# Identifying Challenges and Solutions to Enhance Public-Private Collaboration for Universal Health Coverage

# AN ASSESSMENT TOOL
## FOR COUNTRIES IN AFRICA

AFRICAN DEVELOPMENT BANK GROUP
GROUPE DE LA BANQUE AFRICAINE DE DÉVELOPPEMENT

World Health Organization
REGIONAL OFFICE FOR Africa

HHA



# FOREWORD

While the progress towards UHC is dependent on improvements in public spending on health, the private sector with its vast presence in service delivery is called to play even bigger role. Healthcare is by nature an ecosystem that relies on the conjunction of public and private sector actors to ensure all in need for health care are reached and effectively served by health services. There is considerable scope for greater engagement and development impact from public-private collaboration in the health sector in Africa.

Public-private collaboration in health is gaining considerable traction on the African continent. Clearly, the current level of health budgets of most African governments is not sufficient to meet the growing needs for healthcare resulting from the superposition of continued prevalence of communicable and rapidly rising incidences of non-communicable diseases. The demographic trends and overall demand for quality care call for greater private sector involvement through increased investment in healthcare. Major dialogue events have been recently held on the continent, notably the Second Africa Health Forum convened in March 2019 in Praia, Cape Verde, by the WHO Regional Office for Africa, which dedicated ample space to public-private collaboration in health, including a side event co-organised with the African Development Bank.

Achieving the potential of public-private collaboration in health requires that the challenges and systems gaps impeding a more effective and impactful collaboration be addressed. This implies in first place the mutual recognition of respective public and private sector identities, perspectives, objectives and constraints in serving the people of Africa, with a view to delineate win-win playing fields. Given the diversity of the private sector, and -from public-partnerships to softer but not least useful forms of public-private collaboration, the variety of available options to collaborate, the task faced by African countries is daunting, and cannot be matched by the prevailing capacity to shape and implement collaboration.

This publication reflects the determination of the WHO Regional Office for Africa, the African Development Bank and their partners in the Harmonization for Health in Africa (HHA), to join forces to assist African countries in enhancing the collaboration between their public and private health sectors. It provides for an Assessment Tool that can assist countries, as well as interested development partners, to systematically explore potential collaboration, identifying related constraints and conducting the necessary constructive dialogue towards enhanced public-private collaboration in health. This publication also offers illustrations and insights from Burkina Faso, Malawi and South Africa, where the assessment tool has been tested.

It is hoped that this publication will facilitate the effective engagements between governments and non-government actors committed to working together for continuous improvement in the delivery of health services, and also encourage dialogue processes that will enrich the knowledge base for future collaborative innovations.

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# CONTENT

# ABBREVIATIONS

| | |
|---|---|
| **AfDB** | African Development Bank |
| **CCMDD** | Central Chronic Medicine Dispensing and Distribution |
| **CHAM** | Christian Health Association of Malawi |
| **CME** | Continuous Medical Education |
| **CSR** | Corporate Social Responsibility |
| **DBOT** | Design, Build, Operate and Transfer |
| **DFOT** | Design, Finance, Operate and Transfer |
| **FASPB** | Federation of Professional Private Health Associations of Burkina Faso |
| **GPs** | General Practitioners |
| **GTAC** | Government Technical Advisory Centre |
| **HMIS** | Health Management Information Systems |
| **ICU** | Intensive Care Unit |
| **IDI** | In-Depth Interview |
| **LMICs** | Low- and Middle-Income Countries |
| **MITC** | Malawi Investment and Trade Commission |
| **MOJ** | Ministry of Justice |
| **MOH** | Ministry of Health |
| **MoU** | Memorandum of Understanding |
| **NGOs** | Non-Governmental Organizations |
| **NHI** | National Health Insurance |
| **PFMS** | Public Finance Management Act |
| **PNDS** | Plan National de Développement Sanitaire |
| **PPCs** | Public Private Collaborations |
| **PPPs** | Public Private Partnerships |
| **PPPC** | Public Private Partnership Commission |
| **SDG** | Sustainable Development Goal |
| **SHGs** | Self-Help Groups |
| **SLA** | Service Level Agreement |
| **SPONG** | Permanent Secretariat of NGOs |
| **SPV** | Special-Purpose Vehicle |
| **UHC** | Universal Health Coverage |
| **VfM** | Value for Money |
| **WHO** | World Health Organization |
| **$** | US dollar |

# EXECUTIVE SUMMARY

This assessment tool has been developed under SDG 3 of the Sustainable Development Goals (SDGs) for the promotion of "healthy lives and well-being for all ages". The SDGs, with a 2030 target date, are universal goals which are cross-cutting, cohesive and inseparable, with progress in one area reliant upon progress in others. Attaining Universal Health Coverage (UHC) is considered as the core driver for accomplishing SDG 3, through providing quality and affordable health care services. One of the major levers for achieving SDG 3's targets is through the implementation of the SDG 3.8 health target on UHC, which emphasizes the right of all citizens to access quality health services without financial hardship.

The SDG 17 identifies the necessity of partnerships to achieve the SGD goals, and these are recognised by various countries and confirmed by research as a key driver for achieving the SDGs by 2030. Many of the member countries have been identifying partnership opportunities with different sectors and stakeholders to attain UHC. Engagement of the private, public, and other sectors is vital to meet the health-related SDG 3.

The contribution of the private sector to countries' healthcare delivery is significant and cannot be overlooked. As the world moves towards attaining UHC, health systems in Asia, Africa, Latin America and other developing countries are gearing up for their own expansions in access to care through partnerships with the private sector, to provide investments and skills to help national governments. Africa's healthcare challenges are more pronounced, owing to the extensive diversity of the continent. Sharp discrepancies exist in the prevalence of illnesses and access to treatment. The African continent is undergoing rapid transitions on a number of facets. These range from demographic changes, as witnessed through longer life expectancy and changing age-structures; urban growth; and epidemiological changes, such as the growing burden of non-communicable diseases.

A number of African countries have a limited capacity of raising public revenue and heavily depend on external funds. At the same time, the private sector accounts for a large proportion of healthcare delivery, making it important to delineate its role in the financing and provision of healthcare more clearly. Public-private collaboration (PPC) have the potential to leverage specific strengths of the public sector thus enabling the development of robust frameworks, policies and streamlining capacity-building actions to support the achievement of UHC. Many Low- and Middle-Income Countries in Africa are discovering new and innovative healthcare partnerships. However, these partnerships also often bring their own challenges and controversies. Many have critiqued such partnerships for averting resources from public actions and distorting public agendas in ways that favour the private sector.

In realizing the role of public private collaboration in health for achieving UHC and attaining the SDGs, a wider discussion leading to policy development is therefore crucial. In this regard, the present study is designed to understand stakeholder perspectives on key thematic strands under the broader framework of PPC. To elicit in-depth stakeholder perspectives on PPC, a structured interview tool has been developed to guide the consultative dialogue process on PPC at country level. The PPC assessment tool provides the perspectives of the public and private sectors, and other stakeholders. The key thematic strands and questions under each domain were developed after a review of existing literature and evidence on existing PPC within the health sector.

The assessment tool was tested in three countries (Burkina Faso, Malawi and South Africa) through open-ended questions related to the strengths and challenges for effective engagement across sectors. The six thematic areas of the Assessment Tool include the following:

i. context and understanding of the concepts of PPC in health;

ii. opportunities for engagement with the private sector for improving PPC for achieving UHC;

iii. the political will and policy environment for promoting public private collaboration in health;

iv. understanding the processes, financing and institutional mechanisms of public- private partnership structures and strategies for supporting PPC in the health sector;

v. understanding the implementation issues which hamper PPC; and

vi. monitoring and accountability mechanisms for the implementation of PPC in health.

Findings from the above point to, and confirm research on the need for greater and more streamlined collaboration with the private sector to achieve UHC in the evolving context and need for increased health access outlined above. Additionally, opportunities exist for PPC to bridge the gaps in service delivery.

In addition, the study identified PPC as often complex and in need of a strong regulatory environment. Institutional and technical capacity is therefore a prerequisite for initiating and managing collaborative arrangements between governments and the private sector. Trust between the government and the private sector and other stakeholders is another significant factor impacting partnerships. The study also signaled to a major difficulty in data and health information collection within the private sector. This work also provides a deeper understanding of the role of knowledge management in this field.

**Several key recommendations emerge from the findings:**

- A key recommendation is to enhance the process of PPC including the development of platforms for dialogue between public and private stakeholders. This will enable them to not only clarify and understand their respective roles, but also establish the modalities for engagement and jointly develop solutions. Platforms can be situated within an institution coordinating government affairs or the national development agenda in order to preserve the continuity of dialogue for PPC.

- A second recommendation is the articulation of a “vision” on the role that the private sector is invited to play. In this regard, it is important for governments to acknowledge the diversity of the private sector and tailor their expectations vis-à-vis PPC accordingly, while also aligning with country vision for socio-economic development.

- Once the Vision document is agreed upon, mechanisms for accountability to the professional bodies, political leadership, and other stakeholders can be put into place.

Health sector reform provides opportunities to enhance PCC for accelerated progress toward UHC, as is the case in countries expanding health insurance programmes and adopting strategic purchasing models. Development partners, in particular as part of the Harmonization for Health in Africa (HHA) mechanism, have

an important role to play in these endeavours.


# SECTION 1: INTRODUCTION

**1.1** The concept of Public Private Collaboration (PPC) in the health sector has developed considerable interest around the world in both developed and developing countries. There is ample evidence across the globe, which demonstrates the successful collaboration between the public and private sector in health delivery. Whereas the broader framework of engagement with the private sector is termed as Public Private Collaboration, the Public Private Partnerships (PPPs) are viewed as a legalised arrangement serving as a subset of the wider concept of the PPC domain. PPCs and PPPs in the health sector take a variety of forms with differing degrees of public and private sector responsibilities and risks. PPPs are one of the many types of public -private collaborations in healthcare delivery (Nikolic I. A. & Maikisch H, 2006).

**1.2** PPP's are often seen as formal contractual agreements with private partners regulated by the provisions of the PPP law of the country with a mandated framework on the processes to be followed while developing partnership agreements with the private sector. Whereas PPC's represents a wide range of interactions between the public and private sector. An example includes the complex agreements like collaborations for vaccine cold chain management with the pharmaceutical industry, to simpler forms like sharing of health information between private and public sector. Some turnkey projects which involve value-for-money (VfM) assessments fall under the ambit of PPP's such as Build Operate Transfer (BOT), Design, and Finance and Operate (DFO) . Other interactions like licensing and accreditation, training of government staff in private hospitals, consultative working groups with private sector providers are examples of PPC's in health.

**Figure 1:** Public Private Collaboration and Partnerships in Health Sector


Source: Adapted from Public-Private Partnerships and Collaboration in the Health Sector: An Overview with Case Studies from Recent European Experience

**1.3** Governments are increasingly looking at PPPs to expand access to higher-quality health services by leveraging capital, managerial capacity, and know-how from the private sector. However, many of these partnerships also bring their own challenges and controversies. Many have critiqued such partnerships for averting resources from public actions and distorting public agendas in ways that favour the private sector. There are four basic dimensions that describe the partnerships: i) scope, ii) partners, iii) level of commitment and, iv) type of objective. The scope of a partnership will be at one of three levels: local, national or global. International experience has demonstrated a wide variety of ways for public systems to interact with private sectors through PPCs or PPPs.

However, the private sector itself is heterogeneous, ranging from small clinics and pharmacies in rural areas to corporate multi-speciality hospital chains in urban areas. To gain a better view of the possibility of engaging the private players in the health sector, it is useful to categorise them on parameters profit motive, the degree of organisational complexity, by types of health care services provided, and other support functions provided by them. One way of classifying the private players within the health sector is to look at their organisational complexity vis-à-vis their profit motive (or lack thereof). In this regard, it may be noted that the "non-profit" or "not-for-profit" had been differentiated from the "voluntary" organisations, with the idea that the connotation of "non-profit" applies to organisations not working for profit motive but modelled more-or-less as a corporate body, with formal division of labour and hierarchy. Whereas, the "voluntary" organisation connotes organisations not working for profit and structured informally around a few individuals, working with the community at the grassroots level.

**Figure: 2** Private Players in Health Sector, by type of Organisation & Management

| Type of Organisation | For-profit healthcare providers | Non-profit healthcare providers | Voluntary healthcare providers1 |
|---|---|---|---|
| Highly complex organisation | • Corporate hospital chains<br>• Private medical college & hospitals | • Philanthropic Foundations<br>• Foundations/Mission hospitals operating nationally/ globally<br>• Corporate social responsibility (e.g. Tata Cancer Hospital) | • Health services provided by international Non-Governmental Organisations NGOs and Foundations<br>• Organisations Supported by Development Partners |
| Moderately complex organisation | • Private hospitals, nursing homes, diagnostic centres | • Missionary / Trust hospitals | • Outreach/mobile clinic services provided by National NGOs |
| Simple organisation | • Private doctors, Clinics<br>• Registered Medical Practitioners<br>• Less than fully qualitied providers | • Private doctors providing services in outreach camps organised by missionary/trust hospitals/professional bodies<br>• Traditional healers | • Local NGO providing symptomatic screening & referral services usually by health camps |

Source: Developing coordinated public private partnerships and systems for financing health in Africa; [1]Experiences from Africa and India, 2018, WITS-AfDB Publication.

1 The Voluntary Health Providers are mostly dependent on grants or projects from donor institutions or philanthropic organizations which are mostly short term in nature and once the project funding reaches a closure they also retreat

Also, within the domain private sector in healthcare, some players are not health care providers in the strictest sense of health "care" but play a crucial role in the health sector. Some of the types of such "non-care giving" private players in the health sector may include the following:

- **Academic and Research Institutions –** act as the repository of knowledge and evidence of best practices crucial for training, capacity building and policy advocacy.
- **Professional Associations –** act to protect the professional interest and also lobbying for specific issues (Doctors Associations, Paramedical Associations etc.)
- **Corporate Industry (CSR – Corporate Social Responsibility) –** a major source of grants for community-level programmes and initiatives.
- **Companies that serve health facilities** (eg: cleaning, medical equipment maintenance, etc.).
- **Cooperatives, Self-Help Groups (SHGs) –** ideal for community mobilisation and community financing initiatives.
- **Non-Governmental Organizations (NGOs) not providing healthcare services –** crucial for community mobilisation and awareness generation.
- **Pharmaceutical companies –** active in clinical trials and in sponsoring CME (Continuous Medical Education) and other meetings and conferences
- **Media and Advertisement agencies –** a crucial partner in mass awareness and mobilisation campaigns.
- **Philanthropic Donors (Individuals and Organisations including in particular diaspora) –** a crucial source of monetary or in-kind donations.

The above classification of the private sector shows the diversity of the private sector which involves different identities, whose objectives, accountabilities, etc., range from for-profit to not-for-profit through philanthropy. The diversity also leads to a lack of evidence and understanding of the interactions between the public and private health sector. To have a successful collaboration, one needs to match the strengths and capacities of the available private sector partners in each country.

In many countries in the world, the private sector is not only a key stakeholder in development, but also an indispensable anchor. A well-performing private sector is a major contributor to the GDP and growth of countries, which are basic conditions for addressing issues related to poverty (Diyamett, 2018). A well-performing national private sector grows GDP, generates millions of jobs, and increases per capita income and generates revenues for the government through taxes to enable provision of much needed services, such as education and healthcare (Diyamett, 2018). Moreover, many governments are confronted by economic constraints that force them to carefully prioritize and restrict public expenditures and furthermore, many public health systems are already indebted, and face added financial pressures (Nikolic I. A. & Maikisch H., 2006). Those governments that wish to explore further resources can turn to the private sector to help address specific cost and investment challenges, improved service provision and management at reduced costs, and enhance service quality (Nikolic I. A. & Maikisch H., 2006). In order to achieve UHC, the private sector's biggest potential impact lies in increasing, as well as developing business investment and scalable market-based approaches. There are five areas where the private sector can add unique value to help achieve UHC: (i) understanding patient care, (ii) implementing innovations at scale, (iii) designing the right business model, (iv) building government capacity and, (v) innovations to meet local needs. The policy level factors for pursuing collaborations with private sector, is principally motivated by securing increased funding, introducing private sector efficiencies and encourage public sector reforms.

## 1.1. HEALTH FINANCING IN AFRICA

Africa's healthcare challenges are heightened by the sheer diversity across the continent. The countries are diverse across a broad spectrum ranging from resource-rich ones to poor countries. Others have dynamic economies, while others span conflict zones. Distribution also ranges from large cities to remote villages and/or nomadic lands. There exist sharp discrepancies in the prevalence of illness and access to treatment occur which complicates comparisons for policy-making purposes (Economist, 2012).

Additional issues to take into account are the Africa's rapid transitions on at least three fronts: (i) demographic changes resulting from longer life expectancy and changing age-structure; (ii) urban growth and, (iii) epidemiological changes like shifting the burden of illness toward non-communicable diseases. These changes have profound effects on the type, quantity and costs of healthcare services needed. Further, the national healthcare systems in Africa face severe shortages of suitably qualified health workers and limited availability of quality medicines (UNECA, 2019). Data demonstrates that a disproportionately large number of skilled health personnel are located in urban areas; and with limited resources and access to remote areas which means that populations in rural areas have inadequate access to preventive health services (UNECA, 2019).

Since 2000, Africa has shown a tremendous improvement in various health indicators, and most African countries recognize a right to health in their national constitutions. The Under-5 Mortality Rate in Africa declined from 148 to 62.8 deaths per 1,000 live births over the period 1990 to 2017; the Infant Mortality Rate declined from 91 to 44.1 deaths per 1,000 live births in the same period; the Maternal Mortality Ratio also declined from 542 to 421 per 100,000 live births between 1990 and 2015 (UNECA, 2019). This is because, many African countries are undertaking health systems financing reforms to increase health coverage and financial protection following the path to UHC (Bayarsaikhan, D. & Musango L., 2016). Despite this improvement, there is still much more to do to progress and meet the universal and national standards and goals.

Given the importance of investing in health, many of the African member states have placed healthcare financing as one of the fundamental channels to improve the well-being of their populations. In the year 2001, heads of African Union countries pledged to set a target of allocating 15% of their government budget to the health sector (Bayarsaikhan D. & Musango L. 2016). Even though some countries like Ethiopia, Malawi and Rwanda have increased their public expenditure in health; many other face major constraints in overall health financing. These differences in countries' assurance towards achieving this target indicate that political will and commitment is needed together, along with clear vision, health and development priorities to increase government revenue allocation to health (Bayarsaikhan D. & Musango L., 2016). Health insurance is also now being considered as an option to raise and pool revenues, as well as to provide financial protection in several African countries; Algeria, Gabon, Ghana, Kenya, Mali, Rwanda, Tanzania and Togo had already started practicing compulsory health insurance.

