

# Healthy Partnerships

How Governments Can Engage the Private Sector to Improve Health in Africa



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## Foreword

**H**ealth care systems across Africa urgently need improvement. Despite concerted efforts, many countries in Sub-Saharan Africa are not on track to achieve the Millennium Development Goals. If the region is to realize its considerable promise and potential in the coming years, more Africans need to have access to affordable, good quality health services.

Yet public resources for health are scarce. In fact, the private health sector now provides half of all health services in the region to rich and poor alike. Private health care providers are often the only option for people living in rural regions and poor urban slums. In most of Sub-Saharan Africa, oversight of these health care providers is minimal, if it exists at all.

National governments across the region and international partners are increasingly recognizing that one of the key elements to better health service delivery is improving the way in which governments and the private health sector work together. More effective engagement between the public and private health care sectors in terms of better policies, regulations, information sharing, and financing mechanisms, including for the poor, would improve the performance of African health systems. It would save lives.

I am therefore glad to present to our clients, partners, and other stakeholders this report on “Healthy Partnerships.” It is the first systematic and standardized assessment of government engagement with the private health sector. Along with an assessment, it also offers guidelines for improving the way public and private health sectors work together. I am confident this work will inspire practical discussions and tangible reforms, which will increase the private sector contribution to public health and create investment opportunities aligned with national health goals. IFC and the World Bank look forward to supporting these reforms and investments through our ‘Health in Africa’ initiative and through our work more generally.

I wish to thank the Bill & Melinda Gates Foundation for their support, and to acknowledge the contributions of the RAND Corporation and the Economist Intelligence Unit. I congratulate the project team and our colleagues working in the region for their contributions and partnership in this effort. Their collaboration with external partners and clients throughout the development of this report has brought together public and private perspectives, contributing to a deeper understanding of how we can make quality health care more accessible for all Africans.



Lars H. Thunell  
*Executive Vice President and CEO of IFC*



# Acronyms and Abbreviations

ACT	artemisinin-based combination therapy
AIDS	acquired immune deficiency syndrome
AMFm	Affordable Medicine Facility for malaria
ARI	acute respiratory infection
ARV	anti-retroviral drug
CHAL	Christian Health Association of Lesotho
CME	continuing medical education
CPIA	Country Policy and Institutional Assessment
CT scan	computerized tomography scan
DHS	Demographic and Health Survey
DPT	diphtheria, pertussis, and tetanus
FBO	faith-based organization
FDI	foreign direct investment
GDP	gross domestic product
GHS	Ghana Health Services
HIV	human immunodeficiency virus
HMIS	health management information systems
HMO	health maintenance organization
IFC	International Financial Corporation
IMCI	Integrated Management of Childhood Illness
INSALUD	coordinating organization for more than 100 NGOs
IOM	Institute of Medicine
ISO	International Standards Organization
JCI	Joint Commission International
MCH	maternal and child health
MDGs	Millennium Development Goals
MOH	Ministry of Health
MOU	memorandum of understanding
NGO	nongovernmental organization
NHIF	National Health Insurance Fund
OECD	Organisation for Economic Co-Operation and Development
OHADA	Organisation pour l'Harmonisation en Afrique du Droit des Affaires
P4P	pay-for-performance
PHS	private health sector
PNC	prenatal care
PPH	postpartum hemorrhaging
PPM-Dots	Public Private Mix-for Directly Observed Treatment
PPP	public-private partnership
SSA	Sub-Saharan Africa
TB	tuberculosis
TBA	traditional birth attendant
TMP	traditional medical practitioner
VAT	value added tax
WDI	World Development Indicators
WHO	World Health Organization



## Executive Summary

**H**ealth systems across Africa are in urgent need of improvement. The public sector should not be expected to shoulder the burden of directly providing the needed services alone, nor can it, given the current realities of African health systems. Therefore to achieve necessary improvements, governments will need to rely more heavily on the private health sector.<sup>i</sup> Indeed, private providers already play a significant role in the health sector in Africa and are expected to continue to play a key role, and private providers serve all income levels across Sub-Saharan Africa's health systems. The World Health Organization (WHO) and others have identified improvements in the way governments interact with and make use of their private health sectors as one of the key ingredients to health systems improvements.<sup>1</sup> Across the African region, many ministries of health are actively seeking to increase the contributions of the private health sector. However, relatively little is known about the details of engagement; that is, the roles and responsibilities of the players, and what works and what does not. A better understanding of the ways that governments and the private health sector work together and can work together more effectively is needed.

This Report assesses and compares the ways in which African governments are engaging with their private health sectors. Engagement is defined, for the purposes of this Report, to mean the *deliberate, systematic collaboration of the government and the private health sector according to national health priorities, beyond individual interventions and programs*. With effective engagement, one of the main

constraints to better private sector contributions can be addressed, which in turn should improve the performance of health systems overall.

Collaboration between the government and the private health sector is nothing new in Africa. Private providers, especially faith-based organizations (FBOs), have been serving African communities for decades, often predating political independence. But engagement between governments and self-financing or for-profit<sup>ii</sup> providers occurs far less often, even though the clear majority of private providers are self-financing.

For this Report, a new framework was developed to assess the level of engagement between the public health authorities and private sector providers. A team of researchers collected data through interviews, supplemented by desk research, in 45 Sub-Saharan African countries. More than 750 in-person interviews were conducted with key stakeholders in each country: senior government officials; private sector representatives, including practicing doctors and nurses; and independent experts. The results highlight those places where public-private collaboration is working well and those where it is not. The framework and its indicators also suggest strategies to enhance contributions by the private health sector.

As stewards of the health care system, governments should be seeking ways to leverage available resources, thereby improving quality and access. Our research starts with three observations:

- Africa's health systems need to be improved.
- The private health sector is too large to ignore.
- Engagement can improve the use and effectiveness of existing resources.

i. The term "private health sector," as used in this Report, includes all nonstate providers.

ii. For-profit and self-financing are used interchangeably, as discussed in the Report's introduction.

The poor performance of many of Africa's national health care systems is sobering. Less than 50 percent of all births in the region take place in a health care facility, and only about half the children with serious infections are treated in clinics or hospitals.<sup>2</sup> These averages mask significant disparities in access: women in the top wealth quintile are nearly six times more likely to deliver their baby in a health care facility than women in the lowest quintile.<sup>3</sup> Where pregnant women have access to prenatal care, it is often of poor quality.

The private sector is part of the answer, if only because of its size. More than half of all health care spending in Sub-Saharan Africa comes from private parties,<sup>4</sup> and private providers are responsible for delivering at least half the services.<sup>5</sup> This is true for the poor and the rich, and for urban and rural populations alike.<sup>6</sup> Many patients choose private over public providers because they prefer the care, and others do so because care is not available from public providers. Although the quality of private services can range from very poor to very good, it is comparable to what is provided by public providers, often because many doctors and nurses work in both sectors. The private health sector not only provides additional access to care, but also is a source of much-needed capital, competition among providers, management skills for operating complex systems like hospitals, and innovation and flexibility in health care delivery. Harnessing these potential contributions fully is the critical challenge.

The goal of this Report is not to argue for a greater or smaller role of the private sector in health care, but for a closer collaboration between the public and private sectors and a stronger contribution of the private sector toward national health priorities. The policies and practices suggested here can improve public-private engagement. The private sector must be an integral part of any solution to providing more equitable health care to all people, since the public sector cannot solve the problem by itself. An example of a misconception about equitable health care is that it is sometimes believed that public spending on health care mostly benefits the poor. However, it is frequently the relatively wealthy, not the poor, who

disproportionately benefit from public spending. The disparity is especially pronounced in Sub-Saharan Africa, where the poorest 20 percent benefit from only 13 percent of public money for health care compared to almost 29 percent of public money benefiting the richest 20 percent.<sup>7</sup>

When the public and private health sectors work together, outcomes tend to improve. The literature on maternal and child care shows that closer coordination between the public and private sectors has improved access to family planning and increased the participation of skilled attendants during childbirth, both of which have saved lives.<sup>8</sup> Contracting or purchasing services from the private sector, provided it is done well, can also be effective. Here, too, the results from maternal and neonatal programs have been particularly impressive.

## Findings

Although public-private collaboration is not a new concept, the framework used in this Report to measure it is. Based on a public economics framework, we identified five domains that collectively constitute engagement:

- Policy and dialogue
- Information exchange
- Regulation
- Financing
- Public provision of services.

There is more engagement with the nonprofit sector than with self-financing providers across all domains in all countries. Governments typically trust FBOs, the dominant form of nonprofit providers, because of their social aims and their commitment to the public good. The engagement is also high because FBOs are relatively well organized and often predate the establishment of the public health systems. In many countries, FBO facilities are indistinguishable from public facilities and some serve as public reference hospitals. The close collaboration between the public health sector and FBOs is not without its challenges, however. Shortcomings in each of the five domains frequently reduce the effectiveness of the engage-

ment with the FBOs. The often-blurred lines between FBOs and public facilities make the standardized assessment and comparison of engagement impractical. Therefore, the key findings and conclusions for each domain, described below, refer to the engagement between the government and the for-profit or self-financing providers—the clear majority of the private health sector.

### Policy and dialogue

The policy and dialogue domain concerns the private sector policy framework on paper and in practice, as well as the level of dialogue between the public and private sectors. Policy and dialogue between the government and the private health sector are the foundations of effective engagement; they set out roles and responsibilities of the different actors. A functioning dialogue with private providers is a sign that the government is aware of their presence, takes them into account, and views them as partners.

While more than 85 percent of the countries we studied have an official policy of working with the private health sector, the majority of Sub-Saharan African countries do not actually implement the policy. The level of dialogue

between the government and the private health sector is low across the region. However, there are a growing number of countries in which a dialogue is being (re-)initiated as a necessary first step in improving engagement. In Ghana, for example, the level of engagement between the government and the private health sector has greatly improved since the existing private health sector policy was revived through a new forum for dialogue. The private sector, in turn, has responded by forming an umbrella organization of private providers, a critical step. Indeed, beyond Ghana, the organization of the private sector itself is critical in establishing a dialogue, but is lacking in most countries.

See figure x.1 for a regional summary of the results for policy and dialogue and information exchange. For more details on the individual indicators, refer to Appendix 4 of the Report.

### Information exchange

The information exchange domain concerns information flows between the public and private sectors, and private sector inclusion in national health management information systems and disease surveillance. Accurate information about the scale

FIGURE x.1

#### Summary of Results for Policy and Dialogue and Information Exchange

		Individual indicators	Results for 45 countries
Policy & dialogue		Policy exists for engaging with PHS	
		De facto implementation of engagement policy (1–4)	
		Formalized mechanism for dialogue with PHS	
		De facto dialogue (1–4)	
Information exchange		PHS included in information exchange (1-4)	
		PHS required to provide information to MoH beyond DS	
		De facto information provision by PHS to MoH beyond DS	
		PHS included in Disease Surveillance Program	
		PHS receives DS updates from MoH in emergencies	

Source: “Healthy Partnerships” data, 2010.

Note: PHS = private health sector; MoH = ministry of health; DS = disease surveillance.

Yes / no  
 High / medium / low / very low for 1–4 score  
 For detailed definitions, see Appendix 4 in the Report.

and scope of privately provided care is a key ingredient of engagement. Information systems remain incomplete if they do not include the private health sector. This is especially pertinent if the private health sector is providing a large proportion of health services. Having separate or designated information systems for the private health sector on its own is neither necessary nor more effective.

Information exchange is weak in most countries, with a majority of countries lacking basic elements of a well-functioning system. Despite existing legal requirements for the private sector to provide data to the Ministry of Health, the data seldom reach the government. There are somewhat higher levels of inclusion of the private health sector in disease surveillance programs. Particularly during severe disease outbreaks, governments often reach out aggressively to private health providers and include them in official programs.

The few countries that do relatively well in this domain, such as Burkina Faso and Rwanda, keep the private sector well informed and include private providers in existing public health sector information channels, such as for health management information systems data.

## Regulation

The regulation domain focuses on the ability of the government to design and implement a regulatory framework for the private health sector. The registration of private health facilities, as a basic precondition for effective planning in the health system, falls under regulation. Among the five domains, governments tend to overemphasize regulation, without properly accounting for the lacking enforcement capacity.

The registration of private providers is poor in most countries, which leaves a critical gap in the understanding of “who does what” in the health system. In addition, regulations are often inappropriate or outdated and enforcement is weak across the region. Overly complex frameworks that are contradictory or that cannot be implemented as intended create uncertainty and opportunities for arbitrary enforcement. Even private providers complain about the lack of consistent regulatory oversight, which allows low-quality providers to continue to operate. It is critical for governments, but also for the private health sector, to understand that self-regulation can substitute for enforcement by the government.

A notable exception to the weak regulatory frameworks across the region can be found in

FIGURE x.2

### Summary of Results for Regulation

Individual indicators		Results for 45 countries
Regulation	Quality of private health sector providers registry (1–4)	High / medium / low / very low for 1–4 score
	Reported judgment of quality of regulation	Yes / no
	Regulation is enforced as intended	Yes / no
	Standardized rules exist for opening PHS clinic	Yes / no
	Quality control process for clinics—de jure	Yes / no
	De facto quality control executed for PHS clinics	Yes / no
	Quality control is the same for PHS and public providers	Yes / no
	Cont’d med education requirement for license renewal	Yes / no
	Continued education open to PHS professionals	Yes / no
	Policy/engagement toward traditional medicine exists	Yes / no

Source: “Healthy Partnerships” data, 2010.

Note: PHS = private health sector.

■ ■ Yes / no  
■ ■ ■ ■ High / medium / low / very low for 1–4 score  
 For detailed definitions, see Appendix 4 in the Report.

South Africa, where the private health sector is considered one of the best performing in the world and operates in a highly regulated environment, including strict enforcement. Aside from the fact that the capacity of both government and private health organizations is high, the private sector is primarily funded through insurance. This builds in a strong incentive for compliance with rules and regulations. See figure x.2 for a regional summary of the results.

### Financing

The financing domain covers the revenues that are actually or potentially available to the private health sector and the government's influence of such funds through various mechanisms. The key to financing is to ensure that there is a mechanism that allows poor people to have access to services, and that public funds buy value for money from either public or private services that compete on a level playing field. This principle of strategic purchasing (buying services from the best providers regardless of ownership) is especially important in countries where the private sector is large.

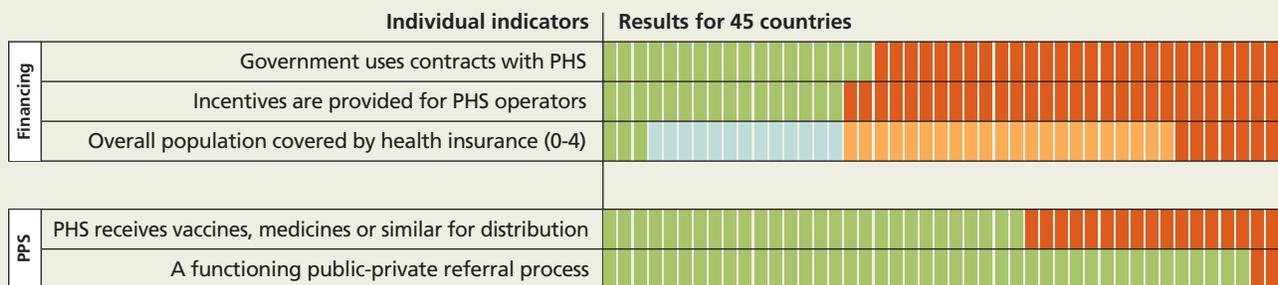
As a proxy for whether governments are committed to improving the effectiveness of public funds, the existence of any ongoing contracts to pay private providers is used. The existence of any

financial incentives specific to private health sector facilities serves as a proxy for whether the government seeks to improve the investment climate for the private health sector. Finally, and perhaps most important, the level of private provider coverage by health insurance is used as a proxy to assess whether a significant part of the population can access the private health sector without having to pay out-of-pocket.

The Report finds that a third of Sub-Saharan Africa governments contract with self-financing providers for services, and half of those governments also offer financial incentives. Seven countries offer financial incentives but no contracts. The level of health insurance coverage that would allow reimbursement for treatment received in a private facility is low; in most African countries, it is available to less than 15 percent of the population. But the levels of health insurance coverage are growing. There is a strong interest in expanding such coverage and a clear momentum to do so. In several countries, for example, Ethiopia, Kenya, Nigeria, and Uganda, the introduction of an expanded (public) insurance scheme is at an advanced stage. See figure x.3 for a regional summary of the results in financing and public provision of services.

FIGURE x.3

### Summary of Results for Financing and Public Provision of Services



Source: "Healthy Partnerships" data, 2010.

Note: PHS = private health sector; PPS = public provision of services

Yes / no
   
 High / medium / low / very low for 0–4 score
   
 For detailed definitions, see Appendix 4 in the Report.



### **Public provision of services**

The public provision of services domain focuses on how governments use the direct production of health care inputs and health services to collaborate with the private health sector. Through strategic allocation of resources, governments can use public production to complement, crowd out, or build a supporting environment for private health care markets. In addition, the public sector can ensure the availability of basic services and institutional support. Like the private sector in general, the private health sector also depends on infrastructure services such as water, electricity, and good roads.

In many countries, there is some evidence that governments and the private sector can collaborate relatively well on disease and immunization programs. In addition, there is some form of patient referral between the private and public sectors in most countries. These instances of collaboration, sometimes prompted by the requirements of donor programs (for example, requirements to make donated medicine also available to patients

in the private health sector), on narrow issues hold some promise for engagement at the systems level.

### **Action plan**

While this Report focuses on the technical aspects of engagement, the importance of the political process cannot be overstated. Sophisticated and technically appropriate solutions are useless if they are not translated into concrete action by the stakeholders. Indeed, the application of the framework proposed here, and the implementation of changes in policy and practice, is a political challenge rather than a technical one. All stakeholders—governments, the private health sector, but also donor and third-party organizations—are impacted by such reform.

Key actions needed include the following:

- For governments, a first step in the short term is to avoid interventions that are unnecessarily burdensome for the private health sector.

Beyond that basic step, an ongoing dialogue with the private sector is needed, as is a basic understanding of its size and activities: who is in business, which services they are providing, and where they are located. A better understanding of what type of private providers are serving the poor, for example, is critical for the success of public health programs. In the longer term, review and reform of the key policy instruments are needed, particularly of regulation. Often it will be a matter of simplifying the rules and bringing them into alignment with what can be enforced. Especially for instruments that are technically and politically difficult, such as financing, it is advisable to start with relatively simple, but concrete, steps. That way the necessary capacity and experience can be developed over time.

- For the private health sector, forming credible associations or representative organizations is an essential first step. Being well represented will enable a productive dialogue with the government, including the identification of priorities and capacities. An especially important area for collaboration in the longer term is quality of care. Provider networks, improvements of internal quality control in clinical practice, and business management training are all effective ways for the private sector to improve the quality of their services.
- Donors are asked to support engagement at all levels and to include the private health sector in intervention programs, where appropriate. Donor funding and project designs should not be based on preconceived notions of the size, ability, and motivations of the private health sector.

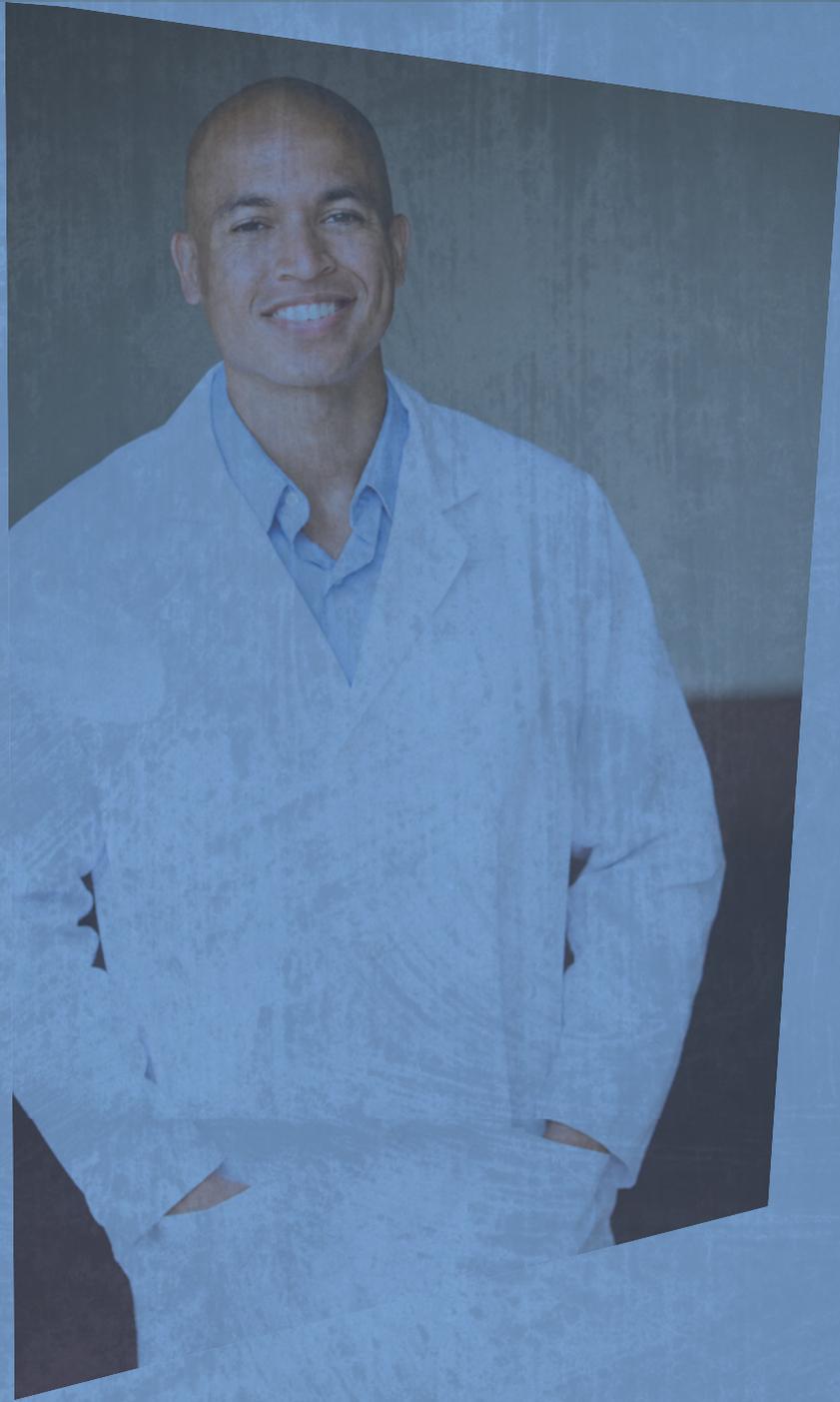
- Third-party organizations, such as insurance agencies and civil society organizations, can play an important role in facilitating and supporting engagement and providing support to the private health sector to upgrade its operations.

With respect to the analytical work, the action plan going forward is to build on this important first step in understanding engagement in a more systematic way. What lies ahead is the further development of the framework for assessing engagement and its application in areas that were beyond the scope of this Report. Further work toward how public-private engagement can be improved will benefit African health systems and their patients.

Designated resources are available for stakeholders interested in taking an active role in the improvement of public-private engagement. A toolkit with detailed information on approaches and practical steps to reforms can be found at [www.wbginvestmentclimate.org/health](http://www.wbginvestmentclimate.org/health).

In conjunction with the other available resources and with the expertise at the country level, this Report should be used as an advocacy tool in the reform process. The framework developed here and used to assess engagement across Sub-Saharan Africa provides a starting point for developing a country-specific reform agenda, and better engagement can lead to reforms in the health sector more broadly.

Even though the challenges are enormous and improvements in African health systems are urgent, the willingness—and even demand—to look at health systems in a new way is reason to hope. When public and private sectors work in partnership, improved access to affordable, high-quality care is achievable in Africa.



Africa's health systems are in crisis. Sub-Saharan Africa accounts for 12 percent of the world's population yet bears 26 percent of the global disease burden.<sup>9</sup> Health outcomes in the region are poor and significantly worse than elsewhere. Patients too often are denied access to high-quality goods and services, and achieving Millennium Development Goals (MDGs) 4, 5, and 6, which are related to health, is unlikely. Most of the region lacks the infrastructure and facilities necessary to provide adequate levels of health services and products. It also faces a severe shortage of trained medical personnel; just 3 percent of the world's health workers are deployed in Sub-Saharan Africa.

Asking governments alone to provide more and better services is not enough. Since the private sector is large, improving services only through improvements of public sector services will be—at best—only partially successful. Although the size of the private sector varies by country, it is surprisingly large and constitutes an important, diverse component of the region's health care systems. Roughly half of all spending across the region is captured by private providers.<sup>10</sup> Helping private providers offer a wider range of quality services is imperative. Part of the solution lies in better collaboration between the public and private health sectors.

The objective of this Report is to suggest policies and practices that improve engagement between the public and private health sectors, based on the needs and priorities of each country. For the purposes of this Report, engagement means the *deliberate, systematic collaboration of the government and the private health sector according to national health priorities, beyond individual interventions and programs.*

A set of measures to assess and compare engagement is presented in Section 2. The emphasis is on a basic level of engagement—whether private health provision is included in the government's policies, planning, and implementation. Especially in countries where the private health sector is large, engaging the private health sector along the basic domains that we have defined is essential for the proper functioning of the health care system. Such engagement should be undertaken strategically rather than piecemeal, and within the context of the country's priorities and political decisions.

In this Report, the term public-private partnership (PPP) is used only as a reference to particular transactions. A public-private joint venture for an individual hospital, for example, would be called a PPP. The other use of the term PPP, to denote ongoing public-private cooperation more generally, is not applied here. PPPs are discussed as one particular form of engagement on individual projects.

### *Definition of the private sector*

The private health sector is defined here to include all nonstate providers. This includes pharmacies, hospitals, retailers, and doctors who operate on both a for-profit and a nonprofit basis. Many countries also rely heavily on traditional healers. There are several organizational forms:

- For-profit operators typically pay market rates to obtain financing and charge a market rate for their products and services. The “for-profit” label can be misleading, however, because many do not make an officially declared profit and some incur significant losses. To account for this, we use the term “self-financing” interchangeably or in conjunction with “for profit.”

- Nonprofits are typically associated with a broader nongovernmental organization, whether domestic or international, from which they sometimes receive financial or managerial support. Some of the declared nonprofits are actually quite profitable, charging market rates for all of their services. Faith-based organizations are the dominant nonprofit health providers in many African countries, and are sometimes so intertwined with the public health sector that they are indistinguishable.<sup>11</sup> As Section 1 explains, however, faith-based organizations—though they are the most important nonprofits—are not as prevalent in the health care system overall as is commonly thought. The self-financing or for-profit facilities collectively provide a far larger share of health care services in most countries.
- Traditional practitioners and informal providers constitute a large group in many countries. Bringing them under the direct influence of policies and engaging with them at the systems level is a major challenge. Their role within the health system must be well understood if health interventions are to be successful.

These different entities that constitute the private health sector, and their engagement with the government, are further discussed in the following sections.

Two additional groups of actors are worth mentioning, though they are not considered a part of the private health sector: (a) intermediaries or third-party organizations, such as insurance authorities, nonhealth private sector organizations, or civil society organizations (such as consumer advocacy groups); and (b) donors, who have an important role in financing health programs and shaping health policy indirectly at a national level.

