



Public financing partnerships to improve private sector health care: Case studies of intermediary purchasing platforms

**UCSF** Institute for Global Health Sciences  
Global Health Group

**Evidence to Policy Initiative**  
The Evidence to Policy Initiative is a project of the Global Health Group at the UCSF Institute for Global Health Sciences.

**Public financing partnerships to improve private sector health care: Case studies of intermediary purchasing platforms**

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# Abbreviations

CHMI	Center for Health Market Innovation	MOH	Ministry of Health
CHAM	Christian Health Association of Malawi	NGO	non-governmental organization
CHAZ	Churches Health Association of Zambia	PBGA	performance-based grant agreement
CHS	commune health station	PPP	public-private partnership
DHO	district health office	SLA	service level agreement
MSV	Marie Stopes Vietnam	TCE	Tinh Chi Em
MOU	memorandum of understanding	UHC	universal health coverage

# Executive Summary

Private providers play a key role in the health systems of many low- and middle-income countries, often providing a large percentage of all health services. At the same time, the private sector is commonly under-regulated and poorly integrated into the public health system – leading to concerns about the fragmentation, quality, and affordability of private health services. To improve the performance of private health providers, policymakers are calling on national governments to take an active role in stewarding both the public and private sectors and are implementing new management and governance strategies to shape the private health market.

One model that shows promise for improving the integration and performance of private providers is the intermediary model. Intermediaries are “organizations that form networks between small-scale private providers in order to interact with governments, patients, and vendors while performing key health systems functions that are challenging for individual private providers to do on their own.” The Center for Health Market Innovations identified six key functions of an intermediary: (1) proactive population management, (2) facilitating comprehensive care, (3) providing effective systems for quality and quality improvement, (4) building management capacity, (5) providing platforms for community engagement, and (6) providing platforms for payment coordination and bulk buying.

While this model holds potential for solving many problems in the private sector, there is little evidence about how intermediaries establish partnerships with governments to achieve these core functions. To close the evidence gap, this report highlights six intermediary programs in Latin America, Asia, and Africa that have successfully developed partnerships with the national government to foster private sector integration. The report provides an in-depth profile of each organization’s financial, managerial, and partnership model; identifies key success factors, challenges, and opportunities

faced in partnership development; and highlights common lessons learned for other private sector organizations seeking to work with the public sector.

Case studies on the Christian Health Association of Malawi and the Churches Health Association of Zambia provide insight into how these faith-based provider networks established agreements with national health ministries, and the terms that have enabled long-term and mutually beneficial partnerships. Case studies on Karuna Trust in India and Possible in Nepal explore partnerships in which non-governmental organizations provide essential health services with public financing, while also implementing innovations in service delivery and health systems strengthening. A brief profile on the State of Hidalgo Public-Private Partnership highlights outcomes from one of the first public-private partnerships in Mexico’s Seguro Popular program. A final case study on Tinh Chi Em in Vietnam describes how a donor-supported social franchise became integrated and financed by local government health systems.

Our findings identify eight key lessons for intermediaries seeking to establish public-private partnerships. These highlight the importance of developing shared public health goals and a mission aligned with that of the public sector; building strong relationships through consistent communication, clear contractual agreements, and formal accountability mechanisms; working at both the national and sub-national level; actively engaging in the policymaking process; building information and delivery platforms that can be integrated into public systems; and focusing on innovation and impact.

Our hope is that this report will be used by policymakers and implementers from health agencies, intermediaries, and other private sector organizations to guide the development and implementation of innovative models for building mixed health systems that leverage the strengths of both the public and private sectors.

## Introduction

In many low- and middle-income countries, private providers deliver a large proportion of all health services, playing a key role in a country's health system. The private sector is often diverse, ranging from small independent drug shops or clinics, to pharmacies, traditional healers, non-profit clinics, religious hospitals, and for-profit specialty hospitals and chains. The private health care market is also commonly un- or under-regulated due to limited capacity of government health system managers, raising concerns about the quality of care provided in the private sector. At the same time, the private sector is typically not well integrated into the public health system, and relies instead on out-of-pocket payments by customers. This raises additional concerns about access and affordability for clients whose nearest health facility may be a private one.

Health policymakers are increasingly calling for health system managers to establish unified regulatory and financing systems in which national governments take an active role in stewarding both the public and private sectors.<sup>1,2</sup> Such a model can be difficult and burdensome for the public sector given the fragmentation in the private sector. The Center for Health Market Innovation (CHMI) recently conducted research showing that “intermediaries” could be one model for facilitating better engagement between the government and the private sector. CHMI defines intermediaries as “organizations that form networks between small-scale private providers in order to interact with governments, patients, and vendors while performing key health systems functions that are challenging for individual private providers to do on their own.”<sup>3</sup> This research identifies six key functions of an “ideal” intermediary: (1) proactive population management, (2) facilitating comprehensive care, (3) providing effective systems for quality and quality improvement, (4) building management capacity,

(5) providing platforms for community engagement, and (6) providing platforms for payment coordination and bulk buying.

While intermediaries theoretically offer great potential for solving many of the problems in the private sector, relatively little is known about how these intermediary organizations establish partnerships with governments or implement systems to achieve the six key functions. Similarly, information is limited on the impact of these intermediary models on private sector performance and public sector management and stewardship capacity.

To address this knowledge gap, the Global Health Group's Evidence to Policy Initiative at the University of California, San Francisco conducted a series of case studies of six private sector programs that have established purchasing relationships with the public sector. We focused specifically on purchasing platforms because this function provides an explicit link between the public and private sectors and can enable the establishment and sustainability of public-private partnerships. Recent research points to strategic purchasing as a way to integrate private sector providers into public health systems, but evidence is limited on how governments and private providers can initiate purchasing agreements, leverage different financing mechanisms, and manage partnerships over time.<sup>4</sup> This series explores these practical considerations across a range of purchasing platforms.

## Methods

We conducted case studies of six intermediary programs in Africa, Asia, and Latin America. Intermediary programs were eligible if they had established a purchasing arrangement with the public sector enabling the program to receive public funds to support their work. We selected programs to represent a diversity of intermediary models – social franchises, faith-based networks, for-profit private clinic chains, and management models – to understand how different types of private sector networks engage with the public sector. Case study programs include: Christian Health Association of Malawi, Churches Health Association of Zambia, Karuna Trust in India, Possible in Nepal, Tinh Chi Em in Vietnam, and the State of Hidalgo-MediAccess PPP in

1 McPake B, Hanson K. Management the public-private mix to achieve universal health coverage. *Lancet*. 2016. Aug6;388(10044):622-30. [https://doi.org/10.1016/S0140-6736\(16\)00344-5](https://doi.org/10.1016/S0140-6736(16)00344-5).

2 Morgan R, Ensor R, Waters H. Performance of private sector health care: implications for universal health coverage. *Lancet*. 2016. Aug6;388(10044):606-12. [https://doi.org/10.1016/S0140-6736\(16\)00343-3](https://doi.org/10.1016/S0140-6736(16)00343-3).

3 Aiyenigba E, Arias J, Bolender T, Dimovska D, Lagomarsino G, Soyinka O. Intermediaries: The Missing Link in Improving Mixed Market Health Systems? Results for Development Institute. July 2016. [http://healthmarketinnovations.org/sites/default/files/R4D\\_Intermediaries\\_Web112216.pdf](http://healthmarketinnovations.org/sites/default/files/R4D_Intermediaries_Web112216.pdf).

4 Montagu D, Goodman C. Prohibit, constrain, encourage, or purchase: how should we engage with the private health-care sector? *Lancet*. 2016 Aug 6;388(10044):613-21. DOI: [https://doi.org/10.1016/S0140-6736\(16\)30242-2](https://doi.org/10.1016/S0140-6736(16)30242-2)



Mexico. Table 1 shows each of the case study programs and which of the key intermediary functions they include in their model.

To complete the case studies, we conducted interviews with key stakeholders for each intermediary program including: staff responsible for negotiating and managing partnerships and financial contracts with the public sector at both the national and local level; representatives from government offices that work with the intermediary at both the national and local level; staff at member clinics in the intermediary networks; and experts in the field of private sector health care and health systems. Interviews for five programs were conducted during two-week field visits to the program

site, while interviews with staff from Mexico were conducted by phone. We completed 90 interviews from March to June 2017. The study received exempt Institutional Review Board approval from the University of California, San Francisco.

This report provides a brief overview of each of the intermediary programs, profiling the organization's history, funding structure, financial management, and the benefits and challenges of the public-private partnership from the perspective of both the private sector and public sector. Following this, we then identify key factors contributing to the success of these models, and draw potential lessons for other private sector programs seeking to engage public sources of finance.

