the cost and effort to collect new primary data.
- Take advantage of increasing global experience and decreasing costs of utilizing GIS equipment and software as part of mapping, and of the power of data visualization to promote changes.
- Consider your dissemination plan from the beginning of the provider mapping, and ensure results are shared with all stakeholders.
- Evaluate and refine the mapping process and consider what worked well and what could have been done differently.
- Track use of mapping results to ensure that the exercise is linked to action.



DON'T

- Hide your results. To build trust and chances for ongoing support of PHC goals by the private sector, share results of mapping exercises as quickly and transparently as possible. The government, private providers, patients, and in some places, development partners should all stand to benefit.
- Limit mapping to geographic locations of providers. While recognizing limits on goals and available resources for mapping, try to include categories such as equipment and skills-based capacities, time, quality, and patient perceptions.
- Start field work without clear plans for how collected data will be analyzed, presented, shared, and, most importantly, used for decision making.
- Stop at dissemination, make sure to track whether disseminated results are being used.



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## JLN APPROACH TO PHC-ORIENTED UHC

Since the 1978 Alma-Ata Declaration, primary health care (PHC) has been touted as key to achieving good health for all, and fundamental to making health care universally accessible. The Joint Learning Network (JLN) Primary Health Care Technical Initiative defines PHC as “the provision of outpatient non-secondary and non-tertiary preventive and curative care, with a particular focus on ensuring the quality delivery of health interventions prioritized by both countries and the global health community to address the highest disease burdens.”<sup>i</sup>

While PHC has gained rhetorical support from governments since the Declaration, it has often not received financial, human resources, and performance management attention needed to achieve its promise. Countries are currently grappling with how to mitigate these challenges, and they do not find all (or even many) of the answers they need in international literature and tools.

At the same time, many countries over the last five years have committed to universal health coverage (UHC), defined by the World Health Organization (WHO) as ensuring that “all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship” (*WHO 2010b*). Indeed, the JLN was

established specifically to share cross-country experiences and knowledge related to UHC to hasten its achievement.

Commonly in moving towards UHC, countries focus on “insurable risks” such as hospitalizations to minimize catastrophic expenses, as opposed to focusing on preventive, promotive, and primary-level curative care. The JLN, however, identified the important connection between PHC and UHC, noting that PHC-oriented UHC could accelerate lowering the disease burden and contribute to achieving the Sustainable Development Goals (SDGs) by strengthening system integration, and offering financial protection within financial limits (see [Box B](#)). This embrace of PHC-oriented UHC led JLN members to establish the JLN PHC Technical Initiative in November 2013. The JLN PHC Technical Initiative focused initially on

## BOX B

### Rationale for PHC-oriented UHC

1. PHC is often the first point of contact for health care, and makes up the majority of client contacts across the health system. It is thereby vital to satisfaction with the health system, and to the functioning of the system as a whole.
2. Promotive, preventive, and curative PHC services are generally more cost effective than higher-level health services, so strengthening PHC can yield greater health and financial protection within limited resources or budget.
3. Effective PHC responses are needed immediately to address large infectious disease burdens and to achieve SDGs and other national priorities.
4. In middle-income countries especially, epidemiological transitions towards costly chronic diseases make PHC increasingly important for health and financial sustainability.

<sup>i</sup> Developed by JLN PHC Technical Initiative members during a workshop in Manila, Philippines, in May 2014.

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diagnosing potential missed opportunities and misaligned incentives between health financing agencies working towards UHC and PHC caused by lack of communication and cooperation among disparate actors within the health system. This diagnosis exercise was done by jointly developing and then applying the JLN PHC Technical Initiative Self-Assessment Tool (see **Box C**). Several PHC Technical Initiative countries, including Ghana, India, Indonesia, and Malaysia, piloted the PHC Self-Assessment Tool. Findings from the pilots were presented and discussed at a workshop in Kuala Lumpur, Malaysia, in November 2014. Review of these findings identified several challenges that the Initiative could address to help achieve PHC-oriented UHC. Among the challenges is engaging the private sector in PHC service delivery more comprehensively to increase access to quality, affordable PHC, thus increasing the likelihood of achieving UHC (Blanchet et al. 2016).

### STATEMENT OF THE PROBLEM

UHC aims to reorient health system resources and utilization towards high quality, comprehensive PHC so that all people have reasonable geographic and financial access to these services that address the greatest causes of disease burden within financial limits and in a way that does not lead to financial hardship.<sup>ii</sup> To achieve such access to quality PHC services for all consumers, the health systems of most countries need to consider (and then aim to optimize and mobilize) both public and private sectors to provide PHC services.

To date, health care policies in most developing countries have focused largely on developing government-owned and operated health facilities and a salaried government-funded health workforce, with fewer policies supporting public purchasing of private health services (Caulfield et al. 2012; IFC 2011; Lagomarsino et al. 2009). Despite this, consumers are increasingly using private sector services either because the services are more geographically accessible or because they

BOX C

## JLN PHC Technical Initiative UHC-PHC Self-Assessment Tool

**In 2014, the JLN PHC Technical Initiative focused on diagnosing potential missed opportunities and misaligned incentives between health financing and PHC, using the jointly developed JLN UHC-PHC Self-Assessment Tool.**

The Tool is a diagnostic instrument (multi-module survey) for identifying practical policy opportunities in the health system to improve the relationship between health financing and PHC efforts.

Several JLN countries, including Ghana, India, Indonesia, and Malaysia, piloted the Tool. Initial findings include: exclusion of PHC services in insurance packages; low budget allocations for preventive and promotive services, relative to curative services; poor provider incentives for the delivery of promotive and outreach services; high OOP expenditures for PHC services at

private facilities; low priority of PHC in health financing agencies; inadequate monitoring of private PHC facilities; and poor medical education at the PHC level.

In response to these findings, countries developed several recommendations, including: increasing recruitment and allotment of human resources for PHC; improving the infrastructure of, and equipment at, PHC facilities; incentivizing private PHC facilities to deliver more preventive and promotive care; and including additional services such as geriatric care, nutrition and lifestyle education, and physiotherapy.

