



HEALTH RETURNS

THE ROLE OF PRIVATE PROVIDERS IN DELIVERING UNIVERSAL HEALTH COVERAGE

Report of the WISH Role of the Private
Sector in Healthcare Forum 2018

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Suggested reference for this report: Roland J, Bhattacharya-Craven A, Hardesty C, Fitzgerald E, Varma N, Aufegger L, Orlović M, Nicholson D. Health Returns: The Role of Private Providers in Delivering Universal Health Coverage. Doha, Qatar: World Innovation Summit for Health, 2018

ISBN: 978-1-912865-07-9

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FOREWORD

Good health is essential for sustained economic and social development, and for poverty reduction. This requires everyone in society to have access to health services, while being protected from financial hardship due to the cost of healthcare, also known as universal health coverage (UHC). Achieving UHC is one of the most pressing global priorities, and is prominent in the Sustainable Development Goals defined by the United Nations (UN) in 2015, most notably the goal to "ensure healthy lives and promote wellbeing for all at all ages."

However, more than 1 billion people worldwide still lack access to even basic healthcare, making the goal of "health for all" by 2030 hardly achievable. To drive UHC on the international agenda, private healthcare providers will be an essential component in the delivery of health services for almost all countries working toward UHC. This is especially relevant for developing countries where public healthcare systems are largely underfunded and underdeveloped.

This report aims to provide policy recommendations for creating the right environment for private partners to invest in changing their business models and services. It offers proposed solutions that would help to accelerate more effective public-private collaborations on a large scale.

Through this report, we aim to spark new ideas and initiatives, share recent stories of innovation, and focus on real-world lessons that can be realistically applied across the globe. Concentrating on service provision – how care is delivered and purchased in a way that aligns with UHC – this report addresses areas that have the greatest scope for innovative thinking and debate.

Every country pursuing UHC will face its own unique set of challenges to align the full potential of private providers with the goal of "healthy lives for all" by 2030. This report's recommendations are aimed at the public and private sectors that can act together to achieve this goal, ultimately improving the condition of people across the world who still lack access to quality healthcare.



A handwritten signature in black ink, appearing to read "D. V. Darzi".

**Professor the Lord Darzi of Denham,
OM, KBE, PC, FRS**

Executive Chair, WISH, Qatar Foundation
Director, Institute of Global Health Innovation,
Imperial College London



A handwritten signature in black ink, appearing to read "David Nicholson".

Sir David Nicholson

Visiting Professor, Institute of Global Health
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EXECUTIVE SUMMARY

Sustainable Development Goal 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services, and access to safe, effective, quality and affordable essential medicines and vaccines for all.¹

Private healthcare providers are an essential component in the delivery of free or low-cost health services for almost all countries working toward universal health coverage (UHC). The UN's Sustainable Development Goal (SDG) 3.8² of "healthy lives for all" by 2030 is too ambitious to be achieved without leveraging existing private capacity, investment and innovation. After all, private providers frequently represent half or more of the provider capacity in health systems that aspire to UHC. They are also leading many promising efforts to develop future care models that can expand access through technology, standardization, skills mix and economies of scale.

As a result, this report argues that the inability of private providers and public payers to work effectively together at significant scale in many countries is a major barrier to achieving UHC by 2030 (SDG 3.8).

This report is divided into four sections:

- **Section 1** looks at the importance of aligning public and private sectors on the provision of health services for UHC.
- **Section 2** asks whether established private providers are responding sufficiently to the size of the UHC opportunity, and if not who is.
- **Section 3** sets out lessons for governments in creating the right conditions for 'UHC-ready' private providers to thrive.
- **Section 4** puts forward three proposed solutions that would help to address underlying issues in the misalignment of public and private sectors for UHC at a global level.

For private providers, UHC represents both an opportunity and a threat. The opportunity comes from the chance to access a larger number of patients under public contracts, often through new national health insurance (NHI) schemes such as those being rolled out by India, Indonesia, Kenya, South Africa, Egypt and many others.

The threat comes from the shift in future spending trends for healthcare. In the coming decades, public payers will take an increasingly dominant position in low- and middle-income countries implementing UHC. As a result, traditional

private sector revenue sources from out-of-pocket payments and voluntary private insurance are projected to grow significantly more slowly than public funding, and in some cases decline in real terms.

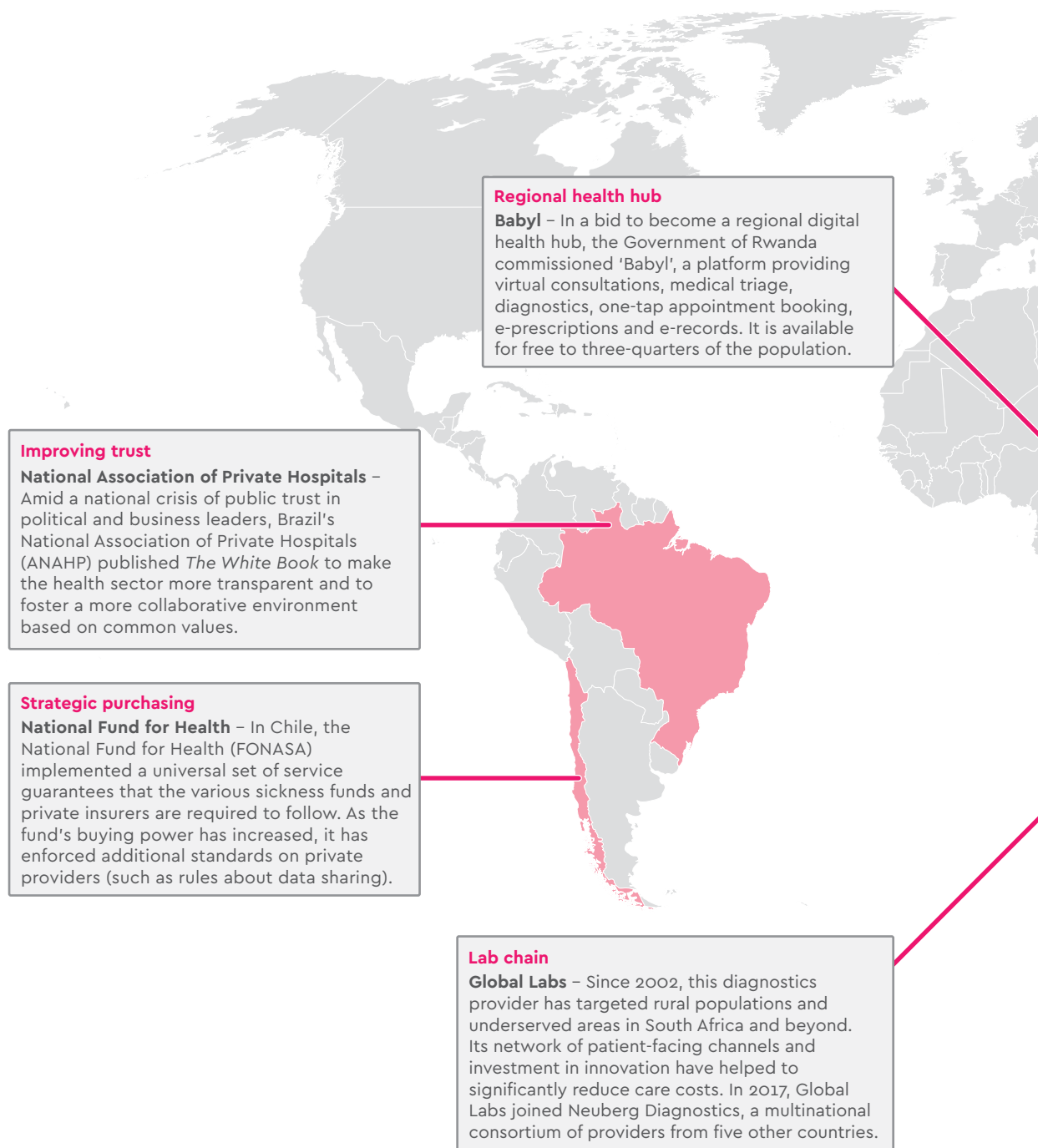
However, future partnerships face the barrier that demand from public payers is likely to be for different kinds of services than many private providers currently offer: for scale and standardization, not fragmentation and variation; for 'last mile' access to the poorest and most vulnerable, not urban islands of excellence; and for innovations that can increase affordability rather than cost.

The World Innovation Summit for Health (WISH) wanted to find out if established private providers are preparing to take up these opportunities of new business and service delivery models. To find out, we surveyed 20 of the largest private provider chains operating across 40 low- and middle-income countries – representing the operators of more than 500 hospitals and 7,000 clinics or lab facilities.

It is clear from our survey results that most are not. Only a quarter of providers expressed a clear intention to shift their business and service delivery models toward publicly financed universal care services. A further quarter expressed a clear intention *not* to do this. The remaining half either expressed a desire to work with governments without significantly changing their mix of patients and reach of services, or planned to broaden their delivery model but without public partnerships.