**Table 1. Case study program intermediary features**

Key intermediary function	Christian Health Association of Malawi	Churches Health Association of Zambia	Tinh Chi Em	Karuna Trust	Possible	Hidalgo-MediAccess PPP
Proactive population management					√	√
Facilitating comprehensive care				√	√	√
Providing systems for quality and quality improvement	√	√	√	√	√	√
Building management capacity			√	√	√	√
Providing platforms for community engagement	√		√	√	√	
Providing platforms for payment coordination	√	√	√	√	√	√

# Christian Health Association of Malawi

## History

The Christian Health Association of Malawi (CHAM) was founded in 1966. Many churches in Malawi had been providing health services for many years prior to the creation of the CHAM network; however, with the formation of CHAM, the faith-based community of health providers began to formalize both the services they provided and their relationship with the government of Malawi.

### Program basics

- CHAM operates a network of 174 health clinics and hospitals offering a diverse range of health services.
- Each facility maintains its own identity, staff, and management, and determines which services to offer based on community demand and facility capacity.
- The CHAM Secretariat establishes professional and clinical standards that facilities must adhere to, supports and oversees facility management and quality, accredits member facilities, and serves as the liaison between the government and CHAM-affiliated churches and facilities.
- CHAM operates 11 training colleges that provide medical and nursing training and certification.

Between 1966 and 2002, CHAM and the government collaborated in a number of ways, such as by including CHAM facilities in free drug distribution programs. During this time, a District Health Office also piloted a small program with the CHAM facility in the district, reimbursing the facility for service provision and engaging the facility more actively in the public health system. The success of this pilot formed the motivation for and basis of the national partnership between CHAM and the Ministry of Health (MOH). In 2002, CHAM and the MOH signed their first Memorandum of Understanding, formalizing their relationship and initiating the MOH's first large scale financial support of a private sector partner.

## Funding structure

CHAM is funded through a range of sources including government, external donors, and out-of-pocket payments from patients. CHAM facilities receive three primary forms of support from government, including (1) payment of **staff salaries**, (2) **reimbursements for service delivery** for a select set of services, and (3) free or subsidized **essential medicines** for programs including TB, HIV/AIDS, immunization, and several other maternal and child health conditions. These sources fund between 40 – 60% of facility costs, with the remaining funding coming from out-of-pocket payments and private donations. The CHAM Secretariat is funded almost entirely by bilateral governmental donors and international non-governmental organizations (NGOs). The Secretariat also runs several business ventures including managing rental properties and providing loan services to hospital and facility members to supplement their income. The Secretariat does not receive any direct funding support from the government; rather, CHAM facilities pay annual membership dues equivalent to 1.5% of the salary support provided by government.

Two contracts govern the financial terms of the relationship between CHAM and the MOH. The first is a **Memorandum of Understanding (MOU)** that broadly outlines the terms of the relationship between CHAM and the Ministry of Health, including the terms of the financial payments from the MOH to CHAM, the criteria and process for CHAM facilities to maintain participation in the government-funded portions of the CHAM network, and the process and terms for resolving disputes and re-negotiating contracts. In negotiating the MOU, CHAM engaged with multiple units within the MOH including the planning and human resource divisions, as well as the Ministry of Justice and the Ministry of Finance.

### Key terms of the MOU include:

- The MOH provides salary support for approved staff in approved CHAM facilities. To be eligible for salary support, CHAM facilities must be located a minimum of eight kilometers away from the nearest public health facility. There are a small number of exceptions made for facilities within eight kilometers but separated by geographic barriers that make access difficult, or in large population centers with need for more than one facility. CHAM facilities must also meet certain criteria related to



the type of services they provide. Facilities that apply for membership in the CHAM network are first assessed and approved by the CHAM Secretariat, and then assessed by the MOH to verify compliance with membership criteria and establish salary budgets.

- The Human Resources Department at the MOH approves the number of staff eligible for salary support at each facility. The MOH assesses each facility to determine the number of staff and a budget for salary support for the facility. The CHAM facility is then responsible for staffing those positions, although the MOH planning and human resources departments participate in developing recruitment plans.
- The government provides subsidies to students attending the CHAM training colleges, with the agreement that 60% of all graduates will work in MOH-run facilities, and 40% will be employed in CHAM facilities.

The second type of contract is **Service Level Agreements (SLAs)** between CHAM facilities and District Health Offices (DHO) in the districts in which they operate. SLAs enable CHAM facilities to receive reimbursement from the DHO for providing services, and are updated annually. SLAs outline the services for which facilities are eligible for reimbursement and the reimbursement amounts. Currently, SLAs cover a limited set of maternal and child health services, however, each SLA includes a different set of services informed by the capacity of the facility and needs and funding constraints of the DHO. Reimbursement rates typically cover around 70% of the cost of service provision in CHAM facilities. The decision to implement an SLA is up to each facility and DHO, and not every CHAM facility has signed an SLA.

#### **Key contractual terms of the SLA include:**

- Maximum reimbursement amounts are set in advance based on the population in the facility's catchment area. Reimbursement rates for each type of service are standardized at the national level by an SLA task force, but the maximum reimbursable rate is set annually for each facility based on assessment by the DHO.
- The type of services eligible for inclusion in the SLA are determined by the DHO based on an assessment of facility capacity, the health needs of the catchment area, and the availability of financial resources at the district level.
- Services covered by the SLA must be provided to patients free of charge.
- Only services provided to patients living within a facility's catchment area are eligible for reimbursement.

The Secretariat manages the finances for the MOU and SLAs. The Secretariat manages payroll for salaries provided by the MOH by invoicing the MOH, and then distributing payments from the MOH to each facility. Reimbursements from the SLAs also pass from the MOH to the Secretariat. Facilities invoice the DHO, which reviews and approves the claims. Once approved, invoices are sent to the Secretariat, which consolidates them into a single invoice submitted to the MOH. Upon receipt of funds from the MOH, the Secretariat disburses funds to the facilities. Initially, payments were made directly by the DHO, but delays in payments led to the consolidation of payment at the national level.

## Benefits

### **Government support enables facility sustainability while maintaining service affordability.**

The largest cost of any CHAM facility is staff salary, and it was challenging for facilities to adequately staff their programs exclusively through user fees and donations. CHAM credits the MOU agreement with keeping many facilities open. Without this salary support facilities had to charge a higher price for services to maintain operations; salary support allows facilities to subsidize services and reduce user fees. For those services eligible for reimbursement through the SLA, service delivery is free. Both CHAM and MOH staff report an increase in the number of people using CHAM facilities following the introduction of the public funding model, and credit the model with increasing service delivery to the poor.

### **The government partnership raises the profile of CHAM.**

The formal affiliation and partnership with the MOH has increased the credibility of the organization in the eyes of patients and other partners. There is greater awareness of CHAM, and more people use the facilities as a result. The DHOs also refer more to CHAM facilities after the introduction of the SLAs.

*“If we charge exorbitant prices to the poor masses then nobody will come to access our facilities and the poor will not get medical services. Then how fair are we as a nation? Because of that, the building principle of the MOU is universal health coverage. Make sure everybody has access to health at a reasonable price. We know that if the facilities have to find their own money to pay salaries, they will have to charge commercial rates. That's why we said we need to partner with the government to ensure that the unreached people are reached.”*

*– National CHAM staff*

### **The government partnership enables participation in national policymaking.**

Given the scale of the CHAM network, the government sees CHAM as a key partner in the health sector, and has engaged CHAM in policy-making at the national level. CHAM participates in the health sector working group at the MOH, and in a number of administrative decision making bodies such as the SLA task force. This enables the CHAM Secretariat to advocate for the needs of member facilities at a high level.

“The fact that we’re associated with the Ministry of Health, has improved our reputation as an organization, and we use it. We use it as a negotiating tool when we’re trying to approach partners and donors.”

*-National CHAM staff*

### **The partnership with CHAM facilitates achievement of universal health coverage (UHC) goals.**

The MOH’s strategic plan for UHC includes a goal of all people having access to a health facility within eight kilometers. CHAM, with 174 facilities located primarily in rural areas, contributes greatly to extending the reach of health services in the country. CHAM provides over 30% of all health services in the country, including over 50% of all health services in rural areas. By operating in predominantly underserved rural areas, CHAM enables the government to provide services without vastly expanding the public health infrastructure. CHAM also trains a significant percent of the health workforce through its 11 training colleges. Both CHAM and MOH representatives credit the MOU and SLA with improving health outcomes in the country, particularly reducing HIV/AIDS and maternal mortality.

“We [government and CHAM] used to treat each other as rivals but now we are taking ourselves as partners. We are doing the same thing for the same purpose so we should be able to share notes. Where there is investment that can be shared let’s share it. It’s this planning together that we’re doing, that is a great shift.”

*-National CHAM staff*

### **The partnership with CHAM streamlines engagement of the private sector.**

Prior to the formal MOU with CHAM, many CHAM facilities were reaching out to the MOH at the district and the national level to negotiate various arrangements for financial or in-kind support. The introduction of the

MOU and the role of the CHAM Secretariat in managing all the finances between facilities, the MOH, and the DHOs has streamlined engagement with the MOH, minimizing the government’s administrative burden of engaging the private sector.