Source: Blanchet et al. 2016

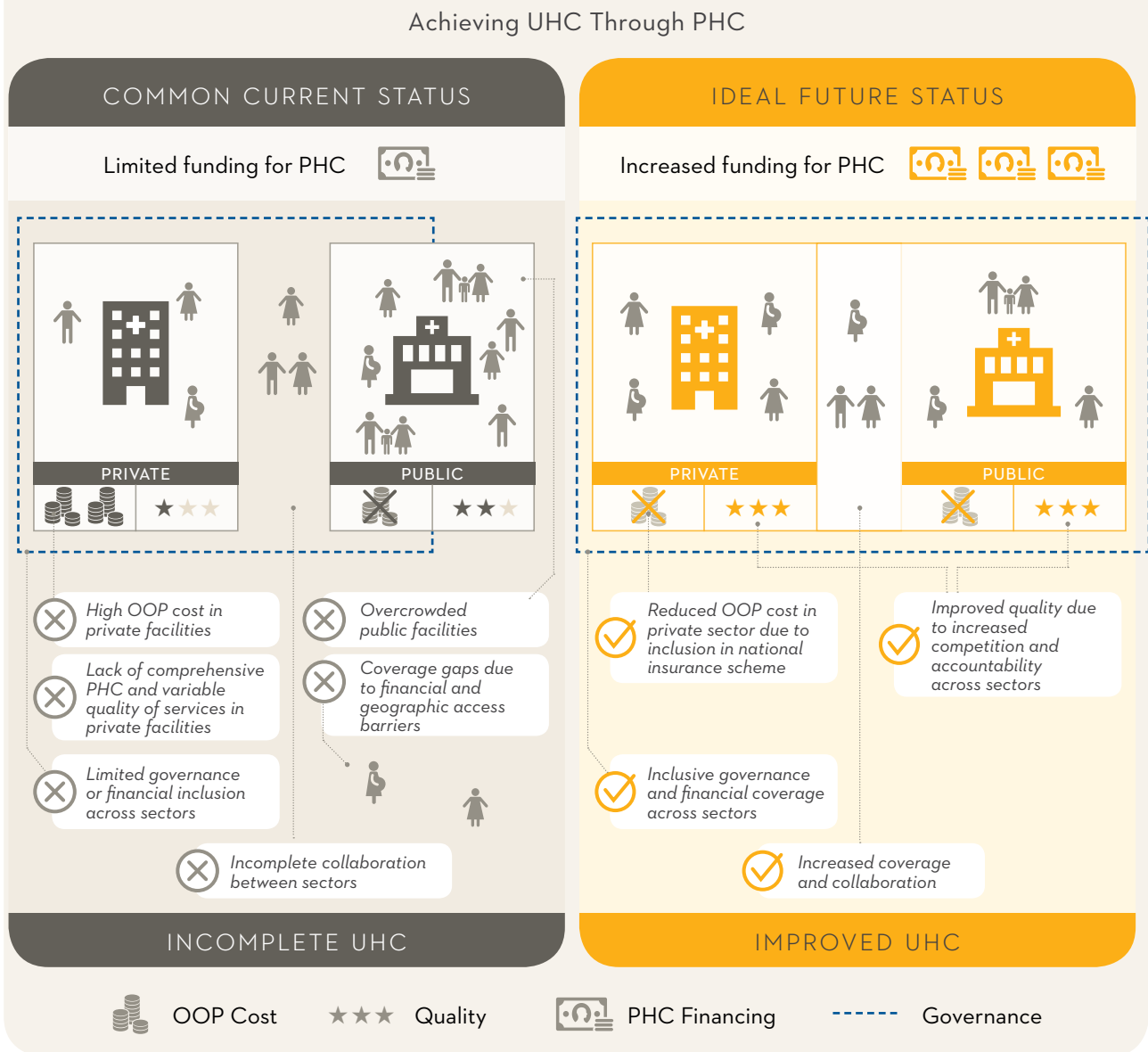


<sup>ii</sup> This statement reflects the view of JLN PHC Technical Initiative members.



FIGURE B

## Engaging with the private sector for improved PHC



are, or are perceived to be, of better quality, despite the need to make out-of-pocket (OOP) payments. When public facilities are overcrowded, paying out of pocket at a private facility may effectively be cheaper than foregoing several hours' wages waiting for free or subsidized public services. However, the private providers often concentrate on providing curative services and offer only limited preventive or promotive services (see [Box A](#) in the Introduction for examples from Tamil Nadu state, India, Ghana, Malaysia, and Vietnam), thus limiting the availability of holistic PHC services (Govindaraj et al. 2014). In addition, some private providers may prefer to treat simpler, acute cases, and refer more complex or chronic cases to the public sector. Services provided by the private sector may also be of variable quality if the sector is largely unregulated. This status of

PHC in most of the countries operating with this type of fragmented health system is depicted on the left side of [FIGURE B](#). These countries are often still struggling to reach UHC and achieve PHC objectives.

There is extensive evidence that the private sector is becoming more active relative to the public sector, especially in the developing world. Two reports from the World Bank Group's International Finance Corporation (IFC) found that more than half of health spending and health care provision in sub-Saharan Africa involves private provision (IFC 2008, 2011). Market assessments in a number of countries show that the private sector is heavily used by all population groups. For example, a 2011 assessment in Ghana commissioned by the World Bank Group showed

that private sources of care were used about 50 percent of the time by the rich and the poor and by urban and rural populations (Makinen et al. 2011). In a World Bank analysis of data from 26 African countries, nearly half of the sick children from the poorest income quintile made use of private providers (Marek et al. 2005).

On the whole, the public and private sectors in most countries are often working in parallel with minimal linkages/collaboration between the two sectors to provide PHC (IFC 2011; Hozumi et al. 2008; Jütting 2002). To maximize the potential of both the public and private sectors to achieve UHC, opportunities to collaborate should be explored. For example, reforming purchasing systems to allow government-operated health insurance schemes and government tax-based health systems to purchase health services (curative, but also preventive and promotive) from private providers may offer consumers greater access to quality services and provide the opportunity to monitor and assure quality by private providers through purchasing as a regulatory mechanism as is the case in Brazil, Cambodia, Chile, and Colombia, among others (IFC 2011). In addition, if private providers offering PHC are accredited and part of a national health insurance scheme, consumers' OOP

payment for services will be lower and service quality could be improved. This collaboration could also increase choice and competition across government and nongovernment facilities providing PHC, thereby increasing the volume and quality of services and improving overall health system performance (IFC 2011). Increased collaboration can also improve policymakers' access to and ability to use data collected at private facilities. The ideal future status of PHC described here is depicted on the right side of **FIGURE B**.

It is also important to recognize the dual practice of some private providers in public and private sectors. To minimize the harm of dual practice and increase its benefit, countries may implement several interventions including: legalizing dual practice after a certain time of day; making it illegal to direct patients from public practices to private practices (making this part of patients' rights that could be posted at public facilities); and allowing private practices to purchase public diagnostic services (rather than just "stealing" them).

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# MAKING THE CASE FOR ENGAGING THE PRIVATE SECTOR IN PHC

## WHY SHOULD THE PUBLIC SECTOR ENGAGE WITH THE PRIVATE SECTOR?

There is growing evidence that it is beneficial for the public sector to work with the private sector to increase coverage and improve equity in accessibility, quality, efficiency, and sustainability of primary health care (PHC) services that ultimately improve health outcomes (*Bustreo et al. 2003; Harding 2009; IFC 2011*).

The partnership can improve access to PHC services for the population, and can complement public sector efforts. See [Box D](#) for an example from Kerala, India, and [APPENDIX C](#) for an example from the Philippines National Health Insurance Program's involvement with the private sector. In addition, case studies from Lesotho and Washington, D.C., USA (see [APPENDIX C](#)) describe how quality of health services can improve when government partners with the private sector.<sup>iii</sup> Some of the reasons cited in the literature for public and private sector collaboration include:

- The private sector is often consumers' preferred vehicle for delivery of PHC services in many developing countries despite requiring out-of-pocket (OOP) payment (*Harding 2009*).
- The private sector provides many PHC services to the poor (*Peters et al. 2002; Waters et al. 2002; Harding 2009; IFC 2011*).
- The private sector is growing quickly (*Forsberg et al. 2011; IFC 2011*).
- Competition can lead to improvement in service quality.
- Effective government regulation of private facilities can lead to improved quality of services through application of technical protocols and reduced costs through regulation of prices and provider enrollment in government or public health insurance schemes (*Tangcharoensathein et al. 2008*).
- Regulation through contracting and purchasing offers another way to regulate the price and quality of services delivered by private providers and enforce data and reporting requirements (*Cashin 2015*).

## BOX D

### Example of advantages of public sector working with the private sector

**A public health insurance program in India increased volumes for both public and private providers, and as a result of patient choice of provider and competition from the private sector in Kerala (India), the public sector responded with reinvesting their insurance earnings to improve their facilities, changed their behavior to attract more patients towards them, and led to overall improvements in user experience** (*Palacios et al. 2011*).

<sup>iii</sup> In Washington, D.C., the government shifted from directly providing health care to purchasing health care services from private providers to improve quality of care and lower costs. The Government of Lesotho, under advisement by the IFC, worked with the private sector to improve and privately operate low-quality public clinics. See [Appendix C](#) for more details of these two cases.