Overall, health spending in Africa remains largely inadequate to meet the growing healthcare financing needs and the rising healthcare demands, creating a huge financing gap of $66 billion per annum (UNECA, 2019). These mainly narrow down the economic growth, showing an average debt to Gross Domestic Product (GDP) ratio increasing by 15 percentage points between 2010 and 2017. However, the total spending on healthcare in Africa remained within a narrow band of 5 to 6 per cent of GDP over the period 2000–2015 (UNECA, 2019). Scarce public resources and volatile donor assistance resulted in private out-of-pocket expenditure as the single largest component of total health expenditure, pushing the majority of African people into poverty. In 2014, out-of-pocket payment (OOP) as percentage of total health expenditure in countries of the World Health Organization (WHO) the African region was estimated from 5% in Botswana to 72% in Nigeria (Bayarsaikhan D. & Musango L., 2016). High OOP is associated with low levels of public financing for health; where the public providers are forced to supplement their budget with various kinds of fees and charges for publicly provided health services (Bayarsaikhan D. & Musango L., 2016). UHC has the potential of achieving improved access for the whole population to good-quality health services without the risk of financial hardship. Regrettably, the public sector in most sub-Saharan African countries lacks the capacity of providing a range of 'essential services' to the whole population to achieve UHC. In order to achieve UHC in the wider context of health financing policy and reforms, the Abuja target of increasing public financing for the health sector

by 15% , is not only pre-defined spending target, but seen as a target to increase compulsory, prepaid and pooled financing to ensure greater health coverage and financial protection (Bayarsaikhan D. & Musango L., 2016).

## 1.2. PUBLIC PRIVATE COLLABORATION FOR HEALTH IN AFRICA

Countries across the world are committed to the United Nation's Sustainable Development Goal (SDG) of "healthy lives for all" by 2030 (SDG goal # 3.8). The SDG Goal 3.8 target promises Universal Health Coverage (UHC): people receive essential health services without being exposed to financial hardship. Over the years, there has been a significant increase in health expenditure across Africa, mainly driven by an increase in Out-of-Pocket expenditure and Development Assistance. However, it may also be noted that only four countries met the Abuja target of 15% of general government spending in 2014. This has posed a "double burden" on many health systems with reduced domestic spending and increased catastrophic health expenditure leading to impoverishment. Around 11 million Africans are falling into poverty every year due to high out-of-pocket expenditure on health care services.

The private sector accounts for delivering 50% of health services and 60% of total health spending in Africa (IFC, 2018). The sheer presence of the private sector along with the low fiscal capacity of most of the African countries to mobilize public funding for health sector engagement with the private sector to achieve the SDG target of UHC. Public private collaborations and partnerships are required to leverage the potential of the private sector in a systematic way to address the health system challenges in Africa. PPPs and PPCs are viewed as social experiments which can complement the public health system by engaging private players. However, realizing the potential of public-private collaboration requires that existing challenges and bottlenecks be addressed comprehensively.

With the recognition of the important role of PPC's in health for achieving UHC and achieving SDG's, there is a need to have wider discussions aimed at strategy development for engaging with private sector. The United Nations General Assembly High-level Meeting on Financing the 2030 Agenda for Sustainable Development held in 2018 recognized that achieving the Sustainable Development Goals will necessitate a wider collaboration with the private sector including philanthropic organizations. Other platforms at the regional level such as those presented during the African Union Summit in February 2019, the African Leadership Meeting for Investing in Health, and the African Business Health Forum have underscored the basic principles of public-private collaboration that are gaining traction on the international stage.

Public Private Collaboration for achieving UHC was one of the key topics for discussion at the 2nd Africa Health Forum convened by World Health Organization (WHO) in Praia, Cape Verde, from 26-28 March 2019. The deliberations aimed at increasing the understanding of the determinants of public-private engagement (spanning dialogue, collaboration, partnership and more) to address these bottlenecks to enhance collaboration and investments in the health sector. The forum brought together select government and private sector actors through a Chatham House conversation to discuss the broader knowledge work on public-private collaboration undertaken by WHO and the African Development Bank. The deliberations were intended to help inform development partners of the best possible ways of supporting public-private collaboration in Africa and developing a working relationship between participants for further dialogue among themselves and with organizing development partners.

Key question discussed during the meeting included:

- How can the different identities, cultures and mandates of public and private actors in health be capitalized to develop dialogue and trust and enhance joint working?
- What institutional development is required to ensure greater PPC? For example, what structures and systems can be established to support these (bullet point above) at technical and decision-makers levels?
- How can development partners best support progress in public-private dialogue and collaboration?

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**Key Highlights of Discussion between the public and private health sector**

- Importance of African pharmaceuticals manufacturing and need to support it so as to make it sustained over time;
- Need for a dialogue forum to bring governments and private sector closer;
- Need for risks to be appropriately shared between both sectors;
- Need for capacity building, including to promote mutual understanding;
- Need to overcome the centrality of governance and corruption issues;
- Need to demonstrate efficiency in public-private collaboration.

### Context of the Study

The African Development Bank (the Bank) has commissioned this study aimed at augmenting and deepening understanding with the ultimate goal of allowing to guide and support the enhanced engagement of the private health sector towards the achievement of UHC. In particular this includes deepening the practical knowledge of issues affecting public-private collaborations and public-private partnerships in health. Besides the outcomes from the analysis of this work, the study will be used to increase understanding of critical partnership value chains to improve the quality of support provided to African countries.

## 1.3. APPROACH AND METHODOLOGY

The approach of the study is to understand the stakeholder perspectives on key thematic domains under the broader framework of "Public Private Collaboration in Health (PPC). To elicit the stakeholder perspectives on PPCs, a structured interview tool was developed to guide the consultative dialogue process on PPC at country level. The key thematic domains and key questions under each domain were developed after a review of existing literature and evidence on Public Private Cooperation in the health sector and understanding the key pathways of effective engagement of private sector towards contributing to UHC. The interview tool aims at identifying strengths and bottlenecks towards enhanced partnerships, as well as unpacking institutional and individual positions among PPC-PPP change agents and dissenters. This interview tool also helps in conducting a "self-assessment" of different stakeholders in health system towards understanding the concept of PPCs, facilitating factors and implementation bottlenecks, governance issues and opportunities for PPCs in accelerating progress towards UHC. The study field tests the assessment tool to guide the consultative process on PPCs and assess the current situation around PPC's across three countries. This interview tool has been field-tested in three countries (Malawi, South Africa, Burkina Faso) which were earlier part of the The Bank project on 'Developing Coordinated Public-Private Partnerships and Systems for Financing Health in Africa'. The diagnostic tool is descriptive on the state of play of PPCs in countries (Burkina Faso, SA and Malawi) and draws on the issues faced by these countries in the implementation of the PPCs. The analysis of the discussion with different stakeholders which provides the varying perspectives on issues and prospects regarding PPC's in health is presented in the later sections

## 1.4. DESCRIPTION OF THE ASSESSMENT TOOL

The tool consists of six key domains and under each domain, there are a set of open-ended questions aimed at understanding the key factors which facilitate or impedes "Public Private Collaboration" in the health sector. The six core thematic domains of the interview tool are depicted in Figure 3.

An Assessment Tool for Countries in Africa

**Figure 3:** Structure of the Assessment Tool


**1. Context and Understanding –**The primary domain looks at the health system context of the country; it gives a brief overview of the health system, regarding the health system profile and key health indicators, and health system challenges faced by the specific country. It also provides an in-depth definition of private sector in health, particularly the delineation between PPP and PPC; it also provides a clear outline of such partnerships in health and other sectors and presents examples of successful and non-successful ones.

**2. Opportunities for Engagement -**This strand explores the current engagement of the country with private sector partners and whether such collaborations are meeting the expectations. The tool identifies the possible thematic (geographical/technical) areas of the country of interest which needs more cooperation with the private sector and how much private sector collaboration can benefit the country health system profile, for example how the private sector can benefit to shortage of human resources for effective health service delivery for achieving UHC.

3. **Political Will and Policy Environment-** The third thematic strand explores the policy design and incentives for promoting public private collaboration in health. It gives a vision of PPC in health and looks out for the existence of strong political will of the country to collaborate with the private sector, whether the National health policy of the country facilitates PPC and regarding the involvement of private sector in policy design. The main aim of this thematic domain is to identify whether PPC is served in the country by legislative/regulatory mechanisms.

4. **PPP structures and strategies -** The fourth thematic strand aims at understanding the processes, financing and institutional mechanisms for supporting Public Private Collaborations in the health sector. It provides an outline of the specific strategy for the effective functioning of PPP/ PPC, regarding the features of partnership, PPC and its working relation with the ministry of health of the country. This domain gives an added dimension on the process of initiation of PPC program in a country, how the PPC structure and system function and how it can be improved, the key challenges faced in the functioning of PPC process and how resource allocation is done for PPC program.

5. Implementation Issues - Understanding of the implementation bottlenecks and capacity issues which hamper public private collaboration is the aim of the fifth domain. It also aims at understanding the existing PPC legislation and regulation, how to go about with the design and management of existing PPC, and how farther can it be improved.

6. **Results and Accountability -** The sixth strand explores the monitoring and accountability mechanisms for the implementation of public private collaboration in health. It covers whether the existing PPC improves coverage of health services, quality of service delivery and promotes equity in access to health care. Additionally, how far the services provided by the private sector can be compared to those services provided by the public sector, how services generate additional value to the government and a notion of public perception.

The interview tool comprises of 45 questions and each interview averages around one-and-a-half-hour time. During the field testing, the tool was administered to a wide range of stakeholders which included in-depth interviews with policymakers and key officials from Department of Health; Finance; Justice; nodal officers of the PPP cell; facility managers of public hospitals, private providers, officials of trade and investment promotion agencies; private hospital managers, Faith-Based Organizations and Non-Government



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Organizations. Field testing did not have the ambition to come up with complete diagnostics in the three countries; rather, it aimed at validating the relevance and comprehensiveness of the assessment tool through interviews with the broad range of institutions and stakeholders involved across countries (i.e. all stakeholders were met globally, not in each of the 3 countries visited). The in-depth interviews focussed on the policy environment in which PPC policies were formulated, success and challenges encountered during the formulation, implementation bottlenecks and strategic solutions to overcome the challenges. Furthermore, the discussions also deliberated on the opportunities or insufficiently explored areas where PPC could be the best alternative in service provision. This included issues such as the need for technical assistance, the need for developing strategies to draw interested private players to engage in partnership, as well as a question of good health governance. The analysis of the structured discussion on stakeholder's view on the six thematic domains is presented in the following sections.

# SECTION 2 : ASSESSMENT OF PPCS IN HEALTH SYSTEM

## 2.1. CONTEXT AND UNDERSTANDING OF PPC

### Definitions: Use of terms Public Private Collaborations and Public-Private Partnerships

Often, the term 'Public Private Collaborations' (PPCs) is used interchangeably with the term 'Public-Private Partnerships' (PPPs) in the health sector. Though they appear similar, there is a clear distinction between these two terms. PPPs are defined as "a long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility, and remuneration is linked to performance" (World Bank, 2018). Public-Private Partnerships are also defined as a contract between a governmental body and a private entity, with the goal of providing some public benefit, either an asset or a service (Rodriguez J, 2018). A crucial component of these contracts is that the private party must take on a significant portion of the risk because the contractually specified remuneration that the private party receives for participation typically depends on its performance. PPPs are mostly formal contractual arrangements which are governed by the PPP act or law of the relevant countries which lays down the framework and processes for entering into agreement with private partners. Mostly PPP's in the health sector entails Build Operate Transfer (BOT), Design Build Operate Transfer (DBOF); or large turnkey projects which focus on building health infrastructure or upgrading existing health infrastructure.

But the term, 'Collaboration' refers to relationships in which two or more parties work together voluntarily to serve a mutual interest, ranging from formal to informal partnerships. (Prybil L., Jarris P. & Montero J., 2015). PPCs are defined as collaborations where the objective is not to shift responsibility and risk from one party to another, but to deliver greater shared public health benefits than each sector could accomplish as an individual player (Nothemba Kula and Robert J. Fryatt, 2014). PPC's can range from diverse forms of collaboration which can involve contractual agreements for specific services like primary care, to simple collaborative engagements with private sector like development of clinical protocols, standard and codes for practice, etc. PPC is a broader concept which looks at all possible ways and methods of engaging with the private sector to accelerate the progress to UHC and PPP forms one component of this larger concept.

But PPP's and PPC's are used interchangeably in country contexts, and most of the stakeholders are familiar with PPPs as they have various forms of partnership agreements with the private sector for infrastructure or service delivery. It is very important to distinguish between PPPs as such, and other forms of collaboration between the public and private sectors. This distinction is very important in particular, to

clarify the expectations that a government may have with regard to the various components of the private sector, which range from non-contractual partnerships of collaboration, up to large-scale service delivery operations delegated to the private sector, as well as agreements as they exist between the State and NGOs / associations for delivering basic health functions. There are also other intermediate forms of contracts like Service Level Agreements (SLA), MOU's or conventions that are more or less complex and legally demanding and which do not fall under the ambit of the PPP law or act. They provide an avenue for exchange of health information and dialogue processes between the public and private sector which comes under the ambit of PPC. Besides there exists the omission of this distinction, which is common in the international development debate where the term "PPP" is most often used interchangeably for any form of collaboration. This may in practice pose problems of clarity in the dialogue between the government and private sector partners, and affect the conceptualization of collaborative projects.

## PPP Policy and Framework

Malawi has a PPP Policy framework (Government of Malawi, 2011), and a PPP act which was enacted in 2010 came into force in 2013 (PPP Act, Government of Malawi, 2010). The bill defines PPP as "A "public-private partnership" which means a form of cooperation in which a Contracting Authority partners with a private sector partner to build, expand, improve, or develop infrastructure or service in which the Contracting Authority and private sector partner contribute one or more aspects. These can range from know-how, financial support, facilities, logistical support, operational management, investment or other input required for the successful deployment of a product. Equally, they can include aspects for which the Contracting Authority and the private sector partner is compensated in accordance with a pre-agreed plan, typically in relation to the risk assumed and the value of the result to be achieved". The Public Private Partnership Commission is the authority for concluding PPP contracts with the consent from the Ministry of Finance and the Office of the President. These PPPs are known as those which serve "hard functions" like infrastructure development, but there are a host of partnerships which focus on "soft functions" like agreements with faith-based organisations or private providers through a Service Level Agreement (SLA's) for provision of certain services. Health PPP's in Malawi mostly cater to the soft functions and they are implemented by the directorates under the Ministry of Health.

According to the PPP law, the definition of PPP in South Africa is as follows: 'A PPP is a contract between a public-sector institution and a private party, in which the private party assumes substantial financial, technical and operational risk in the design, financing, building and operation of a project' (PPP Manual, National Treasury). PPP defined under the law has a risk which the private sector shares while undertaking the investment with government. These partnerships are with big corporations and mostly in Design, Build, Operate and Transfer (DBOT), or Design, Finance, Operate and Transfer (DFOT) etc. The national treasury has a technical unit in place to support these PPP projects and this unit is called Government Technical Advisory Centre (GTAC). The other types are known as public private contracts, which are simple contracts for contracting in and out of certain services and these services do not come under the ambit of the PPP Act/ law. These are small contracts which were executed by the Department of Health at the central and provincial level. In these types of agreements there are no risks involved and hence are not categorized as PPP. These agreements or contracts include contracting of General Practitioners (GPs) for primary care, specialists for providing secondary care, supply chain management of chronic care, etc.

Burkina Faso has also organized the PPP sector by enacting Law No. 20-2013/AN of 23May 2013 and adopting its implementing Decree No. 2014-024/PRES/PM/MEF of 3 February 2014 laying down the legal framework for public-private partnerships in the country (Dr Beatrice Majza, 2018). Public private partnership is defined as "a form of contract that brings together a public authority and a private entity to provide goods or services to the public. It aims to optimize the performance of the public and private sectors and to implement, as soon as possible and under the best conditions, social or infrastructure and public utility development projects". The definition of public-private partnership contracts in Burkina Faso is therefore quite broad because it encompasses any form of partnership between a public authority and a private operator, whether in the design, financing, construction, operation or maintenance of service or public work. The PPP projects are executed by the Department of PPP within the ministry of Finance and supported by the Directorate of Health.

There are many agreements in Burkina Faso between regional health authorities, NGOs and civil society associations. The latter are organized through the Permanent Secretariat of NGOs (SPONG), which in 2018 concluded an agreement with the central government, which allows ensuring greater accountability for the funds used and the results obtained, through systematic monitoring and reporting. There are also collaborations with the Fédération des acteurs privés de la santé which was established in 2013 as the sole representative of the private health sector. They play a key role in Burkina Faso's health and socio-economic development through a dynamic public-private partnership to provide disease prevention, treatment services, and universal access to quality healthcare to the population. This federation has regional offices, which represent a strong potential for promoting problem identification and research, and joint solutions between the public and private sectors. There are existing agreements between the associations and the public service known as 'conventions' for delivering health care services.

There is a lack of conceptual clarity on the understanding of concept of PPCs in health. Mostly the term "partnerships" is commonly used for interactions involving public and private health sector. In PPP's there is a third party involved other than the government and private partner. The third party is mostly the banks or financial institutions which fund the PPP project. This is one of the key attributes which differs from the service level agreements for the management of facilities. The management contracts or service level agreements are input-based, i.e. department of health specifies the input requirements which need to be provided or contracted in/out from the private providers. The SLA's, Memorandum of Understanding (MoUs) and service agreements are not classified as PPPs but are collaborative efforts for increasing access to care. There are other forms of collaborative actions beyond the SLA's or MOU's and these are mostly with NGO's or faith-based organizations supporting specific programs like TB control, HIV AIDS treatment and awareness etc.

In Malawi, the ministry has collaborated with a private provider under which patients from government hospitals are referred for services like Intensive Care Unit (ICU), dialysis, general surgery, scanning and imaging services. Further, the private hospital works with the government training institutions and provide internship training to students of medical, nursing and other paramedical courses. Private for-profit and not-for-profit providers are mandated to share the Health Management Information Systems (HMIS) data with the ministry of health and this also falls under the broader ambit of PPC. In Burkina Faso, the security situation is not conducive in many regions and the public health facilities are not functioning. There are collaborative agreements with the private sector for providing basic health services. The government provides human resource support to the religious and faith-based organizations based on an agreement for providing health services. These examples showcase best practices which demonstrate how collaboration with private sector happens outside the realm of classical "PPP" arrangements.

## 2.2. OPPORTUNITIES FOR ENGAGEMENT WITH PRIVATE SECTOR

Although issues of political will and motivation are a major concerns, new opportunities for collaborations with the private sector are emerging in these countries. The Ministry of Health in Malawi has developed the Health Sector Strategic Plan II (2017-2022) jointly with development partners, NGOs, civil society organizations and other government ministries (Government of Malawi, 2017). The plan advocates for enhancing opportunities and strengthening efficiency and effectiveness in the private sector engagements. The strategies include revisiting the existing PPP framework based on existing partnerships, and more current information and is informed by value for money considerations at national and district levels. Malawi has initiated steps for granting semi-autonomous status to the central referral hospitals to improve service delivery for secondary and tertiary care. The plan outlines the role of collaboration with the private sector for operating and managing medical equipment in these hospitals. Additionally, the Ministry of Health has developed health PPP guidelines to help them in the process of private sector participation.