## **Challenges**

### **Insufficient and delayed payments from government.**

Payments for the salaries and SLAs often arrive late to the CHAM Secretariat and to facilities, particularly reimbursements through the SLAs. This is in part the result of inefficient invoicing and billing, as well as the budgetary mechanism through which funds are accessed. Funds for the salary payments are a separate line item within the MOH’s budget, and are processed through the MOH, which at times leads to delays in salary payment to CHAM staff. The way reimbursement rates and staffing limits are set also leaves CHAM facilities to fill significant gaps in government support.

### **Government human resource policies have a large impact on CHAM’s operations.**

Due to the terms of the MOU linking CHAM’s training colleges and staffing to the public health system, human resource policies at the MOH have significant impact on CHAM’s operations. A notable example is a recent government hiring freeze for health workers. Because salaries for CHAM facility staff are paid by the government, CHAM facilities were unable to fill staff vacancies unless these positions were funded by non-government sources. This put a strain on a number of facilities to meet service delivery demands. CHAM facilities also face some difficulties in recruiting and maintaining staff. Although CHAM’s training colleges train a substantial proportion of all health providers in the country, the MOU stipulates that 60% of graduates must be employed in public sector facilities. In addition, there are better opportunities for promotion in public facilities, and some CHAM facilities struggle with staff retention.

### **Secretariat financing and capacity remain a challenge.**

The MOU and SLA agreements have done much to ensure the financial sustainability of the CHAM facilities and support the alignment of CHAM facilities to the goals and standards of the public sector. However, the CHAM Secretariat does not receive any financial support for its role in managing the MOU or SLA agreements, including its work to manage the large financial transactions between the government and facilities. Member clinics are supposed to pay a membership fee equivalent to 1.5% of the salary payments received through the MOU, enabling the Secretariat to capture some of public funds to support administration. However, many facilities do not pay the fee, and this does not adequately support the needs of the Secretariat.

### **Insufficient management and oversight mechanisms.**

To oversee the MOU and SLA requires new management and monitoring capacity at the MOH to ensure public resources are used efficiently and for their designated purpose. Some District Health Officers expressed the difficulty of monitoring the CHAM facilities and verifying SLA invoices on top of their role overseeing public health services. Over the course of the MOU, there have also been concerns about inaccuracies in the invoices submitted by CHAM, raising issues of mistrust among some government officials, particularly at the district level.

### **Alignment between government mandates and CHAM vision and capacities.**

As the government is paying for much of the CHAM facilities' operating costs, the MOH needs to ensure that CHAM facilities are serving the mission and objectives of the MOH strategy. There are some tensions with how well the CHAM model aligns with the MOH's vision. Three examples highlight this. First, CHAM facilities still charge user fees, and although the services covered through the SLA agreements are provided for free, there are tensions surrounding the allocation of public funds to facilities that charge user fees. Second, some CHAM facilities do not offer family planning services because of their religious beliefs. There is tension between facilities that do not want affiliation with the government to lead to loss of religious identity, and government actors that want publicly funded facilities to provide all services in line with the MOH's vision.

Third, some CHAM facilities are managed by religious leaders rather than trained health professionals, and there is a desire from government actors to have more of a role in making staffing decisions.

### **Insecure funding environment for the MOH.**

The MOH in Malawi is largely supported by external donors, making the office both reliant on and subject to the interests and priorities of donor agencies. This impacts how the MOH can partner with CHAM and the sustainability and reliability of the payments to CHAM under the MOU and SLA. On occasion, donors withdrawing support from the MOH has caused disruptions in support to CHAM. At other times, donor interest in public-private partnerships has increased pressure to engage and set aside funds for private partners such as CHAM.

## **Summary**

The formal partnership between CHAM and the MOH has benefited both partners. Through the incorporation of disparate facilities and affiliated church networks into a single organization, CHAM has been able to successfully advocate for a strong financial partnership with the government. The government has benefited from having a single and unified entity through which it can oversee and manage private service delivery. The partnership has also supported the health goals of both partners – enabling the MOH to efficiently expand services in rural areas, while facilitating the sustainability and affordability of services at CHAM facilities.

# Churches Health Association of Zambia

## History

Faith-based mission hospitals played a large role in health service delivery in Zambia for many years prior to independence in 1964. In 1933, the Catholic Medical Committee and Protestant Medical Committee joined into a loose affiliated network. By the time of independence, the church hospital network was quite well established, leading the government to partner with the faith-based sector, particularly to serve rural areas where the government did not have extensive operations. The Churches Health Association of Zambia (CHAZ) was formally incorporated in 1970 with 16 churches participating in the association. While CHAZ coordinated informally with the government from the time of independence, the first formal Memorandum of Understanding (MOU) was signed between CHAZ and the Government of Zambia in the 1980s.

## Program basics

- CHAZ has over 160 member facilities and provides around 30% of all health services in the country.
- CHAZ member clinics are operated independently by church-based facility managers and each clinic maintains an individual identity.
- CHAZ Secretariat serves as liaison between the Ministry of Health and member facilities, managing administrative and financial processes, providing technical support, monitoring, and evaluation of member facilities to ensure compliance with national and quality standards, and advocating on behalf of member clinics in national policy dialogues.

In addition to working closely with the Ministry of Health (MOH) to administer the health programs through CHAZ facilities, the CHAZ Secretariat plays a central role in health policy at the national level. CHAZ sits on the Central Board of Health (the lead technical health agency), participates in the Interagency Coordinating Committee and Sector Advisory Group (both of which consult with the Minister of Health on implementation of health plans and policies), and participates in all of the MOH technical working groups to shape

disease-specific policies and strategies. CHAZ was part of the team that developed the national health policy framework, and also works closely with other government agencies including the Ministry of Community, Ministry of Finance, National AIDS Council, and Health Professionals Council. At the sub-national level, each CHAZ hospital manager sits on the District Health Management Team in their district. The MOU between CHAZ and the MOH outlines the terms of the policy engagement between the two entities, including stipulating regular meetings between CHAZ senior staff, the Minister of Health, and the Permanent Secretary to ensure coordination across the two agencies.

## Funding structure

CHAZ's operations are funded through **donors** – including bi- and multi-lateral aid agencies and private and philanthropic donations – the **government** of Zambia, and **membership fees** from network facilities. CHAZ is the principle recipient of Global Fund funding in Zambia, and is also a primary recipient of funds from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Donor funding supports the operating and administrative costs of the CHAZ Secretariat, covering over 90% of the Secretariat's costs. Donor funding also supports program implementation costs, including commodities and service delivery at CHAZ facilities.

The primary mechanism through which CHAZ receives government support is its **Memorandum of Understanding (MOU)** with the MOH, which governs the relationship between the two parties, and outlines the funding and other responsibilities for each entity. Under the MOU, the government provides support to CHAZ through the following:

- The MOH deploys health workers to staff CHAZ facilities, and pays the salary for these staff. The MOU stipulates which types of services are covered by salary support, and the number and type of staff needed to provide these services. Facilities are able to offer additional services not covered by the MOU, for example hospice care; however, these services are not eligible for government support and each facility is responsible for staffing and funding these positions.
- The MOH provides a monthly payment to each CHAZ facility to cover the operational costs of running the facility, while CHAZ is responsible for providing the facility infrastructure. Each facility



receives a monthly operating budget based on the level of the facility (primary care clinics, district hospital, tertiary hospital), and the population size of the facility catchment area. These allocations typically cover approximately 75% of a facility's running costs.

- The MOH provides CHAZ facilities with stock of essential medicines. It is estimated that the MOH provides between 70 – 80% of all medicines used at CHAZ facilities.
- The MOH provides a small fee to the CHAZ Secretariat to cover administration costs associated with accounting and reporting on salary support provided by the MOH.

Funding for each of the above activities flows through different channels. Salary payments for CHAZ facility staff are disbursed from the MOH to the CHAZ Secretariat, which is then responsible for allocating salary payments to each facility directly. Operating budgets flow directly to the facility or through the District Health Office depending on the type of facility. For hospitals, payments are made directly from the MOH to the hospital management. For other facility types, funding is disbursed from the MOH to the District Health Office, and the district managers are responsible for allocating payments to each eligible facility.

## Benefits

### **MOH and CHAZ provide complementary services.**

CHAZ operates primarily in rural areas, filling a gap in the public healthcare delivery system, rather than competing with MOH facilities. In this way, CHAZ provides an essential function for the MOH to meet the needs to provide accessible services to rural communities without having to build out the public health infrastructure. CHAZ also provides additional forms of health system support, for example by operating training colleges and managing procurement and supply chains for commodities, such as antiretrovirals for HIV treatment. With strong coordination between CHAZ and the MOH, the two institutions can ensure efficient and accessible service delivery while avoiding duplication. CHAZ's systems also have a higher degree of flexibility than the public health system, and can more quickly mobilize resources or procure supplies in case of stock outs. In this way, CHAZ can step in to play support roles to the public health system at times when there are delays in public operations.