## WHY SHOULD THE PRIVATE SECTOR ENGAGE WITH THE PUBLIC SECTOR?

While there is a strong rationale for the public sector to work with the private sector, it is also in the interest of the private sector to collaborate with the public sector (*Smith et al. 2001; Harding 2009*).

By engaging with the public sector, the private sector can:

- **Increase and expand business.** The private sector can increase and diversify both its service volume and revenues by contracting with publicly financed health agencies to provide PHC curative and preventive services. This public-private collaboration allows patients to access care from private providers without paying out of pocket, and may allow private providers to improve quality and expand their operations. As a secondary benefit, the private sector may also be required or given incentives to provide better quality services, which could attract more paying clientele, increasing and expanding the private sector's business.
- **Gain more favorable financing.** In the absence of collaboration, the main source of private sector financing is through OOP expenditure from the population or through private insurance. In both these cases, no money flows from government to the private sector. However, if the private sector is eligible and paid for providing services under a government-funded insurance program, they can gain considerably more financing, which they could use to target existing problems of lack of resources. In addition, if the private sector partners with the public sector, they may be eligible for funding for preventive services (or in-kind supply of subsidized commodities, e.g., vaccines) and other government-sponsored health programs.
- **Provide comprehensive care.** Most patients visit their private provider when they are sick, rather than to seek preventive care. In turn, most private providers provide mostly curative services to meet these demands. However, if the private sector partners with the public sector, mechanisms can be put in place to give private providers incentives to provide preventive and promotive services that make the range of services they offer more comprehensive.
- **Achieve its social goals.** In addition to profit generation, private health personnel (including owners of private provider units) have a social mission and aim to contribute to at least some well-being of their clients and communities by serving the needy population and contributing towards nation building. By partnering with the public sector and expanding provision of both curative and preventive PHC services to the population, the private sector can contribute towards achieving these social goals.
- **Gain opportunities to upgrade knowledge and skills.** When the private sector collaborates with the public sector, it may gain opportunities for upgrading and improving clinical knowledge and skills through participation in public sector-sponsored trainings. Private providers can use the upgraded skills to “market” themselves to their paying customers.

## WHAT ARE THE CHALLENGES TO PUBLIC-PRIVATE SECTOR COLLABORATION AND PARTNERSHIP?

While there are mutual benefits for public and private sectors to work together, the partnership faces several challenges:

- **Heterogeneous makeup of the private sector and lack of umbrella organizations.** One of the biggest challenges to country governments' engagement with the private sector is the private sector's heterogeneous makeup (*Harding 2009*). The private sector is made up of a variety of providers and manufacturers operating independently, with few organizing bodies that bring the group together. For example, World Bank Group-funded Private Health Sector Assessments in Ghana, Mali, and the Republic of Congo observed that the heterogeneous makeup of private health providers, among other factors, has made systematic collaboration between public and private sectors difficult (*Lamiaux 2011; Makinen et al. 2011, 2012*). These assessments, in fact, recommended development of private health sector representative bodies to give the private sector a consolidated voice for engaging in public-private collaboration.
- **Lack of information about the private sector.** Information about who private providers are and what services they provide is often lacking.
- **Conflicting incentives and motivations for public and private sectors.** Conflicting incentives and motivations exist in both sectors, which need to be harmonized for a successful partnership. This harmonization, however, is often hampered by misunderstandings between the two parties. The public sector often believes that since the private sector is motivated by profit, the pursuit of profit may lead private providers to compromise the well-being of patients. Further, the public sector often doubts the quality of services offered by the private sector and vice versa. While these claims have some truth to them, they often are exaggerated and there is more common ground than initially appears.

For these reasons and others, a single approach to public-private partnering is unlikely to work in all settings; instead, an approach tailored to each situation is called for.

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## BAHRAIN

*Provider Mapping*<sup>iv</sup>

Over the past decade, Bahrain has made significant investments in its health system. The government placed a high importance on effectively managing the country's three large public hospitals, and developed a set of well-functioning primary care centers. Private hospitals, too, have introduced useful innovations, such as information systems for managing health insurance processes from which the public sector may be able to learn.

In considering the introduction of a social health insurance system, Bahrain recognized a need to assess the health sector's capacity to manage health insurance implementation and increase health care demand. To this end, the World Bank and Government of Bahrain performed an assessment and mapping of health care providers in the country, capturing information on the country's health care infrastructure (including facility location), business operations, and decision rights, such as management autonomy. The primary objectives of the mapping were to assess: (1) the supply-side readiness of health service delivery infrastructure to respond to increased demand from insurance implementation; and (2) the adequacy of business function capacity to transact with outside insurance entities. The assessment involved two types of data collection: interviews, group discussions, and visits to facilities; and a facility survey of all public and private inpatient facilities as well as the primary care facilities under the Ministry of Health.

The mapping captured information along the following dimensions:

- Health infrastructure: facility size and bed capacity by location and ownership type, HRH numbers by facility, and inpatient admissions and surgeries;

- Business functions: coding, costing, contracting, billing, and management information systems;
- Decision rights of HRH staff: management autonomy over HRH, budget allocation, the retention of revenues, and market exposure; and
- Utilization of services.

Overall, mapping findings indicated that health facilities in Bahrain will be able to manage the introduction of insurance; however, the country may need to improve coordination across the health care system and address other long-term efficiency issues. The mapping also found that the business functions are largely ready for the introduction of an insurance system, although improvements in ICT and standardization across hospitals are still needed. The mapping demonstrated that public hospitals and primary care centers will need further expansion of decision rights to be ready for the introduction of an insurance system – including the potential of primary care centers operating as independent legal and business entities or as part of a network.

<sup>iv</sup> Raad, Firas et al., World Bank 2015

## BENIN

*Private-Public Engagement Workshop*

On June 2 & 3, 2015, the Ministry of Health of Benin hosted a high-level workshop on regulation of the private sector, with assistance from USAID's Advancing Newborn, Child and Reproductive Health (ANCRE) Program.

The objective of the workshop was to bring together public and private leaders to identify the benefits of and constraints to regulation of the private sector, and to produce a strategic and operational plan for improving regulation. Key participants included the Minister of Health, other key Ministry personnel, the Director of USAID/Benin, the President of the Association of Private Clinics, and leaders of private health professional orders and associations.

In her opening remarks, the Minister emphasized the critical importance of strengthening Benin's private sector, noting that it serves 60 percent of the population but remains largely unregulated, with many private providers operating informally. ANCRE presented data, facilitated small group work, and helped participants reach consensus around recommendations. ANCRE conducted pre-workshop interviews with a sample of the participants from the two sectors to generate a preliminary response to the workshop's objective and ideas about what might be recommended. The results of the pre-workshop interviews were presented at the workshop and seemed to help "seed" the discussions to move the workshop faster and farther toward agreements and recommendations. In the end the

workshop recommendations focused on: (1) texts and laws, (2) organization of regulatory services, (3) public-private partnerships, and (4) "putting in order" private provision (ensuring that providers are in compliance with regulations and that those that are not are shut down).

In the closing session, the President of the Association of Private Sector Clinics highlighted the spirit of collaboration, "l'esprit fusionnel." One of the Minister's advisers closed the meeting for the Ministry by pledging the Ministry's collaboration in achieving the agreed plans and asserting that the Ministry is responsible for the whole health sector, both its private and public components.

## GHANA

*Private Health Sector Engagement*  
*Private Health Sector Assessment**Private Health Sector Engagement*

At the request of Ghana's Minister of Health, in 2009-2010, the World Bank Group funded an assessment of the role of the private sector in Ghana's health sector. The assessment methodology included quantitative and qualitative data collection, analysis of existing data sets, and review of literature and documents. It also included an ongoing engagement process; that process is the focus of this case study.

