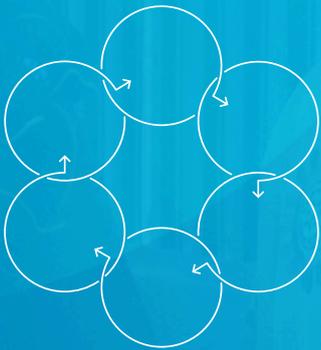




World Health
Organization



Towards better engagement of the private sector in health service delivery

A review of approaches to
private sector engagement
in Africa



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Abbreviations and acronyms

AHF	Africa Healthcare Federation
AIDS	acquired immunodeficiency syndrome
AU	African Union
CSO	civil society organisations
FBO	faith-based organization
GPW13	WHO's Thirteenth General Programme of Work
HGF	health system's governance and financing department
HIV	human immunodeficiency virus
HIS	health information system
LMIC	low- and middle-income country
NGO	non-governmental organization
PHC	primary health care
PPP	public-private-partnership
SDG	sustainable development goal
TB	tuberculosis
UHC	universal health coverage
WHO	World Health Organization

Executive summary

Over the last five years most African countries have integrated Universal Health Coverage (UHC) as a goal in their national health strategies. Yet, challenges still exist to progress in translating this commitment into equitable and quality health services, and to increase financial protection. To attain health-related goals and particularly UHC, the 2030 Sustainable Development Goals (SDGs), emphasize the need to strengthen partnership between government, civil society and businesses (1). To reach the agenda's objectives, governments need to find ways to effectively harness the public and private sectors (2). As also outlined in the WHO's Thirteenth General Programme of Work (GPW13), the response to social, environmental and economic determinants of health requires multisectoral approaches anchored in a human rights perspective (3). To this aim, it is crucial for governments to strengthen their governance approaches. This includes stronger accountability for health and well-being by all sectors and partners in the health system. The African Union (AU)'s "Addis Ababa Commitment toward Shared Responsibility and Global Solidarity for Increased Health Financing Declaration" (4) – also known as the *ALM Declaration* – has been a crucial step towards this direction. It seeks to galvanise greater cooperation between the public and private sectors for delivering sustainable, effective, efficient and equitable health for all, and to safeguard health security.

To effectively engage the private sector in health, countries necessitate greater understanding of the contribution of the private sector to healthcare. This has been spurred by limitations of not having a strategy or the corresponding resources necessary for effectively engaging with the private sector in health. While previous work to engage the private sector in health has largely been vertically driven, often focused on specific diseases or conditions,

a health systems response is needed. This needs to be led by government as part of its stewardship role and cannot be delegated to partners. This ambition aligns with the recently launched World Health Organisation (WHO) strategy, "Engaging the private health service delivery sector through governance in mixed health systems."⁽⁵⁾ The strategy redresses a critical health system governance gap for the effective engagement of the private sector in health in the context of UHC.

The WHO's Health Systems Governance Unit together with the WHO region for Africa and the WHO region for the Eastern Mediterranean undertook a joint landscaping to better understand current approaches to engage with the private sector in health, and governance of the private sector in health. The study reinforced the awareness on the growth in the scope and role of the private sector in health service delivery in Africa. The COVID-19 pandemic has notably served to reinforce the need to engage with the private sector in health in the continent and have exposed the limitations of not having a strategy or the corresponding resources, the "skill and will" necessary to effectively work with the private sector in health.

There is a need for a shift of mindsets to see the private sector as a co-investor and thought partner in the public health systems. This mindset shift is needed at different levels of the health system and along the healthcare value chain. While traditionally the private sector has been viewed as a source of financing to be tapped, governments should reorient their outlook to one of knowledge exchange and co-creation with the private sector as a means of unlocking innovation, building stronger African health systems and delivering health for all.

Introduction

The private sector is ubiquitous in most health systems. It includes all individuals and organisations that are neither owned nor directly controlled by governments and are involved in the provision of health-related goods and services. These consist of formal and informal healthcare providers ranging from drug shops to specialised hospitals, comprising for-profit and not-for-profit entities, both domestic and foreign. The private sector also includes in-kind and financial resources of commercial business, both global and local (5).

Taken together, the private sector in health provides a mix of goods and services including: direct provision of health services, medicines and medical products, financial products, training for the health workforce, information technology, infrastructure and support services (e.g. health facility management) (6). However, there is limited evidence in the literature of the development results achieved through private sector engagement for healthcare service delivery (7). Therefore, understanding the *effective* inclusion of the private sector within national health systems remains integral for accountability, direction, learning and communication purposes (7).

In African health systems the private sector accounts for a large proportion of healthcare service delivery. In sub-Saharan Africa, it is estimated that 35 per cent of outpatient care is delivered by the private-for-profit sector and an additional 17 per cent is delivered by informal private providers (8). Utilisation within and between countries varies; at 52 per cent, Nigeria has the most significant proportion of private sector care seeking, followed by Benin, Cameroon, and Uganda (9). In North Africa, the private sector delivers on average 66 per cent of outpatient services (9). The private sector caters for all wealth quintiles. Though the private sector for inpatient care is used more by wealthier populations, it is a less important determinant of private sources of care for outpatient services, including for the poor (10).