### *The role of the private sector in delivering and financing health care services*

The role of the private health sector is not just a critical issue, but a contentious one as well. This Report does not recommend an appropriate size for the private sector, particularly in terms of health care service delivery. For the public and

private health sectors, the quality of provided care and the ability to deliver care in underserved areas is highly variable.<sup>iii</sup> The growth of the private health sector for its own sake is not the goal of this Report. National governments should, however, make best use of available resources to address the tremendous health care challenges. The insistence that privately provided care should be replaced at any cost by publicly provided care does not provide a practical way forward for African health systems.

With regard to financing of health care services, we refer to the conclusions of the “World Health Report 2010,” which calls attention to the high proportion of out-of-pocket payments for health systems in poor countries, particularly in Africa.<sup>12</sup> The report strongly advocates reducing the share of out-of-pocket payments while increasing the reach of risk-pooling mechanisms, whether public or private. The same conclusion was reached in the International Finance Corporation 2008 report, “The Business of Health in Africa,” which focused on the private health sector in Africa.<sup>13</sup> Reducing out-of-pocket payments is likely to be achieved at least partly by increased public financing and by a lower overall private sector share in health financing. Appendix 5 offers projections for how health financing and the public-private mix in health financing may develop in the coming years.

The focus of this Report is primarily on final service delivery and the facilities that provide such services (hospitals, clinics, pharmacies and, to a limited extent, diagnostic laboratories). Less focus is placed on the private sector’s role in input markets, such as for drugs and equipment, education of medical professionals, and so forth. This prioritization does not imply that the private sector does not matter for input markets, but is simply based on the need to focus the analysis. Engaging the private sector outside of service

iii. The private health sector is said to be better at providing curative care than preventive care, even when preventive care might be more cost-effective. This observed tendency, however, has much to do with the way care is financed (that is, largely out-of-pocket payments paid by individuals only when they get sick) and less with what types of services the private health sector can provide effectively.



delivery (such as support services like nonmedical services for public hospitals) is discussed in Section 3 as an example of how to start with small reforms. The critical role of the private health sector in input markets and potential indicators of public-private engagement in input markets can be addressed in future research.

#### *Type of providers we focus on*

This Report focuses on government engagement with the full range of actors within the private health care system, especially smaller providers of private health services, because they comprise the most numerous and most accessible source of care to many people. The sophisticated and highly specialized institutions, such as private tertiary hospitals for the urban affluent, are also an important part of the landscape. We are a bit less interested in these institutions, however, even though they are of interest to investors. These institutions do not really have a problem with engagement because they are big and prominent; they deal directly with the government and often do so fairly well. Partnerships with these institutions are discussed separately below.

At the other end of the spectrum, health services are often offered by small formal and informal providers, including friends and family.

While a part of this informal provision of care will remain outside the reach of policies and regulations, informal providers who are not registered but who offer services in a commercial fashion are important players in many African health care systems. The quality of care among this group of providers ranges widely. Creating efficient platforms for their formalization and including more of these informal providers in the organization and planning of the overall health sector should be a priority. The best strategies for engaging these groups will vary from country to country, but the potential benefits of forging closer links are large.

#### *Geographic scope of analysis*

The Report focuses on 45 Sub-Saharan African countries, excluding Djibouti, Eritrea, and Somalia.<sup>iv</sup> Page 4 contains a complete list and map (figure 01) of the countries.

It should be noted that the framework for analysis and reform of engagement introduced in this Report may be relevant for developing countries outside of Africa, as well.

<sup>iv</sup>. All countries in the study are grouped in the Africa region of the World Bank Group. Djibouti is part of the Middle East and North Africa region. Data collection could not be carried out in Eritrea and Somalia.

Broadly, the geographic scope of the study is Sub-Saharan Africa. More specifically, the study covers the following 45 countries (shaded blue in figure 01):

- Angola
- Benin
- Botswana
- Burkina Faso
- Burundi
- Cameroon
- Cape Verde
- Central African Republic
- Chad
- Comoros
- Congo, Democratic Republic of
- Congo, Republic of
- Côte d'Ivoire
- Equatorial Guinea
- Ethiopia
- Gabon
- Gambia, The
- Ghana
- Guinea
- Guinea-Bissau
- Kenya
- Lesotho
- Liberia
- Madagascar
- Malawi
- Mali
- Mauritania
- Mauritius
- Mozambique
- Namibia
- Niger
- Nigeria
- Rwanda
- São Tomé and Príncipe
- Senegal
- Seychelles
- Sierra Leone
- South Africa
- Sudan
- Swaziland
- Tanzania
- Togo
- Uganda
- Zambia
- Zimbabwe

**FIGURE 01**

**Map of Africa Displaying the Geographic Scope of this Analysis**



### **Maternal and child health serves as a proxy, where needed**

This Report deals with health systems in general and so does not focus on a particular disease. Where it is useful to be more specific, however, maternal and child health (MCH) is used as a proxy. This is appropriate, because MCH is included in two of the three health MDGs and will therefore rightly capture the attention of policy makers and other stakeholders. On a more technical level, MCH measures are good proxies for the performance of the overall health system, especially in Africa. Indeed, the best current data source for health-related information is the Demographic and Health Survey (DHS), which has good coverage of MCH issues.

### **Assessing engagement across the region**

As mentioned, the objective of this Report is to improve engagement between the public and private health sectors. We identified five “domains” that comprise engagement. They are as follows:

- *Policy and dialogue:* This encompasses the underlying policy framework related to the private health sector and the degree to which the private health sector is included in discussions regarding policy and practices.
- *Information exchange:* This is the flow of operational information between the private health sector and the Ministry of Health.
- *Regulation:* This comprises the rules that govern the private health sector, including the registration of health providers and quality control.
- *Financing:* This comprises the sources of funding and purchasing arrangements to pay for goods and services delivered by private providers.
- *Public provision of services:* This includes the goods and services directly produced by the public sector that impact the operating environment of the private health sector.

The process used to collect data for this Report was as follows.

Between February and July 2010, a team of six consultants conducted more than 750 face-to-face interviews with key stakeholders during on-site visits to the 45 countries mentioned above. Data were collected and coded for each of the five domains from each of the 45 countries. This included written (de jure) information and empirical information—that is, what was happening in practice (de facto), as we describe in Section 2.

Standardized guidelines were used to collect the data, and a key-respondent list was developed to ensure that approximately the same number and type of respondents were interviewed in each country. Interviewees included government officials, policy makers, regulators, private providers, development organizations, and independent experts. The data collected during the interviews were combined, as appropriate, with data from desk research. The team coded the interview data to allow comparison across countries. The results were then validated by two in-country experts to ensure accuracy.

### **Why measure at all**

Introducing new comparative measures in the health sector is especially challenging, because the standard for demonstrating impact is high. For individual interventions or programs, scientifically rigorous impact evaluations are necessary to demonstrate impact. At the systems level, such tools cannot be employed easily, especially with policies or practices pertaining to the private health sector. Most of the effects one might hope to attribute directly to changes in policy will be overwhelmed by other variables, including changes in nonhealth policies, the economy (for example, the recent global recession), weather, agricultural output, and nutrition.

This should not be a reason to ignore the relationship between the private and public health care sectors. The policies and practices of public-private engagement can and ought to be studied.<sup>14</sup> As Section 2 will show, engagement matters in countless cases across the region; successes have been documented where engagement works well, and inefficiencies linger where it does not. We have also explored the more tenuous link between

## The Role of Business Environment Measures in Reform

International organizations that need to assess and compare the operating environment for private business across countries use such sources as the World Bank's Doing Business rankings, the World Economic Forum's Global Competitiveness Index, and the Economist Intelligence Unit's country-risk profiles. These business environment snapshots, while imperfect, are a useful guide to the political, economic, legal, and regulatory challenges firms face when operating locally. In Sub-Saharan Africa, where the private health sector is large and diverse, the quality of the business environment is particularly important, and is likely to be a critical factor in the provision of private health services.

Most Sub-Saharan African countries rank poorly in the global business environment indexes. In the 2011 Doing Business indicators, the 46 Sub-Saharan Africa countries had an average rank of 137 out of 183 countries, the worst in the world. The relative standing for most African countries is similar in other indexes, as well. Although the rankings do not measure conditions for health providers—such as the number of procedures required to open a clinic or a pharmacy—the focus on small, locally owned and operated firms is relevant, because most private health providers are in this category.

Some of the measures have been quite successful in motivating policy reform. For example, Rwanda has steadily reformed its commercial laws and institutions and was the leading reformer in the *Doing Business 2010* report, moving from 143rd to 67th place in the ranking.

*Source: World Bank, Doing Business 2010; World Bank, Doing Business 2011.*

Overall, Rwanda introduced reforms in 7 of the 10 categories, including reducing the time to start a business to three days (involving just two procedures), better than most developed countries. It also cut the time required to register property by 255 days, eased access to credit by allowing a wider range of assets to be used as collateral, and removed bottlenecks at the revenue authority. Rwanda also maintained its place among the top-10 reformers in the 2011 Doing Business report, coming in second of the top-10 reformers and improving its overall rank on the ease of doing business scale to 58th of the 183 economies ranked.

However, health care is not like most other industries, so most business environment measures are insufficient. All global business environment guides assume companies are providing goods and services in a market environment in which the private sector is dominant, the normal forces of supply and demand are paramount, and a lighter regulatory touch is preferred. These assumptions are not always true in health care. Medical care is widely regarded as a human right, not a discretionary service. As such, governments will inevitably play an oversight role, setting national policies and goals and then, ideally, integrating the private sector into a wider plan. The partly public nature of health care usually leads governments to take on the responsibility of ensuring access to and quality of the system, concerns that are typically the responsibility of private firms in nonhealth businesses.

engagement and health outcomes, but these results are not presented here due to their tentative and somewhat experimental nature.

See box 01 for a discussion of how standardized policy measures can be effective in spurring reform, even as the health care sector differs from the business sector in terms of goods and services provided in a market environment.

### *International and regional agreement on the issue—demand for this work*

This Report is not unique in arguing for increased attention to engagement. Internationally, a consensus is emerging that the private sector's role in delivering health care should be understood and better leveraged. Even among critics, the importance of proper engagement is increasingly acknowledged, and prominent international organizations increasingly are endorsing this view. The World Health Organization in 2010 emphasized the importance of “strengthening

the capacity of governments to constructively engage the private sector in providing essential health-care services.”<sup>15</sup>

More important, it is African policy makers and health sector practitioners who are increasingly aware that improved engagement is needed. Policy makers are recognizing the need to employ the resources that are available in their countries and to work with the choices that consumers make, such as when they choose private over public providers. Indeed, we have found strong support for our work among policy makers and private sector representatives, and among independent experts in each country. There is almost universal consensus about the overall approach: the private sector, including the for-profit sector, should be better included in the national health system and can make a greater contribution to it than is currently the case.

### ***Roadmap of the Report***

**Section 1** explains the focus on engagement and why this is an opportune time to offer a framework for analysis and reform.

**Section 2** presents the results of our comparative analysis of engagement in 45 Sub-Saharan African countries. Using a public economics framework, we analyze engagement using the five domains described earlier. Positive and negative case studies illustrate the challenges and potential for reform.

**Section 3** discusses next steps, both in terms of future research and needed reforms. An action plan is presented for each of the relevant stakeholders: governments, the private sector, donors, and third-party organizations. Topics that should guide future policy discussions are introduced and briefly discussed.

Five appendixes present additional indicators for countries covered by this Report and details on the methodology used. Appendix 1 provides a snapshot of each of the 45 countries. Appendix 2 contains data tables with the full set of indicators that are used in the Report. Appendix 3 presents background on the concepts underlying the framework of engagement. Appendix 4 presents the methods used to obtain the engagement data. Appendix 5 offers projections for how health financing and the public-private mix in health financing may develop in the coming years.



## Section 1: What engagement is and why it matters

*In July 2010, 27-year-old Yaaba was admitted late at night to the All Saints Hospital in Western Africa, a private facility run by Dr. Kwabena. Referred from the nearby Sophie's Maternity Home, also a private institution, Yaaba reached the hospital already in shock. She had been in labor for 36 hours and had suffered a uterine rupture before her arrival at All Saints. While Dr. Kwabena performed emergency surgery, other medical staff began blood transfusions and fluid replacement, but neither Yaaba's life nor that of her child could be saved. Her obstructed labor was not in itself a death sentence. Prompt identification of the problem and quick referral to the hospital would almost certainly have saved her life and her child's. To make matters worse, several other pregnant women had been referred from Sophie's Maternity Home too late to make a difference, ending in needless tragedy.*

*Two weeks after Yaaba died at All Saints, 22-year-old Efue arrived at the same hospital. She, too, was in obstructed labor and had been suffering for 10 hours. Fortunately, the problem was identified relatively quickly and she was referred early enough to All Saints—but from a different privately run maternity home. After Dr. Kwabena and two attending nurses performed a cesarean section, Efue delivered a baby girl who required only minor resuscitation. Efue and her daughter recovered quickly. After a week, Efue's stitches were removed and she and her daughter were discharged.<sup>v</sup>*

Some of the solutions for improving the performance of health systems in Africa are not difficult, as the stories of Yaaba and Efue show. From the perspective of both clinical practice and health systems oversight, Yaaba's death was preventable. Had her obstructed labor been correctly identified by the midwife and the referral to All Saints Hospital happened sooner, both she and her child would likely have been saved. Efue was more fortunate in choosing a provider who recognized the limits of her ability and referred Efue in time. While this relatively simple clinical solution can vastly improve health care for pregnant women in Africa, the continued operation of a provider like Sophie's Maternity Home puts expectant mothers with any kind of complication at risk. Had a regulatory board or a midwife's council exercised even the most basic oversight, Sophie's Maternity Home would have been forced to improve or close, and Yaaba and her child might have lived. The private health

sector overall would have had the chance to contribute better service.

Private providers have an important role to play across Africa. Much of the care provided by the private health sector is of high quality. Some is not. As stewards of their health systems, governments should be seeking ways to improve the contributions of the private sector across the region. Many are already doing so, but few details are known about the roles being performed, how they vary across the continent, and what works and what does not.<sup>16</sup> Even less is known about what kind of collaboration between the public and private sector best furthers the public interest in an African context. This Report seeks to fill that gap by presenting and discussing our results in a way that will contribute to the conversation, regionally and in individual countries. (See box 1.1 for a discussion of the broader "Health in Africa" context in which this Report was written.)

v. All names have been changed.

## The Context of the “Healthy Partnerships” Report

This Report’s focus on how governments and the private health sector are working together is being presented in the context of the “Health in Africa” initiative, a joint project of the World Bank and the International Finance Corporation (IFC) (for more information, see [www.wbginvestmentclimate.org/health](http://www.wbginvestmentclimate.org/health)). Assessing and improving public-private engagement is, however, only one element in increasing the contributions of the private health sector in the region. Therefore, some context on the motivation for this Report is useful.

In December 2007, with the assistance of the Bill & Melinda Gates Foundation, the IFC published “The Business of Health in Africa: Partnering with the Private Sector to Improve People’s Lives.” The report concluded that:

- (a) Private providers already play a significant role in the health sector in Africa. A poor African woman today is as likely to take her sick child to a private hospital or clinic as to a public facility.
- (b) The private sector is sometimes the only option for health care in rural regions and poor urban slums. Private providers serve all income levels, have broad geographic reach, and are expected to continue to play a key role in Sub-Saharan Africa’s health systems.
- (c) The private and public sectors must work together to develop more viable, sustainable, and equitable health care systems in Sub-Saharan Africa. The private sector can help expand access to services for the poorest people and reduce the financial burden on governments.

“The Business of Health in Africa” identified a number of significant constraints to the further development of a sustainable and socially responsible private health sector that is integrated into the broader strategies developed by regional governments. These include limited access to capital, shortages of skilled workers, a lack of risk-pooling mechanisms that can mobilize revenue for providers, and an inappropriate operating environment. To improve the operating environment, the report recommends (a) developing and enforcing quality standards through both government and self-regulation, (b) encouraging governments and donors to engage more closely with the private sector, and (c) modifying local policies and regulations to better support and mobilize the private sector.

These findings inform the “Health in Africa” initiative as it aims to increase access to health-related goods and services and improve well-being. Working directly with governments and the private health sectors in the region is a major part of this undertaking, as is the provision of financing mechanisms for private health care providers.

As an integral part of these ongoing efforts, the Healthy Partnerships Report reexamines some of the findings of the “Business of Health in Africa” report and assesses the ways African governments are engaging with private providers. The detailed assessment and the recommendations of how partnerships can be improved are this Report’s principal contributions. With better knowledge about engagement, one of the main constraints to better private sector contributions can be addressed, which in turn will improve the performance of the health system overall.

Collaboration between the private and public sector in health is nothing new in Africa. Indeed, the private sector as a provider of health care services predates political independence and the emergence of the public health sector in most countries. There are many good examples of public-private collaboration within health subsectors and disease programs. Partnerships on specific projects and in individual hospitals are not uncommon. We return to these below, because they constitute elements of what we understand to be engagement.

In this Report, we focus primarily on the degree to which engagement with the private health sector is comprehensive. Thus, in accordance with our definition of engagement, we consider the most basic building blocks of engagement at the systems level: whether governments are taking the private health sector into account at a fundamental level and therefore making the best possible use of available resources in all the subsectors of their countries’ health systems.

Three observations provide the starting point for this Report:

- Health systems in Africa are in urgent need of improvement.<sup>17</sup>
- The private health sector is too large to be ignored, though it is only partly and often poorly integrated into the health system.<sup>18</sup>
- Even a minimum level of public-private engagement can improve the use of existing resources and contribute to better-quality health care in Africa.<sup>19</sup>

### OBSERVATION 1

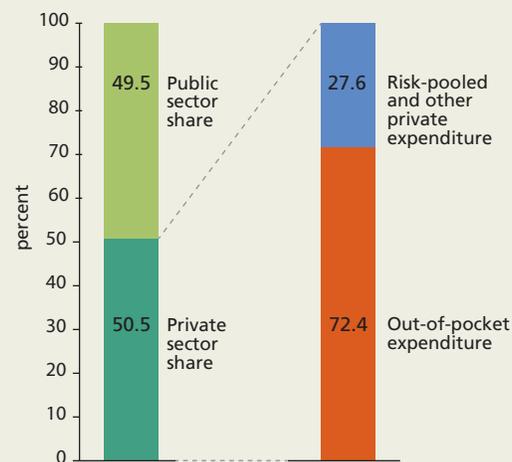
#### Health systems in Africa are in urgent need of improvement

Africa's policy makers face enormous challenges. Even in areas where the solutions are well known, such as improving maternal health, many health systems are not performing well.<sup>20</sup> The story of Yaaba is all too common. In too many countries, the Millennium Development Goals (MDGs) are not being achieved and some trends are going in the wrong direction.<sup>21</sup> At the same time, out-of-pocket spending for health services is high, and the burden of these direct payments, especially on the poor, is potentially devastating (figure 1.1).<sup>22</sup>

An African woman has a 1 in 16 chance of dying in pregnancy or childbirth over the course of her life; in developed countries, the ratio is 1 in 4,000.<sup>23</sup> Although progress has been made on some fronts, health outcomes throughout much of the continent are dismal and hardly improving. Life expectancy at birth was just 53 years in Sub-Saharan Africa in 1990. By 2008, it had increased to only 54 years, a legacy of the acquired immune deficiency syndrome (AIDS) epidemic.<sup>24</sup> In some cases, Africa is backsliding: the number of new tuberculosis cases (TB) in the region each year has more than doubled in the last two decades (figure 1.2).<sup>25</sup> Sub-Saharan Africa accounted for almost 43 percent of all deaths globally in 2004 from communicable diseases, maternal ailments, and poor nutrition, even though it represents only 12 percent of the global population.<sup>26</sup> Even where progress has been made, it has been fitful. Deaths

FIGURE 1.1

#### Breakdown of Total Health Expenditure by Source in Sub-Saharan Africa



Source: World Bank, *World Development Indicators*, 2010.

Note: SSA averages include the 45 countries covered by this report.

of children under 5 years of age in Sub-Saharan Africa have declined by 28 percent since 1990, but every other region has improved even more, and the death rate is nearly twice as high as any place else (figure 1.3).<sup>27</sup>

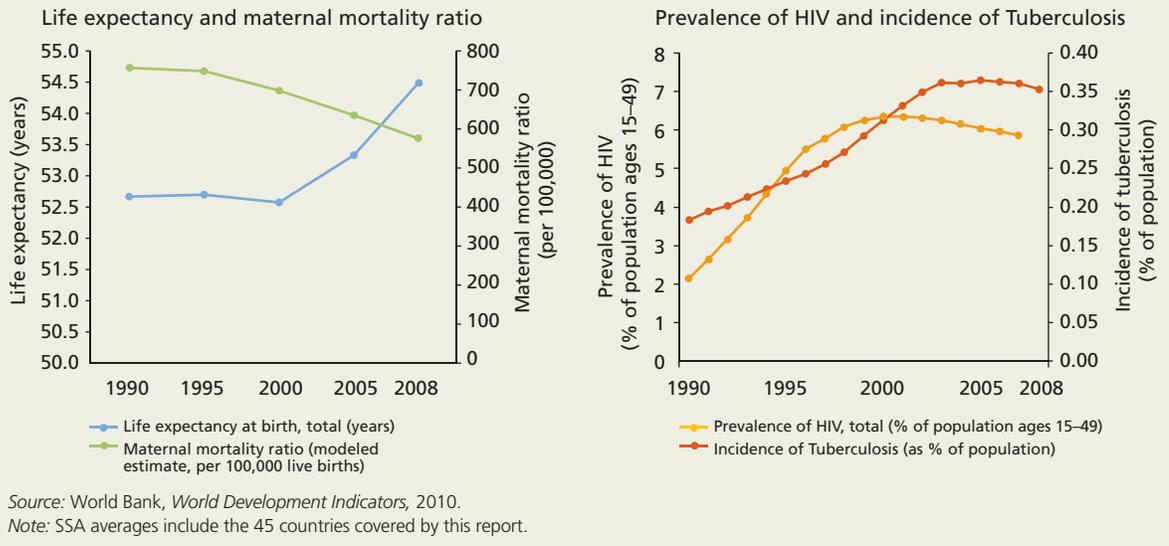
Health systems across the region are not performing nearly well enough to adequately address the dismal state of health outcomes. Across the region, health systems lag far behind in measures of access and quality, and it is the poor who suffer most from this lack of performance. On average in a given country, only about half of all births take place in a health facility, and less than half of all children with symptoms of acute respiratory infection (ARI) are taken to a health care facility<sup>28</sup> (see figure 1.4).

While only 15 percent of women of reproductive age say they use modern family planning methods, a quarter of all women report an unmet need for contraception.<sup>29</sup> Almost one-quarter of children aged 12–23 months have not been vaccinated against measles; diphtheria, pertussis, and tetanus (DPT)<sup>30</sup> (see figure 1.4).

These regional averages mask significant disparities, both among and within countries. In Benin, most women deliver in a facility; in Ethiopia, the vast majority of births take place at home and only

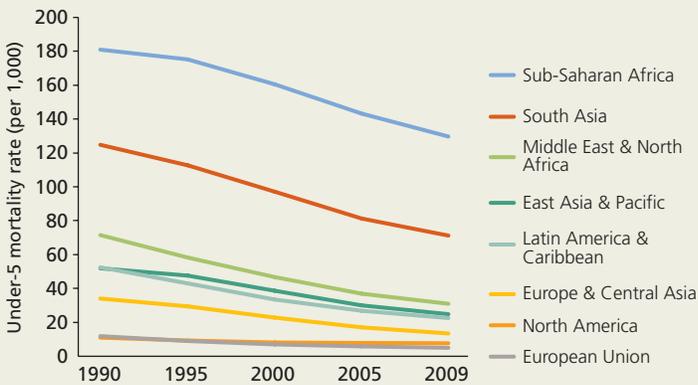
**FIGURE 1.2**

**Health Outcome Trends for Sub-Saharan Africa 1990–2008**



**FIGURE 1.3**

**Under-5 Mortality Rate, Regional Comparison 1990–2009**

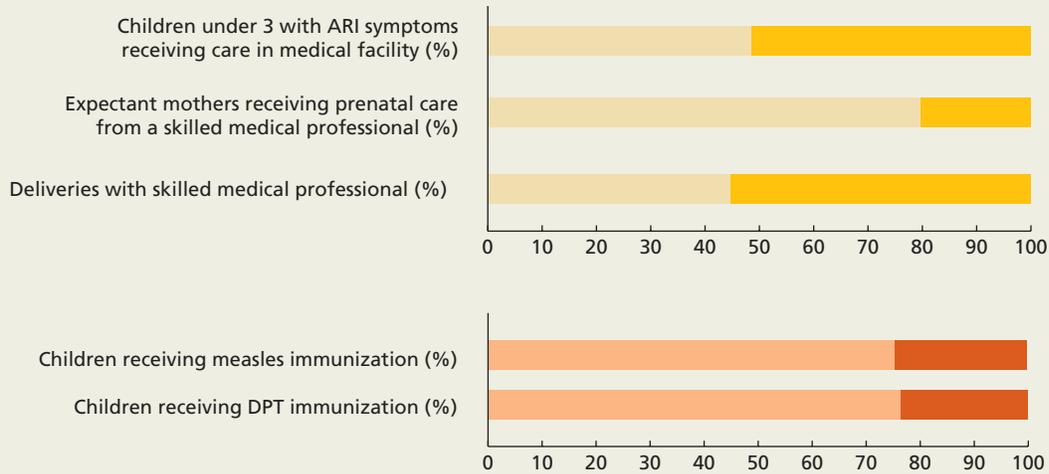


6 percent of women deliver in a formal health care setting.<sup>31</sup> For children suffering from ARI, access to facilities also varies widely across the region. In Uganda, 76 percent of sick children see a provider in a health facility compared with only 9 percent in Chad.<sup>32</sup> In Niger, 16 percent of women of reproductive age report an unmet need for contraception; in Rwanda, the figure is more than twice as large (37 percent).<sup>33</sup> In countries as diverse as Cape Verde, Eritrea, Mauritius, Rwanda, and the Seychelles, reported DPT immunization is almost universal (97 to 99 percent), while in Chad, 80 percent of children have not been immunized.<sup>34</sup>

Even where services are available and used, the quality is far from guaranteed. Across countries, almost 80 percent of women reported receiving some form of prenatal care from a professional health services provider.<sup>35</sup> In Namibia, Rwanda, Tanzania, and Uganda, 94 percent of expectant mothers said they received such prenatal care.<sup>36</sup> However, when asked whether they received all five of the basic prenatal services at some point during their pregnancy (blood pressure checks, blood tests, urine tests, weight check, and discussion of complications), the picture is much bleaker. In Namibia, only 53 percent reported