The engagement process comprised three workshops: one conducted before data collection began, another when the assessment was nearly complete, and a final one at the conclusion of the assessment. All three workshops included participation by representatives of the public and private sectors.

The pre-data collection workshop was opened by the Minister of Health, and presented the main issues the assessment would examine and the corresponding methodology for data collection. The participants discussed and refined the assessment questions in lively plenary and small group sessions. There were clear differences of opinion and tensions between the public and private sector participants. However, at the end of the workshop, one of the private sector association representatives said that he would report back to his constituents that "times have changed, since we [the private sector] often have been the subjects of studies, but for the first time we have been invited to give our input into a study before it starts."

In the second workshop, the assessment team presented preliminary findings, which participants reviewed and debated. The participants and assessment team agreed that additional data collection was needed. The fact that the participants had a chance to learn about the preliminary results of the assessment gave them time to reflect on the results before the final workshop.

The new Minister of Health opened the final workshop, which focused on specific actions to be taken as a result of the assessment's findings. The assessment team presented suggested actions and participants discussed, debated, and refined them. By 2012, many of the assessment recommendations were incorporated into a revision of Ghana's private sector strategy.

## Private Health Sector Assessment<sup>v</sup>

In 2009, Ghana's Minister of Health asked the World Bank Group to help the country conduct an assessment of the role of the private health sector. As part of the assessment, the team mapped all health sector providers (government and private, including for-profit and not-for-profit faith-based and nongovernmental organizations) in seven districts (five urban and two rural), in late 2009. The mapping collected data from all formal providers, from tertiary hospitals to private chemical shops (authorized to sell over-the-counter drugs only). It collected data on: human resources employed by type and by full-time equivalent; services offered; obstacles to growth (including access to financing and sources of financing for major purchases and day-to-day operations); participation in the national health information system; service charges for uninsured patients for normal deliveries and sick child consultations; infection control indicators; and availability of amenities, drugs (five items), and selected equipment.

Findings from the mapping included the total number of formal service providers, pharmaceutical units, and laboratories (730), as well as "related actors" (mainly wholesale and retail pharmacies and chemical sellers, and a few laboratories) (542). Findings also provided information about facility type (self-described), ownership, and numbers of beds, plus information about operations and assets. Some key results are in the tables below.

**TABLE A** shows how the 730 actors were distributed by type of service delivery facility and supplier of related services (pharmaceuticals, laboratory services). Clinics were the predominant type of service provider in both rural and urban areas. Chemical sellers were the major suppliers of drugs overall, but especially in rural areas, where they were found to source 87 percent of pharmaceuticals.

TABLE A	<b>Seven-district mapping in Ghana in 2009: Geographic breakout of actors</b>			
	Two rural districts		Five urban districts	
<b>Providers</b>	Number	Percent of providers	Number	Percent of providers
Hospital	4	15%	40	25%
Clinic	14	52%	94	58%
Maternity home	4	15%	17	11%
Community-level center	5	19%	10	6%
<b>Related actors</b>	Number	Percent of sources for drugs	Number	Percent of sources for drugs
Pharmacy, retail	3	3%	127	33%
Chemical seller	85	97%	255	67%
Pharmacy, wholesale	2	N/A	44	N/A
Laboratory	2	N/A	24	N/A

<sup>v</sup> <http://documents.worldbank.org/curated/en/2011/01/14102245/private-health-sector-assessment-ghana>

**TABLE B** breaks out the actors by government (and quasi-government) and private ownership. Private ownership dominated all provider types in urban areas with the exception of community-level centers. All related actors

(suppliers of pharmaceuticals and laboratory services) in both rural and urban districts were private. In the rural districts, half of the hospitals and all of the maternity homes were privately owned.

TABLE B	<b>Seven-district mapping in Ghana in 2009: Geographic breakout.</b>					
	Two rural districts			Five urban districts		
	Providers	All private	Government & quasi-government	Percent private	All private	Government & quasi-government
Hospital	2	2	50%	26	14	65%
Clinic	3	11	21%	76	18	81%
Maternity home	4	0	100%	16	1	94%
Community-level center	0	5	0%	1	9	10%
<b>Related actors</b>	All private	Government & quasi-government	Percent private	All private	Government & quasi-government	Percent private
Pharmacy, retail	3	0	100%	127	0	100%
Chemical seller	2	0	100%	44	0	100%
Pharmacy, wholesale	85	0	100%	255	0	100%
Laboratory	2	0	100%	24	0	100%

**TABLE C** breaks out the numbers of beds available by ownership of facilities. Government supplies nearly 70 percent of urban beds, but only about half that share in rural

areas. The rural beds are dominated by 253 hospital beds in two hospitals owed by the faith-based Christian Health Association of Ghana (CHAG).

TABLE C	<b>Seven-district mapping in Ghana in 2009: Bed breakout.</b>					
	Two rural districts: all beds			Five urban districts: all beds		
	Providers	All private	Government & quasi-government	Percent private	All private	Government & quasi-government
Hospital	253	128	66%	717	2,925	20%
Clinic	2	19	10%	474	89	84%
Maternity home	18	0	100%	136	9	94%
<b>TOTAL</b>	<b>273</b>	<b>147</b>	<b>65%</b>	<b>1,327</b>	<b>3023</b>	<b>31%</b>

## INDIA

*Continuing Medical Education Case Study  
Uttarakhand Provider Mapping**Continuing Medical Education Case Study*

India has the largest number of medical schools in the world, with an annual student intake of 50,000 prospective doctors. While continuing medical education (CME) is at a nascent stage in India, it is growing rapidly, but there is no systematic approach to match international standards and promote the expansion of CME. India needs to improve national guidelines, regulation, and investment in CME. However, national legislation to make CME mandatory has made little progress as states create their own norms.

Responding to this need for further development and standardization of CME, the Global Alliance for Medical Education hosted a regional meeting in India in 2014 to bring together different parties – both public and private – to discuss regional and national obstacles to implementing federal regulation and solutions for expanding and regulating CME. Participants included representatives from the Medical Council of India, medical education institutions, pharmaceutical industries, and private sector providers of CME programs. Speakers identified local challenges to establishing legal and regulatory frameworks for CME and brainstormed how to implement best CME

practices across both sectors. In these talks, speakers identified private medical education providers as key players given their “major presence” in the country. The group also identified international lessons in CME from Europe, the Middle East, Asia, and Australia to apply in India. While discussions to improve CME regulation, expansion, and improvement through a mixed health systems approach are ongoing, this workshop has started a public-private sector dialogue in India that could help to solve the issue of training and regulation at both the PHC level and higher levels of care.

*Uttarakhand Provider Mapping<sup>vi</sup>*

Uttarakhand, a state with 10 million people and with the Himalayan mountain range located in its north, faces several challenges in the delivery of PHC. Key among them are: difficult geographic terrain, severe human resource constraints, persistent low maternal and child health outcomes, a heavy burden of communicable diseases, an epidemiological and demographic transition, a need for disaster preparedness, and unmet financial protection. The Uttarakhand Health System and Development Project (UKHSDP), a World Bank-funded project that aims to provide improved health care services in remote and

underserved areas, led a provider mapping effort in the state to help address some of its PHC challenges. The mapping aimed to collect information on the location of populations, providers, and services for planning and expanding the scope of RSBY (India’s national health insurance scheme, Rashtriya Swasthya Bima Yojana) to include PHC services.

In order to expand RSBY, the project designed an intervention establishing public-private partnerships (PPPs) that operate as a network to improve access to care, including financial access and availability of services.