The private sector presents an important partner for UHC. In 2019, world leaders adopted the High-Level United Nations Political Declaration on UHC (11), committing themselves to advance better health and wellbeing for all. UHC is based on the principle that all individuals and communities should have access to quality essential health services without suffering financial hardship due to out-of-pocket payments. UHC is not only key to granting every human being the right to the highest attainable standard of physical and mental health, but it is also central to the achievement of the Agenda 2030 as a whole.

Over the last five years most African countries have integrated UHC as a goal in their national health strategies. Yet, progress in translating this commitment into equitable and quality health services, and increased financial protection, has been slow (12). The African Union (AU)'s *"Addis Ababa Commitment toward Shared Responsibility and Global Solidarity for Increased Health Financing Declaration"* (4) – also known as the ALM Declaration (🌐) – seeks to galvanise greater cooperation between the public and private sectors for delivering sustainable, effective, efficient and equitable health for all, and to safeguard health security in Africa.

A critical piece for the implementation of the ALM Declaration is to understand the contribution of the private sector to healthcare in Africa. This has been spurred by limitations of not having a strategy or the corresponding resources necessary for effectively engaging with the private sector in health. While previous private sector engagement has largely been vertically driven, often focused on specific diseases or conditions, a health systems response is needed. This ambition aligns with the recently launched WHO strategy, *"Engaging the private health service delivery sector through governance in mixed health systems"* (🌐). The strategy redresses a critical health system governance gap for the effective engagement of private health service delivery in the context of UHC (5).

Methodology

The aim of this landscaping study was to better understand the role of the private health sector in service delivery and public policy within Africa. The study was conducted between December 2020 and May 2021 and entailed key informant interviews, supplemented by desk review of relevant literature.

A purposive sampling strategy was employed for the key informant interviews. The WHO regional office for Africa and the WHO Regional Office for the Eastern Mediterranean identified potential respondents at country and regional level from both the public and private sectors, based on their role and expertise on governance of the health system as a whole. Respondents were interviewed remotely using a discussion guide and interviews took approximately 45 minutes to one hour. Respondents' written consent was sought in advance of interview. Interviews were taped using a digital recorder and later transcribed. A grounded approach to data analysis was used, whereby all data was reviewed, and themes iteratively introduced through the interviews and desk review. Official exemption from an ethical review was provided by the WHO Ethical Review Committee, Geneva, Switzerland.

In total, 35 key informant interviews were conducted among the five African regions and with regional respondents (Table 1). Within the paper, quotations from country respondents have been identified based on region while regional respondents are not labelled by region given that some respondents span the continent.

In some instances, distinction between sub-Saharan Africa and North Africa has been indicated.

Table 1. Respondent by region

Regions	No. of interviews
Northern Africa	1
Eastern Africa	4
Central Africa	0
Southern Africa	6
Western Africa	11
Regional perspectives	13
Total	35

The landscaping study was not without limitations including the quality of evidence. Data on the private sector in health is available "uniquely" (country-by-country) with significant variation in the type, quantity, quality, and source (13). While comments can be made on the presence or absence of practices within countries, very rarely are they subject to rigorous evaluation. The identification of key informants was also limited within certain regions of the continent, particularly from Central Africa and francophone countries. Given this, the country-specific examples within the report do not signify that the behaviour or activity is not prevalent in other contexts, merely that this perspective was not adequately represented in the interviews.

Findings

Findings have been framed using the WHO governance framework (Figure 1). A brief definition of the governance

behaviour is provided followed by the key themes and study findings.

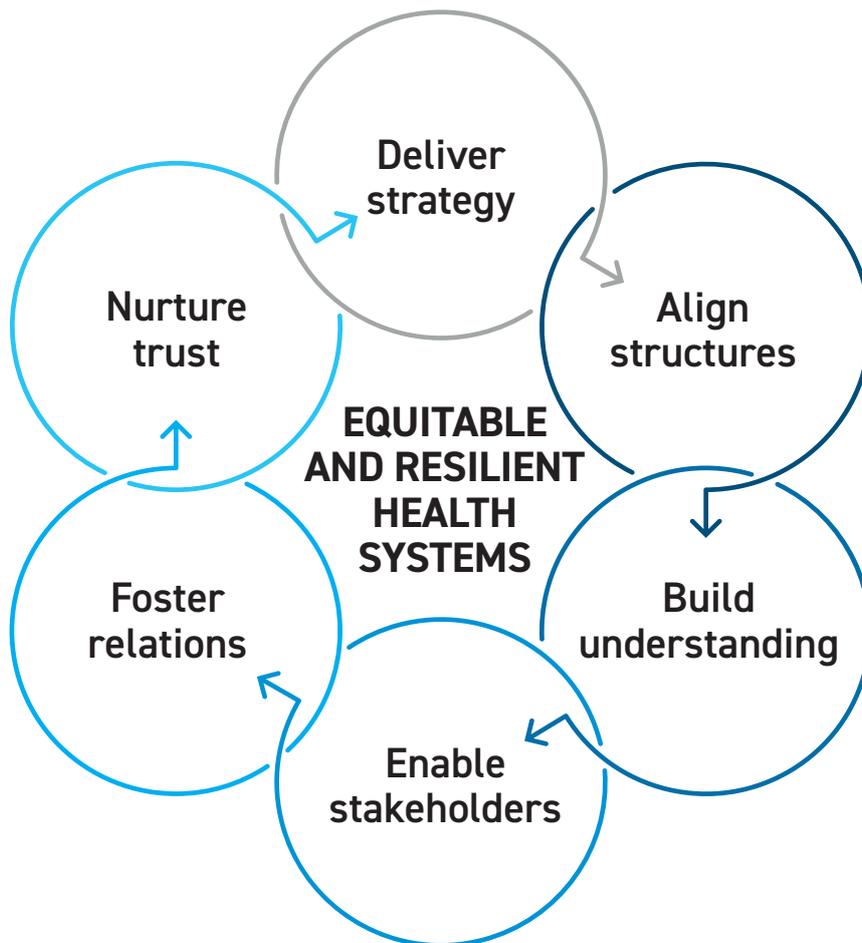
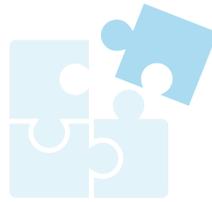