**FIGURE 1.4**

**Health Services Access Deficit in Sub-Saharan Africa**



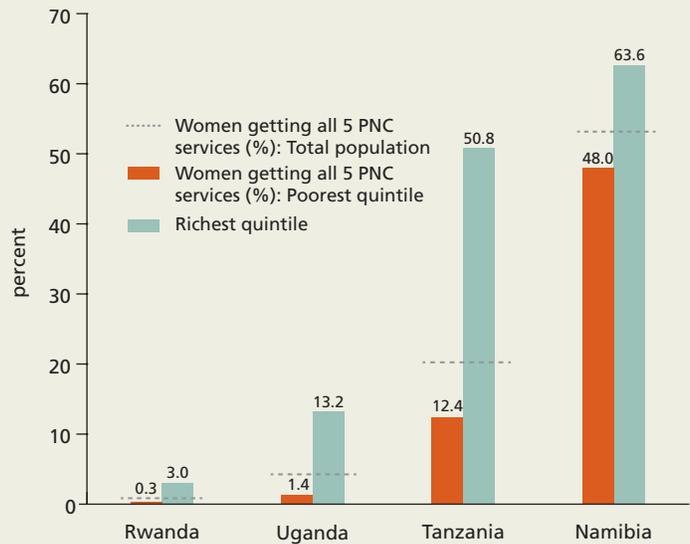
Source: Demographic and Health Survey data; World Bank, *World Development Indicators*, 2010.  
 Note: SSA averages represented for DHS data include the countries for which data are available (see Appendix 1). WDI averages include the 45 countries covered by this report. ARI = acute respiratory infection; DPT = diphtheria, pertussis, and tetanus.

receiving all five services; in Tanzania, only 20 percent did; and in Rwanda and Uganda, less than 5 percent did (figure 1.5).<sup>37</sup>

Worse, large gaps persist among socioeconomic groups in almost all countries. While the quality of prenatal care is fairly constant for women in Namibia, Tanzanian women are four times more likely to receive all five services if they are in the top wealth quintile compared to the women in the lowest quintile.<sup>38</sup> The disparities in quality of care are even bleaker for women in Rwanda and Uganda, as figure 1.5 shows. Similarly large gaps exist in terms of access to care. Women in the top wealth quintile across the region are nearly six times more likely to deliver in a facility than women in the lowest quintile, while women in urban areas are three times more likely to do so than women in rural areas.<sup>39</sup> The lack of overall access exacerbates disparities, as we saw in our earlier examples. In Ethiopia, inequality in access to facilities is stark: the richest women are 35 times more likely to deliver in a facility than the poorest women, and mothers in urban areas are 18 times more likely to do so than those in rural areas.<sup>40</sup> Even at the lower end of the inequality spectrum, Benin, differences persist: the rich-

**FIGURE 1.5**

**Within-Country Disparities in Quality of Care**



Source: RAND analysis of Demographic and Health Survey data, latest survey year included.  
 Note: PNC = prenatal care.

est women are 1.6 times more likely to deliver in a facility than the poorest women, and women in urban areas are 1.2 times more likely to do so than women in rural areas.<sup>41</sup>

## OBSERVATION 2

### The private health sector in Africa is too large to be ignored, though it is only partly and often poorly integrated into the health system

The fact stated in the observation is not well understood, even among policy makers. The private sector—whether funding health care or delivering it—is a large and important part of the landscape in Africa. Of the roughly US\$55 billion spent on health care in Africa in 2007, 55 percent came from private parties, and most of that was paid by individuals out-of-pocket.<sup>42</sup> About half of that expenditure was captured by private providers.<sup>43</sup> Many of the transactions between patients and providers are happening regardless of government policy. Despite the availability of “free” essential services at public health centers in some countries, private facilities still provide a significant portion of the services. In Uganda, for example, more than 60 percent of children with symptoms of ARI taken to a facility are treated by the private health sector.<sup>44</sup>

#### The private sector serves the poor

Private care is not just the province of the rich, who are better able to afford it. While in some countries, such as Namibia and South Africa, the private health sector indeed caters primarily to the wealthy who have private health insurance, this situation does not hold regionally. Studies consistently show that the private sector cares for people from a wide range of incomes, including poor and rural populations.<sup>45</sup> In Chad, Niger, and Uganda, more than 40 percent of people in the lowest economic quintile who seek health care for chil-

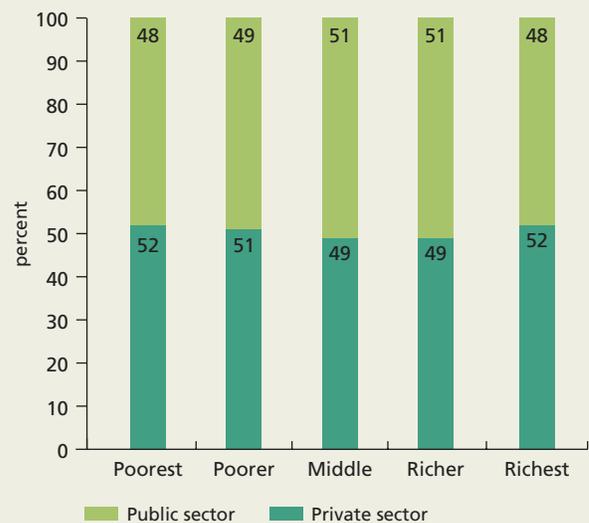
dren with symptoms of ARI do so from private, self-financing providers.<sup>46</sup> Across Africa, 52 percent of those in the bottom income quintile received their care from private providers, equal to the proportion of Africans in the top quintile, as shown in figure 1.6. The figure shows that the private sector’s share in delivering services is fairly constant across the income quintiles, viewed regionally.

#### Consumer choice matters

Many patients have options when they need health services and make thoughtful decisions about where to access care. This is often a separate concern from how far they have to travel or how much they need to pay.<sup>47</sup> Research has shown that consumers choose their health-care providers based at least in part on perceived levels of quality.<sup>48</sup> Studies conducted in rural northern Tanzania found that people will skip providers closer to

FIGURE 1.6

### Source of Health Care by Wealth Quintile for Households in Sub-Saharan Africa



Source: Analysis of DHS surveys; latest survey year available included; Montagu 2010.

Note: All data are drawn from the sum of all Population-Weighted Sub-Saharan Africa Demographic and Health Surveys conducted after 2000. Source of treatment is a summary of respondents with children under 5 years of age reporting treatment in the prior two weeks for diarrhea and fever/cough.

them (or those that are possibly cheaper) and travel longer distances for specific conditions.<sup>49</sup> The severity of particular episodes of illness and a judgment of provider competence were the key deciding factors.

Patients often choose private providers over public facilities because they prefer the type and quality of care being offered by private providers. It is important for governments to acknowledge and, where possible, take advantage of, such health-seeking behavior rather than ignore it.<sup>50</sup> The private health sector, even on a single street, makes up a rich and diverse marketplace of services that, on balance, contribute positively to the health landscape.

#### *Taiwo Road example*

A drive along Taiwo Road in Ilorin, Kwara State, Nigeria, paints a picture of the typical cosmopolitan African town. Buildings of every size, shape, and condition are arrayed in a jumble along the road; dingy and deluxe residential apartments exist side by side with banks, appliance shops, and offices. Tucked between these stores and shops are clinics, pharmacies, and, at the upper end of the road, the federally funded University of Ilorin Teaching Hospital. People come to this almost three-mile-long strip to buy practically everything—from clothes to electronics, groceries to medications. They also come to visit the bank, get a haircut or a manicure, and see a doctor.

The teaching hospital does not charge for consultations, but all surgeries are billed according to a standard price list for the procedure. Medications and medical supplies can also be purchased from the pharmacy department at set fees. Hassanat Memorial Hospital, also on Taiwo Road, is a private establishment where many low-income mothers receive general medical care for their sick children. Use of generic medications keeps prices low, and the average patient pays about 1,000 naira (about US\$7) for malaria treatment, the most common malady the hospital sees. Further along Taiwo Road is Joe-Steve Private Hospital, which is well known for elective surgical services, especially for those who

would rather not linger on the teaching hospital's long and erratic waiting lists. The price differential between the private facility and the government hospital is not large for surgeries, and the level of expertise of the surgeons is the same, although the teaching hospital is better equipped.

Those who need antibiotics, hospital consumables, and other medications not available in the teaching hospital's pharmacy know to visit the private Momrota Pharmacy, which is conveniently located next to the hospital. Ekundayo Pharmacy, another private provider about 300 meters south of Momrota, also stocks everything from over-the-counter medicines to intravenous fluids. Other drug sellers and patent medicine vendors can be found within walking distance on this busy street. A typical consumer walks in with a "prescription," which could have been written by a friend, colleague, or health worker. While some ask the pharmacists and drug sellers to recommend the best drug treatment plan to treat their illness, a final decision may be based on ability to pay.

Ilorin is also home to traditional bone setters, who are well known for their expertise in "curing" fractures of all kinds. But they have been known to refer patients with genuinely serious problems to orthopedic specialists at the teaching hospital. Some of these traditional practitioners charge more than the teaching hospital for fracture management, but some consumers prefer them anyway.

Baptist Hospital, a faith-based facility, is located in nearby Ogbomoso. It was established as Baptist Medical Center in 1917, but has since grown to be a critical care institution with the rank of a teaching hospital. People have been coming from neighboring villages and even states to be treated at Ogbomoso because, like many faith-based facilities in Nigeria, it is considered to be more accessible and affordable than other hospitals.

The private health sector in many African countries is similarly vibrant, demonstrating much of the diversity on display in Ilorin, Nigeria.

### *Wide range of providers— different needs and opportunities*

As the Taiwo Road example shows, health services in Africa are delivered by a wide variety of private providers. They range from formally trained specialists in clinical care to roadside vendors hawking dubious medications to traditional healers in corner shops.

As discussed above, the private sector share of health care provision across income quintiles is very stable. However, the share shifts toward more formal and higher-quality providers in the higher-income population. Figure 1.7 shows the sources of private health care by income. The formal providers are labeled in blue and the informal providers in red.

In some countries, drug sellers are recognized as formal providers and are permitted to sell a limited range of medicines; in other countries, they cannot operate without a supervising pharmacist. Informal and traditional practitioners most often work in rural areas, almost always without government oversight.

Official policies and practices impact different providers in unique ways. The degree to which they are affected by, or are in need of, government intervention differs widely. A critical element of good engagement is the government's understanding of the composition and capacity of the private sector. This includes knowing the approximate range and relative importance of provider types in each country. Some policies are based on an incomplete or inaccurate picture of the actors in the health system. This makes it essential to collect basic information on private- and public-sector activities in a systematic, consistent manner.

As the Introduction indicated, this Report focuses on the full range of the private health sector, including the numerous small, private providers. These are doctors, nurses, and midwives with modest clinics, and lower-level health workers who make primary care more readily available to underserved populations in many countries. These workers go by different names in different countries and include clinical officers, assistant medical officers, medical assistants, physician assistants, and health officers. Many of these providers also work in the public system or supplement the ser-

vices offered by doctors in public facilities. They can triage patients and successfully treat most common ailments, but they face a number of constraints when they practice privately.

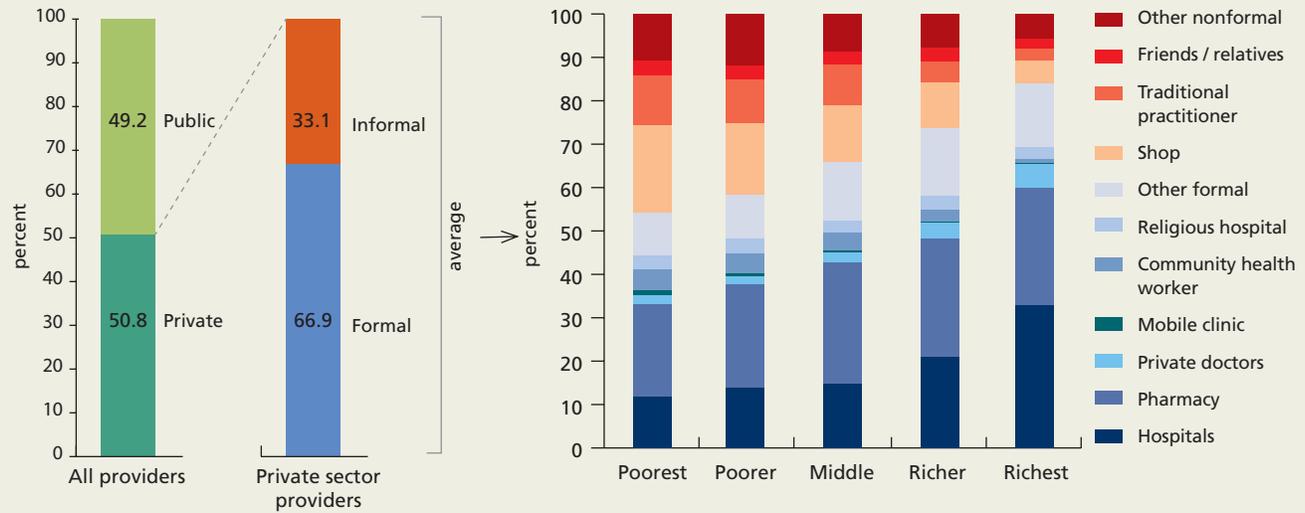
One common complaint among lower-level health workers is the unequal opportunity to practice. They may be allowed to run public facilities on their own, but must find a supervising doctor when they aspire to operate privately. Some of the constraints are imposed for safety reasons—a few providers are overzealous and are tempted to stray beyond their capabilities and training. But other constraints are simply due to poor planning and untargeted policies. Regulators appear overwhelmed by the diversity of actors, levels of training, and the difficulty in finding effective, standardized guides for their practice.

Traditional medical practitioners (TMPs) are a case in point. Policy makers (and international organizations working in health) have found it difficult to integrate them fully into the health systems. However, in some African countries, TMPs far outnumber orthodox practitioners; Swaziland is home to about 11,000 TMPs but only 200 physicians for a population of about 1.2 million.<sup>51</sup> In other countries, the World Health Organization (WHO) reports similarly glaring contrasts in availability of health service providers. WHO cites studies done in Tanzania, Uganda, and Zambia that reveal TMP-to-population ratios of 1:200 to 1:400; allopathic practitioner ratios were typically 1:20,000 or less.<sup>52</sup> Traditional medical practice is a highly lucrative business in some countries, and consumers can sometimes pay more than they would for allopathic clinical care. Zambia, for instance, has an estimated 40,000 healers who garner about 60 percent of total household health spending.<sup>53</sup>

From these numbers, it is evident that traditional medicine is consistently popular among patients even though it comes with many challenges. People have been known to suffer complications because of time lost trying traditional cures, and some herbal medicines are ingested in borderline toxic proportions for long periods, leading to kidney disease.<sup>54</sup> Pregnant women have developed vesico-vaginal fistulas at the hands of overzealous traditional birth attendants (TBAs) who do

FIGURE 1.7

Source of Health Care by Wealth Quintile and Type of Service Provider for Households in Sub-Saharan Africa



Source: Analysis of DHS surveys; latest survey year available included; Montagu 2010.

Note: All data are drawn from the sum of all Population-Weighted Sub-Saharan Africa Demographic and Health Surveys conducted after 2000. Source of treatment is a summary of respondents with children under 5 years of age reporting treatment in the prior two weeks for diarrhea and fever/cough.

not know the limits of their practice.<sup>55</sup> Some unscrupulous TMPs mix up pharmaceutical products into so-called “herbal medicines” without regard for dosage, side effects, drug interactions, or toxicity.

The highly informal care that some providers offer to friends and family will likely remain beyond the reach of regulation. This is true not just in Africa. But the relative size of the informal sector can be influenced by registration policies and practices. At the other end of the spectrum are large private hospitals that are often in a position to collaborate directly with the Ministry of Health. They are often subject to very specific rules and therefore are also outside the normal regulatory framework. The very scale of the collaboration for these large institutions may necessitate such special treatment. The new Queen Elizabeth II hospital in Maseru, Lesotho, is such an example. The collaboration between the government and a consortium led by Netcare, a leading private health care provider in South Africa that manages the hospital, has received much attention and been seen as a model. Since the hospital is the big-

gest in Lesotho and received around US\$100 million in investment, it is governed by different rules than most other health care providers. This collaboration, and similar, specific partnerships, provides an opportunity for improved engagement with the private health sector.

Different rules also apply to the nonprofit sector, especially faith-based organizations (FBOs). These differences tend to persist even as the lines of separation between the subsectors fade or disappear. Here, too, the structure and history in each country matters. Nongovernmental organizations (NGOs) are nonprofit organizations, although many are quite lucrative. Faith-based providers, in particular, are often assumed to dominate the private health sector, but in-depth assessments in several countries show FBOs constitute a smaller proportion than is generally assumed.

In Kenya, for instance, 43 percent of the facilities in the Ministry of Health database in 2006 were privately owned, 41 percent were publicly controlled, and just 16 percent were nonprofits, which includes faith-based facilities. Although the majority of the private sector facilities were

smaller clinics, the utilization data (determined by a 2003 household survey) revealed that outpatient visits to the private commercial sector exceeded those of FBOs in both urban and rural settings. These figures are consistent with the fact that there are 1,400 more (280 percent more) private commercial facilities than FBO facilities in Kenya.<sup>56</sup>

The private health sector assessment in Ghana found that private providers (both self-financed and faith-based) produce 56 percent of all services used by Ghanaian consumers, as measured by the respective shares of self-reported utilization. Only 7 percent of the total comes from the faith-based sector.<sup>57</sup>

Though the relative share of private self-financing, private nonprofit, and public providers differs considerably between countries, the results shown in figure 1.8 for Ghana and Kenya are indicative of the regional averages. An earlier study on the nationwide share of health spending captured by for-profit or self-financing providers compared to nonprofit providers came to a similar conclusion.<sup>58</sup>

**The private health sector offers the full spectrum of quality of care**

The care provided by the private sector is not always as good as it should be. In countries where the private health sector is large and diverse, examples of unethical business practices are all

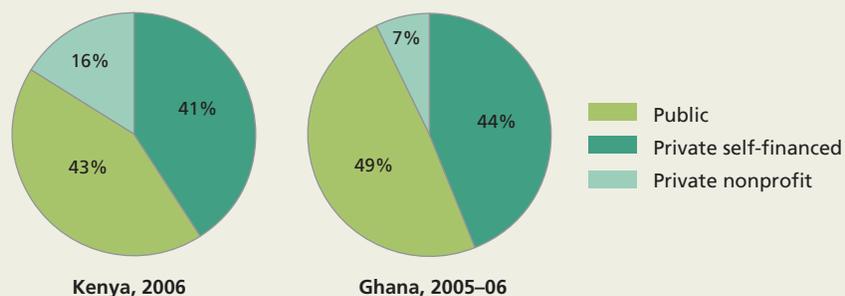
too common. The opportunities to engage in over- and underservicing, false billing, and price gouging are especially damaging when many of the patients are poor, badly informed, or illiterate. Cases of self-referral, in which patients are directed to other services in which the provider has a financial interest, are frequent.<sup>59</sup> And, just like their public sector counterparts, even responsible private health care providers sometimes fail to deliver an appropriate level of care.<sup>60</sup>

The overall impact of private-sector providers on health systems and on equity is itself a much-debated issue. Several studies have shown that the quality of care provided by the private health sector in underregulated developing countries can be poor. This can adversely affect health outcomes, including disease control and drug resistance.<sup>61</sup> But poor quality is also a challenge for public providers, and consumers often prefer the private sector due to perceived better quality, easier access, and greater responsiveness. Evidence from recent multicountry studies suggests that quality of care and provider competence are roughly equivalent in the public and private health sectors (figure 1.9).<sup>62</sup>

A recent cross-country analysis of Sub-Saharan Africa found that private sector participation is positively and significantly associated with better health system performance, improving access, and reducing disparities between rich and poor and

**FIGURE 1.8**

**Distribution of Facility Ownership**



Source: Barnes, et al. 2010; Results for Development Institute, forthcoming.

Note: Kenya data were obtained from the Kenya Ministry of Health data. Ghana data represents provider choice for most recent consultation in Ghana Living Standards Survey-5.

urban and rural populations. The results are robust to controlling for per capita gross domestic product and maternal education, two important confounding factors that are correlated with both increased private sector participation and improved health care access (figure 1.9).<sup>63</sup>

A large private sector share may raise concerns about user fees thought to be associated primarily with the provision of private health services. User fees suggest that increasing the role of the private sector will limit the use of health care among the poorest, who cannot afford to pay, consequently reducing access and equity.<sup>64</sup> Evidence suggests, however, that these concerns are not limited to the private health sector. Indeed, across the region, a considerable amount of “private business” takes place in supposedly free public health care facilities. Visits to public clinics or dispensaries across the region usually require the patient to part with some amount of money for the doctor or health care provider.<sup>65</sup> In some settings, this is a normal practice that is condoned (though not openly sanctioned) by the Ministry of Health to retain poorly paid public sector health workers. In other countries, such “under-the-table” payments in state-owned facilities are frowned upon or even criminalized. Overall, there is no systematic evidence on whether user fees in the public sector are even lower than in the private sector.<sup>66</sup> For example, patient exit surveys conducted as part of a 2009 study in Ghana found that the amount of out-of-pocket payments patients pay is similar in public and private facilities (figure 1.9).<sup>67</sup>

The best approach to improving access to care is to build on the resources of a private health sector that is already responsible for a large part of the current levels of access, especially in light of the resource constraints of existing health systems.<sup>68</sup> Beyond financial resources, the private health sector can bring innovation, competition, responsiveness to patients, and management capacity into the system. A range of interventions designed to improve use and equity through engagement of self-financed providers has been shown to be successful (figure 1.9).<sup>69</sup>

**FIGURE 1.9**

### Contributions of the Private Health Sector

#### COMPLEMENTARY

Services provided by private and public health sectors complement each other; they are overall equivalent in terms of

- Quality of delivered care
- Out-of-pocket payments required to receive care

At the systems level, higher private sector participation in Sub-Saharan African countries is not associated with reduced access or higher disparities in access.

#### SPECIFIC & ADDITIONAL

Private health sector also offers unique contributions to the health system, namely

- (i) technology and innovation;
- (ii) needed financial capital;
- (iii) competition, which can raise overall system performance;
- (iv) management skills; and
- (v) flexibility to adapt to difficult and often fast-changing circumstances.

Plus, there are examples of engagement (e.g. for specific interventions) which have achieved tangible results quickly. They are discussed below in Observation 3.

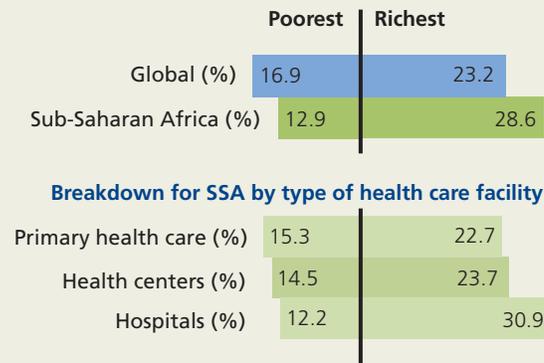
Source: Das, Hammer, and Leonard 2008; Yoong et al. 2010; Results for Development Institute, forthcoming; Patouillard, Goodman, and Hanson 2007.

### Making best use of available resources

This Report does not to argue for a greater share of privately provided care, but for acknowledging the private sector as an important component in the provision of health care to all. While public spending on health care is sometimes believed to mostly benefit the poor, the opposite is true. It is frequently the wealthy, not the poor, who disproportionately benefit from public spending, and not just in Africa. A 2010 study found that 17 percent of the benefits from public health spending globally accrue to the poorest quintile compared with 23 percent to the richest quintile (see figure 1.10). In Sub-Saharan Africa, the disparity is even more pronounced: the poorest quintile benefits from only 13 percent of public money for health care compared to almost 29 percent benefiting the richest quintile.<sup>70</sup> Another study recorded a similar benefit distribution in Ghana: one-third of public health spending benefits the richest quintile, while just 12 percent of public health spending benefits the poorest quintile. The numbers are similar for Tanzania.<sup>71</sup>

**FIGURE 1.10**

**Benefit Incidence of Public Health Spending**



Source: Davoodi et al. 2010.

Note: SSA = Sub-Saharan Africa. Analysis includes 12 countries: Côte D'Ivoire, Djibouti, Ghana, Guinea, Kenya, Madagascar, Malawi, Mauritania, Mozambique, South Africa, Tanzania, and Uganda.

The evidence cited here suggests that the private health sector has a positive contribution to make to meet the formidable challenges that African health systems are facing, even as concerns with private delivery remain. Appropriate collaboration and partnerships within the health system are needed to leverage the contributions effectively.

Despite the private sector's large role, much of what it does is not aligned with national health priorities. In Kenya, for example, a frequently voiced frustration from all parties is that hospital bed occupancy rates differ dramatically between public and private facilities: while several private hospitals in Kenya have empty beds, public hospitals are overcrowded.<sup>72</sup> In some instances, these overcrowded public hospitals are adjacent to underused private hospitals. Elsewhere, the differential bed occupancy rates may be reversed, but the main point holds: in an environment in which overall resources are scarce, inefficiencies are especially costly, pointing to the need for better coordination.

The question we seek to address is how the private health sector's contributions to the public interest can be improved. Replacing privately provided services with publicly provided care—which, it is often argued, should be less expensive, easier to access, and of better quality—is impracti-

cal where an entirely different medical infrastructure has been evolving for more than half a century. Privately provided care should be a welcome addition to government programs.

**OBSERVATION 3**

**A minimum level of engagement is an important part of the solution**

Governments are responsible for improving national health systems, a duty that is enshrined in the constitutions of most countries. But the lack of public resources, and the size of the private health sector in Africa, suggests that governments cannot fulfill this responsibility unless they practice some minimal level of engagement. Indeed, basic elements of engagement are the most important—making the private health sector a fully recognized partner in policy setting, planning, and implementation.

Section 2 offers evidence from our assessments across the region of whether and how governments are currently engaging with the private health sector in each country. Consistent qualitative evidence illustrates the mostly positive effects of engagement. Similarly, the data show how a lack of engagement will hamper the effectiveness of public health interventions.

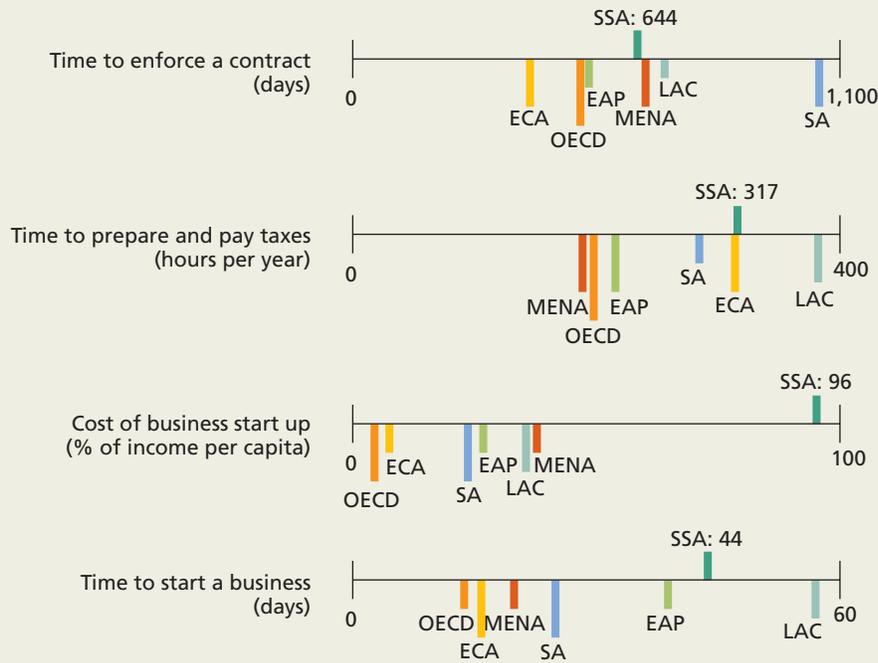
*The government's role in shaping the operating environment*

Engagement is not the only factor that shapes the environment within which the private health sector operates. Just as important are the characteristics of the overall health system, and general government policies toward the private sector and the health sector. To present a more complete picture, measures of engagement are compared with other aspects of the broader business operating environment. The country snapshots in Appendix 1 illustrate a selection of these measures for each country individually.