<sup>vi</sup> Nagpal 2015

The networks will provide self-contained clusters of clinical services to ensure coverage of essential services, free services at private facilities (or at the same nominal charges as any other government facilities), robust oversight and monitoring mechanisms that back the payment and service delivery models, and mobile health vans (MHVs) to provide comprehensive disaster management and trauma services. These networks have been designed but have not yet been implemented.

Implementers conducted the mapping as a baseline assessment prior to network implementation, in the following steps: (1) extensive review of existing state data; (2) primary research including quantitative, qualitative, and geospatial data; (3) stakeholder consultations; and (4) international expert consultations. Implementers also took into consideration the scarcity of qualified human resources (particularly specialists, such as pediatricians and obstetricians), geographic access issues, and ongoing PPP pilots in the state when designing the Uttarakhand mapping. After implementation of the network model, a systematic impact evaluation will be conducted, assessing the networks' impact on quality, equity, and other domains.

The mapping collected information on:

- The GIS location of all public and private providers with qualified doctors delivering both primary and secondary providers (includes community health centers, dispensaries, district-level facilities, and base hospitals in each district);
- The location of specific services, including PHC, specialty, and diagnostic services;
- Facility accreditation/empanelment information, staffing levels, and utilization data;
- The district lines, state and national highways, and MHVs, which helped to organize findings on the availability of services; and
- Village location and size, which also helped to provide important contextual information.

Mapping results showed that Uttarakhand's northern region is sparsely populated, with little road coverage; the south is more populous. On average, one MHV covers 200,000 people. In addition, where there have been early interventions for the introduction of primary services into insurance coverage, most of the providers are still public, though there are some private providers.

## LESOTHO

*Private Sector Engagement**Private Sector Engagement*

In Lesotho's capital city of Maseru, poor quality clinics hurt the entire region's health ecosystem. The clinics were aging, experiencing shortages in drugs and human resources for health, and owned poor quality or low-functioning equipment. As a result, many people delayed seeking care at the clinics or bypassed the clinics to seek basic services at the main hospital. The poor quality and bypassing had the following deleterious effects on the health system: (1) a main hospital overburdened with delivering basic services, (2) worsened patient conditions that would have been easily treatable had the patient had access to good care at a clinic earlier in the course of illness, and (3) increased treatment costs, both because of the worsened patient condition and the marginally higher costs to system at the hospital.

Under advisement by the International Finance Corporation, the Government of Lesotho worked with the private sector to improve and privately operate the low-quality public clinics. Netcare, South Africa's largest private health care provider, led a consortium of private sector stakeholders – including local women-owned businesses, expat and local health care providers, and other

investors – that took control of the public clinics. They have renovated clinics, equipped clinics, trained staff, and expanded services to improve public health efforts. The renovated clinics began serving patients in May 2010.<sup>vii</sup>



## PAKISTAN

*Private Sector Engagement in Primary Health Care**Private Sector Engagement in Primary Health Care*

The public-private partnership in Northern Pakistan between the Government of Khyber Pakhtunkhwa, Chitral district, and Aga Khan Health Service, Pakistan (AKHS,P).<sup>viii</sup>

**INTRODUCTION**

In 2001, the Department of Health (DOH) of the Government of Khyber Pakhtunkhwa (KPK) built a rural health center (RHC) in remote Shagram village, Torkhow tehsil (sub-district), Chitral district (see map below). The RHC was designed to provide standard health care services, including essential PHC and emergency obstetric and neonatal care, to clients referred from PHC facilities located throughout the tehsil. After visiting the RHC and reviewing its operations, the government officials determined that the facility had insufficient staff, was providing poor quality services, and was offering only limited PHC services to mothers and young children. The government team also found that the RHC building was in very poor structural condition.



<sup>viii</sup> Dr. Zafar Ahmed, Head of Operations at AKHS,P, provided the data and reviewed the text of this case study.

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In the same period, the AKHS,P was assessing the feasibility of opening an entirely new, privately owned health facility in the same location. Aware of the investigations of AKHS,P, the then KPK Director General of Health Services suggested that AKHS,P enter into a public-private partnership (PPP) that would authorize AKHS,P to take over the management of the RHC Shagram, add staff, and provide a full complement of care. AKHS,P had a long-standing presence in Chitral district and, at the time, was operating a medical center in Booni Town and an Extended Family Health Centre in Chitral Town. These units provided emergency obstetrical operations as well as a full range of curative care. In addition to these two units, AKHS,P owned and operated eight health centers, 17 Maternal and Child Health (MCH) Centres, and four dispensaries across the district, a mountainous area dotted with remote settlements both in valleys and at high elevations.

The general health centers and the MCH Centres formed the core of a system designed to provide preventive and promotive care to women of reproductive age and young children residing in the catchment areas of the health facilities. These units, staffed principally by Lady Health Visitors (LHVs) (trained midwives offering health information and PHC to mothers and children), served clients and supervised volunteer CHWs who spend five to seven hours per week visiting families.

In response to the invitation by the Government of KPK and with the strong endorsement of the District Health Officer-Chitral, AKHS,P entered into the PPP. As defined following many lengthy discussions between representatives of the government and AKHS,P, the partnership was formed to avoid duplicating services and to improve access to essential services. The government was keen to prevent maternal and child deaths due to the limited availability of high quality care in the tehsil. Both the government and AKHS,P were interested in providing care closer to this remote community and in reducing travel time by sick and emergency cases to the medical center in Booni and the District Headquarters Hospital in Chitral Town. As shown on the map above, both of these health facilities are situated at a great distance from Torkhow tehsil and reaching them requires a considerable expenditure of time and money.

After conducting a situation analysis, meeting with representatives of the local community and the district government and identifying health professionals – in particular, a female physician – willing to serve at Shagram, AKHS,P responded positively to the request of the government and on July 21, 2008, signed an MOU that

called for AKHS,P to manage the facility for five years (2008–2013) and outlined the terms of the partnership.

### **MOU OBJECTIVES AND PARTNERS**

As defined in the MOU, the partnership was formed to accomplish five objectives:

- Provide essential quality health care services at Shagram RHC to the community of Torkhow tehsil;
- Ensure the availability of basic maternity services as well as comprehensive emergency obstetric and neonatal care;
- Involve representatives of the local community in the management of the RHC;
- Determine the feasibility of achieving the financial sustainability of the facility and services by increasing the level of services and introducing financing mechanisms, beginning with user fees at levels acceptable to the community; and
- Document and share the experience of the partnership model in national and international forums.

Four partners are named in the MOU; each has well-defined responsibilities and authorities. The Government of KPK through the DOH is responsible for entrusting the RHC to AKHS,P, the facility manager. The government also provides the annual operating budget of the RHC and some human resources, specifically the dispensers, the EPI technician, the vaccinators responsible for outreach, and some support staff, including a guard and driver. In return, the government has a right to see routine reports on the activities underway at the RHC and to conduct annual supervisory visits at the facility.

In operation when the MOU was signed, the government's District Advisory Committee is mentioned in the partnership agreement and was made responsible for receiving and reviewing the routine reports provided by AKHS,P and for working with AKHS,P to take the actions needed to ensure the successful operation of the RHC.

In return for receiving the right to manage the clinic, AKHS,P is responsible for ensuring the availability of medical consumables and pharmaceuticals, enlisting a full staff complement (specifically female doctors and nurses), offering a full range of essential health services that include PHC, and forming two committees composed of community representatives.

Requested by AKHS,P and in compliance with the terms of the MOU, the local community was asked to identify representatives to form and serve on the two committees. The Facility Management Committee was charged with

overseeing the operations of the RHC, while the Health Committee is the interface between the RHC and AKHS,P and supports the health promotion/disease prevention programming and other outreach efforts in the community, for example, immunization days. Its members come from the different villages/communities within the catchment area of the RHC.