Fig. 1. Analytical framework

Align structures



Government takes the required actions to align public and private structures, processes and institutional architecture

Governments are called to develop and implement policy frameworks to strengthen health systems, achieve better health outcomes and guide the behaviour of health actors. These should ensure fit between public policies and their organizational structures and culture. This behaviour considered the role and growth of the private sector and its alignment with public structures.

Health systems have evolved over time – the private sector has been part of this evolution and filled gaps in public provision. In general, faith-based networks are more integrated within national health systems and are “legacy structures”, often established prior to independence. In exchange for extending public health services to underserved regions, faith-based facilities may receive government grants and free inputs, such as commodities, for priority services. As a result, services delivered through faith-based networks are more likely to be captured within national health information systems and recognised by government, at national and sub-national level. This is often not the case for the for-profit private health sector.

Public sector weaknesses have resulted in “uncontrolled” growth of the private for-profit health sector in many contexts. The reasons for uncharted growth are attributed to deteriorating services in the public sector, “*the private health sector found a big space for it to go so it jumped in*” (Regional respondent). This space was further enlarged as the private sector acts like a “magnet”, attracting both human, material, and financial resources. The private sector also acts like a “mirror” and may reflect structural inequities within countries. For example, the South African health care system reflects its apartheid past where a disproportionate amount of health spending (estimated at 50 per cent) is through

private medical schemes, that serve only 15 per cent of the population (Country respondent, Southern Africa). South Africa is not alone in this regard, as the private sector tends to serve the urban and wealthier populations in most countries and may not be regulated to redress inequities. In Morocco for example, legislation on how and where healthcare facilities can be built has been developed, however, it does not apply to the private sector (Country respondent, Northern Africa).

The public sector is typically well-structured however its very delineation may create disconnects for private sector engagement. Respondents reported that only small and often under-resourced public-private-partnership (PPP) units within ministries of health were mandated to formally contract the private sector, often for infrastructure projects. Other health departments tended to rely on informal or non-binding agreements.

The PPP unit “needs to be a more active, proactive and an effective institution...right now it doesn't feel like it's like it's actually there to do what it's mandated to do.”

Country respondent, Southern Africa

In some contexts, such as Nigeria, there was reportedly greater experimentation with policy frameworks for the management of public hospitals and other healthcare facilities at state level. While these frameworks were seen as viable for the for-profit private sector, other partnerships have relied on memorandums of understanding including with global commercial entities and non-governmental organisations. This has also been the case with donor cost sharing agreements, which may be a contributing factor for commitments not being fully honoured as they are not viewed as binding.

There is reportedly varied appetite in countries for honest reflection on the role of the private sector in health or its relationship with the public sector. In some contexts, the “short comings” of the public sector have to be recast,

“...it's not really the environment that you can point out to problems and in a way blame government...in many of the reports...we had to revise the language because it wasn't politically appropriate.”

Regional respondent

Faith-based networks in their interaction with government also reported challenges with government engagement, as it may look like you are “biting the hand which is feeding you” (Country respondent, Southern Africa). In Malawi, a faith-based network worked through civil society organisations to raise issues of delayed funding; even then, “it took about four to six years for somebody to shout” (Country respondent, Southern Africa). In Nigeria a large faith-based network (with about 440 facilities across the country) reported that there was no formal agreement in place with government. The network was taxed as a profit-making venture and not provided with any financial or in-kind support. Furthermore, the faith-based facilities were viewed as competitor to the public health sector.

Country demand for aligning structures varies across regions and within countries. While there is recognition of fragmentation within the private sector, a similar lens has not been used with the public sector for private sector engagement, particularly in devolved health contexts, where the private sector facilities may not be considered governable entities.

“The private for profit is not ‘for loss’, but it also doesn't mean ‘for plunder’, government should see the private sector as a partner not as a competitor.”

Regional respondent

The lack of public sector structure for private sector engagement has created instances of partner duplication, fragmentation and inefficiency. This was not seen as a “problem of the private sector, it is the problem of the government” through the lack of governance of these engagements.

“If you have the mandate, you have the powers, then you can't blame the private sector.”

Regional respondent.

