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Role and contribution of private sector in moving towards universal health coverage in the eastern mediterranean region

Shehla Zaidi

Aga Khan University, shehla.zaidi@aku.edu

Atif Riaz

Aga Khan University

Ali Thaver

Aga Khan University

Aftab Mukhi

Aga Khan University

Latif Afzal Khan

Aga Khan University

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**Role and Contribution of
Private Sector in Moving Towards
Universal Health Coverage in the
Eastern Mediterranean Region**

Acknowledgment

This publication was prepared by Dr. Shehla Zaidi, Associate Professor, Aga Khan University, Pakistan. Contributions were made by research team members: Atif Riaz, Ali Thaver, Aftab Mukhi and Latif Afzal Khan. It landscapes regional country experiences in harnessing private health sector to expand access to health care through regulation and purchasing of health services. It pulls together current published and unpublished evidence, to highlighting key lessons learnt, underlying drivers and areas where more information is needed. The study was funded by the Health Systems Division of Eastern Mediterranean Regional Office-World Health Organization. Technical guidance was provided by Dr. Hassan Salehi at WHO-EMRO. The opinions expressed in this report are those of the authors and do not necessarily reflect the views of WHO-EMRO.

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Acronyms

AFR	Africa Region
AIDS	Acquired Immune Deficiency Syndrome
AJK	Azad Jammu & Kashmir
ANC	Antenatal Care
BCC	Behavior Change Communication
BHU	Basic Health Unit
BPHS	Basic Package of Health Services
CCC	Chronic Care Center
CBHI	Community Based Health Insurance
CCT	Conditional Cash Transfer
DM	Diabetes Mellitus
DoH	Department of Health
EmOC	Emergency Obstetric Care
EMR	Eastern Mediterranean Region
EMRO	Eastern Mediterranean Regional Office
GCC	Gulf Cooperation Council
GoB	Government of Bangladesh
HMIS	Health Management Information System
IEC	Information Education and Communication
LIC	Low Income Countries
LMICs	Lower Middle Income Countries
MHOs	Mutual Health Organizations
MNCH	Maternal, Newborn & Child Health
MoH	Ministry of Health
MoPH	Ministry of Population Health
NGOs	Non-Governmental Organizations
NHI	National Health Insurance
NPPI	Norwegian Pakistan Partnership Initiative
OOP	Out of Pocket
OPD	Outpatient Department
PHC	Primary Health Care
PHS	Private Health Sector
PNC	Post Natal Care
PPHI	People's Primary HealthCare Initiative
PPP	Public Private Partnership
SBA	Skilled Birth Attendant
THE	Total Health Expenditure
TB DOTS	Tuberculosis Directly Observed Treatment Short Course
UAE	United Arab Emirates
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
YMCA	Young Men's Christian Association

Executive Summary

Attainment of Universal Health Coverage is a progressive realization for EMR Member States and can be accomplished by expanding breadth of population covered by services, depth of services covered and expanding extent of financial risk protection. The private sector has grown exponentially in most EMR states, and remains an untapped key partner for moving towards Universal Health Coverage. Regulation, information provision and purchasing of services remain important tools for harnessing private sector towards strategic UHC goals.

Private sector potential and pitfalls: Private sector growth has taken place with too little policy to guide growth. Private sector utilization is particularly high in EMR states where public sector spending on health is low and consequently shows private sector emergence as a result of insufficient or underperforming public sector services. Essential information on private sector composition, service coverage, quality and pricing continues to be patchy, although notable efforts have started in many states. We find from recent studies that the private sector has fairly adequate quality of services in middle and high income countries but needs quality oversight in low income countries. Payment for private health services can be substantial to catastrophic even for routine, less complicated procedures such as C-sections, highlighting need for safety net.

Public Private Partnerships are shaped by local context: Private sector contribution varies according to the context of particular countries, and hence demands locally responsive strategies for harnessing the value added services. In certain states, government partnerships with private sector have focused on specialty hospital services to complement gaps in government services, in others states these have been targeted towards private sector management experience of hospital and diagnostic facility, while in yet other countries private health sector has established itself in providing primary care services in urban centers and also expanding to rural areas.

Regulation to harness private sector: approach, coordination and enforcement: Regulation of entry of private health providers and of Industry in some form is in practice in all EMR states. However, regulation of hospitals and clinics remains a grossly overlooked area, least innovations have been practiced here and is necessary for harnessing private sector towards UHC. For enactment of regulation, policy coordination is required between larger economic private sector growth policies and those enacted by Health. The notion of stewardship is only beginning to be realized in Ministries of Health and needs to be practically backed up by formal dedicated structures for regulation either within or outside the Ministry of Health. These need to be supported by databases for private sector mapping, accreditation tools and adequate human resource and budgetary support. The essential approach to regulation remains undecided and uncertain in most states, and new approaches involving multi-stakeholder regulation and use of incentives and self-accreditation options are important options as opposed to punitive action and state as the sole actor. Consumer information while available to varying extent for drugs and food products, has not been extended to health services in the EMR, requires a multiplicity of arrangements to serve as an effective tool for patient safety and financial access. Consumer information and protection relies on a multiplicity of arrangements across Legal Ministry, Health Ministry, Consumer Bodies and Private Health Providers, and if hastily introduced can lead to delays in redress, unnecessary litigations and growth of expensive medical technology as defensive mechanism by medical sector.

Purchasing Health Services: Financial, Technical, Market & Political Considerations: Purchasing private health services has been more widely practiced than regulation in developing economies and also has a growing body of evidence on its effectiveness. Purchasing of private sector services for Health initially started out in the EMR in the area of support services for hospital, expanded to hospital beds and specialty services, and more recently has involved purchasing primary and preventive care services from NGOs. Purchasing by the state in the EMR has usually been through evolving national health insurance schemes, contracting out the management of government health facilities, contracting out private sector for specific service delivery schemes, and in a couple of countries through health vouchers and community health insurance.

But can PPPs work? Global evidence provides encouraging and significant evidence of overall impact of PPPs on increasing the use of primary care services but there is uneven increase across different services and much depends on design of PPPs. Although PPPs have increased access to services, they have generally not reached the poorest segments of the population. Amongst the different PPPs, vouchers have the best service coverage, at least for safe motherhood and primary care, followed by CBHI and NHI schemes. PPPs have resulted in improvement of infrastructure; availability of drugs, staff and supplies, but information on technical process of care remains thin. There is inconclusive evidence as to whether PPPs can bring about a reduction in patient OOP expenditure. Few instances of reduction in client expenditure have been reported for CBHIs and NHI schemes but there are data gaps for contracting out and voucher schemes. Drivers and constraints for PPPs: Contracting experiences has shown that the private sector grows and adapts in response to purchasing. However, necessary preparatory work within government needs to be built prior to purchasing of services. This requires demarcated structures for open competitive tendering to avoid monopolies as well as skills for prior estimation of unit costs, development of performance based contracts, and independent monitoring. Costs of purchasing private sector services and enrolment of low income clientele can be high, and need to be built into state budgets prior to embarking on PPPs. Policy support for purchasing and financing the private sector for UHC has tended to be lukewarm and country experience shows that a slow and cautious expansion of PPPs over time has been better for fostering trust and harmonial working between public and private sectors. Lastly, while the policy push for PPPs has usually come from international donors, there needs to be caution in use of donor funding for embarking of PPPs for UHC as this can lead to fragile programs.

Chapter 1:

Introduction and Overview of Private Health Sector in EMR

Background

Universal Health Coverage: The background paper of World Health Assembly 2005 defines Universal Health Coverage (UHC) as “access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access” (World Health Assembly, 2005). The diverse definition attempts to include disadvantaged and excluded groups in terms of access to care ensuring that financial hardships do not act as a barrier in that regard (O’Connell et al, 2013). Universal Health Coverage (UHC) is an integral approach to a country’s overall human and economic development strategy. UHC has also been defined in the Rio+20 Political Declaration as being crucial to “enhancing health, social cohesion and sustainable human and economic development” (United Nations Conference on Sustainable Development 2012, p. 25) and has received considerable attention at a global stage, particularly within the debate on the post-2015 development goals (United Nations 2013, p. 38). Importantly the WHO-EMRO has developed and endorsed a framework for action on advancing Universal Health Coverage in the Eastern Mediterranean Region based on the following four domains:

- *Developing a vision and strategy for universal health coverage*
- *Addressing coverage of financial risk protection*
- *Expanding the coverage of needed health services*
- *Ensuring population eligibility, entitlement and actual coverage*

Challenges to UHC: The private sector has in the past two decades expanded significantly in this Region. In some countries, an estimated 70% of the population seek healthcare from the private sector.¹ Yet issues related to the private health sector [PHS] have not been addressed properly by many Ministries of Health [MoH]. In most low and middle income countries of the Eastern Mediterranean Region [EMR] the perceived quality of care in the public sector is poor and accessibility and affordability to comprehensive health services is a challenge. Even in high income EMR states, where quality is expected to be less of an issue, there is insufficient information and lack of database on private health sector. Moreover, private sector health care providers have no or minimum role in national health policies. This is not only due to lack or insufficient information and intelligence with regard to the private health sector, but also lack of trust between public and private sectors, poor or absence of regulatory mechanism that can bring the health care providers at public and private sectors together etc. However, there is evidence across the world that the private health sector can contribute effectively in all three dimensions of universal health coverage [UHC].

Public Private Partnerships for UHC: Public Private Partnerships (PPPs) have gained significant global policy attention in recent times, and have been implemented by a growing number of countries within and outside the EMR. A notable although less visible trend is also seen now in focal countries of the EMR. PPPs in the health sector can be defined as an institutional relationship between the government and the private sector (non-profit organizations, commercial private sector), to achieve a shared health goal on the basis of a mutually agreed division of labor (Buse and Walt 2000). It requires a written agreement that specifies the obligations of each organization involved, the objectives of the partnership, and how the partnership will be managed or governed (Widdus 2003).

¹ Health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action, EM/RC59/Tech.Disc.1. http://applications.emro.who.int/docs/RC_technical_papers_2012_Tech_Disc_1_14613_EN.pdf

Public private partnerships are essential in moving towards Universal Health Coverage so as to fill gaps in coverage, prevent government from over stretching its capacity in delivering for all, and harnessing the siloed and rapidly growing private sector towards national and state policy goals. Regulation, provision of consumer information, and purchasing of private health services are essential to ensure that issues of quality of services and patient safety are integrated into private health care delivery, in addition to access and equity of public sector services.

Public private partnerships can be informal such as involving the provision incentives, target setting , training and support for supplies to the private health sector by the state, or can be more explicit and formal involving purchasing of services by the state or binding legislative control.

Recent work by WHO-EMRO: Mapping the PHS in EMR countries is one of the priorities which have been identified by the Regional Office. A commitment to do so was included in a paper presented to the 59th session of the Regional Committee held in Egypt during October 2012². Developing a regional strategy for cooperation with private sector was the main message of the private sector side meeting discussion of the 60th RC side meeting. Over 2013, EMRO completed preliminary analysis of private sector in EMR countries and two studies on regulation of private sector in the region and presented in RC 60.

Purpose

This paper provides material for discussion on harnessing of the private health sector in the EMR, by pulling together published material from within the region, and supplementing with hard evidence from outside the EMR. Despite limitations in availability of data and the challenges associated with data mining, a systematic effort has been made to pull together the best available data and information.

Specifically, this paper provides information for discussion on the following areas:

- Current role of the private sectors with a particular emphasis on regulation, consumer information and purchasing/ financing of private health services towards UHC.
- Analysis of success drivers and constraints in strengthening role of private health sector in setting regulatory mechanism and service provision in the countries.
- Based on the above to propose a framework that includes regulations, service provision, and financing as basis for enhanced role of the private sector in moving towards UHC.
- Propose a list of priorities for EMR states and role of the WHO in supporting member states in strengthening Public Private Partnership.

Private Sector in EMR: An Overview

The important role of the private health sector [PHS] in care delivery of most countries of the Eastern Mediterranean Region ^[1] is increasingly being acknowledged by the ministries of health in the Region. Despite this recognition, it has not been possible to formulate an evidence-based strategy on the role and contribution of the private health sector in provision of health care services in moving towards universal health coverage.

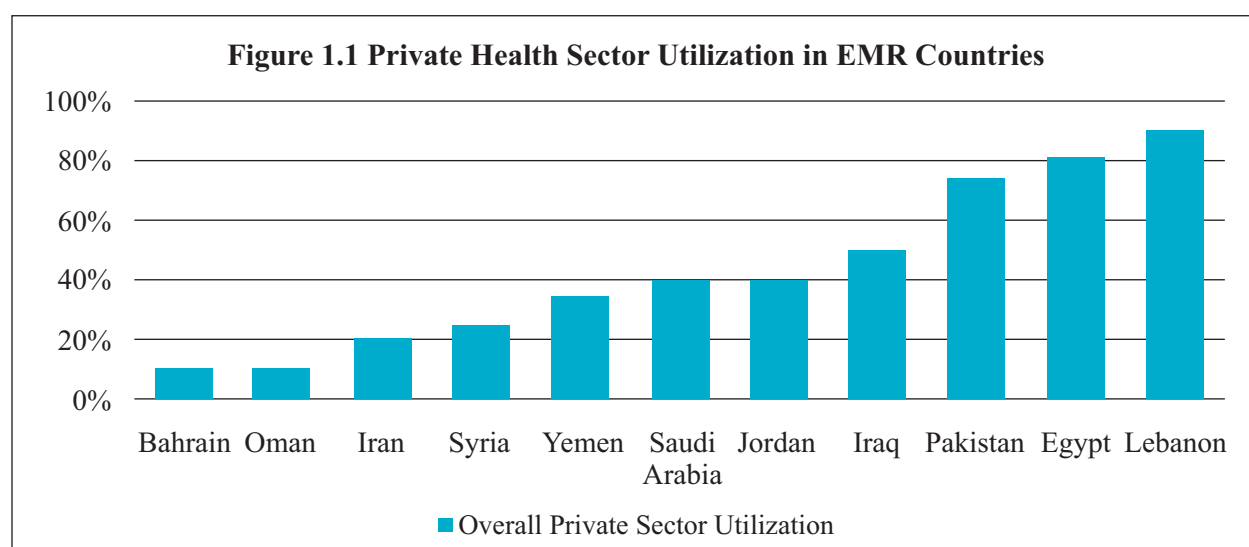
¹Group 1: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates; Group 2: Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Libya, Morocco, occupied Palestinian territory, Syrian Arab Republic and Tunisia; Group 3: Afghanistan, Djibouti, Pakistan, Somalia, South Sudan, Sudan and Yemen.

² Health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action EM/RC59/Tech.Disc.1 September 2012. Regional Committee for the Eastern Mediterranean Fifty-ninth session.

Eastern Mediterranean Regional Office [EMRO] recent assessment of private health sector in twelve countries shows that the role of the private health sector is not well defined, its capacities are poorly understood, their contribution in preventive care and screening is not optimal and even practices and care delivery are not monitored. The range of services provided is variable from one to another private care provider within same country, standards are questionable, regulation is poor and there is insufficient information about financial burden to the users of these services. The user rates for private sector in relation to outpatient services ranges from 33% to 86%³. From 11% to 81% poorest quintile in the same groups of the countries uses private sector services⁴.

Private Sector Composition and Contribution to Healthcare Delivery in EMR Countries

The data from the recent surveys and reports from World Health Organization and other sources acknowledge the growing influence of the private health sector in the health systems and service delivery of these countries. The private sector accounts for 10% -90% of health service utilization in EMR member states with some much as 50%-90% in some of the low and middle income countries (Figure 1.1).



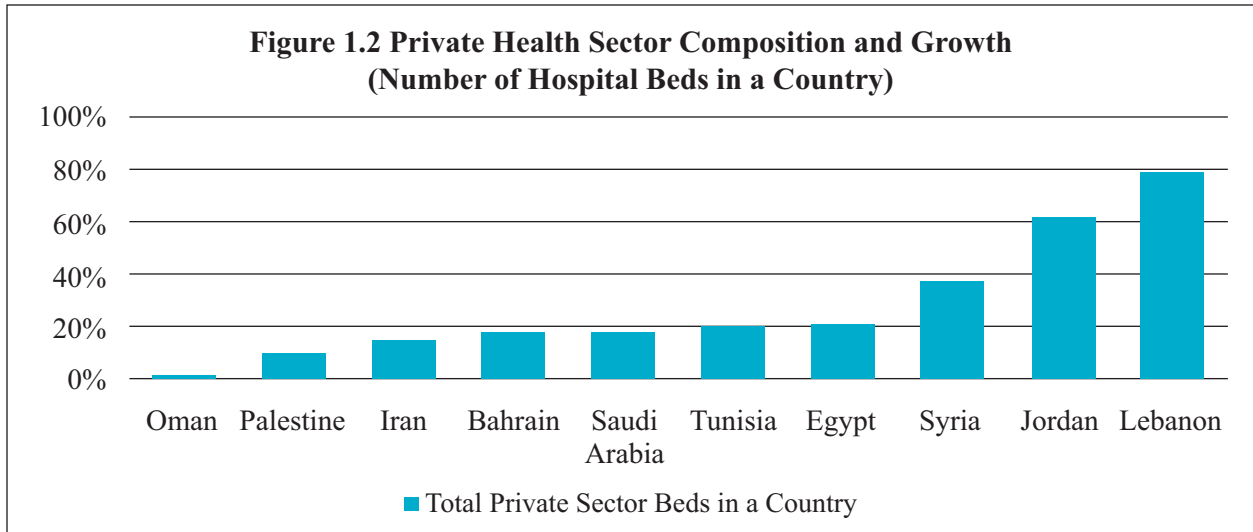
Source: Assessment of Private Health Sector in 12 Countries. WHO EMRO, 2013

Private Sector Growth in the EMR

The need for better understanding of the role, capacities and contribution of the private health sector in the EMR region has been identified. Despite a paucity of data, available information suggests unprecedented growth of private sector in many countries of the region. The private sector hospitals make up for up to 20% of the total number of hospital beds in most countries and even go up to a range of 40-80% in certain countries (Figure 1.2).

³ Assessment of private health sector in 12 countries. WHO EMRO, 2013.