**STAFFING, TRENDS IN HEALTH SERVICES, REFERRALS, AND FINANCIAL PERFORMANCE**

TABLE E, TABLE F and TABLE G provide information on the staffing pattern of Shagram RHC and the trends in health services and referrals to and by the RHC for the first phase of the partnership, 2008-2013, and 2014, the first year of the second five-year partnership agreement. TABLE H presents financial data for the RHC for the same period.

As indicated in TABLE E, most of the clinical staff and a good number of the support staff are employees of AKHS,P. The Resident Medical Officer, the LHVs, the Ayas, and the Community Health Nurse are female health professionals who are culturally acceptable and able to serve women residents of this conservative area. While the number of staff have varied over the period, AKHS,P has always provided more than half of the staff complement and all the female health professionals serving at the RHC.

TABLE F provides data on the health services provided by the RHC from 2008 through 2014. The Outpatient Department provides minor curative services, such as dressing and suturing, and PHC services, which include Expanded Programme on Immunization (EPI), Integrated Management of Neonatal and Childhood Illnesses (IMNCI), directly observed treatment, short course (DOTS) for tuberculosis, antenatal and postnatal care, family planning, and growth monitoring.

The outreach services organized and delivered at Shagram are not shown in any of the attachments and the data are not currently available. Still, AKHS,P reports that mobile clinics visit different locations in the catchment area to conduct health awareness/health promotion sessions, to meet with and support the work of the LHVs, to train and support the CHWs volunteering for AKHS,P, and to meet with the Health Committee.

The operating costs of the RHC are covered partially by the government, the community, and AKHS,P. The Facility Management Committee has endorsed a fee-for-service model that requires community members to pay all or some of the fees approved by the committee.

Ensuring that the poorer segments of the community have access to quality health care is an important objective for both the government and AKHS,P. In addition, both partners recognize that out-of-pocket payments by the poor are regressive and that, in general, poorer patients pay both higher rates for goods and services and a higher percentage of their household income for medical goods and services.

At the same time, AKHS,P believes that asking clients to pay some amount for service, as approved by the Facility Management Committee, gives clients dignity and the right to voice their opinion on the quality of care provided. Unfortunately, there are no data to indicate the extent to which charging a fee for service at RHC Shagram, or the other facilities managed by AKHS,P, has been a barrier to access for the poor. Still, to take this very serious concern into account, AKHS,P looks to the Facility Management Committee, whose community representatives know the community, to set fees and to identify those who should pay only a portion of the fee or nothing. In 2014, 273 patients, five percent of those seeking outpatient services, were exempted from payment. In addition, AKHS,P has mobilized the Community Health Committee to create a Welfare Fund, consisting of community contributions and currently generating 20,000-30,000 Pakistani Rupees annually, to be used to pay the fees of the poor and ultra-poor and to cover the operating deficits of the facility.

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## CHALLENGES AND THEIR MITIGATION

In the course of implementing the terms of the MOU, AKHS,P has encountered several challenges. First was the need to hire and place qualified clinical and managerial staff in a very remote location. To address this challenge, AKHS,P agreed to pay a ‘hardship’ allowance, that is, a salary that is significantly higher than the level of compensation that would be paid for assignment to a different, more accessible site.

Second, at all times, AKHS,P has found it necessary to deal with local politics. When fees for services were first introduced at RHC Shagram, there was some level of community resistance. Working with the Facility Management Committee and the Community Management Committee, AKHS,P was able to persuade the community to accept the new policy. At the same time, AKHS,P has been aware for some time that a fee-for-service approach will not ensure the financial sustainability of operations. As a consequence, efforts are in place to introduce community-based health financing approaches and proto-insurance measures to create a pool of funds capable of meeting the financial sustainability objectives of AKHS,P and the need for care by all members of the community.

Third, on entering the area, AKHS,P found that the community had limited awareness of measures to take to protect and promote its health. AKHS,P has relied heavily on the LHWs, CHWs, and Community Health Committee to keep the community informed and willing to adopt measures to protect and improve health status.

Finally, while the government pledged to make regular payments to AKHS,P to support the operations of the health center, payments have often been delayed, making it difficult for AKHS,P to pay staff. To overcome this problem AKHS,P has worked closely with the District Advisory Committee to ensure that the government transfers the approved budget amount to AKHS,P on time.

## LESSONS LEARNED AND THE WAY FORWARD

AKHS,P points to several lessons learned from participating in this PPP. Two are of paramount significance.

1. Combining the resources of government and a private entity can improve health services, especially in remote locations, and avoid duplicating investment and operations. By partnering with the government, AKHS,P was able to revitalize the services at RHC Shagram. Before forming the partnership, the RHC was unable to provide the full range of services. With the participation of AKHS,P, the facility was upgraded, new clinical and managerial staff were brought on board, and the community had financial and physical access to services that were not previously available. According to anecdotal reports, increased access to primary care, especially services for women and young children, are highly valued.
2. The effective and supportive involvement of the community is critical to forging a PPP and to sustaining services. Since the Government of Pakistan endorses the principle that health services should be free, although unofficial fees are commonly charged, AKHS,P would not have been able to put a fee payment mechanism in place without the strong and continued support of the community. In the case of RHC Shagram, AKHS,P successfully argued that requiring clients to pay a fee, no matter how small, gives value to the service and dignity to the client. While the issue of paying fees for service is raised on regular occasions, especially by politicians, the strong support of the community is needed to uphold the principle that the community should contribute in some fashion to meeting the cost of health care.

After reviewing the activities, results, and challenges associated with the partnership, the Government of KPK, the communities in Torkhow tehsil, and AKHS,P agreed to renew the MOU underlying the PPP for a second five-year term (2014-2018). In addition, AKHS,P has been asked by the government, and has agreed to enter into two more PPPs to manage other government health facilities in Chitral district. One PPP will manage the health center at Mastuj; this agreement was signed in 2012. The other PPP, to manage the government’s Civil Hospital at Garam Chasma, was established in 2013.

## ANNEX DATA AND CLARIFICATIONS FOR PAKISTAN

TABLE D

INDICATORS	2008	2013
Infant mortality rate	45	17
Number of maternal deaths	9	-
Antenatal care coverage (%)	34%	72%
<1 year old children fully immunized (%)	75%	99%

TABLE E

### RHC Shagram List of Personnel

		EMPLOYER	
Designation	No.	Government	AKHS,P
Administrative Officer	1		1
Resident Medical Officer	1		1
Staff Medical Officer	1		1
Receptionist	1		1
X-Ray Technician	1	1	
Lab Technician	1		1
Dental Technician	1		1
Sr. Lady Health Visitor	1		1
Lady Health Visitor II	1		1
Lady Health Visitor I	1		1
Aya*	3		3
Sr. Community Health Nurse	1		1
Community Health Nurse	1		1
Pharmacy In-charge	1		1
Dispenser	2	2	
EPI Technician	1	1	
Vaccinator	2	2	
Driver	2	1	1
Guard	2	1	1
Washer	1	1	
<b>Total Staff</b>	<b>26</b>	<b>9</b>	<b>17</b>

\* The Aya is the person (female) who prepares the pregnant woman for delivery and cleans the room and the instruments following the delivery.