This mixed picture raises the question of who else may be willing to take up the opportunities created by countries aspiring to fund large-scale UHC programs, and suggests that there may be space for new market entrants. The investment community has the opportunity to play a powerful role in readying the private provider market for UHC, but needs to broaden the narrow lens with which most investors currently assesses impact on the wider health system.

Governments also have much to improve in the way they engage private providers on the journey to UHC. A lot of attention and resourcing goes into the design and technical aspects of policy reforms, but more fundamental building blocks such as trust, dialogue and relationships are often forgotten.



Regional health hub
Babyl – In a bid to become a regional digital health hub, the Government of Rwanda commissioned 'Babyl', a platform providing virtual consultations, medical triage, diagnostics, one-tap appointment booking, e-prescriptions and e-records. It is available for free to three-quarters of the population.

Improving trust
National Association of Private Hospitals – Amid a national crisis of public trust in political and business leaders, Brazil's National Association of Private Hospitals (ANAHP) published *The White Book* to make the health sector more transparent and to foster a more collaborative environment based on common values.

Strategic purchasing
National Fund for Health – In Chile, the National Fund for Health (FONASA) implemented a universal set of service guarantees that the various sickness funds and private insurers are required to follow. As the fund's buying power has increased, it has enforced additional standards on private providers (such as rules about data sharing).

Lab chain
Global Labs – Since 2002, this diagnostics provider has targeted rural populations and underserved areas in South Africa and beyond. Its network of patient-facing channels and investment in innovation have helped to significantly reduce care costs. In 2017, Global Labs joined Neuberg Diagnostics, a multinational consortium of providers from five other countries.

Partnerships

Sidra Medicine and Al-Ahli Hospital – In Qatar, private providers have sought to complement the existing system of public and private facilities through a range of partnerships. These include sharing staff and equipment with public hospitals and clinics, and implementing referral protocols and scope-of-service agreements for seamless patient care between different types of facilities.

New models of care

Mohalla Clinics – A network of lean primary care clinics has rapidly expanded in Delhi by using a mixed public-private model. Several other states in India are now learning from and implementing similar models.

Providers

Apollo Hospitals – This group is India's largest hospital, clinic and pharmacy chain. Having built the business predominantly on self-paying patients, the leadership sees publicly-funded services as significant to its future growth. A partnership for 164 Electronic Urban Primary Health Centers (eUPHCs) is already operational in Andhra Pradesh. Apollo is now reconfiguring its offerings to state governments around four key propositions: population wellness, rural primary care, urban primary care and hospital services.

Digital Health

Telenor Health – This digital healthcare platform has more than 5 million members across Bangladesh. It offers a 24/7 doctor-led healthline, a patient navigation system, discounts at more than 1,700 enrolled providers, and personalized wellness information. Initially launched as a value-added service to Grameenphone subscribers, Telenor Health is now actively exploring opportunities to adapt its business model into a free public service funded by governments.

Driving out poor performance

SafeCare Foundation – To create an appropriate model of accreditation for lower-level private providers in newer health systems, SafeCare was developed to enhance and regulate quality via a process that could realistically be maintained by public payers across Africa.

Social franchising

The African Health Markets for Equity Program – In Kenya, the AHME program was created to aggregate, train, brand and contract small-scale, low-cost primary care providers – turning a fragmented market into a coherent network of private providers for payers to work with.

While there is no perfect route to creating the right conditions for a 'UHC-ready' private sector, this report highlights five elements of an enabling environment. Each of these are illustrated with a case study of practical progress around the world.

- 1.** Provide certainty over future public financing and purchasing of UHC for the poorest and most vulnerable – and follow through on funding commitments.
- 2.** Provide clarity over the direction of UHC reforms, and what is required of public and private providers.
- 3.** Improve trust between public and private stakeholders through transparency and measures to address the most common concerns over collaborations with government.
- 4.** Drive out poor performance from all providers using 'carrot and stick' mechanisms.
- 5.** Encourage and co-invest in new models of care and new market entrants, particularly for primary care.

This report concludes with three proposed solutions that would help to accelerate more effective public-private collaborations on a large scale:

- 1.** A global network of 'Investors for Health' dedicated to developing 'UHC-ready' approaches to selecting and managing their investments in private healthcare companies.
- 2.** A mediation service to improve the quality of dialogue between public and private sector organizations in UHC-aspiring countries, hosted by a neutral international group or platform.
- 3.** A sector collaboration charter to assess the readiness of the public and private sectors in a country to work together to achieve UHC.

SECTION 1. THE IMPORTANCE OF ALIGNING PRIVATE HEALTHCARE PROVISION TO UHC

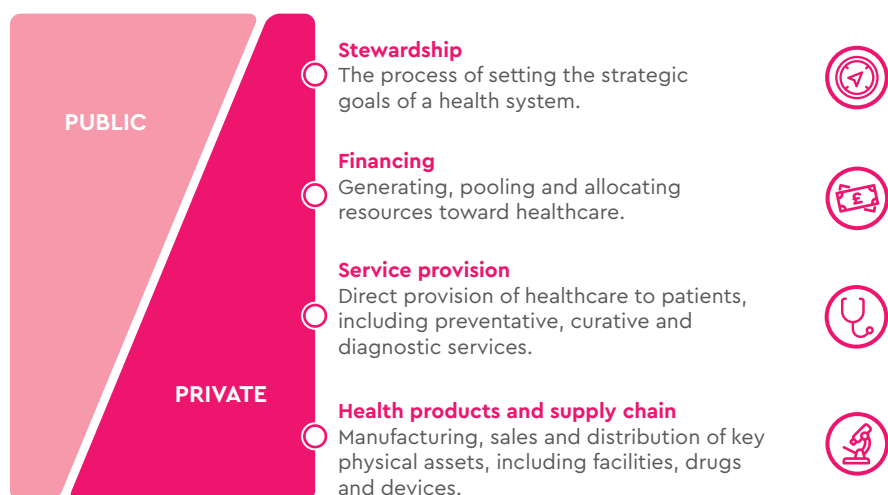
UHC: All people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. (World Health Organization)

The question at the heart of this report is how we can create more effective, ambitious and scalable public-private collaborations to achieve universal health coverage (UHC). As befits the mission of WISH, our aim is to spark new ideas and initiatives, share recent stories of innovation, and focus on real-world lessons that can be realistically applied across the globe.

While there are innumerable ways that the private sector impacts health, this report concentrates on service provision – how care is delivered and purchased in a way that aligns with UHC – as the area with the greatest scope for innovative thinking and debate.

There is a great deal of consensus in existing research literature that areas such as health system governance and stewardship are best led by the public sector (see [Figure 1](#)).³⁻⁶

Figure 1. A typical public-private mix in many health systems



Source: Reproduced with kind permission of Julio Frenk, President, University of Miami, Mexico, and former Minister of Health for Mexico

This is also the case with the majority of health financing – preferably via mandatory, state-funded systems – as argued in the previous WISH report *Delivering Universal Health Coverage: A Guide For Policy Makers*.⁷ On the opposite side, there is little debate that the manufacturing and supply of health products (for example, drugs and devices) is best led by the private sector on the whole.⁸

Where there is far less consensus is the *provision* of free or low-cost healthcare services under systems pursuing UHC. Here, there are as many models as there are nations with UHC, as each country strives for an optimal balance between risk and control, affordability and innovation, competition and consistency. Because of this diversity, governments currently engaged in devising their UHC strategies are faced with an array of complex choices about the role they see for private sector providers, including:

- **What** services should be purchased from private providers?
- **Who** should (and shouldn't) they be purchased from?
- **How** can the right kinds of care be scaled up, and low-value or low-quality services be discouraged?
- **How much** should be paid and under what kind of contracts?
- **When** should private providers collaborate with public ones, and when should they compete?

These decisions will have a profound and long-lasting impact on progress toward UHC between now and 2030.

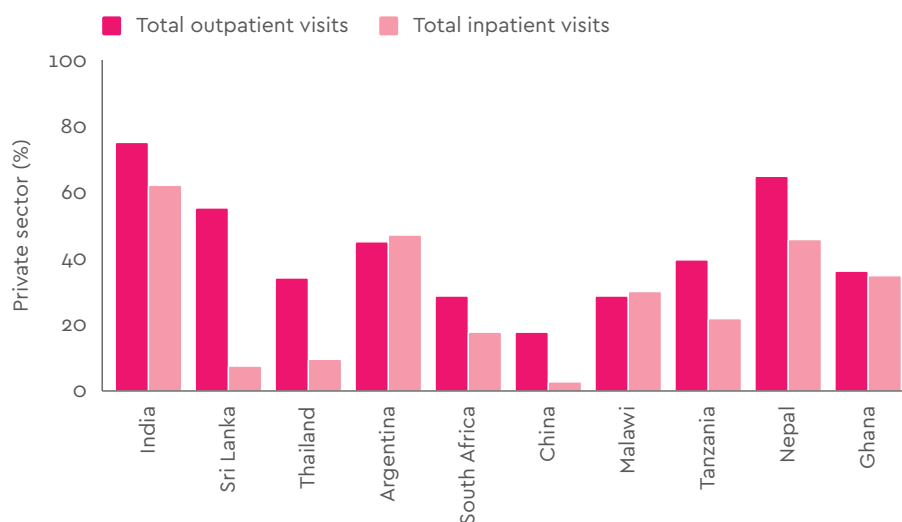
There are three primary reasons why the case for alignment between public and private sectors on UHC is so compelling.