Build understanding



Government facilitates information-gathering and sharing about all elements of service provision in the health system

To build understanding of the private sector's role in health systems goals, collection and analysis of data is crucial. Knowledge on the size and scope of the private sector is required for governments to regulate care provision, ensure proper allocation of resources, and foster environments of accountability (10). Functioning information sharing systems allow all actors in the healthcare system to align on priorities for action, identify problems and design a strategy for change. This behaviour is critical to support the implementation of change objectives and generate learning about effective strategies for improving the performance of health systems. To assess how African countries are exercising the behaviour “build understanding”, we considered both the existence of systems for data capture and whether private sector data is being used at the national and sub-national level for decision-making.

Given the heterogeneity of the private sector, it is difficult to capture the breadth of its role and contribution to healthcare (14). To overcome this constraint, private sector assessments have been conducted in several contexts. While these draw on a variety of data sources and methods, they do not capture the evolution of the private sector in health, nor are they available for all countries. As these data are often externally commissioned, there may be lack of ownership of the findings or they may not be tailored to the country's requirements. Rarely are subsequent assessments conducted to verify how information and recommendations are used.

In North Africa, data capture on the private sector has focused on technical papers and resolutions. These have been informed by in-depth assessments of the private sector in health in several North African countries. The contents of these reports were cleared by government, which, in itself was considered a milestone, as “*talking about the private sector in our region, it is kind of a sensitive*

issue, it is not an easy thing” (Regional respondent). There were plans to follow this milestone with national policy dialogues, based on the assessment findings, but plans were delayed. This would have involved interlocutors from the ministries of health, the medical syndicate and private sector providers.

More routine sources of data exist but are often not used for information exchange between sectors.

A 2011 assessment of health system governance in 45 African countries found that information exchange was generally weak across the region, with most countries lacking basic elements of a well-functioning health information system (HIS) (15). While many countries have established national HIS, the quality of data and its use remain sub-optimal. Increasingly HIS include the private sector but tend to restrict this to clinical care providers. More recently, countries such as Uganda, Eswatini and Nigeria have extended their HIS to include private pharmacies, given their critical role in consumer care pathways. However, it is unclear how well data sets are collated and used, despite this being an essential building block to understand care-seeking levels, inequities in care seeking, and access to particular sources of care (16).

As affirmed through the interviews, there remains a data lacuna between the public and private sectors, despite both sectors having large “reservoirs of data”.

It was indicated by some regional respondents that the private sector does not report and there is no enforcement for this, although this may not be the case in all contexts and for all private providers. WHO is working with Member States to strengthen HIS, to facilitate private sector reporting and build a comprehensive picture of national health systems. At country level, this is hands-on work while at regional level, this is normative, through the development of guides, tools, training packages, and models. The private sector for their part, want to understand the minimum set of data that they need

to share with ministries of health, suggesting the need for greater regional alignment on requirements as well alignment of interests and incentives to improve reporting (Regional respondent).

"We don't have good data that gives us a helicopter view of the entire country. We have pockets of data that the public sector has, that doesn't speak to the very rich pockets of data that the private sector has..."

Country respondent, Southern Africa

"Efforts have been made to make the data more inclusive so that we're not so siloed as a sector. But it depends on the individual institution to go after this data. If I work in a medium to small private hospital, I don't necessarily have to access or engage with the data."

Country respondent, Southern Africa

Foster relations



Government establishes mechanisms that allow all the relevant stakeholders to participate in policymaking and planning

To build and sustain engagement between public and private actors, regular communication channels and coordination mechanisms are needed. It is crucial for the public and private sectors to be engaged in meaningful dialogue through formal mechanisms to build trust and tackle systemic issues through processes of problem identification and co-design of solutions. To assess progress made on fostering relations, the study considered the existence of public-private dialogue and sectoral coordination mechanisms.

The review established that demand for public-private dialogue mechanisms remains high across Africa. As far back as 2011, the World Bank found that 50 per cent of countries had public-private dialogue mechanisms in place in a variety of forms. At the time, there was differing levels of utilization with only 16 African countries (of the 45 assessed) demonstrating on-going dialogue (15). Since then, the establishment of such mechanisms have continued to grow. However, the effectiveness of platforms is not well documented, monitored or evaluated. Furthermore, these platforms may not include the voice and perspectives of all private sector actors, particularly rural and primary care providers, who may not be well represented.

Demand for public-private dialogue is demonstrated at a continental level through the creation of the AU private sector sub-committee itself, established to improve coherence and alignment of private sector engagement between sectors and across Member States. The sub-committee contains a number of private sector entities, including those without offices on the continent, but which do business in Africa. This level of intentional engagement was seen as unprecedented,

"...the private sector, don't typically have that kind of access...this has allowed for greater understanding of who the partners are."

Regional respondent

As the interviews affirmed, country public-private dialogue has often lagged behind efforts to "build understanding" through private sector assessments and other guidance. While intermediaries have focused on building understanding of the private sector for more than a decade, dialogue has not been as prevalent. This is seen as a matter of capacity as governments don't have the technical skills to draft policy on engagement with the private sector in health or run dialogues with private sector representatives. Beyond skills, there is issue of will,

"They (government) also have their own political agenda, and they would like to maintain the day-to-day work as it is, so they cannot have dramatic changes."