One of the government's principal roles is to create a business environment conducive to investment and growth and to create a "level playing field" for all private firms. This overall business environment will also impact private providers in the health sector. But how well are governments

**FIGURE 1.11**

**Comparison of Selected Business Environment Measures across Regions**



Source: World Bank, *Doing Business 2011*.

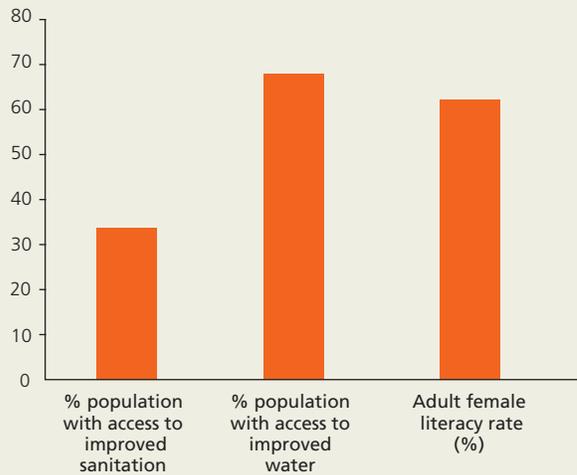
Note: EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development; SA = South Asia; SSA = Sub-Saharan Africa.

fulfilling this role? The World Bank’s Doing Business indicators provide measures of the business environment for the private sector overall, as discussed in box 01 in the Introduction. The regional Doing Business averages show that Africa lags behind in these measures and in its overall operating environment. Figure 1.11 shows selected proxy measures for the Africa region compared to other regions and to countries belonging to the Organisation for Economic Co-operation and Development (OECD). The average among SSA countries for number of days it typically takes to enforce a contract is similar to the averages in other regions. In terms of paying taxes and starting up a business, however, the measures are significantly worse for Africa. Only in Latin America and the Caribbean does it take longer to pay taxes or start a business. When it comes to the cost of starting a business relative to income, Africans have to pay the most by far.

In Section 2, where the operating environment for private health providers is examined in more detail, we see that important differences emerge between the private health sector and the non-health private sectors.

Infrastructure and the availability of essential services like water and electricity matter for any enterprise, including health providers. Whether such services are available, especially in rural areas, will significantly impact the cost of doing business. Given the distributed benefits of providing these services,<sup>vi</sup> ensuring their availability is usually a responsibility of the government. Access to clean water and provision of sanitation, as well as other inputs, are especially critical for private

vi. That is, because many benefit from the services, any single person will not want to bear the costs of providing them. Therefore, a mechanism is needed through which many collectively can bear the cost, since many will reap the benefits. In short, public financing is needed.

**FIGURE 1.12****Availability of Supporting Services in Sub-Saharan Africa**

Source: World Bank, *World Development Indicators*, 2010.

operators who want to provide uninterrupted care to patients. As proxy measures for the availability of key services, we include the World Bank's World Development Indicators on water and improved sanitation. These are also featured in the country snapshots. As an additional proxy measure for supporting services by the government, we include the rate of female literacy. Mothers who can read are not only an important determinant of child health—the education of women is an indirect way for the government to improve the welfare of children—but is also a proxy for the degree to which the private health sector's patients are in a position to make more informed decisions.

As figure 1.12 shows, the private sector in Africa cannot rely on much support in terms of the availability of essential services. The connection between the engagement indicators and the other indicators of the operating environment is further elaborated on in Appendix 4.

One relatively uncontroversial avenue for engaging the private sector is providing financial or technical assistance for activities that have large public health benefits. The control of vaccine-preventable and other infectious diseases is a good

example. Extending the provision of goods that are to be distributed to the private sector can improve the effectiveness of these public health interventions. Box 1.2 discusses this example from the perspective of private health providers.

### *Impact on outcomes*

Evidence of the need for engagement at the systems level is instructive, but understanding the impact on intermediate outcomes (access, equity) or even health outcomes (maternal mortality, under-five mortality, life expectancy, and so forth) may be the ultimate test. Such estimates are part of the future research agenda. In the meantime, the evidence in the program evaluation literature offers clues to the impact of including the private health sector in specific interventions.

### *Program evaluation evidence from maternal and child health literature*

An overarching theme of the maternal and child health (MCH) literature is that strategies must first identify capacity to build on it.<sup>73</sup> There is growing evidence and an emerging consensus that these strategies must be targeted at the community level and executed by local stakeholders. This approach has accelerated improvements in outcomes across Sub-Saharan African countries.<sup>74</sup>

Successful maternal health interventions using the private sector show how initiatives can be scaled up to achieve better health outcomes. The following three interventions have benefited from extensive evidence and support in maternal health literature:

- *Family planning:* Ample evidence demonstrates that family planning is key to improving MCH outcomes and that family planning ideally lends itself to scale-up through the private sector. One-third of maternal deaths could be preventable if all families had access to family planning technology.<sup>75</sup> For example, private sector distribution of condoms and oral contraceptives has been under way with good results in several countries for decades. Indeed, around 57 percent of the developing world's expenditure on family planning is made by consumers

### Government Financial or Technical Support for Public Health Activities in the Private Health Sector

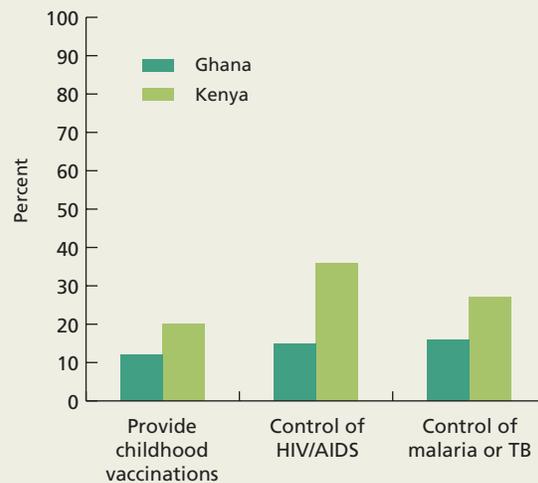
We surveyed private clinics in Ghana and Kenya to assess whether they received any financial or technical assistance from the government for conducting activities that had potential public benefits, including childhood immunization programs, control of HIV/AIDS, and antimalaria or tuberculosis initiatives. Figure B1.2 shows that in both Ghana and Kenya, relatively few private clinics report receiving assistance for these key public health activities.

For example, in Kenya, roughly 20 percent of clinics said they received support for providing childhood vaccinations, 36 percent said they received support for HIV/AIDS prevention, and about 25 percent said they received support for malaria or tuberculosis activities. In Ghana, government engagement with the private health sector for these key health activities is even lower. Only 12 percent of private clinics received financial or technical assistance for childhood vaccinations and only about 15 percent received assistance for HIV/AIDS, malaria, and tuberculosis programs. These data suggest that existing government engagement with the private health sector for key public health activities is relatively limited.

Increasing the level of engagement is likely to provide significant benefits, given that a large share of the population in Ghana and Kenya, and Sub-Saharan Africa more generally, accesses health care at private facilities. Since a significant share of low-income households seeks health care from private facilities in Sub-Saharan Africa (see

Observation 2, above), by targeting only public facilities, a significant fraction of the poor population may not benefit from public health interventions. This is especially unfortunate in light of the scarce available resources for such interventions, since in effect excluding indigent patients of private providers is likely to decrease the returns on the public funds spent.

**FIGURE B1.2**  
Private Providers Receiving Financial or Technical Assistance for Delivering Public Health Services, Ghana and Kenya



Source: "Healthy Partnerships" provider survey, 2010.

themselves,<sup>76</sup> with the private sector capturing the vast majority of that spending. In terms of quality, community workers, who include pharmacists, health workers, volunteers, and dispensers, have been shown to safely and effectively administer injectable contraceptives at the household level.<sup>77</sup>

- *Misoprostol home deliveries for prevention of postpartum hemorrhaging*: The efficacy of misoprostol in the treatment of postpartum hemorrhaging (PPH) has been established by the obstetrics research community for settings where oxytocin is not available.<sup>78</sup> Misoprostol

is not intended to discourage a movement toward more facility deliveries, but it is a practical, scalable, and relatively inexpensive intervention that can reduce severe, life-threatening PPH, and can buy a woman time to reach a facility. Extensive evidence supports expanded efforts either through governments or NGO partners to train TBAs and other community health workers to administer misoprostol to women in labor in the home.<sup>79</sup> Scale-up of these efforts requires the implementation of safeguards to ensure that misoprostol is not administered until the third

stage of labor<sup>vii</sup> and to ensure against diversion of misoprostol for alternative uses.<sup>viii</sup> Second-generation studies abound that model deaths averted<sup>80</sup> and costs saved from community-based TBA training in misoprostol administration, all of which confirm a high degree of cost-effectiveness.<sup>81</sup>

- *Expanding skilled birth attendance:* Expectant mothers are much more likely to live if a skilled attendant is present at childbirth and an obstetrician is available for backup at a hospital.<sup>82</sup>

vii. Administration prior to the third stage is associated with a higher risk of uterine rupture.

viii. Misoprostol's potential use as an abortifacient has led to black market sales of the drug. Well-intentioned distribution of misoprostol to prevent maternal hemorrhage without safeguards could trigger removal of the drug in settings where anti-abortion activists are likely to exploit any evidence of misoprostol diversion.

The stories of Yaaba and Efue at the beginning of this section showed the importance of obstetric support and the availability of emergency obstetric care. The best ways to ensure quality of care are through midwifery training programs or through obstetricians where they exist, the financing of private-practice establishment, franchising, and strengthening accreditation.<sup>83</sup>

In addition to the positive effects of the inclusion of the private health sector in interventions, the opposite has been documented: when interventions are designed and implemented without the private health sector in mind, they are less effective. Box 1.3 presents an example in the area of child health.

### BOX 1.3

#### What Happens When We Ignore the Private Health Sector?

An example of what happens when we ignore the private health sector is the Integrated Management of Childhood Illness (IMCI) program, which is designed to promote improvements in child health in developing countries. It is based on the concept that treatment of the common childhood illnesses should be provided in an integrated and holistic manner, maximizing the health benefits of each contact the sick child has with public health facilities. IMCI was widely introduced between 1996 and 2001 in most countries with moderate-to-high levels of child mortality and formally targeted three areas: (a) the quality of clinical care, (b) the functionality of basic facilities, and (c) the effectiveness of outreach activities. This usually involved the training of frontline staff in how to treat the most common childhood illnesses, public facility improvements such as staff supervision and drug availability, and efforts to expand community education about good health practices in the home.

Source: Harding, forthcoming.

The IMCI program encountered several strategic and systemic failings. Most important, however, it failed to expand community outreach activities or achieve sustainable results. While treatment quality in frontline public clinics has improved in some countries, measurable improvements in child health attributable to IMCI have only been found in Tanzania. Equally critically, the program has generally not explored the role and potential contribution of the private sector, because the IMCI approach has really only included activities to improve services provided in public clinics, even in countries where private providers were actually seeing the large majority of sick children. Program designers apparently believed that if they could substantially improve the services offered, the large number of people who were going elsewhere (or not seeking care) would quickly switch to them. But much evidence shows that people continue to go to providers in the community that they trust and find convenient—and these providers are very often private.

### *Contracting or purchasing*

A major, recurring question is whether the private sector should be employed to deliver health care goods and services on behalf of the public sector. While this is only one part of engagement, the results from our research show the relationship between the public and private health sectors is frequently dominated by that question. Interest has been growing in financing mechanisms that focus more on outputs or the services produced, and less on the inputs or the costs associated with operating a facility, for example. The private health sector is far more inclined to organize seriously and work with the government if there is a realistic chance of being contracted to provide clinical services. From the government's perspective, purchasing services from providers, whether public or private, offers an alternative to simply allocating budgetary funds to public facilities. The government can also use limited resources on the most needed services, choosing flexibly from public or private facilities. However, such financing arrangements also require the capacity to oversee them. Practical toolkits have been developed to help governments with contracting.<sup>84</sup>

Impressive results have been recorded when purchasing or contracting is done well. A systematic review of studies in developing countries<sup>85</sup> identified eight cases that showed measured improvements in quality, access, or both, from contracting services in maternal and child health. Indeed, the studies found that contracting improved coverage in all cases, even in poor and remote areas, with median coverage increasing in program areas by 3.4 percent to 26.0 percent over control areas. Based on measures of both coverage and quality of care, six of the studies found that contractors were more effective than government providers. An evaluation of Rwanda's pay-for-performance (P4P) scheme by Basinga et al. (2001) found statistically significant improvements in the maternal and neonatal health indicators of institutional delivery and quality of prenatal care, which increased by 21.0 percent and 7.6 percent, respectively, over the baseline in the P4P districts.<sup>86</sup>

### *Dangers of excessive engagement*

Not all government intervention or engagement is benign. As we advocate for improved government engagement with the private health sector, it is important to acknowledge that potentially negative impacts from inappropriate intervention by the government are real. Some governments fail in their basic duties to provide oversight in the economy. This can be a matter of capacity, but also of corruption or willful neglect. In considering the options for effective engagement, such constraints must be taken into account. Examples of such inappropriate intervention, often in the form of excessive rules, abound in Africa for the private health sector. Section 2 presents a number of these examples.

Beyond the health sector, much of the work on improving the investment climate in developing countries focuses on keeping the points of contact between the government and the private sector to a necessary minimum (box 1.4). Each contact point is an opportunity for delays, arbitrary application of rules, graft, or for capacity constraints by the government to impede the development of the private sector. When it comes to health care, not every additional contribution by the private sector requires more government involvement. In Mauritania, only citizens can own private health sector facilities and only citizens of a few additional countries can freely work in them. This has thwarted the attempts by foreign investors and physicians to set up much-needed private clinics. In Comoros and the Democratic Republic of Congo, the private health sector has faced tax increases and has been denied investment incentives, burdens that were not inflicted on the private sector more generally.<sup>87</sup>

There is a fine line between government engagement with the private sector and burdensome intrusion. Greater attention to improved engagement is to be understood relative to the current, prevailing approach to engagement in the region. The appropriate amount and type of engagement is defined in the regional context, as box 1.4 discusses in more detail.

### How Much Engagement Is the Right Amount?

The framework for assessing engagement was designed to be relevant in the African context (see Appendixes 3 and 4 for more details on the framework and the indicators). In general, public-private engagement in Africa is very low, so we looked for the presence of the most basic building blocks. The goal was not to assess and contrast sophisticated levels of engagement, but to identify policies that provide the foundation for a basic level of interaction. This approach makes sense for two reasons: (a) the observed variation in levels of engagement in Africa suggests this is the appropriate level to focus on for now, and (b) we can safely say that these building blocks are important for health systems with a sizable private sector. By extension, Africa's mixed public-private health systems are more likely to perform better when these basic elements are in place.

Source: "Healthy Partnerships" data, 2010.

This framework is less relevant for most Western European countries, where these basic building blocks have been in place for decades, and the level of engagement is advanced. As one senior official at the OECD noted, the private health sector in OECD countries "cannot breathe without the government being involved." There is, of course, an ongoing debate about the appropriate level of engagement in OECD countries as well; in some instances, there may be too much of it.

Notwithstanding these caveats, the framework provides useful and important insights also for the health systems in Africa's higher-income countries, such as Botswana, Mauritius, and South Africa. They are more akin to OECD countries in terms of the organizational capacities of the private and public health sector. And yet, while these countries receive fairly good scores in general, our assessments still highlight areas where engagement can and should be improved.

### Not all oversight requires government intervention

The government is not always best placed to fill an oversight role of the private health sector. Indeed, self-regulation and third-party accreditation have often proven to be more effective.<sup>88</sup> A prominent example from the United States is The Joint Commission on Accreditation of Healthcare Organizations, which was created by American and Canadian medical professionals and hospital associations to provide voluntary accreditation for health facilities. The Joint Commission accredits and certifies more than 18,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.<sup>89</sup>

Examples of successful self-regulation can also be found in Latin America.<sup>90</sup> In the Dominican Republic, a coordinating organization for more than 100 NGOs, INSALUD, participates in the National Commission for NGO Qualification and Accreditation. It works in partnership with the government to ensure that NGOs receiving public funding comply with minimum requirements, standards, and norms. Similarly, the Ministry of Health in El Salvador contracted with an NGO to establish quality-of-care requirements and assess compliance.

Similar examples from Africa, where self-regulation is slowly becoming more widespread, are discussed in Section 2. Social franchising, a particular form of accreditation carried out without government influence or control, is discussed in box 1.5.

### (Social) Franchising as a Way to Expand Quality Improvements

**F**ranchising is the use of a successful business model and common brand across several firms. For private health providers, it can be a good approach to benefit from brand recognition in exchange for adhering to strict standards in terms of quality processes, prices, or both. A derivation of this concept is called social franchising, in which a successfully tested model of service delivery is offered by the franchisor. The participating providers, or franchisees, replicate the model and often receive assistance to ensure they are able to adhere to the required standards. The social goal, sometimes coupled with subsidies for the service delivery, is a particular element of this approach. However, as in commercial franchising, the participating firms in social franchising can capitalize on a recognizable brand name or logo that identifies participating service delivery points to consumers. In

return, the franchisees are obligated to comply with quality standards, report sales and service statistics, and, in some cases, pay franchise fees.

Social franchise models of service delivery exist in several African countries. Many of the wider networks focus on provision of family planning and reproductive health services; others provide general health care services. Whether the private provider operates fully under the auspices of the franchise or not, the training received has been found to improve quality of those services covered. This is expected to diffuse into the other aspects of care offered by these providers. Although the current evidence for the effectiveness of social franchising as a quality improvement tool is limited, preliminary results from program evaluation suggest that the model holds considerable promise.

*Source:* World Health Organization and the United States Agency for International Development 2007; Bishai et al. 2008; Koehlmoos et al. 2009; Prata et al. 2005.

#### **Obstacles to engagement, especially at the systems level**

Engagement between the public and the private health sectors does not happen automatically, and cannot happen without political will. For both sides, significant obstacles exist. The transaction costs of engaging remain high and, as others have pointed out,<sup>91</sup> developing effective government engagement with the private sector is challenging. Many questions remain.

From the government's side, the obstacles to engagement include limited capacity on the one hand and a relative lack of incentives to engage on the other. In addition, there is a lack of trust, as we discuss below. This Report argues that precisely because the government's capacity is limited, smart engagement with the private sector—for example, to kick-start a productive dialogue—is worthwhile, despite the up-front costs. Incentives for the government to engage may also be missing, due either to conflict of interest (the Ministry of Health has responsibility not just for setting policy

but also for managing public providers of health care services) or because of the structure of donor-funded programs. Engagement must begin with recognition of the size of the private sector, and a willingness to set aside stereotypes, especially with regard to for-profit or self-financing providers. Interviews conducted for this Report revealed a lingering suspicion of the for-profit health sector in many, though not all, countries in the region. Yet, many private providers offer good-quality services to patients who need them, extending access well beyond the reach of underfunded government providers.

Notwithstanding our relative focus on the role of the government, engagement is a two-way process. Intermediaries, such as health insurance authorities, may even turn engagement into a multiparty process. But certainly private providers must be ready to reciprocate when the government extends a hand, even if the hand is not completely open and was, perhaps, partly forced by international donors. Part of the engagement



### *Trust and predictability as key ingredients*

Trust among government, the private sector, and intermediaries is essential<sup>92</sup> for a productive operating environment. Stability within government is a critical first step to increasing trust and improving public-private collaboration.<sup>93</sup> Conversely, uncertainty has a negative effect on business investments. Along with inappropriate policies and practices, which we discuss in Section 2, unpredictable changes in taxation, legislation, regulatory enforcement, and subsidy allocations are a major obstacle to scaled-up investments. Such changes create instability in private health delivery markets in Africa, increasing the cost of capital and slowing both investment and growth.<sup>94</sup> The high degree of authority vested in governmental leadership in many African countries means changes in government often result in about-faces on legislation, partnerships, or developing relationships. In Sierra Leone, for example, a public-private partnership, which had been initiated by the private sector itself, aimed to create a dialysis center in a government hospital, for the private and public sectors to use jointly. Even though room had been allocated and the equipment had been purchased, the partnership was abandoned because of a change in leadership at the Ministry of Health.<sup>95</sup>

Instability resulting from change at the Ministry of Health is a common problem in the region. The Gambia had four health ministers, five permanent secretaries, and three directors during 2009 alone. In Niger, the Minister of Health changed 10 times in seven years (2003 to 2010). In several countries in the region, the average tenure of health ministers is a mere six or seven months.

Adding to the instability, distrust between the public and private sectors remains a hindrance, and partly prevents the allocation of public resources to the private sector commensurate with the scale of private financing and provision.<sup>96</sup> Perceived profit motives by the private sector remain a limiting factor on contracting, facilitating legislation, and formal recognition by governments, leading to unregistered facilities and dual

process will necessarily be an articulation early in the process of what each side has to gain.

For private providers, engagement can be difficult if there is no organization to coordinate the effort, and because of the time and effort required to attend meetings, review documents, and so forth. The private sector is typically diverse, and it is this diversity that makes organization difficult. The cost of engaging can be especially prohibitive if the private health sector does not clearly understand what the benefits will be.

practice (that is, working in both the public and private sectors), among government-employed clinicians.<sup>97</sup> Private practitioners, themselves, further distrust government for fear of regulation, taxation, or rent taking by formal or informal means.<sup>98</sup> When nonstate providers operate without security or predictability, the incentives for growth and investment are sharply curtailed.<sup>99</sup>

Corruption, whether real or perceived, is a major impediment to government engagement with the private sector in many countries.<sup>100</sup> When real, it introduces tremendous inefficiencies and disincentives into the health market, which increases operating costs for private providers, reduces quality because of nontransparent criteria for subsidy and operation, and greatly increases the barriers to entry and expansion of care-providing entities. Whether real or perceived, corruption reduces trust and transparency in the relationship between government and private partners and so limits the effectiveness of the engagement.

### ***Building trust and predictability***

Despite these impediments, improvements in trust between the public and private health sectors is not only possible but is actually happening in several countries, leading to increased dialogue. In Ghana, Kenya, and Mali, for example, dialogue has evolved from the exchange of general thoughts and priorities to specific instances of collaboration and reform. In Mauritius, the

government is actively courting professionals and investors from the private health sector, both domestically and internationally, to further develop high-quality health services. In other countries, the process of rebuilding trust and predictability is not far behind.

The recognition of mutual reservations can be a positive initial outcome of such a process. On the private sector side, it is a matter of getting past the view that the government is responsible for everything yet lacks the capacity or will to do anything. On the government side, it is a matter of rejecting the notion that the private sector is only interested in profit and lacks the ability or willingness to work toward public health goals in good faith. Surrendering or softening such views and gaining a basic understanding of the financial and organizational constraints of both parties is the first step toward real engagement.

Building sustained partnerships between the government and the private health sector is a two-way process. Ultimately, engagement will yield positive results only if both the public and private sectors are willing to work together and are committed to furthering public-private collaboration. In Section 2, we examine engagement from the government perspective first: How should the steward of the health system approach this issue? In the latter part of Section 2, we highlight the role the private health sector itself must play in the engagement process.



## Section 2: What our research tells us about engagement

*From Dakar to Dar es Salaam, policy makers across the Sub-Saharan Africa region are searching for effective ways to tackle the most pressing health challenges. As Section 1 noted, part of the solution will be to engage all actors in the health system, including the private sector.*

There is at least some government engagement with the private health sector in every country, evidenced in examples of public-private collaboration to improve the quality, accessibility, and efficiency of health care. At the same time, the overall level of engagement is low in many countries, and there is a noticeable lack of engagement with for-profit or self-financing providers. Policy makers are becoming increasingly aware of this, and are looking for ways to increase and improve collaboration. Many opportunities exist, and it will be up to policy makers to follow through.

This section analyzes how governments are currently engaging private providers within the context of the five domains discussed earlier. The results, a summary of which are presented in table 2.1, are based on original research conducted for this Report.<sup>ix</sup>

The overall messages are as follows:

- **Government engagement at the systems level is underway.**  
Governments are already working with the private health sector, to some degree. Notable examples include widespread collaboration with faith-based organizations (FBOs) and with private providers for specific disease or immunization programs.
- **The level of engagement with self-financing providers is low.**  
Government engagement with for-profit providers at the systems level needs urgent improvement. Even though policies may be in place for engaging such providers, implementation is generally weak, and self-financing providers often are not included unless connected to a specific disease or immuniza-

**TABLE 2.1 A Brief Glance at the Results**

Policy and dialogue	Governments have private health sector policies in place, but implementation is a challenge; more dialogue is required to improve collaboration.
Information exchange	Information exchange is weak and needs to improve, but there is good cooperation for disease surveillance.
Regulation	Private sector regulations are in place but may be outdated or inconsistent; enforcing regulations is a major problem.
Financing	Governments are using some (limited) financing to engage providers in many countries and are open to more.
Public provision of services	There is good cooperation on referral systems and immunization and other disease programs.

ix. Unless otherwise stated, all data cited in Section 2 are based on the “Healthy Partnerships” Report data collection, carried out between February and July 2010.

tion program. (See box 2.1 for a brief discussion of why we concentrate on self-financing providers.)

- **There is much opportunity for increasing systemic public-private collaboration.**

Further engagement is not a question of reinventing the wheel. If governments seek to leverage the capabilities of the private health sector, much can be achieved by including private providers in already existing arrangements.

#### *Data collection and assessment framework*

This section provides background on the assessment framework used to measure engagement. As noted in the introduction, data were collected in 45 countries between February and July 2010 through in-country visits. The results presented here are based on interviews with more than 750 government officials, policy makers, regulators, private providers, and other experts across the region.

As explained, the assessment framework developed to measure government engagement includes five domains, each describing a key aspect of the government's relationship with the private health sector. Each domain can be seen as bidirectional, that is, to and from the pri-

vate sector, and each interacts with the others. The policy and dialogue domain concerns the underlying policy framework for the private health sector and its implementation, and the level of dialogue between the public and private sectors. The other domains cover the range of policy instruments that governments can use to engage private providers: information exchange, regulation, financing, and public provision of services. More information on the methods behind the engagement data, including the selection of indicators, and on the conceptual development of the framework, can be found in Appendixes 3 and 4.

The overall assessment framework is shown in table 2.2. Since engagement consists of both policy and its implementation, the framework contains both de jure and de facto indicators to fully capture how governments are engaging private providers. De jure indicators rely on fact-based measures that focus on the existence of policies, laws, or regulations. De facto indicators are based on expert opinion of policy implementation or inclusion of private providers in government programs or structures.