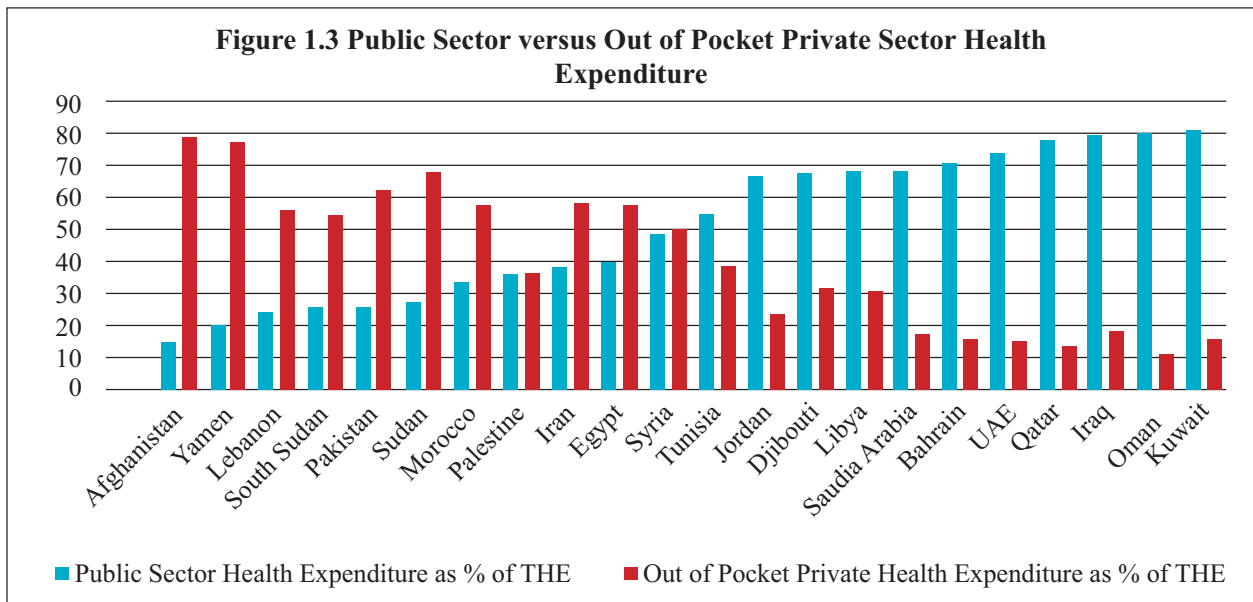
⁴ Demographic Health Survey (DHS) for selected EMR countries,



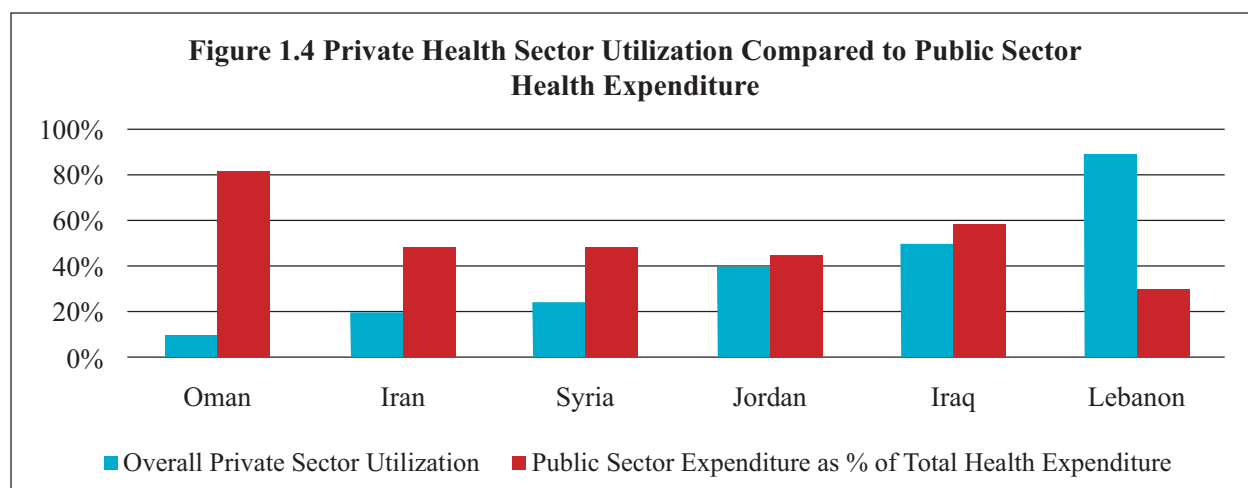
Source: Assessment of Private Health Sector in 12 Countries. WHO EMRO, 2013

A Comparison of Private vs. Public Health Expenditure and Utilization

Private health expenditure, mainly in the form of patient Out of Pocket (OOP) Payment, in the EMR is higher in Low income (LIC) and Lower Middle Income Countries (LMICs) such as Afghanistan, Yemen and Pakistan as opposed to GCC countries of Oman, UAE, Qatar, Kuwait etc. Member states, such as the higher incomes states in the EMR, that have higher levels of public spending on health have lower spending by households (Figure 1.3). Interestingly as spending by public sector decreases on health, there is higher utilization of private healthcare sector (Figure 1.4) demonstrating that declining budgets lead to ineffective public sector services providing opportunity for growth and replacement of services by private sector.



Source: WHO Global Health Expenditure Online Database, 2013



Source: Assessment of Private Health Sector in 12 Countries. WHO EMRO, 2013

On a larger landscape, it is quite evident that the private healthcare sector has shown tremendous growth in recent years in the EMR countries and despite lacking the sufficient data on the effectiveness, quality of care and its overall impact on respective health systems, the private health sector is playing a significant role in these economies. In some of the countries, it is a source of boost of the economy and in many; it is the major source of healthcare access and availability for a larger proportion of the population.

Private Health Sector in EMR Countries: Applying the Quality Lens

The perceived quality of the private healthcare services is generally considered to be high amongst the population. However, there have been contradicting reports in this aspect and there is also evidence suggesting that the ‘usual higher expenditures’ in private sector doesn’t necessarily translate into high quality. By applying the lens of quality of care in terms of drugs availability, patients’ records and their satisfaction, the quality and availability of infrastructure, staff capacity and skills, it could be seen that private sector in different EMR countries exhibit different characteristics.

Quality of Out-patient Services: Case of Diabetes Mellitus Care

A recent study conducted by WHO-EMRO (WHO, 2013) suggests that most of the outpatient settings in private facilities had availability of basic infrastructure for patient examination, equipment, and maintained patient records. However the only low-middle income country assessed showed sub-optimal levels availability of essential drugs, patient record maintenance and availability of recommended tests. Common quality issues seen in the private sector of different states included the provision of refresher courses to staff, presence of IEC material, patient feedback mechanisms and availability of cost effective test for screening of complications. Overall, patients were satisfied with the quality of care provided but in some countries they had reservations regarding staff attitude.

Table 1.1: Quality Indicators for Diabetes Mellitus Management in OPD Setting of Private Health Sector in Selected EMR Countries						
1	Availability of Infrastructure	Saudi Arabia	Lebanon	Jordan	Morocco	Pakistan
	Physical Examination Room	100%	100%	100%	100%	46%
	Urine Dipstick for Glucose Test	100%	100%	100%	100%	69%
2	Basic Equipment Availability					
	Examination Table	100%	100%	100%	100%	77%
	Functional Glucometer	100%	100%	100%	100%	74%
	Fundoscope	100%	75%	100%	7%	31%
	Weight Machine	100%	100%	100%	100%	93%
3	Availability of Essential Drugs					
	Availability of WHO recommended oral Hypoglycemic Drugs	100%	70%	100%	100%	57%
	Availability of WHO recommended Insulin Injections	100%	100%	100%	100%	57%
4	Availability of diagnostic Tests					
	Availability of fasting blood glucose	100%	92%	100%	100%	69%
	Availability of Hb A 1 C	100%	78%	100%	20%	-
	Availability of Guideline for performing Test	100%	65%	100%	100%	78%
5	Health Management Information System					
	Keeping records of diabetic patients	100%	100%	100%	100%	31%
	Sharing data with MoH	100%	38%	0%	0%	0%
6	Staff Strength					
	Physicians Attended Refresher Courses on Diabetes	100%	80%	-	100%	50%
	Facilities having service Guidelines for Diabetes Mellitus	100%	100%	100%	100%	-
7	Process of Care Counseling for Diabetes Patients					
	Health education on life style, diet provided to % of patients	100%	65%	100%	100%	100%
	Percentage of patients received IEC material on DM	67%	77%	44%	99%	96%
8	Patient Follow Up					
	Facilities send reminder for Follow Ups	100%	100%	100%	100%	-
	Facilities having feedback Mechanism	100%	30%	50%	80%	-
9	Patient Satisfaction					
	Percentage of patients who are satisfied with care they received at facility	100%	80%	94%	97%	99%
	Percentage of patient who are satisfied with Staff attitude	98%	48%	90%	94%	64%

Source: Quality Assessment and Cost/Pricing Estimates of Diabetes and C-Section Services at Private Health Sector in Selected EMR Countries. WHO EMRO, 2013

Likewise, the private sector in GCC states performs quite well in terms of staffing strength which also includes refresher trainings and courses for the staff as well as availability of care and service delivery guidelines and patient follow up. The private sector in these countries also demonstrate strength in other areas like availability of diagnostics tests, maintenance of patients' records and providing patients with health education sessions. These countries though demonstrate need for improvement in terms of distribution of information and education material for the patients and instituting feedback mechanisms in terms of patients' follow up care. The Lebanese private health sector is a mediocre performer in most of the quality

relevant domains whereas the private sector of Pakistan fares the worst. The only area where all the five countries need tremendous amount of work to be done is establishing coordination mechanisms between the private health sector facilities and the Ministry of Health (MoH). There is little evidence across the board regarding sharing of data and statistics with the ministry thus inhibiting regulation and affecting quality of care.

The patients' satisfaction levels with the quality of private healthcare services were generally high among the five countries that are subject of discussion. Quite surprisingly, this was also the case for Pakistan. However, in Lebanon and Pakistan, a significant proportion of patients expressed their dissatisfaction with the staff's attitude.

The Quality of In-patient Services: Case of Caesarean Section

Quality parameters of infrastructure, service availability, essential drugs and diagnostic services were generally satisfactory in the private sector of the reviewed EMR countries. However, the private sector in Pakistan had gaps in terms of critical aspects of neonatal and maternity services delivery infrastructure, patients' record keeping, and the availability of guidelines for performing an emergency C-section (Table 1.2). Generally the private sector performed better in terms of in-patient quality parameters as compared to out-patient settings. Several of the EMR states reviewed showed high levels of elective emergency sections being performed in the private sector with as much as 90% in Saudi Arabia. There was unevenness in terms of communication to patient on reason for C-section. A major weakness across all reviewed states was the low sharing of data with MoH.

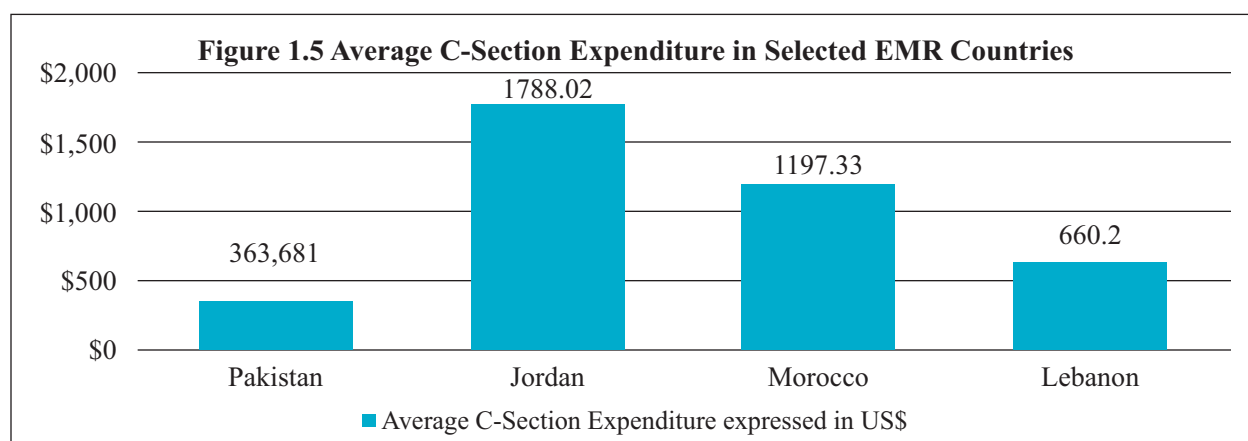
Table 1.2: Quality Indicator for C-Section Performed in Private Health Sector in Selected EMR Countries						
1	Availability of Infrastructure	Saudi Arabia	Lebanon	Jordan	Morocco	Pakistan
	Operation Theater	100%	80%	100%	60%	100%
	Maternity Ward	100%	100%	100%	100%	100%
	Nursery	100%	100%	100%	100%	60%
2	Availability of Services					
	Blood Bank	100%	80%	100%	0%	100%
	NICU	100%	80%	100%	60%	60%
	Laboratory	100%	100%	100%	40%	100%
3	Availability of Essential Drugs & Supplies					
	WHO recommended Antibiotics for C-Section	100%	100%	100%	80%	100%
	Calcium Channel Blockers	100%	100%	100%	100%	80%
	OT supplies	100%	100%	100%	100%	100%
4	Availability of diagnostic Tests					
	Facilities performing Anti HCV/HBV	100%	100%	100%	20%	100%
	Facilities performing CBC	100%	90%	100%	20%	100%
	Facilities performing Ultrasound Pelvis	100%	100%	100%	100%	100%
5	Health Management Information System					
	Keeping records of C-Section patients	100%	100%	100%	100%	60%
	Sharing data with MoH	100%	100%	0%	0%	20%
6	Staff Strength					
	Physicians Attended Refresher Courses on Normal delivery/C-Section	100%	100%	100%	100%	40%
	Facilities having service Guidelines for Performing C-Section	100%	100%	100%	100%	0%
7	Process of Care					
	Percentage of Emergency C-Section Performed	10%	54%	40%	22%	50%
	Percentage of Elective C-Section Performed	90%	32%	60%	78%	50%
	<i>Post-Operative Care of Mothers</i>					
	Post-Operative pain was successfully managed	100%	100%	100%	100%	100%
	Percentage of patients suffered from post-partum Hemorrhage	0%	0%	0%	2%	0%
	<i>Post-Operative care of Babies</i>					
	Percentage of babies APGAR score was recorded	100%	98%	100%	100%	-
	Percentage of babies ID bracelet was allotted	100%	60%	100%	80%	-
8	Patient follow up & Awareness					
	Percentage of patients informed about their follow up visits	100%	100%	100%	100%	-
	Percentage of patients aware of C-Section indication	3%	80%	99%	92%	80%
9	Patient Satisfaction					
	Percentage of patients satisfied with care they received at hospital	100%	100%	90%	94%	76%
	Percentage of patients satisfied with staff attitude	100%	85%	76%	84%	58%

Source: Quality Assessment and Cost/Pricing Estimates of Diabetes and C-Section Services at Private Health Sector in Selected EMR Countries. WHO EMRO, 2013

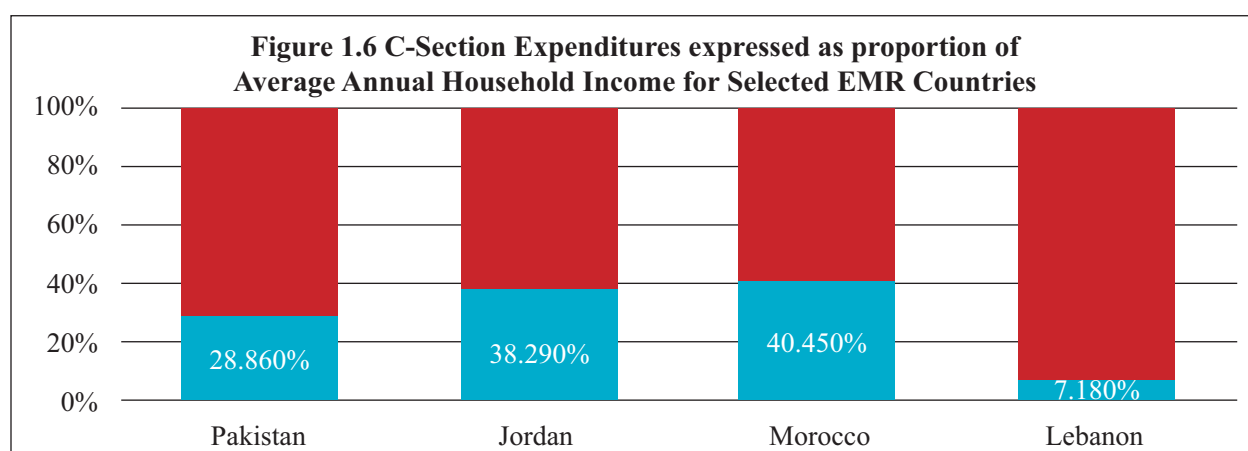
Private Health Sector in EMR Countries: A look through the Cost and Pricing Lens

There is considerable variation in private health sector in terms of unit cost of hospitalization as seen in the case of C-section assessed in selected EMR countries (Figure 1.5). While allowing for purchasing power disparities, the range varies considerably even within similar economic bracket countries such as Jordan, Morocco and Lebanon, and maybe due to level of competition offered by the private sector market.

Expenditure on hospital care availed at private health sector consumes a significant proportion of the annual household income in most of the reviewed EMR countries (Figure 1.6). This was seen to range from 28.6% to 40.5% bordering on catastrophic health expenditure for at least 2 of the four countries reviewed, while only Lebanon with an expansive private sector market showed rates had adjusted to meet patient incomes.