Regional respondent

A private sector respondent confirmed the lack of dialogue and engagement in policy, stating that WHO would be the "best referee" but that the country office is "only talking to the public sector." (Country respondent, Northern Africa)

Healthcare federations have emerged on the health landscape and have assumed a central interlocutor function. Healthcare federations have been set up in a number of countries (>25) and are at varying levels of maturity. Early precursor federations emerged as a result of large donor-funded private sector assessments and have been externally supported to some extent. They were established to defragment the private sector and create a platform for "improved dialogue, building trust and leveraging each other's strengths more effectively for health" (Regional respondent). The Africa Healthcare Federation (AHF) is the umbrella federation and has provided a pinnacle role in country peer engagement and learning through regional events.

Despite the mushrooming of healthcare federations, the private sector is still poorly organized in many contexts. For example, in the Democratic Republic of the Congo, the private sector does not have a voice at the national level, since vast, diverse and fragmented private entities are spread throughout the country making it difficult to communicate and promote sectoral interests with the public sector (17). In Angola, private entities have been excluded from discussions on new health regulations because they were not represented by a single, organized association (15).

Despite their proliferation, there were concerns voiced that federations did not reflect sectoral interests. In Ghana and Nigeria, it was reported that federations tended to reflect individual interests and not sectoral concerns.

“We had a Private Health Sector Alliance, which was very vibrant, but kind of went to sleep...the healthcare federation, focuses on private sector but more at individual level.”

Country respondent, Western Africa

In South Africa, the federation has yet to be “slotted in” to what is considered a well delineated and tiered system of private sector organisation. In Kenya, this level of organisation is not in place and concerns of private sector voice have emerged. It was reported that rural private hospitals have specific issues relative to their size and the populations that are not reflected in the national federation,

“We know where the shoe pinches, we know where the actual problem is in terms of the health system.”

Country respondent, Eastern Africa

In the Kenyan context, a national health insurance directive to limit out-patient visits was protested by rural hospital owners who “came to discover that it was the [national] healthcare federation that had actually proposed the change.” The rural hospitals have since organised themselves and engage in direct communication with the national insurer to resolve their issues.

In most African contexts, participation of the private sector in public policy is not the default. Rather private sector respondents reported being “granted permission”

to participate in policy development. In Ghana for example, national policy outlines government’s intent for private sector engagement but this has not been implemented. It was further noted that the private sector may not know what national policy exists or the private sector’s potential role in it. When donors “forced” private sector engagement this was reported to work for a while, but “when the funding is withdrawn, they [government] will go back to their comfort zone” (Country respondent, Western Africa).

There was also recognition of the potential of professional associations to take a more central and active role in facilitating private sector engagement in public policy. While many professional associations have foundation in acts of parliament, a clear mandate and structure, they are often not well resourced and may only operate at national level. In some instances, healthcare federations have displaced or duplicated the roles of professional associations and other indigenous platforms.

“They [professional associations] should play a role in quality of care, professional practice, and enforcing norms and standards, but they are of two or three people manning the national office, they are cash strapped.”

Regional respondent

Private sector representative bodies, such as healthcare federations and professional associations, could help members improve transparency within national health systems, and advocate for greater use of partnerships and legal structures to increase economies of scale and mobilize health financing (18). However, this would require strong management and governance skills of these organisational bodies. Their inadequacy may challenge policy makers willing to engage beyond individual contracts or builds relationships beyond larger, known, private sector entities. In this regard, it was acknowledged that the private sector in health had evolved over time, but the same known private entities were represented at the policy table. This did not reflect the diversity and contribution of the sector. A shift to online forums during the emergency context provided opportunity to expand the “virtual table” and improve private sector representation and engagement in a number of countries.



Enable stakeholders

Government authorise and incentivise health system stakeholders to align their activities and further leverage their capacities, for national health goals

Both public and private actors should have the power and capability to properly carry out their activities.

This can be achieved when the “tools of government” are used to manage the private sector for health goals. This includes the use of contracting to engage with private providers, and the development and enforcement of regulations. Regulation entails a “*spectrum of rules, procedures, laws, decrees, codes of conduct, standards*” that guide a health system (19). The 2011 World Bank assessment found that only 15 per cent of countries were satisfied by the quality of the regulatory framework in place (15). This governance behaviour therefore considered the availability of tools of government, focusing on regulation and contracting and the quality of their deployment.

Many African countries have tools of government in place, however not all tools are used optimally.

In some countries, accreditation and registration schemes help to enforce regulations, as private facility eligibility for contracting or inclusion in national health insurance relies on it. In Kenya, free or subsidised publicly funded training programs for accredited private facilities have been used to promote the use of standard treatment guidelines (20). Similarly, in Nigeria, private facilities are required to go through an accreditation process to be eligible for contracts with the government. To ensure minimum quality standards are delivered by qualified providers, governments need to be able to both enact and enforce legal restrictions and regulatory functions (13).

Regulation is a “non-negotiable” tool for health service accountability and needs to strike a balance between too much and too little regulation so that private sector participation in health system goals is facilitated. This is needed at different levels of the health system in order to create greater regulatory certainty. However, within the African context, there are examples of regulation being applied more rigidly in the private

sector as compared to the public sector, or unevenly across private sector entities (9). It was further speculated that uncontrolled growth of the private sector had been enabled by inadequate regulatory tools and resources. In general, capacity to regulate is considered weak and it is unclear if this has improved over time.