There are plenty of opportunities for collaboration with the private sector with the implementation of the National Health Insurance (NHI) reform in South Africa (Department of Health, 2017). There is considerable demand and collaboration with private sector that can help in improving the management of public sector facilities. The Presidential Health Summit which was held on October 2018 was an attempt to bring diverse stakeholders to solve problems facing the public health sector in South Africa. (Presidential Health Summit Compact, 2019). One of the key thematic pillars of the "Presidential Health Summit" was pathways to

"Engage the private sector in improving the access, coverage and quality of health services". The health summit document is an example of improving collaboration with the private sector as it brought together all key stakeholders in the private sector, during the document process. Suggestions were taken from all stakeholders, and the document established the areas where collaborative efforts can be strengthened.

In Burkina Faso, the Government has adopted a new five-year health plan (Plan National de Développement Sanitaire, (PNDS), (2016-2020), which is composed of eight strategic objectives. In October 2017 the Government developed its first National Health Financing for UHC Strategy (2017-2030). The key objectives include i) reducing fragmentation of health financing; (ii) increasing fiscal space for health through domestic revenue mobilization and efficiency gains; (iii) improving quality and coverage of health services through strategic purchasing; and (iv) improving financial protection through the rollout of the national health insurance scheme.

> "In order to ensure accountability in collaboration with the private sector, an enforceable contract is a necessity. The contract obligations need to be very clearly specified and the contract should be binding so that government gets value for money. The exit clauses should be clearly specified in the contract. Further, a competitive bidding process should be followed and no single sourcing. Even in the event of single sourcing, a proper analysis of "value of money' for the government should be looked into before signing the agreement"
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> Excerpt from Stakeholder Interview

The Universal Health Insurance Law establishing the National Health Insurance is adopted, and proposes to cover around 70,000 poor and impoverished population in the first phase, and cover the rest of the population in phases. For the Universal Health Insurance to be successfully implemented it requires an effective partnership with the private sector in the country. Universal health insurance programs would entail "strategic purchasing" of a defined package of services from providers and the private sector can be a crucial potential partner in service delivery. Strategic purchasing of services from the private sector can help in addressing the critical gaps in public sector through building of synergy with the private sector to deliver quality services as per predefined norms set by the purchaser. Government can act as a facilitator to offer a comprehensive health care package that can be bought from the private sector.

> When ministers change, there is a change in administration leading to a change in interlocutors and then the dialogue process needs to start from scratch. The vision of each minister will be different, and the dialogue process loses continuity. Political will is not the only sufficient condition, but we also need continuity in policy perspective"
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> Excerpt from Stakeholder Interview

## 2.3. POLITICAL ECONOMY AND POLICY ENVIRONMENT OF PUBLIC PRIVATE COLLABORATION IN HEALTH SECTOR

It is very important to understand the political economy of PPCs in health given the negative outcomes of some partnerships across the Low- and Middle-Income Countries (LMICs). Some of these outcomes are mainly due to conflicting goals and motivations of governments and their private-sector partners in PPPs. To understand the value of collaborations, we need to understand how it is going to improve or enhance service delivery and attain maximization of social welfare (Boardman A. E & Vining A. R, 2012). From a policy level aspect, the three core elements of PPCs consist of the autonomy of each partner, mutual assurance to settled objectives, and mutual benefit for the stakeholders. But most often it is misunderstood as an attempt at privatization, especially when a private entity is part of such partnerships. Engaging with the private sector,

describe a range of possible relationships among public and private entities in the continuum between nationalization and privatization, depending upon the objectives which they seek to succeed (Rajasulochana S. & Dash U. 2018). By combining a political-economic perspective of PPCs with normatively appropriate goals for government, a realistic outcome in terms of social welfare can be achieved (Boardman AE & Vining A.R, 2012). Enabling factors for effective PPCs includes sustained political support and government commitment needed for developing and implementing effective collaborations.

Consultations with various stakeholders gives a clear understanding of the political-economy and policy level framework of PPCs in health. Both public and private partners often raise the issue of "political will" as the key for facilitating a sustainable PPC in health. The lack of political will and motivation of government was one of the major challenges for improving collaborations with the private sector. The political interference in the process of developing PPP projects was a major hurdle, and many a times this leads to the derailing of the processes set in place. Private partners always want the certainty of political and policy perspectives when it comes to investment in classical PPPs. When it involves large turnkey projects of DBOT projects, funding by financial institutions is a key to implement the project. Banks always review the regulatory structure and if they see political turmoil or volatility, they would not like to risk investment. Many a time, it is factual that there is not much political acceptance of PPP projects as they take time to materialize and are therefore not prioritised by political powers.

The issue of trust deficit which exists between the public and private sector is a commonly observed phenomenon. The government view the private sector participation from a profit motive. The private sector also has apprehensions about the resource constraints of the government in entering collaboration. Further, there are many negative experiences in the implementation of major infrastructure projects in health, which deter governments from initiating collaborations. In the South African context, there is a general perception that PPPs are a very complex, cumbersome and costly procedure. The South African health care market is characterised by polarised views and ideological positions which is seen as a big impediment for a smooth collaboration. The government thinks that PPPs increase the cost significantly whereas the private sector thinks that PPPs increases their risk significantly. PPPs are not seen as a mainstream procurement option by the national government as they are not a viable option from the affordability point of view.

## 2.4. INSTITUTIONAL STRUCTURES AND REGULATORY FRAMEWORK FOR PPCS IN HEALTH

This section gives an overview of the institutional structures and strategies for PPCs in health based on country assessments. Generally, the institutional structures are mostly focussed on PPP aspects, while in reality, there are no formal structures in place for ensuring actions for public-private collaborations.

### Program Management Structures for PPCs in Health

As detailed in the previous section, South Africa, Burkina Faso and Malawi have enacted PPP laws and have defined institutional frameworks and regulatory structures. In South Africa, the Public Finance Management Act (PFMS) provides guidelines and manuals for undertaking PPPs. This has laid down a clear framework on the processes to be followed in developing a partnership agreement with the private sector. Any PPP project involves a feasibility study which assesses the "value for money" of the project, tests affordability, cost-effectiveness, and the degree of risk transfer. Once the feasibility study is approved and the treasury grants final approval to the project, a Special Purpose Vehicle (SPV), which is then floated to fund the project. The private partner finances the SPV either through equity or through loans from financial institutions. There is the whole process of negotiation with the private partner before the final agreement is signed and the government normally aims at transferring the maximum risk to the private partner. The whole process takes around 2 to 3 years and there are many projects which get cancelled in between. If the private partner is contracted for less than three years, those collaborations need to go through the process laid down in the PPP Act. These agreements are processed through the procurement division of the Department of Health based on the procurement rules (National Qualification Framework).

> "The biggest challenge while implementation of the PPP's is lack of clarity in the understanding of how an MOU or SLA should be framed, even though they look similar, the implications are entirely different. There is a need to enhance the skills to understand the boundary and implications of the contracts. The skill set to draft, and review contracts would also always help the ministry while contract negotiations happen with private providers. Moreover, there are technical aspects related to the equipment or service delivery which is better understood by the health ministry rather than the Ministry of Justice. Hence it is imperative to develop the capacity and skill set of officials to understand the drafting of contract and contract negotiation."
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> Excerpt from Stakeholder Interview

In Malawi, the Public Private Partnership Commission acts as the regulator for implementation of PPP projects. The Commission has put in a structured process for initiation of the PPP projects. The PPP project cycle covers five distinct phases: project identification, initial viability assessment, project preparation and development, project procurement, and the post-contract phase. In the first phase known as the project identification phase, the project owner registers the project with the commission and during this period, the Commission helps in the screening of the project. In the second phase, the Commission conducts a feasibility study of the proposed project. The Commission develops the terms of reference and recruitment of consultants who will undertake the study. The Commission also monitors the quality of the product delivered by the consultants. In the third stage, which is the stage related to tendering for procurement of the private provider, the Commission takes the lead in the procurement process and helps in the identification of the private partner. In the fourth stage which is the procurement stage, the contract is developed, and the document is reviewed by the ministries of justice, finance and health before it is signed. In the final stage, after signing of the contract, the Commission also helps in monitoring how the private sector is implementing the program and sourcing finances to implement the program.

When it comes to SLA's where the total investment value is less, the processes set by the Commission is not feasible due to resource constraints. In such instances, the commission does the scrutiny of the process undertaken by the ministry based on the guidelines, manuals and templates for conducting each stage of these processes. The service level agreements are mostly executed by the different directorates of the Ministry of Health. The directorate of planning and policy development oversees the initiation and implementation of public private projects in the Ministry of Health. In addition to this, the directorate of technical services is also involved in the process when it comes to provision of the diagnostic services and maintenance of infrastructure and the acquisition and maintenance of equipment. In Malawi, the Ministry of Justice (MOJ) also plays an important role in the finalisation of the contract process. In both cases, the MOJ reviews the principles of the contract based on the applicable laws of Malawi reviews whether there are any loopholes which can put the government to disadvantage. The MOJ provides an advisory function on the review of the contacts drafted by the ministry.

In Burkina Faso, the PPP law has mandated the establishment of the Public-Private Partnership Commission, which is entrusted with the (i) validating the draft PPP projects programme prepared by the Ministry of Finance before it is tabled before the Council of Ministers for approval; (ii) Making the necessary recommendations for PPP development in Burkina Faso; and (iii) Ensuring the monitoring and evaluation of the draft PPP projects programme. The PPP unit under the Director-General of Finance is the nodal institution for all activities related to the implementation of the PPP projects which includes the preliminary appraisal, conducting feasibility studies, contract negotiations and award of contract. The list of projects is submitted to the inter-ministerial committee for their approval and the final approval is granted by the National Assembly.

However, Burkina Faso presents a unique aspect for public private collaboration and has a separate Directorate of Private sector under the Ministry of Health. The directorate of the private sector started in early 2000, with the objective of supporting the functioning of the private sector as complementary to the public sector. In the later years, the Directorate became a unit within the Department of Health and this change led to a lack of resources and funds to handle the core functions. In 2018, during the reorganization of the administrative functions of ministry, the unit was again designated as the directorate of the private sector. The

directorate plays an important role in facilitating the establishment of the private sector, coordination with the private sector for service delivery, regulation and monitoring of the private health sector in the country. The directorate is responsible for providing authorization letters for establishing private facilities, monitoring of the private training facilities, overseeing the sharing of health information from the private sector and regulating the functioning of these facilities. The directorate is working together with the Federation of Private Providers for developing a strategic action plan.

## 2.5. IMPLEMENTATION BOTTLENECKS AND CHALLENGES IN PPC'S IN HEALTH

Although there are substantial benefits associated with any public-private collaboration; caution should be applied in thinking that private sector investments need to be a responsible investment that accepts the social responsibility and mutual commitment of such collaboration. Bringing private capital and innovation into development should not be through models that are privatizing development but rather adding a private-sector dimension to development (CABRI, 2016). Further, such collaborations require the suspension of suspicion of the private sector and this should help governments create an enabling environment for effective, responsible business engagement in development. Therefore, contribution to common goals and objectives for both partners should be enabled while pursuing a collaborative relationship (Nistar 2004). The other challenge with PPC in health is the nature of procurement of the private party, especially where there are several players who can deliver the required service. Introduction of some form of competition among the private players would help in bringing the value for money for public sector.

Accompanying such collaboration are robust regulatory mechanisms by the government which protects individuals and communities. This is done by ensuring the quality and safety of services provided as well as incentivizing private-sector actions that align with the health needs of communities. In the developing world, there is a general failure, to have overarching legislation relating to public-private partnerships and as a result, such arrangements develop on an ad hoc and opportunistic basis and may have questionable credibility, because of the failure of specific operational strategies (Nistar 2004). Regulatory authorities and systems do help to drive science-based approaches, data and transparency for decision making and actions. These regulatory systems are essential for the success and sustainability of global health investments from all stakeholders across civil society, industry, government, and international organizations. (The National Academies Press 2017).

> "There are capacity issues in management of PPP. In 2016, we got the support of the ministry of finance as some of them were trained in developing contracts. But since there is no significant amount of activities, sustaining the skillset attained by training is very difficult. Need hands on experience for development of various stages of PPP".
>
> Excerpt from Stakeholder Interview.

In terms of implementation of collaboration, whether it is funded or not, the institutional capacity for program management is very important. Mostly the collaborations with the private sector involve contracts, Service Level Agreements or Memorandum of Understanding. The ability to develop these instruments and to enforce them prudently is always a daunting task within the government. The key objective of program and contract management is to specify the terms of reference and to obtain the services specified in the output specifications and ensure ongoing affordability, Value for Money (VfM), and appropriate management of risk transfer if it is a PPP contract. The contract management is the process that enables both parties to meet their respective obligations in order to deliver the objectives required from the PPP contract. This means that this is an ongoing process which does not end with the signing of the contract. Effective contract management requires systems to be in place for regular monitoring of the terms of the contract and the outputs of the collaboration.

## Issues in program management and contract negotiations

Workable partnerships require a well-defined governance structure to be established to allow for distribution of responsibilities to all the players (Nistar 2004). But many governments in LMICs face major challenges with the private sector, because their existing governance and regulatory arrangements are not designed to effectively manage and coordinate mixed health systems (Clarke D et al, 2019). For example, the for-profit private sector in many countries are not appropriately managed or regulated which can threaten the basic concept of UHC. Another challenge for the governments in these LMICs is that they lack the capacity to connect the efforts of the not-for-profit private sector to help meeting the health objectives of governments (Clarke D. et al, 2019). Here the governments find themselves incapable of using governance tools to help align the activities of its private partners with national priorities Further in many instances there are some policy related issues in collaborating with private sector, such as: insufficient PPP implementation guidelines for monitoring or performance auditing, lack of proper maintenance approach for the whole long term operational phase of the partnerships, and failure of assessment of unforeseen risks and issues with life cycle assessment of assets (Hashim H. et al, 2017). The wide diversity of such partnership and plurality of providers imposes complexity of the PPP structure and therefore monitoring, and regulation becomes a mammoth task.

The weak contract negotiation capacity of the government is one of the major hindrances to effective PPC. The major challenge is that government gets into an agreement with the private partner with skill sets that are inadequate for negotiating. These not sufficiently robust compared to those of the private partner who is well prepared to defend their case. It is only when the agreement comes to force, and when problems arise, that the government then realizes the issues in the contract. As noted in many cases, once the issue of contracts crops up, there is a tendency of animosity to the private sector. However, it should be noted the problem does not only arise from the way private sector behaves, but also on the composition of internal government capacity in contracting and contract negotiations. The private sector would always try to undertake contracts which benefit them. The government needs to shape the contract in such a way to safeguard government and public interests. In such contracts, it is easier to manage them as though they are for specific services. This mode would enable easier negotiation and monitoring of obligations for both parties.

The internal institutional capacity for administering and negotiating contracts of the ministries in all the three countries is also found to be weak. There are no dedicated PPP units in the health ministry and mostly contract management and other tasks are done by officers of the various departments. To cite the case of Malawi, for any PPP project, ministries of finance, Justice, PPP Commission and the Office of the President and Cabinet are involved and play different roles aligned to their mandates. A monitoring committee is also in place which includes all the above stakeholders and the private partner. The role of the committee is to ensure that the objectives of the project are being met based on the service levels contained in the agreement. If there are any issues hindering the successful project implementation, corrective action is agreed at such meetings. But there is no single coordinating focal point or unit in place whose function is to steer the entire exercise and monitor the implementation. In order to foster a better collaboration, there is a need for more interdepartmental coordination and communication. There exists scope for streamlining the processes and improving communication among the various entities. In Burkina Faso, the PPP department under the ministry of finance coordinates with the Directorate of General Health Services. Although the PPP department within the finance oversees all functions related to the development and implementation of PPP, this is still

> "There are various issues which affect the implementation of the partnerships. The system requires a very strong and dedicated audit system. In many cases, when the private partner raised the invoices, we can see that there are duplicate invoices, invoices exaggerated in terms of quantity and prices. This needs to be found out before the payments are made. Hence this calls for a very strong internal audit mechanism. Secondly the procurement department which now looks into contract signing does not have enough staffing and skill sets to handle all the key aspects. Currently there is only a medial engineer who manages the procurement and contacts. But he is not trained in contracts management. There is a need for a contract management unit which is separate from the procurement department"
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> Excerpt from Stakeholder Interview

not recognised as a formal unit as the "decree" to establish the unit is not promulgated. Instead, it continues functioning as a department under the Department of Director General of finance. This impedes the autonomy and independence when it comes to making critical decisions.

In evidence is the lack of comprehensive databases for the various types of contracts, SLAs, MoUs in place. The availability of such a database would easily help in identifying the common issues faced in contract negotiations and management of the contracts. The database could also help in understanding the failures and success of the collaborations and hence serve as a reference tool for contracts management. Both public and private partners advocated the need to have dedicated PPC units within the ministry which can be an entry point for any collaboration and help in the management of collaborations. The dedicated unit can draw resources from the other departments involved in the process but will serve as a single focal point when it comes to contract negotiations and monitoring. The unit needs to develop a database of contracts and analyse the obligations, the costing framework and the performance monitoring clauses in these contracts which would be helpful for negotiations.

## Capacity related issues for implementing PPC's

In several cases it is evident that capacity issues are one of the key limiting factors of engagement with the private sector. The major challenge is the lack of skills and unavailability of key personnel for the implementation of such projects. There is also lack of knowledge about the mechanisms of collaboration among the key stakeholders. The availability of skilled personnel with knowledge and understanding of drafting the terms of contract, contract negotiations, monitoring of the contracts, costing etc. is a major challenge for the public sector. In Malawi, as discussed in the previous section, there is no dedicated unit in the directorate for undertaking PPP contract negotiations, and there are no legal experts in the negotiation team. The capacity of the personnel at the directorate of planning and hospital services is also limited and there are no legal experts in the team. When it comes to the drafting of the contracts for the Service Level Agreements or MoU's the review is done by the legal experts in the Ministry of Justice. The MOJ reviews the principles of the contract based on the applicable laws of Malawi, reviews whether there are any loopholes which can put the government in difficulty. MOJ conducts a risk assessment and if certain contracts are not seen by the PPPC, it is sent back to them through the Ministry of Health (MOH). Quiet often the technical aspects related to the purchase of the equipment or the maintenance contracts are better understood by the health ministry rather than the MOJ, and hence it is imperative to develop the internal capacity and skill-sets for officials to understand the drafting of the contract and contract negotiation.

There are two divisions within the PPP department of Director General of Health Services in Burkina Faso. They have two divisions which include the legal department and economics and evaluation department with five staff in each division. But the staff do not have the adequate experience and skillsets to undertake all key activities required to support PPP project implementation[2]. Their counterparts in the Director-General of Health Services do not have adequate skills and capacity to develop the feasibility studies, costing of the contracts, or for contract negotiation and monitoring.