#### **BOX 2.1**

##### **Placing the Focus on the Self-Financing Providers**

The results presented in this chapter refer to government engagement with the for-profit or self-financing sector only. They do not analyze engagement with the nonprofit sector. There is more engagement with the nonprofit sector than self-financing providers across all domains in all countries. In many countries, FBOs are indistinguishable from the public sector. Many FBO facilities serve as public reference hospitals. The high level of integration between the public sector and FBOs makes cross-country analysis difficult because FBOs are considered an extension of the public sector in many countries. Their partnership is discussed in more detail at the end of this section.

Source: "Healthy Partnerships" data, 2010.

**TABLE 2.2 Overall Assessment Framework**

Domains	Subdomains	Indicators
Policy and dialogue	Policy	<ul style="list-style-type: none"> <li>• Policy for engaging the private health sector</li> <li>• Level of policy implementation in practice</li> </ul>
	Dialogue	<ul style="list-style-type: none"> <li>• Formal dialogue mechanism with the private health sector</li> <li>• Level of dialogue in practice</li> </ul>
Information exchange	Information flows	<ul style="list-style-type: none"> <li>• Governments include the private health sector in their information flows.</li> </ul>
	Private health sector inclusion in the national health information system	<ul style="list-style-type: none"> <li>• The private health sector is required by law to provide health-related data.</li> <li>• Governments are receiving this information from the private health sector.</li> </ul>
	Private health sector inclusion in national disease surveillance program	<ul style="list-style-type: none"> <li>• The private health sector is included in a country's national disease surveillance program.</li> <li>• Governments are sending out regular surveillance updates to the private health sector.</li> </ul>
Regulation	Quality of the registry of private health sector providers	<ul style="list-style-type: none"> <li>• Quality of the registry of private health sector facilities</li> </ul>
	Quality of regulatory framework	<ul style="list-style-type: none"> <li>• Reported judgment of quality regulation framework</li> <li>• Standardized rules for opening private health clinics</li> <li>• Inspection process for private health sector clinics in place</li> <li>• Same regulations for inspections as for the public and private sectors</li> <li>• Continuing medical education (CME) requirements for private health sector professionals</li> <li>• Policy for traditional medicine</li> </ul>
	Enforcement of regulation	<ul style="list-style-type: none"> <li>• Regulation is enforced as intended.</li> <li>• Inspection process for private health sector clinics is carried out.</li> <li>• Public sector CME training is open to the private health sector.</li> </ul>
Financing	Contracting	<ul style="list-style-type: none"> <li>• Contracts in place with private health sector facilities or private practitioners (at any level of government)</li> </ul>
	Financial incentives	<ul style="list-style-type: none"> <li>• Government offers financial incentives specific to private health sector facilities.</li> </ul>
	Level of private provider coverage through health insurance	<ul style="list-style-type: none"> <li>• Percentage of population covered by public or private health insurance paying (potentially) reimbursements for services provided at private facilities</li> </ul>
Public production	Distribution of vaccines or medicines to private health sector	<ul style="list-style-type: none"> <li>• Government provides the private health sector with vaccines or medicines from a government or a government-sanctioned program.</li> </ul>
	Functioning referral system	<ul style="list-style-type: none"> <li>• Functioning referral process between the public and private sector</li> </ul>

Source: "Healthy Partnerships" data, 2010.

## Results from the data collection

### Policy and dialogue

The policy and dialogue domain concerns the private sector policy framework on paper and in practice, and the level of dialogue between the public and private sectors. This domain summarizes overall government engagement, since policy and dialogue provide the foundation for the other domains. See figure 2.1 for description of good practice and summary of results in policy and dialogue.

The top-performing countries (a score of 8 or more out of 10) in this domain are Kenya, South Africa, Burkina Faso, Ghana, Mauritius, Nigeria (Lagos State), Rwanda, and Tanzania. See box 2.2 for a good practice example in Ghana.

**FIGURE 2.1**

### Good Practice and Results in Policy and Dialogue

#### Good practice in this domain is to have four elements in place:

- A government policy to work with the private sector as a partner in the delivery of health care services
- A high level of day-to-day implementation of the policy of engagement
- A formally instituted dialogue mechanism
- An ongoing dialogue between the government and the private health sector

#### Our research revealed the following:

- More than 85 percent of countries in Sub-Saharan Africa have an explicit policy toward the private health sector.
- Implementation of policies, however, is severely lacking in a majority of the countries.
- Levels of dialogue are low across the region but are growing.

Source: "Healthy Partnerships" data, 2010.

## BOX 2.2

### Good Practice Example on Policy and Dialogue: Ghana

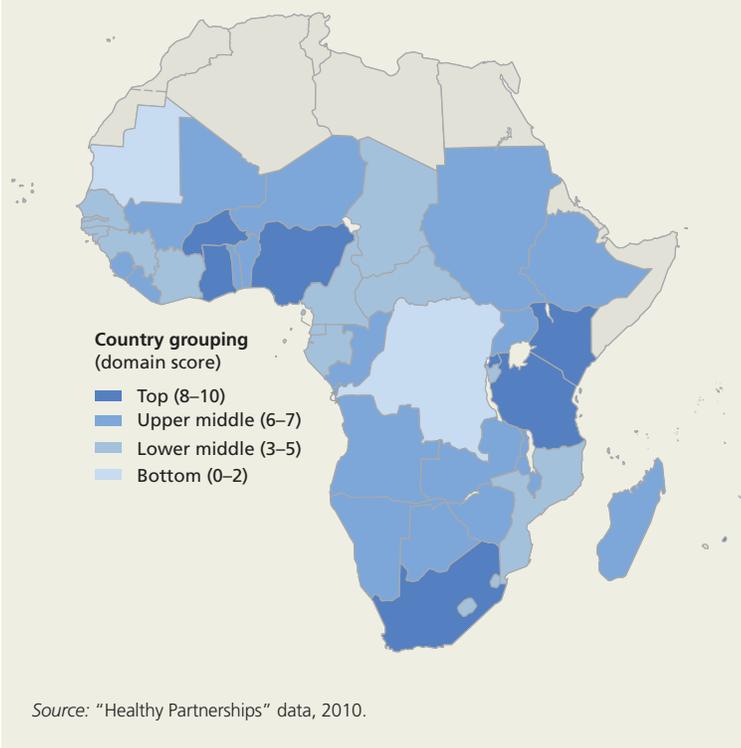
The level of engagement between the Government of Ghana and the private health sector has greatly increased in recent years. While implementation, for example of suitable regulation, is not yet where it should be, it is an example of good practice in the domain of policy and dialogue. The Ghana Private Health Sector Policy prescribes in detail how the public and private sectors can work together to meet national health priorities. It covers the key issues affecting private sector growth and participation in the health sector, the rationale and objectives of the policy, the specific policy areas for public-private collaboration, and strategies for implementation. It also details the composition and capacity of the private sector.

This policy has been implemented on various fronts, most prominently with the inclusion of private providers in the Ghana National Health Insurance Scheme. Though many challenges remain, respondents noted the positive impact of the recently revived dialogue process. Even though the private sector policy existed before, it was not until the recent reactivation of the dialogue that the policy really became operational. The private sector, in turn, has responded by forming an umbrella organization of private providers, with the representatives coming from the health subsectors and professional groups.

Source: "Healthy Partnerships" data, 2010.

## FIGURE 2.2

### Map of Policy and Dialogue in Sub-Saharan African Countries



### Results

The policy and dialogue domain presents an encouraging picture, overall. A number of countries score highly by combining a good private sector policy framework with implementation in practice. The top performers include more developed countries like Mauritius and South Africa, but also low-income states like Burkina Faso and Rwanda (figure 2.2). This suggests that not just resources, but also a broader commitment to engagement, backed by positive actions, are important to successful engagement.

The difference in performance among countries is generally the degree of implementation. Although many countries have policies or dialogue mechanisms, implementation is a big challenge and is lacking in many places. For example, Zambia has a number of private health sector initiatives, including a public-private partnership (PPP) policy and a task force to promote PPPs. It also held a private health sector trade fair. Implementation, however, is lacking for various reasons, including an uneven political environment. Implementation of any policy is difficult, not just in Zambia, but also in coun-

tries such as The Gambia and Niger, where health ministers and permanent secretaries change frequently and with them their priorities and their views on the private health sector. Across the region, the overall picture remains broadly positive, however, and most policy makers understand the need to make tangible public-private collaboration a priority.

### **Private sector policies are often in place**

The majority of countries in the region (more than 85 percent) have a private health sector policy. Both Ghana and Sudan stand out for having specific stand-alone policies (indeed, Sudan has two policies—one for the self-financing or for-profit sector and one for the nonprofit sector). Other countries are moving toward a specific policy, even though the private health sector is already included in other strategic documents. In South Africa, the public and private sectors are jointly developing a “Charter for the Public and Private Health Sectors.” Both Ethiopia and Uganda are in the process of ratifying stand-alone policies, and Mali and the Republic of Congo are currently drafting a specific policy.

Elsewhere, private health sector policy is usually contained within the Ministry of Health’s strategic plan. The level of detail regarding the private health sector in such documents varies. For example, in Angola, the policy is found in an addendum to the national constitution and simply recognizes the role of the private health sector. By contrast, the Tanzanian private sector is given a prominent role in the country’s strategic plan. Going beyond simple recognition, it details the role private providers can play in the country’s overall health strategy. It also sets out potential areas for public-private collaboration to achieve national health goals.

Six countries do not have a private sector policy for health. This does not necessarily mean that there is no engagement in practice, but that such engagement neither benefits from a guiding document nor is underpinned by a policy framework. This makes good engagement all the more difficult. As the assessment framework suggests, the majority of countries without a policy perform less well across the domains.

### **Implementing the policies is a big challenge**

While having a private health sector policy is an element of good engagement, implementation matters more. Countries can generally be placed into one of four groups, as figure 2.3 indicates.

Countries in the two upper bars in figure 2.3 implement policy well. A snapshot of Rwanda illustrates this. All Rwandan health policy and strategy documents over the last several years include the private health sector. The latest strategic plan (2009–12) states the importance of “engaging all private providers to improve access and quality.” To further this end, the Ministry of Health has created the Private Medicine desk to act as the focal point for private providers. In terms of implementation, there is a clear commitment to following the policy. The public sector has explicitly included private providers in a range of major public health initiatives, including for HIV, tuberculosis (TB), family planning, and human resources for health. In the area of health financing, there is also close public-private collaboration. Private providers are involved in the government’s performance-based financing program, and they can apply for accreditation to participate in the public health insurance scheme that covers 86 percent of the population.

**FIGURE 2.3**



Lesotho and the Seychelles are unusual in that they do not have an explicit private health sector policy but score highly on implementation. Lesotho boasts many examples of constructive public-private collaboration, most prominently the PPP developed for the new Queen Elizabeth II Hospital. In the Seychelles, where most people go to a well-run public sector, and where the private sector is small (less than 10 private providers), the Ministry of Health has developed areas of collaboration with private providers when needed, without explicit guidance or reference in the overall health sector plan or strategy.

Countries in the two lower columns in figure 2.3—approximately 75 percent of those studied—have difficulty implementing a private sector health policy, if one exists. The majority of countries fit this category. While some public-private collaboration may exist in these countries—for example, with disease programs or referral processes—implementation at the systems level is poor when measured against stated policy intentions. Governments are missing significant opportunities to engage or include the private sector.

***Dialogue mechanisms but a lack of dialogue***

Ongoing dialogue between the public and private sectors is a key element of good engagement, and a specific public-private dialogue mechanism can help institutionalize the process. Approximately

50 percent of countries have a mechanism at present, in a wide variety of forms. In Ghana and Kenya, for example, a specific public-private health sector mechanism is in place to further develop collaboration. Dialogue mechanisms should be the first step in countries without a strong foundation of public-private engagement. In Mali and the Republic of Congo, a dialogue mechanism was put in place to build momentum for future collaboration.

Elsewhere, in the absence of a specific mechanism, the private health sector is often included in a larger dialogue mechanism that includes all actors in the health sector. In Uganda, the private health sector plays a prominent role in the national health coordinating mechanism that meets four times per year. Private providers in Rwanda take part in an annual meeting with all stakeholders to review progress and chart strategies and priorities for the following year.

Even though a dialogue mechanism is a sign of good engagement, actual levels of communication are low in many places, as figure 2.4 indicates. Strong levels of dialogue exist in Kenya and Mauritius, with Ghana and another 13 countries following close behind with reasonable levels. In the top-performing countries, there is constant dialogue between the public and private sectors—often not just through a mechanism, but also through private sector involvement in Ministry of Health committees or other forums. In Mauritius, the private sector has been involved in Ministry of Health committees for nutrition, tobacco, and contingency planning. Many of those interviewed for this report said increased dialogue improved trust between the public and private sectors and provided a foundation for systemic engagement. The majority of countries that have strong or reasonable levels of dialogue perform notably well across all the domains. This is as we had expected, since a policy framework established outside of a dialogue with the private health sector is unlikely to be supported by action in the longer term.

Beyond these countries, levels of public-private dialogue overall are low. A substantial number of countries (18) have poor communi-

**FIGURE 2.4**



cation, held back in some instances by the absence of a public-private mechanism. Most dialogue in these countries is ad hoc or occurs only when considered necessary, for example, during a disease outbreak. In such cases, the dialogue is usually the product of a donor mandate, such as from the Global Fund related to public-private collaboration on HIV/AIDS, TB, or malaria. Respondents in several countries, such as Botswana and Madagascar, said public-private dialogue occurs primarily or even exclusively within such programs.

Although outcomes of the dialogue process were not measured, respondents in a few countries said the extensive time and effort involved in fostering communication did not result in tangible public-private collaboration. In Niger, the public and private sectors have met frequently to develop a “contracting strategy” within the 2005 Health Development Plan. Since then, however, no practical steps have been taken to implement this strategy, even though regular meetings continued for some time. It was not obvious what all the root causes of this inaction were. Since then, much momentum has been lost and, as a result, private providers have stopped attending meetings. Although Niger is one example of how implementation can fail, respondents in other countries noted a similar feeling as it became clear no action was forthcoming. The driving force behind a dialogue mechanism should be tangible public-private collaboration, not simply talk and no results.

### Information exchange

The information exchange domain concerns information flows between the public and private sectors, and private sector inclusion in governmental programs for national health management information systems (HMIS) and disease surveillance. See figure 2.5 for description of good practice and summary of results in policy and dialogue.

The better-performing countries in this domain (score of 6 or more out of 8) are Mauritius, the Seychelles, Botswana, Burkina Faso, Ethiopia, Liberia, and Rwanda. See box 2.3 for a good practice example in Burkina Faso.

### Results

The exchange of information between the public and private sectors is generally weak across the region. As figure 2.6 shows, few countries have a comprehensive information exchange. Those that perform best in this domain, such as Burkina Faso and Rwanda, keep the private sector well informed and include private providers in existing public information channels, such as for HMIS data. The weak information exchange in many countries is a concern to both public and private providers, albeit for different reasons. The public sector must be aware of what is happening in the private sector to have a more complete picture of how the health system is performing. The private sector needs to be kept up to date on issues that affect its operating environment. Respondents in nearly every country noted the need to improve information exchange, especially given its relevance for the other domains.

FIGURE 2.5

### Good Practice and Results in Information Exchange

#### Good practice in this domain is to have five elements in place:

- Information flows between the government and the private health sector, in both directions.
- There is a legal requirement for the private health sector to provide health-related data.
- The information from the private sector actually reaches the government.
- The private health sector is included in a country's national disease surveillance program.
- The government sends out regular surveillance updates to the private sector.

#### Our research revealed the following:

- Information exchange is weak in most countries; a majority of countries have less than half of their basic elements in place.
- Private provider data are not reaching the government, despite legal requirements.
- There are somewhat higher levels of inclusion for disease-surveillance programs.

Source: “Healthy Partnerships” data, 2010.

## BOX 2.3

### Good Practice Example: Burkina Faso

In citing an example of good practice, information exchange was assessed as being poor in almost all countries in the region. Among them, Burkina Faso made some positive changes and seems to be addressing remaining issues. In recent years, the government has made a concerted effort to improve the policy and regulatory environment for the private sector, in general. A few years ago, the Ministry of Health established a Public Private Dialogue Framework and a Private Sector Directorate at the central level, which has dedicated staff at the district level who act as focal points for the private sector. In the wake of these reform efforts, there is a consensus among respondents that the exchange of information is reasonably good and will continue to improve.

The key to a strong information exchange is not to create parallel structures for private providers, but to include them in already existing arrangements. In Burkina Faso, the private sector is required to provide information,

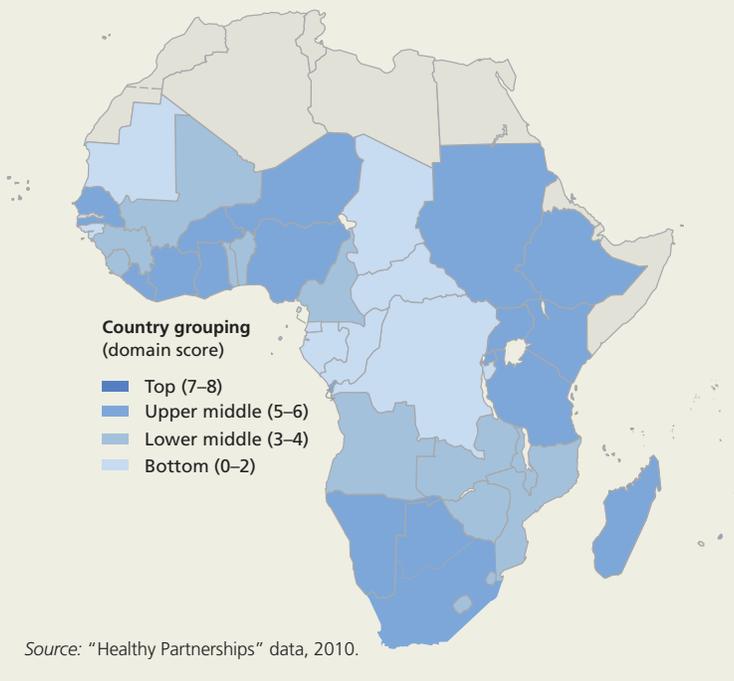
and the compliance rates with this requirement seem to be good (estimated at 80 percent by some respondents, with a consensus that a majority complies). The private sector is generally included in the disease surveillance program, though larger clinics are curiously less represented. The Ministry of Health has a toll-free number for reporting emergencies, but it is currently available to only a fraction of the private health sector. Although the government does not report disaggregated data for the public and private sectors, the private health sector is generally kept informed.

A recent decision by the general tax directorate recognized private health facilities as “civil enterprises,” thereby allowing them to avoid a commercial label for tax purposes. This change likely contributes to the relatively good relationship between the government and the private sector and, in turn, is likely a positive influence on the high levels of compliance with information provision.

Source: “Healthy Partnerships” data, 2010.

FIGURE 2.6

### Map of Information Exchange in Sub-Saharan African Countries



### *Information flows across the region are very poor*

Governments do a poor job of keeping private providers informed of vital information. As figure 2.7 shows, only two countries—Mauritius and the Seychelles—have strong information flows, through which the government sends out information on changing regulations, treatment protocols, and other programs, while also receiving feedback from the private sector. Another 12 countries are also quite strong in this domain. For example, in South Africa, the Department of Health website contains updated regulations and forms pertinent to the private sector.

Elsewhere, information flows are weak, and government information channels do not routinely include the private health sector. In Cameroon, for example, a Ministry of Health official who also runs a private hospital said he only became aware of certain regulations that should have guided his private practice when he started working for the ministry. In almost a third of countries, there is no tangible information exchange between the

**FIGURE 2.7****Information Flows Across the Region**

Source: "Healthy Partnerships" data, 2010.

public and private sectors. Private providers in Burundi said they received no information at all from the Ministry of Health. In Sudan, private providers said health inspectors visit facilities bearing regulations and guidelines they have never seen before. In one instance, a private provider said he had not heard of the new private sector health policy. In such circumstances, it is difficult to expect the private health sector to comply with regulations or use treatment guidelines of which they have not been informed. See box 2.4 for an example of a marked improvement of information exchange under special circumstances.

***Private providers' data is not reaching the Ministry of Health***

Since the private health sector provides a sizable percentage of care in many countries, collecting key HMIS data is necessary to give policy makers a full picture of national trends. Most countries require private firms to provide HMIS data, but in practice few do. Figure 2.8 shows that, of the countries where private providers are required to provide data, only a small number actually do so. In a few countries, no requirement even exists.

The lack of private sector data is a concern for policy makers, especially in countries where private operators supply a large percentage of care. In Uganda, the private sector provides up to 58 percent of health services, but compliance rates for HMIS data are less than 20 percent. In the Democratic Republic of Congo, the private sector supplies 46 percent of care but the compliance rate is less than 10 percent.

**BOX 2.4**

**Good Collaboration for the 2010 FIFA World Cup in South Africa**

There is often no inherent reason why information exchange might be poor. We see this confirmed in instances where external events focus the efforts of the stakeholders.

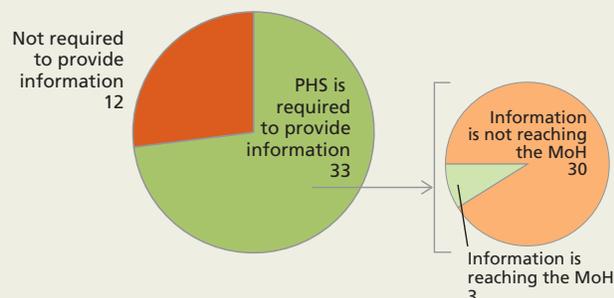
One example relates to the preparations for the World Cup 2010. The public and private sector in South Africa worked closely to prepare to host the Fédération Internationale de Football Association (FIFA) World Cup. Among other things, the government created an online "Notifiable Medical Conditions Early Warning Surveillance System," where the private sector (and the general public) could track and upload incidences of disease outbreak.

Source: "Healthy Partnerships" data, 2010.

However, when compliance with provision of data is incentivized by the provision of consumables like anti-retroviral drugs or vaccines, the private providers have been found to comply well. Medicines or vaccines are provided to private health facilities on the condition that they report how much has been delivered and to whom. Such improved compliance was observed as a part of donor-funded HIV treatment programs, as well as regular public health interventions. For example, in the city of Bulawayo in Zimbabwe, the municipal health department provides vaccines to private health facilities for distribution in exchange for timely provision of information. On a monthly basis, the facilities have been submitting informa-

**FIGURE 2.8**

**Health Information Requirements and Provision in Sub-Saharan Africa**



Source: "Healthy Partnerships" data, 2010.

Note: MoH = ministry of health; PHS = private health sector.

tion on vaccine usage, which in turn gets aggregated at the national level.

Including private providers in overall HMIS, however, is a challenge even in countries that perform well in the information domain. Data from private health sector surveys in Ghana and Kenya provide a further glimpse of data provision rates for private hospitals and clinics. Table 2.3 shows that fewer than 50 percent of private clinics submit their data on a regular basis in Kenya; this drops to just over a third in Ghana. These information gaps make it difficult for the national Ministry of Health to analyze how the health system is performing. Although the data submission rate is higher for private hospitals, there are fewer private hospitals than clinics across the region. For that reason, the hospitals tend to be more prominent and may even have contracts with the public sector, which would require the submission of information.

**TABLE 2.3 Private Providers that Submit Data to the Ministry of Health on a Regular Basis, Ghana and Kenya**

Country	Hospital	Clinic
Ghana	7/10 (70%)	12/33 (36%)
Kenya	2/3 (67%)	17/35 (49%)

Source: "Healthy Partnerships" provider survey, 2010.

**Why is private health sector data not reaching the Ministry of Health?**

Many reasons were given to explain why private sector data are not reaching the government. In some countries, public and private respondents were not clear whether a requirement exists to provide HMIS data. This, predictably, prevented virtually any data from flowing. Elsewhere, the information requirements are so heavy that many private providers simply do not comply. Table 2.4 shows the requirements for Burundi and Tanzania. In each of these countries, compliance rates are low, at least in part, because private providers see the requirement as exceptionally onerous. Tanzanian private providers said they had to dedicate one staff member to the task full time to compile all of the data. For smaller-scale clinics, this kind of resource commitment is simply not possible, so their data never reach the Ministry of Health. At the same time, some policy makers believe the requirements should be even higher. In Nigeria, a senior official stated that all facilities should provide all of their data on a weekly basis, even though most providers feel that the current monthly requirement is already excessive.

In many other countries, there is no HMIS data exchange system in place. Many private respondents complain of the difficulty of providing information when no forms or guidance are provided on how the data should be presented. Even when a system is in place, disagreements often arise. In Zambia, forms are provided to private providers, who then expect the Ministry of Health to come and collect the information. The Ministry of Health, on the other hand, says private providers are responsible for bringing the data to them. The result is a stalemate in which no private sector HMIS data are reaching the ministry.

**TABLE 2.4 HMIS Data Reporting Requirements, Burundi and Tanzania**

Country	Requirement
Burundi	27 forms per month
Tanzania	12 reporting books per month

Source: "Healthy Partnerships" data, 2010.

Private respondents were also dismayed at the lack of feedback in some countries. In Madagascar, interviewees said they hardly ever hear how their data are used after they take it to the local district health office. With so little feedback, they are not inclined to share their information with the government.

In addition, there are financial disincentives for some private providers to share information. In the Central African Republic and Niger, the tax rate for private health providers is linked to service utilization rates; that is, the more patients a facility treats, the higher the tax bracket. As a result, many facilities are reluctant to provide HMIS data to the Ministry of Health. Resolving this issue is difficult unless the disincentive is removed.

### *Good levels of private sector inclusion in national disease surveillance programs<sup>x</sup>*

Private sector participation is better in national disease surveillance programs, and many respondents noted good public-private collaboration in this area. In two-thirds of the countries, private providers are included in the national surveillance programs. Even when they are included, however, private facilities are typically less involved than public facilities: disease surveillance officers in Liberia visit all public clinics but only 40 percent of private facilities. In Mauritius, it is up to district health officers to choose a small number of private providers to take part in the program. During emergencies or outbreaks, such as the H1N1 flu epidemic, public-private collaboration in this area intensifies. Angolan private providers are still part of a special phone network—a legacy of civil-war-era emergency information systems—that permits the rapid transmission of surveillance information.

Respondents in nearly every country said governments do a far better job of distributing information during disease outbreaks. In Mauritius, even small private facilities are invited to meetings to receive updates. While such infor-

mation exchanges are an element of good engagement, the challenge is to elevate this to a more systematic approach. In Benin, for example, private providers are sent a disease surveillance report annually, but this is the exception and not the rule around the region. See box 2.5 for how Cape Verde handled communication during a dengue fever outbreak.

### **Regulation**

The regulation domain focuses on the ability of the government to design and implement a regulatory framework for the private health sector. As a proxy for all private health facilities, the focus is on private clinics. See figure 2.9 for description of good practice and summary of results in regulation.

The top-performing countries in this domain (score of 11 or more out of 13) are South Africa, the Seychelles, Mauritius, and Namibia. See box 2.6 for a good practice example in South Africa.