1. The scale of the technical and resourcing challenge facing many countries is enormous. An analysis by Stenberg and colleagues showed that, across 67 low- and middle-income countries, there is an annual health spending gap of between \$274 billion and \$371 billion for them to make significant progress toward their 2030 commitments for UHC.⁹ Similarly, the WHO's most recent analysis estimates a shortfall of 17 million people in the global health workforce (including doctors, nurses and midwives by 2030), the majority in Asia, Africa and the Middle East.¹⁰ Most governments will struggle to fill this shortfall alone. Private investment and expertise will be needed to close the gap and find more cost-effective ways of delivering more with less.

2. The scale of the private health services sector is too big for many governments to ignore as they plan for universal access by 2030. As Figure 2 shows, the private sector makes up a large proportion of outpatient and inpatient care in many major health systems.¹¹ In a separate study surveying 77 low- and middle-income countries over a 25-year period, more than 50 percent of people reported using private providers as their first choice for basic care.¹²

3. Many countries at the forefront of UHC have chosen models that will rely heavily on private providers in the future. NHI schemes form the cornerstone of UHC reforms in Egypt, India, Kenya, South Africa, Indonesia and many other countries – mostly with an explicit intention to purchase publicly funded health services from private providers on behalf of patients, and especially the most vulnerable. Even in countries pursuing alternative models to NHI, there is strong growth in the size and number of healthcare public-private partnerships (PPPs). A 2017 analysis by KPMG showed strong rates of growth in the PPP healthcare market shifting from mature European systems to Asia, Latin America and Africa.¹³

Figure 2. Share of private sector in visits for treatment by country



Source: Macintosh M et al. (2016)¹⁴

With such momentum, it is vital that the private sector's role in delivering countries' UHC ambitions is properly co-ordinated. Alignment can accelerate progress toward UHC by providing investment, innovation and expertise. Misalignment brings a danger of purchasing poor-value care, of partnerships proving unsustainable, or of profiteering actively delaying the achievement of health for all.

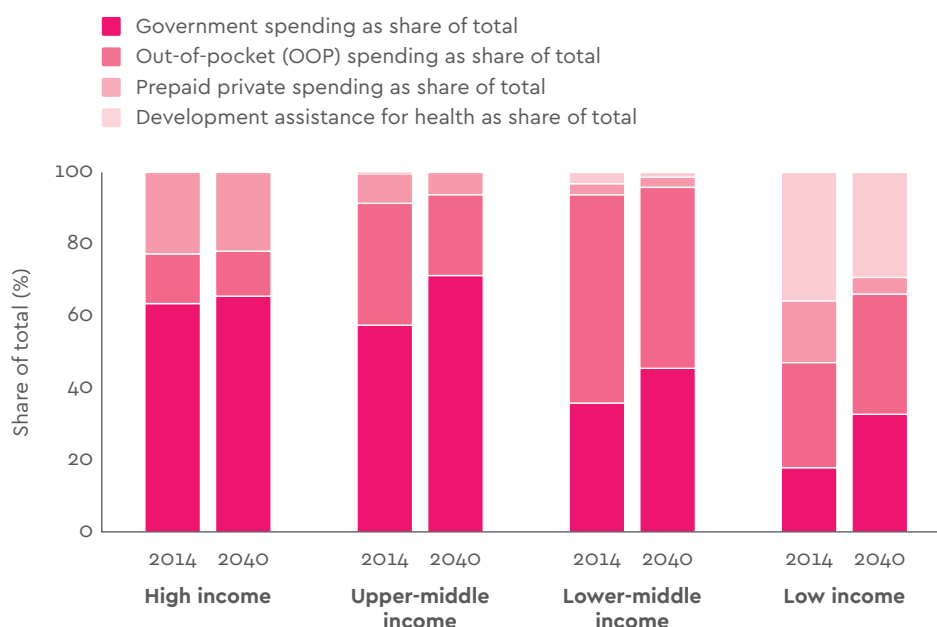
SECTION 2. HEALTH FOR ALL: THE BUSINESS CASE FOR PRIVATE PROVIDERS

Political momentum behind UHC is at an all-time high. Governments around the world are making major financial commitments toward universal coverage, and many national leaders are also grasping its political value at the ballot box. For the private healthcare sector, this rise represents a threat and an opportunity.

The threat comes from the decline in the proportion of self-paying and privately insured patients, which can be expected as a result of a rise in well-designed and funded public UHC programs. As Figure 3 shows, the share of health spending from out-of-pocket (OOP) and prepaid private sources is projected to fall across countries of all income levels over the next two decades, with the exception of OOP in the lowest-income countries which will remain flat. This is good news for UHC, but a challenge for the majority of providers in emerging markets where OOP and private insurance make up the vast majority of revenues.

On the positive side, the comparatively stronger growth in public spending represents an unprecedented opportunity. National UHC programs can be enormous in scale and spend: the World Bank's analysis of 24 UHC reforms in developing countries found that the median annual spend on national programs was 1.4 percent of the countries' gross domestic product (GDP) and as high as 6.8 percent in some.¹⁵

Figure 3. Projected total health expenditure by source¹⁶



Source: Global Burden of Disease Health Financing Collaborator Network (2017)¹⁷

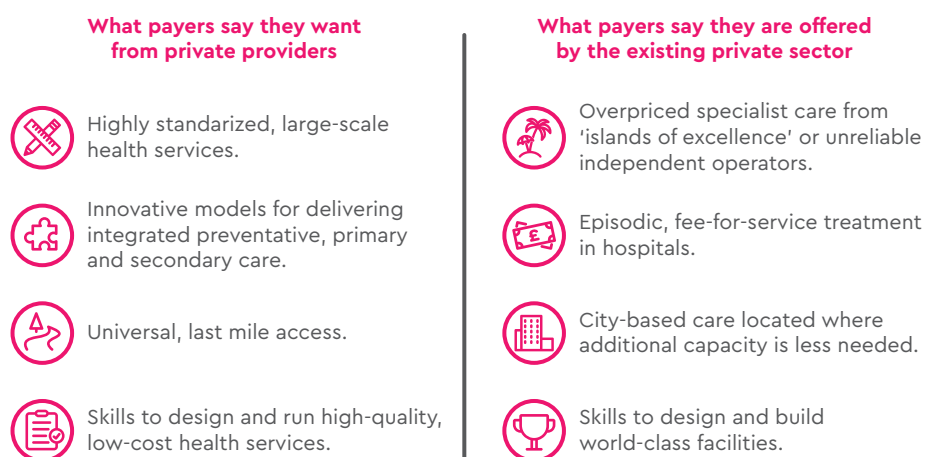
Large-scale publicly financed UHC programs have the potential to create entirely new markets for healthcare. In Indonesia, for example, the NHI scheme Jaminan Kesehatan Nasional (JKN) launched in 2014 as a purchaser of comprehensive primary, secondary and tertiary care services on behalf of the population. By 2016, more than half of the nation's private hospitals were enlisted as providers of JKN's services, and around 60 percent of the \$6 billion budget for hospital services was being channeled toward these organizations to offer free services delivered under JKN.¹⁸

Defining the opportunity: What do public payers want from private providers?

Private providers keen to pursue the opportunities of publicly financed health-care will have to adapt to the different priorities that public payers may have, and shift their service delivery models accordingly.

Interviews for this study with large public organizations in Ghana, Kenya, Morocco, Indonesia, Chile and India revealed that, in looking ahead to UHC by 2030, their future purchasing decisions will be different from what their local private market is currently focused on. They expected to focus less on infrastructure and episodic care, and much more on the areas they see as in greatest need of new ideas, expertise and investment. These include integrated pathways of care, both in and out of hospital, primary care in rural and underserved areas and innovations in digital healthcare.

Figure 4. Misalignments between public payers and private providers in UHC



For all of these areas, a priority will be having the capacity to treat very large numbers of patient, with a high level of consistency in the quality of care through standardization. Small-scale purchasing models simply won't have the reach to make them worthwhile in the race to increase access for millions of people.

Comparing this anticipated demand with how interviewees in our survey characterized the current private sector in their systems – fragmented, narrow, episodic and either overpriced or highly unreliable – there is clearly a gap. This misalignment illustrates the private sector's current failure to address the health needs of the bottom of the pyramid in many countries. It also shows that it will be a challenge to adapt to a near future where public payers in many markets will be increasing their will, skill and resources to buy UHC-ready services.