The lack of skill sets is also another challenge hindering the monitoring of the engagements after the execution of the agreement. The monitoring system requires human resources with sound knowledge of the audit and legal issues. To illustrate this, in Service Level Agreements, when the private partner raises the invoices, there should be a review of whether the invoices are in tune with the agreement or whether the invoices are billing for additional quantity and prices before the payments are made. For conducting such reviews, a strong internal audit mechanism should be in place. Similarly, the procurement department should also have enough staff trained in contract management to handle the execution and monitoring of the contracts. There is a severe shortage of capacity which limits the governments' negotiation and monitoring ability; which often leads to issues of "trust" and failures in collaborative programs. Another major challenge in the implementation of PPCs, is respect of the terms of the contracts by the private sector, in particular the transmission of health information from the health establishments.

2 Note however, that the legal facility of The Bank has provided support to develop the procurement and standard bidding documents for the PPP department.

There is a clear room for improvement of monitoring systems for various SLA's and contractual agreements with the private partners for government to achieve value for money. Generally, with the constrained resource environment, allocating resources for such activities as feasibility studies becomes a challenge. But developing a dedicated team and handholding them with the adequate skill sets in contract management, internal audits and performance management can improve the system considerably. This also underlines the fact that training and continuous capacity building is also a very critical issue. Further an ideal situation would be to have a legal team within the health department who can help in streamlining the contract negotiations.

## 2.6. RESULTS AND ACCOUNTABILITY

An argument exists that PPCs in health contribute to improvement in access to services, especially in rural and remote areas. The collaborations in building both the health infrastructure and service provision are seen as "complementary" to the existing service provision by the public sector. The key motivation of the government to collaborate with the private is to bridge the gaps in service provision, improve access to care.

Most of the Service Level Agreements are providing specific inputs to the health department which they are not able to provide. For example, the contracting of primary care providers, specialist doctors, outsourcing of the dialysis, imaging services etc. There is a huge demand for these services and the collaboration with the private sector in providing these services has contributed to an increase in access to care. In Malawi, the Christian Health Association of Malawi (CHAM), a network of church-supported health facilities and the network is present in all except one district of Malawi. CHAM provides around 29% of the health services in Malawi and is the second major provider after the government. The CHAM facilities cover 85% of the rural, hard-to-reach areas and the rest are in urban poor settings. Most of the facilities provide primary and preventive care services and there are also hospitals which provide secondary care services. The Government is collaborating with CHAM for improving access to services, enhancing service delivery, reducing the cost of care and moving towards UHC. In Malawi, after the collaboration with CHAM there is a clear improvement in service delivery, mainly in rural areas, where there are no other health providers or where the public sector is absent.

Similarly, in South Africa, where the PPP's is mostly concentrated in building health infrastructure, the Inkosi Albert Luthuli Hospital in KwaZulu-Natal is a successful model in terms of the contractual agreement. The PPP model was successful in improving service delivery, bringing in change management, improving hospital efficiency. When it comes to the service delivery the 'Central Chronic Medicine Dispensing and Distribution' programme (CCMDD), distributes and dispenses medicine from a central point for patients with chronic conditions who are stable on their medication. The CCMDD initiative aims to increase the accessibility of medicine by providing medicine parcels to registered patients

> "Many professors own clinics and this is against regulation. There is a lack of accountability and such practices needs to be controlled. But there is lack of political will and weak systems to find a solution to this issue".
>
> Excerpt from Stakeholder Interview

> "Another major challenge is the need of change management within public sector to embrace these partnerships. PPP in health sector is not only building infrastructure it also involves changes in the management of the service delivery and if there is no change in the attitude of health personnel, these partnerships are bound to fail."
>
> Excerpt from Stakeholder Interview

from outlets that are convenient for them. The CCMDD programme adopts a task-shifting approach – taking the responsibility of a high volume of patients out of the hands of the public health facility staff and placing it into the hands of the external service provider (Pharmacy Direct) which dispenses and distributes medicines.

The issue of accountability was highlighted in the discussions about the existing collaborations with the private sector in Burkina Faso. Generally, it is highlighted that the public sector has human resource shortages, but in Burkina Faso, the private sector does not have its own staff. They use the staff working in public sector hospitals in their facilities. This "dual practice" is creating issues in monitoring and governance of public hospitals and so far, no solutions have been developed. Lack of financial resources is one the important challenges for having a dedicated monitoring system in place. This is much more pronounced in collaborations with the not-for-profit health sector, who also suffer from inadequate financial resources.

## Grievance Redress Mechanism

The presence of a robust grievance redress mechanism is prerequisite for any successful collaboration. As discussed in the previous sections, PPC involves diverse stakeholders with differing interests and hence different stakeholders follow different routines. A successful collaboration is always based on how relationships are forged and maintained during the implementation of the program. The SLA's and MoUs mandate that there should be a periodic meeting of the partners to discuss the issues in implementation and resolution of the issues. But it was found that such meetings are irregular and happen once a major issue affecting service delivery emerges. Often there are issues of resource constraints which leads to delays in payments to the private partners. This, in turn, affects the service delivery and leads to implementation issues in the program.

The private sector for-profit providers also shared a similar view that there are no adequate forums available to discuss the issues facing them. There are often issues between the private sector and the regulatory environment provided by the government. The implication of the regulatory systems will vary depending on whether it is a for-profit, or not-for-profit service provider. Sometimes the regulatory issues incapacitate service delivery and hospitals are not able to deliver effective service delivery. In many cases, the tax laws are applied uniformly, but this has negative consequences for not-for-profit service providers like faith-based organizations. The traditional platforms are not enough to have a smooth dialogue process. The regulatory bodies should provide enough space to various types of private providers to represent their views and an effective dialogue process is a prerequisite for collaboration in this sector.

# SECTION 3: STAKEHOLDER PERSPECTIVES ON IMPROVING PPC'S IN HEALTH

A major stake holder perspective constantly echoed by public and private sector players was the importance of forging a collaborative environment which will help the optimum use of resources. The three country cases addressed in the study, demonstrated that the health systems across the three countries face diverse issues, ranging from service delivery, reduction of out-of-pocket expenses, increasing access to services, and improving supply chain mechanisms. All these issues cannot be resolved by the public or private sector on their own and finding an optimal win-win situation for both sides would be ideal. Public Private Collaboration can help in restructuring the health care markets and jointly progress countries towards achieving UHC.

## 3.1. KEY FACILITATING FACTORS

The study points to the need for enhanced collaboration with the private sector to bridge current gaps in service provision and to accelerate the progress towards achieving UHC. Achieving UHC has become a priority for improving coverage and reduction of out-of-pocket expenditure for all countries since it became a mandate under the Sustainable Development Goals (SDGs). The current pathway of achieving UHC in these developing countries, indicates that even though there is a clear demand for health service delivery, it is not matched by the supply of services within the primary, secondary or tertiary health care. This is resultant mainly from the demographic and epidemiological changes based on population growth and composition. The spectrum of diseases is changing rapidly from communicable to non- communicable diseases. Along with this, with an increase in longevity, the demand for secondary and tertiary care speciality services is on the increase. Accompanying these there are also changes in the financing of the health systems, with the change towards National Health Insurance Schemes as a means of improving access to services and protecting households from incurring out-of-pocket expenditure on health services.

> "There is also lack of clarity in terms of "whether an investor should come and knock the doors" or a proactive system of attracting investment. There needs to be a step by step road map and we don't have the same in health sector. Energy sector is a good example where there is a clear blueprint of how investments has to be done and what are the role of each of the stakeholders."
>
> Excerpt from Stakeholder Interview

Another facilitating factor for public private collaboration in the health sector is the policy environment. In Malawi, a process is already set to give semi-autonomous status to the four central referral hospitals,

taking into consideration the enhancement of service delivery for secondary and tertiary care in the country. The National Health Insurance reform in South Africa offers opportunities for enhancing public private collaboration in the health sector. In Burkina Faso, The Universal Health Insurance System provides an opportunity to put in place a mechanism for Strategic Purchasing of services from the private sector. Developing such systems will require collaborative action between the public and private sectors to define the bundle of services, costing of the packages, defining the modalities of strategic purchasing, developing accreditation and quality management systems, and monitoring the of purchasing services from the private sector. Existing policy backed by a legislative framework already in place in these countries provides an enabling environment for future collaborations. The demand-supply gap requires expansion and improvement in health care infrastructure and human resources for health, which the public sector cannot fulfil on its own. There is also a change in the health-seeking behaviour with the rise in economic status of the middle class, creating a demand for high quality care. A key problem area for both government and market failure is within essential medicines and diagnostics supply. In countries like Burkina Faso which face security issues, public health disaster owing to conflicts provides a strong case for private sector collaboration in order to build a resilient health system.

> "We are a strong partner for government. However, over the years this is weakened due to the current contractual arrangements. Both parties want collaboration, but there are many hurdles in maintaining the same. Even though the relationship is through SLA's both parties are not fully satisfying the obligations states in them. There is a need for role clarity, responsibility needs to be defied clearly. There is also an issue of "trust" most of which can be traced to lack of knowledge on the cost elements"
>
> Excerpt from Stakeholder Interview

## 3.2. MAJOR BOTTLENECKS

The major bottlenecks experienced by various stakeholders are the challenges faced for developing a collaborative environment for nurturing public private partnerships in health. The various bottlenecks identified generally are at the different levels including policy, implementation of programs, financing, and monitoring and other issues that are related to capacity.

There exist varying degrees of understanding both among public and private sector players about the understanding of "Public Private Collaboration". It is evident from the existing literature that there is a need for greater conceptual clarity on what constitutes a Public Private Partnership and Public Private Collaboration. PPP is a more familiar terminology to both public and private stakeholders as there are policies, legislation and frameworks for entering into a partnership. While PPP's are generally forged through a contractual process, PPC's envisage a broader vision of developing a shared understanding of the motivations of each side, developing a platform for engaging in the continuous dialogue process, building trust and mutual accountability. Hence PPC advocates for a broader framework which can support both contractual and non-contractual relationships between the public and private sectors.

In the research, the lack of political will which mainly stems from distrust between the government and the private sector was often reflected as the major bottleneck. This is mainly due to lack of clear communication channels between the partners, lack of clarity on the motivation and objectives of entering into collaboration, and also due to the experiences of the unsuccessful models of partnership. The expectations from the public and private sector in entering collaboration is often not aligned, which leads to challenges during the implementation phase. To cite an example, in cases of the contracting-out model of facility transfer, where private sector takes over the management of facilities, in most cases the staff remain government employees and this often leads to operational challenges. In such instances, the private sector wants operational autonomy, including control over human resources, without which the model fails during implementation. Even in instances where agreements and service level arrangements are in place, monitoring of the adherence to the obligations set out, still does not optimally leading trust in the relationship. The absence of regular interactions or platforms to discuss and intervene on implementation issues faced both at government and

the partner side exacerbates failure. This creates a lack of confidence on both sides and does not augur well for establishing a fruitful collaboration.

The issue of trust was a recurrent theme in all types of arrangements, from service level agreements or classical PPPs like the Build Operate Transfer models. In instances where there is lack of trust, and suspicion exists, a favourable collaborative environment is hampered. The issue of trust was raised by both partners in CHAM in Malawi, which has a long-existing Service Level Agreement with the government. The government should initiate and facilitate a favourable environment for better use of the private sector. The improvement of the working relationship between public and private sectors would enhance not only service delivery, but also the training and capacity building of the medical personal in the country.

Another major bottleneck which was expressed by both the public and private sector relates to the "lack of capacity" and "skill sets" to manage such partnerships and collaborations. In Malawi, there is no dedicated unit within the Ministry of Health to manage the PPC/PPP arrangements. There are no formal PPPs in the health sector, but as a country, it has several projects running under the PPP framework. Currently, the Directorate of Planning is implementing the PPP programs, and other stakeholders from the Directorate of Technical Support, and the Procurement Division are also part of the process. Enhancing capacity and skill sets in contract management, internal auditing, performance monitoring and evaluation and a single dedicated PPP unit to oversee the implementation and monitoring process would improve delivery. A recommendation is for the establishment of a dedicated unit for supporting all PPP/PPC efforts. Such a unit would provide a single coordination point between the various ministries such as Health, Finance, Justice; and entities like the Public Private Partnership Commission, and the Malawi Investment and Trade Council.

The absence of clear inter-ministerial coordination and harmonised working concepts on collaboration with the private sector serve as impediments. There are a wide range of stakeholders, both within the ministry and across other ministries, like finance, justice and trade who are all involved in the process. The lack of concepts and mechanisms for collaboration on the private health sector side, also exist for these stakeholders. A more structured dialogue process or communication channel between the various stakeholders at both the policy and implementation levels would enhance the quality of delivery.

In terms of policies, the Ministry of Health, Finance, and Justice are involved along with the PPPC, MITC, and private partners. However, various directorates of health at a central level and health facilities at the end-user point are involved in the implementation process.

In South Africa the National Treasury, Government Technical Advisory Centre (GTAC), the national and provincial departments of health are involved in the process. The discussions seemed to point to a lack of coordinated communication within the implementing agency, and between the implementing agencies and the partners. Therefore, clear communication channels with the private partners are vital as they are key stakeholders in the collaboration, and the issues they face differ based on their very nature. Equally, the for-profit private sector issues differ from those of the not-for-profit sector, such as SLA -related issues and those involving informal agreements which are different from formal contractual partnerships. These need to be taken up separately and hence a dialogue process is necessary for facilitating partnerships as it will help in ensuring accountability. Further, many projects that have been implemented by PPP's have a very high risk and chances of failure. It is therefore imperative to have feasibility studies undertaken -together with political economy analysis, before embarking on contractual agreements. Failures occur either during the procurement, implementation, or early part of the operation. Proper feasibility studies should be conducted prior to the contracting, otherwise the project costs cannot be verified and this could render the project unaffordable.

# SECTION 4: LESSONS LEARNT FROM PPC ASSESSMENT

In all the three countries PPP programs are very few, or in early stages of development. There are currently no PPP projects in Malawi and Burkina Faso executed by the PPP Commission. In South Africa, there are only seven PPP projects which are mainly big infrastructure projects and since 2010-12, there are no new PPP projects initiated under the ambit of the PPP Act.

## Challenges and bottlenecks for better understanding of collaborations across the sectors and their impact on improved delivery of UHC.

The study aimed to facilitate the process of increasing public private collaborations through a better understanding of the facilitating factors and bottlenecks. The assessment tool developed as part of the study was used to understand the issues and challenges involved for enabling a smooth collaborative environment. The key recommendations of the study are outlined below.

The overall finding was that all stakeholders agree that public private collaboration is necessary to increase access to health services and service coverage. Opportunities for PPCs to bridge the existing demand-supply gap exist. Therefore, enhanced collaboration with the private sector is essential for bridging current gaps in service provision and for accelerating progress towards achieving Universal Health Coverage. As noted, the health systems are in a transitional phase due to demographic and epidemiological transition, along with a transition in service delivery. Many national governments are constrained in increasing investment in health owing to fiscal stress and budgetary constraints. Therefore, a considerable gap exists in health infrastructure and the necessary human resources. These can be bridged through an effective public private collaborative environment, coupled with relevant multisectoral approaches

In this research, the health sector reforms in these countries aimed at reaching Universal Health Coverage as mandated by the Sustainable Development Goals (SDG's) which also provides an opportunity for enhancing collaboration. Malawi is going ahead with providing semi-autonomous status to the referral hospitals to improve service delivery, specifically on secondary and tertiary care. The country has already implemented the semi-autonomous model through the development of the Central Medical Trust for the procurement of essential medicines. In South Africa, the National Health Insurance (NHI) reforms are expected to assure equitable access to quality health services by 85% of the population who are currently not covered by health insurance programs. The Universal Health Insurance program in Burkina Faso aims to use strategic purchasing for negotiating long-term contracts with the private sector, and to regulate the cost of service delivery for the entire population.

**Examples of PPC's in Health**

**Malawi**

- SLA's with Christian Health Association of Malawi (CHAM) - CHAM is the second major provider of primary health care services across Malawi after Ministry of Health
- Mwaiwathu Private Hospital-Agreement with Ministry of Health for providing certain services like ICU, dialysis, general surgery, scanning and imaging services.; Training for medical, paramedical staff from government medical colleges; Collaboration with ministry for national programs like prevention of HIV and TB
- Central Medical Stores Trust- Collaboration with local private sector manufactures for promoting local drug manufacturing.

**South Africa**

- Central Chronic Medicine Dispensing and Distribution' programme (CCMDD): This is a unique and innovative collaboration where a private partner distributes and dispenses medicine from a central point for patients with chronic conditions.
- Practice Code Numbering System (PCNS) Board of Health Care Funders (BHF) has developed a numbering system which is used by the medical schemes for claims adjudication.

**Burkina Faso**

- Annual high-level dialogue with private sector- Meeting chaired by Minister of Health with partners from private facilities where they share information and have discussions with the Ministry of Health
- Directorate of Private Sector, Ministry of Health- The directorate of the private sector was started in early 2000, with the objective supporting the functioning of the private sector as complementary to the public sector.
- Agreement with hospital associations for service delivery- Agreements between the hospital federation, NGO, s and Ministry of Health to provide health services especially in rural and remote areas.

Further, the government's aim is to strengthen the existing collaborations with the private sector by replacing the conventions with more elaborate forms of contracts, which would aim to put in place performance incentives. The existing arrangements prefigure the future health system as envisaged through the generalization of health insurance, which will dictate the separation between the service provider and the payer.

Primarily, it is important to distinguish between PPPs as such, and other forms of collaboration between the public and private sectors. This distinction is crucial as far as it allows, a clarification of government expectations. This applies to the various components of the private sector, which range from non-contractual partnerships of collaboration, up to large-scale service delivery operations delegated to the private sector. Additionally, this would include agreements as they exist between the State and NGOs / associations, and intermediate forms of contracts that are more or less complex and legally demanding. The omission of this distinction, which is common in the international development debate where the term "PPP" is most often used interchangeably for any form of collaboration, may in practice pose problems of clarity in the dialogue between the government and private partners, and affect the conceptualization of collaborative projects. This also blurs the lines over and above the other existing challenges outlined, such as responsibilities and accountability.

These classical PPP engagements are based on the overall PPP framework laid out by the legislation in the respective countries. The execution of such PPP arrangements is done through PPP Commissions or PPP nodal agencies following the due diligence processes.

## Additional Opportunities for collaboration with the private sector

Other opportunities for collaboration with the private sector exist, but they lie outside the ambit of the classical "PPP". Opportunities for such collaborations are often crowded out when the policy focus is skewed towards PPPs. Often, the processes for undertaking PPP's also acts as a deterrent to develop such collaborations and there is a general perception that is that PPP's are a very complex, cumbersome and costly procedure. Further, a strong regulatory environment, institutional and technical capacity is a prerequisite for initiating such arrangements. The example of Burkina Faso illustrates this point clearly. The Ministry of health prioritised 17 projects which could be undertaken in a PPP model, but none of them could be operationalised. Most of the projects had no feasibility studies and the others had financial restructuring making them very high-cost projects. The bottlenecks cited in the failure of PPP proposals in health include a design challenge, where the proposed projects are drawn from the government's investment program project list without their

conception and adapted to the requirements of PPPs. In particular, these project proposals obscured the operational phase of the PPP and focused only on the provision of infrastructure and equipment. As a result, the bids received were themselves conceived as a financing service, and their cost was unaffordable for the Government.