“The problem is that the agencies that are carrying out regulations or implementing legislation, are poorly funded, they don’t have a lot of capacity... the deficit is evolving, most of these regulations are developed from the perspective of control, they are not very facilitative in engagement, in ensuring that the private sector can play a bigger role when it comes, for example, to research and development of new technologies.”

Regional respondent

National health insurance schemes have improved regulation in some contexts, but gaps remain.

While the expansion of national health insurance is a key approach to UHC, there were concerns expressed that this may create an uneven regulatory environment between formal, accredited private providers and informal, unregistered providers. In some contexts, a deteriorating public sector has accelerated growth of informal providers given low entry costs into the market. Reference was made to the United Republic of Tanzania and Nigeria where medicine outlets have been engaged to scale up services, adding to the complexity of regulation, “*it is the informality of those arrangements... it makes regulation very, very complex.*” (Regional respondent).

In other contexts, such as North Africa where national health insurance coverage is higher, there has been fragmentation of the health system into two or more tiers of care. For example, in Morocco, wealthier, urban populations can access private facilities under the

national health insurance while poorer and indigent populations access care through public facilities. This system has led patients on an “erratic” healthcare journey, largely dependent on the financing capacities of the individual, with no coordination between health sectors (Country respondent, Northern Africa).

There are also other actors in health that fall outside of regulatory oversight (these range from the informal to global actors). There were concerns voiced that regulation should extend to these private sector players, including global commercial actors, non-governmental and civil society organisations (NGOs and CSOs).

“Everybody should have somebody supervising them, everybody should be accountable to somebody.”

Regional respondent

International NGOs involved in service delivery and product distribution were considered more “accountable to their donors than the minister of health” (Regional respondent). This was viewed as particularly problematic in fragile and humanitarian contexts. The role of more indigenous CSOs was also a concern given that they are not registered with ministries of health or other regulatory bodies.

Contracting was a widely used tool of government for engaging the private sector in health systems goals. Examples of successfully contracting of health care services were found across the continent. Capacity to engage in formal contracts varies and challenges remained. These included continued lack of trust between the sectors, and procedural issues, such as delays in reimbursement and limited financial capacity to contract.

As affirmed by respondents, contracting experience has tended to instil distrust, given weak contracting systems and practices in many contexts. Respondents referenced examples of poorly negotiated contracts that did not provide value for money for government (e.g., the Lesotho Alzira model), “the negotiation was so poor...the health budget was swallowed up by one facility” (Regional respondent). In Zambia, contracts were considered “more political and don’t last long” (Country respondent, Southern Africa). In general, respondents acknowledged that there was need for adequate resources, capacity, and transparency to contract well. Past experience and perceptions – real or otherwise – of corrupt and nepotistic practice have left countries in a deficit position. There is need to (re)build accountable and transparent systems for contracting to be a viable tool of government.

The inclusion of private sector perspective and greater transparency in the formulation and implementation of regulation was identified as an area for improvement. Government needs to understand the sector that they are trying to regulate – “take the industry with you” – to improve compliance and prevent unintended consequences. It was suggested that the more “public” government can be with regulation the greater the ease of doing business transparently. It was recognised that some countries, such as Zimbabwe and Rwanda, had made this a policy imperative.

“The more public governments can be, the more transparent they can be, using digital technology, and talking with the private sector through those mediums and getting inputs, I think that is really, really helpful. So not going the traditional methods of putting something out in a government Gazette.”

Country respondent, Southern Africa

Nurture trust



Government leads the establishment of transparent, accountable and inclusive institutions at all levels to build trust

To ensure the accountability of actors in healthcare systems, the efforts of public and private entities should establish a foundation of trust. Lack of dialogue and engagement may result in mistrust and blame shifting between public and private partners, to the detriment of health system goals. Improvement requires an understanding of the factors that promote or hinder accountability environments. Critical to managing conflicts of interest is recognising public and private sector motivation for engagement and the incentives that underpin this.

“It is not a two-way street, you find that government might have certain interests in engaging private sector, and private sector may have different interests in engaging with government. One of the major issues that we found in this engagement was the issue of trust, where the private sector hasn't really developed a lot of trust in working with the government.”
Regional respondent

A key lever in accountability, the consumer, is not leveraged in many contexts, despite political commitment to UHC. Trust is needed between public and private entities to nurture consumer trust in the health system (21). In many contexts, this is highly inequitable “universal” care. As reported, inequities in access and quality of care were not “pain points” for governments which invest in areas with higher political returns. Given that health systems are characterised by asymmetries of power and information, consumers are reliant upon the professionalism and ethics of health actors and the institutions governing care environments.

“People don't know their rights...so you never really know what are your missing unless you see it.”
Regional respondent

“It is the middle and upper middle class that cause trouble ...but the poor and the very poor... don't put any pressure to better the situation.”
Regional respondent

A lack of dialogue was found to hinder trust despite the existence of formal engagement structures. As reported, government structures exist “on paper” but often the reality is different. In some instances, they may even be comprehensive, they “tick most of the boxes” (Country respondent, Southern Africa). These may include formal processes related to new legislation as well as more quotidian issues,

“The structure is there, you have issues, you know who to speak to, but there are lots of blockages.”
Country respondent, Southern Africa

Bureaucratic bottlenecks and the wider political economy hinder dialogue, and constancy in private sector engagement.