"We cannot buy the services we want because they are not there. Ours is a large and diverse country across many islands – but private investment remains only in the large cities."

Atikah Adyas, Senior Researcher, Ministry of Health of Indonesia

"We understand that private sector is not philanthropy, it is driven by the need to make profit. We want to see a focus on the whole spectrum of care – prevention, diagnostics, primary care – but as government we need to provide the right incentives for them to respond to."

Julia Ouko, Health Economist, National Hospital Insurance Fund, Kenya

Without exception, the public payers interviewed for this report accepted that the current failure of the private sector to address their needs was as much due to unclear market signals from payers as any fault of the providers. The scale of public purchasing planned under UHC, however, meant that they now had the opportunity to create much more attractive markets around priority health goals. There were three main ways they planned to do this:

- 1.** Offering standardized service packages and prices that apply to all socio-economic levels – incentivizing evidence-based care and inclusion of the most vulnerable or hard-to-reach patients.
- 2.** Providing assurances around scale and large volumes of patients.
- 3.** Imposing quality and reporting standards that would reward high-value care for those private providers that truly provided it.

Is the private sector responding?

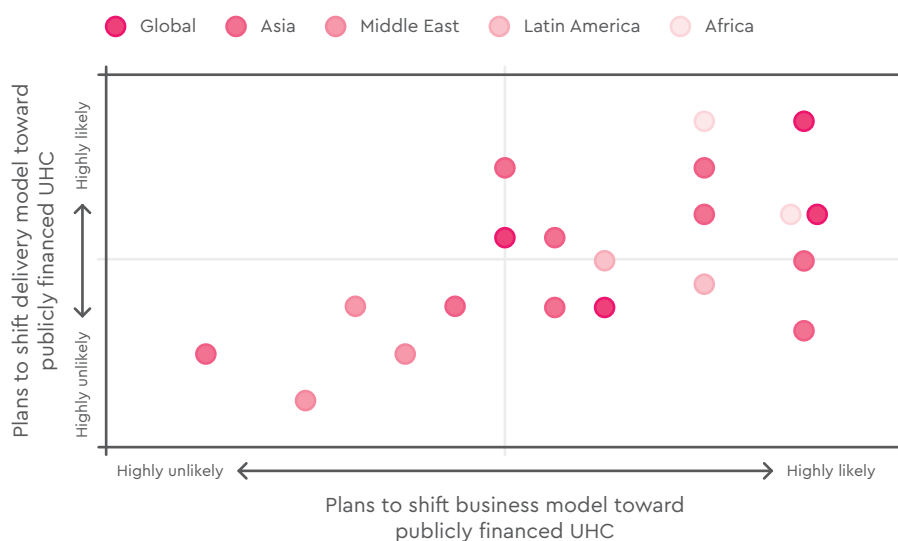
The evidence from our interviews with payers and from current trends in health financing point to a growing opportunity for private providers to deliver mass-scale, publicly funded services under UHC.

Our survey was designed to assess whether established private players in low- and middle-income countries were preparing to capitalize on this market. The research team contacted 24 of the world's largest private hospital and clinic chains operating in low- and middle-income countries. Of these, 20 responded (83 percent response rate).

These respondents represented a mix of large-scale, multinational inpatient and outpatient chains, collectively owning more than 500 hospitals and 7,000 clinic or lab facilities across 40 low- and middle-income countries. Their existing business models were strongly weighted toward self-paying patients (that is, OOP), with 15 respondents stating that this was their largest share of revenue. Four listed private insurers as their dominant payers, and only one listed public financing.

The overall picture suggests that most large private providers are not yet gearing up for the potential opportunities of publicly financed UHC. In response to questions about their plans to change their business model to work with governments, only nine responded 'agree' or 'strongly agree', against a standard five-point Likert scale. Of these, only half responded that they were planning to change the types of services they offered as a result (for example, providing more care to patients of low-socioeconomic status, or those living in rural areas).

Figure 5. Expectations of multinational private providers to change their business models in response to UHC



As [Figure 5](#) shows, roughly one-quarter of responding organizations could be categorized as planning to make a significant shift in their business and service delivery models as providers of publicly financed UHC (top-left quadrant). Another quarter could be categorized as having no intention of changing delivery or business model. The remaining half show some intention either to work with government, but without changing how they provide care, or to change how they provide care, but without looking to government to fund this.

The investment community's role

The survey findings suggest that there may be growing gaps in the market for publicly funded, privately delivered healthcare in countries pursuing UHC. These opportunities could be taken up by:

- Established providers able to develop leaner ways of operating
- Smaller 'UHC-ready' providers looking to scale up
- Non-health players entering the health sector.

In all three cases, the investment community has an important role to play.

All investors in healthcare, whether strictly for-profit or those that incorporate social dimensions, should be mindful of the basic standards that private providers should adhere to. This includes giving safe care, not overtreating patients and not overcharging payers. This is the minimum, but far from all that the private providers and their investors should think about when considering their impact. Interviews with large public payers as part of this study showed a variety of ways in which private providers were seen as uncooperative in their government's pursuit of UHC.

A review by Imperial College London and the CDC Group found that: "private providers cannot be assessed only by how well they care for their patients. Their effect on the broader health ecosystem, often fragile in [low- and middle-income countries], should also be carefully considered, and positive outcomes for the whole health system built into any investment".¹⁹

PUBLIC PAYER PERSPECTIVES ON BARRIERS TO CONTRACTING WITH PRIVATE PROVIDERS

What did we hear from governments?



"The private sector collects data to make money related decisions. They do little with that data to improve services."



"The private sector regards regulation as a nuisance."



"Supplier induced demand is rife. The private sector has benefited from NHI participation as their occupancy rate has improved. But at the same time we see worrying rates of hospitalization."



"As a purchaser, I have no control over how much they will bill my members."



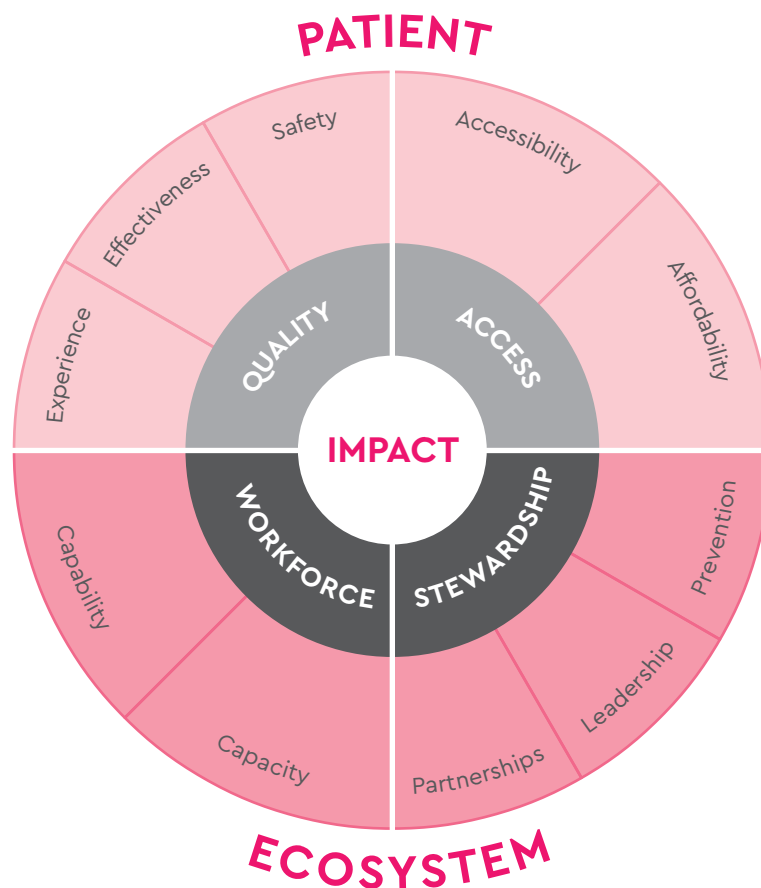
"Hospitals are mushrooming everywhere. It is easy to set these up and they just assume that the government would recognize them - rarely do they actually ask what we need."



"The private sector have their own agenda. So when they come to meet, they already have strong positions and there is limited room for dialogue. Often we have to hire moderators."

Figure 6 displays the framework that resulted from this research.²⁰ It includes the quality of care and access for patients, but also the broader ecosystem effects of private healthcare providers, such as whether they are a net drain on the country's healthcare workforce, and whether they contribute to wider public health efforts.

Figure 6. Health impact framework



Source: Institute of Global Health Innovation, Imperial College London (2017)

To claim any level of alignment or contribution to UHC, private providers and their investors need to think more deeply about their impact, along the lines of the framework in Figure 6. This would have two major benefits for UHC: first, encouraging existing providers to think more deeply about their impact on the wider health system and its goals; and second, increasing the attractiveness of smaller UHC-ready providers so that more responsible companies are able to attract greater investment and support. Interest in these approaches has been growing, but there are currently few opportunities to share learning and approaches across the investment community globally (see Section 4).