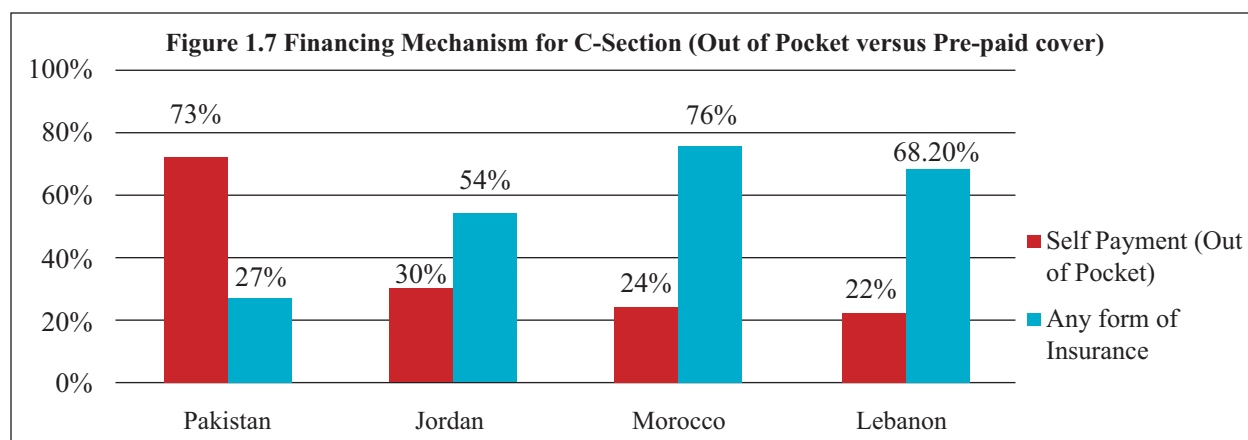


Source: Quality Assessment and Cost/Pricing Estimates of Diabetes and C-Section Services at Private Health Sector in Selected EMR Countries. WHO EMRO, 2013



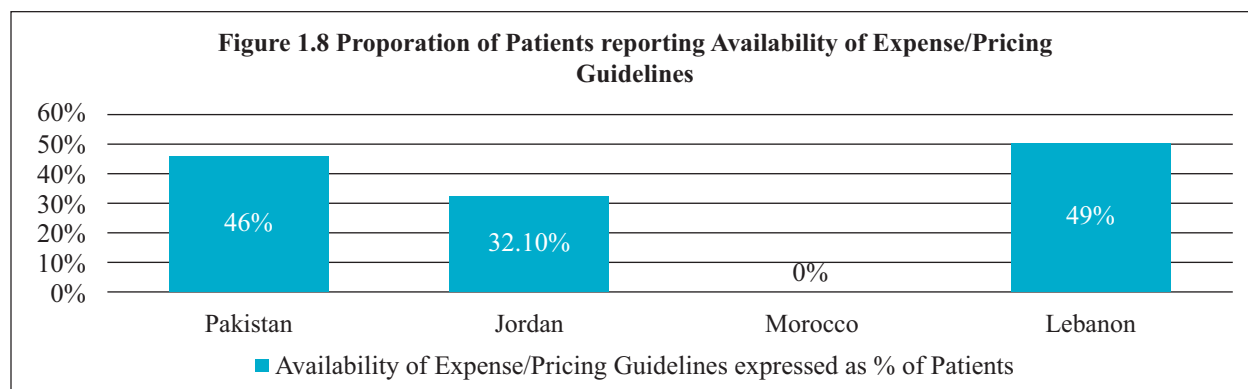
Source: Quality Assessment and Cost/Pricing Estimates of Diabetes and C-Section Services at Private Health Sector in Selected EMR Countries. WHO EMRO, 2013

Financing and Pricing for In-patient Care: Financing mechanism for in-patient care in private setting is predominantly pre-paid cover in three out of the four EMR member states reviewed. More than half of the users of in-patient services for C-section were covered by any form of insurance in Jordan, Morocco and Lebanon. However, major source of financing is out of pocket payment in Pakistan for in-patient services (Figure 1.7).



Source: Quality Assessment and Cost/Pricing Estimates of Diabetes and C-Section Services at Private Health Sector in Selected EMR Countries. WHO EMRO, 2013

Less than half of the users of C-section services reported availability of pricing guidelines in Private sector health facilities in Pakistan, Jordan and Lebanon. The situation is even worse in Morocco where such pricing guidelines are almost non-existent and not a single patient could access such guidelines (Figure 1.8).



Source: Quality Assessment and Cost/Pricing Estimates of Diabetes and C-Section Services at Private Health Sector in Selected EMR Countries. WHO EMRO, 2013

Summary

Private sector growth has taken place in all EMR countries with private sector as an important player for UHC. Private sector utilization is particularly high in EMR states where public sector spending on health is low and consequently shows private sector emergence as a result of insufficient or underperforming public sector services. Essential information on private sector composition, service coverage, quality and pricing continues to be patchy, although notable efforts have started in many states.

Data collected from outpatient for diabetes and from inpatient for C-section has shown high scores on: availability of appropriate infrastructure, equipments, drugs, staff; and patient satisfaction in private sector of most EMR countries. However, absence of proper Health management Information System (HMIS) and co-ordination mechanism with MoH was a common lacking in most of EMR countries with potential to affect regulation and quality of care.

OOP expenditure is higher in countries where there is more utilization of private sector. However, substantial variations have been seen for in-patient care according to country context. In at least two of the four states reviewed for OOP expenditure, the OOP spending was close to or at catastrophic expenditure. While private sector cannot be overlooked for UHC, strategies, plans, and implementation roll outs, states must build in adequate safety nets while involving private sector use and also data sharing on health services and oversight on quality standards.

Chapter 2:

Regulation of Private Health Sector

What is Regulation and Why Regulate?

The private health sector although robust and expanding in most EMR countries, is faced with issues related to uncertain quality, high pricing, skewed distribution in major urban centers, and dual links between public and private sector, as discussed in above section. The large and expanding size of the private sector and too little policy defining parameters for private sector growth has increasingly ‘marketized’ the health sector (Teerawattananon Y 2013).

Regulation is one of the key mechanisms that can be used for addressing some of these areas and harnessing the private sector towards accessible and quality care for UHC. Regulation occurs when government controls or deliberately tries to influence the activities of individuals or institutions through manipulation of target variables such as quantity, quality, price, distribution and provision of certain services such as public goods (Kumaranayake 1998; Kumaranayake and Lake 2002).

Specific issues that call for policy regulatory action are:

- There are significant areas of overlaps of service provision between the public and private sectors, leading to unnecessary duplication of infrastructure in urban areas while gaps in service access remain in rural areas. Besides from *gaps in access*, it also causes *cost inefficiencies* as limited resources are directed at providing the same service and a *culture of competition* rather than complementary provision prevails.
- Growing and uncontrolled private sector has led to supplier induced demand for high cost diagnostics, deviations in prescription from National Essential Drug Lists, and an unnecessary use of expensive services and procedures (Bennet 1994). Hence expansion of private sector, while often meant to provide better access to health care usually comes with an escalation in out of pocket expenditure.
- With growth of private sector there has been an expansion in private medical insurance which while expanding access to services has *not always resulted in patients consuming the right balance of promotive and preventive care, with tilt instead towards curative care*, and its role in overall improvement in health indicators remains unestablished.

Regulatory Approaches, Control Knobs and Implementation Mechanisms

Four Regulation knobs as outlined in Table 2.1 can be used to exert regulatory changes for Health Services or Medical Products. These can be used singly or in combination, and include Quantity, Distribution, Quality and Cost/Pricing. Regulation in most countries is focused on Quantity of providers/services, with less use of other controls.

Currently there are two types of approaches underpinning choice of control knobs. The ‘social approach’ focusing on quality and patient safety has been the one more widely practiced across most countries with varying success (Kumaranayake 1998). The other ‘economic approach’ is more expensive dealing with the larger health market and issues of quantity of private sector providers/ facilities, their distribution and fee charged for services (Kumaranayake 1998). This has been less well practiced in LMICs but has been the focus of reform and innovations in more established economies. Countries embarking on private sector regulation need to decide upfront as to largely which type of approach, the ‘social’ or ‘economic’, they will be adopting.

Table 2.1: Regulation Recipients, Knobs and Mechanisms

What to Regulate	Regulation Knobs	Regulatory Mechanisms
I. Services: Institutions & Professionals	Quantity	Restricting entry of providers and purchase of specialty equipment; Incentives for expansion of certain services/ providers
	Distribution	Entry into market; Relocation of professionals; competitive practices
II. Goods: Drugs, Technologies, Food	Quality	Standard setting; Changes to Medical, Dental, Nursing, Pharmacist & Paramedic curricula; Drugs Control; Food Control;
	Cost/ Pricing	Minimum salary levels; ceilings for fee setting; cover to non- affording patients

A number of measures applied singly or in combination can be used to implement regulatory control knobs. Common measures applied in countries are:

- *Legal Control*
- *Policy Guidelines/ Codes of Practice*
- *Financial Incentives*
- *Consumer Information*

Country Experience of Regulatory Measures

Generally in the EMR, regulation has received insufficient attention in national policies and strategies. Regulatory frameworks have been rarely updated, and emphasis continues to be on initial entry rather than equitable distribution, complementary service packages, improved quality and affordable pricing. A widely unregulated private sector has left consumers unprotected. External assistance, in the low and lower middle income countries, has tended to focus more on quick gains through purchasing and less on the long term gains through strengthened regulations. There is thin documentation of country experience with different forms of regulation and their effectiveness, and the section below attempts to highlights experiences from the EMR and other countries.

Legal Control of Individual Providers

Legislation is the most common form of regulation of private sector in most countries, and can carry sanctions or closure in case of non-compliance. This is practiced in all countries, is commonly directed at licensing of providers but vaguely applied to medical conduct and ethics. Professional councils or syndicates are usually responsible for licensing providers as well as medical and allied training institutes and universities. The modus operandi followed is that of self-regulation rather than state regulation. Experience from a number of countries, such as Pakistan, Yemen, Egypt, Tanzania and Zambia has so far shown that even where detailed laws are present, the implementation is usually weak. Subjective interpretation, protection of members by professional community, and internal rivalries tend to blunt implementation.

Legal Control of Private Facilities

A small number of countries have extended legislation from individual providers to the accreditation of clinics, hospitals and nursing homes. There is considerable variation on function that is regulated – quality is more commonly regulated with less instances of price control.

In both Yemen and Egypt (as in most of EMR countries) private health facilities undergo mandatory licensing. Yemen's Private Health and Medical Institutions Law is precise in terms of procedures for licensing and periodic relicensing but specifications are more general in terms of quality of care, number, distribution and advertising (WHO-EMRO 2013). Lack of crisp specification, database for monitoring and low awareness of laws amongst public sector officials constrains oversight.

Bargaining by private health facilities is seen in Yemen where a Union of private hospitals has been formed (WHO-EMRO 2013). This is primarily centered on the benefits of the owners but also coordinates referral amongst private hospitals and has started continuous medical education which is at early stage. The Union has been involved by the MoPH in implementation of regulations.

In Egypt, the entry of private health clinics and hospitals controlled through mandatory registration with the Ministry of Trade and Foreign Industry and the Ministry of Investment, followed by licensing from the Ministry of Health. The Health licensing aims to ensure a minimum uniform standardization and involves fixed parameters of licensed staff, Medical Director's registration, and price list. It is unclear what quality standards are included as part of licensing and the extent to which these are enforced. Prices are also regulated and professional syndicates are required to set price ceilings for charging by professionals; however rules are insufficient, vague and not implemented. On ground evaluation shows that implementation can be improved with stronger checks and governance, and putting up sufficient budgets for enforcement.

Another parallel is provided, from India where regulation can be enacted both by the Federal and State levels. Private small hospitals in India, of less than 25 beds, are largely unregulated. But two states, Maharashtra and Delhi have enacted the Nursing Home act for compulsory registration, undertaken by local municipality and strict board, with yearly reveals (Bhat 1996). Despite a forward moving act, several Nursing homes remain unregistered due to lack of inspectors, while those registered, lack standard setting and reporting systems. Similarly, in the case of Tanzania and Zimbabwe, while there is mandatory registration for clinics and hospitals it is weakly enforced (Kumaranayake 2000).

Provision of Policy Guidelines & Codes of Practice

Lighter touch regulation is provided through provision of policy guidelines and codes of practice but not backed by a legal act that may lead to sanctions. These can be in form of general guidelines or detailed prescriptions of quality parameters.

Provision of Accreditation Certificates, trainings and re-accreditation through professional medical, nursing, dental or pharmacy councils has also been used as 'lighter touch' attempt towards regulation.

In certain countries, these have followed more formalized processes and compliance agreements have been developed between private providers and accreditation bodies. In the USA for example, enforcement of codes of practice is basically on the premise of self-regulation rather than state regulation and large independent accreditation agencies such as JCAHO and NCQA undertake periodic accreditation of private hospitals based on established parameters of compliance (Jacobson 2001).

In Pakistan, the devolution of Health from Federal to provincial level has provided an important stewardship space that provinces have been quick to capture. Structures for standard setting in both private and public sector facilities have been recently set up in two of the four provinces of Punjab and Khyber Pakhtunkhwa while the third province Sindh has recently passed supporting legislation for setting up a Health Commission

along similar lines. The forums in the three provinces are intended to provide standard setting and formal accreditation but short of punitive action. Accredited facilities will have an edge in government's purchasing of private sector services that are simultaneously underway in the provinces. Much would depend on extent of autonomy granted to regulatory structures, and robustness of monitoring and inspection systems in rolling out of accreditation.

Financial Incentives

Tax breaks and provision of subsidies are important concessions strategically given for expansion of private sector into required areas of growth. Incentives can be targeted for filling geographical gaps in provision through incentives for private sector provision in rural areas. These can also be targeted for filling *service* related gaps such as setting up of Nursing & Midwifery Colleges in underserved rural locations. Conversely removal of financial subsidies can also act as a regulatory tool such as partial fee recovery in heavily subsidized public sector medical schools to restrict excessive production of doctors.

In Egypt for example, private health sector has benefitted from the growth incentives for general private sector growth provided by the Ministry of Trade and Foreign Industry and the Ministry of Investment (WHO-EMRO 2013). Tax breaks and reduced custom duties on import of equipment have been provided through the Companies Corporate Law and the Investment Guarantees & Incentives Law for expansion of private sector investment in business and also health infrastructure. Additionally, contracts have been made with private sector for infrastructure expansion. Private health facilities have been provided with a ten year period of tax exemption in return for providing 10% of bed capacity free of charge, as per the investment Law designed for encouraging private sector expansion. Incentives are considered by the private sector to be insufficient, and require careful reconsideration with private sector feedback. Consumer awareness has not been simultaneously addressed, and most consumers follow provider reputation rather than registration status.

Consumer Protection and Information

Consumer protection involves restricting and monitoring the advertising of private clinics, hospitals, diagnostic centers, medical and food products for medical safety. This is in place for infant formulas, other related food products and sometimes for medical products across more countries, but rarely seen for health services. It also involves addressing information asymmetry in health care by providing patients with information about clinical process of care, pricing and enhances accountability through provision of grievance measures.

In India, the Consumer Protection Act was enacted for quick redress of patient grievances and although resisted by the medical professionals but support by Supreme Court resulted in widespread implementation (Bhat 1998). The Act allows for quick addressal of patient grievances, majority of doctors are aware of the Act and its implications, and there are calls for orientation of newly graduated doctors entering private practice. Defensively increased the use of diagnostics and spend longer time with patients but at higher fee charges. Further the level of information shared with consumers also needs to be widened to include schedule of fee and some incorporation of penalties for those who file false case.

Lawsuits on medical negligence have also grown side by side with an increasing private sector and rise in patient information. This has produced a market of medico- legal fraternity in Western countries such as the USA and is also on the rise in countries such as Thailand (Teerawattananon Y 2013 et al). In some countries such as Pakistan medical negligence are increasingly being picked up through Suo Motu action by legal courts as a result of recent judicial activism. Although consumer information and empowerment must be addressed, litigation processes are not always in the best interest of patients, and can lead to escalated use of expensive technology by private sector in an attempt to avoid litigations.

Regulatory Structures

Professional Councils

Throughout the region Professional Councils i.e. medical syndicates and associations, have been in existence for mandatory licensing of providers at the time of entry into the health market, although extent of activity and independence varies. Their role has been principally targeted towards education registration as opposed to medical practice legislation.

Councils typically comprise of professionals drawn public and private colleges, and are usually based in the Ministry of Health and only in rare cases have been given an autonomous status for independent working. While Medical, Dental and Nursing Councils are commonly seen, however councils of paramedics have largely been overlooked and require attention given the extensive variation in quality of paramedic training. Professional Councils in the EMR are targeted towards the social approach to regulation overseeing issues of patient safety and quality; however their role is mostly limited to individual providers and does not extend to facilities. Functions found across most member states include: i) standardization of medical dental, nursing and pharmacy curriculum; ii) inspection and licensing of teaching colleges, and registration; iii) licensing of private health providers after completion of training; and iv) disciplining individual providers based on professional Codes of Conduct.

Such associations are well developed in Lebanon where they engage in self accreditation of professionals. In Iran the Medical council's role also extends to accreditation of hospitals and medical facilities, licensing, pricing, and quality control of medicines, laboratory materials, and food products (Bakhsh AF 2006). Registry rolls are not pro-actively maintained and many providers remain unregistered or do not renew licensing on regular basis, due to lack of inspector checks by Councils and Ministry on maintenance of active registration status, as well as meager budgets for registration.

Professional bodies are less effective than their intended role, and have been seen in certain countries to become forums for medical self-protection. Politics, corruption and undesirable practices have been reported from India (Bhat 1996 India), unchecked growth in medical colleges and universities without due teaching faculty and required teaching bed capacity from Pakistan (Ghaffar et al 2013), and turf issues between public and private sector in Yemen (WHO-EMRO 2013).

Regulatory Authorities

Regulatory bodies are increasingly found in countries both within the EMR and outside the region engaging in health reforms. Their main function is to target health facility accreditation, inclusive of hospitals, clinics, nursing homes, across both public and private sectors. These functions can range from mere standard setting to accreditation and further to price control. Medical Negligence and consumer information and protection remain a grey area that may fall across Regulatory Authorities or Councils.

National Health Authorities have been established in Bahrain and Jordan, to oversee health services, Food and Drugs (Ajiluni MT 2006; Tahoo LA 2009). Pakistan Blood bank Regulatory Authorities have been in place over the last decade starting with provision of training and protocols to private sector and have now expanded to active inspections and sealing of blood bank empowered by strong Parliamentary regulation and field budget support. Several states are making efforts to strengthen Drug Regulatory Authorities. Extent of autonomy varies, with some regulatory structures nested within the Ministry and others as independent structures. In Tunisia for example, the services regulation set up is within the Ministry of Public Health, and health professionals and services are highly regulated through defined accreditation norms that are carefully revised and updated. Tunisian regulation also extends to distribution with number of private pharmacies restricted and defined by needs of the population. In contrast, the Jordan and Saudi Food and Drug Administration, on the pattern of the US structure, are independent of ministries of health (Ajiluni MT 2006; Khalil R), providing them a strong leverage across the industry and providers.

However caution is needed in setting up regulatory bodies, if political will and strong governance are lacking. In Yemen while a regulatory body exists, there are instances reported of subjective enforcement, and use of informal payments to bypass health standards. Technical weaknesses also exist with limited data on beds, professionals and procedures collected during the inspection visits. Such risk are also inherent for other developing economies that are about to embark on regulation reforms.

Regulation of Insurance Schemes

Regulatory requirements and ensuing policy recommendations depend on the stage of health insurance development in the country. A clear distinction between public and private sector roles is necessary to avoid escalating health expenditure resulting from cream skinning of the population, unnecessary use of high technology services, service cost escalations and fraud. Additionally, up front target setting is required to move towards desired health outcomes that may get lost in using up less valued services and also to cover the underserved.

Coordination is a key to successful implementation but can be problematic. Private health insurance in Jordan operate under a general insurance law but regulation of hospitals and facilities is undertaken by both the Ministry of Trade and Industry and the Ministry of Health resulting in instances of multiple coverage overlaps and resulting cost inefficiencies (Ajiluni MT 2006; Khalil R). In Lebanon each separate branch of the insurance industry is associated with a separate supervising ministry, making public oversight difficult (Ali AM 2005). Lack of an effective supply control system in Lebanon has led to cost and premium escalation in the health sector. It has also resulted in equity gaps, with low income populations spending on average 20% of their income on health care as compared to 8% in the higher income groups (Ali AM 2005).