TABLE F

**RHC Shagram Patient Volumes and Services (2008-2014)**

	2008	2009	2010	2011	2012	2013	2014
Outpatient Services	2,468	4,657	5,196	5,056	4,191	4,978	5,451
Admissions	404	618	761	723	693	756	869
Deliveries	142	165	193	227	193	251	304
Minor Surgeries	34	65	120	139	69	116	132
C-sections	0	6	6	6	6	5	4
Dental Visits	-	-	449	801	1,230	1,179	1,213
X-rays	-	-	221	631	286	569	498
Ultrasounds	362	503	830	952	759	931	1,109
Laboratory Tests	2,107	4,867	5,664	6,510	6,808	6,922	7,903
Bed Occupancy (%)	27%	31%	39%	34%	37%	37%	43%

TABLE G

**RHC Shagram Referrals to/from RHC (2008-2014)**

	2008	2009	2010	2011	2012	2013	2014
<b>Referrals to RHC from:</b>							
AKHS,P facilities in Chitral	45	24	31	45	35	15	19
Lady Health Workers	87	115	1,732	1,213	1,127	1,615	383
<b>Referrals from RHC to:</b>							
Booni Medical Centre	41	37	34	21	28	4	46
District Headquarters Hospital	7	15	23	14	26	36	40
Peshwar	1	8	5	4	13	8	20

TABLE H

**RHC Shagram Income/Expenses PkR (000s) (2008-2014)**

	2008	2009	2010	2011	2012	2013	2014
<b>Operating Income</b>							
User fees	1,251	3,209	4,580	4,767	5,559	6,173	7,322
Government cash grant	387	1,624	1,712	2,706	-	2,889	3,162
Government salary payment	752	1,730	2,033	1,929	3,182	3,500	3,850
<b>Total Income</b>	<b>2,390</b>	<b>6,563</b>	<b>8,325</b>	<b>9,402</b>	<b>8,741</b>	<b>12,562</b>	<b>14,334</b>
<b>Operating Income</b>							
Salaries – AKHS,P	19,624	3,769	4,661	6,017	6,635	7,566	9,323
Government staff	7,521	1,730	2,033	1,929	3,182	3,500	3,850
Supplies	3,980	1,473	2,101	2,290	2,481	2,560	3,360
Administrative support	9,249	1,489	1,764	2,290	2,393	2,409	3,035
<b>Total Expenditures</b>	<b>40,374</b>	<b>8,461</b>	<b>10,559</b>	<b>12,526</b>	<b>14,691</b>	<b>16,035</b>	<b>19,568</b>
<b>Operating Deficit</b>							
Operating Deficit	-37,984	-1,898	-2,234	-3,124	-5,950	-3,473	-5,234
Deficit financed by AKHS,P	-37,984	-1,898	-2,234	-3,124	-5,950	-3,473	-5,234
Cost recovery %	6	78	79	75	59	78	73
Community contribution %	3	38	43	38	38	38	37
Government contribution %	3	40	35	37	22	40	36
AKHS,P contribution %	94	22	21	25	41	22	27

## PHILIPPINES

*Private Sector Involvement in Philippines National Health Insurance Program  
Benefit Development Process for Enhanced Primary Care Benefit****Private Sector Involvement in Philippines National Health Insurance Program***

The Philippine National Health Insurance Program (NHIP) is mandated to provide all citizens with mechanisms to gain financial access to health services. It is a single payer system with compulsory coverage for all citizens through family-based membership. Benefits are uniform (inpatient and catastrophic) to all membership segments except for the PHC benefit, which is currently only available to indigent and sponsored members but will eventually be rolled out to all members. Payment is also uniform to both government and private health facilities that apply for voluntary accreditation to the program.

The private sector has been an integral part of NHIP implementation in terms of the following:

1. Expanding coverage, with the private sector as contributing members, collecting agents, and sponsoring institutions
2. Benefit development, in setting clinical standards and setting cost of care
3. Service delivery, in providing additional access points to quality health care
4. Quality assurance, in providing technical assistance to benefit development and monitoring and in representation during decision making (Board of Directors, Accreditation Committee, etc.)
5. Information systems, in development of an interoperable national health system that allows for payment and monitoring processes in the NHIP

***Benefit Development Process for Enhanced Primary Care Benefit***

In 2013, the Philippines Universal Health Care Stocktaking Activity recommended that the Philippines enhance the current PHC benefit in its social health insurance system. The Philippine Health Insurance Corporation (PhilHealth) responded by forming a Technical Working Group (TWG) to address this need. The TWG was composed of PhilHealth, the Department of Health, development partners, subcontracted agencies for technical assistance, professional bodies, pharmaceutical players, and local government organizations, as well as other key stakeholders and informants identified during the process.

First, the TWG assessed the PHC situation, including the PHC benefit, and found results in the following areas:

- Political: devolution of health care to local government units
- Economic: continuing high out-of-pocket expenditures, high doctor-to-patient ratio in government facilities
- Social: continuing low utilization of health services, continuing low voluntary enrollment in PhilHealth
- Technological: automation of payment mechanisms, use of health data to guide public health policies
- Legal: sin tax law subsidizing premiums of indigents who are eligible for the PHC benefit, with the benefit currently available only in government health facilities



Based on the initial analysis, PhilHealth decided to engage in the following public-private partnerships for the benefit enhancement process:

- Stakeholders from the public and private sector were part of the benefit design process, providing assistance and feedback along the process
- A public health nongovernmental organization was subcontracted and funded through technical assistance to design an enhanced benefit that covers full cycle of care of PHC conditions causing the most Disability Adjusted Life Years (DALYs)
- A consultant funded through technical assistance who would conduct actuarial analysis of cost implications of the revised package using information and forming relationships with both public and private providers
- Private electronic medical record (EMR) and electronic prescription providers were involved in the creation of a health information system for primary care that will be interoperable with other available public and private EMRs
- A private communications group was subcontracted and funded through technical assistance to create a communications strategy for marketing the enhanced primary care benefit once for roll-out
- A private training facility of the Philippine Academy of Family Physicians embarked on voluntary piloting of benefit expansion to the private sector to deliver the initial primary care, formalized by a memorandum of understanding
- A private drug outlet was contracted to provide medications for non-communicable diseases diagnosed by accredited PHC providers as a pilot for inclusion of medications in the benefit

### ***Lessons of Private Provider Engagement in the TB DOTS Program***

Based on low levels of tuberculosis (TB) being recognized in the Philippines, and that many consumers prefer to access services through the private sector, The Philippine Coalition Against Tuberculosis (PhilCAT) was established in 1994 to bring together government and nongovernment agencies, professional medical societies, and private groups including academic institutions to coordinate TB control efforts in the Philippines. In 2003, the Philippines National Tuberculosis Control Program (NTP) adopted a public-private mix (PPM) model for providing directly observed treatment, short-course (DOTS) for TB to increase case detection and improve treatment. USAID Philippine Tuberculosis Initiative for Private Sector and the Global Fund (funding to PhilCAT) supported the roll-out of PPM DOTS across the country. According to a USAID report, as part of this roll-out, funders established “networks of DOTS referring private physicians through certification trainings,” with the intention of making PhilHealth’s TB/DOTS outpatient benefit package a possible funding source for sustainability of the program.<sup>ix</sup> The report went on to say that “Though over 4,000 DOTS referring private physicians were trained, a significant number chose not to pay the PhP 500 certification fee that would include them in PhilCAT/PhilHealth’s official roster of physician beneficiaries for qualified cases claimed by accredited centers, as they were yet to be convinced of the benefits of such status.”

<sup>ix</sup> United States Agency for International Development. (2014). “USAID/Philippines: External Evaluation of the Tuberculosis Portfolio 2006-2011.” USAID: Washington, DC.

## SUDAN

*Collaborating with the Central Bureau of Statistics to Obtain Critical Health Sector Data for Improvement of PHC*



***Collaborating with the Central Bureau of Statistics to Obtain Critical Health Sector Data for Improvement of PHC<sup>x</sup>***

Sudan is a vast country populated by over 35 million people, 67 percent of whom are living in rural areas. In order to meet the health needs of its widely distributed population, Sudan established a PHC delivery system even before the 1978 Alma-Ata Declaration, adopting PHC as a key priority. However, the system has been performing below expectations, and in 2008 the Federal Ministry of Health (FMOH) was inspired by the WHO report “Primary Health Care Now More Than Ever” to strengthen its PHC system to achieve UHC.