Innovation case studies: Private providers preparing for the opportunities of 'health for all'

This section features case studies of private healthcare providers preparing to become 'UHC ready' by changing their business models, service delivery frameworks and scale to meet the opportunities of 'health for all'. They include telecommunications companies, major laboratory chains, private providers, and public-private partnerships. While none claim to have completed this journey, their stories represent the strategies and challenges of private providers actively investing in the possibilities and profit of UHC.

1. Telenor Health, Bangladesh

Telenor is one of the world's largest mobile telecommunications networks, with the bulk of its 173 million subscribers based in low- and middle-income countries. Healthcare is a core part of the organization's strategy to continue growing its offering in emerging markets. This led to the creation of an in-house start-up, Telenor Health, in 2015.

Telenor Health's first product was Tonic – a digital healthcare platform launched in Bangladesh in 2016 that now has more than 5 million members across the country. Tonic comprises six core services which are offered to all Grameen-phone SIM card holders for free:

1. A doctor-led advice health line, with an artificial intelligence (AI)-led chat function also available online 24 hours a day, seven days a week.
2. Discounts of up to 30 percent for patients seeking care at one of more than 2,000 recommended providers.
3. Hospicash benefit worth up to \$30 that pays out in the event of an inpatient stay.
4. A fully portable personal health record.
5. A provider navigation system to guide patients to the best place to seek care anywhere in the country, as well as reviewing their experience online.
6. Personalized health content that, in response to a person's interests and interactions, provides information and reminders about their health.

Within a year, the platform had become Bangladesh's largest voluntary health insurer by lives covered, as well as its largest telemedicine supplier. The company attributes this success to a combination of convenience, popular demand for reliable health information and value-conscious consumers seeking help with the costs of healthcare.

Looking to the future, Telenor Health is now developing a growth plan to scale the business within Telenor's global footprint and beyond. This includes adapting Tonic into a publicly funded service that could be delivered free as a 'digital front door' to the government's UHC strategies.

"Working directly with health systems through public-private partnerships is the fastest way to scale our impact and help to close these gaps ... We are now actively looking to collaborate with health ministries to use our platform to make UHC more financially sustainable, while also improving patient experience and population health outcomes."

Matthew Guilford, Chief Growth Officer, Telenor Health

The move from a value-added consumer service for Telenor subscribers to a public service is not entirely straightforward, however.

"One of the biggest challenges in scaling these kind of PPPs for UHC is in 'making the case' for governments to invest ... We do need to provide evidence that digital platforms can increase access and lower cost, but there's also a risk of missing the moment for these solutions to have maximum catalytic impact. Finding that balance is something we need to work hard with governments to do."

2. Global Labs, South Africa

Founded in 2002 during the height of the HIV/AIDS epidemic, Global Labs has become one of Africa's fastest-growing pathology providers. It has more than 400 staff across South Africa, and operations that cover Nigeria, Botswana, Namibia, Malawi and Zimbabwe.

Its strategy has been to target rural populations and primary care centers in some of South Africa's most underserved areas. The business model often involves initial entry into a local market through large clinical trials contracts. Clients include Médecins San Frontières (MSF), Centre for the AIDS Programme

of Research in South Africa (CAPRISA) and the Centers for Disease Control and Prevention (CDC). This provides a stable income base from which to grow a much larger commercial business with doctors, hospitals and patients directly.

Global Labs has worked hard to bring costs down as low as possible without compromising quality. They have done this by:

- Targeting busy primary care centers with large volumes of patients – to offset low margins with mass scale
- Standardizing testing procedures to enable a greater volume of work to be conducted by medical technologists rather than more expensive pathologists
- Creating a 'hub-and-spoke' logistics structure that minimizes fixed infrastructure
- Launching an app for doctors that allows instantaneous, paperless reporting of results
- Investing in product innovations, including dry-blood spot tests that patients can take and submit by post, and the domestic manufacture of common consumables that previously needed to be imported.

Recognizing the gaps in traditional provision in many of its communities, Global Labs' delivery model involves a significant number of patient-facing channels. These include walk-in testing sites, home visits and placing their own nursing staff in some clinics.

The organization already has a range of partnerships with the South African Government to provide services on behalf of the public. These include conducting state-funded training programs for medical technologists and developing new mobile clinics to serve rural areas. They also provide pathology services for the National Health Laboratory Service when they require additional support.

The company's founder and CEO, Dr Lorna Madurai, says that partnerships with the public sector to provide mass-scale pathology services in community and hospital settings are central to the company's future growth strategy:

"Governments, both South Africa's and across the continent, are realizing that the private sector can be a great partner for delivering consistent, mass-scale UHC – and in cases like ours often cheaper than is possible as the public system alone."

However, Dr Madurai says that the company is looking to develop a very different business model as part of their five-year growth plan to expand into other Sub-Saharan African markets.

"We're very conscious of resentment that can be generated by outside companies coming in and being seen to take resources out of less-mature economies. For the markets we're looking at, the equipment is often very good but the skills aren't there and local prices are very high, sometimes 300 percent of what we would charge. We could come in with a traditional acquisition or 'greenfield' strategy and make money in the short term, but that doesn't excite us or seem sustainable. Instead, we want to invest in training the local providers that are there to improve quality and become more efficient. That way we create a more long-term role for ourselves in quality assurance and as a referral lab for these countries. Our bet is that, if we focus on giving back, this will be better for the country and in the long-term better for us commercially too."

Recently, Neuberger Diagnostics – a newly formed multinational chain of pathology providers from five different countries including India, Sri Lanka and the United Arab Emirates – acquired a 70 percent stake in Global Labs. This new consortium will create a unified global brand of affordable pathology providers. The deal also means a significant capital injection, with the group aiming to use this to fuel expansion across Africa, as well investment to further increase efficiency.

3. Apollo Hospitals Group, India

Apollo Hospitals Group is India's largest private healthcare provider chain, with 70 hospitals, more than 100 primary care clinics, 3,000 pharmacies and a popular digital healthcare platform. The Group's business model has been built primarily from self-paying patients, and it has a strong track record of making innovations to continuously reduce the cost of care.

In terms of its future strategy in India, however, the Group's leaders are clear that this will need to change. "Slowly but surely, UHC is coming to India," says Dr Preetha Reddy, Executive Vice Chairperson of the Apollo Group.

"With the announcement of National Health Protection Mission (NHPM), government has clearly reaffirmed its role as the custodian of health for all in India, particularly for the financially challenged population. Our mission is to provide affordable care to everyone, regardless of their ability to pay and, in keeping with it, we will now be looking to forge new partnerships with the public health sector in the country."

Apollo already successfully delivers one large-scale PPP for primary care. Since October 2016, they have opened 164 Electronic Urban Primary Healthcare Centers (eUPHCs) to serve the urban poor across nine districts of Andhra Pradesh. Each center is staffed by a general practitioner, two nurses, a lab technician, an IT executive and a general assistant. Each center is also video-linked to specialists in nearby Apollo hospitals, which provides teleconsultations. All services (including prescriptions) are provided free of charge to patients, with payment coming from the state government via the NHPM.

The eUPHCs have proved popular, with more than 5 million consultations (including 400,000 teleconsultations) and more than 3 million lab investigations to date. As Dr Reddy highlights:

"The remote link with specialists in the hospital as well as the Apollo brand helps people to see the value in visiting the primary care centers rather than going straight to a big hospital."

Looking to the future, the Group sees four major areas of opportunity as a provider of publicly funded healthcare services: hospital care, urban primary care, rural primary care and population wellness programs. They are working with a number of state governments to ensure that their hospitals can be enlisted under the NHPM, but are also encouraging them to develop new models of care that will better reach rural and underserved populations.

"Of course, our future role is dependent on the pricing structure of the new scheme and other details ... but we believe the shift to public-private participation is inevitable, and moreover the passion to serve will always be the most critical element."

Dr Preetha Reddy, Executive Vice Chairperson, Apollo Group

4. Sidra Medicine and Al-Ahli Hospital, Qatar

Qatar has experienced massive growth and increased demand for healthcare over the past two decades. Private sector providers have played a pivotal role in meeting this demand while complementing and coordinating with public providers.

Sidra Medicine is a 400-bed academic medical center in Qatar specializing in care for women, children and young people. A private institution for public benefit, the hospital represents the vision of its Chairperson, Her Highness Sheikha Moza bint Nasser, for a world-class hospital and research center that could complement and positively disrupt the existing government and non-government healthcare systems.

Inpatient services commenced in January 2018, and are undergoing a phased ramp-up toward an official opening ceremony in November 2018. Sidra's goal is to create a sea change in the quality of maternity and pediatric services across Qatar – widely seen as an area of unmet need – while maintaining seamlessly integrated pathways of care for patients across different types of facilities.