Consumer Protection Bodies

While consumer protection is a nascent area in the EMR, when practiced in other developing economies it has usually relied on a multiplicity of arrangements ranging from consumer judicial courts, consumer protection bodies and Citizen inclusive Hospital boards. However there is little evidence on relative effectiveness of these bodies and forums.

India's Consumer Protection Act provides quick resolution of consumer complaints through quasi-judicial bodies at district level, avoiding lengthy litigation processes (Bhat 1996). However the implementation experience shows room for improvement on several fronts. Lack of adequate staff and infrastructure results in delays in consumer courts, doctors aware and wary of the Act. The absence of doctors in consumer courts remains a contentious issue with high pressure by medical associations for inclusion but while this will be beneficial in providing technical depth, it can lead to defensive protection of genuine neglect by fellow doctors.

Drug and Food Authorities

Product licensing through Drug and Food Control Authorities is a separate and substantial function undertaken by verticalized structures within the MoH. Functions include licensing of i) industrial drug manufacturing units; ii) registration of drugs; iii) price setting; iv) trade parameters for export and import of drugs; v) market surveillance of quality of drugs. Essential Medicine Program of WHO has been active in supporting Drug Regulation in many member States, however while drug Acts are found, implementation continues to be largely weak. In certain countries Drug Regulatory Authorities have been made semi- autonomous to remove political interference in drug licensing and surveillance.

While Drug Control structures are available across all countries however presence of Food regulatory authorities is rare. Usually this function is coordinated with Food and Agriculture Ministries which have at least an enforcement arm comprising of Food in sectors that can carry out checks on advertising, processing and distribution issues related to key food products that have direct health implications such as infant milk formulas for reduction in diarrheal deaths, iodized salt for reducing iodine deficiency, and control of sugared and carbonated drinks.

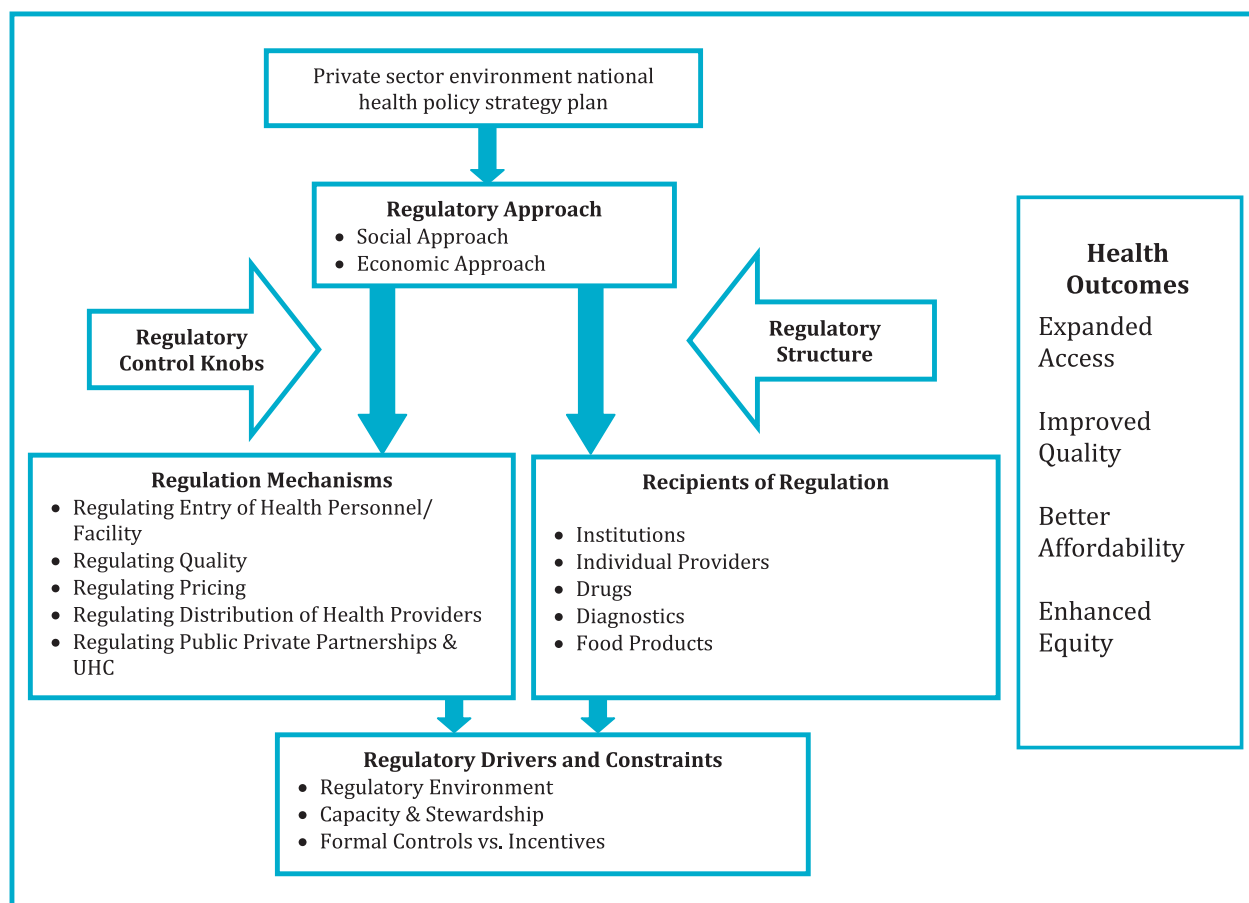
Summary

- *Regulatory Environment:* Regulation of health providers is influenced by the larger Economic and Public Administration policy context, with Health building on important inter connections to introduce health regulatory reforms. Economic incentives to the private sector, as in case of Egypt and Yemen, encouraged growth in infrastructure of private sector; however these were insufficient and required further specific incentives within Health for effective implementation. More often there is too little formal policy in developing countries but this implicitly sets out encouragement and unchecked growth of private sector. Regulation also requires strong and mobilized stakeholders beyond Health, with a network of support in Planning, Finance, Legal Sectors as well as the executive leadership. The political economy of regulation has not been studied, except in the case of pharmaceutical reforms (Reich 1993), and needs attention by policy researchers.
- *Stewardship and Capacity for Implementation:* Capacity to undertake regulation is limited in developing economies, however all countries are practicing at least some basic form of regulation and a number of less developed countries have an expanded set of regulations. Regulatory reforms of private sector therefore need not be shelved until capacity building is undertaken, and can be introduced as ‘Little Rs (reforms)’ involving sharpening of existing laws or can be ‘Large Rs (reforms)’ introducing new structures and reform initiatives. Information for regulation such as database of private providers, monitoring and inspection systems, and guiding protocols are essential steps. A more fundamental issue preceding capacity is that of having a stewardship vision with broadening of focus from direct service delivery harnessing the private sector towards meeting health targets. Stewardship is a nascent notion in most Ministries of Health; hence regulation, sector wide target setting for both and private providers, and purchasing of private sector are needed areas that get overlooked in favor of more programmatic diseases focused activities. Formal structures for stewardship need to be set up and well separated from the usual business of service provision.
- *Incentives and Formal Controls:* Regulation has often been regarded as a State prerogative, vertically implemented and driven by punitive action. However there have been important changes to regulatory approaches within the evolving context of developing countries. Regulation in Health is no more a single stakeholder domain, involves dealing with powerful groups of private medical providers, frontline health workers and Drug and Food industry. Multi stakeholder consultations, bargaining, negotiating with legitimate private sector groups are now new approaches to regulation commonly

practiced in OECD nations. The role and inclusivity of professional associations is of key importance because of significant leverage over both public and private sector providers. Use of incentives, and the right set of incentives emerging from fruitful discussions, may prove to be an increasingly powerful tool rather than lengthy litigations.

- *Pricing control:* A major challenge is regulating prices in the private health sector through regulatory controls. Pricing regulations particularly need to be carefully developed and enforced prior to expanding insurance based schemes so as to avoid sharp escalation in health expenditure, at expense of little health status gain. Private hospitals and facilities are largely unregistered in EMR states are registered with trade and investment sector whose goals of private sector encouragement and growth maybe in conflict with equitable coverage goals of Health Ministries. While quality standards to some extent have started being developed in EMR states, pricing remains a challenge both in terms of who has legal authority, capacity within ministries to come up with prior costs estimates and lack of databases for monitoring. There are also implications of substantial political resistance to price control due to an entrenched private sector and avenues for collusion.
- *Preventive and Curative Care:* Regulation practices in countries have been largely targeted towards curative care at the detriment of important preventive and promotive care measures. While the underlying economics behind private sector expansion has been and will remain curative and diagnostic care, preventive care activities such as immunizations, TB DOTS, opportunistic screening for hypertension and diabetes can be introduced as important and compulsory conditionality for private sector expansion.

Figure 2.1: Regulatory Framework for Private Health sector



Chapter 3:

Purchasing Private Sector Health Services

Purchasing health services by state from the non-state sector is being increasingly practiced in a number of EMR Member States as well as countries in other regions such as Cambodia, Senegal, Costa Rica, Nicaragua, Guatemala, Bangladesh and India (Perrot 2006). The underlying objectives can be multiple and may include rapid roll out of services to enhance access or involve better quality and cost efficiency of services. While there has been a tradition of purchasing private sector services support services such as construction works, hospital food and laundry services etc. by the public sector, purchasing of primary care and hospital services provides a new modus operandi for government in moving towards universal health coverage (Siddiqi 2006; Loevinsohn & Harding 2005). Partnerships are being developed with the private medical sector for hospital services, diagnostics and clinical care at primary level in a range of EMR countries. Within the area of public health and primary care, there is now an increasing emphasis on partnering with non-profit development organizations, over the private commercial sector, mainly driven by their perceived attributes of more transparent and client oriented processes, ability to reach marginalized groups, and emphasis on promotive care (Edwards & Hulme 1997).

Purchasing private health services necessitates a new role of the public sector with a shift from direct service provision to a strategic center that commits funds for contracts, determines the service package, and selects and monitors providers as part of 'buying results' (Loevinsohn and Harding 2005; Taylor 2003). This is a major departure from past policy practice whereby governments have traditionally directly provided and funded health services. Engendering competition between private providers and stipulation of performance targets are key areas promoted by the New Public Management Approach for effective purchasing of private sector services (Walsh 1997).

Purchasing of private sector services has five key elements:

- Defining services and targets;
- Choosing providers;
- Identifying relative responsibilities for services and financing;
- Setting up structures for fund flows and implementation; and
- Monitoring and oversight.

Purchasing private sector services can take different forms, with differences being in service delivery and financing arrangements, as outlined below:

Contracting out: Contracting out involves purchasing private sector services by the public sector for a time bound period based on a stipulated agreement and targets and using public sector financing. This has been fairly extensively applied in a number of EMR states and will be dealt in detail in this paper. There are two types of contracting:

- Management Contracts are whereby the budget and managerial authority of a public sector facility gets transferred to the private sector for more efficient management and increased utilization by patients.
- Service Delivery Contract involves public financing for provision of a defined service by the private sector, usually specialist services that are difficult for government or in geographical areas where government faces coverage gaps.

Vouchers: Voucher is a pre-paid card or token provided to clients for obtaining a particular service or package of services from trained and accredited health service providers that can be from private sector or involve both private and public sectors (Zaidi et al. 2012). Vouchers are redeemed by the health care provider in lieu of services provided, with funds provided by the state. Vouchers engender competition amongst providers and are thereby expected to increase the quality of services. The difference from Contracting out is that vouchers are distributed to clients at the community level and payments provided to health providers on redemption while, the contracting is a single point process involving contract and its payment at single to health provider. Vouchers have been rarely used in EMR countries, however a snapshot of global experience has been provided.

National Health Insurance: National Health Insurance (NHI) programs are funded by the state through services purchased from public and private health providers. More and more, private health providers are becoming an important source for expanding insurance coverage to uncovered population through state spending. It involves risk pooling across entire or large segment of the population to ensure coverage for a package of health services.

Community Based Health Insurance (CBHI): This is a risk pooling mechanism for the rural poor and those working in the informal sectors that are less likely to be covered by formal insurance. It involves voluntary contributions by households and management of funds by an organized and registered community organization that in turn purchases services through formal contractual agreements from private and public hospitals and primary facilities. CBHI schemes provide a niche for larger state funded insurance schemes, as seen in Sub-Saharan Africa where CBHI schemes rapidly expanded and were converted into national health insurance schemes with supplementation of state support.

Country Experiences with Purchasing Private Sector Services

Afghanistan: Afghanistan's health system in the post conflict period has been based on extensive purchasing of NGOs for service delivery at both frontline facilities as well as district hospitals. The decision to involve the private sector emerged from almost three decades of conflict left behind a devastated health infrastructure and the MoPH with strong technical support of international donor agencies decided to rapidly roll out services to the population by pulling in the NGO sector to deliver district level services and outreach. In 2003 the MoPH developed a Basic Package of Health Services (primary care level) and Essential Package of Health Services (secondary care level), which defines a set of cost-effective interventions with particular focus on women and children, and delivered at Health Posts, staffed with Community Health Workers, Basic Health Centers, Comprehensive Health Centers, and District Hospitals. The estimated cost of delivering the BPHS is about US\$4 per person per year; this excludes contracting and management costs as well as vertical programs such as immunization and TB control. The coverage of BPHS included 34 provinces, 355 health facilities, 4000 health posts, and 77% of country population (Palmer N 2006). It is mainly financed by international development partners and co-financed by the MoPH, while the rest of the facilities are directly managed by the MoPH through internal contracts (Sondorp 2004).

Pakistan: In Pakistan there are several indigenous examples of purchasing health services from the private sector that have rapidly sprung up in the last decade. The major initiatives have been purposively introduced by the state as part of health systems strengthening. The most extensive initiative is the President's Primary health Care initiative in place nationally across all four provinces through which the front line government Basic Health units have been contracted to a government sponsored NGO. Through this initiative, the management of government Basic health Units (BHUs) have been contracted out across all four provinces, Azad Jammu & Kashmir (AJK) and Gilgit-Baltistan to a national NGO which manages 48% of all first level Primary Health Care (PHC) facilities (Martinez et al. 2010). Additionally from 2003 to 2008, extensive contracting out of HIV control services was undertaken in Pakistan, with government purchasing services from NGOs through performance based contracts (Zaidi et al 2012).

Additionally, since devolution of Health and other social sector subjects to the provinces in 2011, there has been a spurt in Public Private Partnerships as part of health sector policy and reforms in the provinces, and there are contextual variations shaped according to their particular provincial needs. The main objective has been to fill coverage gaps in remote locations or to improve the functionality of existing services across the province

In Khyber Pakhtunkhwa, out-sourcing of district health delivery to national and international NGOs is underway in six underserved districts whereby selected NGOs would be responsible for entire district health systems from district hospitals to primary facilities and outreach programs. Additionally, in previous years 2 selected public sector hospitals in 2 districts and focal primary care facilities are formally contracted to four local NGOs and one INGO.

In Sindh, as part of the reforms program, tenders have been advertised for NGO management of poorly functioning Rural Health Centers and secondary care Taluka Hospitals in 9 districts, in an attempt to expand access to underserved (Government of Sindh 2013). The contracts are intended to implement an Essential Package of Health Services at facility and the outreach, and will be financed through government funds. In recent years, Maternal and Child Health vouchers and contracting were implemented in 2 districts each in Sindh through the Norwegian Pakistan Partnership Initiative (NPPI), involving private sector harnessing to expand quick coverage.

In Punjab, also as part of the reforms program there is policy thinking on introduction of a voucher scheme for maternal and child care services financed by government and international donors, however design and implementation are still to take place (Government of Pakistan 2013). Currently, a Voucher Card “Sehat Sahoulat Card” Scheme targeting both private and public providers is being implemented in two districts for emergency maternal care services, by a national NGO but lacks funding support from state (Zaidi et al 2013).

Baluchistan has 3 major PPP initiatives to expand access to services whereby large international NGOs, namely Mercy Corps, Medicine San Frontier and Save the Children have entered into formal agreements with the government to strengthen health care facilities including 90 Basic Health Units, four district hospitals and establishment of birthing stations (Zaidi et al 2013). Unlike KP and Sindh the financing is provided by the NGOs rather the state. However a PPP policy is under development.

Yemen: In Yemen as yet there are instances of limited purchasing of individual private providers to perform specialized services but lacks a larger contracting framework and policies. However, under the upcoming law, both the private and public sector would compete to provide the healthcare services and Health Insurance Authority will act as the regulating body to the contracting process, insurance and quality control of services.

Jordan: The Jordanian MoH has extensive experience in hospital contracting with both public and private sector. Since 1970 there has been steady expansion of private for-profit hospitals while MoH hospitals instead have under-funded and consequently less developed (Musa 2006). However the MoH facilities form the backbone of affordable Jordan hospital services providing highly subsidized (80-85 per cent) services for the uninsured, free of charge services for the insured and the poor, and have relatively high occupancy rates. As a result of over-burdening of public sector hospitals and capacity constraints to offer tertiary specialized services, the MoH during the last three decades has been extensively contracting with the private sector and other autonomous public sectors to meet the health needs of its beneficiaries and uninsured poor people. Private sector services are purchased for the insured population, to complement public sector delivery. The MoH has at least 8 formal contracts or agreements for purchasing health services, 5 with private

hospitals and 3 with autonomous public providers (Musa 2006). In addition to these formal contracts, the MoH has informal contracts with private hospitals to admit insured patients in case of emergency. Purchasing of services is considered to have multiple objectives that include enhance equity by expanding service coverage levels for the poor, cost curtailment of outing up expensive infrastructure through using underutilized beds in private sector, and provide incentives to the private sector to stay in business and attract patients from other countries (Musa 2006).

Tunisia: Tunisia also has considerable experience with purchasing private sector to complement hospital services. Purchasing of private services was started with Hemodialysis services for which the public sector had limited capacity, and is expected to expand to other services (Siddiqi et al).

Egypt: Purchasing of public and private providers for delivery of the Basic Benefits Package of curative and preventive primary health care (Egypt report 2006). The Basic Package is designated for all family members in the population and designed to cover child care, maternal care, primary care for all groups and laboratory services. Contracting takes place under a framework of recognized quality standards, facilitating competition and availability. Contracting is managed by the Family Health Fund which contracts directly with individual providers in public facilities, NGOs/private as well as through the District Provider Organization.

Lebanon: In Lebanon there has been a well-established practice of purchase of private sector medical services by the MoPH in order to supplement the damaged and weakened public sector during conflict. Services are purchased for citizens that do not receive coverage from any other financing agencies (Arabia). The MoPH contracting was initiated in 1968 and there has been a steady expansion in number of hospitals contracted. In 2000-2001, private hospitals that were contracted by the MoPH amounted to 140 out of a total of 167, while the number of beds amounted to 2,026 out of 11,533^{5,6} (Ammar 2003). The MoPH contractual relationship with the private sector is not only limited to hospitals but also include partnership with NGO's for the provision of primary health care services. The MoPH provides NGOs with drugs, equipment, supplies and staff training, while NGOs in turn report on patient volumes and quality of care. Additionally, the MoPH also has contracts for design and delivery of larger public health services such as chronic disease control, blood bank services and emergency transportation.

