To meet the needs of all segments of the population, countries must make the best use of all available public, private, donor, and nongovernmental organization (NGO) resources. Thus, the final component of the EQUITY Framework calls for yielding public-private partnerships (PPPs) for equity (see box). Few government health systems can meet the health needs of all citizens. And for health systems in developing countries that are facing severe gaps in human capacity, financial resources, and infrastructure, the situation is even more critical. Leveraging resources from across sectors can enhance program reach and impact, expand client choices, and, ultimately, foster greater equity for underserved groups. A “total market approach” aims to ensure that the public sector and/or subsidized NGO, faith-based, and private sector services cater to the needs of the poor, while clients who can afford to pay for health services use the commercial sector.

Public-private partnerships in the health arena can capitalize on each sector’s strengths, achieve economies of scale, create competition, maximize the use of existing capacity, and extend health service delivery networks. They are also useful in mobilizing additional resources and targeting efforts to reach the poor and underserved populations. The USAID | Health Policy Initiative, Task Order 1, has developed a strategic process to mobilize the private sector and promote effective public-private partnerships. This process begins by understanding the policy environment and the market, then creating an enabling environment, and finally, defining public and private sector roles and fostering PPP models.

Through this multi-stage process, partners work to determine needs and define their niche and target population(s). Strong partnerships help both the public and private sectors leverage one another’s resources and strengths to reach common objectives. Each partner must jointly agree on appropriate roles, responsibilities, shared goals, and the strategic options to be developed. Appropriate PPP models are then designed and tested to evaluate impact. Based on lessons learned, costed scale-up strategies are designed to ensure sustainable financing and link with the policy framework. Government leadership, trust among stakeholders, and broad participation and country ownership are key elements throughout the process.

The following examples highlight how countries are successfully mobilizing the private sector and promoting effective public-private partnerships to enhance equitable access to health services.
Vouchers Expand Access to Health Services for India’s Low-income Families

The U.S. Agency for International Development (USAID) and government of India have collaborated to promote PPPs for family planning/reproductive health (FP/RH) service delivery and financing. As part of these efforts, they have developed and pilot-tested demand-side financing schemes and partnership models to mobilize public and private sector resources, strengthen existing health systems, expand access to services, reduce inequities in the use of reproductive and child health services, and improve service quality.

In particular, with support from the USAID-funded ITAP,3 India tested and scaled-up various types of voucher scheme models to provide affordable reproductive and child health services to below poverty line (BPL) families in the states of Jharkhand, Uttarakhand, and Uttar Pradesh. The Health Policy Initiative has worked to share best practices and foster enabling policy environments in these states, including supporting the design of policies to scale up PPP models, integrate RH/HIV services, and reach the urban poor. As part of this effort, the project documented ITAP’s establishment and early implementation of the voucher scheme in Agra District, Uttar Pradesh.4

The Agra Voucher Scheme launched in January 2007. NGOs implemented the activities in six blocks, and the Medical Officer In-Charge of the Primary Health Center implemented activities in one block. Setting up the voucher scheme involved training and supervision of accredited social health activists (ASHAs); design of the patient-held records and vouchers; design of a marketing and communication strategy; and creation of management information systems.

The Agra Voucher Scheme required that private providers and nursing homes accredited to receive reimbursement from the scheme achieve a minimum level of quality. Under the scheme, BPL families redeem vouchers at accredited private hospitals in exchange for free RH services, including antenatal care, institutional delivery, postnatal care, and FP services. The private hospitals then submit the vouchers to the government for reimbursement. The early assessment of the scheme showed that many poor women used the vouchers to access services. After nine months in operation (March–December 2007), the scheme was on track for or had exceeded some of its Year 1 goals. More than 7,000 poor women in target blocks sought antenatal care and about 1,400 institutional deliveries were performed. Field visits revealed numerous stories of women who were motivated and assisted by the ASHAs to seek health services.