The Directorate General of PHC and Preventive Medicine was charged with leading this initiative to strengthen the PHC system to achieve UHC, beginning with the development of a PHC revitalization strategy. By 2009, the strategy was drafted and endorsed by all departments at the FMOH, State Ministries of Health (SMOH), development partners, and other health sector stakeholders. As a first step in implementing the strategy, Sudan updated its clinical standards and protocols in 2010 through a participatory process involving experts from both national and international institutions, including academia. FMOH also partnered with the Central Bureau of Statistics (CBS) to conduct a second Sudan Household Health Survey (SHHS2), covering more than 50 health outcome and impact indicators. Based on the findings of SHHS2, as well as Sudan’s revised clinical standards, FMOH and CBS conducted a comprehensive nationwide mapping of PHC facilities in 2011.

The aim of the mapping was to assess the geographic distribution of facilities delivering PHC, the services being provided at each level (including family health units, family health centers, and local hospitals), as well as the infrastructure, equipment, and human resources at each facility. In addition, the mapping exercise set out to understand the availability and distribution of community level care providers, including community midwives and CHWs. The provider mapping was also complemented by a survey assessing local health management capacity. The box below describes how FMOH and CBS collaborated on the two assessments, including processes, roles, and responsibilities.

<sup>x</sup> Source: Dr. Suleiman Bakheit, Director General, State Ministry of Health, Northern State

## Process of institutional collaboration between the FMOH and CBS to implement the second Sudan Household Health Survey (SHHS2) and PHC facility mapping

### Stage 1: Preparation and Planning

- FMOH developed the conceptual framework for the household surveys and facility mapping, including the objectives and scope.
- FMOH held joint meetings and workshops with CBS to further develop a survey and facility mapping proposal consisting of a methodology and budget.
- FMOH approved the proposal and presented the budget to government and development partners interested in the results in order to secure funding.
- A joint steering committee was formed, co- led by FMOH and CBS. The committee also included representation from the Federal Ministry of Finance and National Economy, as well as other ministries and institutions in the health sector, including academia. The role of the steering committee was to oversee implementation of the surveys, guide the technical committee, mobilize resources, and build political support for the surveys.

- A technical team was formed under the guidance of the steering committee, co- chaired by FMOH and CBS. The technical committee also included representatives from development partners, academia, and local or international experts, according to the scope and complexity of the survey. The role of the technical committee was to develop detailed operational plans, including activities, time frame, and division of roles and responsibilities among teams.

### Stage 2: Implementation and Field Work

- Training workshops were conducted for field supervisors and data collectors in the states, facilitated by representatives from FMOH, CBS, and SMOH offices. The workshops resulted in field work plans.
- Field work plans, namely data collection, were implemented.

### Stage 3: Analysis, Dissemination, and Use

- Data were entered and analyzed.
- Data were validated and disseminated.
- Data were used for decision-making.

Based on the gaps identified by the provider mapping exercise, stakeholders developed a strategic PHC expansion program (2012-2016) aiming to achieve full population coverage with an accessible package of PHC services. The program has eight key targets:

1. Establishing new service delivery outlets to fill geographic coverage gaps based on revised national clinical standards;
2. Providing equipment and furniture according to revised national clinical standards for each level of care;
3. Rehabilitating existing facilities;
4. Increasing the number of health workers;
5. Basic training of community midwives and CHWs;
6. In-service training of all PHC providers, including medical doctors, technicians, medical assistants, nurses, etc.;
7. Strengthening the supply chain management; and
8. Improving quality of services.

Despite some implementation challenges, Sudan expects to meet most of its targets by the end of 2016. The PHC expansion program receives 90% of its funding from the Federal Ministry of Finance and National Economy. The remaining budget is provided by bilateral and multilateral development partners.

## UNITED STATES OF AMERICA

*Expanding Health Coverage in Washington, D.C.  
by Engaging the Private Sector**Expanding Health Coverage in Washington, D.C. by Engaging the Private Sector*<sup>xi</sup>

In the late 1990s, the city of Washington, D.C. faced a crisis in the health delivery system serving its large low-income population. Its public hospital and associated clinics were offering poor quality care at high cost per patient. Low-income residents had poor access to primary or specialty care and relied heavily on emergency departments. Health outcomes were abysmal.

Starting in 1999, the District initiated a series of health reforms to expand access to health care and improve residents' health. The city closed the public hospital's inpatient facility, transferred control of the hospital's emergency department and affiliated clinics to a nonprofit health care provider, and created the DC HealthCare Alliance to pay for health services for uninsured low-income District residents who were not eligible for Medicaid. The District government shifted from directly providing health care to purchasing health care services from private providers.

The closure of D.C. General Hospital was controversial and politically unpopular, but officials determined it was necessary based on the hospital's out-of-control finances, serious quality problems, and low utilization rates. By setting up the DC HealthCare Alliance, the city created an insurance-like program that allowed low-income residents to access primary and specialty services from participating private providers. Enrollment in the Alliance program exceeded 50,000 in 2009. As a result of the Alliance and a generous Medicaid program, the District currently has one of the lowest uninsured rates in the country. The Alliance helped stabilize and strengthen community health centers – both the former public clinics and nonprofit community health centers – since it attached a revenue stream to patients that the centers had been serving without reimbursement.

The District's successes and challenges in redesigning the health care system for low-income residents provide important lessons for other states and localities. To be sure, some of the District's circumstances were unique: The political opposition to closing the public hospital and the public clinics was neutralized by congressional pressure for cost containment. Moreover, the reforms were supported by a federally-appointed Control Board, which managed the city's finances from the mid-1990s until 2001 as the city emerged from insolvency. But the city's experiences in shifting its role to a purchaser of health care services rather than an operator of a public provider system highlight common opportunities and pitfalls:

- Providing access to health services via insurance coverage is a viable option for governments, as an alternative to providing services through a public hospital and associated clinics. The shift to “buying” from “making” health services is a challenge, but a manageable one. Either approach can work well or poorly, depending on choices in design, financing, implementation, and ongoing management.
- However, key to the success in “buying” health care is the existence of a functioning health care delivery system – a network of providers (primary care, specialists, diagnosticians, and so on) willing and able to serve low-income patients, and able to communicate with each other and coordinate care. The Alliance had difficulty recruiting providers, especially physicians. Access to primary and specialty care is still inadequate, and the city is still struggling to create an integrated model of care.

<sup>xi</sup> Meyer, J.A., R. R. Bovbjerg, B.A. Ormond, et al. (2010). *Expanding Health Coverage in the District of Columbia: D.C.'s shift from providing services to subsidizing individuals and its continuing challenges in promoting health, 1999-2009*. Washington, D.C.: Brookings Institution and The Rockefeller Foundation.

- Health outcomes are still poor. The District’s health care system is still struggling to improve health outcomes by focusing on chronic diseases, increasing primary care usage, and reducing reliance on emergency departments and other hospital-based care.
- Moreover, health system redesign does not address the social determinants of health, such as personal behavior, income, education, and environmental factors. Improving health outcomes will take not only reforms in health care delivery, but improved education, housing, and job opportunities, as well as changes in diet and exercise and reductions in smoking and substance abuse. Many of these factors are outside the control of the health care system and require major coordinated efforts across multiple agencies.

The key lessons for privatization and coverage expansion alike are that changes in health care financing cannot succeed to their fullest without supportive changes in delivery of care and complementary efforts in public health and other areas that greatly affect health status.

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