### **Access to government funding supports CHAZ sustainability and flexibility.**

The salary and operational support from the MOH is crucial to the sustainability of CHAZ and its member facilities. The type of funding the MOH provides – particularly the operational cost investments – is flexible funding that enables facility directors to manage

expenditures to the best purpose. This is in contrast to much funding from donors where funds are earmarked to specific diseases and activities that may not always align with community priorities.

### **CHAZ serves as an advocacy partner for the MOH.**

In addition to public funding supporting CHAZ operations, CHAZ's role in health sector policy and advocacy supports the strength of the public health system. For example, CHAZ works with the MOH to advocate to the Ministry of Finance for more health sector finance, and supports the MOH in applications to bi- and multi-lateral finance institutions for grants that support public and private sector activities.

### **Strength of CHAZ network enables MOH to partner efficiently with the private sector.**

The MOH has an interest in stronger engagement with the non-state sector, but fragmentation in the private sector makes this difficult. CHAZ's strong organization and central management unit enables the MOH to efficiently partner and oversee the work of the faith-based sector in a way that has not yet been feasible in other parts of the non-state sector. CHAZ's strong financial and quality management systems further facilitate this relationship, as the MOH seeks to collaborate with local organizations that are transparent, accountable, and in line with the government's mission and priorities. The MOU enables this kind of deep collaboration with the CHAZ network.

“Our [government] responsibility is to reach each and every Zambian who needs health services. But where we cannot manage, that's where we search for partnerships. That's where the private sector comes in, civil society, development partners. We may not be everywhere at the same time, and that's where we need engagement with institutions like CHAZ.”

*-Zambia Ministry of Health staff*

## Challenges

### **Limitations and delays in government payment.**

While government funding provides crucial support to CHAZ, there are gaps between these funds and CHAZ's operational requirements. First, the government does not provide financial support for the CHAZ Secretariat, and CHAZ's central and regional management units are insufficiently staffed to conduct all management and quality assurance activities. Second, the human resource and operating budgets provided to the facilities does not cover all costs, and many facilities report the need to fund supplemental staff positions or

deal with challenges of under-staffing. Finally, in some districts, CHAZ has faced delays in disbursement of funds from the district health office.

**Continued reliance on donors.**

CHAZ remains heavily reliant on donor funding to support the Secretariat, operations, and health service delivery. Some CHAZ staff report that the need to bring in external financial support leads CHAZ to take on programs and activities outside of their central mandate that would be better done through or in collaboration with the government.

**Varying priorities at the district level.**

While at the national level CHAZ and the MOH report strong coordination and alignment, there are some challenges at the sub-national level between provincial offices and CHAZ facilities. CHAZ facilities are often better resourced than public facilities in the same district because of the donor support they receive. This has resulted in some challenges with district

and provincial health offices who do not feel there is sufficient transparency about how much government support CHAZ facilities need.

## Summary

The partnership between CHAZ and the MOH has facilitated both organizations in meeting their health care delivery goals – supporting the MOH to reach universal health coverage targets, particularly in rural areas, and enabling CHAZ to provide free and subsidized services. The partnership also extends well beyond service delivery. CHAZ now serves as a key partner to the MOH in developing and implementing national health policies, and in supporting the mobilization of donor funds and implementation of donor-funded programs. This high-level partnership benefits both organizations, enabling CHAZ to negotiate health sector policies that are supportive of private sector engagement, and providing important technical support to the MOH.



## State of Hidalgo Public-Private Partnership

In 2012, the State of Hidalgo, Mexico, initiated an innovative public-private partnership (PPP) with the private company MediAccess in partnership with the Hospital Consortium of Catalonia to expand provision of services through the national health insurance program Seguro Popular. The model was inspired by and based on a model in Catalonia, Spain, in which different partners operate 70 of the state's 300 public primary health centers. The program was designed to fill a gap in Hidalgo's public health system, where there was adequate hospital infrastructure but insufficient access to primary health care services.

Under the Hidalgo PPP, MediAccess was contracted to renovate and manage two primary health centers serving a population of around 40,000. MediAccess was responsible for constructing new infrastructure, equipping the facilities, contracting facility staff, and providing high quality primary care services. MediAccess then received two forms of public finance to support service delivery. First, MediAccess was provided with a fixed **per capita payment** for each person within the facility catchment area. Second, MediAccess was eligible to receive a **performance-based payment** if the clinics met service delivery and quality criteria. This payment structure incentivized MediAccess to focus on preventive care, and in particular the prevention and effective

management of chronic and non-communicable illness.

The model was successful in improving access to care, increasing quality, and improving cost effectiveness of primary health services delivery. MediAccess was able to provide higher quality services at a lower per capita cost than in the state's public facilities.<sup>5</sup> At the same time, the program was financially sustainable for MediAccess; the company was able to recover their initial infrastructure investments and over time make profit through the partnership.

This was one of the first PPPs in Mexico to engage a private partner in the delivery of public services through payments from the Seguro Popular program. The program has faced challenges in scaling up due to restrictions in the allocation and utilization of Seguro Popular funding as well as political considerations in engaging with the private sector. The program credits strong leadership at the State Ministry of Health in Hidalgo in enabling the successful roll out of an innovative public-private partnership model.

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5 Figuerola-Lara A, González-Block MA. Cost-effectiveness analysis of an alternative for the provision of primary health care for beneficiaries of Seguro Popular in Mexico. *Salud Publica Mex* 2016;58:569-576. <http://dx.doi.org/10.21149/spm.v58i5.8247>

## History

Founded in 1986, Karuna Trust is a non-profit organization in India that aims to improve government health services for underserved and poor populations in remote regions of the country. Karuna Trust's work to "reach the unreached" began in India's Karnataka state to lower high rates of leprosy in tribal regions. Karuna Trust worked with the national leprosy program and developed expertise in meeting the unique health needs and challenges facing rural populations. After lowering the leprosy rates in hard to reach areas, Karuna Trust convinced the Karnataka state government in 1996 to hand over one of its primary health centers to Karuna Trust. Under this new non-profit public private partnership model, Karuna Trust was given the authority and responsibility to manage this facility, with government financing. Within a span of 10 years, Karuna Trust expanded the model to manage 30 primary health care facilities across Karnataka state. Other state governments requested Karuna Trust's support, and today the organization manages facilities across six states.

## Program basics

- Karuna Trust manages 68 primary health care health facilities across six states in India: Karnataka, Odisha, Arunachal Pradesh, Manipur, Meghalaya, and Rajasthan.
- Karuna Trust works with state and district government health departments to manage primary health care facilities and sub-centers. Karuna Trust takes over these facilities, hires new staff, and works with the local community to introduce its program model.
- Facilities managed by Karuna Trust provide comprehensive primary health care services, aligned with the Indian Public Health Standard and with a particular focus on the National Health Mission's priority to improve maternal and child health. Karuna Trust has also introduced additional programs, such as mental health, traditional medicine, dental services, and vision centers. All services at Karuna Trust facilities are provided free of charge.
- Karuna Trust is overseen by a Secretariat headquartered in Bangalore. Staff at the state level manage relations with local governments and support facility operations.

In the regions where Karuna Trust works, the public sector has struggled to meet the health needs of remote, rural populations. These geographies are hard to reach, with limited roads, unreliable electricity, and poor infrastructure. Local governments struggle to recruit and retain doctors and staff for these areas because of the challenging conditions. Karuna Trust is able to address many of these problems through its mission-driven, innovative model and specialization in serving remote, rural populations.

To establish a new public-private partnership, the National Health Mission within a state will typically release an "expression of interest" for non-governmental organizations (NGOs) to manage facilities identified as particularly challenging. In some cases the National Health Mission will directly invite Karuna Trust to partner due to its reputation for improving facilities and lower costs, and may seek the organization's advice early on in shaping the partnership.

When primary health care facilities are officially handed over to Karuna Trust, government staff are transferred out and Karuna Trust hires and trains its own staff. When entering a new community, Karuna Trust holds public meetings in villages with local panchayat and government leaders to present their work, explain the services available, and build rapport and trust with the public. Community-specific outreach and empowerment campaigns – such as education programs on the "right to health" – are customized to meet local needs. This outreach is a core feature of Karuna Trust's model to ensure public ownership and accountability for each clinic and partnership.

*"The main reason we partnered with Karuna Trust is because of the hard to reach areas. We wanted to collaborate with them because our health services at that point in time was very, very poor. So we came up with the idea of partnering with the private sector to improve the health services."*

*– State National Health Mission staff*

“Karuna Trust is a very good leader...They have reached many people which you would never reach. They have given family welfare and family planning services for many people who are otherwise unreached. They have shown an example that even in these remote areas a hospital can run.”

– State National Health Mission staff

## Funding structure

Karuna Trust’s primary work is its public-private partnerships with multiple state and local governments to manage health facilities. This is funded almost entirely by the public sector. In addition, Karuna Trust leads innovative health projects and other community-based development programs that are supported by private philanthropy.