### **Results**

Most governments see regulation as the most important element of engagement with the private health sector. Regulation is clearly essential, but our research shows most governments have a difficult time designing and implementing an adequate regulatory framework. Most countries do

#### **BOX 2.5**

### **Beating Dengue Fever in Cape Verde**

Cape Verde provides another example of how close collaboration is possible when the two sides are willing or motivated by external events. During a 2009 outbreak of dengue fever in Cape Verde, the public and private sectors—including clinics, pharmacies, and laboratories—were in constant contact, sharing information in real time to coordinate their response to the epidemic. Both public and private respondents said the close collaboration allowed them to contain the outbreak faster than they otherwise might have.

Source: “Healthy Partnerships” data, 2010.

x. The most common type of disease surveillance program is one in which private providers are required to supply information only in cases of notifiable diseases. The next-most-common program is one in which a percentage of facilities act as sentinel reporting units.

FIGURE 2.9

### Good Practice and Results in Regulation

#### Good practice in this domain is to have the following ten elements in place:

- The government knows who is operating where, by way of a registry that is updated to contain all private facilities currently in operation.
- The regulatory framework is well designed and appropriate.
- Standardized, written rules exist for opening private health facilities.
- There is an inspection process for private health facilities.
- There is no explicit discrimination against private facilities in terms of quality oversight.
- There is an effort to include all groups of providers that are relevant in the health sector (as a proxy, the focus is on traditional medicine) with a designated policy or office.
- There is good enforcement of regulation.
- An inspection process for private facilities is actually carried out.
- There is a requirement for private health sector professionals to do continuing medical education (CME) before renewing their professional operating license.
- CME training for public sector professionals is also open to health professionals from the private sector.

#### Our research revealed the following:

- The registry of functioning private providers is poor in most countries.
- Regulations are often in place but are inappropriate or outdated in many cases.
- The enforcement of regulations is weak across the region.

Source: "Healthy Partnerships" data, 2010.

not have a comprehensive list of private providers in their national health network. Regulations are usually in place, but they are frequently outdated or inappropriate and do not adequately address quality of care. Most of the problem, however, lies with enforcement of regulations. Most governments lack the capability to exercise even a minimum amount of oversight. As figure 2.10 shows, only a handful of countries perform well in the regulation domain overall, and the results would be even worse if enforcement was weighted more heavily. Even private providers complained about the lack of regulatory oversight, which can have serious implications for quality of care: quacks can operate freely, damaging the reputation of the whole sector.

#### *The quality of private sector registries is extremely poor across the region*

The concerns with regulation across the region are encapsulated by the poor quality of the registries of private clinics. An accurate registry is one of the fundamental elements of good engagement.

It ensures that the Ministry of Health is aware of who is doing what in the health sector. Yet most governments are not aware of the scale of private provision of health services, as figure 2.11 summarizes. Only six countries across the region have a comprehensive registry. In these countries, the registry is a working document that is comprehensive and updated frequently. This includes Cape Verde and the Seychelles, small countries with few private providers.

These two island nations are the exception, not the rule. Most registries are woefully incomplete and often inaccurate. Some countries try to update their registries regularly but do not do a very good job. In Niger, for example, one government department said there was no list of private providers; a second department said one existed but only for pharmacies; a third claimed there was a list but it had not been updated since early 2009; and a fourth finally produced a reasonably updated list, but for the Niamey region only. In another country, three public sector respondents named three different units responsible for the registry, and

### Good Practice Example: South Africa

South Africa is unique in the Sub-Saharan health context in that its private health sector is regularly rated as one of the most advanced and best performing in the world. However, the private health sector is used by only 14 percent of the population, primarily the wealthy. Aside from the fact that the capacity of both government and private health organizations is high, the private sector is primarily funded through insurance. This builds in a strong incentive for compliance with rules and regulations. The strong legal and regulatory frameworks in place have ensured that there is a plethora of regulation in South Africa—some would say overregulation. It has also led to a strong, at times even combative, private sector, which, in 2010, (successfully) took the Department of Health to court to fight a regulation that would have compelled them to use a reference price list for pharmaceuticals.

South Africa scores the maximum in terms of the elements identified as good practice. Echoing the sentiment of the Organization for Economic Co-operation and Development (OECD) official cited earlier in the report, one respondent said “everything is regulated to the nth degree in South Africa.”

The registry of private facilities is fully updated. A contributing factor in South Africa is health insurance, since insurance companies can only reimburse facilities licensed by (and registered with) the Department of Health. Opinions diverged among respondents about the regulatory framework. Public sector respondents felt that there was too little or inappropriate regulation compared to other advanced economies, while private sector respondents felt that they were overregulated.

Compared with other countries in the region, regulation is at an advanced level in South Africa, and there is consensus that the enforcement of regulation is generally good. Since enforcement is the responsibility of provincial departments of health, the quality of enforcement varies somewhat depending on the resources of the province (Gauteng and Western Cape have far more capacity than the Eastern Cape, for example).

Respondents also felt that the inspection regime is generally well designed on paper, and that in practice it is well coordinated, fair, and transparent. There is an initial inspection and subsequent annual inspections, and although some private sector respondents stated that they are treated more strictly than the public sector, there is no explicit discrimination.

Opening a private health facility in South Africa follows standardized rules. Nonhealth professionals can open a private facility, and most private hospitals and clinics or chains of hospitals or clinics are owned by corporations listed on the stock exchange. Health professionals must register with the Health Professions Council every year and do continuing medical education (CME). Failure to comply with this requirement results in removal from the registry. This is strongly enforced because health insurance is only allowed, by law, to reimburse currently registered doctors.

In line with World Health Organization recommendations, the Department of Health established a Directorate of Traditional Medicine in 2006 and passed a Traditional Health Practitioners Act in 2007. The government has also provided funding for research and development of how traditional practitioners can be integrated into disease control and management programs.

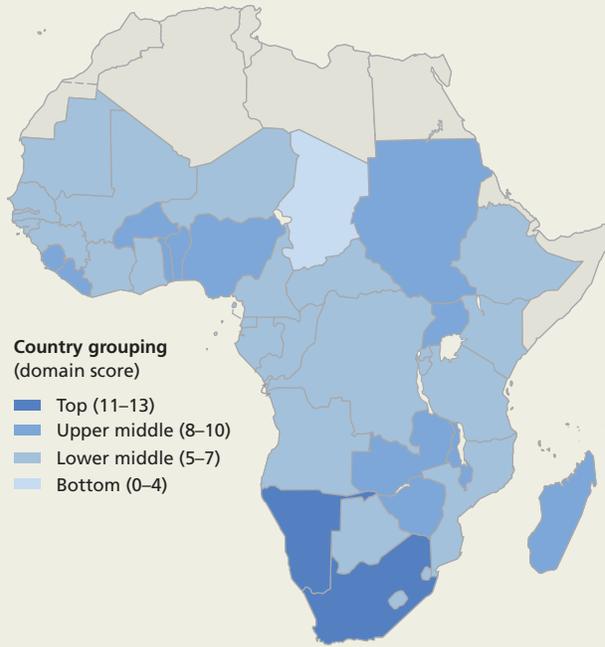
*Source: “Healthy Partnerships” data, 2010; Worrall-Clarre 2008.*

none could produce it. Other countries make only passing attempts to update their registry; Gabon’s Ministry of Health does so only every three years. In a few countries, there is no working registry of any kind. Some governments think they are more aware of the scope of private sector activity than they really are, as illustrated by the situation in Mauritius described in box 2.7.

Conditions are especially bad in countries with a large informal sector, where many providers are not registered and are largely out of sight of the government. Even many private providers said the informal sector needed to be supervised and regulated. Encouraging unregistered providers to come forward and engage with the government will be an important part of proper oversight of

FIGURE 2.10

Map of Regulation in Sub-Saharan African Countries



Source: “Healthy Partnerships” data, 2010.

the entire private health sector. Health facility surveys that include all types of public and private providers are another way to address this need for better information in the shorter term.

**Regulations for basic functions are in place, but overall regulatory quality is poor**

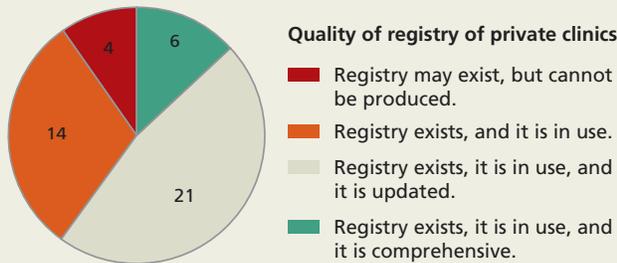
Governments frequently have rules for basic health care functions. For example, all countries in the region have standardized regulations for opening a private health clinic and for monitoring or inspecting private facilities. Although this is an element of good engagement, it does not tell the whole story. Both public and private respondents in most countries say the quality of the regulatory framework is low, inconsistent, frequently outdated, and full of gaps.

Respondents are satisfied with the quality of the regulatory framework in only 15 percent of countries. In Mauritius, Namibia, and South Africa, for example, respondents said regulations addressing clinical standards are based on current international best practice, and are updated regularly to ensure both public and private providers perform to the highest standards. A number of countries have begun to replace their outdated regulations. Benin, Equatorial Guinea, and Togo have implemented completely new private health sector frameworks. These have often been developed by engaging private providers and seeking their input during the development of the regulations. By contrast, respondents in 85 percent of countries we studied said the regulatory framework is inappropriate. Some countries’ regulatory frameworks for the private health sector have not been updated in nearly 50 years. Cameroon, Chad, and Lesotho, for example, have regulatory frameworks that date back over 40 years, and in the Democratic Republic of Congo, the main regulations have not changed since before independence, in 1960.

In other places, respondents believed regulations were inadequate. In São Tomé and Príncipe, for example, the only regulations for the private health sector pertain to opening a clinic. Elsewhere, the regulatory system for inspections—which exists in every country—is often not adequate to address quality of care.

FIGURE 2.11

Quality of Registry of Private Clinics



Source: “Healthy Partnerships” data, 2010.

### The (In)Complete Registry in Mauritius

Mauritius has a good regulatory framework and scores relatively well across the indicators. Yet there is a gap in oversight when it comes to registering private health care providers. A medical doctor in good standing (that is, one with a current registration with the Medical and Dental Council) can open a private practice without registering anywhere. This is not considered a clinic, for which there is a complete list, but merely a consultation room, for which the government has no list at all. This particular gap in the regulation is not reflected in the scores, since our assessments are focused on the registry

of clinics, but it exists all the same. It is a gap that should not matter much in a country where publicly provided health care is, in theory, available to all residents at no cost, as is the case in Mauritius. But, also in many other countries, anecdotal evidence suggests that despite the free care at public facilities, a significant proportion of care is provided through the individual providers, though exact figures or official statistics do not exist.

Source: "Healthy Partnerships" data, 2010.

Private sector respondents also noted different quality standards for the public and private sector; more than half of countries make a clear distinction between the two. In Ethiopia, the private sector is held to stringent inspection standards, yet private respondents said public sector facilities would not pass similar inspections. This situation was noted elsewhere, including in Angola, where private providers said they were held to higher standards than their public counterparts.

The regulatory framework should also include the entire range of actors found in the health system. What it means to have a comprehensive framework in place will differ among countries. Given the high importance of traditional medicine across the region and its existence at the relative fringes of the policy framework (that is, most of the rules, as well as the [self-]regulatory bodies deal with allopathic medicine only), the question of its inclusion in a country's policy framework becomes a useful proxy.

Approximately 75 percent of countries have some form of policy or program to engage with providers of traditional medicine. Just as for the overall policy, however, the important part lies in the implementation, which was not assessed separately for traditional medicine policies. Having a policy for traditional medical practitioners (TMPs) is an important first step though, because they are a major presence in many countries. In Swaziland, there are about 11,000 TMPs and only 200 physicians. In Equatorial Guinea, about 80 percent of

people in need of treatment visit a TMP before going to a conventional doctor. The existence of a policy or program for this important group of providers indicates the government has a comprehensive framework for all private players, not just private clinics and pharmacies.

#### *No CME or renewal requirements and lack of CME opportunities*

Continuing medical education requirements for licensed health professionals are much in vogue and are a requirement in most developed health systems. However, they are currently a requirement in only 20 percent of countries in our study.

There is a clear need for reform of requirements for medical licenses in some countries. Some countries do not require that medical licenses get renewed at all. In Senegal and Togo, among others, it is currently not necessary to renew a medical license, let alone to attend CME classes. A medical license is valid for life once granted. This stark omission is tempered somewhat by the recognition among policy makers of the benefits of CME requirements, and medical councils in several countries are planning to introduce them.

Private providers can attend government CME training in two-thirds of the countries, allowing them to fulfill the requirement relatively easily. Actual attendance by private providers is, however, rather low, often for avoidable reasons. Many providers in Lesotho complained about receiving invitations on the same day of the training, or

### Time It Takes to Open a Clinic

There are clear differences across the region in the length of time it takes to open a clinic. For example, a clinic can be opened in a few days in Rwanda and Uganda, while respondents in Chad said a decision from the government can take almost nine months. Given the delay, many providers ignore the official channels and open anyway. It should be noted that a standardized measure for ease of opening a private health clinic in Africa is not (yet) feasible, even though the time it takes to register a firm is considered an important proxy for assessing the general, nonhealth business environment (for example, the Doing Business indicator “starting a business”), as discussed in Section 1. Entry regulations for private health clinics vary dramatically among countries, and

often within countries, depending on the size and type or service level of the facility. In some countries, the main registration requirements, and therefore the most time in the process, is dedicated to the professional accreditation; in other countries, such requirements and time for compliance are imposed primarily on the facility. Defining a unique case that would be a suitable proxy across the region is therefore not feasible. In addition, the data collection for such a measure would be tricky, since our data collection showed that typically only a few individuals know the existing requirements or how they are enforced in practice.

Source: “Healthy Partnerships” data, 2010; World Bank, *Doing Business 2011*.

even after the event had taken place. In Guinea, the level of disorganization of publicly offered training has forced private practitioners to go elsewhere in the region, or even to France, to access CME opportunities.

Even in countries where a CME requirement exists, actual levels of participation can be low. Table 2.5 shows the percentage of private providers who had been invited to public-sector CME training over the last three years in Ghana and Kenya. The figures for private clinics in both countries show that many private providers are not being invited to public sector training. Yet, both Ghana and Kenya have a CME requirement for medical doctors and courses offered to public sector professionals. The relatively low invitation rates in these two countries are emblematic of the experience of private providers in many countries across the region.

**TABLE 2.5 Private Providers Invited to Public Sector CME Training over the Last Three Years, Ghana and Kenya**

Country	Hospital	Clinic
Ghana	2/10 (20%)	12/33 (36%)
Kenya	2/3 (67%)	9/35 (26%)

Source: “Healthy Partnerships” provider survey, 2010.  
Note: CME = continuing medical education.

### *Enforcement of regulations is a major problem*

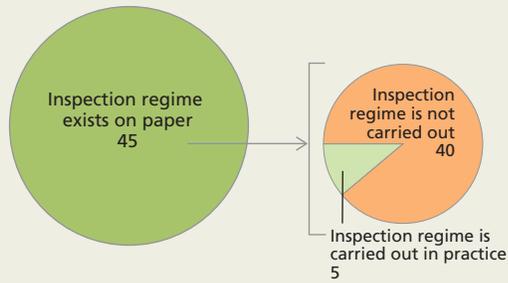
Enforcement of health care regulations is poor almost everywhere in Africa. That regulation is well enforced in only six countries, based on our research, indicates the breadth of the problem. Indeed, most government respondents readily admitted regulations are not well enforced.

Figure 2.12 highlights the lack of enforcement across the region. Although every country has written rules governing inspections, in practice they occur regularly in only five countries. They take place infrequently in other countries, if at all. In Niger, for example, private respondents said no inspections had taken place in more than 10 years. A private provider in Madagascar said facilities had not been inspected in 15 years, even though they were located in the capital city. Elsewhere, inspections seemingly are only carried out if a problem is brought to the attention of the Ministry of Health.

Regulation can be especially difficult if several agencies have overlapping oversight mandates for the sector. In Kenya, the Medical Practitioners and Dentistry Board, the Ministry of Health’s Department of Standards and Regulation, and the local District Health Office all have some regulatory responsibility for the private health sector, but there is no clear agreement on who conducts

**FIGURE 2.12**

**Inspections—Paper Compared to Practice**



Source: "Healthy Partnerships" data, 2010.

**TABLE 2.6 Resource Problems for Inspections**

Congo, Dem. Rep.	Inspectors routinely have not been paid in months and so facility inspections rarely take place.
Côte d'Ivoire	Inspectors are performing inspections out of their own means.
Ethiopia	No Ministry of Health vehicles are available to inspectors so they have to use public transportation at their own expense to monitor over 400 private clinics in Addis Ababa.
Uganda	Private providers have to pay for inspectors to come and do the inspections if they want to open their clinic on time.

Source: "Healthy Partnerships" data, 2010.

inspections. In Lesotho, the Ministry of Health, the Maseru City Council, and the District Health team all have responsibility for inspecting private medical facilities in the Maseru area, and all frequently expect the other to do it. Often, it is not done at all. On the flip side, District Medical Officers in several countries are responsible for overseeing the quality of care in all public and private facilities in their district, while also being responsible for the management of public facilities. This dual role creates a clear conflict of interest for them.

Lack of resources is a major reason regulations are not properly enforced in many countries, according to public-sector respondents. Table 2.6 illustrates this point.

While resources are important, other countries have tried various methods to improve enforcement of regulation. In Botswana and Ghana, inspections by the insurance authority for accreditation (to become eligible to receive reimbursements) have become the dominant oversight mechanism for the private health sector. In Liberia, the Private Clinics Association initiated discussions with the Liberia Medical Board to participate in the regulation of facilities run by health professionals who are not doctors. There is much need for this kind of oversight, because the Medical Board does not have the capacity to carry out the large-scale inspections needed to identify and bar unlicensed professionals from practice.

Initiative among larger providers who seek to improve their quality is on the rise among the

African private health sector. One example is the sophisticated hospitals that are seeking recognition for their efforts through accreditation by international accrediting bodies, as discussed in box 2.9.

**Financing**

The financing domain covers the revenues that are actually or potentially available to the private health sector and the government's influence of such funds through various mechanisms. See figure 2.13 for description of good practice and summary of results in financing.

The top-performing countries in this domain (score of 4 or more out of 6) are Cape Verde, Rwanda, Burundi, Equatorial Guinea, Ghana, Mauritania, Mauritius, and Sudan (Khartoum State).

In the financing domain, however, the measures are imperfect proxies for the constructs they are designed to capture: strategic purchasing, attention to the investment climate, and access for the broader population to the care they seek. Developing better standardized measures should be possible but was beyond the scope of this report, since more work is needed to obtain an accurate picture of this critical domain. In the meantime, however, the chosen proxies provide a good overview of the trends. We do not propose an overall good practice example here or show a heat map for the continent. However, even though public financing of private providers is contentious in terms of

## Voluntary Certifications by Third-Party Organizations

### International Standards Organization (ISO) Certification

The Nairobi Hospital in Nairobi, Kenya, was opened in 1954. It has earned recognition as a center for medical practice excellence in many respects. The hospital has also demonstrated a commitment to delivering high-quality health care to its patients, by going beyond what was locally required to comply with international standards and acquire ISO's certifications. It is ISO 9001:2008 certified; that is, its Quality Management System has been certified. In addition, the hospital achieved ISO 2200:2005 Food Safety Management System and ISO 14001:2004 Environmental Management System certifications. The multiple certifications show the commitment of the Nairobi Hospital management to quality improvement principles. ISO relies on the individual organization to establish, document, implement, and maintain a quality management system and continually improve its effectiveness.

### Joint Commission International (JCI)

The JCI is the international arm of The Joint Commission on Accreditation of Healthcare Organizations. It has accredited over 350 organizations outside the United States, where The Joint Commission was founded in 1951, and has accredited over 18,000 health care organizations and programs in the United States.

The International Clinical Laboratories in Addis Ababa, Ethiopia, was first accredited by the JCI in 2004 and has been reaccredited twice. As of 2010, it was the only facility in Africa with JCI accreditation. Other facilities mentioned plans to acquire this mark of international quality, mostly to be able to attract patients from outside their borders.

*Source:* International Standards Organization 2011; Joint Commission International 2011; The Nairobi Hospital 2011; International Clinical Laboratories 2011.

FIGURE 2.13

### Good Practice and Results in Financing

#### Good practice in this domain is to have three elements in place:

- The government is committed to improving the effectiveness of public funds by partly using the private sector to deliver services (existence of any ongoing contracts to pay private providers for services with public funds used as a proxy).
- The government seeks to improve the investment climate for the private health sector (existence of any financial incentives specific to private health sector facilities as a proxy).
- A significant part of the population can access the private health sector without having to pay out-of-pocket (the level of private provider coverage by public or private health insurance used as a proxy).

#### Our research revealed the following:

- A third of governments are contracting with self-financing providers; half of those are also making financial incentives available.
- Another seven countries offer financial incentives but no contracts.
- The level of private provider coverage through health insurance is small but growing; a clear momentum is building.

*Source:* "Healthy Partnerships" data, 2010.

overall benefit to the health system, there is strong interest on the part of policy makers in further exploring ways to provide publicly financed services through private providers (that is, public financing of privately provided services), and it is undoubtedly a motivating factor for private providers.

A critical dimension in financing is finding an effective mechanism that lets poor people have access not only to public health services but also to private services, if that is where they seek care. This should not result in financial ruin for the patient or in sustained losses for the private provider. Although, in principle, patients who cannot pay can be turned away, in practice, this is not easy to do. When someone cannot pay or things go wrong during the course of treatment, it is often the provider that has to bear the burden of the bad risk. It is often not easy to transfer or refer patients who cannot pay to a public facility.

***Contracting is increasingly common, and policy makers are eager to explore it further***

Fifty percent of governments have contracts with private providers in a wide variety of forms, evidence that there is substantial collaboration between the public and private sectors.<sup>xi</sup> In several countries, public-private partnerships involve entire facilities, as table 2.7 highlights.

Some countries practice smaller-scale contracting that involves specific clinical services or procedures. In Rwanda, for example, the decentralization of budget management in the public sector has allowed public hospitals to subcontract some clinical services to private facilities. In Nigeria, what started out as an informal agreement between Lagos State University Teaching Hospital and Saint Nicholas Hospital has led to a formalized contract to carry out kidney transplants for the public sector. In Guinea-Bissau, governments have engaged private laboratories to perform tests for HIV patients. In Angola, the Ministry of Health has entered into several contracts with private providers for hemodialysis. Especially for smaller-scale contracting, both public and private respondents noted general satisfaction with the agreements in place.

xi. The indicator only measured government contracting for clinical services and not contracts with the private sector for ancillary services in public facilities.

Scarcity of specialized resources does not always lead to collaborative efforts, however. In Comoros, respondents recalled a time when a radiologist was not available at the main public sector hospital. Even though the expertise was available in the private sector, and private providers were available to help, the Ministry of Health refused to enter into an agreement with them. As a result, respondents said the hospital could not perform surgeries for over two weeks.

In other cases, governments have eschewed public-private collaboration in favor of competing with private providers. In Sudan, computerized tomography (CT) scans were only available in the private sector at a relatively high cost of US\$100. This dropped to US\$60 after the public sector purchased CT scanners and offered the service at US\$50. Instead of compromising with the private sector to provide public CT scans, the government is now competing with the private sector. Some respondents said patients tend to prefer the private sector, even though it is more expensive. The Sudanese Ministry of Health does have an agreement with private providers for kidney dialysis treatment, however.

**TABLE 2.7 Selected PPPs across the Region**

<b>Lesotho</b>	A PPP hospital with Netcare (South Africa) is to replace the old Queen Elizabeth II Hospital. The PPP comprises the hospital and two satellite clinics.
<b>Madagascar</b>	The IMM Clinic in Antananarivo is a PPP between a private provider, General Electric Corporation (GE), and the government. The government supplied the building and GE supplied the equipment. A private provider manages the facility, which offers reduced-fee services.
<b>Nigeria</b>	Abuja's Garki Hospital is also a model PPP hospital, where a private provider manages a government structure. Patients get higher-quality services than at public hospitals and at cheaper rates than other private centers.
<b>South Africa</b>	The Settlers Hospital in the Eastern Cape is a PPP among Nalithemba Hospitals, Netcare, and the Eastern Cape Health Department. Previous collaborative efforts involving the group have resulted in the construction and successful running of Port Alfred Hospital.
<b>Sudan</b>	The Ministry of Health has turned over several public facilities to private providers for free in exchange for offering reduced-fee services to the public and helping to train Sudanese medical students.

Source: "Healthy Partnerships" data, 2010.

Note: PPP = public-private partnership.

***Financial incentives are sometimes available to private providers, but the private health sector is often treated harshly***

The range and scope of financial incentives varies considerably across the region, but private providers can access at least one incentive in 33 percent of countries.<sup>xii</sup> The most common types of incentives are duty exemptions, value added tax (VAT) exemptions, and general corporate tax exemptions, as shown in table 2.8. Some countries, such as Ethiopia and Rwanda, offer all of these incentives to private providers, while other countries are much less generous. Many private sector respondents, especially small clinics, said such incentives are often crucial to the financial viability of their facility. They also should be easy to access. Private providers in Lesotho said the administrative burden for taking advantage of these incentives is so high that most private providers prefer not to deal with them.

Several countries have developed incentive programs to engage the private health sector strategically. For example, both Ethiopia and Sudan offer incentives to private facilities that are willing to locate outside Addis Ababa or Khartoum. By offering reduced (or in some cases free) land and reduced property taxes, the government hopes to lessen the concentration of private providers in the capital city. Governments can also use an incentive program to ensure increased access for populations who could not otherwise afford it. In Madagascar, the government offers private providers tax reductions if they agree to treat a certain number of indigent patients.

**TABLE 2.8 Most Common Incentives to Private Providers**

Type of incentive	Incidence
Duty exemptions on medicines or medical equipment	17
VAT exemptions	13
General tax exemptions	9

Source: "Healthy Partnerships" data, 2010.

Note: VAT = value added tax.

xii. We measured financial incentives that are available specifically to the private health sector. In addition, in a number of other countries, private providers can benefit from general incentives offered to all private industry, even though there is nothing specific to the private health sector. These countries are not included in this figure.

Elsewhere, the operating environment for private health providers is more difficult. Private firms that find themselves in such circumstances say it is not a case of seeking favors but of being treated the same as other private sector businesses (box 2.10). The Comorian government, for example, taxes the private health sector more heavily than other private sector businesses.

***Level of private provider coverage through health insurance at a glance***

As part of our data-collection effort, respondents were asked to estimate the percentage of people covered by health insurance schemes, whether public, private, or community based, that would reimburse for treatment received in a private facility.

Table 2.9 provides a country breakdown of current coverage levels. For the most part, coverage levels are low. In the four countries with coverage greater than 50 percent, the government has enacted a public insurance scheme that covers the majority of citizens and allows them some access to private providers. Ghana and Rwanda are recent examples. Patients have the option of going to public or private facilities (which have to be accredited before they can participate), and the health insurance authority reimburses private providers. As the example of Tanzania shows, the private sector can become an important participant in public health schemes (box 2.11).

While private sector respondents were mostly positive about taking part in insurance schemes, Ghanaian respondents noted instances of late reimbursements. Clearly, private sector participation in public programs is dependent on being able to bill public insurers and being sure of timely reimbursement. Private participation can bring other benefits. For example, the Botswana Insurance Authority plays an important role in fostering public-private dialogue and also collects data on service utilization in the private health sector.