Good for People, Good for Business: Private Companies Address HIV in the Workplace

Efforts to involve the private sector typically focus on the role of the commercial, NGO, and faith-based groups as providers of health services. Increasingly, private companies are coming forward to promote the well-being of their employees, workers’ families, and, in some cases, communities. The USAID-funded POLICY Project and, subsequently, the Health Policy Initiative have mobilized the private sector by helping to form and strengthen HIV business councils; integrate HIV workplace policy management into MBA curricula; and assist companies to design HIV workplace policies. These initiatives have led to the adoption of anti-discrimination policies, introduced HIV prevention and care in workplaces, and encouraged business leaders to speak out against stigma. From an equity perspective, such initiatives promote equal rights for people living with or affected by HIV, ensuring their access to employment and the benefits of employment (such as an income and health insurance).

- **Formation of HIV/AIDS business councils in Mexico, Guatemala, and Jamaica.** Business councils have become key forums for sharing HIV information within the business community, encouraging members to adopt HIV policies and leverage resources, and fostering partnerships across government, civil society, and private sectors.5 For example, Mexico’s National HIV/AIDS Business Council (CONAES) is a voting member in the National AIDS Council Governing Body. Also, the 26 members of CONAES, which have adopted anti-discrimination and HIV policies, reach about 150,000 employees in Mexico.

- **Adoption of HIV workplace policies by businesses across sub-Saharan Africa, including Mali, Mozambique, and Tanzania.** One of the companies to adopt an HIV workplace policy is Grupo Madal SARL, a large agro-industrial company operating in Mozambique’s Zambezia Province, where adult HIV prevalence is 19 percent. The company’s HIV policy prohibits discrimination on the basis of HIV status and affirms the right to confidentiality. Because many of Madal’s employees are illiterate, the company has adapted HIV prevention materials to meet their needs. The company also plans to assist employees living with HIV by supporting provision of antiretroviral treatment and food baskets. As many of the employees live in rural areas surrounding the plantation areas, the company has also supported voluntary counseling and testing efforts, which benefit the broader community as well.
In addition, the assessment found that private providers viewed participation in the Agra Voucher Scheme as advantageous because of increases in the use and estimated revenues of the participating nursing homes. Other nursing homes also requested to be accredited to participate in the voucher scheme.

In 2008, the government of Uttar Pradesh scaled up the approach as the Sowbhagyavati scheme, accrediting 150 private hospitals using guidelines and financial compensation used under the pilot voucher scheme.

Public-Private Dialogue Charts a New Roadmap for Peru

In 2008, the Health Policy Initiative assisted stakeholders in Peru to explore the private sector’s role in the provision of health services, particularly FP/RH services. This involved assessing PPPs as a viable model to improve access to and quality of FP/RH services, particularly for populations in rural and remote areas.

A review of the literature revealed that, while technical expertise and the potential for partnership existed in Peru, PPP models had been mainly limited to infrastructure and industrial development sectors. Market segmentation studies of the ENDESAs (demographic and health surveys) suggested a recent shift toward the private sector for FP services and demonstrated a diverse private sector client demand. The project also conducted 55 interviews in Lima, Piura, Cajamarca, San Martin, La Libertad, Junín, and Cusco districts to explore barriers to greater private sector engagement and effective implementation of PPPs.

Despite a potentially favorable legal and policy environment, one challenge has been continuing confusion over the definition and functions of public-private partnerships—for example, limited understanding of the crucial differences between PPP initiatives and the privatization of health services. In addition, perceived cost disincentives had dissuaded the private sector from participating in PPPs, thereby limiting opportunities for further private sector contributions to health service delivery.

Recognizing the importance of sharing public-private models that define each sector’s roles and responsibilities, the project prepared country case studies of different models. The case studies highlighted the need for well-constructed contract mechanisms (e.g., contracting out, voucher schemes, and corporate social responsibility initiatives). Such models address stakeholders’ concerns that ambiguous incentive mechanisms had been deterrents to effective partnership in the past; they also highlight reductions in costs for services while encouraging investments in health systems from both sectors.