“Other African nations are further ahead... you can get an appointment with the Minister of Health in Rwanda and Minister of Finance in three days. In South Africa, you can't get past the receptionist.”
Country respondent, Southern Africa

“You can't erase conflicts of interest...when there's dialogue and conversation, that's how [issues] are addressed.”
Regional respondent

In most contexts there is no opportunity for regular dialogue to engender understanding between sectors and stakeholders. This reportedly pushes issues to implementation when the structures are needed to deliver intended functions. A lack of proactive engagement

serves to deepen the mistrust over time. Private sector respondents recognised the need for more frequent and more structured dialogue. Other respondents suggested shifting the locus of decision making to more neutral bodies such as parliamentary committees, to reduce “street level” interference by bureaucrats. The issue of mindset was raised as an important ingredient for effective collaboration.

“It takes someone who understands the perspectives of the private sector, who has worked in the private sector, or who knows how to design partnership models with the private sector, to be able to begin that trust building process.”

Regional respondent

Recognition of the potential role of intermediaries in brokering dialogue and building “skill and will” was raised in several contexts. Given temporal lapses in engagement and entrenched mistrust, there was

recognition of the need for additional intervention through intermediaries. This varied by region. In sub-Saharan Africa, there was reportedly more dialogue, but it was an ill honed skill.

“Some people don’t know how to dialogue... there is also a lot of arrogance with larger private sector which may put off ministries of health.”

Regional respondent

Mechanisms to manage conflicts of interest were also reported as lacking.

“Now, when you talk in whose interest are you talking? Do you talk in the interest of the population or in your own interests?”

Regional respondent

Dialogue grounded in evidence and experiential knowledge as well as a common “pain point” may reduce this. The emergency response provided such as focus.

Deliver strategy



Government establishes the priorities, principles, and values for the health system, and works out how to translate these priorities, principles and values into practice

There is a lot to learn about private sector engagement to deliver effective health strategy. While the 2030 Agenda “calls on all businesses to apply their creativity and innovation to solving sustainable development challenges”, there is limited evidence of the development results achieved through private sector engagement (7). This governance behaviour therefore considers the need for calibration of health system objectives and strategies to gird private sector contribution – from impact investors to primary care facilities – underpinned by the development of robust monitoring, evaluation, learning and knowledge management functions and capacities.

The review showed that most countries have inclusive health strategies that define roles for the private sector. This has mainly focused on private health service delivery providers such as “legacy” faith-based structures. Despite private sector inclusion in national strategy, this remains conceptual and is often not monitored or evaluated (or implemented in some contexts). Regional respondents confirmed that a critical ingredient for successful partnerships related to clarity of vision, and purpose, which often don’t emerge from broader strategies - this is where “engagement starts to go wrong” (Regional respondent). In contrast, defined partnership requests from government for specific interventions provide clarity of purpose. Priority health programs such as HIV/AIDS, TB and immunization tend to have more experience with these requests. However, these vertical forms of partnership have contributed to uneven skill and strategy for private sector engagement across public health structures.

Novel forms of private sector engagement have emerged, many centred around harnessing business acumen to effectively deliver strategy. These have been conceptualised as “cross sectoral partnerships” in which the public, private, and social sectors collaborate for public benefit. Two areas that have received attention within Africa are supply chains and HIS. In these partnerships, commercial private sector entities work in lock step with public sector counterparts

through commercial “knowledge transfer” a wedge to drive improved performance of health systems. These and other innovative private sector engagement have not been evaluated and may pose risks if not carefully managed and governed.

Existing tools of government offer opportunity to deliver strategy through greater regulation and organisation within the health system. For example, UHC schemes allow government to redefine its role as purchaser of services. This has accountability advantages over direct provision as governments are likely to be more objective in evaluating the work of contracted private entities than in evaluating their own work (22). Tracking fund flow through a purchaser-provider split is also considered one of the most reliable mechanisms to ensure accountability (23) and build understanding through data. While these mechanisms remain under-utilised, there are efforts under way in a range of contexts to create a purchaser-provider split. These require data and information to benchmark performance and hold sectors and stakeholders to task, “we need more granular accountability to perform” (Country respondent, Southern Africa).

Better metrics and mechanisms are needed for effective monitoring of the private sector in health system goals. This applies equally to innovative and more traditional forms of private sector engagement. These should articulate clear outcomes and means of verification, capture learning and knowledge management. Learning is integral to health systems - or should be. Health systems that do not learn from their own or others’ experiences can repeat mistakes. However, many African health systems do not have sufficient capacity to effectively collect, use, and retain available knowledge and information, and to generate new knowledge; furthermore, professional or bureaucratic norms may not encourage self-reflection and positive learning cycles (24).

Conclusion

The private sector presents an important partner for UHC if governed to do so. However, the private sector is often disparate and requires effective governance to deliver on strategy set by government as part of UHC. This increasingly includes a diverse set of private sector entities with different expectations of returns—from philanthropists and foundations, to impact investors, and financial institutions, among others. Health is a “lion on the move”; the high growth and high returns of this lion may overshadow more quotidian private sector health service delivery, particularly at primary healthcare level.