## Addressing the Trust Deficit

Another important aspect for improving Public Private Collaboration would be to address the issue of trust deficit between the government and private sector stakeholders. The lack of regular interactions between the partners involved makes it difficult to discuss implementation issues and to address problems which arise. Public Private Collaboration can work towards relationship building for a shared understanding of the health system challenges and develop jointly owned solutions between the parties involved. The Burkina Faso case showcases best practices through the regular interactions with the private sector. The private health sector is seen as "complementary to public system" and they are part of the Health Development Plan of the Ministry of Health. The annual meeting of private sector actors initiated by the Ministry of Health is also a vital component for strengthening collaboration. The establishment of a Directorate of the Private sector within the ministry of health is another good example of how the government is facilitating the process of building dialogue with the private sector.

> "There exists a 'trust deficit' between the public and private sectors. To cite an example, contracting in models where private sector takes over the management of facilities, the staff remains with the government and this often leads to operational challenges. The private sector wants operational autonomy, but they could not get the autonomy and then the model fails during the implementation."
>
> Excerpt from Stakeholder Interview.

## Structured Channels of Communication

Structured communication channels for ensuring continuous dialogue between the various entities in the public and private sector is required to foster PPCs. The government itself is not a single entity as there are many different departments involved, including health, finance, justice, trade, autonomous organisations like PPP technical units, PPP Commission, trade and investment organizations. Similarly, the private sector is also not homogenous and involves a range of entities including the following among others: private hospitals, faith-based organizations, NGO's, pharmaceutical suppliers, diagnostic chains, hospital associations and doctor associations. Other important players include user groups, professional unions, and academic and research institutions which can support these processes. All these stakeholders have diverse views on PPC and can help in building consensus through an understating of each partners roles, views and understanding.

### Development of Communication: Policy, Dialogue and Accountability Channels

The study noted that the private sector is often not actively engaged in dialogue with the ministries of health on how it can contribute to UHC. In South Africa, for example, the health service delivery regulatory frameworks do not require private providers of health services to interact with the Department of Health. Hence, it is only now that the Government of South Africa is in the process of defining the service delivery standards needed to operationalize the National Health Insurance (NHI) Fund. In Malawi, the private hospitals advocate for a better working relationship with the public sector to enhance not only service delivery, but also training and capacity building of the medical personal in the country. In Burkina Faso, there is a strong demand for support from the private sector, which would need more favourable conditions and simpler ways to develop and strengthen its engagement in the health sector. The establishment of such conditions should be in line with the concerns and objectives of the Government and Ministry of Health, if they are to favour the development of the private health sector, and could be covered by a Sector Development Strategy, as seems to be envisaged by the Ministry of Health.

## Development of Adequate Management, Capacity and Skills for Sector Collaboration

While embarking on collaborative programs with the private sector, developing adequate management capacity and skills is also a prerequisite. The second issue that becomes apparent is that the ministry of health officials often lack the capacity and skillsets to manage their partnerships/collaborations with the private sector. In addition, there are no dedicated units within the ministries to manage these arrangements. It was noted that building the knowledge base of government decision-makers on the types of contractual agreements, internal audits procedures and procurement procedures would be important to enhance the capacity of ministries of health to negotiate sound collaborative arrangements with the private sector. Skills in these areas would most likely enable more proactive government-led calls for private sector engagement which is currently not happening in Malawi, Burkina Faso and South Africa. A good example is drawn from Malawi where the Ministry of Health, Finance, Justice along with the PPP Commission are developing guidelines, templates for drafting MoUs, SLAs and other contractual arrangements. There is also an attempt to broaden the scope of the SLAs depending on the type of the private provider.

## The Role of Ministries of Health, Cross-Governmental Players, Private Sector and other Partnerships

The capacity of the Ministries of Health to develop strong alliances with the private sector is challenged in the visited countries. A key emerging discussion point was on the need to incentivize government and non-government entities to engage in PPC activities. In Malawi and South Africa, the Ministries of Health need to work more closely with the institutions managing PPPs, such as the PPP Commission in Malawi and National Treasury/Government Technical Advisory Centre (GTAC) in South Africa, to be able to distinguish what constitutes a PPC arrangement as compared with a PPP arrangement. The private sector Directorate of the Ministry of Health is a good example for developing such alliances, but they need to be strengthened to allow for ongoing dialogue, with the support of the PPP Directorate of the Ministry of Finance. It is also important to understand other dimensions, such as the place of the banking, trade and investment sectors and their role in strengthening the public/private collaboration in health. They play a very important role in supporting an incentive structure which can ensure investments for PPC in health.

### The Role of PPCs in Prompting Start-ups and Innovation

PPCs can help in promoting start-ups and innovative ideas from the private sector and create a pipeline for creative projects and investments. Normally, the public sector lags in coming up with “original ideas” and this issue can be approached through a collaborative approach. A major challenge for such efforts is the need to create a framework for the collaborative structure to balance the potentially negative incentives from both sides. There are multiple actors in the system with multiple interests. Hence there should be a framework which clearly stipulates the rules of engagement and safeguards in place for all partners in the collaboration, also capturing the paramount interests of service users.

### Strategic Funds and Resource Management

A plethora of funding sources exists in the health sector and the government has limited information and control of how they are utilised. Hence the articulation of aid policy in the health sector is vital, particularly one which provides the conditions of engagement with the private sector and their modes of operation and collaboration with the public sector. One proposal put forward for further reflection is the benefit of having a policy which clearly recognizes the important roles and contributions of the private sector, particularly in countries that have well defined public-private partnership laws. As private sector actors are also diverse in nature, ranging from service delivery to manufacturers of inputs for the health sector, it is vital to understand their scope and strength in relation to the health system goals set by national health policy. Malawi has initiated a resource mapping exercise which captures the list of the various types of private organizations which are working in the health sector as part of the National Health Accounts development. This data is being used to start the process of re-engaging with the private sector entities for developing collaborations.


# SECTION 5: CONCLUSION AND RECOMMENDATIONS

For any successful UHC system, knowledge, expertise and responsibilities must be drawn from all stakeholders, including national government authorities, civil society, patient groups, healthcare professionals and private sector partners who are all vital to succeed. Knowledge management is also critical as is monitoring, evaluation and review. The strategy outlined by the UN Roadmap for Financing the 2030 Agenda for Sustainable Development aims to "Mobilize development and private partners to support countries, increase the quantity and quality of financing for social protection, including to achieve universal health coverage". With regard to private participation in delivering UHC, a 'public policy vacuum' exists. The private sector comes with its own policies, which are supply-side driven and may not align with UHC deliverables or national priorities, which are demand driven. A particular challenge for the governments is that they lack the capacity to connect the efforts of the non-government sector to help meeting their health objectives.

## Enhancing the Dialogue and Ensuring Participation

The most important aspect for facilitating PPC in health is the development of a common dialogue platform for the diverse public and private stakeholders to understand how each of these entities function and their roles and responsibilities. To create an enabling environment, it is necessary to create platforms in which the two sectors can work together. The availability of such a platform would help in developing a common understanding of the health system challenges and envisaging joint solutions, thereby paving the way for jointly agreed PPC strategies. It would be interesting to assess and appreciate the conditions of a relationship of trust between the different stakeholders, including representatives from the community. The participation of civil society organizations would also help in raising the issues and concerns of the citizens and ensure accountability. In Africa, decentralisation could be looked as an opportunity while developing common platforms for public and private sector. Work primarily with like-minded private sector stakeholders interested in the UHC space can be a good starting point.

The Ministry of Health can play an anchor role in developing a common platform. It could bring other government entities such as the ministry of finance, trade, investment commissions, and associations of the private for-profit and not-for profit sectors, as well as civil society organizations, stakeholder representatives and knowledge institutions. However, Ministers tend to be busy and by and large, when there are other conflicting commitments the dialogue process may suffer. They are also appointed for a fixed term which in some cases may be shorter than the administrative term if there are cabinet reshuffles. Hence the dialogue process might be better driven by someone outside the Ministry in close collaboration with them. It could

prove effective to have a private sector industry champion or civil society representative acceptable to the Ministry, to lead the dialogue process, as this would also help in maintaining the continuity of the process. Similar arrangements can be thought out at the provincial level, where hospital associations and civil society organisations already play a key role with public sector in delivering healthcare services.

## Jointly Identifying Problems and Envisaging Innovative Solutions

A robust dialogue has to be anchored into a common perception of problems and solutions along the PPC value chain. The public sector needs to provide an enabling environment, so that collaborating with the private sector adds value to its healthcare system. This is to be done by establishing a conducive regulatory and legal framework, a stable political and macro-economic environment, strong institutions and governance systems for advocacy and independent monitoring and evaluation. On the other hand, the private sector should support UHC on access to technology innovation, and developing clinical pathways and protocols; educational programmes for capacity building of the health workforce; financing solutions that support public budgetary guarantee for health coverage; deliver quality patient care and comply with regulations, standards and professional guidelines.

The private health sector has key strengths when it comes to ideation of innovative programs and implementing them, and it is often difficult for the public sector to acquire such skills due to budgetary and human resource constraints. There are many examples where private sector brings in innovative solutions for addressing health system challenges. The 'Central Chronic Medicine Dispensing and Distribution' programme (CCMDD) in South Africa, which distributes and dispenses medicine from a central point for patients with chronic conditions is one among them. The Emergency Management System (EMS) of Ambulances in India is a very good example of harnessing private innovation which is financed by the public budget. Prior to the introduction of this model, the ambulance services were under the domain of the public health system and was riddled with multiple inefficiencies. The objective of this innovative model was to provide access to emergency services through emergency/referral transport which is managed by a private service provider. The private partner is responsible for transportation of the patient and "in-transit" stabilisation of the patient. This innovative model has helped greatly improving the access to Emergency Management System across the country in a span of 10 years.

## Mapping Public and Private Sector strengths and complementarities

Developing a vision document can help in mapping the relative strength of public and private sector across the "building blocks" of country health system. The key outcome of this study is the PPC assessment tool which can guide the dialogue process on PPC at the national level. The assessment tool serves as the starting point to identify the current situation, issues and challenges around the thematic areas of PPC in health. Countries initiating conversations around the ways to harness private sector can use the assessment tool as starting point to develop a joint vision for both public and private sector. The framework captures in detail the core areas of (a) Context and Understanding of PPCs in health (b) Opportunities of engaging with private sector (c) Policy environment for PPCs (d) Institutional Structures and Strategies for PPCs (e) Implementation Challenges of PPC's (f) Results and Accountability framework for PPCs. The tool is meant to facilitate discussion on each of these aspects between the public and private stakeholders to evolve a framework and a vision for collaboration across various levels of the health system. This can be done through a workshop bringing together key stakeholders to discuss the issues and prospects regarding PPC (see proposed modalities at Annex 1).

## Articulating a Vision

A key factor for fostering PPC's in health is the articulation of a vision regarding the role of private sector in shaping the health system of a country. It is necessary to acknowledge the presence and diversity of the private sector and tailor the expectations of the government regarding collaboration. Good governance and project management, along with accountability structures and mechanisms, risk mitigation and quality control,

are essential elements of managing successful collaborations. Many partnerships do not ensure, or can't enforce, that all players are held accountable for the delivery of efficient, effective and equitable services. Often in public-private relationships it is unclear as to whom these partnerships are accountable to, according to what criteria, and who sets priorities. The complex transnational nature of some of these partnership arrangements necessitates that they be guided by a set of global principles and norms. Participation of international agencies warrants that they are set within a comprehensive policy and operational framework within the organizational mandate and involvement of countries requires legislative authorization, within the framework of which, procedural and process related guidelines need to be developed.

**Opportunities from Health Insurance in India**

The National Health Insurance Scheme in India (RSBY) presents an example of how private providers can be leveraged for service delivery through a publicly financed health insurance program. RSBY program in India was initiated in 2007 by the federal government of India, to provide financial-risk protection for inpatient health care to poor populations. The insurance scheme was implemented on a public-private collaboration model where the financing of the program was shared by the federal and provincial governments and the service delivery was provided by private and public service providers. The scheme was revamped in 2017 by the federal government by enhancing the service and benefit coverage through strategic purchasing of health services. The program covers 500 million population and provides a health coverage of USD 7000 annually for secondary and tertiary care. In order to facilitate the process of program implementation, the federal government has constituted a National Health Agency (NHA) with full functional autonomy. NHA works very closely with private institutions including not-for-profit institutions, banks, insurance companies, academic institutions, think tanks, and other national and international bodies for developing the various aspects of the Health Insurance programs. The private sector is actively involved in developing various processes like the IT infrastructure, hospital quality management, accreditation, clinical protocols and costing of packages. This model presents a unique approach of leveraging the strengths of both public and private sector through a collaborative effort.

## Seizing opportunities

Many countries in Africa are either in the process of initiating, or have already initiated Strategic Purchasing or National Health Insurance Programs for Universal Health Coverage. Research increasingly demonstrates that the private sector can accelerate the attainment of healthy lives for all by 2030. For any such program to be successful, an enabling environment for both the public and private sectors will be required. Strategic purchasing involves mostly three sets of decisions: (i) identifying the interventions or services to be purchased, taking into account population needs, national health priorities, cost-effectiveness and other factors; (ii) choosing service providers, giving consideration to service quality, efficiency and equity; and (iii) determining how services will be purchased, including contractual arrangements and provider payment mechanisms (Figueras J., 2005). Implementation of health insurance programs requires identification of providers, developing benefit packages, accreditation of providers, costing of provider packages, information systems and developing monitoring provider behaviours. This policy shift presents an opportunity for augmenting PPCs in health and bringing together both sectors to align with the UHC priority.

## Working with Development Partners

Development Partners can play a crucial role in facilitating the process of PPC in health. There are four main specific activities which they can take up:

i. **Facilitating the process of developing "Vision document" for PPC's in Health.** Development Partners provide technical and financial support to the development of "Vision Document" for private sector. Evolving a framework for PPC's depends on the health system context of the countries and Development Partners can work with the Ministries of Health and other key stakeholders to evolve this document.

ii. **Knowledge Support for PPC's in Health:** Knowledge Support would include development a repository of various types of contractual arrangements across countries which includes RFPs SLAs, MOUs etc. The repository can collate country experiences, innovations and best practices in PPC in health. This can also help in mapping private entities providing support to the development of technical and consultancy reports when it comes to implementation of PPP projects. In addition, preparation and implementation of PPC projects requires feasibility studies, value for money analysis, cost effectiveness studies, financial audits, RFP preparation, contract development and independent evaluation work for which skillsets are concentrated in the private consulting space and are not available in all African countries.

iii. **Capacity Building:** Training and capacity building activities can where necessary be supported by Development Partners. Development partners are already supporting the capacity building in various aspects of PPC in many countries and sharing to this effort can minimize duplication of efforts and improve outreach.

iv. **Advocacy for PPC in Health Sector:** Advocacy on concepts, processes and the pathways of implementation of PPCs would be necessary for spreading the message. Development partners can also support sector working groups which can articulate the requirements and challenges for PPC's within various domains of health sector. This could be done through regular webinars, virtual platforms and development of Community of Practice (CoP). Most importantly, Development partners can also advocate for mainstreaming PPC strategies in the national health sector priorities, with related strategies, defined targets and adequate resources for implementation, and progress monitoring.

# CONCLUSION

The main goal of the tool was to review how PPC can enhance and fast-track UHC. For this to happen, the sequencing of the key recommendations with clear action planning, managing timelines and milestones, and implementation, accompanied by a clear framework of authority, delegation, communication and accountability is critical. The implementation of the PPC assessment diagnostic tool at the country level can be the starting point in this direction. This can contribute to initiating a systematic dialogue process between governments and the private sector, and deepening dialogue with development partners. Burkina Faso presents a very good example of private sector engagement, with their high-level dialogue held annually. Countries interested in facilitating the process of PPC in health can make use of the diagnostic tool as an opportunity to interact with the private sector and other stakeholders, and set the milestones for prioritising strategies of collaboration with the private sector to achieve UHC. This can also create an opportunity for common goal setting, understanding and mutual recognition of the distinct roles of the public, private, and other entities, and enable a clear identification of commonalities, strengths, constraints and differences within the sector as a whole. It would also help in delineating roles, relationships and collaborations between the various actors for the purpose of enhancing healthcare provision across society and maximising progress toward UHC.

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# ANNEX I - SAMPLE WORKSHOP MODUS OPERANDI FOR ASSESSMENT OF PUBLIC PRIVATE COLLABORATION IN COUNTRY HEALTH SYSTEMS

The key outcome of this exercise is the development of the tool which can be used as a guide for consultative dialogue on PPC and PPP at country level. The tool aims at identifying strengths and bottlenecks towards enhanced partnerships, as well as unpacking institutional and individual positions among PPC-PPP change agents and dissenters. The tool is a self-assessment guide for understanding the stakeholder perspectives on PPC's in health. The current tool consists of 45 open ended questions, which are divided into six thematic areas. Currently, the tool is administered through one-to-one interviews with the key stakeholders from public and private sector. The pilot testing during of the tool was done is South Africa, Malawi and Burkina Faso and the discussions provided insights to the alternative ways of using the tool for assessment of PPC's in health. After the field testing of the tool, the tool is revised and customized based on specific thematic areas for stakeholders in public and private.

A workshop method can be adopted to do the assessment bringing together all the different stakeholders to a common platform. The workshop will bring together various stakeholders and help in deepening knowledge of government and private sector on issues and prospects regarding PPC's in each country. Ministry of Health in can anchor the workshop with the support of development partners who can help in bringing both government and private stakeholders. The process flow of administering the tool in a workshop mode is outlined as follows.

The first step of organizing the workshop is the identification of the key stakeholders from both government and private sector who can influence the policy and implementation of PPC's in health in each country. Once the list of key stakeholders is collated, as a prelude to the workshop, an online version of the tool will be emailed to each of them for understanding for collating the diverse views of the key stakeholders. The responses would be analysed and used for the discussion during for each thematic session of the workshop.

The key informants from both public and private sector who completed the online tool would be invited to participate in a two-day workshop to discuss the six thematic domains of the assessment tool. The main objective of the workshop is to discuss the key findings of the six domains of the assessment tool and develop a "Vision" for Public Private Collaborations in health. The workshop will have an initial plenary session which will deliberate on the SDG goals and the progress towards achieving UHC and the concept of Public Private Collaboration in health and its relevance in accelerating the progress towards UHC. The plenary session would also present a country assessment of the health system and the role of private sector contribution across the building blocks of health system. The second part of the workshop will be discussions on the six thematic areas of the assessment tool and synthesize the findings which would be used for developing a vision document on PPCs in health.

The third part of the workshop will be used for developing a vision of how private sector can be involved in shaping the health system priorities of the country. The sessions will be used to develop a a "Value Chain" for health sector which encompasses the private sector engagement in achieving Universal Health Coverage. The "value chain' process will help in mapping all entities which includes the human resources, providers, manufactures, distributors and their contribution to provide better quality health care services at affordable cost. This would help in identifying the bottle necks, financial flows and optimization resources for improving overall efficiency of the health system and creating better value in both government and private sector. There are various frameworks of value chains in health and one example is the Wharton School Study of the Health Care Value Chain which is based on the US health system. This value chain model maps the major segments and key players in the health care value chain and their capabilities (Exhibit-I.) Another example is the value chain model developed for maximising provision of public and private health services in Malta (Exhibit-II)

The concluding plenary of the workshop will synthesize the findings of the discussions on the assessment framework and value chain analysis to articulate a vision for private sector collaboration in health systems. A vision document will be prepared as an output of the workshop and the document will set the pathways for public private collaboration for achieving UHC.