The role of the Qatar Foundation, Sidra's parent company, has been critical in ensuring that the design and delivery of the project has stayed focused on the hospital's place within the wider health system, rather than as a stand-alone institution. This has meant that, even prior to the formal opening, a range of model partnerships and protocols were in place.

First, Sidra has worked with Qatar's primary state-owned hospital entity, Hamad Medical Corporation, to devise detailed protocols and network agreements governing the scope of its services compared to existing public facilities. Staff, equipment and patients can be transferred seamlessly and there are clear restrictions on Sidra's ability to recruit staff from public providers. Second, the hospital is leading the establishment of a private sector network across Qatar, aiming to standardize referral pathways for private-to-private patient transfers. Third, Sidra's specialists are placed in public primary health clinics to deliver maternity care in the community.

Established private providers have also developed mechanisms for collaboration with the wider health system. Al-Ahli Hospital is a prestigious 250-bed private general hospital providing a wide range of high-quality services to the Qatar community and beyond. Similar to Sidra, Al-Ahli Hospital works collaboratively with the Ministry of Public Health and other healthcare providers, including Hamad Medical Corporation, to promote quality, standards-based healthcare delivery across the country. The hospital works with other providers to enable smooth transition of care between facilities if required.

Particular priorities for joint working are patient safety and the quality of care improvement. Al-Ahli Hospital actively contributes to a number of public-private initiatives in Qatar. One example is the creation and adoption of National Clinical Guidelines across Qatar – 31 of which have now been completed, with up to 30 more planned over the next two years. Many of Al-Ahli Hospital's most experienced clinicians worked on the expert groups that designed the new guidelines. The hospital is also a leading sponsor and contributor to events, such as the annual Qatar National Patient Safety Week, that help to reinforce their take-up in an effort to promote standardized, evidence-based care to the community.

SECTION 3. HOW TO CREATE THE RIGHT CONDITIONS: FIVE LESSONS FOR THE PUBLIC SECTOR

For private providers to successfully contribute to the delivery of UHC, a range of factors in the policy and business environment need to be aligned: coherent health system plans, effective pools of public financing and rules to support fair competition. Without these, commercial organizations will struggle to invest, or investment will be directed toward the wrong goals.

The track record of many low- and middle-income countries shows that often this enabling environment has not been in place – suspicion, division and a lack of dialogue were noted by interviewees on both sides. The raw financials have also been less than attractive in many countries, with promises of large-scale public reform and investment not followed through.

This has done little to galvanize private-sector confidence in future partnerships. Consequently, many countries have seen two-tier private provider systems evolve – high-quality, high-cost care for the top of the wealth pyramid and under-regulated, often unsafe services for the underserved at the bottom.

As the responses to our private sector survey show, large-scale established providers describe a range of barriers to effective partnership with public payers.

In recent years, a number of reports have explained mechanisms for the public sector to create an enabling environment for the kinds of 'UHC ready' private investment and innovation described in [Section 1](#).²¹⁻²⁶ Together with peer learning networks such as the Joint Learning Network for UHC, these efforts are helping to develop a better understanding of how to do this. In this section, we draw together five key lessons, illuminated by practical, real-world examples:

- 1.** Provide certainty over future public financing and purchasing of UHC for the poorest and most vulnerable – and follow through on funding commitments.
- 2.** Provide clarity over the direction of UHC reforms and over what is required of public and private providers.
- 3.** Improve trust between public and private stakeholders through transparency and measures to address the common concerns over collaborations with government.
- 4.** Drive out poor performance from all providers using 'carrot and stick' mechanisms.
- 5.** Encourage and co-invest in new models of care and new market entrants, especially for primary care.

BARRIERS FOR PRIVATE HEALTHCARE PROVIDERS WORKING WITH GOVERNMENT



"We might sign a Memorandum of Understanding with government, but can we trust that they will actually implement it?"



"There is no transparency or clear governance to monitor and reward the cost, quality or appropriateness of care."



"There is not a level playing field to compete with public providers – they pay less tax and their capital costs are paid via a separate fund."



"Government is not willing to pay the costs of world-class medical care – and we do not want to compromise quality."



"Doctors are in very short supply, and even with salary incentives it's hard to get them to move to areas where government would like us to work."



"Officials and politicians change over quickly, which makes the partnerships we've built unstable."



"Decision-makers are conservative about new ideas and partners, and we encounter a lot of bureaucratic hurdles."

1. Provide certainty over future public financing and purchasing of UHC

Financing levers have a critical role to play in directing private investment in a health system and improving standards of care. Due to a host of political, financial and technical reasons, governments have not always used these levers to align provider markets to their countries' pressing health priorities. Two of the most important initial steps are to increase public funding to a level where it is going to attract providers to participate, and to consolidate existing pools of finance (or at least align them). Together, these steps can significantly increase a government's 'payer power' and its ability to shape the market.

"National Hospital Insurance Fund (NHIF) is member-led and split across three different plans. In order for NHIF to become a powerful purchaser, we need increased financing through taxation or budget allocations and improved pooling so we can speak with a stronger voice when shaping the provider market."

Interviewee from Kenya NHIF

Thailand is one country that has navigated this path well over the past 15 years, with a series of incremental reforms to health financing and spending that have made it a trailblazer for UHC success. Due to Thailand's sizable informal sector, efforts to finance healthcare through payroll taxes and employee benefit schemes never managed to progress beyond 30 percent of the population. With the introduction of the Universal Coverage Scheme (UCS) in 2002, the Government took three critical steps:

1. Consolidating two suboptimal schemes for the poor (the Medical Welfare Scheme) and the near-poor (the Voluntary Health Card Scheme) to form a bigger, well-defined budget for health.
2. Making the UCS a mandatory, automatic-enrollment process to avoid the pitfalls (and costs) of means testing and inaccurate targeting.
3. Introducing a 2 percent levy on tobacco and alcohol sales, in addition to the consolidated budget that was solely earmarked for health.

The consolidation of revenue streams meant that UCS now covers nearly 48 million people (75 percent of the population), making it the largest scheme in the country, working alongside schemes for the formal sector (24 percent). The 2 percent levy for health was used to strengthen preventative and primary healthcare – a cross-cutting intervention that worked across all schemes to

benefit the entire population. These changes ensured a steady flow of additional funds for health. To date, they have also paid for more than 700 new healthcare initiatives, ranging from population engagement programs to increasing capacity at the community-health level.

Having pooled financing, it is important to use it to create the right incentives, commonly known as 'strategic purchasing'. The recent history of Chile's health system (see [Box 1](#)) is a powerful example of aligning private providers toward the common goal of UHC.

Box 1. Strategic purchasing in Chile

In Chile, the National Fund for Health, known as Fondo Nacional de Salud (FONASA), covers 80 percent of the population through a combination of general taxation and a mandatory 7 percent employment contribution from the formal sector. The implementation of the Universal Access with Explicit Guarantees (AUGE) reform in 2005 has seen a significant movement in the health market, where private providers have reconfigured business models to work in co-ordination with FONASA. AUGE stipulates a minimum benefit package, caps on co-payments and waiting-time targets for all citizens. As of 2016, the AUGE benefit package covers 80 percent of all priority health services. The package is implemented by a range of public-owned sickness funds, as well as private insurers who are mandated to follow AUGE guidelines. Private insurers offer complementary insurance for services not covered by AUGE.

Service provision is mixed, with FONASA gradually purchasing more care from private providers over the last five years. FONASA's leading position in the healthcare market has made private providers increasingly dependent on it. This, in turn, has enabled FONASA to stipulate and enforce contractual terms, as well as, to encourage data sharing. This strength has had a positive effect on private health insurers who are also starting to adopt efficient payment mechanisms, such as diagnosis-related groups (DRG) and case-based reimbursement, currently used by the public sector. On the whole, this is helping to drive efficiency in the overall system, according to Dr Jeanette Vega, Director of FONASA: "Once FONASA set the direction, both private providers and payers started following suit, so it has increased the alignment of the overall system."

2. Provide clarity over the direction of UHC reforms

Deciding whether to fill gaps in provision through a 'build' strategy of investment in public institutions or a 'buy' strategy of working with private organizations is a key choice for countries looking to achieve UHC. Most systems use a mix of the two approaches, but setting the direction early is important in giving clarity to the private market and encouraging investment in the right places.

Balancing considerations around existing capacity, transaction costs, quality and care integration is difficult. One of the most challenging aspects for payers is how to co-ordinate the often essential role of small- and medium-sized private providers. In what is usually a highly fragmented market, traditional models of contracting, financing, quality assurance and referral often do not work. Kenya's Amua program, and the wider growth of social franchising approaches globally, provide some interesting lessons about how to aggregate disparate groups of small providers to have an impact on a large scale.