Only in Mauritius, Namibia, and South Africa are more than 10 percent of the population covered by private—as opposed to public—schemes. Botswana and Senegal have small but growing

**TABLE 2.9 Level of Health Insurance Coverage Where Reimbursement for Privately Provided Services Is Theoretically Possible<sup>a</sup>**

Country	Public	Private	Community	Total
Angola	—	2–4	—	2–4
Benin	—	1–2	—	1–2
Botswana	7–9	8–9	—	15–18
Burkina Faso	—	1–2	—	1–2
Burundi	—	12	<1	12
Cameroon	—	2–4	<1	2–4
Cape Verde	55	5	—	60
Central African Rep.	—	1–2	—	1–2
Chad	—	1–2	—	1–2
Comoros	—	3–5	<1	3–5
Congo, Dem. Rep.	—	1–2	<1	1–2
Congo, Rep.	—	1–3	—	1–3
Côte d'Ivoire	10–12	3–5	<1	13–17
Equatorial Guinea	25–28	1–2	—	26–30
Ethiopia	—	1–2	—	1–2
Gabon	55–60	1–2	—	56–62
Gambia, The	—	—	—	0
Ghana	60	1	—	61
Guinea	—	1–2	—	1–2
Guinea-Bissau	—	1–2	—	1–2
Kenya	9–18 <sup>b</sup>	1–2	<1	10–20
Lesotho	—	3	—	3
Liberia	—	1	—	1
Madagascar	—	5–10	—	5–10
Malawi	—	1–2	—	1–2
Mali	—	3–5	<1	3–5
Mauritania	8–10	5–8	—	13–18
Mauritius	—	10–15	—	10–15
Mozambique	—	1	—	1
Namibia	1	15–19	—	16–20
Niger	—	1	—	1
Nigeria	1	3–5	—	4–5
Rwanda	86	6	1	93
São Tomé and Príncipe	—	—	—	0
Senegal	5–8	8–10	—	13–18
Seychelles	—	—	—	0
Sierra Leone	—	1–2	—	1–2
South Africa	0	14	—	14
Sudan	10–12	5–8	—	15–20
Swaziland	—	1–2	—	1–2
Tanzania	5–8	1–2	—	6–10
Togo	—	1	—	1
Uganda	—	1–2	—	1–2
Zambia	—	1–2	—	1–2
Zimbabwe	—	8	—	8

Source: "Healthy Partnerships" data, 2010.

Note: — = not available.

a. The table reflects the answers of key respondents. The numbers have been verified through desk research and by consulting independent experts. They are not, however, intended to fully capture the complexities of health financing (reimbursements that are available in theory may not fully cover expenses, for example, and, therefore, private providers may not accept them), and they do not take into account availability of public services without insurance. Rather, they show the level of private provider coverage through health insurance at the time of the data collection (Spring 2010), as defined within each country.

b. The wide range in the estimate for coverage of public insurance in Kenya (National Hospital Insurance Fund, NHIF) is based on two sources. While earlier studies based on Demographic and Health Survey (DHS) data and interviewed experts estimated the total coverage to be around 10 percent, more recent studies find the coverage to be significantly higher. This results in a wide range for total coverage of between 10 and 20 percent. The discrepancy in this particular estimate illustrates the lack of reliable data and, therefore, the difficulty of making precise estimates.

## BOX 2.10

### Incentives for Some but not All in the Democratic Republic of Congo

In the Democratic Republic of Congo, an incentive program that offers a reduction in the cost of infrastructure services is open to private companies but not to the private health sector. In addition, the incentives that would in theory be available to the private health sector are not applied equally to providers. Virtually all private sector respondents recalled how the government offered many incentives, including free ambulances, for the construction and operation of a high-profile hospital owned by a famous expatriate Congolese citizen while ignoring clinics that have been serving communities for more than 20 years.

Source: "Healthy Partnerships" data, 2010.

## BOX 2.11

### Private Sector Participation in Public Schemes— The Evidence from Tanzania

The Tanzanian national insurance authority accreditation has a built-in bias against the private health sector with pre-accreditation of public facilities. Despite this bias, consumers predominantly choose the private health sector to provide their care. Seventy-five percent of accredited facilities belong to the public sector, yet 75 percent of the reimbursements go to the 25 percent of facilities in the private sector.

Source: "Healthy Partnerships" data, 2010.

private health insurance sectors. Private health insurance exists in the Democratic Republic of Congo mostly for people who can access treatment abroad.

The issue of health insurance is high on the agenda across the region. Many countries are interested in introducing some form of public risk-pooling, and are looking at the systems in Ghana or Rwanda for inspiration. The introduction of a public scheme is at an advanced stage in Ethiopia, Kenya, Nigeria, and Uganda. Other countries are actively considering the feasibility

of a public system. Notwithstanding the difficulty of implementing such a system, there was a consensus across the region that health insurance coverage levels would increase substantially over the next five years. This would also benefit private providers who can participate in the system.

The introduction and expansion of health insurance, when successful, has been found to be a game changer in many countries that have gone down this path. This is especially true when the program includes premium subsidies to allow the poor to be part of the program and when accompanied by changes in the providers that are eligible for reimbursement and in the payment system used to reimburse them. In Ghana and Nigeria, introduction of premium subsidies for the poor under their current health insurance system led to a significant increase in utilization of health services among poor people. In Nigeria, people who are covered through their health maintenance organizations (HMOs) have more choice among the health care providers from which they can seek care. Provider behavior changes significantly when the reimbursement system shifts from fee-for-service to case mix or capitation payments, as was seen, for example, in Hungary and other East European countries. Similar changes were also seen among providers after Ghana shifted from fee-for-service to case mix reimbursements.

### Public provision of services

The public provision of services domain focuses on how a government uses the direct production of health care inputs and health services to collaborate with the private health sector. See figure 2.14 for description of good practice and summary of results in public provision of services.

Many countries score well in this domain. In addition to most of the high-performing countries mentioned in earlier domains, this category includes Angola, Cameroon, Mali, and Uganda.

#### **Good public-private collaboration: Specific disease or vaccine programs**

The private sector participates widely in government disease and immunization programs across the region, marking one of the better areas of engagement. Private providers are included in these programs in 66 percent of countries. Donor programs such as the Global Fund are a big driver of such collaboration, and extensive programs for HIV and TB are present throughout Africa. Significant, positive spillover effects emerge from this collaboration, especially in terms of increased dialogue and information exchange. But more can be done. On a broader scale, public-private collaboration on disease-specific programs can be a catalyst for further engagement. For example, Ethiopian respondents said the country's widely supported Public Private Mix—for Directly Observed Treatment—short course (PPM-Dots) program for tuberculosis, which involves the public and private sectors, was the starting point for further engagement that is now culminating in the development of a specific private health sector policy. Once governments see the tangible benefits of working with the private health sector, the motivation to extend the engagement to other areas increases.

In Angola, private providers are included in the government-funded program on malaria. If patients choose private health providers, they may have to pay a nominal consulting fee for the physician's time; the drug itself is free of charge. Similarly, in Tanzania, the Ministry of Health approached the Association of Private Health Facilities to distribute anti-retroviral drugs (ARVs) through their member clinics. By engag-

ing the private sector, the Ministry was able to significantly increase the supply of ARVs in the country. The Tanzanian government has also extended such collaboration to small-scale drug shops, working with them as Accredited Drug Dispensing Outlets. The national rollout strategy offers training and accreditation to drug retailers in exchange for supplying quality drugs and participating in consumer awareness efforts. The program increases the availability of good drugs and helps to bring smaller drug shops into the formal sector through accreditation and training.

A related form of engagement is supranational financing to subsidize vital technologies with significant externalities, taking advantage of the private health sector for disease-specific interventions, for example. One prominent example of this is the Global Fund's Affordable Medicine Facility for malaria (AMFm), discussed in box 2.12.

#### **Referral systems in place but not always smooth**

The referral process between the public and private sectors can also be an area of collaboration in every country. The most common type of referral

FIGURE 2.14

### Good Practice and Results in Public Provision of Services

#### **Good practice in this domain is to have the following two elements in place:**

- The government takes advantage of the private health sector for public health programs (distribution of vaccines or medicines for public health programs through private sector facilities used as a proxy).
- The public and private facilities work together when necessary (existence of a referral process between the public and private sector used as a proxy).

#### **Our research revealed the following:**

- There is good public-private collaboration for disease and immunization programs.
- There is some form of a referral system in all countries.

Source: "Healthy Partnerships" data, 2010.

is a patient moving from a small private facility to a larger public one for more advanced treatment. The process is more systematic in some countries than others. In Ethiopia, for example, private providers fill out a referral form that the patient can take to the public hospital to ensure some level of continuity of care.

Many patients are also referred from the public sector to the private, although the traffic is generally less in this direction. Countries with private providers able to offer highly advanced treatment often receive patients from the public sector. In Botswana, the Gaborone private hospital receives cancer patients from Prince Marina public hospital who require radiotherapy. This type of practice is fairly common across the region (table 2.10).

Referrals can also be an alternative to sending public sector patients abroad for treatment

(table 2.11). In Malawi, the Mwaiwathu Hospital regularly receives patients from the Queen Elizabeth public hospital, including referrals for serious cases or for government officials, who might otherwise have been treated abroad. Since the services are less expensive domestically than abroad, the government saves money. This is not a common practice throughout the region, however, and some private sector respondents said governments preferred sending high-profile patients abroad rather than treating them in-country.

Governments can also use the referral process to bring informal providers into the system. In Guinea-Bissau, the Ministry of Health worked with *matronas* (traditional birth attendants), offering them formal training to improve the quality of deliveries and mitigate the risk of complications. A key part of the training was to

#### BOX 2.12

### High-Level Subsidy for Malaria Drugs

Recognizing that most people in poor countries are treated for malaria in the private sector, in 2005 the Institute of Medicine (IOM) called for new funds to subsidize coformulated artemisinin-based combination therapy (ACTs) for the entire global market to achieve end-user prices in the range of US\$0.20 to US\$0.50 per course of treatment, the current cost of chloroquine. This recommendation describes a global subsidy that enters the system high in the drug distribution chain, meaning that highly subsidized drugs would be available to all high-level purchasers, both public and private sector. In this way, drugs would enter the existing public sector and private commercial channels much as any other drug, including chloroquine.

In May 2010, the first purchase orders for ACTs subsidized under Affordable Medicines

Facility–malaria (AMFm) were authorized. The high level of indirect subsidy is a first. It is indirect because the manufacturer receives the subsidy; an importer, wholesaler, retailer, or consumer simply sees a less-expensive product traveling through the supply chain system, as would any other drug. There remains uncertainty regarding the impact of AMFm. Early results from Ghana and Kenya suggest, however, that retail prices have indeed dropped dramatically for ACTs. Retail prices in Accra were about US\$0.70 per adult treatment, which is sharply lower than the pre-AMFm retail prices of up to US\$9.00. In Kenya, some outlets sold the ACTs for about US\$0.60, which is also considerably less than the pre-AMFm average price of US\$6.00.

Source: Global Subsidies Initiative 2008; The Global Fund 2011.

**TABLE 2.10 Intramural Private Practice in Public Facilities**

Namibia	Private doctors are allowed to use public facilities to see private patients in exchange for time dedicated to treating public sector patients for free.
Zambia	Prince Marina public hospital has invited private doctors to commit some hours each week to public sector work.
Zimbabwe	Private doctors can admit their patients in public hospitals if they agree to charge less.

Source: “Healthy Partnerships” data, 2010.

**TABLE 2.11 Selected Public-to-Private Referrals across the Region**

Angola	Partnerships with private clinics for hemodialysis prevent the need for medical evacuation to Brazil or Portugal.
Guinea-Bissau	Clinica Madrugada is the reference cardiology facility in the country. It is privately owned and receives patients from public facilities.
South Africa	The Department of Health has engaged private hospitals to clear up public sector waiting lists for certain services, such as magnetic resonance imaging scans.

Source: “Healthy Partnerships” data, 2010.

help matronas identify difficult cases and refer pregnant women to formal public or private clinics.

Referral processes can of course be improved. Both public and private respondents complained about inefficiencies. Information is not always shared when a referral is made, so patients may have to start treatment again in the public sector or undergo tests they have already paid for in the private sector. In some cases, there is a strong bias against people coming from the private sector. Private sector respondents in Mali described patients who arrive at a public hospital in their ambulances only to be refused treatment. In the Seychelles, a patient referred from the private sector must pay to access the public sector. There is no charge if coming from another public sector facility.

The referral process is also susceptible to manipulation by doctors who work in both the public and private sectors. Public sector respondents in many countries complained of self-referrals—the tendency of doctors who work in both sectors to refer public patients to their private clinic instead of continuing treatment in the public sector. Although this can speed up treatment for the patient, the cost is usually much greater.

**A different type of engagement: How governments partner with faith-based organizations across the region<sup>xiii</sup>**

As noted, government engagement with FBOs is more extensive than with other private players across all domains and for all countries.<sup>xiv</sup> This close collaboration is partly explained by the perception among policy makers that the public sector and FBOs share similar social goals and are committed to public health goals. Research also shows that some FBOs have intrinsic motivation to serve poor people.<sup>101</sup> Faith-based facilities in many countries predate public health care delivery, especially in rural areas, and FBOs sometimes charge less than other private providers. Faith-based associations of providers also tend to be well organized and have a leadership structure that provides policy makers with a clear point of contact.

Notwithstanding the relatively high levels of integration between the FBOs and the government, the engagement is not without considerable challenges. Lack of resources in the public sector often spill over to FBO facilities and cause financing shortfalls or duplication of oversight and information systems.

High levels of engagement, in practice, are fueled by the full or partial public financing of

xiii. As was noted earlier, the majority of nonprofit providers are FBOs. This section focuses on FBOs, though the discussion and the higher levels of engagement are largely applicable to secular nonprofit organizations. Prominent examples of this, for example for Liberia or in the domain of financing, are noted below.

xiv. There are no faith-based facilities in the Seychelles.

FBO facilities, which occurs in 75 percent of countries. This usually goes beyond providing public funds to one facility for a particular service, as is often the case with individual for-profit or self-financing providers. Rather, the public sector will provide financing for the entire network of FBO facilities. Although they often continue to be managed by staff in the faith-based group, such facilities are treated as an extension of the public sector and are considered as such by the general population. This, as box 2.13 shows, changes the nature of engagement. Faith-based facilities are integrated into the public sector as a matter of course—for example, larger facilities often act as reference hospitals for the public sector.

Many of the indicators in the assessment framework are included in the contract or agreement with the faith-based providers, as examples from across the domains show. Even when there is no agreement in place, engagement with FBOs is consistently higher because of the perceived alignment of social goals.

### ***Policy and dialogue***

In many countries, contracts or agreements are essentially policy frameworks for FBOs. They provide the foundation for engaging in practice by comprehensively setting out the roles and responsibilities of private sector providers. The implementation of such agreements requires close coordination between the Ministry of Health and the FBO, illuminating the intensity of engagement, as in the Lesotho example. Frequent meetings occur in most countries to coordinate activities and monitor performance of the contract.

### ***Information exchange***

Where FBOs are closely integrated into the public-provision network, faith-based facilities are typically fully included in the national health management information system. Providing information is generally required as part of any agreement. The same is true for their involvement in the national disease surveillance program. Often, FBO providers follow the same process as public sector facilities in providing information to the Ministry of Health.

In some countries, the FBOs are responsible for collecting the information and sending it on. For example, in certain Democratic Republic of Congo health zones, public sector health centers send health-related information to a higher-level, faith-based facility.

### ***Regulation***

In many countries, the FBO umbrella organization has a comprehensive registry of all the facilities under its jurisdiction. Often, the umbrella organization will also have its own inspection regime for its facilities, and the government will defer to it to ensure quality control. For example, in Uganda the Catholic Medical Bureau's own group of inspectors reviews their facilities twice a year. They keep records of their visits and pass on all relevant information to the Ministry of Health representative at the district level. Generally, public inspectors do not visit facilities already cleared by the umbrella organization. In Liberia, where secular nonprofit organizations provide a large share of health care in the country, it is the umbrella bodies for nonprofit providers that are responsible for managing entire health zones, and the inspection process is left entirely to them.

### ***Financing***

Public money flows to the FBOs in many ways, beyond the contracts and service agreements. In many countries, some form of budget support is available to subsidize the operations of FBO operators. This can be through direct financial support, although in many countries it takes the form of human resources, as in Zimbabwe, where the government provides nurses to small nonprofit health centers. A similar situation occurs in Rwanda, where the government provides community health workers and attaches them to small nonprofit health outposts in rural areas. In addition, FBO providers are often able to benefit from financial incentives, such as reduced rates of tax or exemptions from customs duties on equipment and medicines.

### ***Public provision of services***

Many of the agreements reviewed for this Report call on the government to provide vaccines or

## The Christian Health Association of Lesotho

The Christian Health Association of Lesotho (CHAL) provides 40 percent of health care in the country. In 2007, a memorandum of understanding (MOU) was signed between the government of Lesotho and CHAL that provided public funding for 80 percent of CHAL's budget in return for standardizing quality of health services and abiding by the same rules as all public facilities. CHAL retains management control of hospitals and clinics.

The MOU integrates the faith-based group fully into the public system. The Joint Commission for Cooperation, consisting of Ministry of Health and CHAL officials, acts as the official coordinating mechanism for the agreement. Monthly meetings are held to evaluate performance and raise issues of joint concern.

CHAL facilities must submit HMIS data monthly and are fully involved in the disease surveillance program. Information is exchanged just as it would be with any public facility.

Although the regulatory framework is outdated, CHAL abides by the same rules as public sector facilities. There is a Ministry of Health (MOH) accreditation process for all their CHAL hospitals and clinics. If they do not perform well, the government can remove funding for a specific facility. CHAL officials form part of joint inspection teams that regularly conduct oversight of all public and faith-based facilities in a health district.

A key part of the MOU stipulates that CHAL must charge the same price for services as public sector facilities. CHAL must also bring salaries in line with the public sector. The government also supplies CHAL with drugs and vaccines as part of national programs.

The difference in engagement between the government and a CHAL facility, on the one hand, and the government and a purely for-profit provider, on the other, illustrates the special treatment that is accorded faith-based providers. The differences in Lesotho mirror the differences elsewhere in Africa.

**TABLE B2.13 CHAL Facility Requirements Compared to those of Self-Financing Providers**

Domain	CHAL facility	Self-financing providers
Policy and dialogue	<ul style="list-style-type: none"> <li>MOU as policy</li> </ul>	<ul style="list-style-type: none"> <li>No explicit policy</li> <li>No dialogue mechanism</li> </ul>
Information exchange	<ul style="list-style-type: none"> <li>Requirement to submit data</li> <li>100% compliance rates</li> <li>Full involvement in disease surveillance program</li> </ul>	<ul style="list-style-type: none"> <li>No requirement to submit data</li> <li>Very few private providers submitting data voluntarily</li> <li>Not involved in disease surveillance program</li> </ul>
Regulation	<ul style="list-style-type: none"> <li>CHAL facilities following public sector regulation, which is outdated</li> <li>Regulated to charge same price as public facilities</li> </ul>	<ul style="list-style-type: none"> <li>Outdated and inappropriate regulatory framework</li> </ul>
Financing	<ul style="list-style-type: none"> <li>Government provision of 80% of CHAL's funding</li> <li>No explicit incentives</li> </ul>	<ul style="list-style-type: none"> <li>Contracts with some individual private practitioners for specialized services</li> <li>No explicit incentives available</li> </ul>
Public provision of services	<ul style="list-style-type: none"> <li>Strong involvement in disease programs</li> <li>Act as public sector reference facilities</li> </ul>	<ul style="list-style-type: none"> <li>Strong involvement in disease programs</li> <li>Referral system functioning but weak</li> </ul>

Source: "Healthy Partnerships" data, 2010.

other medicines to the nonprofit sector. In terms of the referral process, many of the secondary or tertiary faith-based facilities act as public reference hospitals and so are an essential part of the national referral system. In Rwanda, two of the five public reference hospitals in Kigali are nonprofit facilities that have long-standing agreements with the Ministry of Health.

### *Increased engagement does not come without challenges or problems*

Getting engagement right is a constant process, including with respect to the relatively close collaboration between faith-based providers and the public sector. Public financing, for example, does not always arrive promptly. In Lesotho, the Christian Health Association of Lesotho said payments



from the Ministry of Health routinely arrive late, affecting its ability to provide uninterrupted services. Similar concerns were also raised about drugs and other commodities. In addition, the administrative burden increased, not just for HMIS data but in terms of general financial reporting and other requirements imposed by the government. In the Democratic Republic of Congo, the manager of one midsize FBO hospital said all of her time is spent dealing with the paperwork required for the contract; she hired extra staff just for this purpose. In Lesotho, Zambia, and elsewhere, some respondents said quality of care has actually fallen in faith-based facilities since public funding began.

### **Engagement in low-resource environment**

When the government has very few resources, which is the case in many African countries, the prioritization of its activities or responsibilities toward the private health sector becomes especially important.

In terms of setting priorities for reform, post-conflict countries face particularly tight constraints. They are often faced with the question: If the ministry of health has the capacity to do only one or two things, what should they be? Letting associations and umbrella organizations carry out some of the activities that our framework identified as good practice can be a relatively effective approach, even where such examples of self-regulation are not initiated by the government. In the midst of conflict, large and fragmented private health sectors arise when the government cannot continue to provide essential health services. Such private providers are often individuals running their own practices and various types of nonprofits. The individual practices could be owned by skilled professionals or by unqualified people who would otherwise not be in business, leading to a particularly wide range of providers. Especially in the aftermath of war, government capacity and oversight mechanisms take a long time to develop. Thus, the existing organizations either continue to provide services in different areas or

they coordinate themselves to fulfill what may traditionally be seen as the oversight by the ministry of health.

In Liberia, the private providers came together to form an association that performs self-regulatory functions. The Private Clinics Association of Liberia was established by physician assistants, certified midwives, and registered nurses. To combat the high degree of informality that characterized their ranks, they began a process of self-regulation to complement the activities of the underresourced Liberian Medical Board. With permission from the Medical Board, which has the mandate for registering all private clinics, the Private Clinics Association performs the initial inspection to ensure that the professionals are duly licensed and that the facilities are worthy of certification. They also perform inspections before facilities can have their licenses renewed by the Medical Board. The Private Clinics Association is able to reach areas the Medical Board would otherwise not have been able to inspect, and they have the mandate to close facilities that are not run by appropriately licensed professionals, thus maintaining quality within their professional ranks.

In a more deliberate initiative, the government of Liberia runs a system where nongovernmental organization (NGOs) are given contracts

to run the county health systems. The NGOs currently work with the various county health departments to develop their stewardship capacity. At an even earlier stage of its development is South Sudan, as box 2.14 illustrates.

### **Level of organization of the private health sector matters**

One of the key ingredients for successful public-private collaboration is the organization of the private sector. As discussed earlier, both public and private respondents called lack of organization one of the biggest barriers to further engagement. Even measured at a very basic level of organization, the private sector is organized in only 40 percent of countries in the region. In the rest, there is either no organization or it is dormant (figure 2.15).

Some countries have an umbrella organization covering the entire private sector, while others have one or more organizations representing different areas of private health provision. Umbrella organizations for the entire private sector exist in Ghana, Kenya, Nigeria, and South Africa. The group in Kenya, which was only recently formed, played a role in the development of the government's health care financing strategy.

#### **BOX 2.14**

### **The Example of South Sudan**

**T**he historic peace agreement between the government of Sudan and the Sudan People's Liberation Movement in 2005 created the semiautonomous South Sudan. In view of the independence referendum in 2011, the "Healthy Partnerships" interview team visited Juba in March 2010, even though it was not yet a separate country. The current assessment is about the state of government engagement in Sudan as a whole, using Khartoum state as a proxy where the federal system necessitates it.

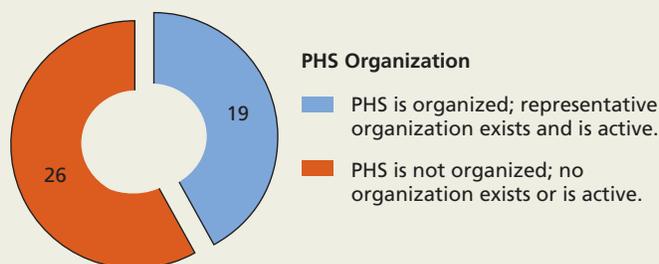
Since South Sudan is emerging from decades of civil war, and most infrastructure was destroyed during that

period, it is no surprise that the health system is still in its nascent stages. The government of South Sudan is heavily reliant on donors for both funding of the Ministry of Health and for health service delivery. Over 80 percent of all health services are delivered by nongovernmental organizations that are connected with the state. There is also a small but growing self-financing or for-profit health sector, concentrated in Juba. In any case, the Ministry of Health appears open to the private sector and recognizes that it is going to be a vital partner in the coming years.

*Source:* "Healthy Partnerships" data, 2010.

**FIGURE 2.15**

**Private Health Sector (PHS) Organization**



Source: "Healthy Partnerships" data, 2010.

In many countries, poor organization of the private health sector creates a challenge for policy makers who are willing to engage beyond individual contracts or have relationships with more than just high-profile providers. In Angola, private providers were excluded from discussions about new health regulations because they did not have an industry association. By contrast, Côte d'Ivoire's well-organized Private Medical Practitioners Association and its Trade Union of Private Medical Practitioners convinced the Ministry of Health to include their input in the National Health Sector Strategic Plan for 2009–13. In a few cases, as in Lesotho, countries can suffer from too many industry associations, leaving the Ministry of Health unsure of whom to work with. Table 2.12 provides evidence of how private sector organizations have positively influenced public-private collaboration.

**TABLE 2.12 How Private Sector Organizations Have Positively Influenced Public-Private Collaboration**

Republic of Congo	The Pharmacists Association has successfully lobbied to be included in selling ARVs at a reasonable cost.
Tanzania	The Association of Private Health Facilities of Tanzania was engaged by the government to distribute vaccines and other goods from public health programs to private providers who make them available to patients.
Togo	The Association of Private Medical Practitioners took the lead in setting the rules for the cost of general medical consultation for their members in 1993 and reviewed them in 2009.

Source: "Healthy Partnerships" data, 2010.

Not surprisingly, the level of private health sector organization is highly correlated with the level of policy and dialogue; the better the organization, the better the dialogue. While this may be unsurprising, good levels of private sector organization can also have benefits for other domains; there are many examples where good private health sector organization has played a key role in encouraging public-private collaboration. Box 2.15 provides specific examples. In a more general sense, private health sector organizations can exercise some self-regulation and therefore lessen the burden on the public sector to do everything.