Palestine: The MoH has been purchasing tertiary care from private providers. A greater role of private sector is seen in the post-Oslo period of relative political stability and economic security of the providing opportunity for private sector growth and complementary service delivery arrangements with the MoH (Zaineh M 2010).

Kingdom of Saudi Arabia: In Saudi Arabia with increase in the number of hospitals and simultaneous population demand for specialized services there was increasing pressure on the MoH to effectively manage new public sector hospitals (Khalil R). Purchasing of private sector services was carried out for effective management of hospitals so as to supplement MoH capacity with management contracts given to international management companies and later to local companies working alone or in partnership with foreign companies. However the increase in expenditure after contracting and poor performance of some of the management companies pushed the government to return to directly manage hospitals replacing contracting with autonomy and greater flexibility provided to public sector management.

⁵ Ammar W. Health System and Reform in Lebanon. 2003. World Health Organization–Eastern Mediterranean Regional Office and Ministry of Health Lebanon. Ref Type: Report

⁶ The soaring cost of health: no quick cure. Information International Monthly 2002

Bahrain: In Bahrain experimentation with purchasing private sector services has started with purchasing of international private sector services for management of newly constructed hospital in 2010. Given the increasing maturity of the private sector there is developing policy thinking on contracting of demarcated clinical services such as maternal delivery or beds for chronic care services but these are yet to be formalized and implemented (Tahoo LA 2009).

Countries outside the EMR

National Health Insurance: There are at least 14 countries mainly from Africa and East Asia with National health Insurance schemes. These include Ghana (1), Taiwan (2), Peru (1), Vietnam (1), China (1), Philippines (1) Mauritania, Argentina, Bolivia, Thailand, Mexico, Kenya and Nigeria.

National Health Insurance schemes in American and Western Pacific countries were introduced in the 1990s and adapted by a few African countries in 2000's. Most of the national health insurance schemes are supported by the state except in Nigeria and Argentina where these are partially supported by international donor funds. Schemes managed by public funds are centrally managed while those involving premium payments or local committees managed reimbursements for services. Population covered has been large ranging from 99% in Taiwan, 95% in Mauritania and 70% in China while other countries had a range of 40-70% coverage. Purchasing from private sector was particularly seen in Ghana, Kenya and Philippines. Specific targeting towards the poorest population groups was seen in Thailand, Peru and Argentina.

Premiums were either voluntarily contributed or deducted from salaries of the employed sector. Schemes were also supported by taxation.

Health Vouchers: Health Voucher schemes involving purchasing of private sector services have been implemented in at least 9 countries, that include three in South East Asia (India, Bangladesh, and Indonesia), three in Africa (Uganda, Sierra Leone and Kenya), and one country each from America (Bolivia), Western Pacific (Cambodia) and Eastern Mediterranean (Pakistan) regions. Five of the countries of implementation, are low income countries (Uganda, Sierra Leone, Kenya, Cambodia and Bangladesh) while the remaining four may be grouped as low middle income countries (India, Pakistan, Indonesia and Bolivia).

Voucher programs are supported by Ministries of Health (MoH) in six of the nine countries and are financed by large NGOs in three countries through donor support. Technical assistance in all countries is provided by international donor agencies including UN agencies (Bangladesh, Pakistan), World Bank (Bangladesh, Indonesia), USAID (India, Pakistan) German Development Bank (Kenya, Uganda), Belgian Government (Cambodia) and Norwegian Government (Pakistan).

Private sector purchasing through prepaid vouchers has been exclusively for basic and comprehensive maternal care in four countries including Cambodia, Bangladesh, Uganda and Bolivia while in other countries such as India, Pakistan, Indonesia, Kenya and Sierra Leone there were also added components of family planning and reproductive tract infections. Five out of nine schemes provided support for caesarian sections while all the schemes provided vouchers to avail Antenatal, Delivery and postnatal care services.

Most of the implementing countries are in the piloting stage with a limited client base. The largest interventions with vouchers for basic and comprehensive maternal care have been in Kenya and Uganda with voucher distribution to 38,595-60,581 clients. Other countries have much lower distribution levels ranging between a few hundreds to few thousand clients. Schemes in Bangladesh and India have reached out to approximately 7000 clients. Lowest distribution has been reported from Sierra Leone (290 clients), Indonesia (565-1164 clients), Pakistan (2000 clients) and Cambodia (2725 clients). Many of these countries are in the process of scaling up the services. Voucher redemption has been high with 75.6% of the distributed vouchers were redeemed in Cambodia and 98.4% in Pakistan.

Community Based Health Insurance: Distribution across countries: Substantially scoped CBHI schemes have been implemented in at least eleven countries, including China, India and several African countries including Ghana, Senegal, Mali, Rwanda, Congo, Sierra lone, Burkina Faso, Guinea and Togo. Of these, seven are low income countries (Rwanda, Guinea, Mali, Togo, Congo, Burkina Faso and sierra lone), three are lower middle income countries (Ghana, Senegal and India), and one is an upper middle income country (China).

Community based Mutual Health Organizations (MHOs) were used in most African countries to manage CBHI and were essentially owned, designed and managed by their community members, provided voluntary health insurance coverage to members and contracted with health facilities to reimburse providers. In Ghana and Congo the insurance scheme started out as a provider managed hospital based insurance and subsequently included community in its management. In India, varying arrangements for voluntary community based schemes were found with some managed by community based organization or NGOs on behalf of community and in others managed by an insurance agency. In China, the new rural cooperative was designed by the state but managed by community, with supplementary contributions provided by local and national government.

Highest population coverage of CBHI is seen in China covering up to 86% of the population, followed by Rwanda at 73% population coverage by 2006. High levels of coverage are also expected for Ghana which moved to coverage of CBHI in all districts however exact population estimates are not available. In other countries, although there was proliferation in number of CBHI schemes, population coverage estimates, where available, indicate less than 1% coverage of population. In most countries, health centers acted as gate-keepers for EmOC referrals and consequently contracts of CBHIs were with health centers. In certain settings such as Ghana contracts were only with the district hospital and not lower levels of care provision.

CBHIs largely relied on household payments while individual payments were seen in India and Burkina Faso. Annual fixed low cost payments ranging from \$1-\$21.6 were charged in most countries and often timed and collected around crop harvesting in rural communities. In most schemes there was a lack of differential charging for the poor with all members charged at a flat rate. The exceptions included Rwanda where the poor were exempted from payments and Burkina Faso where the poorest 20% of households paid at half the premium. Little information is available about how decisions were taken on exemption of premium and/ or copayment.

Implementation arrangements for purchasing

Afghanistan: In Afghanistan a dedicated unit within the MoPH is responsible for managing the contracts. Purchasing in Afghanistan includes three different models. Large province wide lump sum contracts or sub provincial contracts covering a cluster of districts, or a mix of both are provided. Contracted organizations were mostly International NGOs at the outset but now local NGOs are also implementing contracts showing an evolving internal market. NGO are supplemented with extensive capacity building support, are also closely monitored both technically and financially mostly using a system of monthly reimbursements based on a line item budget. NGOs are mostly reimbursed through line item reimbursement most of which is given on advance and performance bonuses are also provided. In one instance at least, a NGO's contract as terminated on non-performance. Both monitoring and support are provided through an international non-profit organization that manages service delivery contracts. Performance bonuses linked to monitoring of health services performed by an independent group. NGOs are directly accountable to the donor that funds these contracts, and the in-country donor mission monitors NGOs' performance. However the MoPH has taken a more central role in recent years with respect to NGO monitoring.

Pakistan: Pakistan presently has a variation in contracts and contract management for private sector purchase. The newer initiatives in the post devolution period are evolving and are supported by formal reform strategies, while older initiatives of BHU contracting is supported by legal frameworks but does not link up with health policies and strategic plans. Traditional experience has been in purchasing one off services through sole source contracting whereas dedicated structures for health services purchasing, and required monitoring and oversight systems are presently lacking (Zaidi et al 2010). Donor assistance has recently supported price estimation studies for implementing and contracting Essential Package of Health Services, cost and quality guidelines for purchasing, and assisted in oversight provision on tendering process. Vouchers schemes are newly introduced in Pakistan, and emerging lessons indicates the readiness of private commercial sector in participating, use of existing network of community based lady health workers in implementation but also require considerable support and supervision by the implementing NGO. Pakistan has a moderately sufficient market of both local NGOs and INGOs in Pakistan for undertaking PPPs. Although performance evaluations are commonly lacking, PPPs have succeeded in providing staff and support for functioning of health facilities in remote locations (Zaidi et al 2013). However NGOs prefer contracting with intermediaries, such as UN agencies or contract management agencies, rather than the government as centralized procedures, instances of rent seeking and apprehensions on timely release of funds are key NGO concerns in entering into contracts with government (Zaidi et al 2012).

Egypt: Favorable policies by the Ministry of Health and Population and ministerial decrees to emphasize the role of the contracting entity - Family Health Fund – have facilitated the purchasing of private sector services. Successive decrees over the years have supported in terms of opening a bank account named for the “Family Health Fund of the Health Sector Reform Program”, constituency of the governing bodies of the Fund, laying the basis for management of this account and its responsibilities, and determining the organizational structure of the Family Health Fund on the central and peripheral levels, sources of revenues and expenditures, and legal support for contracting. Tendering processes are relatively well developed and private providers have to pass through several steps for selection.

Jordan: Jordan is one of the few EMR states that have had extensive experience with contracting. Private providers are reimbursed on a fee-for-service system, but this creates incentive for at times unnecessary procedures and over billing by providers. The MoH has introduced new payment mechanisms such as leasing private hospital beds for a fixed payment per bed or a defined payment per episode. There have been recent efforts to undertake cost and price analysis prior to negotiations for new contracts, but is constrained by the lack of comprehensive and advanced computerized information system. Controlling the quality of private sector contracted services is an area that requires future attention. Presently there is a lack of treatment protocols and guidelines to control and monitor the quality of services. Even in the presence of these protocols, several private hospitals stated that they would be unwilling to participate in the Health Insurance. There are also reported delays in payment due to centralized bureaucratic procedures or budgetary deficits leading to poor satisfaction of contractees with the Health Insurance Directorate. Mutual trust and confidence gaps have also been reported in the relationship between the MoH and the private sector.

Lebanon: Purchasing of private sector services is supported by a nationwide 1993 policy to support primary health care (PHC) and integrates a network of non-governmental comprehensive health centers towards this objective. MoPH contractual relationship with the NGO sector has been reported to be more successful than the MoPH contractual relationship with the private hospitals in the country. Examples of contracted NGOs include: the Young Men's Christian Association (YMCA); for a chronic disease drug management program; the Red Cross for the national blood bank and emergency transportation; the Chronic Care Center

(CCC) for the treatment of thalassemia and juvenile diabetes; the United Nations Children’s Fund. Purchasing private sector hospital services is historically more established practice governed by a decree under which private sector hospitals have to classify for purchasing by meeting specific standards and conditions. The specifications have evolved over time and governed by Hospital Classification Committee.

Tunisia: The Tunisian experience with hemodialysis services purchased from private institutions showed that the private providers had to accept a flat rate determined by the MoH and not to charge co-payments. There is little information on private sector comfort and compliance with this arrangement.

Kingdom of Saudi Arabia: There has been an evolving experience in KSA for purchase of private sector services. Purchasing of services started with hospital housekeeping services, then general maintenance and catering, followed by hospital management (Khalil R). Problems initially arose due to unclear demarcations between responsibilities of the private companies and the MoH and affected the efficiency and quality of services provided. Lengthy procedures of obtaining clearance from the Ministry of Finance and Civil Service Bureau delayed the execution of the contract, leading to contracting the full range of services in the hospital to one single company. The increase of expenditure and poor performance of some of the management companies later resulted in reverting to direct management of hospitals by the government.

Summary

Policy Commitment: Strong political support by governments has been seen across different regions for National Health Insurance and support and up scaling of Community Based Health Insurance. However contracting out of services in the absence of insurance schemes, and particularly when involving the leasing out of management control to private sector has faced issues of low buying and tight control over administrative and financial powers.

There are also concerns about the lack of commitment in low-income countries such as Afghanistan to purchase private sector services once donor funds dry out. In Pakistan while state funds have been put up for purchasing of private sector health services to manage government facilities as a result of support of higher bureaucracy, there is resistance from government health staff and frontline managers, and longevity and maturity of these measures is to be seen. Middle income countries such as Egypt and Jordan have supportive policies while too little policy is seen in remaining EMR countries. For the GCC countries, where public sector systems are well equipped and functioning, it is less of an imperative to purchase private services, however purchasing needs to be given due attention to fill the two fold objectives of plugging coverage gaps for the uninsured population, and to serve as a tool strategically harness unchecked growth of private sector.

Nature of Service: Purchasing of focal services from private sector such as support services for hospital kitchen, laundry, or within health services, and purchase of sub-specialized services such as hemodialysis, diagnostics or chronic care beds have a more established tradition in EMR countries. There is lesser practice of more radical initiatives involving large scale strategic purchasing of private medical services for insurance and vouchers for expanding access, or contracting out the management of hospital and clinics to the private sector for improving utilization and efficiency. There is as yet low ownership for large scale initiatives whereby private sector harnessing is a cornerstone to meet policy goals, and need to be endorsed by policy shifts.

Private Sector Market: Most countries have a reasonable supply of private sector for provision of hospital services and urban and semi-urban areas; can well do with supplementing public sector bed with private beds which may be a more cost effective option than investment in new specialist infrastructure. There are limited number of providers in rural areas which can serve as a potential constraint to purchasing services

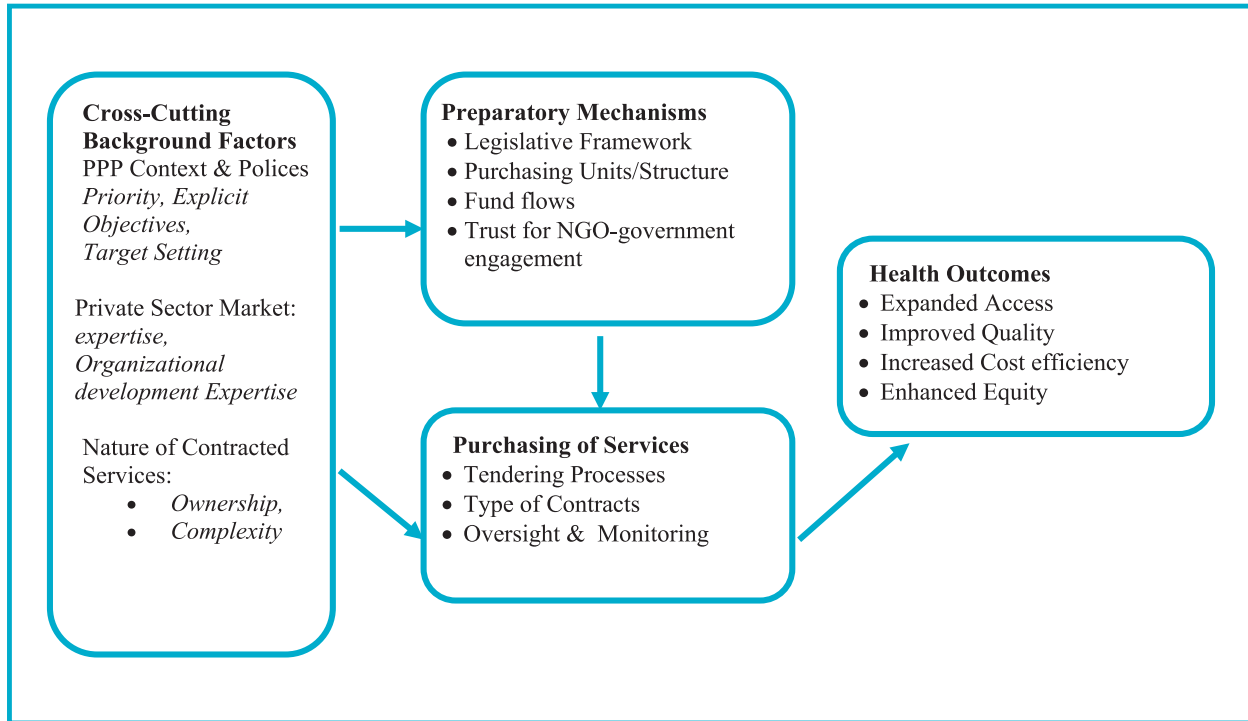
in areas that are more in need. However the recent examples of Afghanistan and Pakistan shows that NGOs can be pulled into under covered areas if adequate incentives and financing are provided, with contracting used to create new markets within health.

Preparatory Arrangements: The legal and administrative framework for contracting out health services needs updating in many countries. Experience with contracting over a number of years has helped in developing the required changes in bureaucratic process to avoid delays, issue with fund flows and necessary accountability. Politics of contracting out has been less well reported, however there have been instances of parties with vested interests gaining control over the contracting process. Independent purchasing structures and some level of third party oversight of the contracting process needs to be incorporated as government Health Ministries and Departments get reorganized for purchasing of services. Independent structures as opposed to those embedded within the usual running of Health Ministries, are also important for timely flow of funds and avoidance of cash flow problems for purchased services. Most member states lack a dedicated unit for purchasing services. Transaction cost estimations of costs required for implementation and monitoring of purchasing were also usually not carried out.

Capacity Gaps in Implementation: There is limited capacity of the public sector to design, negotiate and award health services contracts; undertake a cost, price and volume analysis; optimize payment methods; and effectively monitor performance (Siddiqi et al 2006). With the exception of Egypt and Afghanistan, performance indicators are rarely included in the design of contracts. Management information systems in most counties were inadequate to monitor the performance of private providers. Third-party evaluations of purchased services were rare and only seen in Afghanistan and in one instance in Pakistan, with both of these instances supported by donor funding.

Financial Protection: There is considerable variation in terms of financial protection to the poor offered by private sector purchasing initiatives and can benefit from more learning across countries. Some of the National Health Insurance schemes have exempted the poorest from premium payment; however there is lack of standardization in terms of financial protection. Implementation of Voucher schemes from Pakistan and other regions shows that these provide free cover for promotive care visits, and more than half also cover the cost of complicated deliveries including Caesarian sections. Community based insurance schemes involve premium from community enrollees, and copayment in the range of 10-20%, with some instances of exemption of the poor from copayments. Insufficiency of funds has remained a major concern with experience from Nigeria suggesting that funds provided under HIPC agreement were limited and could cover only a fraction of the target population of pregnant women (Briscombe 2010). Similar concerns have also been reported from Argentina where financial sustainability and limited package of services are a question mark (Cortez R 2009).