Box 2. Social franchise contracting in Kenya

The African Health Markets for Equity (AHME) is a five-year program in Ghana and Kenya to support the conditions needed to scale up primary health services among private providers. The five main goals of the program are to ensure that:

1. lower income households are enrolled in national health insurance plans;
2. private facilities are contracted by NHI;
3. essential primary care services are included in the NHI benefit package;
4. providers offer quality services; and
5. providers run a sustainable business.

In both countries, AHME works with existing low-cost and single-operator service providers, giving them training, branding, subsidies, business support and standardized protocols using a franchising model – commonly defined as 'clinical social franchising'.

In Kenya, AHME works with Amua, a social franchising network comprising 360 low-cost providers, of which 185 are being, or are in the process of being, contracted by NHI. The franchisor is tasked with brokering these contracts, as well as acting as a network manager. This process is allowing the government, through NHI, to capture and shape a fragmented market of primary care providers into a more coherent and consistent delivery network.

A recent survey of enlisted providers suggests that many have benefited from greater income through NHI contracts compared to previous walk-in trade paid through out-of-pocket payments.²⁷

3. Improve trust between public payers and private stakeholders

Even with the right financing and contracting mechanisms, many countries will still need to overcome a legacy of mistrust between public and private sectors. Cultural and relational barriers came through just as strongly as transactional ones in the interview and survey components of this study, as demonstrated in [Section 2](#).

For UHC to be achieved by 2030, there is an urgent need for effective engagement and collaboration between public and private sectors. This means a health agenda that is sustainable for the government, services that are equitable and accessible for everyone, and profit for the private sector.

Resolving trust issues is often not about political ideologies, but about simple matters such as making sure that claims data is accurately coded by providers and that payers transfer money on time. For example, in Ghana nearly 4,000 private providers depend on NHI schemes for 80 percent of their revenue, yet it can take several months for payments to be made for the care they have delivered.²⁸⁻³⁰

For governments and public payers thinking about how to engender trust, the following three steps are a good starting point:

- 1.** Design a communication strategy that clearly defines which private stakeholders to engage, the policy objectives for engagement, and a team to implement and manage the strategy over the long term.
- 2.** Listen to and acknowledge the valid concerns of the private sector.
- 3.** Recognize common ground and develop participatory solutions. With an agenda as big as UHC, choosing battles will be important. Selecting a subset of issues to more easily agree on would generate confidence on both sides before moving on to more difficult issues.³¹

Box 3. Improving public–private trust in Brazil: *The White Book*

In recent years, Brazil has been beset by a far-reaching political and economic crisis of public trust, including a scandal in which more than \$5 billion in illegal payments are believed to have been made. This has involved dozens of the country's political and business elite – including former presidents and Latin America's largest engineering firm, Odebrecht.

In the health sector, these and other events have worsened an already difficult environment for public–private collaboration. Brazil's health system is already highly fragmented: on the public side, funding and decision-making is split across multiple municipality, state and federal levels (there are more than 5,000 health ministers nationwide). Meanwhile, the private healthcare sector operates largely in isolation from the public system, with its own payers and providers catering to the more affluent quarter of the Brazilian population – typically in larger cities.

In an attempt to foster a more constructive debate, the National Association of Private Hospitals (ANAHP), a confederation of Brazil's highest quality private hospitals, published *The White Book* as a tool for discussion with public health leaders across the country.³² The book serves two purposes: first, it includes a large compendium of data on Brazilian healthcare – both public and private – to make both sides of the system more transparent and for use as a quality improvement tool; second, it sets out 12 proposals to better integrate and manage healthcare across the public and private systems. These proposals include portable records and patient information exchanges between different tiers of healthcare providers, a nationwide drive toward standardization around evidence-based medicine, and a strengthened primary care system to prevent people needing to seek care in hospitals (whether public or private).

Dr Francisco Balestrin, Board Member and former President of ANAHP, explains that *The White Book* is an attempt to 'make the first move' in the debate over how the private and public sector collaborate: "It's our attempt to show the values that exist within our sector, and to start the debate from a common foundation that both public and private sector can agree on, which is high-quality care for all Brazilians."

4. Drive out poor performance

Quality is often a forgotten dimension in countries' pursuit of UHC, and systems too weak to encourage and enforce high-quality care have hampered the development of a UHC-ready private sector.³³ A number of private sector interviewees said it was the inability of payers to separate quality private providers from the less scrupulous that deterred them from partnering with government.

'Stick' approaches such as licensing, antitrust, sanctions and price regulation (such as India's recent price controls on stents) are often an important and effective means of addressing market failure.³⁴ However, regulation doesn't have to be about strong prohibitions and controls. Softer 'carrot' tools that encourage improvements in quality and coverage, such as accreditation and public information campaigns, have an equally important role to play.^{35,36}

Effective systems of transparency are another way of promoting a degree of low-cost self-regulation in the market. Yet a recent global ranking of health system transparency across the G20 nations showed a marked difference between high- and low-income countries in how they were using transparency as a performance improvement tool.³⁷

Box 4. Phased accreditation in Africa

NHI schemes in the Philippines, Thailand, Kenya, Ghana and South Africa have increasingly made accreditation a key criteria for enlisting private facilities – where payment from the schemes has been contingent on compliance with set quality standards.

In collaboration with Joint Commission International (JCI) and the Council for Health Service Accreditation in Southern Africa (COHSASA), the PharmAccess Foundation developed a phased accreditation tool for lower-level private providers so that poorer people can access good-quality care. The process enables the SafeCare Foundation to target an array of providers. They then guide providers through the five development stages, each of which is associated with rewards, access to credit to make further investment for improvements and advanced market positioning to attract more clients. Facilities accredited by SafeCare are assessed every two years with a view to developing a quality improvement plan related to clinical and non-clinical aspects of care. SafeCare is now an integral part of managing the enrollment of lower-level providers in the Kenyan NHIF program, and has shown positive early results in Nigeria in trials to improve quality of care.^{38,39}

5. Encourage new models of care and new market entrants

Many public purchasers interviewed for this report were clear that, while they welcomed private investment to increase healthcare access, it was the sector's ability to innovate and create new care models that was of greatest interest to them.

There is no question that new care models will be critical to the achievement of UHC. If every country without UHC were to increase health spending per capita to the average OECD level by 2030, the world would be spending \$27 trillion extra on healthcare – a 400 percent increase on total worldwide health spending today. Clearly this is unrealistic. Low- and middle-income countries will need to forge new ways of delivering maximum health benefits from the resources available.

"Our need for the private sector is not so much in the delivery of traditional care models – where we have many strong public providers already. What we need them to do is to innovate and find the new, more efficient ways of working – perhaps using telemedicine or home care. It's so important that at FONASA we actually have a separate fund for private providers, just to help them invest in R&D."

Dr Jeanette Vega, Director of FONASA

Delhi's Mohalla Clinics are a powerful recent example of encouraging existing private providers to begin working in new and different ways (see [Box 5](#)). As well as looking 'within', however, countries can also seek to encourage new entrants to the market who have implemented successful new models of care elsewhere. This can be a useful way of fast-tracking innovations toward mass-scale delivery, as demonstrated by Babyl in Rwanda (see [Box 6](#)). It can also be a helpful procurement strategy on the part of purchasers if the domestic private sector is proving uncooperative or unwilling to move quickly enough.

Box 5. New models of care in India: Expansion of low-cost primary care in Delhi⁴⁰

Delhi's community or Mohalla Clinics are one notable example of government forging practical ties with the private sector to provide care for underserved communities. Led by the State Government of Delhi since 2015, 164 Mohalla Clinics have been set up across the city state, with plans for 1,000 such clinics by the end of 2018.

The upfront cost of establishing each clinic is as low as \$30,000, with many operating out of pre-fabricated portable cabins, shipping containers or rented properties situated in low-income neighborhoods. The clinics operate four to eight hours a day, with flexible working hours. They are staffed by government and private doctors and allied clinical professionals. Attracting private clinicians to work under government contracts in urban slums has been possible because of three factors: the clinics are not seen as competition, as doctors can keep their private practice and supplement it with additional patient volumes; opening hours are flexible and, as a result, they do not interfere with the doctors' private practice; and provider reimbursement is largely based on a 'pay for performance' approach, where better-performing providers receive higher remuneration. This incentivizes providers to do more.

While reimbursement rates are not as competitive as normal private prices, the high volume generates a sufficient supplementary income. On average, each clinic sees 70 to 100 patients a day, and this attendance has been increasing over time. All services are delivered free at the point of service for patients, with the costs covered by the government.

While the growth of the model has been relatively organic, Mohalla Clinics seem to have a high level of political attention to ensure strategic scale-up. Punjab, Karnataka, Gujarat, Maharashtra and Andhra Pradesh have already adopted, or are considering, similar models for expanding primary care access. The roll-out of Basthi Dawakhana in April 2018 in Hyderabad demonstrates the positive results – with 17 clinics already established and plans to open 200 city-wide.