The funding structure of the public-private partnership follows the same basic structure in each state. After an initial assessment and planning period, the state’s National Health Mission and Karuna Trust will negotiate a **Memorandum of Understanding (MOU)**. The MOUs outline facility budgets, health indicators to measure progress, and administrative procedures.

They stipulate mandatory service packages and operating hours for each facility, including for the outpatient department, inpatient facilities, essential laboratory services, reproductive and child health service packages, and community outreach programs. The terms of the MOU are re-negotiated each year, signed by the state’s National Health Mission Director and the head of Karuna Trust. Based on this agreement, Karuna Trust receives support from District Health Officers for local program implementation.

Although Karuna Trust establishes a MOU with the state government, the partnership is funded largely by the central government’s National Health Mission. While the MOU is being established, the state government sends Karuna Trust’s proposal to the central government to request funding. Once the Government of India decides how much funding it will provide, the state may try to meet the remaining budget. However, the states where Karuna Trust operates are typically not able to generate much additional revenue and rely heavily on central government financing for the state health budget.

Government funds are used to pay the operational and delivery costs of running the facilities, including salaries for facility staff, training, essential medicines, and building maintenance. The central government sends funds to the state, which then transfers money

to Karuna Trust. Karuna Trust releases this money to each facility to pay salaries and cover other operational expenses. The local districts provide vaccines and medicines through various national health programs to Karuna Trust facilities. Karuna Trust procures essential drugs, laboratory items, equipment, and surgical items for the facilities. All services are provided free of charge to patients.

In addition to the provision of government funds, the MOUs stipulate that Karuna Trust will cover 10% of facility costs. Karuna Trust funds its share through privately raised funds from individual donors and philanthropic organizations, such as the Tata Trust and MacArthur Foundation. In practice, it is difficult for Karuna Trust to generate substantial private funds and its contribution usually falls below 10%. It manages this shortfall by covering the facility operational costs with only government funds. Costs for staff that manage the local government partnerships and provide support to facilities are also paid through government funds. Karuna Trust sometimes uses its privately raised funds to supplement fees for facility maintenance or additional medicines. At times, a donor will support a special project that will offer an additional service or feature to facilities, such as an eye care clinic, and this will be provided on top of existing government-funded services.

Karuna Trust facilities also process government funding for health schemes that provide extra benefits to specific populations or for specific health outcomes. For instance, the National Health Mission provides special incentives to expectant mothers to deliver at a facility, and reimburses for certain services, such as transportation for women and children referred to a higher-level clinic. Karuna Trust acts as a pass through for these government funds to the beneficiaries and vendors.

The MOUs typically plan for Karuna Trust to be paid bi-annually or quarterly. Each Karuna Trust facility submits a Financial Monitoring Report on its costs to the state health office. The state government conducts audit on the accounts every six months and based on the audit report, the state releases funds to Karuna Trust directly. The state government also conducts a review of the performance of health facilities at state and district level.

Over the years, the amount of money Karuna Trust receives for each facility has increased to match the expanded health services made available by the government. Karuna Trust has also made requests for budget increases to support staff salaries and additional activities. Karuna Trust manages its funding according to the local needs at each facility. Every year Karuna Trust reports on its spending through an audited report by a chartered accountant, and the National Health Mission also conducts a separate annual audit.

## Benefits

### **Karuna Trust helps the government meet public health goals.**

The state governments where Karuna Trust operates report that Karuna Trust successfully provides services in places that would never have been reached otherwise. Government officials report that Karuna Trust has helped improve maternal and child health, serving as a model for the level of care that can be achieved in remote areas. Karuna Trust's work helps the National Health Mission reach its goals, to the benefit and "relief" of government officials. Operating at a lower cost than government facilities, and with dedicated community engagement programs, Karuna Trust is able to better serve very remote populations.

### **Working through government facilities increases Karuna Trust's reach and financial sustainability.**

By taking on poor performing health centers in the government's network, Karuna Trust expands its impact and reach in rural communities. This helps Karuna Trust serve its organizational mission, and clinic staff report being motivated and satisfied by their work with vulnerable communities. Government financing allows Karuna Trust to be far more sustainable than private dollars alone could provide, and provides some flexibility to allocate funds towards priority efforts. Karuna Trust is able to focus on effectively utilizing government funds to improve health services, rather than attempting to raise large amounts of money.

### **Innovations have broader reach through the public private partnership.**

Karuna Trust has experimented over the years to hone its management techniques, such as developing a logistics software that collects real time data on which medicines are available at each health center. This software has been picked up by government officials and expanded to at least 18 government health centers in Karnataka and 25 in North Eastern states. Furthermore, Karuna Trust plays an important knowledge sharing role by providing technical assistance and management support to other non-governmental organizations managing facilities through public-private partnerships.

*"Initially when we started, we were just the partner in the managing health centers. Now we are involved in the state health policy making process. The government knows that Karuna Trust has rich knowledge in the public health system, management of health centers, and work at the grassroots level. The government involves Karuna Trust in their different departments, committees. We are a state level partner."*

*– Karuna Trust staff*

## Challenges

### **Despite successes in recruiting staff, Karuna Trust has high staff attrition.**

Both Karuna Trust staff and government officials report this is the biggest challenge for the partnership. Karuna Trust medical officers and staff work in remote areas that are known to be difficult postings. Karuna Trust manages to recruit staff for these roles, offering an inspiring mission and professional training, but still has high staff turnover. Many staff leave after only a few months to work in an easier geography or because they are recruited for government roles that offer more job security and benefits. Due to the nature of its government contracts, Karuna Trust is only able to offer short-term contracts to staff, not career positions. The frequent staff turnover creates major strains on the organization to regularly recruit new talent and rebuild trust between new staff and the local community. It also burdens the local government to provide frequent staff trainings.

### **Significant delays with government funding make it difficult for Karuna Trust to operate.**

Due to challenges in how government funds are disbursed from the central and state government, payment to Karuna Trust is regularly delayed for three to four months, or at times even longer. This delay leaves Karuna Trust unable to pay its staff or cover maintenance fees for months at a time. Staff, who are already working under difficult circumstances, can become discouraged by chronic delays in payment and end up leaving. Other facilities and sectors also experience delays with government funding, but Karuna Trust is not set up to cover funding gaps.

### **Frequent changes in political and administrative leadership means Karuna Trust must continually manage and cultivate its government and community partnerships.**

Changes in leadership within the health sector can dramatically shift government capacity to assist and support Karuna Trust. There have been problems with new leaders who are skeptical of the partnership, even going so far as to withhold funds from Karuna Trust and withdraw the MOU. Karuna Trust must monitor changes in government leadership and be ready to re-establish credibility with new officials. Overall, both government officials and Karuna Trust staff report having a positive relationship, made stronger by cooperation and regular communication. Karuna Trust must also regularly monitor its relationship with the local community to address local political issues or complaints. Karuna Trust staff work in partnership with government officials to ensure community needs and concerns are met.

## Summary

The partnership between Karuna Trust and multiple state governments in India leverages the specialized expertise that Karuna Trust has developed in serving remote, rural populations and strengthens the government's network of primary health care facilities and sub-centers. Karuna Trust has expanded its model

based on government demand, effectively engaging communities and providing essential services at lower cost. The partnership allows Karuna Trust to use public financing to reach underserved populations, and it helps state and local government health offices improve health outcomes in hard to reach geographies.

## History

Possible began working in Nepal in 2008, when they first approached the Ministry of Health (MOH) of Nepal to take over management of a non-operational district hospital in Accham, a rural, impoverished, and underserved district. Without a track record of successful service delivery, the MOH initially declined Possible's request, and the program instead began to run a small primary health center near the hospital. After gaining the trust and backing of the community and district health officials, establishing data showing their impact, and developing stronger relationships with MOH staff, Possible re-approached the MOH and was approved to take over operation of the district hospital in Accham.

### Program basics

- Possible operates two district level hospitals in Accham and Dolhaka that provide comprehensive in-patient and out-patient care including surgical and mental health services, as well as a number of primary health care clinics in surrounding areas.
- A community health worker program provides in-home access to preventive, reproductive, maternal and child health services, and links households to care through referral and follow-up. Community health workers also conduct quarterly disease surveillance activities to identify people needing health services.
- Possible operates an Electronic Medical Record program to ensure continuity of care and effective management of chronic conditions across community health workers, clinics, and hospitals.
- Possible's model emphasizes data to drive program decisions. It has introduced a number of data sources from implementation research testing program innovation to extensive patient satisfaction surveys to inform program design and implementation.

Possible staff worked closely with both the MOH and the District Health Office to develop a public-private partnership. A **memorandum of understanding** with the national MOH office granted Possible a contract to manage the government facility in Accham. In 2015, following a devastating earthquake in Nepal, the MOH approached Possible about taking over management of a second hospital in Dolhaka province, one of the areas most severely affected by the earthquake. Both facilities are fully managed by Possible, but are staffed by both Possible and government staff. Possible also has agreements with the District Health Offices, which are responsible for approving and overseeing the community-based components of the program, including the primary health centers and the community health worker program.