Targeting the under-served: Voucher schemes and National Health Insurance schemes invariably involve some level of targeting mechanism to reach the poor and underserved population. Experience from other regions shows that vouchers specifically targeted the poor and used systematic means. These also have administrative cost implications, however there is little reporting on proportion of costs spent on implementing systems versus actual services. Moreover, there have been instances when lack of proper dissemination of information to the eligible population deprived the poorest women from making use of voucher schemes. National Health Insurance schemes although having a pro-poor focus in intent have less vigorous means verification. Most contracting out initiatives across different countries have not had a pro-poor focus in contract design however recent primary care focused contracting initiatives in other regions, particularly in South Asia, have targeted the poor using systematic methods.

Figure 3.1: Purchasing Framework for Private Health Sector

Chapter 4:

Performance Outcomes of Public Private Partnerships: Existing Evidence

While public private partnerships are well underway in several countries and incrementally started in others, a major question arises about their effectiveness so far in expanding access, increasing quality and efficiency. We fill some of these knowledge gaps by highlighting solid performance outcomes achieved and comparative strengths of Contracting Out, Community Based Health Insurance (CBHI), Vouchers, and National Health Insurance. Data from EMR Member States is extremely limited and therefore a snapshot of evidence is presented from other countries.

Performance of PPP in EMR Countries

An increasing number of PPPs have been implemented in the EMR and developing countries. However, a major gap is the lack of collated evidence on PPP performance to choose between competing PPP models. Despite many international publications on PPPs, there is need to sift for high quality evidence for basing conclusive recommendations and is provide through a process of systematic review of evidence.

Pakistan: There are number of initiatives where the public sector fully or partially finances the NGO sector for primary healthcare service provision, usually through contracting out and voucher schemes. The President's Primary Health Care Initiative (PPHI) comprises the largest contracting out initiative which started in 2005; however, other smaller contracting out schemes have also emerged. Third party evaluation of PPHI revealed general increase in BHU utilization and improvement in some aspects of quality (Martinez et al. 2010). Outpatient attendance increased by 20% on average in PPHI districts. Use of antenatal care, postnatal visits and facility based births also increased in PPHI districts compared to those managed by health department. Customer satisfaction was better in PPHI districts mainly due to improved quality of services (Martinez et al. 2010). Table 2 in annexure provides details of impact of contracting out on service utilization and quality improvement. Another initiative of purchasing maternal and neonatal services from private sector in rural health centres showed higher utilization of ANC, facility based births, PNC and newborn care in contracted out centres compared to non-contracted. However, it was insufficient to improve overall coverage of maternal and newborn services at population level (Zaidi S et al. 2013).

Three different voucher schemes have been implemented for maternal and neonatal health services in Pakistan. However, evaluation is available from one of the schemes only. Results of evaluation showed increase in ANC (21.6%), PNC (31.2%), and facility based births (19.2%) among beneficiaries of voucher scheme after one year of implementation (Sohail A 2011). Subsequent section provides details of impact of voucher scheme on service utilization and quality improvement.

Iran: Like Pakistan, Iran has also experienced indigenous initiative of purchasing primary healthcare services from cooperatives at small scale. The Ministry of Health and Medical Education has pilot purchasing of primary care services in several provinces of the Islamic Republic of Iran. Although no comprehensive evaluation has been conducted, early evidence suggests that purchasing primary health services from private sector has helped improve certain aspects of access and quality, and decreased the cost of services. (Siddiqi S 2006).

Maternal health care indices were also better in CHCs nearly in all areas indicating that they perform better than PHCs. Contrary to other preventive health care services, maternal health care is widely provided in private clinics in Iran but the difference is that services delivered in PHCs are free of charge and focused

on essential health cares aimed to increase equity of receiving these services. When Cooperatives are entered in this area, it seems that many problems with PHCs like low availability, lower quality and lower client satisfaction can be cleared while preserving the advantages of public service delivery. Furthermore, the study of PPP case in Iran reveals that subsidizing payment system is different from a fixed subsidization and per capita payment in that amount of payment can differ depending on quality of services as evaluated periodically by provincial health department. Management process inside each cooperative can be quite effective because of two reasons: first that Health Cooperatives are not large scaled and have small number of personnel, and second that all of the personnel in a Health Cooperative are responsible for their practice that directly affects their income by improving the quality of their service.

Afghanistan: Purchasing of services from local and international non-governmental organizations (contracting out) and from MoPH facilities (contracting in) to provide a Basic Package of Health Services (BPHS) and hospital based services in post conflict period. A recent balanced score card assessment demonstrated some improvement in health services. Nationally, the benefits of BPHS were reaching to the poor than less poor, and to women than men, making it more equitable. However, some serious deficiencies were found in five domains, and particularly in counselling patients, providing delivery care during childbirth, monitoring tuberculosis treatment, placing staff and equipment, and establishing functional village health councils (Peters 2007).

Jordan, Lebanon and Tunisia: Jordan, Lebanon and Tunisia have had extended experience with contracting out of hospital services. In Lebanon, the public sector outsourced a wide range of services in over 100 hospitals to cover its uninsured population. Some limitations were fragmentation of the contracting process between different agencies, the limited leverage of public over private sector, the inability to contain escalating health care costs and lack of public sector capacity to monitor performance (Siddiqi S et al. 2006). Jordan showed that most of the purchasing arrangements with private sector had positive impacts and resulted in improved access, efficiency, sustainability, promoted public health goals, and created an environment conducive to public- private collaboration (Siddiqi S et al. 2006).

Kingdom of Saudi Arabia (KSA): In order to close the gaps in skills necessary to run the hospitals, government agencies contracted with management companies to either fully or partially manage their hospitals. Few years ago most of the hospitals were either fully or partially managed by a private company. But increase of expenditure and poor performance of some of the management companies, convinced the government to return to direct operation in a program format.

Egypt: The Family Health Fund is permitted to contract with a wide range of public and private providers. The main role of the Fund is to purchase curative and preventive primary health care to be extended to secondary care in the future. Some facilities show interest to join the program, but need major renovation such as equipment and furniture to meet the quality standards, and at the same time they are not willing to account for such expenses and changes.

Palestine: MoH is contracting-out tertiary care from private providers. Palestinian health care provider and beneficiary survey 2005, which assessed beneficiaries' perceived satisfaction of quality of health care services in both of public and private sectors, showed that the majority of patients were more satisfied from the care provided by the private sector compared with those provided by public and NGO sectors in terms of both quality and availability of care.

Performance of Global PPPs: Evidence from numbers

The data presented is restricted to high quality studies and the tracer lens of ‘maternal and newborn care’ has been taken to see effect on primary care (Zaidi et al 2013). Similar data on curative care was not sufficiently available.

Contracting out with private sector for primary healthcare

Review of evidence suggests that information on performance of contracting schemes addressing maternal care mainly relates to service coverage and some reporting on quality of care indicators. There is less information about equitable utilization, OOP reduction and health outcomes. The studies had minimum intervention period of 1 year and maximum intervention period of 5 years.

Service Utilization: Contracting out had positive impact on reproductive health services utilization (table 4.1 annex). Increase in utilization of ANC is reported in India (Baqui 2009), Bangladesh (World Bank 2005), Cambodia (Bloom 2005), Bangladesh Urban PHC (ADB 2007), and a smaller suggestive increase in Pakistan (Martinez 2010). Similarly, contracting out health services with private sector has shown increase in facility based births (institutional delivery) in Guatemala (Bloom 2005), India (Bhat 2009, Baqui 2009), Bangladesh (ADB 2007), Bolivia (Lavadenz 2001), and Pakistan (Martinez 2010). There is inconclusive evidence for impact of contracting on service utilization of C-section, complicated deliveries and PNC. However, there has been no improvement in immunization coverage with contracting out, due to incomplete transfer of outreach facilities and responsibilities. There has been very little assessment of impact of contracting out on care seeking in childhood illnesses. Few available evaluations of contracting out have also shown reduction in Malnutrition (Karim R. 2003; Marek T 1999).

Quality of care: Available studies have documented improvement in only few aspects of quality of care while information about process of care is missing (Zaidi S et al 2012). PPHI from Pakistan showed improvement in: infrastructure; availability of drugs, staff and supplies; and patient satisfaction (Martinez 2010; Loevinsohn 2009). Evidence from Bangladesh Urban PHC shows significantly higher satisfaction amongst female clients of contracted BHUs over non-contracted BHUs but no information about infrastructure and process (ADB 2007). Contrary to that, the Indian Chiranjeevee scheme reports no significant increase in patient satisfaction as a result of contracting to private providers (Bhat 2009).

Equity Aspects: Very few studies have reported effect of contracting on equity. No significant benefit can be traced for disadvantaged population as a result of contracting in Cambodia (Bloom 2005, Bhushan 2002), Guatemala (Danel & LaForgia 2005), and Pakistan (Loevinsohn 2009).

Community Based Health Insurance Schemes (CBHIs)

Available evidence on performance of CBHI relates mainly to health care utilization, out-of-pocket expenditure reduction, enrolment characteristics of insured members, and assessment of equitable utilization of service coverage. There is less information about quality of care.

Service Utilization: In Rwanda (Schneider et al 2001), Zaire (Criel 1999), and China (Long 2010b), there has been increase in C-section rates after introduction of CBHIs. Similarly, facility based births (institutional deliveries) increased in China (Long 2010b), Rwanda (Soeters 2006), Senegal (Smith 2006), Mali and Ghana. CBHI has also shown increase in 4+ ANC visits in Mali (Smith 2008) and China (Long 2010a) while suggestive increase is seen in first trimester ANC visits in Senegal (Smith 2006) and some sites in Rwanda but not in other sites (Schneider et al 2001) (table 4.2 annex). CBHI schemes mostly have not assessed neonatal and child health service utilization.

Out of Pocket Expenditure: Reduction in OOP is seen across CBHIs in all six countries (Zaidi S et al 2012). Specific reduction in delivery related expenditure reported from Senegal and Mali shows 12 to 13 times higher likelihood of reduced expenditure in insured women for delivery as compared to non-insured (Smith 2008). For Rwanda and India descriptive statistics are present suggesting OOP expenditure reduction by a third in Rwanda (Soeters 2006) and halving of catastrophic hospitalizations in India (Ranson 2002).

Equity Aspects: Enrolment related evidence from Senegal, Rwanda, Mali and Ghana and is highly indicative of adverse selection. Enrolment, utilization and OOP expenditure reduction are significantly associated with higher income, higher education, those residing closer to health facilities and in urban areas (Zaidi S et al 2012). Although CBHIs were implemented in disadvantaged communities however exemption mechanism for those who could not afford were missing in most schemes, and maybe the underlying reason for regressive findings. Interestingly evidence from India focusing on catastrophic rather than general OOP reduction is suggestive of greatest decrease in the lowest income tercile (Ranson 2002).

Vouchers Schemes

Review of evidence highlights that information on performance of maternal voucher schemes is confined to two countries and is mainly related to service coverage with some information on targeting. There is no information about quality of services and about impact on health outcomes. The studies had minimum intervention period of 1 year and maximum intervention period of 2 years.

Service utilization: Studies from Pakistan (Agha S 2011) and Bangladesh (Ahmed S 2010) report positive impact in treatment for complicated delivery (table 4.3 Annex). Beneficiaries of Voucher schemes in both countries were highly likely to use pre and postnatal care, and deliver in health facility. Neonatal and child health service utilization has not been assessed with voucher schemes.

Quality of Care: Significant improvement in various qualities of care parameters including antenatal checkups, behaviour and counselling practices due to voucher scheme is reported. The findings also show reduction in pregnancy complications and lesser delay in service provision (Zaidi S et al 2012).

Equity aspects: There is low volume of equity related data on maternal voucher schemes, and is a major gap given that considerable efforts of these programs are invested in systematic targeting of beneficiaries (Zaidi S et al 2012). Although, Agha (2011) shows that majority of vouchers were distributed to the poor with 54% to the most under privileged quintile and 24% to the second most under privileged quintile. Overall utilization of services remained higher in upper socio-economic strata but lower two strata showed higher improvement in utilization in the one year period as compared to control after interventions despite lower overall utilization remained lower. Similarly those closer to health facility and having higher education levels reported greater odds of utilization.

Ahmed S et al (2010) also shows lower overall utilization for the poorest quintiles in Bangladesh, however there is no control for confounding effects.

Hence, findings from both Pakistan and Bangladesh are indicative that even when voucher distribution is progressive with greater penetration to the poorer groups, their redemption will still be regressive with poorer groups making lesser use of services but at least showing visible improvement in utilization over their previous rates.

National health insurance

Information on performance of National Health Insurance (NHI) schemes relates mainly to health care utilization, and assessment of equitable utilization of service coverage. Enrolment characteristics of insured members are provided only by 1 study. There is no information about quality of care and out-of-pocket expenditure reduction. The studies had minimum intervention period of 1 year.

Service Utilization: Significant increase in C-section rate is reported from China and Taiwan, mixed results are seen in Ghana and there is incomplete reporting from other schemes. However, except for one scheme; none of the other schemes showed a significant increase in institutional delivery. In Peru, insured beneficiaries were twice as likely to deliver in health facility compared to uninsured (McQuestion 2006). ANC utilization is reported by nearly all studies but except for Taiwan where there is significant increase in 4+ ANC visits (Chen 2001), there hasn't been any improvement reported in other schemes (table 4.4 annex). Almost negligible information is available on neonatal and child health service utilization with NIH schemes.

Equity Aspects: The study from Ghana shows that enrolment is positively related to higher income and education status while there is no significant difference in terms of urban/ rural residence (Chankova S 2009). Largely inequitable results are seen for utilization of maternal services. There is more likelihood of health facility utilization for C-section amongst higher income terciles in China (Wei-Wei 1998) and amongst more educated members in Taiwan (Chen 2001). Significant positive correlation of institutional deliveries with income and education is seen in Vietnam and Philippines and as well for members residing in urban areas in Philippines (Sepheri 2008; Kozhimannil 2009). Similar results are seen for ANC utilization with higher likelihood linked to income, education and urban areas (Zaidi S et al 2012).

Summary

Global evidence provides encouraging and significant evidence of overall impact of PPPs on increasing the use of primary care services but there is uneven increase across different services and much depends on design of PPPs. Within the PHC area, most consistent increase is seen in institutional delivery, followed by ANC, there are mixed results for PNC and Nutrition, and little impact on immunization. Evidence is inconclusive for EMOC and neonatal health services. Amongst the different PPPs, vouchers have the best performance, at least for safe motherhood, followed by CBHI and NHI schemes. However, PPPs have generally not reached the poorest segments of the population. Although there is reaching out to the poor, the benefits within are to those who reside closer to health facilities, have higher levels of education and income than more marginalized groups in the community.

There is inconclusive evidence as to whether PPPs can bring about a reduction in patient OOP expenditure. Few instances of reduction in client expenditure have been reported for CBHIs and NHI schemes but there are data gaps for contracting out and voucher schemes.

Also there is lesser information available that whether PPPs can or cannot induce higher quality of services from the private sector. Generally, purchasing has resulted in improvement of infrastructure; availability of drugs, staff and supplies, while information on technical process of care remains thin. There have also been instances of staff demotivation as a result of increased patient volume from insurance schemes.

Chapter 5:

Emerging Lessons, Recommendations and Proposed Framework

I. Overview of Policy Drivers and Constraints

Attainment of Universal Health Coverage is a progressive realization for EMR Member States and can be accomplished by expanding breadth of population covered by services, depth of services covered and expanding extent of financial risk protection. The private sector has grown exponentially in most EMR states, and remains an untapped key partner for moving towards Universal Health Coverage. Regulation, information provision and purchasing of services remain important tools for harnessing private sector towards strategic UHC goals.

Private Sector Potential & Pitfalls: Private sector growth has taken place with too little policy to guide growth. Private sector utilization is particularly high in EMR states where public sector spending on health is low and consequently shows private sector emergence as a result of insufficient or under-performing public sector services. Essential information on private sector composition, service coverage, quality and pricing continues to be patchy, although notable efforts have started out in many states.

Private sector contribution varies according to the context of particular countries, and hence demands locally responsive strategies for harnessing the value added services. While a certain level of overlap between private and public sector is healthy for quality of services, much depends on development of informed state policies for channelizing the growth and distribution of private sector for access to UHC. In certain states, government partnerships with private sector have focused on specialty hospital services to complement gaps in government services, in others states these have been targeted towards private sector management experience of hospital and diagnostic facility, while in yet other countries private health sector has established itself in providing primary care services in urban centers and also expanding to rural areas.

Latest evidence shows that despite apprehensions, the quality of private sector services is reasonably satisfactory in GCC and middle income countries, and further improvements are needed in the area of staff refresher trainings for staff, health communication to patients and reporting of data to ministries. However, in low income countries private sector faces serious quality gaps and caution is needed in first careful capacity building and stewardship of private sector before involvement in UHC schemes.

Charging for health services by private sector goes largely unregulated except in certain states of the EMR that have attempted to cover the unaffording clientele through state purchasing of private sector services. Recent most evidence shows that charges even for routine inpatient admission such as C-sections can be at catastrophic level in some countries requiring strong regulations while in others the private sector market is offering competitive affordable prices. Pre-paid cover for health services is found in middle income countries but needs extension, is low in lower income countries placing patients at risk of debt or service denial, while consumer accountability is generally weak with poor availability of pricing guidelines across most EMR states.

Can Public Private Partnerships Deliver?

Global evidence provides encouraging and significant evidence of overall impact of PPPs on increasing the use of primary care services but there is uneven increase across different services and much depends on design of PPPs. There is inconclusive evidence as to whether PPPs can bring about a reduction in patient OOP expenditure. Few instances of reduction in client expenditure have been reported for CBHIs and NHI schemes but there are data gaps for contracting out and voucher schemes.

Regulation & Information Provision: A Matter of Approach, Coordination & Enforcement

Regulation of health providers including Industry in some form is in practice in all EMR states. However this is the area where least innovations have been practiced, practice has been confined to entry of individual practitioners in the market and drug licensing and trade. Regulatory approaches have typically relied on Professional syndicates, enactment of punitive laws recourse to which involve lengthy litigations and lack budgets and personnel for field implementation.

Health services regulation of the private sector remains a grossly overlooked area across most EMR states and is critically required to harness the expanding private sector towards UHC. Moreover, regulation where present is targeted towards curative care overlooking involvement of private sector into preventive, promotive and rehabilitative services while some middle income countries have taken steps in this direction, those states with higher private sector utilization are yet to be mobilized and the area so far remains in infancy. Such regulation will need to involve oversight on service packages, distribution, quality and pricing; however any of these can be an important entry point for extending modifications to the others.

For enactment of regulation, policy coordination is required between larger economic private sector growth policies and those enacted by Health – are these in synch for uncontrolled growth, confined growth or exertion of controls? Regulation of insurance can be particularly complex with coordination required with multiple entities for different tasks.