The study affirmed the range of private sector actors engaged in health service delivery chains in Africa. While their diversity and attraction – their drawing power– has evolved over time, public sector structures have remained relatively static. More attention has been put on reducing atomisation in the private sector, with less attention to fragmentation of the public sector and the limitations this poses to private sector engagement

in public policy. Current events have served to reinforce the need for such engagement and have exposed the limitations of not having a strategy or the corresponding resources, the “skill and will” necessary to effectively work with the private sector in health.

The findings further affirmed the importance of the intermediaries’ role in supporting member states to more effectively engage with the private sector. This includes building from existing initiatives such as efforts to address regulation at a regional level. The findings also affirmed the importance of robust governance of the *whole* health system. This is good for both the private and public sectors, but most importantly, population health. In times of crisis such as the world is currently experiencing, real solutions do not benefit from divisive tactics, but arise through collective action, one that places the “public” at the centre of health systems and public-private engagement.

Policy implications

The following policy implications seek to support countries in building a more inclusive and effective governance of the health system as a whole, underpinned by robust monitoring, evaluation, learning and knowledge management.

Private sector as co-creator and thought partner in health

Recognize the breadth of the private sector and the myriad roles it plays in healthcare value chains. These encompass both formal and informal actors ranging from drug shops to specialised hospitals, comprising both for-profit and non-profit entities, domestic and foreign. Increasingly, non-traditional health actors are also part of healthcare value chains and may include global commercial brands, banks, logistics and tech companies. All should be held accountable to improve or maintain health outcomes and avoid unnecessary or ineffective care.

Shift mindsets to private sector as a co-investor and thought partner in health systems. This mindset shift is needed at different levels of the health system and along the healthcare value chain. While traditionally the private sector has been viewed as a source of financing to be tapped, particularly in light of contracting donor resources in many African contexts, governments should reorient their outlook to one of knowledge exchange and co-creation with the private sector as a means of unlocking innovation and advancing health system maturity. Government needs to ensure that such co-investment and partnership arrangements are guided by UHC as the over-riding goal, so that investments and actions that promote and sustain equity in service use, quality, and financial protection are assessed at the level of the entire population. Equally, the private sector in health should approach engagement with government through research and deeper understanding of context as part of “doing social business”.

Government as orchestrator and modulator of the private sector in health

To instil greater accountability between sectors, there is need to formalise and organise sectoral engagement. Atomised relationships between and within the public and private sectors divide up accountability relationships and loosen accountability chains. There is greater need to formalise relationships with the private sector so that they can be “onboarded” into health reforms and policy formulation. A more coherent and organised “whole of public sector” approach should be taken to private sector engagement.

Create greater regulatory certainty for the private sector in regional and national healthcare value chains. This should strike a balance between too much and too little regulation so that private sector participation in health system goals is facilitated. Regional approaches to regulatory system strengthening for some aspects of the healthcare value chain, such as medicines, have shown promise and could be extended to other areas, such as vaccine development. Private sector perspective should be solicited as part of regulation. Greater feedback loops (such as helpdesks) could be introduced as well as opportunities for “workshopping” concerns. In general, greater digitization of regulatory processes is recommended to improve transparency and ease of doing business.

Consumers at the centre of health value chains

Consumers should be repositioned as the “North Star” of private sector engagement in healthcare value chains and public policy. The efforts of both sectors should establish a foundation of trust between consumer and the health system, irrespective of point of care. Government should set standards (or support professional associations to

do so) that provide a compelling vision and “rules of engagement” for all actors for more responsive, resilient, and equitable health systems. Where the public sector has pursued private sector initiatives, the primary rationale has not always been that of equity. This needs to remain a primary objective of public health policy and private sector engagement.

Reinforce indigenous and regional roles and peer engagement in health

Reinforce the role of professional associations in private sector engagement in public policy. As the landscaping attested, associations are a ubiquitous and often under-utilised resource in private sector engagement in many African contexts. They can be more deliberately engaged and supported to work with the public sector to develop and institutionalise conventions, norms, behaviours and ethics within healthcare value chains and systems.

Reinforce good practice to build effective private sector engagement and promote peer learning. There is opportunity to learn from practice and reinforce good practice. A number of regional bodies and initiatives can be harnessed for this purpose. Cataloguing and

coordinating these initiatives is important to ensure coherent technical and political support that meets the needs of countries in their engagements in “real time”. There was demand expressed through the landscaping for more regional dialogue, greater emphasis on collective work, and the establishment of a learning platform.

Frame engagement in health and ground this in data and evidence

Build governance behaviours for private sector engagement in healthcare value chains and public policy. The landscaping highlighted the human element of public and private engagement and its vagaries. While individual countries have taken different stances on engaging the private sector in health, there was overarching recognition of the need for improved governance, grounded in data and evidence. These sentiments resonate with the recently launched WHO strategy, *“Engaging the private health service delivery sector through governance in mixed health systems.”* It is recommended that WHO works towards operationalizing the governance behaviours and support countries to benchmark progress. This should include “building fluency” in evidence with policy makers and other key stakeholders, including local researchers.

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