## Funding structure

Possible's operations in Nepal are funded through a combination of donor and government funding. Philanthropic contributions currently make up just over 75% of the organization's budget, while government funding makes up the remaining 25%. Possible receives several sources of public funds to support their operations.

In 2015 Possible signed a **performance-based grant agreement (PBGA)** with the MOH. Under this agreement, Possible's district hospital in Accham is eligible to receive an annual payment of USD 30,000 if they meet established performance criteria. Possible created an impact dashboard that tracks monthly performance on over 80 indicators, and, in collaboration with the MOH, identified 16 priority indicators tied to the PBGA payments. These key indicators include data on surgical coverage and quality, institutional birth rate, chronic disease control, and contraceptive prevalence. PBGA funds are released annually to the District Health Office, which then releases funds to Possible. This PBGA is the first of its kind in Nepal between the MOH and a private sector organization, and Possible hopes to expand the PBGA over time to cover a greater percentage of the organization's costs.

The MOH also contributes to Possible's **capital infrastructure funds**. The MOH currently covers 50% of all capital expenses for constructing new clinic and hospital infrastructure. To date, the Ministry has invested one million USD to support infrastructure development. These funds are released directly from the MOH to Possible.



Finally, Possible's programs are integrated with several MOH programs through which they receive **in-kind support** and direct **reimbursement for service delivery**. Possible is eligible to receive free drugs included on a list of 72 essential medicines in the country, and currently one-third of all of Possible's medicines are supplied for free through government programs. The MOH and District Health Offices also pay the salaries for some of the hospital staff. When Possible began managing MOH facilities, they maintained some of the existing government staff. These 'integrated' positions continue to be funded through the government, including 10% of staff in the Accham hospital and 30% of staff in the Dolhaka hospital, as well as some of the community health workers. The MOH is in the process of rolling out a national health insurance scheme that will cover 65 essential health services, and Possible is working to increase the number of services for which it can be reimbursed. However, at present, Possible only receives reimbursement for maternal health services covered through the MOH's Safe Motherhood program.

## Benefits

### **Financing partnership builds a path to Possible's sustainability.**

By working in partnership with the Government of Nepal, and building on and supporting government health systems, Possible is creating a more feasible pathway towards sustainability in terms of both operations and finance. Operationally, Possible's preference to build systems that can integrate into and support government health services builds credibility with the MOH, and enables scale up throughout the health system. Financially, the partnership has built a strong foundation for accessing public finance, and it facilitates the potential future expansion of public funding through health insurance and growth of the PBGA. The close partnership with the government also builds Possible's credibility with external donors and supports fundraising efforts.

### **Partnership supports the achievement of government's public health goals.**

Through partnership with Possible, the MOH has been able to expand high quality primary and tertiary care services in remote and underserved areas, and improve service delivery in earthquake affected areas. The government often faces difficulties in recruiting and retaining qualified providers in rural health facilities, and Possible is able to provide comprehensive care in the Accham hospital including surgical and psychiatric care, which are services the government had not previously been able to provide. In Dolhaka, the partnership with Possible has also enabled the government to serve more people and introduce new services at the facility. Both Possible and MOH staff credit the partnership with achieving increased coverage and improved health outcomes in participating districts. The success of the programs has raised the recognition of the work of

Possible's partners in District Health Offices, who have presented their work to the central government. These opportunities in turn serve as a motivator for public health facilities in the same district to improve their performance.

*"We want to be transparent. We want to be accountable. Because this is a model that we want the government to replicate in other districts, or even other organizations, if they're interested. We want them to see how our system works, and whatever system they want they can take up."*

*– National Possible Staff*

### **Learning opportunities in management and clinical skills.**

Possible's emphasis on designing systems compatible and scalable within the government model has facilitated learning opportunities for government staff to gain knowledge and skills in private sector approaches to management, efficiency, and program design. As an example, Possible has pioneered an electronic medical record system that is enhancing service delivery, quality, and procurement. This system was designed on an open-source platform to align with government health systems, and with the intention that the program be scaled to facilitate stronger information systems within the public sector. Possible's medical staff also provide training and support to government staff in nearby district hospitals.

### **Serves as a pilot for private sector engagement.**

As the MOH seeks to expand its efforts to develop public-private partnerships, the Possible model offers a strong example for such engagement. Possible's emphasis on engaging government actors as partners and on accountability to government provides opportunities to innovate new models of transparency and accountability, for example through the performance-based payment agreements.

*The government has their own systems and their own modality of implementing programs. When we as an innovator try to bring something new, there's a kind of resistance. At the same time, we also get very constructive feedback. When they look at some issues, they have a different lens than we do. They bring new concepts and new approaches to the interventions we design. One thing was working collaboratively to get the feedback and improve the systems"*

*–National Possible staff*

## Challenges

### **Maintaining a strong relationship with government.**

There is a high level of government staff turnover at the district level, and Possible staff have to continually work to build interest and commitment of new district health officials for the program and partnership. Much of the success of the program at the district level depends on individual relationships and the motivation of health officials to approve and facilitate Possible's programs, making relationship-building essential. With continual change in the staff and the political affiliations of the government officials, this is difficult for Possible to manage.

### **Building and aligning partnerships at the district level.**

District health officers feel ownership for what goes on in the district, and there is a level of competition about Possible's work at the district level due to fear of Possible replacing government systems. District Health Officers often feel left out of important decisions, as they are told to implement decisions made at the national level without being consulted about the impact on their work at the local level. District Health Officers also report being overwhelmed by the additional responsibilities they take on to manage Possible's activities in addition to their work managing public health services. Navigating these relationships requires continual effort to build strong personal relationships and trust with the District Health Office. Some government staff report a desire for more communication from Possible about their programs, particularly if they are introducing new systems or innovations in the model.

### **Lack of a specific policy and unit within the MOH focused on public-private partnerships.**

The idea of public-private partnerships is new in Nepal and there is not yet an overarching governing law that guides these partnerships in the health sector. At the same time, there is not a single unit within the MOH responsible for overseeing private sector engagement. Possible's partnership staff regularly work with multiple divisions and departments within the MOH to establish various agreements with vertical health teams. There is also no MOH staff designated to manage monitoring and regulation of the partnership, which is difficult for oversight of the PBGA. The MOH is currently going through a process of approving a public-private partnership policy, and this is anticipated to facilitate a smoother relationship between Possible and their government partners.

### **Reducing reliance on donors, and expanding government funding.**

Possible remains reliant on donor funding, and there is no clear pathway through which government funding will quickly replace donor funders. In addition, the MOH is largely supported by donors, leading to some uncertainty in the funding environment for the MOH and the PBGA. There are also limitations in what kinds of public funding Possible can access. For example, the government has been more willing to invest in capital expenses than in operational expenses, although over time it is the government's share of operational expenses that Possible hopes will increase. There is also more government finance available for some types of services than others. For instance, Possible is reimbursed for some maternal health programs but not for mental health services.

### **Retaining and motivating staff.**

Government staff are paid more, provided pensions, and have more job security and opportunities for professional development, which creates challenges in the facilities where both Possible and government staff are employed. Both government and Possible facilities face challenges in recruiting and retaining staff in the remote Accham district.

### **Ensuring services are complimentary and aligned with government.**

Although Possible in many ways seeks to work in collaboration with the government, there are areas of tension where Possible's service goals and government systems are not yet in alignment. For example, the Accham district is in the process of rolling out a national health insurance program and encouraging households to enroll. However, Possible's programs provide access to free comprehensive care, impeding motivation for people to enroll. The District Health Office worries about people in the district not enrolling in health insurance, and also how to continue supporting public health facilities in the district that are now underutilized due to the availability of Possible's services. Respondents from Possible and the government spoke to the need to build partnerships that expand, not duplicate, the strength of local health systems in order to truly build the government's capacity.

## Summary

Possible's partnership with the MOH is a unique one in Nepal, where public-private partnerships are in a nascent stage. Possible's emphasis on working with government officials and systems to build on and strengthen the public sector supports the government's health system vision, and facilitates the expansion of services to rural and underserved areas. At the same time, the financial partnership enables Possible's longer-term sustainability.

## History

Tinh Chi Em (TCE) is a government social franchise in Vietnam focused on providing reproductive health services at Commune Health Stations (CHSs), the lowest level of health facility within the government health system. TCE clinics are staffed and managed by CHS staff, and funded by provincial Departments of Health, with training and managerial support from Marie Stopes Vietnam (MSV).