# ANNEX II - ASSESSING THE CHALLENGES AND POTENTIAL FOR ENHANCED PUBLIC-PRIVATE COLLABORATION IN HEALTH AT COUNTRY LEVEL

## CONTEXT AND UNDERSTANDING

- Overview of health system and challenges.
- How do you define the private sector in health?
- How present is private sector in!oo health in the country?
- How would you define PPC and PPP?
- What type of PPC and PPP mechanisms/programmes exist in your country? How much of this is in the health sector?
- Tell us about a most successful programme, and a programme that has not succeeded well.

## OPPORTUNITIES FOR FURTHER ENGAGEMENT

- Does current collaboration between public and private sector meet your expectations? Please explain.
- What should be improved in PPC and to achieve what results?
- Are there (geographical/technical) areas in which private sector should be more involved?
- What are the categories of private sector partners you would bank on to improve Universal health coverage in your country (pharma industry; healthcare service providers; providers of support or ancillary services; NGOs/Religious sector; etc.)?
- Do you see any engagement with private sector possible and beneficial to alleviate HRH shortages?
- What kind of dialogue and working relationship do you have with the government? Is it a regular one?
- According to you, what are the 3 key bottlenecks/risks that would need to be removed to enhance PPC and its results in your country?

## POLITICAL WILL AND POLICY ENVIRONMENT

- What is your vision on PPC in health?
- Is there political will to collaborate with private sector in health?
- Does national health policy adequately provides for PPC? What are the objectives and expected results?
- Has the private sector been consulted during policy design? How? What have been the outcomes?
- Is PPC served by adequate legal cover (e.g. PPP Law; MOUs)? Please explain.
- What are the incentives for private sector investments in the health sector? Does this need improvement and how should it be improved?

## PPC STRUCTURES AND STRATEGIES

- Is there a specific strategy for PPC/PPC in health in your country? What are its main features?
- Is there a PPC unit in your country? What kind of working relationship does it have with MoH?
- Are there structures and systems in place for PPC concertation and follow up? Please describe them.
- How well are PPC structures and systems functioning? How could they be improved?
- What types of regulatory mechanism exists in your country for PPC in health?
- What is the process for initiation of PPC programmes in the health sector? How do you intervene?
- Does the current process work well? How should it be improved and how do you see your role in this regard?
- What are the key challenges faced in the financing of PPC programmes? How are they being handled?
- How is resource allocation done for PPC programmes? What are the strengths and weaknesses of the process and what have been the outcomes so far? If this requires improvement, what should be improved and how?

## IMPLEMENTATION

- Is the existing PPC legislation/regulation adequately applied?
- How would you quality the design of current PPC programmes: (i) overall; and (ii) in the health sector?
- How would you qualify the management of existing PPC? Does it need improvement and how?
- Do you see PPC implementation issues in terms of governance? Please explain.
- Do you see PPC implementation issues in terms of management of PPC projects? At what level:
  - Financing?
  - Procurement?
  - Contracting?
  - Contract implementation?
  - Measuring results?
- In your view, to what extent are HRH shortages affecting PPC?
- Apart from the issues already reviewed above, are there other factors that impede the development of PPC and/or negatively impact on its results?

## RESULTS AND ACCOUNTABILITY

- Doe current PPC improves coverage of health and related services? Why?
- Does current PPC improve access to health services? Why?
- Does current PPC improve equity in the access to health services? Why?
- Would you say the services currently delivered by private sector are of good quality? How do they compare with services rendered by the public health sector. Please explain.
- Do PPC programmes bring additional value to government in terms of know how? More generally, what are the benefits of PPC for the government?
- Would you say that existing PPC in health brings good value for money?
- Is PPC/PPP popular?
- What types of monitoring systems are in place for implementation of PPC programmes? How well do they work?
- Is information on PPC implementation available?
- What type of grievance redress mechanisms exist for PPC programmes?
- What are the accountability mechanisms available with regards to PPC? What additional mechanisms would you like to see and why?
- How would you see your role or that of your institution in strengthening accountability mechanisms vis-à-vis PPC?

# ANNEX III - IDENTIFYING CHALLENGES AND SOLUTIONS TO ENHANCE PUBLIC- PRIVATE COLLABORATION FOR UNIVERSAL HEALTH COVERAGE IN AFRICAN COUNTRIES

## Interview and Data Collection Tool – USER VERSION

### Instructions for the Interviewer:

The following is to be read verbatim to the respondent prior to the interview. If the subject then agrees to participate, you must sign on the line marked "Witness to Consent Procedures" at the end of this form. Also mark the date on the appropriate line.

### PURPOSE

You are invited to take part in a study commissioned by the African Development Bank (the Bank) aimed at augmenting and deepening the practical knowledge of issues affecting public-private collaboration and public-private partnerships in health, with the ultimate goal to guide and support the enhanced engagement of the private health sector towards the achievement of Universal Health Coverage (UHC). In addition, the outcomes from the analysis of this work will be used to increase understanding of critical partnership value chains in order to improve the quality of business development opportunities that the Bank can leverage during the period of the next phase of its human capital strategy.

### PROCEDURES

The interview will take about 1 to 1.5 hours of your time. With your permission, we will take a record of the interview. You do not have to answer any question that you feel uncomfortable with and you are free to stop the interview at any time.

### RISKS/DISCOMFORTS

We do not think that being part of this project will create any risk for you. If at any point you feel uncomfortable, do not want to answer a specific question, and or decide you no longer want to participate, just let us know and we will skip the question or end the interview. You do not have to answer any questions you would prefer not to answer. The transcript of the interview will only be accessible to members of the project team and they will not be allowed to share it with anyone else. The transcripts and all records will be kept confidentially.

### VOLUNTARY PARTICIPATION

You do not have to agree to participate in this project, and you may change your mind at any time. If you have any questions or problems, please contact our Lead Investigators (Provide details, if asked)

### PERMISSION TO PROCEED

Is it okay to proceed with the interview?

# PART- A

## I. INTRODUCTION

The concept of Public-Private Collaboration (PPC) in the health sector has developed tremendous interest across the world in both developing and developed countries. There is ample evidence across the world which demonstrates the successful collaboration between public and private sector in health sector. While the broader framework of engagement with private sector is termed as Public Private Collaboration, Public-Private Partnerships (PPPs) are viewed as a legalized arrangement that is a subset of the wider Public-Private Collaboration (PPC) domain. PPC's and PPP in the health sector can take a variety of forms with differing degrees of public and private sector responsibility and risk. They are characterized by the sharing of common objectives, as well as risks and rewards, as might be defined in a contract or manifested through a different arrangement, to effectively deliver a service or facility to the population. PPPs are one of the many types of public–private collaborations in healthcare delivery. However, PPPs, involving the structured collaboration of one or more public and private entities to achieve a common objective, represent a distinct model for engagement.

However, realizing the potential of public-private collaboration requires that existing challenges and bottlenecks in health system are addressed in a comprehensive manner. A successful engagement with private sector through public private collaboration would require plugging of health systems issues and challenges. This implies in the first place the mutual recognition of respective public and private identities, objectives and constraints with a view to delineate new win-win playing fields. Hence it is imperative to deepen the understanding of practical issues affecting public-private collaboration in health, with the goal to guide and support the enhanced engagement of the private health sector towards the achievement of UHC.

In view of this, the African Development Bank has commissioned this study aimed at augmenting and deepening the practical knowledge of issues affecting public-private collaboration and public-private partnerships in health. The ultimate goal of these actions is to guide and support the enhanced engagement of the private health sector towards the achievement of UHC. This study would form the basis for the Bank along with other development partners like WHO to support the policy advocacy for engagement of private sector for realizing better health outcomes. The outcomes of this mission would be used by the Bank to strategize its work with the private health sector and to develop its portfolio of non-sovereign operations in a way that maximizes impact on UHC.

One of the key outcomes of this study is the development of an interview and data collection tool which could guide consultative dialogue process on PPC at country level. This tool aims at identifying strengths and bottlenecks towards enhanced partnerships, as well as unpacking institutional and individual positions among PPC-PPP change agents and dissenters. This interview tool which is developed as part of the study is being field tested in three countries (Malawi, South Africa, Burkina Faso) and the final knowledge product will be utilized in other African countries for supporting public private engagements in health sector.

## II. ROLE IN HEALTH SYSTEM

1. What is your position in the organization?
2. Can you briefly explain your role within the organization[3]?

How are you involved in the policy making and strategy development process for Public Private Collaboration (PPC's) in Health?

3 Organization here denotes Ministry of Health, Ministry of Finance, Directorate of Health Services, Community organization etc.

## III. CONTEXT AND UNDERSTANDING

4. Can you provide a brief overview of the health system in your country? What are your key health system challenges? (Probe for the health systems profile, key health indicators, health system challenges faced by the country)
5. How do you define the private sector in health? What is the presence of private health sector in the country? (Probe for the areas where they operate; size of the private health sector; type of private health sector, or profit and not for profit)
6. How would you define Public Private Cooperation in health (PPC) and Public Private Partnership (PPP)?
7. What type of PPC and PPP mechanisms/programs exist in your country? How much of this is in the health sector? (Probe for overall scenario in the country and what is the situation in health sector)
8. Can you briefly illustrate about a most successful program, and a program that has not succeeded well in this area?

## IV. OPPORTUNITIES FOR ENGAGEMENT

9. Does current collaboration between the public and private sector meet your expectations? Please explain. (Probe for the reasons if the respondent says yes or no)
10. Are there (geographical/technical) areas in which private sector should be more involved? (Probe for the thematic areas where there is scope for more cooperation)
11. What are the categories of private sector partners you would bank on to improve Universal Health Coverage in your country? (Probe for the types of private partners; pharma industry; healthcare service providers; providers of support or ancillary services; NGOs/Religious sector; etc.)
12. Do you see any engagement with private sector possible and beneficial to alleviate human resources for health (HRH) shortages? (Probe for the ways of engagement)
13. What kind of dialogue and working relationship do you have with the government? Is it a regular one?[4]
14. According to you, what are the 3 key bottlenecks/risks that would need to be removed to enhance PPC and its results in your country?

## V. POLITICAL WILL & POLICY ENVIRONMENT

15. What is your vision on PPC in health?
16. Is there political will to collaborate with private sector in health? (Probe for the reasons in either case)
17. Does national health policy adequately provide for PPC? What are the objectives and expected results? (Probe for the key strategies envisaged for PPC in national health policy).
18. Has the private sector been consulted during policy design? How? What have been the outcomes? (Probe for how the consultation process happens and who were involved)
19. Is PPC served by adequate legal cover (e.g. PPP Law; MOUs)? Please explain. (Probe for the legislative/regulatory mechanisms in place to support PPC) [5].
20. What are the different types of incentives for private sector investments in the health sector? Does this need improvement and how should it be improved?[6] (probe for the tax incentives, fiscal incentives for private sector investment; other forms of incentives).
21. What role do financial institutions, trade and investment commissions play in facilitating PPC's in health. Is the support adequate? (Probe for the current level of engagement with these entities, the issues in getting support from them, how it can be improved).

4 This response of this question is specifically for the interviews with private sector, community organisations etc.

5 Regulatory framework envisages setting of standards and guidelines, monitoring performance, setting entry and exit requirements to the sector etc.

6 This question is specifically addressed to the representatives of the private sector, not-for-profit sector and industry representatives.

## VI. PROCESS MAPPING OF PUBLIC PRIVATE COORDINATION IN HEALTH SECTOR

22. Is there a specific strategy for PPC/PPP in health in your country? What are its main features? (Probe strategies for providing enabling environment to PPC).
23. Is there a PPC unit in your country? What kind of working relationship does it have with MoH? (Probe for the institutional mechanisms in place for implementing the PPC programs and their functions).
24. How well are PPC structures and systems functioning? How could they be improved ? (Probe for functional aspects of the PPC units if they exist).
25. What is the process for initiation of PPC programmes in the health sector? How do you intervene? (Probe for the role of key stakeholders; role of ministry of finance; ministry of health; private sector; the process followed while PPC projects and initiated)
26. Does the current process work well? How should it be improved and how do you see your role in this regard?
27. What are the key challenges faced in the financing of PPC programmes? How are they being handled? (Probe for development of the financing models for PPC programs; issues related to delay in payments to private providers).
28. How is resource allocation done for PPC programmes? What are the strengths and weaknesses of the process and what have been the outcomes so far? If this requires improvement, what should be improved and how? (Probe for how the budge process is done. How long it takes? What happens during the process?

## VII. IMPLEMENTATION OF PPC PROGRAMS

29. Is the existing PPC legislation/regulation adequately applied? (Probe for the implementation challenges in the regulatory mechanisms in place?
30. How would you qualify the design of current PPC programmes: (i) overall; and (ii) in the health sector?
31. How would you qualify the management of existing PPC? Does it need improvement and how?
32. Do you see PPC implementation issues in terms of management of PPC projects? At what level?
33. In your view, to what extent are human resource shortages affecting PPC? (Probe for the issues related to adequacy of technical experts like health economists, M&E specialists etc.)
34. Apart from the issues already reviewed above, are there any other factors that impede the development of PPC and/or negatively impact on its results?

## VIII. RESULTS AND ACCOUNTABILITY

35. Does current PPC improves coverage of health and related services? Why?
36. Does current PPC improve equity in the access to health services? Why? (Probe for reasons of how PPC improves access and equity in health services).
37. Would you say the services currently delivered by private sector are of good quality? How do they compare with services rendered by the public health sector? Please explain. (Probe positive and negative feedback).
38. Do PPC programmes bring additional value to government in terms of know how? More generally, what are the benefits of PPC for the government?
39. What is the public perception towards PPC/PPP programs? (Probe how popular are PPC programs among the public).
40. What types of monitoring systems are in place for implementation of PPC programmes? How well do they work? (Probe for systems for measurement of outcomes; evaluation framework for collaboration; indicators for performance measurement).
41. What are the internal audit systems for PPP/PPC programs? (Probe for how well the systems are working; bottlenecks for performance; capacity issues).
42. Is information on PPC implementation available? (Probe how and in what form its available).
43. What type of grievance redress mechanisms exist for PPC programmes? (Probe for institutional avenues for conflict resolution; citizen partnership in program implementation).

44. What are the accountability mechanisms available with regards to PPC? What additional mechanisms would you like to see and why?
45. How would you see your role or that of your institution in strengthening accountability mechanisms vis-à-vis PPC?

## IX. ROLE OF THE BANK AND DEVELOPMENT PARTNERS IN IMPROVING PPC IN HEALTH

46. How do you foresee the role of African Development Bank and other developing partners in strengthening the efforts of PPC's in health in your country? (Probe for the key areas of support required from the Bank and partner institutions).

## X. RECOMMENDATIONS

47. Any other recommendations?

Thank you for your time.

## SEQUENCING OF THE QUESTIONS

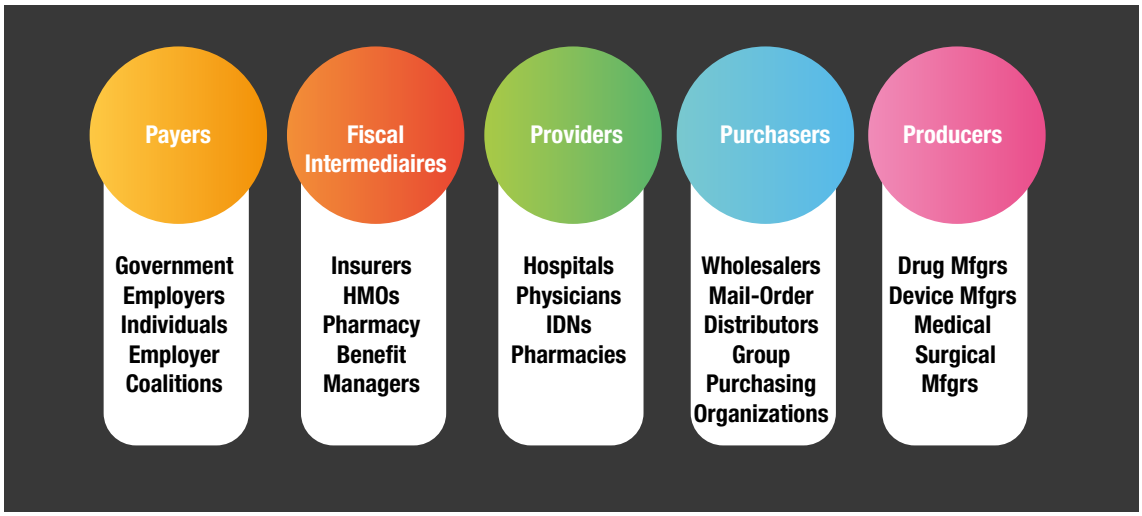
A. Questions which are common for all key stakeholders- Questions 1,2,3

B. Questions for Ministers/Parliamentarians and other key policy interlocutors and bureaucrats from Ministry of Health/Finance/Planning/Justice - Question number 6,7,8,9,10,11,12,14,15,16,17,18, 19,20,45.

C. Private Sector Hospital Associations/Organizations: Question Numbers 4,5,6,7,8,10,12,13,14,15, 16.17,18,19,20.

D. Consumer Organizations, Civil Society Groups: Question number 6,7,8,13,21,23,28,29,30,32,33, 34,35,36,37,28,40,41,42,43,44.

# EXHIBIT I - WHARTON SCHOOL STUDY OF HEALTH CARE VALUE CHAIN




Source: Burns L.R, DeGraaff R.A, Danzon P.M., Kimberly J.R, Kissick W.L., Pauly M.V. The Wharton School study of the health care value chain, in Burns LR, (editor). The Health Care Value Chain: Producers, Purchasers and Providers. San Francisco: Jossey-Bass; (2002). p. 3–26.

# EXHIBIT II - VALUE CHAIN OF PRIVATE HEALTH CARE

| | Pre Hospital | Referral | Healthcare facilities | Admission | Treatment / Care | Outcome (discharge, referral, rehab, death) | Follow up | Patient experience |
|---|---|---|---|---|---|---|---|---|
| S | - Health education | - Infrastructure | - Accessible<br>- Full service<br>- Infrastructure | - Silos | - Available diagnosis spectrum | - N.C.I. | - Check up | |
| W | - Ad hoc<br>- Not well structured<br>- Budget constrains | - Lack accountability<br>- Easy access<br>- Inappropriate referrals<br>- Low lab support | - Free access<br>- High cost | - Lack of proper gate keeping | - Easy access<br>- Unnecessary treatment<br>- Variation in care | - Delayed discharge<br>- Lack of community support | - Lack of structures | - Lack of monitoring |
| O | - Social media<br>- Website | - IT | - Restructuring along care pathways | - Better gate keeping | - Organization along care pathways<br>- Algorithms<br>- Space | - Planned process & criteria<br>- Information exchange | - Follow-up management | |
| T | - Undisciplined Maltese culture | - Risk aversion junior staff | | - Silos | - Risk aversion | | | |

Source: Buttigieg, Sandra C. et al. "Value Chains of Public and Private Health-care Services in a Small EU Island State: A SWOT Analysis." Frontiers in public health vol. 4 201. 14 Sep. 2016, doi:10.3389/fpubh.2016.00201.