Implementation of health services regulation on private hospitals, nursing homes and clinics will remain a key challenge. The notion of stewardship is only beginning to be realized in Ministries of Health and needs to be practically backed up by formal dedicated structures for regulation either within or outside the Ministry of Health. While technical aspects of regulation implementation such as databases for private sector mapping, accreditation tools and checks have been highlighted before, the essential approach to regulation remains undecided and uncertain in most states. Multi-stakeholder regulation that includes private sector as an entity as opposed to government only led regulation, use of incentives and self-accreditation options as opposed to punitive action and concept of bargaining and negotiation rather than imposition are new approaches for governments to consider.

Provision of consumer information from minimal to more comprehensive levels has been routinely practiced for drugs and food products across all member states. However extension of consumer information for health services as a tool for patient safety and on pricing of private health services for financial access has been less well practiced. Consumer information and protection relies on a multiplicity of arrangements across Legal Ministry, Health Ministry, Consumer Bodies and Private Health Providers, and if hastily introduced can lead to delays in redress, unnecessary litigations and growth of expensive medical technology as defensive mechanism by medical sector.

Purchasing Health Services: Financial, Technical, Market & Political Considerations

Purchasing private health services has been more widely practiced than regulation in developing economies and also has a growing body of evidence on its effectiveness. Purchasing provides formal controls to the state over cost, quality and service package offered by private sector. Purchasing of private sector services for Health initially started out in the EMR in the area of support services for hospital, expanded to hospital beds and specialty services, and more recently has involved purchasing primary and preventive care services from NGOs.

Purchasing by the state in the EMR has usually been through evolving national health insurance schemes, contracting out the management of government health facilities, contracting out private sector for specific service delivery schemes, and in a few instances through health vouchers and community health insurance. In most EMR states the agenda has been to complement public sector services in areas of gaps, and only in rare instances has radical purchasing of private sector as the mainstay of stay of UHC response been practiced.

Policy support has been higher for insurance schemes that involve purchase of limited private sector services alongside public sector services, as insurance schemes are seen to have lukewarm support and even active resistance for contracting out management of government facilities to private health sector or commissioning NGOs to supplement services as these are seen by local level implementers as diversion of state budget and control to private sector. Support for health vouchers is donor driven, confined mainly to Pakistan, and there is absence of state funding for up scaling, while community health insurance schemes have not taken off due to low levels of community organization as well as weak organizational support by the state. The politics of purchasing is also complicated by private sector-government relations, with private sector concerns of government as a reliable payer and state concerns on profit making by private sector. Slow and cautious expansion of purchasing over time has been seen for better trust and harmonial working between public and private sectors, with issue resolved through relational rather than punitive mode.

Two other factors are pertinent when purchasing private sector services. Demarcated structures for purchasing of services are needed in Ministries of Health, capacities built for open competitive tendering to avoid monopolies of a single organization, prior estimation of unit costs, writing of contracts with service delivery targets and independent monitoring are technical prerequisites for private sector purchasing. There are often concerns whether there is a sufficiently developed private sector market in EMR to contract with, comprising in particular a sufficient number of organizations having programmatic and financial absorptive capacity rather than individual providers. Contracting experiences has shown that the private sector grows and adapts in response to purchasing.

Costs of purchasing private sector services can vary with extent of sophistication and can be high, and need to be built into state budgets prior to embarking on PPPs. Systematic means targeting to reach the poorest as part of insurance or voucher schemes, can be particularly high and measures to reduce include piggybacking these on databases of social protection schemes. On the supply side global budgets and per capita payments are less costly financing measures for private provider payments as opposed to volume and service based payments, but involves an inherent level of flexibility transferred to the private provider. Delays in release of funding as a result of layers of bureaucracy is an overarching issue across several PPPs, and calls for upfront designing of speedier fund flow mechanisms with some level of institutional reorganization, as part of rolling out implementation.

Lastly, while the policy push for PPPs has usually come from international donors there needs to be caution in use of donor funding for embarking of PPPs for UHC as this can lead to fragile programs. International partner involvement may instead be best used for short and medium terms technical assistance in harnessing private sector for UHC.

II. Emerging Priorities for WHO-EMRO in Enhancing Private Sector Harnessing for UHC

- Supporting Country Commitment: WHO-EMRO can foster dialogue with Ministries of Health of member states at Regional and Country level to include private sector harnessing for UHC as an intrinsic health agenda.
- Development Partner Coordination: Providing catalytic support for regional and country level coordination amongst partners to harmonize positions on private sector harnessing, for supporting country governments.
- Policy dialogue between public and private sectors: Facilitating dialogue and communication between Ministries of Health, line Ministries, private sector and international development partners through setting up of policy roundtables for development of inclusive, realistic and context specific country priorities for private sector.
- Diffusion of Innovations: Provide platforms for synthesis and presentation of evidence on PPP innovations from other regions and countries, so as to allow for cross country learning and policy diffusion.
- Stewardship Forums: Support country government in development of stewardship forum and governance bodies for harnessing private sector potential towards UHC. Such bodies can take the form of Regulatory Authorities, Health Commissions, PPP Units or Contracting out
- Mapping of Private Sector: Provide tools and technical assistance in undertaking mapping surveys of private sector in member states, with a focus on composition of private sector, geographical concentration and extent of activity across services.
- Technical Assistance: Provide and mobilize technical support in designing and undertaking PPPs, providing attention to Contracting Out, insurance schemes, Regulation etc.
- Best Buys: Collate, synthesize and disseminate a list of best buys for PPPs, based on experiences from within and outside the region, for sharing with country governments.
- Evaluation of PPPs: Develop comprehensive and elastic frameworks and tools for evaluating PPPs for use of member states, incorporating measurement of hard data as well as capturing design and health systems related influencing factors.

III. Proposed Framework of Action for Engaging Private Sector in Moving Towards UHC

Commitments	Actions for countries	WHO support
Building platforms for dialogue	<ul style="list-style-type: none"> Setting up Taskforces for communication and dialogue between state and private sector Inclusion of private sector in setting national health policies, strategies and health sector reform process Joint setting up of targets for PPPs and process of measurements 	<ul style="list-style-type: none">
Policy & Stewardship	<ul style="list-style-type: none"> Building coherence of PPPs in Health as part of larger public sector economic and reform measures, through joint forums involving related line departments of Finance, Planning and Legal Development of strategy to shift public health sector responsibilities from direct service provision to a strategic oversight involving both public and private health providers 	<ul style="list-style-type: none">
Mapping private sectors	<ul style="list-style-type: none"> Identification of licensed and unlicensed providers, and geographical distribution Differentiation of 'pure private sector' from those in dual practice Assessment of basic organizational capacity, individual practitioners versus institutions Identification of services (preventive, screening, curative and rehabilitate) provided, areas of overlap and complementarity with public sector 	<ul style="list-style-type: none">
Regulation and Governance	<ul style="list-style-type: none"> Development of Regulatory Framework for private and public providers Enactment of laws for entry, distribution, quality and price control of health providers Setting up Regulatory Bodies, within or outside the MoH, with budgetary and human resource support Undertaking accreditation and providing capacity building through trainings and protocols Piloting of self-regulation innovations, backed by incentives 	<ul style="list-style-type: none">
Purchasing & Financing Private Sector services	<ul style="list-style-type: none"> Identify package of health services for purchasing from private sector, geographical areas for purchasing and target recipients Determine unit costs of services, identify performance targets, and contractual safeguards Set up purchasing bodies in ministries of health, distinct from supplies procurement Establish speedy fund flow systems for timely disbursements and working out of payment modalities (volume based/ capitation/ block grant) 	<ul style="list-style-type: none">
Leveraging Quality & Access	<ul style="list-style-type: none"> Set standards for quality of care, recording and reporting mechanism by the private care providers Periodic surveys of private and public sector on health care utilization, differentials in utilization by socio-economic groups, and quality of care, using independent monitors where possible Establishment of separate monitoring and evaluation cells within MoH for execution, collation and synthesis of in-house monitoring and independent surveys 	<ul style="list-style-type: none">
Patient information, engagement and satisfaction	<ul style="list-style-type: none"> Introducing checks on unrestricted advertisement of health services and medical products Public dissemination of information on accredited providers Setting up of client feedback mechanisms for hospitals Review and redress of laws for medical negligence Periodic assessment surveys of clients satisfaction for public and private sectors 	<ul style="list-style-type: none">

Annexure 1:

Tables on Performance Impact of PPP Schemes

Table 4.1: Impact of Contracting Schemes on Service Utilization

Country/Study Design	Service coverage	Tests of significance
Eastern Mediterranean		
Pakistan PPHI national evaluation Martinez 2010 End line assessment with a control 1 year intervention	ANC at BHU: Difference of 31% point in population served by contracted BHU over non-contracted BHUs ANC 1+: Difference of 9% point Institutional delivery: Difference of 19.4% point	N/A N/A N/A
Loevinsohn 2009 PPHI pilot End line assessment with a control 1 year intervention	ANC coverage: Difference of 2% point Skilled birth attendance: Difference of 4% point	N/A N/A
Bangladesh Urban PHC Program ADB 2007 Before and after study 5 year intervention	ANC visit 1+: Difference of 79% points in contracted over non-contracted. Institutional delivery: Difference of 26% points PNC Visit 1+: Difference of 68% points	N/A N/A N/A
Bangladesh Integrated Nutrition Project (BINP): Before and after with a control 5 years of intervention	Vitamin A supplementation: Difference of 2.7 % points, in intervention areas over non-contracted. Iron supplementation: Difference of 47% point in contracted over 3non contracted. ANC 1+ visit: Difference of 27% points Mean no. of ANC visits: Difference of 1.4	N/S P<0.05 P<0.05 P<0.05
Bangladesh Rural community nutrition services Karim R. 2003 Before and after study with six experimental and two control sub-districts 6 years of intervention	Malnutrition rates declined 18% points compared with 13%p in controls (5% double difference) Vitamin A: Double difference for vitamin A was 27% points	N/A N/A
India Chiranjeevi Scheme Bhat 2009 Endline assessment with control 2 year intervention	Institutional Delivery: Difference of 7% point in beneficiaries over non beneficiaries of contracting PNC Visits: Decrease by 2%	T=0.63 P<0.05 N/S

<p>India Integrated Nutrition and Health Program Baqui 2009 Before and after with control</p> <p>2 year intervention</p>	<p>ANC 1+: Difference of 32% point.</p> <p>Institutional Delivery: Difference of 6% points</p> <p>Household practices for birth preparation: Positive increase seen in contracted over non-contracted.</p> <p>Household practices for emergency preparation: Larger positive increase seen in contracted over non-contracted.</p>	<p>P<0.001. Change in Conc Index: 0.15. 95% CI (0.18, 0.12)</p> <p>Change in Conc Index 0.09. 95% CI (0.12, 0.06).</p> <p>Change in Conc Index: 0.09. 95% CI (0.14, 0.04).</p> <p>Change in CI: 0.15. 95% CI (0.18, 0.12).</p>
Americas		
<p>Guatemala: Danel & La Forgia 2005</p> <p>End line assessment with control</p>	<p>ANC 1+ visit: Difference of 11% point in management contracts (MC), 3% change in service delivery contacts (SC) over control</p> <p>ANC in first trimester: Marginal increase of 3% point in MC and decrease in SC</p> <p>Institutional deliveries not reported.</p> <p>After adjustment for distance to health facility, the performance of SC improves to similar as that of control</p> <p>Significant reduction in neonatal immunization rates</p>	<p>OR of 1.69 for management contract, p<0.05; NS for service delivery contract</p> <p>OR 0.94 [0.92, 0.96]</p>
<p>Schwartz 2004</p>	<p>After 2.5 years of intervention substantial increase in the proportion of children who were fully immunized</p>	<p>N/A</p>
<p>Bolivia: Lavadenz 2001 Before and after with control 1 year intervention</p>	<p>Institutional deliveries: Increase by 41 % points in hospital; only 4% % point in HF</p> <p>Hospital stay: Increase in average length of stay by 8.3 % points but little change in bed occupancy</p>	<p>N/A</p>
Western Pacific		
<p>Cambodia Bloom 2005</p> <p>Randomized cluster trail 5 year intervention</p>	<p>Antenatal care: Difference of 14% point in contracted over non-contracted.</p> <p>Institutional delivery: Difference of 18% point in contracting in and 30% point in contracting out.</p>	<p>P<0.01 ITT: 0.28 SE:0.08</p> <p>P<0.01 SE: 0.07 ITT contracting in: 0.09. ITT contracting out:0.04</p>
<p>Cambodia Bhushan et al, 2002,</p> <p>Cluster Randomized Controlled trial 2 and a half year intervention</p>	<p>ANC visits 2+: increased by 73% point in contracting in and 241% point in contracting out.</p> <p>Institutional delivery: Increase by 225% in contracting in and 142 % point in contracting out</p>	<p>N/A</p> <p>N/A</p>
Africa		
<p>Madagascar & Senegal Community Marek T 1999</p>	<p>Malnutrition: Sever and Moderate Malnutrition declined 6% points and 4% popints respectively.</p>	<p>N/A</p>

Source: (Zaidi s et al. 2012)

Table 4.2: Impact of CBHI Schemes on Service Utilization

Country/Study Design	Service Utilization
<p>Senegal, Mali & Ghana Smith 2008; End line assessment with control Intervention period: 2001-04</p>	<p>ANC visit in 1st trimester: Senegal: 7% pp increase, Mali 25 pp increase; Ghana : N/A</p> <p>4 + antenatal visits: Senegal: 2 pp increase, Mali 36 pp increase</p> <p>Institutional delivery: Senegal; 22 pp increase, Mali: 30 pp increase, Ghana: 10 pp increase.</p>
<p>Diop 2006 End line Assessment with Control Intervention period: 2001-04</p>	<p>Institutional Delivery: Increased utilization in Ghana, OR of 1.98, p<0.01; Senegal & Mali NS</p>
<p>Senegal (Smith 2006) End line assessment with control 2001-2004 Juttings 2004 End line Assessment Intervention period: 1990-2000</p>	<p>ANC visit in 1st trimester: Difference of 39% point over control, 4+ ANC visits: no increase Institutional delivery: 24% point increase Skilled delivery at home: 26% point decrease PNC: decrease of 10% point Hospital utilization: Difference of 27 % points in insured over non-insured</p> <p>Hospital utilization in females: higher utilization in females</p>
<p>Mali Franco 2008 End-line Assessment with control Intervention period: 2003-2004</p>	<p>ANC4+: higher utilization in insured over non-insured, OR of 2, p<0.1</p>
<p>Rwanda Soeters 2006; Before and after study Intervention period: 2003-2005</p>	<p>Institutional deliveries: Increased by 36% point from 25% (CI: 15-35) to 61% (CI:49-71)</p>
<p>Schneider & Diop 2001b End line Assessment with Control Intervention period: 1998-2001</p>	<p>ANC 3+ visit: Difference of 9.6% point in insured over non-insured.</p> <p>Skilled Birth Attendance: Difference of 16%point in insured over non-insured</p>
<p>Schneider 2001et al; Before After with Control Intervention period: 1998-2001</p>	<p>Total number of Antenatal care in Health Centers: Increase of 47% 4% 5% pp from baseline in insured districts compared to -20% -6% in control areas</p> <p>Total deliveries in Health Centers: Increase of 49%, 43%, 14% in insured districts compared to -12%, 14% in Noninsured areas</p> <p>Total deliveries in hospitals: Increase of 17 and 28% point in two insured districts and decrease of -28% in one insured district compared to 65 and 23 % point increase in non-insured districts.</p> <p>C section ratio as proportion of all hospital deliveries : Increase of 20% 26% 34% point increase in insured districts compared to 21% 26% in Noninsured districts</p>
<p>Congo Criel et al 1999 Case control; retrospective analysis of claims</p>	<p>Hospitalized referrals for EmOC: Difference of 9.4% point in insured over non insured, with 11% hospitalization rate in insured versus 1.6% in non insured</p>
<p>Intervention period: 1993-1994</p>	<p>C-section to delivery ratio: 1,97% in insured population vs. 0.74 % in noninsured, 1.23% point difference</p>

<p>China Long 2010a ; End line Assessment with control (Control are those where ANC is excluded from insurance package) Intervention period: 2002 -2007</p> <p>Long 2010b End line Assessment with control Intervention period: 2002-2007</p>	<p>ANC visits 5+: increase by 6-11 % point over the 2 control sites. P<0.01</p> <p>Process of ANC care: Advice on nutrition: 6-14% point increase over control sites, p<0.01 Hemoglobin tested: Decrease in recommended number of Hb testing by 10-12% point, p<0.01 Urine testing: Decrease in recommended number of urine tests by 33-36% point, P<0.01 US screening: 5-9% point increase over control, p<0.01</p> <p>ANC visits 5+: Increased by 10.5 %point (95% CI :+4.7, +13.6) ANC visits <12 gestation weeks: Increase by 20% point (35% to 55%) 95% CI: (+14.6, +24.0) Delivery at township health facility: Increased by 14% point (95% CI :+9.6, +18.1) Skilled birth Attendance: unskilled birth Attendance at home decreased by 18% point (95% CI :-14.1 to 21.8) Assisted delivery: no change Caesarean section: Increased by 11% point (95% CI : +7.6, +13.9)</p>
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Source: (Zaidi s et al. 2012)