### Program basics

- Reproductive health services, including family planning, reproductive health counseling, cervical cancer screening, and screening and treatment for STIs, are provided in a TCE-branded room by nurses, doctors, or midwives on the regular staff of the CHS.
- The program emphasizes client-centered care including counseling, good communication, and positive and welcoming interactions with clients.
- Provincial master trainers, on the staff of the Provincial Department of Health, provide training and regular monitoring supervision visits for CHS staff.
- Brand Ambassadors work in each community to raise awareness about and promote the program and increase utilization of CHS services.
- MSI staff provide quarterly monitoring and support for master trainers, and technical and quality oversight at participating CHS.

The program started as a collaboration between MSV, Atlantic Philanthropy (the program's initial funder), and the provincial Departments of Health in pilot provinces. MSV and Department of Health staff found that although CHSs were providing reproductive health and other preventive and family health services, many people were bypassing the CHS to attend district or provincial hospitals. This created problems both for the CHS, which were not able to provide enough services to sustain their operations, and for the district hospitals,

which were overburdened by many patients seeking services that could be well served at the community level. The TCE program was therefore designed with a goal of improving the quality of care at CHS to reduce the number of clients bypassing these facilities and increase access and use of to quality health services at the local level.

The TCE program is governed through a **Memorandum of Agreement** signed between MSV, the District Health Office, the CHS, and the local government in each district where the program operates. Approval from Provincial and Commune People's Committees is required before any new program can begin. The program was first piloted in 38 facilities in two provinces, and currently operates in about 300 facilities.

## Funding structure

The TCE program was initially funded through a combination of both donor and government funding. Start-up funding came from Atlantic Philanthropies, and was later supplemented by additional donors including the European Union. These donor funds, channeled to the program through MSV, were used to support training for provincial master trainers, branding of the TCE rooms, branded educational materials for TCE providers to use during counseling, technical supervision and support both for master trainers and TCE providers, and the creation of monitoring and evaluation materials used by master trainers and district health staff. MSV also provided small stipends – around USD 15 per month – to participating CHSs to support the facility in fixing clinic infrastructure and purchasing supplies.

The majority of the program's operational expenses were supported through public funds. All program staff were part of the government's public health service. The District Health Office also provided all funding for the CHS clinic infrastructure, service delivery, and some brand promotion activities. Local government at the district and commune level – District People's Committees and Commune People's Committees – also contributed resources to support the program and the CHS. These sources of support, funded through local taxes, varied across program site depending on the wealth of the local community and available resources. At the CHS level, facilities also received some reimbursements through social security and health insurance programs, and fee for service charges.

Donor funding for the program ended in 2016, and the program is now fully supported by the government. CHS and District Health Offices have incorporated program funding requirements into their annual budget requests to the Provincial Health Offices and in their advocacy to local government. The majority of participating districts have sustained, and in some cases expanded the program. For example, Dak Lak province expanded the TCE program to 45 CHS, although the initial MSV program worked in only 30 facilities. While some provinces have had a harder time accessing on-going government support overall both government and MSV staff report that the TCE program continues to be a success.

## Benefits

### **Improved quality of care.**

The program has resulted in a measurable improvement in the quality of reproductive health services provided at participating CHSs. The program has also improved patient-centered care, including the quality of counseling and the customer orientation of the CHS staff for all services, not just reproductive health. The program increased the community's trust in the commune health stations and the facility staff, and improved patient satisfaction with the care they receive and the way they are treated at the facilities.

### **Increased utilization of services at the CHS.**

Because of the improved quality of care and improved trust in the community, the TCE program increased the number of people accessing services at the CHS. The program increased demand for family planning and service utilization for family planning, reproductive health, and all other services at the CHS. Improving the quality and reputation of the CHS for reproductive health increased the reputation for the CHS as a whole.

For the first time, the local health authorities have regular updates of the results and actually hear a lot of positive feedback from the women in the community. The commune health station had been experiencing low utilization, low levels of confidence in the community for a long time. Now for the first time, the people in the community saw a difference.”

– National MSI staff

“Even though TCE's goal is to provide assistance to improve service quality and client access in reproductive health and family planning areas, through training and monitoring support all the staff learned how to be more confident, how

to be more professional, and how to provide good services to all clients including women, men, and small children. The positive change was not only seen in terms of reproductive health and family planning but in general.”

–Commune Health Station staff

### **Training and professional development opportunities for CHS staff.**

The TCE program provided regular training and monitoring supervision and enabled the CHS staff to improve and expand clinical, interpersonal, and management skills. Program staff reported greater confidence in their ability to provide high quality care to clients, and felt that this enabled them to improve their reputation in the community.

### **Build capacity of the local health system to manage health service delivery.**

The program engaged local government and local health officials at the commune, district, and provincial level, and in this way supported the strengthening of the public health infrastructure. Technical support provided by MSV included clinical care management, facility and program management, quality improvement, and monitoring and evaluation. District and provincial health staff were able to take the tools and skills developed through the TCE program to replicate the successes of the program in other health facilities and strengthen training and management procedures across all facilities. CHS staff were able to implement broader quality improvement and management changes across all services provided at the facility.

## Challenges

### **Maintaining sustainable finance following end of donor support.**

Although the program was primarily funded through existing government sources, donor funds did provide essential support for the start-up and scale-up phases of work. Overall, the program has been quite successful in mobilizing public funds to sustain and expand the work, but there are challenges particularly in poorer provinces and districts with less resources available for health.

### **Building sustainable relationships between government and private sector partners.**

The TCE franchise model is different from the standard model of care at CHS, in terms of the emphasis on patient-centered care and the business focus. Gaining support from public sector partners required on-going sensitization and communication to bridge gaps in working styles and minimize feelings of competition.

The success of the program depended on the motivation and effort of the CHS head, leadership of Provincial/District Department of Health, and support of the District Health Officer to implement the program. Staff turnover in these positions was a challenge to maintaining interest and support for the program.

## Summary

The TCE program helped to improve reproductive health services by improving the quality of care and utilization of services at CHSs, and increasing the capacity of CHS staff. Although initially funded by donor and government financing, once donor funding ended, local governments have continued to manage, fund, and in some cases expand the program.



# Lessons learned from implementation

Across the private sector programs in this study, there are several key factors that have helped enable the success of their government partnerships, purchasing platforms, and service delivery. Each model and setting is different, with a unique history and financial arrangement with local government partners. However, there are common themes that key stakeholders from each partnership pointed to as important to the program's success. These lessons learned can help inform private sector programs hoping to establish or expand similar models and partnerships in other settings.

## Key lessons for private sector intermediaries establishing public financing partnerships

1. Work from shared public health goals.
2. Build strong relationships with government partners through early engagement, regular communication, collaboration across the public sector, understanding government processes, and building strong accountability mechanisms.
3. Have a dedicated position or office to oversee and guide public private partnerships with the Ministry of Health.
4. Engage in policy making.
5. Establish a clear and long-term Memorandum of Understanding outlining terms of relationship.
6. Building systems that can be integrated into, and are valuable for, government.
7. Focus on innovation, data, and impact.
8. Prepare mechanisms to prevent and overcome financial constraints.

### 1. Work from shared public health goals.

Having shared motivation and program goals facilitates strong partnerships between private sector programs and the public sector; aligning the goals and incentives of both partners is essential to success. For example, both CHAM and CHAZ have focused on creating a network that could help the government achieve its

UHC goals by expanding access in rural areas, while the partnership enabled CHAM and CHAZ facilities to expand access to poor populations and increase the sustainability of network facilities. Similarly, Karuna Trust specializes in serving rural populations that the public health system struggles to serve, and through its government partnership the organization gains greater stability and reach. TCE worked with district health officials to identify a challenge in the public sector – utilization and quality in commune health stations – and design a program that strengthened community health systems, improved utilization of commune health stations, and met MSV's goal of improving access to reproductive health services.

They are not competitors but partners, with the same goal to save the same community.”

– *Regional CHAM staff*

“The best of CHAZ and the best of government finds itself in each facility. The beneficiary is the people. NGOs innovate, we try new things and we move faster. Government has got huge resources at their disposal, they've got steady resources. You have two groups of imperfect people, two imperfect entities bringing their comparative strengths in one institution.”

– *National CHAZ staff*

### 2. Build strong relationships with government partners.

All programs discussed the importance of building strong and transparent relationships with public sector partners at the national and local level, and each program had staff positions dedicated to establishing and sustaining these relationships. Key factors for strong partnerships include:

- **Engaging government from day one:** Possible and TCE both engaged government partners in the process of identifying problems, designing implementation solutions, and evaluating impact. This ensured a higher level of buy-in and support from government staff, and ensured that programs were



better aligned, and not in competition with, public sector programs. Engagement at senior levels of government also facilitated stronger relationships. CHAZ works closely with the minister of health, minister of finance, and permanent secretary, setting a strong collaborative relationship that supports engagement down to the district level.