Box 6. Digital health in Rwanda: Babyl

Rwanda is known for its strong political leadership and nationally mandated community-based health insurance (CBHI). In a bid to position the country as the digital hub of the region, the Rwandan government partnered with a UK-based digital health provider to introduce lean technologies in healthcare.

From a concept by UK company Babylon Health, Rwanda-based Babyl provides virtual consultations with doctors and clinical professionals, cutting-edge monitoring and diagnostics, one-tap appointment booking, e-prescription and secure access to clinical e-records. A reliable mobile network and high mobile penetration rate, combined with strong political willingness, provided Babylon with the certainty it needed to invest in customizing Babyl for the Rwandan health system.

Babyl is now recognized as a key primary healthcare provider for CBHI beneficiaries, who number about three-quarters of the population. But, unlike conventional modes of delivering primary care which can cost between \$10 and \$13 per consultation, a lean virtual or telephone consultation through Babyl costs just \$1 on average. Around 70 percent of Babyl users live in rural areas, and within the space of nine months, more than 100,000 consultations have been completed. On average, the system can deal with 2,000 appointments a day. As a result, Babyl has demonstrated significant take-up with more than 600,000 registered users. Babyl Booths equipped with digital tablets, are currently being piloted in rural areas where people have limited funds to travel to towns. There are now plans to expand these booths to 2,500 government health posts across the country.

SECTION 4. PROPOSED SOLUTIONS

Every country pursuing UHC will face its own unique set of challenges to align the full potential of private providers with the goal of 'health for all' by 2030. Throughout this report, recommendations have been made for how those in the public and private sectors can better act to achieve this goal.

However, the current pace of progress in many countries is not sufficient. Some external support and impetus may be helpful in catalyzing the vision of this report – governments and private providers working in harmony and at significant scale to achieve UHC.

To conclude, we offer three solutions for how countries could be supported to go further and faster:

1. A global network of 'Investors for Health' dedicated to developing 'UHC-ready' approaches to selecting and managing their investments in private healthcare companies.

The results of the private sector survey for this study suggest that the majority of established providers are not gearing up for large-scale provision of publicly funded UHC services. This suggests a need, in some cases, to influence them to see the opportunities, but also to see that significant opportunities exist for the expansion of newer and smaller players that are more UHC-ready. Healthcare investors – both for-profit and those with a social dimension – are slowly beginning to take account of the broader health systems' impact on the companies they invest in. There is a need to accelerate this from a gradual trend to a global movement.

Taking lessons from the Joint Learning Network for UHC's work among policymakers, a peer-led community of practice of like-minded healthcare investors is proposed to mainstream and refine how UHC should influence their investment selection and management decisions. This 'Investors for Health' group could share lessons and work collectively on themes of mutual interest, such as collective approaches to measuring impact, sustainable approaches to health promotion, models to support outreach from tertiary centers, and workforce training.

2. A mediation service to improve the quality of dialogue between public and private sector organizations in UHC-aspiring countries, hosted by a neutral international group or platform.

It was clear from interviews with public payers and private providers alike that a legacy of mistrust is one of the biggest barriers to better alignment and co-operation around UHC. Compounded by the fragmentation of most

private provider markets and the rapid turnover of politicians and officials in many countries, it is clear that some external mediation would help to improve the quality of dialogue.

A professional negotiation support and conciliation service for UHC could provide countries with a faster and more effective means of collaboration. Support could include early-stage relationship and trust building, joint vision for future states, drafting support for legal agreements, commercial negotiations and grievance management. It is suggested that the most appropriate host of such a service would be an international organization perceived as effectively neutral by both sectors.

3. A sector collaboration charter to assess the readiness of the public and private sectors in a country to work together to achieve UHC.

Given the importance of effective public–private collaboration, it would be helpful to have a means of assessing the readiness for this to happen across UHC-aspiring countries. A charter setting out the key actions and commitments of the government and private sector in health systems could provide both sides with a series of prompts to create a better enabling environment (as described in [Section 3](#)). This could refocus attention on some of the basic payer behaviors that providers said were so often ignored – such as timely payments (perhaps using escrow accounts held by a third party or part-payment upfront), independent quality assessment and price determination bodies – as well as efforts by providers to overcome common issues such as fragmentation by sector, lack of standardization and workforce training. Such a charter could be used by countries to guide their own strategies, as well as by major donors, lenders and investors that are funding UHC initiatives globally.

ABBREVIATIONS

AHME

African Health Markets for Equity

ANAHP

National Association of
Private Hospitals, Brazil

AUGE

Universal Access with
Explicit Guarantees

CAPRISA

Centre for the AIDS Programme
of Research in South Africa

CBHI

community-based health insurance

COHSASA

Council for Health Services
Accreditation of Southern Africa

DRG

Diagnosis-Related Group

eUPHC

Electronic Urban Primary
Healthcare Center

FONASA

Fondo Nacional de Salud
(National Fund for Health, Chile)

GDP

gross domestic product

JCI

Joint Commission International

JKN

Jaminan Kesehatan Nasional

MOU

memorandum of understanding

MSF

Médecins Sans Frontières

NHI

national health insurance

NHIF

National Hospital Insurance Fund

NHPS

National Health Protection Scheme

NHS

National Health Service

OECD

Organisation for Economic
Co-operation and Development

OOP

out-of-pocket costs

PPP

Public-Private Partnership

SDG

Sustainable Development Goal

UCS

Universal Coverage Scheme

UHC

Universal Health Coverage

WHO

World Health Organization

ACKNOWLEDGMENTS

The Forum advisory board for this paper was chaired by Sir David Nicholson, Visiting Professor, Institute of Global Health Innovation, Imperial College London.

This paper was written by Sir David Nicholson in collaboration with Jonty Roland, Program Director, KPMG Center for Universal Health Coverage, Adrita Bhattacharya-Craven, Independent Health Systems Consultant, Chris Hardesty, Director, Global Life Sciences, KPMG, Edward Fitzgerald, Global Healthcare Executive, KPMG and Nilaya Varma, Partner and Head of Government, Infrastructure and Healthcare, KPMG India. The WISH Research Fellow was Martina Orlović, Centre for Health Policy, Institute of Global Health Innovation, Imperial College London, with support from Lisa Aufegger, Centre for Health Policy, Imperial College London.

Sincere thanks are extended to the members of the advisory board who contributed their unique insights to this paper:

- Khalid Al-Emadi, CEO, Al-Ahli Hospital
- Francisco Balestrin, President, International Hospital Federation
- Dave Easton, Head of Consumer Businesses, CDC Group plc
- Tim Evans, Senior Director of Health, Nutrition and Population, World Bank
- Sanjeev Gupta, Former Deputy Director, IMF's Fiscal Affairs Department and currently Visiting Fellow, Center for Global Development
- Dana Hovig, Director of Integrated Delivery, Bill & Melinda Gates Foundation
- Tom Kibasi, Director, Institute for Public Policy Research
- Mark McClellan, Director, Robert J Margolis Center for Health Policy, Duke University
- David Miller, Director, Guest Safety, Quality and Accreditation Systems, Al-Ahli Hospital
- Sajid Rahman, CEO, Telenor Health
- Preetha Reddy, Vice Chairperson, Apollo Hospitals
- Devi Shetty, Chairman and Founder, Narayana Health

- Shubnum Singh, Director – Medical Education, Medical Research & Advisor – Healthcare Framework, Max Healthcare Institute Ltd
- Jeanette Vega, Director, Fondo Nacional de Salud (FONASA)
- Suwit Wibulpolprasert, Board Member, National Health Security Board of Thailand
- Kristina Yarrow, Director, Policy and Strategy, Global Health, United Nations Foundation
- Rob Yates, Project Director, Universal Health Coverage Policy Forum, Chatham House

The chair and authors thank all who contributed, including:

- All respondents to the multinational private provider survey conducted as part of this research
- The Joint Learning Network for Universal Health Coverage's Engaging the Private Sector in Primary Health Care Collaborative
- Atikah Adyas, Senior Researcher, Ministry of Health of Indonesia
- Anuschka Coovadia, Head of Healthcare for Africa, KPMG Center for Universal Health Coverage
- Charles Dalton, Senior Health Specialist, International Finance Corporation
- Mahmoud El-Achi, Research and Policy Development Officer, WISH
- Guillaume Favier, Associate Director, Global Strategy Group for Health and Life Sciences, KPMG
- Gianluca Fontana, Senior Policy Fellow, Imperial College London, Institute for Global Health Innovation
- Julio Frenk, President, University of Miami
- Matthew Guilford, Chief Growth Officer, Telenor Health
- Shifa S. Habib, Senior Manager for Research, Monitoring and Evaluation, Community Health Solutions
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Any errors or omissions remain the responsibility of the authors.

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40. Information provided by Chandrakant Lahariya, National Professional Officer, World Health Organization (WHO) India.

WISH RESEARCH PARTNERS



WISH gratefully acknowledges the support of the Ministry of Public Health





ISBN 978-1-912865-07-9



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