Table 4.3: Impact of Voucher Schemes on Service Utilization

Country/ Study	Service utilization and Quality of Care	Test of Significance
<p>Pakistan Sohail A 2011 Before and after comparison based of household surveys before intervention in 2008 (n=681) and after intervention in 2009 (n=741).</p> <p>Pakistan Sohail A et al. 2011 Before and after study with control based of household surveys</p>	<p><u>ANC utilization</u> Increase by 21.6% points in voucher beneficiaries one year after intervention Odds of 4.98 as compared to before intervention</p> <p><u>Institutional Delivery:</u> Increase by 19.2% points in voucher beneficiaries one year after intervention Odds of 4.04 as compared to before intervention</p> <p><u>PNC utilization</u> Increase by 31.2% points in voucher beneficiaries one year after intervention Odds of 5.8 as compared to before intervention</p> <p><u>Complicated Delivery</u> Odds of 1.5 as compared to before intervention</p>	<p>p=<0.001</p> <p>p=<0.01</p> <p>p=<0.001</p> <p>p=<0.01</p>
<p>Bangladesh Ahmed S 2011 <i>End line assessment of Intervention and control area</i> Household surveys of one intervention (n=600) and 5 control sub-districts (n=3000)</p>	<p><u>ANC utilization</u> Odds of 1.91 (SE=0.294) as compared to control</p> <p><u>Postnatal Care utilization</u> Odds of 2.78 (SE=0.298) as compared to control</p> <p><u>Institutional Delivery:</u> Odds of 2.53 (SE=0.182) as compared to control</p> <p><u>SBA guided Delivery</u> Odds of 3.5 (SE=0.14) as compared to control</p> <p><u>Treatment for obstetric complications</u> Odds of 1.53 as compared to control</p>	<p>p=<0.001</p> <p>p=<0.001</p> <p>p=<0.001</p> <p>p=<0.001</p> <p>p=<0.001</p>
<p>Hat et al End line assessment of Intervention and control area Household surveys of 21 intervention and 21 control sub-districts</p>	<p><u>ANC utilization</u> Positive difference of 16% points as compared to control</p> <p><u>Postnatal Care utilization</u> Positive difference of 11% points as compared to control</p> <p><u>Institutional Delivery:</u> Positive difference of 25% points as compared to control</p> <p><u>Cesarean Section</u> Positive difference of 1% points as compared to control</p> <p><u>SBA Assisted Delivery</u> Positive difference of 41% points as compared to control</p>	<p>N/A</p>
<p>Rob et al 2010 Before and after study without control: Household Surveys of the intervention sub-districts</p>	<p><u>ANC utilization</u> Increase by 33.2% points in voucher beneficiaries after intervention</p> <p><u>PNC utilization</u> Increase by 14.9% points in voucher beneficiaries after intervention</p> <p><u>Institutional Delivery:</u> Increase by 16% points in voucher beneficiaries after intervention</p> <p><u>SBA guided Delivery</u> Increase by 16% points in voucher beneficiaries after intervention</p>	<p>P=<0.01</p> <p>P=<0.01</p> <p>P=<0.01</p> <p>P=<0.01</p>

Source: (Zaidi s et al. 2012)

Table 4.4: Impact of National Health Insurance on Service Utilization

Country/study design	Service coverage	Test of Significance
Ghana Chankova S et al. 2009 Before and after study with control 2004-2007	ANC utilization (4-5): Insignificant Increase of 2% points after intervention. Significant negative difference of -6%points as against non-insured Institutional delivery : Insignificant Increase of 1% points after intervention. Significant negative difference of -11%points as against non-insured C-section deliveries: Insignificant change of -1% points after intervention. Significant positive difference of 11%points as against non-insured Delivery by untrained BA Insignificant Increase of 9% points after intervention. Significant negative difference of -25%points as against non-insured	p= 0.53 p= 0.002 p=0.08 p=0.004 p=0.82 p=0.004 p=0.13 p=0.005
Taiwan Chen LM 2001 Before and after study without control 1989 and 1996	ANC utilization (4-5): Significant Increase of 14.8% points after intervention C-section deliveries: Insignificant change of 6.7% points after intervention. Quality of care Significant improvements in laboratory and radiological investigations	P=<0.01 P=<0.001 P=<0.01
Taiwan Liu TC et al. 2007 Before and after study without control 1989-2003	C-section deliveries: Impact of NHI on Cesarean section was statistically insignificant with OR=1.05 Institutional Delivery Hospital Delivery increased from 49.6%in 1989 to 54.4% in 1996 (p-value is not available)	N/A
China Wen-Wei 1998 Interrupted time series 1960 – 1993	C-section deliveries: Increase from 4.7% (1960-79) to 9.3% (1980 to 1987) and 22.5% (1988 to 1993). Women who had C-Section for most recent birth was 45.2% in women with Government Insurance compared to 40.5% for labor insurance 10.8% in Cooperative Insurance and 10.3% with Partial Insurance (OR=5.8)	95%CI=2.72-12.24) (cooperative insurance as reference), P<0.001
Philippines Kozhimannil KB et al. 2009 Before and after study without control 1998-2003	ANC utilization Insignificant Increase of 6% points after intervention Institutional Delivery Insignificant Increase of 3% points after intervention	N/A
Peru McQuestion 2006 End line assessment with control of 29 treatment and 29 control facilities	Institutional Delivery Insurance beneficiaries twice more likely to deliver in health facility	OR=2.01 SE=0.25 P=<0.05
Vietnam Sepahri A 2008 End line assessment with control	ANC utilization Insignificant positive association of insured relative to no-insured Institutional Delivery Insignificant positive association of insured relative to no-insured	OR=1.19 SE=0.29 P=n/s OR=1.06 SE=0.29 P=n/s

Source: (Zaidi s et al. 2012)

Annexure 2:

References

- Ahmed, S, and M. Khan, A maternal health voucher scheme: what have we learned from the demand side financing scheme in Bangladesh? *Health Policy Plan.*2010 26(1): p. 25-32.
- Ahmed, S. and M.M. Khan, Is demand-side financing equity enhancing? Lessons from a maternal health voucher scheme in Bangladesh. *Soc Sci Med.*2011 72(10): p. 1704-10.
- Ajluni MT. Harnessing the private health sector to achieving public health goals in Jordan. World Health Organization Eastern Mediterranean Regional Office (EMRO). 2006.
- Ameli O, Newbrander W. Contracting for health services: effects of utilization and quality on the costs of the Basic Package of Health Services in Afghanistan. *Bull World Health Organ*, 2008. 86(12): p. 920-8.
- Ammar W. Health System and Reform in Lebanon. World Health Organization–Eastern Mediterranean Regional Office and Ministry of Health Lebanon. 2003.
- Ali AM, Harnessing the Private Sector to Achieve Public Health Goals in Countries of the Eastern Mediterranean: Focus on Lebanon, American University of Beirut. 2005.
- Asian Development Bank (ADB), Bangladesh: Urban Primary Health Care Project, 2007
- Bakhsh AF. Harnessing the private health sector to achieving public health goals in Jordan. World Health Organization Eastern Mediterranean Regional Office (EMRO). 2006.
- Baqui et al. NGO facilitation of a government community-based maternal and neonatal health programme in rural India: improvements in equity. *Health Policy and Planning* 2009; 23:234–243
- Bennett, S. & Tangcharoensathien, V. A shrinking state? Politics, economics and private health care in Thailand. *Public Administration and Development*, 1994, 14, 1-17.
- Bhat, R. Regulation of the private health sector in India. *The International journal of health planning and management*, 1996, 11, 253-274.
- Bhat R et al. Maternal Healthcare Financing: Gujarat’s Chiranjeevi Scheme and Its Beneficiaries. *J HEALTH POPUL NUTR* 2009 27(2):249-258
- Bhat R, Huntington D, Maheshwari S. Public-Private Partnership, Contracting Arrangements and Managerial Capacity to Strengthen RCH Programme Implementation. IIMA Working Papers, 2007.
- Bhushan I, Keller S, Schwartz S. Achieving the twin objectives of efficiency and equity: contracting health services in Cambodia. 2002: Asian Development Bank 2005.
- Bloom E, Brookings I. Contracting for health: evidence from Cambodia. 2006: Brookings Institution 2005.
- Briscombe, B. and W. McGreevey, The Costs and Benefits of a Maternal and Child Health Project in Nigeria. 2010, USAID.

Buse, K. & Walt, G. Global public-private partnerships: part I-a new development in health? *Bulletin of the World Health Organization*, 2000, 78, 549-561.

Cercone J et al., Health System Innovations in Central America Lessons and Impact of New Approaches; Contracting Primary Health Care Services—The Case of Costa Rica, World Bank working paper no.57. 2005.

Chen, L.M., S.W. Wen, and C.Y. Li, The impact of national health insurance on the utilization of health care services by pregnant women: the case in Taiwan. *Matern Child Health J*, 2001. 5(1): p. 35-42.

Chankova S, Sulzbach S. An evaluation of the effects of the National Health Insurance Scheme in Ghana. Bethesda, MD. *Health Systems*. 2009; 20:20.

Cortez R. Argentina: Provincial Maternal and Child Health Insurance. A result based financing project at work. World Bank. 2009.

Criel, B, Van der Stuyft P, Van Lerberghe W, The Bwamanda hospital insurance scheme: effective for whom? A study of its impact on hospital utilization patterns. *SocSci Med*, 1999. 48(7): p. 897-911.

Danel I, La Forgia GM. Health System Innovations in Central America Lessons and Impact of New Approaches, Contracting for Basic Health Care in Rural Guatemala— Comparison of the Egypt report: Harnessing the Private Health Sector to Achieving public Health Goals 2006.

Eichler R, Auxila P, Pollock J. Performance-based payment to improve the impact of health services: evidence from Haiti. *World Bank Institute Online Journal*, 2001.

Eichler R, Can “Pay for Performance” Increase Utilization by the Poor and Improve the Quality of Health Services? Working Group on Performance-Based Incentives, Center for Global Development, 2006.

Islam MT, et al. Improvement of coverage and utilization of EmOC services in southwestern Bangladesh. *Int J Gynaecol Obstet*, 2005. 91(3): p. 298-305;

Jacobson, P. D. Regulating Health Care: From Self-Regulation to Self-Regulation? *Journal of health politics, policy and law*, 2001, 26, 1165-1177.

Karim R, Lamstein SA, Akhtaruzzaman M, Rahman KM, Alam N. The Bangladesh integrated nutrition project community-based nutrition component endline evaluation. Institute of Nutrition and Food Sciences, University of Dhaka, Bangladesh and International Food and Nutrition Center, Tufts University, USA, 2003.

Khalil R, Assessment of the Private Health Sector at the Kingdom of Saudi Arabia Dar Al- Noor Health Studies & Consultation.

Kozhimannil, K.B., et al., The population-level impacts of a national health insurance program and franchise midwife clinics on achievement of prenatal and delivery care standards in the Philippines. *Health Policy*, 2009. 92(1): p. 55-64.

Kumaranyake, L. The role of regulation: influencing private sector activity within health sector reform. *Journal of international development*, 1997, 9, 641-649.

Kumaranayake, L. & LAKE, S. Regulation in the context of global health markets. *Health Policy in a Globalising World*, 2002, 78-96.

Kumaranayake, L., Lake, S., Mujinja, P., Hongoro, C. & Mpembeni, R. How do countries regulate the health sector? Evidence from Tanzania and Zimbabwe. *Health policy and planning*, 2000, 15, 357 -367.

La Forgia, et al., *Health Insurance in Practice: Fifteen Case Studies from Developing Countries*. 1993: Health Financing and Sustainability (HFS) Project, Abt Associates.

La Forgia, *Health System Innovations in Central America Lessons and Impact of New Approaches; Is the Perfect the Enemy of the Good? A Case Study on Large-Scale Contracting for Basic Health Services in Rural Guatemala*, 2005.

M, A, N. Conditional Cash Transfers for Improving Uptake of Health Interventions in Low- and Middle-Income Countries: A Systematic Review. 2007. Vol 298(16):1900-1910.

M, N. The impact of user fees on health service utilization in low- and middle-income countries: how strong is the evidence? *Bull World Health Organ* 2008 Vol.86 (11): 839-848.

Lagarde M. Conditional Cash Transfers for Improving Uptake of Health Interventions in Low- and Middle-Income Countries. A Systematic Review. *JAMA*. 2007; 298(16).

Lameea Al-Tahoo, *Assessment of Private Health Sector in the Kingdom of Bahrain*, Ministry of Health – Bahrain, 2009.

Lavadenz F et al .Redespúblicas, descentralizadas y comunitarias de salud en Bolivia *Rev Panam Salud Publica/ Pan American Journal of Public Health* 9 (3), 2001.

Le secteur sanitaire libéral en Tunisie Mai 2005.

Liu X, Hotchkiss D, Bose S. The effectiveness of contracting-out primary health care services in developing countries: a review of the evidence *Health Policy & Plan* 2007. Vol 23(1): 1-13.

Loevinsohn B, et al. Contracting-in management to strengthen publicly financed primary health services--the experience of Punjab, Pakistan. *Health Policy*, 2009. 91(1): p. 17-23.

Loevinsohn B, Harding A. Buying results? Contracting for health service delivery in developing countries. *The Lancet* 2005, 366(9486):676-681.

Long, Q., et al., Utilisation of maternal health care in western rural China under a new rural health insurance system (New Co-operative Medical System). *Trop Med Int Health*.2010 15(10): p. 1210-7.

Long, Q., et al., Utilisation, contents and costs of prenatal care under a rural health insurance (New Co-operative Medical System) in rural China: lessons from implementation. *BMC Health Serv Res* 2010. 10: p. 301.

Marek T, Diallo I, Ndiaye B, Rakotosalama J. Successful contracting of prevention services: fighting malnutrition in Senegal and Madagascar. *Health Policy Plan* 1999; 14: 382–89.

Martinez DJ, et al. Third-Party Evaluation of the PPHI in Pakistan, DFid-HLSP, Technical Resource Facility and SOSEC, 2010, Vol. 17 2,

Mavalankar D et al.b, Saving mothers and newborns through an innovative partnership with private sector obstetricians: Chiranjeevi scheme of Gujarat, India. *Int J GynaecolObstet*, 2009. 107(3): p. 271-6.

Mavalankar D, et al.a, Maternal health in Gujarat, India: a case study. *J Health PopulNutr*, 2009. 27(2): p. 235-48.

Mcquestion MJ. Evaluating program effects on institutional deliveries in Peru. *Health policy* 2006;77:221-32

McNamee P, Acharya A. Public-private partnerships to reduce maternal mortality: silver bullet or smoking gun? Conference paper, XXVI International Population Conference.

Musa T, Harnessing the private health sector to achieving public health goals in Jordan Division of Health System and Services Development (DHS), Health Policy and Planning Unit, WHO Jordan, 2006.

NPPI. Strategy Document, Norway –Pakistan Partnership Initiative (NPPI), Department of Health Sindh and One UN, Pakistan, 2010.

O'Connell T, Rasanathan K, Chopra M. What does universal health coverage mean? *The Lancet*. 2014; 383(9913): 277-9.

Palmer N, Strong L, Wali A, Sondorp E. Contracting out health services in fragile states. *BMJ*. 2006; 332(7543): 718-21.

Patel A, et al, Implementing a Public Private Partnership Model for Managing Urban Health in Ahmedabad. Indian Institute of Management, 2007.

Performance of Three Delivery Models, World Bank working paper No. 5 7, 2005.

Perrot, J. Different approaches to contracting in health systems. *Bulletin of the World Health Organization*, 2006, 84, 859-866.

Peters H et al. A balanced score card for health services in Afghanistan, *Bulletin of the World Health Organization* 2007; 85(2):146-151.

Private Health Sector in Yemen Health Policy Unit Ministry of Public Health and Population.

Ranson, M.K., Reduction of catastrophic health care expenditures by a community-based health insurance scheme in Gujarat, India: current experiences and challenges. *Bull World Health Organ*, 2002. 80(8): p. 613-21.

Schmidt, J.O., et al., Vouchers as demand side financing instruments for health care: a review of the Bangladesh maternal voucher scheme. *Health Policy*. 96(2): p. 98-107.

Siddiqi Sameen, Masud Tayyeb Imran, Sabri Belgacem. Contracting but not without caution: experience with outsourcing of health services in countries of the Eastern Mediterranean Region. *Bull World Health Organ* [online]. 2006, vol.84, n.11.

Singh, A., et al., Providing skilled birth attendants and emergency obstetric care to the poor through partnership with private sector obstetricians in Gujarat, India. *Bull World Health Organ*, 2009. 87(12): p. 960-4.

- Schwartz JB, Bhushan I: Improving immunization equity through a public-private partnership in Cambodia. *Bull World Health Organ* 2004, 82(9):661-667.
- Smith K, Sulzbach S. Community-based health insurance and access to maternal health services: evidence from three West African countries. *SocSci Med*, 2008. 66(12): p. 2460-73.
- Smith, K, Quijada C. 2006. Mutual Health Organizations and Reproductive Health in Senegal. Partners for Health Reformplus Project, Abt Associates Inc.
- Soeters R, Griffiths F. Improving government health services through contract management: a case from Cambodia. *Health Policy Plan*, 2003. 18(1): p. 74-83.
- Soeters R, Habineza C, Peerenboom PB. Performance-based financing and changing the district health system: experience from Rwanda. *Bull World Health Organ*, 2006. 84(11): p. 884-9.
- Sondorp E, et al. Afghanistan: Paying NGOs for Performance in a Post conflict Setting, Center for Global Development. 2009.
- Sohail A. Changes in proportion of facility based deliveries and related maternal health services among the poor in rural Jhang Pakistan: Results from a demand side financing intervention. *International Journal for Equity in Health* 2011, 10:31.
- Sohail A. Impact of a maternal health voucher scheme on institutional delivery among low income women in Pakistan 2011.
- Sohail A. The context for and development of a voucher program in rural Pakistan. 2009, Greenstar Social Marketing Pakistan.
- Tahoo LA. Assessment of Private Health Sector in the Kingdom of Bahrain- Ministry of Health Bahrain 2009.
- Taylor R. Contracting for Health Services. The World Bank. 2003.
- Teerawattananon, Y. Advanced health biotechnologies in Thailand: redefining policy directions. *BMC Journal of translational medicine* 2013, 11(1).
- Walsh K. Public Services and Market Mechanisms: Competition, Contracting and the New Public Management. Macmillan Distribution: Basingstoke UK. 1997.
- Widdus, R. Public-private partnerships for health require thoughtful evaluation. *Bull World Health Organ*, 2003, 81, 235-235.
- World Bank. , Reaching the poor with health services Mexico: Providing Subsidized Health Insurance to the Poor. 2008, World Bank.
- World Bank. Bangladesh Integrated Nutrition Project Effectiveness and Lessons, Bangladesh Development Series – paper no.82005 2005.
- World Health Assembly. Social health insurance: sustainable health financing, universal coverage and social health insurance: report by the Secretariat. 58th World Health Assembly; Geneva, Switzerland; May 16–25, 2005.

Zaidi S, Mayhew S, Palmer N, Bureaucrats as Purchasers: Limitations of Public Sector for Contracting, Public Administration and Development.2010. DOI: 10.1002/pad.581

Zaidi S, Mayhew SH, Cleland J, Green AT. Context matters in NGO-government contracting for health service delivery: a case study from Pakistan. Health Policy and Planning.2012. 27(7):570-81

Zaidi S, Bhutta Z, et al, Landscaping Finance Support Platforms for the Improvement of Basic and Emergency Obstetric Care Abstraction Report, Aga Khan University March, 2012.

Zaidi, S., Rabbani, F., Riaz, A., Pradhan, N., Hatcher, P. Improvement in Access and Equity for Maternal and Newborn Health Services: Comparative Advantages of Contracted out versus Non-Contracted Facilities, Research and Advocacy Fund, British Council - Islamabad. 2013.

Zaidi, S., Salam, R., Rizvi, S. S., Ansari, S., Bhutta, Z., et al. Public Private Partnerships for Improving Maternal & Neonatal Health Service Delivery, Research and Advocacy Fund, British Council Islamabad. 2013.

Zaineh M, Private Health Sector in the Occupied Palestinian Territory: Assessment of Challenges and Opportunities, WHO Draft for Consultation 2010.