# COMPANION LITERATURE REVIEW

# COMPANION LITERATURE REVIEW

## INTRODUCTION

Healthcare partnerships and collaborations have emerged over the past 20 years to improve hospital infrastructure and to deliver non-clinical and clinical services. A majority of such partnerships have been implemented in non-health sectors in developed countries. However, many Low- and Middle-Income Countries are discovering new and innovative healthcare partnerships. But often these partnerships also bring their own glitches and controversies. Many have critiqued such partnerships for averting resources from public actions and distorting public agendas in ways that favour the private companies. This review tries to identify the various challenges and solutions to enhance Public-Private Collaboration for achieving Universal Health Coverage in African countries. The review is divided into the following sub-headings: context and need for public-private collaboration in health sector; operational definitions pertaining to public-private collaborations; pre-requisites of public-private collaborations in health sector and regarding the implementation issues and challenges of public-private collaboration in the health sector. To conclude, this review highlights two relevant case-studies.

## CONTEXT AND NEED FOR PUBLIC-PRIVATE COLLABORATION IN HEALTH SECTOR

In general, there are three crucial reasons for partnerships in health to become a major force in health care: a shift in philosophy about the roles of the private and public sectors; recognition by both the public and private sectors of their interdependence; and better understanding of how each party can gain from partnership.[1] This section of the review focuses on understanding the context of Public-Private Collaboration (PPCs) for achieving the Sustainable Development Goals (SDGs) of attaining Universal Health Coverage (UHC). Further the section moves to understand the health systems and financing challenges in Africa. More details regarding the need and potential for collaboration with the private sector to achieve UHC and the role of private sector in Africa follows. Later the review covers the limitations of the public sector and health systems strengthening, and its alignment with public-private collaborations policy; which is followed by the Political Economy of PPCs.

## CONTEXT OF PUBLIC-PRIVATE COLLABORATION FOR ACHIEVING THE SUSTAINABLE DEVELOPMENT GOAL OF ACHIEVING UNIVERSAL HEALTH COVERAGE

We are all aware of the fact that the Sustainable Development Goals were adopted by all United Nations member states in 2015 as a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity by 2030.[2] The highlight of these seventeen goals are that they are all integrated. This means that either any action in one area will affect outcomes in other areas and such a development should balance social, economic and environmental sustainability. Attaining Universal Health Coverage is considered as the core driver for accomplishing SDG 3: 'Good health and well-being' by providing quality and affordable health care services. One of the major levers for achieving SDG 3's targets is through the implementation of SDG 3.8 on UHC, which emphasizes the right of all citizens to access quality health services without risking financial hardship.[2] With eleven years left for each of the member country's to achieve the SDGs; each member country is adopting its own strategy in this short run to achieve UHC. In this process the national governments are creating plans and identifying various opportunities through partnerships with various other sectors and stakeholders. SDG 17: 'Partnerships to achieve the goal' is identified by various countries as a way of achieving the SDGs by 2030.

Findings show that people in Low- and Middle- Income Countries (LMICs) still lack even basic access to care, innovative medicines and medical resources.[3] Here the patients are often excluded from existing health care systems or merely have access to sub-standard care because they are required to pay out-of-pocket

(OOP) but lack the means to afford it. As the health system in these countries develop and the optimal aim is to achieve UHC and to ensure that all people obtain health services they need without spending OOP expenditure.[3] For any successful UHC system, knowledge management and knowledge expertise and financial responsibilities must be pooled from all stakeholders, including national government authorities, civil society, patient groups, healthcare professionals and private sector partners are all vital requirements.

Private sector in health care, particularly in LMICs is very diverse and wide-ranging across the sector from independent practitioners to speciality clinics to corporate hospitals to large private insurers. In today's world both private and public sectors co-exist and interact and therefore any policies for addressing UHC must address the multifarious private sector for effective Public Private Collaboration in health sector. Public Private Partnerships (PPPs) in general can combine the strengths of private actors, such as their innovation, technical knowledge and skills, managerial efficiency together with the role of public actors, including social responsibility, social justice, public accountability, and global, local knowledge and indigenous knowledges, to create an enabling environment for delivering high-quality health services and outcomes.[4] For achieving the SDGs which are ambitious in nature, each of the member countries should start engaging with the private sector in a dynamic new way, paving the way to advance them by mobilizing private capital and private-sector innovation for a collective approach in accomplishing UHC as a public good.

In a partnership towards UHC, the public sector has first to anticipate universal a health care strategy, making health care a priority on its development and budgetary plans. The public sector should provide an enabling environment so that partnering with the private sector adds value to its healthcare system by establishing the regulatory and legal framework, a stable political and macro-economic environment, strong institutions and governance systems for advocacy and transparency5, and most importantly in meeting the needs of the populace. In a resource-constrained region, it is crucial that governments choose reforms which achieve universal coverage that are affordable and in an efficient way and which does not cost the economy5 heavily. The public sector should also design bankable projects and programmes, where private support demonstrates lower costs and high quality value for UHC. On the other hand, the private sector should support UHC on access to technology innovation, and monitoring tools for patient performance; educational programmes for capacity building of health workforce; financing solutions that support public budgetary guarantee for health coverage; deliver quality patient care and comply with regulations, standards and codes of conduct.[5]

Generally, PPPs in health are any formal collaboration between the public sector and the private health sector; and such partnerships are built to enhance and accumulate capacity and effectiveness in service delivery and with that kind of effective collaboration, each organisation can play to its strengths. The benefit of the governments in such partnerships is that they are able to provide need-based and high-quality health services to the population.

## HEALTH SYSTEMS AND FINANCING CHALLENGES IN AFRICA.

Africa's healthcare challenges are heightened by the sheer diversity of the continent. The countries range from the resource-rich to the impoverished, from those with dynamic economies to those where conflict zones rumble; from large cities to remote villages and nomadic lands. There exists sharp discrepancies in the prevalence of illness and access to treatment which complicates comparisons for policy-making purposes.6 The African continent is also undergoing rapid transitions on at least three fronts: demographic changes – longer life expectancy and changing age-structure; urban growth and epidemiological changes are shifting the burden of illness toward non-communicable diseases.[7] All of these changes have profound effects on the type, quantity and costs of healthcare services needed. Further the national healthcare systems in Africa face severe shortages of suitably qualified health workers and limited availability of quality medicines[7].Another challenge is that a disproportionately large number of skilled health personnel are located in urban areas; and with limited resources and access to remote areas, populations in rural areas have inadequate access to preventive health services[7].

Since 2000, Africa has been showing a tremendous improvement in various health indicators and most African countries recognize a right to health in their national constitutions. The Under-5 Mortality Rate in Africa

declined from 148 to 62.8 deaths per 1,000 live births over the period 1990 to 2017; the Infant Mortality Rate declined from 91 to 44.1 deaths per 1,000 live births in the same period; the Maternal Mortality Ratio also declined from 542 to 421 per 100,000 live births between 1990 and 2015.[7] In Africa, malaria has been reduced by 34 per cent since 2000 and the mortality rate by 54 per cent.[8] This is because, many African countries are undertaking health systems financing reforms to increase health coverage and financial protection following the path to universal health coverage.[9] Although there is an improvement, there is much more to go.

With health care being a public good, many of the African member states have placed healthcare financing as one of the fundamental doctrines to improve the well-being of their populations. In the year 2001, Heads of African Union countries pledged to set a target of allocating 15% of their government budget to the health sector.[9] Even if some of the African countries like Ethiopia, Malawi and Rwanda have increased their public expenditure to health; still for many other African countries, the overall health financing remains a major constraint. These differences in countries' assurance indicate that political will and commitment is needed, along with clear vision, health and development priorities to increase government revenue allocation to health.[9]

Health spending in Africa remains largely inadequate to meet the growing healthcare financing needs and the rising healthcare demands, creating a huge financing gap of $66 billion per annum.[7] These mainly narrow down the economic growth, showing an average debt to Gross Domestic Product (GDP) ratio increasing by 15 percentage points between 2010 and 2017, while the total spending on healthcare in Africa remained within a narrow band of 5 to 6 per cent of GDP over the period 2000–2015.[7] Because of the scarce public resources and volatile donor assistance resulted in private out-of-pocket expenditure as the single largest component of total health expenditure, pushing the majority of African people into poverty. In 2014, out-of-pocket-payment (OOP) as percentage of total health expenditure in countries of the World Health Organization (WHO) African region was estimated from 5% in Botswana to 72% in Nigeria.[9] High OOP is associated with low levels of public financing for health; where the public providers are forced to supplement their budget with various kinds of fees and charges for publicly provided health services.[9] With provision of UHC, there will be improved access for the whole population to good-quality health services without the risk of financial hardship. Regrettably, the public sector in most sub-Saharan African countries lacks the capacity to provide range of services to the whole population for achieving UHC.

In the wider context of health financing policy and reforms, the Abuja target of increasing the public financing of 15% to health sector, is not only pre-defined spending target, but seen as a target to increase compulsory, prepaid and pooled financing to ensure greater health coverage and financial protection.[9] Health insurance is considered as an option to raise and pool revenues, as well as to provide financial protection in several African countries; Algeria, Gabon, Ghana, Kenya, Mali, Rwanda, Tanzania and Togo had already started practicing compulsory health insurance.[9] But the major methodical issues are that there are limitations of how to cover non-salaried employees engaged in the informal sectors and other marginalized groups.

## NEED AND POTENTIAL FOR COLLABORATION WITH THE PRIVATE SECTOR TO ACHIEVE UHC

The improvement of healthcare delivery in Africa is also constrained by gaps in financing. Sub-Saharan Africa makes up 11% of the world's population but accounts for 24% of the global disease burden; the region commands less than 1% of global health expenditure and the public-sector funding for healthcare remains uneven across the continent.[6] In addition to health financing issues, there are major challenges in improving health care in Africa. Currently Africa is undergoing rapid demographic, urban and epidemiological transitions that will have profound effects on the type, quantity and cost of health-care services for the future.[7] Additional epidemiological challenges, with the communicable disease burden still high, many countries are also facing an increasing threat from non-communicable diseases and injuries, imposing a direct financial burden on governments, employers and households. The sub-Saharan Africa has long faced a heavy burden of disease, with malaria, tuberculosis, and, more recently, HIV being among the most prominent contributors to that burden.[10] It remains the only major area in the world where the burden of infectious disease still outweighs the burden of non-communicable disease and injuries.[10] Many African countries, however, are still unable to provide basic sanitation, clean water and adequate nutrition to all of their citizens, and also those affected by

the latest onset of non-communicable diseases.[6] Another feature of Africa is that, it has among the lowest densities of skilled health professionals in the world. These countries, tormented by poor infrastructure, a shortage of skilled professionals and geographic and socio-economic inequalities, face an uphill struggle in delivering adequate healthcare.[6] Further to these major challenges, as we have already reported there is a burden of financing health care; an estimated health financing gap of $66 billion per annum for the continent based on the threshold of 5 per cent of GDP for government expenditure.[7]

The major highlight to be noted, when we talk about the African continent, there is a huge influx of private sector in health care financing, which can be seen as a huge gateway for improving health outcomes, enhancing labour productivity, creating employment, and accelerating progress towards SDG goals.[7] Therefore this influx of private sector should be seen as an opportunity to complement government financing. It is true that importance has to be given on strengthening the public health sector despite the resource limitations; while the private sector is a potential resource for covering the gaps in the public sector.[11] Improving access to care in underserved communities in Africa further requires stronger partnerships that leverage the unique skills and resources of governments, civil society and the private sector alike. When it comes to achieving UHC, the private sector's biggest potential impact lies in increasing, as well as developing business investment and scalable market-based approaches. There are five areas where the private sector can add unique value to help achieve UHC: understanding patient care, implementing innovations at scale, designing the right business model, building government capacity and innovations to meet local needs.[12]

Despite the many challenges, African governments need programmes that respond to malaria, TB and HIV/AIDS and, at the same time, strengthen health systems to deal adequately with chronic illnesses. Therefore the need for integrating disease-specific programmes into health system strengthening while tackling the same from a universal healthcare perspective within a basic benefits package, should be the answer.[8] Creating an effective environment for health financing and coupling the strengths of the private health sector are key strategies to help bridge the already mentioned health financing gap of $66 billion per annum. The policy level factors for pursuing PPPs, is principally motivated by securing increased funding, introducing private sector efficiencies and encourage public sector reforms.[13] These policy objectives lead to various PPPs characteristics of financial, legal and contractual complexities. This often led to long term political, financial and contractual commitment and between 2004 and 2017, around 30 African countries have adopted laws regarding Public-Private Partnerships.

## ROLE OF THE PRIVATE SECTOR IN AFRICA

In any country in the world, the private sector is not only a key stakeholder in development, but also an indispensable anchor and a well-performing private sector is a major contributor to the GDP and growth of countries, which are basic conditions for addressing issues related to poverty.[14] A well-performing national private sector grows GDP, generates millions of jobs, and thereby increases per capita income and generates revenues for the government through taxes to enable provision of much needed services, such as education and healthcare.[14] Moreover many governments are confronted by economic constraints that force them to carefully prioritize and restrict public expenditures and furthermore, many public health systems are already indebted and face added financial pressures.[15] Those governments that wish to explore other avenues can turn the private sector to help address specific cost and investment challenges, improved service provision and management at reduced costs and enhance service quality. [15] The governments are turning to the private sector to design, build, finance and operate infrastructure facilities previously provided by the public sector. PPPs offer policy makers an opportunity to improve the delivery of services, management of facilities, mobilizing private capital for investment in public services.[16] Therefore access to private capital can speed up the delivery of public infrastructure.

Currently much of the aid in Africa is concentrated on the global issues such as health, environment and food security.[14] The three main sources of financing health expenditure in Africa are public, private and donor agencies. A study of the National Health Accounts (NHA) estimates on the financial burden of 20 selected sub-Saharan African (SSA) countries reveals that, the main financing sources of health expenditure are the private sources contributing between 33% and 70.5% in 14 countries. The share of government contribution to financing the Total Health Expenditure (THE) is quite low in most of the countries.[17] The public contributed

less than one third in 15 countries, implying that the government commitment to financing health expenditure in these countries was playing just a second fidget to private sources. In some countries like Cote d'Ivoire, Democratic Republic of Congo, Liberia, Sierra Leone and Uganda, the public accounts for less than 20% of THE.[17] Dependence on external sources for financing health expenditure in SSA countries is significantly high, contributing on the average 30.3% of THE in the selected SSA countries.

If the poor countries have full decision-making powers over where aid should go in development, and if they have control over earnings from the private sector, which if fully developed, can cater to all the social and economic needs of the country; therefore a greater private-sector participation in development is strategic.[14] PPPs require governments to contemplate and behave in new ways that require new skills as these partnerships can be a tool for reforming procurement and public service delivery and not merely a means of leveraging private sector resources.[16] They need to be based on firm policy foundations and long-term political commitment. But these partnerships are not easy; both PPPs and PPCs may take a long time to establish and bring to fulfilment, and in many cases may not be the most effective or efficient option available.

## LIMITATIONS OF THE PUBLIC SECTOR AND HEALTH SYSTEMS STRENGTHENING AND ALIGNMENT WITH PUBLIC-PRIVATE COLLABORATION POLICY

Public–private collaborations in the provision of health services have a very long history in wealthy and developed countries, however, the same experience is not easily replicated where regulatory and financial institutions are weaker, as in most LMICs. Public-private partnerships are being increasingly encouraged as part of the comprehensive development framework.[18] The rise on the international advocacy for UHC and limitations in public health financing lead to the promotion of new health financing policies, which was adopted by many African countries such as health insurance, user fee exemption, and outcomes-based financing. The need for public-private partnerships arose against the backdrop of scantiness on the part of the public sector to provide this public good on their own, in an efficient and effective manner, owing to lack of resources and management issues.[18] These considerations led to the evolution of a range of interface measures that brought together organizations with the mandate to offer a public good on one hand, and those that could facilitate this goal though the provision of resources, technical expertise or outreach, on the other.[18] The former category includes governments and inter-governmental agencies, and the non-profit and for-profit private sector.

## POLITICAL ECONOMY OF PUBLIC PRIVATE COLLABORATION

Indeed, we have underlined the need for such Public Private Collaboration in the health sector especially in LMICs. But what we often hear are the botched outcomes of such partnership. Why does it even happen? This needs to be explored further from the policy level aspect of such collaboration and partnerships. Some of these outcomes are mainly due to conflicting goals and motivations of governments and their private-sector partners in PPPs. To judge the value of any given PPP, it is best to analyse it from two perspectives. One method is from a societal perspective; like how it is going to improve or enhance the value of PPPs in the maximization of social welfare.[19] What is often referenced and through observation of the policy environment is that, such collaborations are supported by and used by governments in the context of limited resources or in the case of deferring expenditures or when placing expenditures 'off budget'; cannot justify the actual role of such partnerships which leads to destruction of social value rather than its development.[19] Another way of judging the value of PPP is through the political economic perspective, which focuses on governments' actual motive. From a political, economic perspective, for understanding the outcomes of PPP, it can be considered as a form of regulation, in terms of what government should do in the presence of market failures.[19] Therefore in health sector, PPPs have emerged as a policy option mainly on the context of limited and constrained budgetary support and in the context of dominance of neo-liberal ideas, such as new public management in the ongoing health sector reforms.[20]

From a policy level aspect, the three core elements of PPPs consist of autonomy of each partner, mutual assurance to settled objectives, and mutual benefit for the stakeholders. But most often it is misunderstood as an attempt at privatization, especially when a private entity is part of such partnerships. In fact PPPs describe a range of possible relationships among public and private entities in the continuum between nationalization and privatization, depending upon the objectives which they seek to succeed.[20] Our major aim with PPPs are that the proposed government goals should be considered with crucial interest as our aim is to deliver a public good, no matter who delivers or funds them. Therefore by combining a political economic perspective of PPPs with normatively appropriate goals for government, a realistic PPPs outcome in terms of social welfare can be prepared.[19] But what we often see is that, at the end, the reality of such partnership, where the governments' tendency is to maximize votes, partners tendency to profit maximize, and users' tendency to want free infrastructure services results in some unpredictable consequences of PPPs.

Enabling factors for effective PPPs includes sustained political support and public sector commitment needed for developing and implementing effective PPPs, through government support.[13] The government should be able to create a favourable investor climate for private sector investment in public sectors. Public sector should be able to assess the risk management effectively and finally both the partners should work in the protection of public interests.[13]

This following section covers the operational issues with Public-Private Partnerships (PPPs) and Public Private Collaborations (PPCs).