Based on this initial work, government, NGO, and private sector stakeholders in Peru acknowledged the need for an extensive review of the national legal framework, focusing on public-private implementation at the local and regional levels. Stakeholders were optimistic about the prospect of alleviating unmet FP need through public-private alliances. This optimism was based on strong interest in partnerships from both sectors, Peru’s legal framework, established quality standards for systems delivery, and a political environment geared toward universal health coverage. Stakeholder workshops and public-private dialogues among Peru’s Ministry of Health (MINSA), NGOs, and commercial service providers helped to clarify PPP objectives, define potential contractual models (e.g., the types of mechanisms to be implemented and returns on investment in the long run), and outline the operational scope for both sectors.

Based on stakeholder responses to the interviews and first roundtable, the Health Policy Initiative constructed diagnostic tools and regional surveys to further assess the legal and policy framework in the public health system. In October 2009, the project organized a regional workshop with high-profile public sector and regional government health providers, including MINSA, representatives from the Agency for Promotion of Private Investment (Proinversión), and EsSalud, the Peruvian Agency for Social Security and Investment. Keynote speakers and PPP experts from Argentina, Brazil, and Mexico shared their assessments of the legal and political frameworks related to partnership and health investment in their countries. As this was the first meeting of its kind in Peru, the overall consensus indicated a need for further sensitization and dialogue on appropriate PPP models for the country.

Following the October 2009 workshop, stakeholders came together to establish the Investment and Development Group for Public-Private Partnerships in Health. With
technical assistance from the Health Policy Initiative, the Investment and Development Group produced Peru’s first roadmap for implementing sustainable public-private partnerships in health; the roadmap received official MINSA approval and endorsement in January 2010. Using the roadmap and regional diagnostic results, the Health Policy Initiative is collaborating with MINSA and regional health directorates from the Cajamarca and Trujillo districts to begin designing a preliminary contract between public and private sector providers to establish health services to better reach underserved areas.

Given the positive responses from MINSA and other key participants, the project team sponsored a second technical meeting in January 2010. The meeting’s goals were to continue to foster a public-private dialogue, share additional lessons learned from the regional studies, and mobilize key private sector providers, NGOs, and other cooperative agencies. The meeting concluded with the official launching of MINSA’s Public-Private Partnership website, accessible at http://www.minsa.gob.pe/ogpp/APP/evento2.html. The website includes a comprehensive database library containing relevant publications, links to past initiatives, and references to current activities in Peru.

Initial Policy Dialogue and Assessments Highlight Options for PPP Models in Rwanda

Increasing FP demand in Rwanda requires greater resources to meet the population’s needs. The Health Sector Strategic Plan (2009–12) revealed that the greatest funding gap is in the FP/RH and maternal and child health program area. The private sector can play an important role in filling resources gaps to bolster FP programs. By targeting resources and efforts to specific populations, the private sector—a preferred provider for young and unmarried people, and for those who can afford to pay—can help reduce the public sector’s burden. However, while the Rwandan government is committed to expanding the private sector’s involvement, there is no policy framework or platform to guide collaboration for health and family planning.

Using an intensive review process with strong stakeholder involvement, the Health Policy Initiative recently examined how the private sector’s role can be strengthened to support FP/RH efforts. The project found that a number of capacity-building initiatives are underway that include the private sector. There is also untapped potential to strengthen the involvement of NGOs. Possible next steps include creating a coordinating body for PPPs in health and family planning; designing a PPP strategy; and developing innovative partnerships with NGOs and social marketing groups to expand services to hard-to-reach areas and help serve the poor. Stakeholders have also suggested including the private sector in health insurance schemes; implementing a social franchising model to reach specific populations; using mobile clinics to offer a range of health services in remote and rural areas; and including FP services in the workplace by collaborating with the Private Sector Federation.

A public-private sector roundtable took place in August 2010 to share findings and identify specific actions to strengthen collaboration among the various sectors.

ENDNOTES

3 ITAP is the Innovations in Family Planning Services II Technical Assistance Project funded by USAID and implemented by Futures Group.