- **Keeping open lines of communication:** All programs talked about the importance of trust in facilitating a successful partnership, and pointed to the role open communications and relationships had in building trust. Continuous sensitization about the program and planned work also built transparency, buy-in, and trust from government partners. Government partners appreciated being regularly consulted and engaged to improve the program, share lessons learned, and troubleshoot challenges.
- **Working at the national and local level and across multiple agencies:** Each program emphasized that government partnerships don't work without strong relationships at every level of government. TCE, CHAM, CHAZ, Karuna Trust, and Possible have staff dedicated to leading advocacy at the Ministry of Health at the national or state level to raise awareness of the program and negotiate MOUs and contracts, but also have staff in district and regional offices responsible for liaising with local health and government officials, managing implementation challenges and disputes at the local level, and generating greater commitment from and coordination with local partners. Without this multi-level approach, these partnerships would not be possible. Working with multiple departments within the MOH and with multiple ministries is also essential. Possible has strong relationships with at least seven MOH departments, while CHAM coordinates closely with several units in the MOH. CHAZ works closely with the MOH as well as several other ministerial and policy agencies. Liaising with other ministries who have a role in establishing health insurance and health finance programs that have an impact on intermediary operations enable these organizations to ensure a place for their programs in developing health systems.
- **Understanding government norms and systems:** Understanding the legal, policy, and bureaucratic systems, as well as the work culture and process of government agencies, was essential to the success of these partnerships. Programs that spent time learning the "language and processes of their partner entities were better prepared to navigate public bureaucracies and negotiate advantageous partnership agreements.

- **Implement strong accountability systems:** Several programs reported that financial accountability and transparency systems were crucial to building and maintaining a trusting and strong relationship with government partners. For example, CHAZ reports that they are one of the primary government partners because they are seen as a "credible" organization as a result of their focus on accountability to the government in terms of program results, financial management, and transparency.

"It takes a lot of time, it's a process. But through these years we have been able to establish the fact that together we can do better. We are growing together as partners. We don't want to undermine the authority of the government, we want the government to continue to have the ownership, regulation, and financing as part of their responsibility. We are not creating a parallel system. We are strengthening the government infrastructure, the government system."

– National Possible staff

### **3. Have a dedicated position or office to oversee and guide public private partnerships with the Ministry of Health.**

All programs mentioned the challenges in working with ministries of health when there is not dedicated staff with which to liaise. Having a central point of contact who can provide guidance on relevant policies and administrative processes is crucial for gaining access and operating smoothly. In a decentralized government such as India, this central point of contact is critical at the state level. Program staff in Malawi, Vietnam, India, and Nepal also mentioned that frequent turnover of district health officials posed a challenge, as staff had to continually build new relationship and explain the value and role of private partner. In some cases, this was made more difficult due to the lack of consistent leadership and guidance from the MOH regarding the relationship between the public and private sector. In Malawi, a recent change to have all finances flow through the MOH has facilitated a much smoother relationship as compared to the earlier arrangement where each contract was managed at the district health level and variation in the interest and capacity of district health managers resulted in wide variability of implementation across districts. The Malawi MOH recently established a new PPP unit that will be supporting the CHAM-MOH relationship, and many respondents feel this will improve the relationship and operation of the MOU and SLAs. In Nepal, the MOH is also in the

process of passing a PPP act that Possible hopes will help facilitate a stronger relationship and expansion of the partnership.

“Our reputation, our legacy in Accham, that’s why we are here in Dolhaka. We had to keep building the relationship, no matter which government came, no matter who the minister or who the cabinet is. We had to have all our team members focusing on building up that relationship with the ministry, with our donors, at the district level. All kind of relationship building was very critical.”

–*National Possible staff*

#### **4. Engage in policy making.**

Government policies, outside the specific contractual agreement, have a significant impact on how private sector organizations can operate and what role they can play within the health system. Programs that were engaged in national and state level health policy discussions were better able to negotiate policies that facilitated their operation. For example, in Vietnam, MSV staff worked with the General Office for Population and Family Planning to ensure that sexual and reproductive health guidelines allowed the operation of programs like TCE. CHAM and Possible are engaged in national discussions about establishing PPP policies and departments, contributing their experiences and lessons learned to future guidelines and practices governing public-private collaborations. CHAZ plays a central role in health policy making in Zambia, participating in both system-wide and disease-specific policy and implementation discussions. This role enables CHAZ to build a supportive policy and financing environment for their network. In India, Karuna Trust has played an important role in helping inspire and support state governments to establish policies to create PPPs and the appropriate MOUs to facilitate success.

“We needed to have one body, one voice. We needed to strengthen our advocacy role and we needed to strengthen our representation... We have a national presence, and we articulate our national presence... That’s what we bring to the table in the health sector, the experience at the community level, the experience in health services delivery, the experience in working with government.”

– *National CHAZ staff*

#### **5. Establish a clear and long-term MOU outlining terms of relationship.**

Programs that had clear and binding agreements with the government reported this as the foundation of a successful partnership. For example, CHAM reports that the five-year MOU provides more sustainability and security to both parties than the SLAs, which vary year by year. CHAZ has also moved towards longer-term MOUs that enable parties to ensure commitments will be met over time while also building in opportunities to review the terms of the agreement. In both cases, the MOU includes mechanisms for reviewing contractual terms and outlines processes for renegotiating contracts and handling conflicts between parties. In contrast, Karuna Trust staff hope to lengthen the duration of their one-year MOUs with state governments to increase program stability.

#### **6. Building systems that can be integrated into, and are valuable for, government.**

All programs reported that the key to success is operating programs that are complementary to, not duplicative of or in competition with, government health services. This includes operating in underserved areas, as in the case of CHAM, CHAZ, Karuna Trust, and Possible, or providing services that the public sector was not previously providing, such as TCE’s focus on reproductive health. In addition, programs that build new systems to support the government or that could be integrated with government programs provided an added benefit to both parties. For example, Possible’s model emphasizes working with and through government systems, rather than as a parallel private entity, and has established a number of systems with the goal that these be replicated in the public health sector. Possible’s electronic health record system was designed on an open platform and following a model that enables it to be integrated with government information systems. Possible also follows all government guidelines and processes regarding procurement, and uses its own procurement system only as back-up when government is unable to provide necessary stock. The program tries to balance its organizational goals with government and community demand. For example, Possible worked closely with the District Health Office to design the community health worker program, and responded to the government’s request to expand to Dolhaka even though that wasn’t a district that matched with the mission of serving rural areas in Nepal. Likewise, TCE developed capacity-building, management, and quality assurance programs that could be easily integrated into the local health system, enabling the expansion of the program beyond TCE’s initial program sites. Similarly, Karuna Trust doesn’t intend to manage their facilities forever and is investing in improvements that can be maintained when its clinics return to government management.

## **7. Focus on innovation, data, and impact.**

By starting small, building a track record, and using this to scale the program, these intermediaries were able to build trust with the government. All programs reported that being able to show impact helps with gaining support from the government, and in many cases, enabled them to expand their partnership from a non-financial to a financial one. Innovation, piloting, and testing programs, and using evaluation and implementation research to identify and scale successful programs was key for several programs, such as Possible and the Hidalgo PPP. For example, Possible collected extensive data on program quality and efficiency that enabled the program to build stronger health services and supply chain programs, and that data was also used by the government in the process of establishing health insurance programs and budgets. Possible has since signed an MOU with the Nepal Health Research Council to establish an implementation research unit in Nepal to support with public and private sector operations. Likewise, TCE was able to use their performance and cost-effectiveness data to build buy-in for the program from government partners.

## **8. Prepare mechanisms to prevent and overcome financial constraints.**

Each of the programs had increased financial sustainability due to the purchasing platforms established with governments, but simultaneously struggle to manage delayed or insufficient public sector funding. CHAM, CHAZ, and Karuna Trust regularly experience delays in receiving government funding due to complicated administrative processes between the national and sub-national governments and the organizations. These delays create funding gaps that hinder service delivery and staffing. Related, Possible and TCE are both concerned about increasing and sustaining government funding. Each of the organizations also have substantial financial costs beyond service delivery to manage the public-private partnership. As these organizations look to continue these partnerships, establishing improved payment processes and methods to sustain ongoing government resources will be essential.

# Conclusion

This series of case studies examines six different private sector intermediaries and health delivery programs with established partnerships with the public sector. Based in India, Malawi, Mexico, Nepal, Vietnam, and Zambia, and varying in size and reach, these programs each have agreements with their governments that allow them to access and manage public sector funding. As we learn through this series, these purchasing platforms are significant because they help integrate private providers into the public health system and provide a mechanism to facilitate improved access and quality of health services. These platforms can help achieve public health goals, while also providing increased financial sustainability for private sector programs, and methods of accountability for both parties.

To address the evidence gap in how public-private financing partnerships operate, this series documents a diverse range of program, partnership, and financing models. We identify practical learning from program staff and their government partners on how these partnerships were established, how the funding arrangements are structured, and benefits and challenges in implementing the partnership. We also synthesize lessons from these case studies to help inform policymakers and practitioners in other settings on strategies to develop and leverage public-private partnerships to help achieve universal health coverage.