## DEFINITIONS

The term 'Public Private Collaborations' is used interchangeably with the term 'Public-Private Partnerships' in the health sector. Although it sounds similar, it is imperative to know if there exists any significant difference between these two significant and considerable terms. Whether its PPCs or PPPs, there is an interactive fairness between the government and the private entity, where each does something for the other to achieve a common public good. It is important to unpack the meaning of Public Private Partnerships as it is a commonly used terminology, used in the health sector. The concept of PPPs materialized in the early 1990s. Most of the literature accepts that there is no uniformly accepted definition for PPPs in general. PPPs is defined as *"a long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility and remuneration is linked to performance"*.[21] According to Rodriguez, a Public-Private Partnerships is a contract between a governmental body and a private entity, with the goal of providing some public benefit, either an asset or a service.[22] PPPs typically are long-term and involve large corporations on the private side. A crucial component of these contracts is that the private party must take on a significant portion of the risk for the contractually specified remuneration that the private party receives for its participation which normally depends on its performance. However Rao K.S. in her book; PPPs defines this as *"the combination of a public need with private capability and resources to create a market opportunity through which a public need is met and profit is made"*.[23] A working definition of Public-Private Partnerships constitutes; first, that these partnerships involve at least one private for-profit organization and at least one not-for-profit or public organization. Second, the partners have some shared objectives for the creation of social value, often for disadvantaged populations and finally, the core partners agree to share effort, risks and benefits.[24]

Largely, the term 'collaboration' refers to relationships in which two or more parties work together voluntarily to serve a mutual interest, ranging from formal to informal partnerships.[25] The framework of an empirical model of collaboration suggests that the environmental context in which public-private partnerships operate, the structure and configuration of participating organizations and the nature of potential activities will affect collaboration.[26] Public Private Collaborations (PPCs) should be distinguished from the realm of simple contracting out services and kindness in allocation of services. Because PPCs are a larger concept and most often encompass the PPPs, as most often, such partnerships involves collaboration between partners. An unique form of PPCs, named collaborative governance is defined as *"the pursuit of authoritatively chosen public goals by means that include engaging the efforts of, and sharing discretion with, producers outside of government"*.[27] The reasoning for such collaboration emerges from the miserable budgetary allocation, widening gaps in health service delivery and private investment in areas where there are no providers.

Therefore, in tangible terms, Public Private Partnership is a kind of collaboration which occurs between public sector and private sector and it is a form of relationship where the public sector engages a private partner to increase the amount of private capital on delivering a public good. PPPs are clearly not privatization and they do not involve disinvestment or getting the public sector out of providing services.[28]

## KEY TYPES

There are four basic dimensions that describe the partnerships: scope, partners, level of commitment and type of objective.[1] The scope of a partnership will be at one of three levels: local, national or global. Within public-private partnerships, under discussion, there are many different types of partners such as private-for-profit companies and individuals, private-not-for profit organizations, donor organizations that include multinational, bilateral or private donors.[1] Another dimension of partnership is the level of commitment of the partners to the partnership, the goals and to each other. One way of looking at the level of commitment between two organizations is the level of decision making which will be shared: whether the partnership occur at the governance level or at the managerial level with shared funding and control in only a limited area, or at the operational level at which tasks but not strategies are shared.[1] The fourth dimension by which partnerships vary is in the type of objective that is to be achieved through the development of a partnership. This could include the basis of financial goals to reduce the total cost of the production of services; disease specific objectives like eradication of a disease; objective to improve access to health services; or the development of any relevant innovative approaches in health sector.[1]

PPPs and PPCs in the health sector can take a variety of forms with differing degrees of public and private sector responsibility and risk; characterized by the sharing of common objectives, as well as risks and rewards and here the private sector partner may be responsible for all or some project operations, and financing can come from either the public or private sector partner or both.[15] Several key types of PPPs and PPCs are frequently encountered in the health sector, depending on the objective they seek to fulfil.[20] Contracting-out involves publicly-financed investments aiming to improve efficiency and quality by awarding a service contract, a management contract, a construction, maintenance, and equipment contract, or various hybrid contracts to serve a specific need or situation, or a lease to a private partner or partners.[15] is the traditional public contracting for clinical and non-clinical services in the health sector. Here a private operator operates and delivers public funded health services operating on a performance-based contract or as concession lease.[5] Partnerships can also enhance the technical strength by capacity building training to improve the clinical skills of professionals as well as involving corporate sector and professional associations for improving and delivering public health to all.

Concessions are arrangements with the private sector in which, for existing facilities, asset ownership remains in public hands but where the private partner is responsible for new investments, as well as operating and maintaining the existing assets. Different contract types, such as performance-based management contracts, leases, build-operate-transfers or even divestitures under license, can be used and have various degrees of underlying risk allocated to the public and private parties.[5,15] There are various types such as: BOT (build, operate, and transfer) or DBFO (design, build, finance, and operate) or when the infrastructure is not returned to the public sector, referred to as BOO (build, own, and operate) contract.[16] In a concession PPP, a public authority grants a private party the right to design, build, finance, and operate an infrastructure asset owned by the public sector for a fixed period, after which responsibility for operation reverts to the public authority.[16] The private party recovers its investment, operating, and financing costs and its profit by charging members of the public a user fee. Concessions typically shift much of the investment risk to the private sector, although the government often provides an explicit or implicit guarantee to protect the private partner against the risk of lower than expected revenues or other related risks. Private Financing Initiatives (PFIs), which normally involve a concession contract, have evolved in practice as a distinct means of funding major capital investments in the health sector through financing provided by private partners.[15]

Some other forms of partnerships address the access issues like introducing voucher schemes like a service purchase coupon for consultations, lab tests, surgical procedures and drugs.[5] Some modes of addressing access issues in difficult terrain where transport connectivity is a challenge is through the introduction of mobile health units by partnering with private sectors. Introducing community-based health insurance is a way

to reduce out-of-pocket expenditures among poor and to make health care costs affordable is also a kind of partnership.[5] By providing autonomy to health service establishments, lending more flexibility in decision making, and improving efficiency and accountability are also seen as a part of the form of partnerships. Another mode of partnership aims at outreach activities through social marketing as well as partnering with grass-root organizations.[5]

## PREREQUISITES OF PUBLIC PRIVATE COLLABORATIONS IN HEALTH SECTOR

In this section the paper appraises the process for implementing PPCs through the various frameworks for delivering PPCs, project management and assessment of PPPs and with a brief on the procurement phase of PPPs. In the context of limited public funding, governments around the world are backing the concept of public-private collaborations in health sector. There are four key factors driving governments to use the PPP model for health sector improvements [28]:

- The desire to improve operation of public health services and facilities and to expand access to higher quality services.
- Opportunities to leverage private investment for the benefit of public services.
- A desire to formalize arrangements with non-profit partners who deliver an important share of public services.
- Developing additional partnerships for governments as private healthcare sector develops.

Diplomatically, the concept of public-private partnership has been advertised as a mystic recipe that will fix a country's infrastructure and service blockages, reduces the problems of privatization, either the rising prices, job losses, corruption and the sale of public assets; while maximising the benefits to society. Nevertheless, the various experience in Africa shows that PPPs suffer many of the same troubles as that of privatisation and public tendering.

## FRAMEWORKS FOR PUBLIC-PRIVATE PARTNERSHIPS

Owing to these challenges outlined, a proper foundation is vital to provide a clear public-private partnership (PPP) policy rationale, a legal framework, an investment framework including an approval process, along with a well-organized operating framework. Informing potential investors of their existence will ensure a much better private sector response when project procurements are launched.[16]

**i) PPP Policy Rationale[16] –** A policy framework helps both the public and the private sectors to understand the core rationale for PPPs and how the public sector will go about making them happen. The private sector expects to see a PPP policy that sets out the rationale for using PPPs; the guidelines that the public sector will use to assess PPP projects in a reliable way; the determination of who approves what and when throughout the process of project selection, preparation, and procurement; and the process of resolving disputes. The more transparent the objectives, targets and consequences of the PPP, the more effective the partnership will be.

**ii) Legal framework[16] –** Legislation may be needed to allow a private sector company to charge and collect user fees under a concession PPP. Specific laws may also be required to allow the public sector to contract with private bodies for the delivery of services previously provided only by the state. Investors have a strong preference for certainty, detail, and clarity in the legislative framework. It may be preferable to set out core principles based on international best practice in framework legislation and to use administrative rules to set out more detailed laws that may respond in a logical and consultative way over time to inevitable changes in policy and the market.

**iii) Investment Framework[16]** – PPP programs often start with one-off projects that deliver experience and build confidence in the ability of government to develop programs later. Wherever possible, an infrastructure investment plan is a good way for government to present its approach to investment to the private sector and to demonstrate top-level political commitment. Such plans generally do not commit to using the PPP process

for the entire program, but instead set out the level of investment required, the links between private and public investment, and areas within the plan where government expects PPPs to play a role. A well-prepared investment plan that sets out project plans help the private sector to understand the general environment for individual projects and also encourage more bids from high-quality investors; therefore investors are more likely to take an interest in a program than in a one-off project.

**iv) Operating Framework[16] –** This is important as investors want assurances that the operating framework within government is capable of managing the PPP process and that policy makers and the parties implementing projects have a realistic understanding of the complexity of PPP projects. In particular, public procurement authorities often fail to appreciate the significant differences between PPPs and traditional forms of procurement in terms of level of resources, unique skills, and the new processes and institutions required.

Overall, for any successful public-private partnerships, there should be clarity in the policy framework, as the private sector needs to understand the drivers that lie behind the projects.[16] As well establishing a clear legal framework is essential, as PPPs depend heavily on contracts that are effective and enforceable.[16] Use of legal terms and approaches, which are familiar to the international private sector helps in drawing up investment plans, which can be useful to demonstrate high-level political support, which indicate the potential flow of future projects. Such credibility skills can send a powerful signal to the private sector about the public sector's competence and seriousness of intent.

## PROJECT MANAGEMENT FOR PUBLIC-PRIVATE PARTNERSHIPS

The project selection phase involves a series of steps; such as to conduct a high-level review of the services need, the justification for a project and its prospects for delivery as a PPP. The government may rely on key advisers to help the public sector with its decision making; as projects that are unlikely to deliver the government's overall policy requirements or that have few prospects as a PPP can be eliminate at an early stage, before incurring significant costs and damaging the credibility of the project and the government.[16] The next step seeks to turn the projects with a greater chance of success into realistic opportunities for private sector participation through initial market assessment, although projects may be eliminated throughout the process. The project selection phase seeks to answer three key questions, initially at a high level and then in more detail as the project becomes defined more clearly, in an iterative manner:[16]

- What are the project's scope and requirements?
- Can the project be delivered as a PPP?
- Should the project be delivered as a PPP?

A disciplined approach to establishing the scope and requirements for a project usually involves identifying the business need, assessing the relative costs and benefits of different options for project investment. The public sector's requirements need to be identified clearly and unmistakeably and expressed in the form of an output requirement. For delivering the project as a PPP, it is always necessary to look into: affordability - as who will pay for the project and how, risk allocation - what are the risks inherent in the project, and how should these be dealt with, bankability - will the resulting project be able to raise the required debt financing and attract contractors and other equity investors.[16] Finally the question of value for money for the project to be delivered as PPP. Governments can consider the case for a PPP project in the light of its potential impact beyond the project itself and its wider policy benefits, like procuring a public service through a PPP can drive change or reform, in effect holding up a mirror to the existing delivery of public services.[16]

The project preparation phase has two major aspects.[16] Foremost is the activity of ensuring that the public sector is adequately prepared and organized to manage the process. This activity is likely to include greater use of external advisers and consideration of budgets to fund the work. Following, is the parallel activity of completing the full project assessment to ensure that the project is being developed on a comprehensive basis. Good governance and good project management, along with risk mitigation and quality control, are essential elements of managing a successful PPP process.[16]

## PROJECT ASSESSMENT FOR PUBLIC-PRIVATE PARTNERSHIPS

Assessing the various factors that affect the scope, affordability, risk allocation, value for money, and contract development of a project involves various skills in the project assessment phase.

**i) Legal Assessment[16] –** In this step, the issues that are internal to the public authority like whether there are no legal impediments to the public authority entering into the various project agreements, and that the procurement process envisaged is legal or not are assessed. The legal assessment also covers the relationship between the public authority and the project and between the project and other relevant parties, that is, issues that may be considered external to the authority. The legal team also needs to develop other key components of the PPP contract, including provisions for resolving disputes and mechanisms for governing changes in the project.

**ii) Technical Assessment[16] –** It determines whether the project's output requirements are technically feasible, and the likely capital and operating expenditure required. Designs with reasonable detailing may be developed in certain projects, to illustrate to the bidders how the output requirements may be interpreted and to support estimates of the likely project costs for the affordability assessment. There may also be an insurance review at this stage to assess the likelihood of transferring risk to the insurance markets, the expected costs, and the availability of insurance cover. An important component of the technical assessment is an analysis of environmental and social issues to ensure that there are no adverse environmental or social impacts to hamper delivery of the project.

**iii) Financial Assessment[16] –** It involves various activities like by bringing together the various elements of project cost, enables an analysis of the expected long-term project revenue requirements, which are particularly relevant to the affordability analysis. This analysis estimates the expected level and conditions of debt and equity funding required and the exposure to long-term currency mismatch or interest rate movements.

## PROCUREMENT PHASE OF PUBLIC-PRIVATE PARTNERSHIPS

The purpose of the procurement phase is to develop and conduct a process that accomplishes the following: selects a bid, maximizes the benefits of competitive tension between bidders, delivers the best bid from the most competent bidder, minimizes time and cost and stands up to scrutiny from citizens and both the public and private sectors.[16] The PPP bidding process is usually divided into a series of steps and these steps ensure that increasingly detailed information is provided by both the public and the private sectors and that evaluation takes place to ensure an effective process while minimizing the time and costs required of both parties.[16] Another objective is to elicit comparable bids, throughout the process. The public authority needs to be mindful of the output requirements and affordability limits of the project. In the later stages, the public authority is usually more interested in the quality of bids; higher-quality bids with better information are likely to receive a smaller number of well-qualified bidders.[16] By reducing the number (around 3 to 5) of bidders to a manageable size, the public authority also needs to have enough bidders to ensure a healthy dose of competition.

## IMPLEMENTATION ISSUES AND CHALLENGES OF PUBLIC PRIVATE COLLABORATION IN THE HEALTH SECTOR

This section covers the various systemic design and operational challenges of Public-Private collaboration in health sector.

Although there are immense benefits associated with any Public-Private Collaboration; we should be cautious enough to think that private sector investments need to be a responsible investment that accepts the social responsibility and mutual commitment of such collaboration. The major ethical challenge is that there is lack of global norms and principals to set frameworks as most of these partnerships are global in nature.[18] It involves different jurisdictions and multiple procurement authorities, placing further pressure and risks on governments

as the private sector does not expect to have to resolve jurisdictional issues.[16] Mark Malloch-Brown of UNDP was quoted as saying that bringing private capital and innovation into development should not be through models that are privatizing development but rather adding a private-sector dimension to development.[8] Further such collaboration requires those in the development community to suspend their suspicion of the private sector and to help governments create an enabling environment for effective, responsible business engagement in development. Therefore, contribution to common goals and objectives for both partners should be enabled while pursuing a relationship.[18]

In the midst of these goals and objectives, what is lacking in such collaboration is a strong regulatory mechanism by the government which ensures and protect individuals and communities by ensuring the quality and safety of services provided as well as incentivizing private-sectors actions that align with the health needs of peoples. In the developing world, there is a general failure, to have overarching legislation relating to public-private partnerships and as a result, such arrangements develop on an ad hoc and opportunistic basis and may have questionable credibility, because of the failure of specific operational strategies.[18] Mary Lou Valdez from the U.S. Food and Drug Administration (FDA) indicated that such regulatory authorities and systems do help to drive science-based approaches, data and transparency for decision making and actions.[4] As Valdez suggested, these regulatory systems are essential for the success and sustainability of global health investments from all stakeholders across civil society, industry, government, and international organizations. Juergen Voegele of the World Bank suggested that achieving the SDGs across nations will not be possible without addressing the policy, legal, and regulatory environment in each country.[4] He further added that although there are industries to invest in LMICs, the public sector of these countries should ensure and develop operating environments for private-sector engagement.

PPP governance consist of rules and procedures that define the incentives and restrictions guiding the strategies of the various stakeholders that participate in a PPP project cycle.[29] From a regulatory standpoint, good PPP governance can promote PPPs that create social value. Workable partnerships require a well-defined governance structure to be established to allow for distribution of responsibilities to all the players.[18] But many governments in LMICs face major challenges with the private sector because their existing governance and regulatory arrangements are not designed to effectively manage and coordinate mixed health systems.[30] For example the for-profit private sector in many countries are not appropriately managed or regulated which can threaten the basic concept of UHC. One another challenge for the governments in these LMICs is that they lack the capacity to connect the efforts of the not-for-profit private sector to help meeting the health objectives of governments.[30] Here the governments find themselves incapable of using of governance tools to help align the activities of their private partners with national priorities. Such strong collaboration requires strong government policy position on private providers, which is often seen lacking in many countries. As Clarke D. et al. suggests with regard to private participation in delivering UHC a 'public policy vacuum' exists; as the private sector comes up with its own policy, which are supply-side driven and may not align with UHC deliverables or national priorities which are demand driven.

It is an accepted norm that there are some policy related issues in collaborating with private sector, such as insufficient PPP implementation guidelines for monitoring or performance; auditing; lack of proper maintenance approach for the whole long term operational phase of the partnerships and; failure of assessment of unforeseen risks and issues with life cycle assessment of assets.[31] There are also reported cases of negotiation issues between the partners as public–private partnership as a kind of procurement strategy. There have been problems associated with the initial stages of the process in terms of unduly high bidding costs and pre-contract time overruns due mainly to the extended nature of the negotiations. The criteria for selection are an important issue both from an ethical and process-related perspective as it raises the questions of competence and appropriateness.[18] In many instances the public sector is vague about important issues related to screening potential corporate partners and those in the non-profit sector. PPP agreements are particularly vulnerable to corruption because of their complexity and the central role of its design stage.[32] Corruption practices in public procurement can take place at different stages of the procurement process such as in planning, tendering, contracting, or execution. Many partnerships do not ensure all players accountable for the delivery of efficient, effective and equitable services in a partnership arrangement. Often in public-private relationships it is unclear as to whom are these partnerships accountable to, according to what criteria, and who sets the priorities?[18]

The wide diversity of such partnership, plurality of providers imposes complexity of the PPP structure and therefore monitoring, and regulation becomes a mammoth task. The complex global nature of some of these partnership arrangements necessitates that they be guided by a set of global principles and norms. Participation of international agencies warrants that they are set within a comprehensive policy and operational framework within the organizational mandate and involvement of countries requires legislative authorization, within the framework of which, procedural and process related guidelines need to be developed.[18]

## CONCLUSION

To attain healthy lives for all by 2030 and to achieve SDG goal, it is important to acknowledge the role of the private sector. The power and influence of Public Private Collaboration, within the national interest and priorities of most LMICs will help to achieve UHC in the long run. For this there is a need to design new models of such Public-Private Collaboration rooted in strong partnerships. This will firmly support each country to attain the three dimensions of Universal Health Coverage: population coverage, service coverage and financial risk protection.

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