### Trade Associations as a Conduit for Engaging with the Private Sector

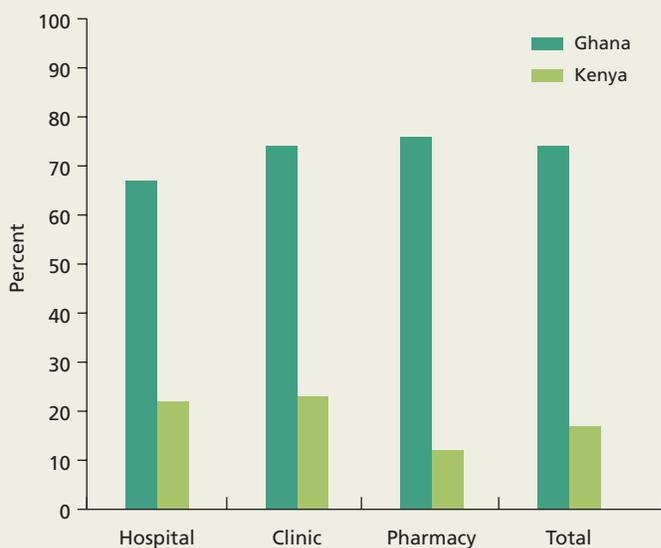
To shed light on the question of whether trade associations are an effective conduit for engaging with the private sector, we report data from a survey of private health care providers in Ghana and Kenya that examines (a) the popularity of trade associations in the private health sector, and (b) to what extent trade associations engage with the government.

The data in figure B2.15a show that the vast majority of private providers in Ghana—nearly 80 percent—were members of trade associations. The picture for Kenya is dramatically different: less than 20 percent of private providers report trade association membership. Interestingly, the data also show that in both Ghana and Kenya, trade association membership does not vary much by type of facility. This suggests that trade associations might be an equally effective conduit for communicating with different types of providers, including hospitals, clinics, and pharmacies.

Figure B2.15b shows the extent to which trade associations help their members communicate with the government and register with statutory authorities. Roughly three quarters of providers in Ghana and Kenya say trade associations act as a communication intermediary between facilities and the government, with a slightly higher fraction of Ghana’s facilities reporting this type of support. By contrast, only 25 percent of Ghanaian providers say they received help with registration. A larger percentage of Kenyan facilities received this kind of assistance from their association.

Overall, the data suggest that trade associations can provide a diverse range of private providers with a common voice. However, both trade association membership and the role associations play can vary significantly across countries. In at least some countries, such as Ghana, engaging with trade associations may be an important and efficient way for governments to work with the private sector.

**FIGURE B2.15a Trade Association Membership in Ghana and Kenya**



**FIGURE B2.15b Role of Trade Associations in Engaging with the Government**



Source: “Healthy Partnerships” provider survey, 2010.



## Section 3: Conclusions and action plan for stakeholders

*The central argument of this Report is that public-private engagement can play a positive role in enhancing the efficient use of scarce resources for health and can improve access to quality care in Sub-Saharan Africa. As Section 1 noted, improvements in health systems are urgent and cannot be left to the public sector alone. The private health sector is already making significant contributions to health systems in Africa. Therefore, improvements in the efficiency of these systems and their overall performance need to include the private sector. But not all government intervention or engagement with the private health sector is good. How should governments approach this challenge?*

The results in Section 2 provide insights into the breadth and depth of government engagement with the private sector and highlight good examples of public-private collaboration. There is a general positive trend toward improved coordination between the public and the private health sectors across the continent. What is needed is the support of all stakeholders to accelerate this process and to approach public-private engagement in a systematic manner.

How does the assessment across domains help in prioritizing reforms going forward?

As an illustrative example, we look at Rwanda. As described in Section 2, Rwanda performs relatively well across all five domains; it has the highest scores, on average, for a low-income country. This finding is not unexpected and is supported by previous studies of the health sector in Rwanda<sup>102</sup> and by recent reports on documented improvements in the business environment.<sup>103</sup> Based on these external studies, and in line with the results from our assessment, the government of Rwanda seems to have done well in engaging with the private health sector (figure 3.1).

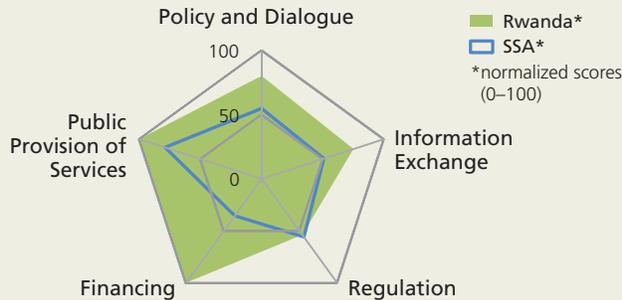
Despite the good scores, however, there are still many remaining challenges in Rwanda that

the framework helps to highlight. The good practice elements identified per domain can be used as a checklist to identify these gaps. They include needed improvements of the regulatory framework, including a mechanism for regular inspection of all facilities, and insufficient attention to the continued education of private medical professionals. Integration of all private providers into the national health management information system is also urgently needed. These are the priorities for reform. They are also the priorities identified by stakeholders in Rwanda. It is encouraging that, thanks to strong political commitment to public-private collaboration, policy makers in Rwanda have begun to address exactly these issues.

The key recommendations from this study are provided in the following sections. Ideas on how the findings can be used to inform policy reform are offered first. Then, we put the assessment framework in the context of health systems components. We offer conclusions along the five domains and propose key actions for different stakeholder groups to strengthen public-private engagement in Africa. We end with an action plan for the research agenda following from this Report.

**FIGURE 3.1**

**Detailed Domain Scores: Rwanda Example**



**Policy and dialogue**

Policy exists for engaging with PHS	✓
De facto implementation of engagement policy	✓ ¾
Formalized mechanism for dialogue with PHS	✓
De facto dialogue	✓ ¾

**Information exchange**

PHS included in information exchange	✓ ¾
PHS required to provide information to MoH beyond DS	✓
De facto information provision by PHS to MoH beyond DS	✗
PHS included in Disease Surveillance Program	✓
PHS receives DS updates from MoH in emergencies	✓

**Regulation**

Quality of private health sector providers registry	✓ ¾
Reported judgment of quality of regulation	✗
Regulation is enforced as intended	✓
Standardized rules exist for opening PHS clinic	✓
Quality control process for clinics—de jure	✓
De facto quality control executed for PHS clinics	✗
Quality control is the same for PHS and public	✗
Continued medical education requirement for license renewal	✗
Continued education open to PHS professionals	✓
Policy/engagement toward traditional medicine exists	✗

**Financing**

Government uses contracts with PHS	✓
Incentives are provided for PHS operators	✓
Overall population covered by health insurance	✓ ¾

**Public provision of services**

PHS receives vaccines, medicines or similar for distribution	✓
A functioning public-private referral process	✓

✗ = no or score of 0 for this indicator  
 ✓ = yes or score of 1 for this indicator  
 ✓ ¾ or ✓ ¼ = score of 3 or 4, respectively, for this 1-4 or 0-4 indicator

Source: “Healthy Partnerships” data, 2010.  
 Note: PHS = private health sector; MoH = ministry of health; DS = disease surveillance.

**Reforms as a political process at the country level**

After years of benign neglect, policy makers are increasingly open to working with the private health sector. The framework offered here provides a useful starting point for the process. Notwithstanding the conclusions that follow, however, it is important to keep in mind that reforms happen in the context of a particular country and are subject to its political process.

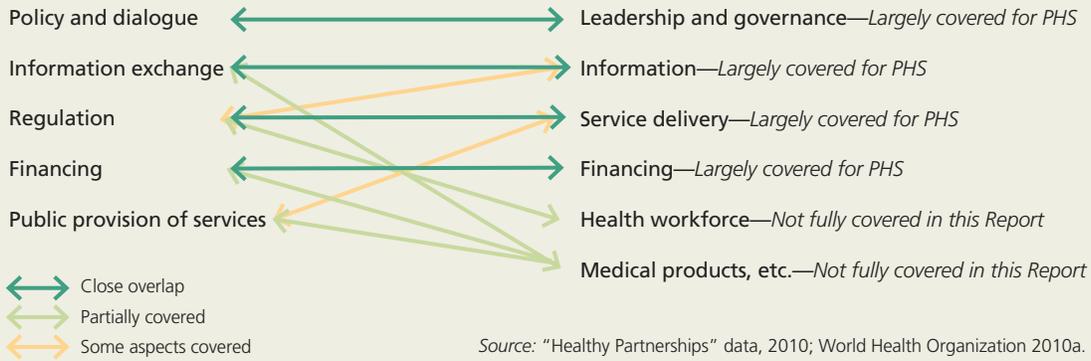
This Report offers a framework for policy makers and stakeholders more generally to approach this critical issue. Instituting the necessary changes, however, is generally not a technical issue, but a political one. Therefore, the political process demands as much attention as the technical contents. Technically sophisticated solutions are useless if they are not translated into changes in the national health system. To navigate the political process of reform, stakeholders can build on the cumulative experience of countries that have gone through this process, as the examples mentioned earlier attest. Reforms can also build on the experience obtained through the “Health in Africa” initiative’s ongoing support of the policy process in several African countries.<sup>104</sup> Translating technical solutions into realized changes also requires vigilance; governments and the private health sector must continue to work together throughout the policy cycle.

The goal is to have the private sector fully embedded in the overall health system so that all providers, public and private, compete for funds from public and private sources by offering high-quality services. The establishment of appropriate structures and capacities to handle such a system takes time. All stakeholders—governments, the private health sector, but also donor and third-party organizations—will need to adjust. This is also true for faith-based providers who engage more closely with national governments, currently often through informal arrangements.

In terms of prioritizing reforms, the political process also matters. Having manageable, concrete elements to engage on improves the chances for sustained change, since successful reforms are the key ingredient to further successful reforms.

**FIGURE 3.2**

**Alignment between Framework Domains and Health Systems Building Blocks**



And since some of the changes, such as overseeing contracts with the private sector, require development of the appropriate capacity, starting with some concrete and relatively easy steps is the right thing to do from both a political and a technical point of view.

**Engagement through health systems strengthening approach**

Since the health systems approach is now widely accepted as a logical way of strengthening sector performance, the recommendations can also be considered in the context of the health systems building blocks, as per the classification of the World Health Organization (WHO). Another compelling reason for using the health systems approach is that not all countries undertake sectorwide reforms all the time. This is particularly true of donor-supported projects that tend to focus on specific issues or systems. Adoption of this approach allows stakeholders to engage meaningfully in partial reforms. As a recent WHO report notes,

To achieve their goals, all health systems have to carry out some basic functions, regardless of how they are organized: they have to provide services; develop health workers and other key resources; mobilize and allocate finances, and ensure health system leadership and governance (also known as stewardship, which is about oversight and guidance of the whole system).<sup>105</sup>

As seen in figure 3.2, there is considerable alignment between the domains of our framework and health systems building blocks. As mentioned in the introduction to the Report, input markets are not the focus here, and so the elements of “health workforce” and “medical products, and so forth” are only partially addressed here. We expect to highlight the particular issues regarding public-private engagement in input markets in follow-on work.

**Key conclusions by domain**

The conclusions offered here, and the action plan below, relate to the entire private health sector, including faith-based organizations (FBOs) that are also looking for reforms. Indeed, the push for better engagement offers a good opportunity for FBOs to redefine and develop their current working relationship with governments. Improving engagement is about bringing all the relevant actors in a country’s health system to the table to establish a more efficient way of working together within the national priorities.

**Policy and dialogue**

Policy and dialogue between the government and the private health sector are the foundations of effective engagement. Our research shows that many countries have policies on paper but are lacking in implementation.

- A meaningful dialogue between the private health sector and the government about mutual expectations and constraints sets the stage for follow-on actions by stakeholders. Setting up a formal process helps, but it is far more important to ensure that the dialogue takes place on an ongoing basis.
- Implementation matters. Concrete steps are needed to show that the intention of engaging with the private health sector and with the government is real. A mechanism to monitor actual implementation, for example, by a third party, can build trust.
- The organization of the private sector itself is critical in establishing a dialogue. The private health sector needs credible representation for the government to engage with.

#### Information exchange

- Existing information systems remain incomplete if they do not include the private health sector. Having separate or designated information systems for the private health sector is neither necessary nor more effective.
- Excessive reporting requirements for the private sector are not useful. Requirements should be aligned with the following:
  - What the private health sector can reasonably be expected to provide
  - What the public sector can reasonably use and give feedback on (that is, data that are collected but not processed, analyzed, or reported in a meaningful way create an undue burden on private providers)
  - National priorities.

In all of these three points, dialogue with the private health sector is important.

- Private providers can be incentivized to provide data to the Ministry of Health, for example, through the inclusion in public health interventions. At a minimum, the motivation can involve the provision of feedback and results of analysis of data submitted.

- Information disclosure and availability of information that allows patients to make informed choices is important for the entire health system. The tendency toward secrecy in the private sector is still too common.
- Health facility surveys that include all facility types in the private health sector can provide a basic level of information for planners.

#### Regulation

- A complete and up-to-date registry of private health facilities is a basic precondition for effective health system planning. Where such a registry is not yet feasible in the medium term, alternatives are available for updating the information on “who does what,” such as the surveys mentioned above. It may not be necessary for the Ministry of Health to fulfill this function directly, because other umbrella organizations can play an important function here and subsequently share their data with the ministry.
- Overly complex frameworks that are contradictory or that cannot be put into practice as intended create uncertainty and opportunities for arbitrary enforcement. While a full-on overhaul will not be feasible in the near term, identifying and correcting the most urgent “mistakes” in the regulatory framework is. Therefore, review and revision of the regulatory framework is needed to ensure that:
  - It is appropriate for the country’s health system, including the size and type of the private health sector.
  - It establishes a straightforward regime of licensing of professionals and of facilities that is appropriate and aligned to the country’s health care needs. Restrictions on competition, for example, through protection of current practitioners from foreign practitioners or investors, deserve particularly close scrutiny for relevance.
  - It is appropriately simple and aligned with enforcement capacity. At least part of the oversight functions can be fulfilled by private organizations or associations; enforce-

ment capacity is to be understood in that broader sense.

- It addresses issues of quality in some fashion through facility-based (inspections) or profession-based (continuing medical education [CME] requirements and offerings for all professionals) approaches. The recognition of voluntary approaches has been successfully used to incentivize quality improvements. For example, facilities can be awarded a certificate or other recognition that can be displayed for patients or other visitors to see.
- Self-regulation can substitute for enforcement by the government. In dialogue with private provider associations or third-party organizations, the extent and type of authority can be determined.

### **Financing**

The key to financing is to ensure that there is a mechanism that allows poor people to have access to services, and that public funds buy value for money from either public or private services that compete on a level playing field. The principle of strategic purchasing (buying services from the best providers regardless of ownership) is especially important to consider in countries where the private sector is large.

- The inclusion of the private health sector in public health programs including (partial) public funding for privately provided services can improve health systems performance. Where the private sector provides health services efficiently and to the poor population, it can be a well-placed channel for publicly financed care.
- Taxation regimes that disadvantage the private health sector, including excessive import tariffs on inputs (pharmaceuticals, equipment, and so forth) are damaging to the health system overall. Taxation and incentive issues can become highly technical, which calls again for dialogue on priority areas between government (for example, the tax authority) and the private health sector. Private health facilities may be

classified as noncommercial enterprises for tax reasons if, for example, they are committed to also serving the poor and therefore provide partly public services.

- The expansion of health insurance toward universal coverage—ongoing in several African countries—has the potential to fundamentally change the dynamics in, and improve performance of, national health systems. Insurance, especially when appropriate focus is put on expanding coverage to the indigent, not only decreases the financial risk of impoverishment from ill health. Higher levels of private provider coverage through health insurance also offer a more easily predictable revenue stream for providers, which improves the business case for increased investment in the health sector. In addition, the accreditation process required to receive insurance reimbursements has proven to generate powerful incentives for providers to focus on improving quality. The intermediation of the insurance system's accreditation process (or similar function) alleviates capacity constraints in the government for enforcing regulations.
- Using financing as an instrument for engagement is difficult, both technically and politically. While the appetite for big changes (for example, insurance) is clearly present, small changes provide the opportunity to build technical capacity and (political) trust in the concept. Starting to contract out for ancillary services at public hospitals, for example, if it has not been instituted yet, can provide experience before launching major service delivery contracts.

### **Public provision of services**

In areas where there are no viable markets or when there are large externalities, there is a need for the public sector to step in and ensure the availability of both basic services and institutional support. Like the private sector in general, the private health sector also depends on publicly financed services such as water, electricity, and basic education.

- Similar to the financing domain, our research suggests that the inclusion of the private health sector in public health programs, including public provision or financing of goods and services, can benefit health systems performance. Immunization programs, for example, will be less effective if the private health sector and their patients are excluded.
- On a related note, the explicit inclusion of private providers in the health system maps of local governments (for example, municipal, county, district, or province) and associated referral channels will benefit the efficiency of the whole health system, especially if it is accompanied by public-private dialogue to work out technical modalities.
- Conduct a basic analysis of the private health sector, including the composition and capacity of private providers. This need not be a sophisticated, time-consuming, or expensive analysis. Establishing a basic level of information and understanding of the private health sector is critical. Without it, policy makers will not be able to carry out their work in a strategic manner.
- Start with manageable, concrete changes; success builds on success. Technical and political hurdles, for example, in using financing as an instrument, can be tackled by building trust in the engagement process itself.

### Recommended actions by group of stakeholders

The following are guidelines for an action plan for each group of stakeholders: governments, the private health sector, donors, and intermediaries or third-party organizations. The action plans are summarized in figures 3.3, 3.4, 3.5, and 3.6, respectively.

#### Governments

##### SHORT TERM

- Stop interventions that are inadvertently harmful to the private health sector; keep the effects on the private health sector of all interventions in mind. Effective engagement with the private health sector is not always about doing more; sometimes the solution is to do less. Section 2 points to a number of government interventions that create massive distortions; they should be eliminated as soon as possible.
- Establish a mechanism for ongoing dialogue with the private health sector to define common priorities and strengthen partnerships. There is an urgent need for increased communication in many countries. The good practice example of Ghana highlights the advantages of (re-)establishing a specific public-private health sector dialogue.
- Formulate a policy for engagement if one does not exist, or revive and revise the existing policy if there is one; the policy should focus on what is feasible and most desirable to be implemented.
- Use the full range of instruments, across all five domains, to engage with the private health sector. The framework presented here includes the basic elements and provides a useful guide to engagement. It can also help identify the key areas of reform. Beyond these initial guidelines, it is imperative for governments to develop a more comprehensive reform agenda appropriate for the particular country context.
- Simplify the regulatory framework. The key is to prioritize and align with the priorities identified in dialogue with the private health sector.
- Encourage the private health sector and third-party organizations to take an active role in addressing the issue of quality of care. If responsibilities and authorities are clearly defined, self-regulation or similar mechanisms may be effective in promoting quality while avoiding unnecessary burdens on private providers.
- Ensure that health professionals have access to CME courses offered by public or private institutions. In particular, professionals from the private sector should have similar access to such courses as their colleagues from the public sector.

**FIGURE 3.3****Summarized Action Plan for Governments**

- Establish or strengthen ongoing dialogue with private health sector.
- Formulate or refine policy of engagement.
- Know at a basic level what the private health sector does.
- Simplify regulatory framework to match enforceable standards.
- Challenge private sector organizations to take on some oversight responsibilities.
- Level the playing field between public and private providers.
- Start with small, concrete steps to develop capacity when reforms are politically or technically difficult.

Source: “Healthy Partnerships” data, 2010.

**FIGURE 3.4****Summarized Action Plan for the Private Health Sector**

- Form a credible and representative organization, including an umbrella organization, if needed.
- Seek meaningful dialogue with government.
- Build capacity toward credible and fair self-regulation on issues discussed with the government, especially quality of care.
- Strengthen facility–internal quality control and business management at private facilities.

Source: “Healthy Partnerships” data, 2010.

- Establish or revive a basic oversight function for the private health sector, including monitoring and evaluating the impact of government policies on it. Ideally, a focal point should exist within the Ministry of Health that deals solely with the private health sector.
- Establish an up-to-date and comprehensive registry of private sector providers in the health system. This is a central element of good engagement. Encouraging informal providers to at least undertake basic registration is crucial if governments are to accurately map the scale and scope of who is doing what in their health system. Registration will be effective only if it is simple, cheap, and fast.
- Develop the capacity for strategic financing and contracting of services to the private health sector. This can be used to fill the access gaps that exist in specific health services within regions or population groups. It may also include preventive care, which the private sector often does little of, since most of the revenue comes from out-of-pocket payments.

**Private health sector**

- Form a representative body to participate in the engagement process. While there is some evi-

dence of private health sector organization across the region, it is insufficient in most countries. Where more than one organization of the same facility type exists, the private sector should consider merging or forming an umbrella organization that gives the public sector a single focal point for interaction. The representative body’s role will also be to effectively communicate the contributions that private providers are making to national health goals.

- Seek meaningful dialogue as a first step in improving public-private engagement. The previous section showed how private sector initiative has driven the engagement process in some countries.
- Collaborate with the government to address the issue of quality of care. Provider networks, capacity building in clinical practice (through CME), and business management training are all ways that private groups can help improve the care offered by their members.
- Offer credible solutions to shift some oversight responsibility from the government to the representative body. While the government remains the steward of the health system, effective self-regulation can improve the sector overall and ease the capacity constraints of the government.
- Strengthen internal quality control and business management processes at private facilities. Especially in terms of business management practices, most private providers have a lot to catch up to. Associations of private providers have a

role to play in providing guidance and support for improvements at individual facilities.

- For FBOs: Seek to review and develop the existing relationship with the government as part of the overall engagement process.

### Donors

Donors can play an important role in supporting both the public and private sectors as they seek to improve engagement.

- Include the private sector in bilateral discussions and design of projects; support the engagement process; take an active role in improving communication.
- Provide funding for activities that are aligned with overall development goals. Funding for service delivery should be appropriately balanced to enhance the relative advantages of both the private and public sectors. The main driver should be national health priorities.
- Ensure that donor harmonization processes do not cling to preconceived ideas about the relative merits of public compared to private service delivery.
- Improve the predictability of donor funding and increase the duration of commitments. This will support long-term planning. It will

also help prevent long-term losses, for example, through temporary elimination of domestic markets for health care goods or services being created out of short-term gains.

- Ensure that donor funding does not do more harm than good; for example, donor efforts on malaria control that have supported the provision of high-quality drugs at highly subsidized prices can negatively affect local manufacturing of generic drugs (which may have a better chance of longer-term sustainability for the countries involved).

### Third-party organizations

Third-party organizations can be insurance authorities, civil society organizations (for example, consumer advocacy groups), and others.

- Support and urge the increased organization of the private health sector.
- Provide training and support to private providers who need it, including on the management or business aspects of their work.
- Support the ability of patients to make informed choices. Third-party organizations are often effective in providing actionable information to consumers of health care about the quality of various providers and about the rights and options that individual patients have but may not know about.

FIGURE 3.5

#### Summarized Action Plan for Donors

- Include private health sector in discussions and design of new projects.
- Support dialogue between government and private sector; align projects with national priorities defined by such dialogue.
- Ensure that donor funding does not undermine local markets in health care goods and services.

Source: "Healthy Partnerships" data, 2010.

FIGURE 3.6

#### Summarized Action Plan for Third-Party Organizations

- Support the increased organization of the private health sector.
- Provide training and support where needed, also in business management.
- Support improved information for consumers.

Source: "Healthy Partnerships" data, 2010.

### Action plan for future research

In addition to the action plan suggested for all stakeholders, we consider the action plan for taking this work forward: what is the follow-up in terms of analytical work from this report? The following elements are under consideration on the analytical side (see figure 3.7 for a summary).

- *Replication.* The work presented here constitutes an important first step toward assessing the policy environment of the private health sector and how engagement is shaping the environment. We expect that in future work, the relative levels and types of engagement can be assessed again to measure and discuss the progress made and the relative effectiveness of various reforms. It will be important that future iterations build on the work done here while refining and further developing the framework and the individual indicators.
- *Estimating impact.* The link between engagement and intermediate outcomes (access, quality, equity) or health outcomes (for example, maternal or child mortality) can start to be examined, based on the developed indicators. As the measures of engagement are refined, such analyses can improve our understanding of what type of engagement achieves the best results.
- *Thematic expansion.* Three points are among the agenda items for future (and currently ongoing) research.
  - The report focused on service delivery. Additional analytical work is underway to further highlight the role of the private sector in input markets (for example, manufacturing, importing, and distributing and retailing pharmaceuticals and medical equipment). The private sector also has a major role to play in the education of the health workforce. The framework for assessing engagement can contribute to the discussions in this area, as well.
  - Africa is becoming a destination for foreign investors in the health care market. While this Report has not focused on the foreign direct investment dimension, such considerations will be increasingly on the agenda for policy makers. Several countries in the region have already devoted significant efforts to attracting investors, for both final service delivery and input markets.
  - Subregional dimension: This report has only discussed the national level. Policy makers in Africa are exploring the potential of sub-regional coordination. This exists on the business side with the West African Organisation pour l'Harmonisation en Afrique du

FIGURE 3.7

#### Summarized Action Plan for Future Research

- Replicate assessment to measure progress.
- Further develop framework/indicators.
- Estimate impact of engagement on outcomes.
- Expand assessment thematically to include (a) private sector role in input markets and health worker education, (b) foreign investment in the health sector, (c) sub-regional dimension.
- Expand geographically to apply framework to developing health systems in other regions.

Source: "Healthy Partnerships" data, 2010.

Droit des Affaires (OHADA). The move toward similar frameworks for the private health sector holds great promise to leverage scarce oversight capacity.

- Future rounds of this work may address how the framework and the indicators developed here are applicable to developing countries in other regions.

### **Toolkit for further guidance**

A toolkit is available online to provide further guidance to stakeholders interested in improving the public-private engagement in health. See [www.wbginvestmentclimate.org/health](http://www.wbginvestmentclimate.org/health).

In conjunction with the other available resources and with the expertise at the country level, this Report should be used as an advocacy tool in the reform process. The framework developed here and used to assess engagement across Sub-Saharan Africa provides a starting point for developing a country-specific reform agenda, and better engagement can lead to reforms in the health sector more broadly.

Even though the challenges are enormous and improvements in African health systems are urgent, the willingness—and even demand—to look at health systems in a new way is reason to hope. When public and private sectors work in partnership, improved access to affordable, high-quality care is achievable in Africa.

## APPENDIXES

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APPENDIX 4 – Methodology for data collection	140
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## APPENDIX 1—Country snapshots

### General notes on the country snapshots

This appendix contains country snapshots with selected indicators for each of the 45 Sub-Saharan African countries covered in the Report. Collectively, the indicators provide a snapshot of the operating environment for the private health sector. Along with the new data on engagement discussed throughout the report, the operating environment is shown from the private sector side (also affecting nonhealth private firms) and from the health side (also affecting public health providers). In order to complete the logical framework, further discussed in appendix 4, intermediate and ultimate outcomes are included as well.

Many of the indicators are proxy or tracer indicators. They are not meant to fully capture the theme for which they are chosen. Instead, they represent the best existing standardized data for cross-country assessment. The fact that the indicators are imperfect proxies illustrates the dearth of reliable data in general. For example, robust data for fundamental vital registration indicators (births and deaths, including cause of death) barely exist in many countries in Sub-Saharan Africa.<sup>106</sup> Policy makers face the daunting task, therefore, of improving health systems often despite lacking basic information, such as who has died from what. Improving the availability of data for decision making is critical, as is making the best use of existing data. While comprehensive and reliable information is scarce, the snapshots and the data in Appendix 2 constitute a big improvement over what has been available so far for assessing the contributions of the private health sector and its operating environment.

The following explains the sections included in each snapshot.

Table A1.1 at the end of the country snapshots provides further details on the indicators used in the snapshots that are derived from third-party sources.

### 1. The banner

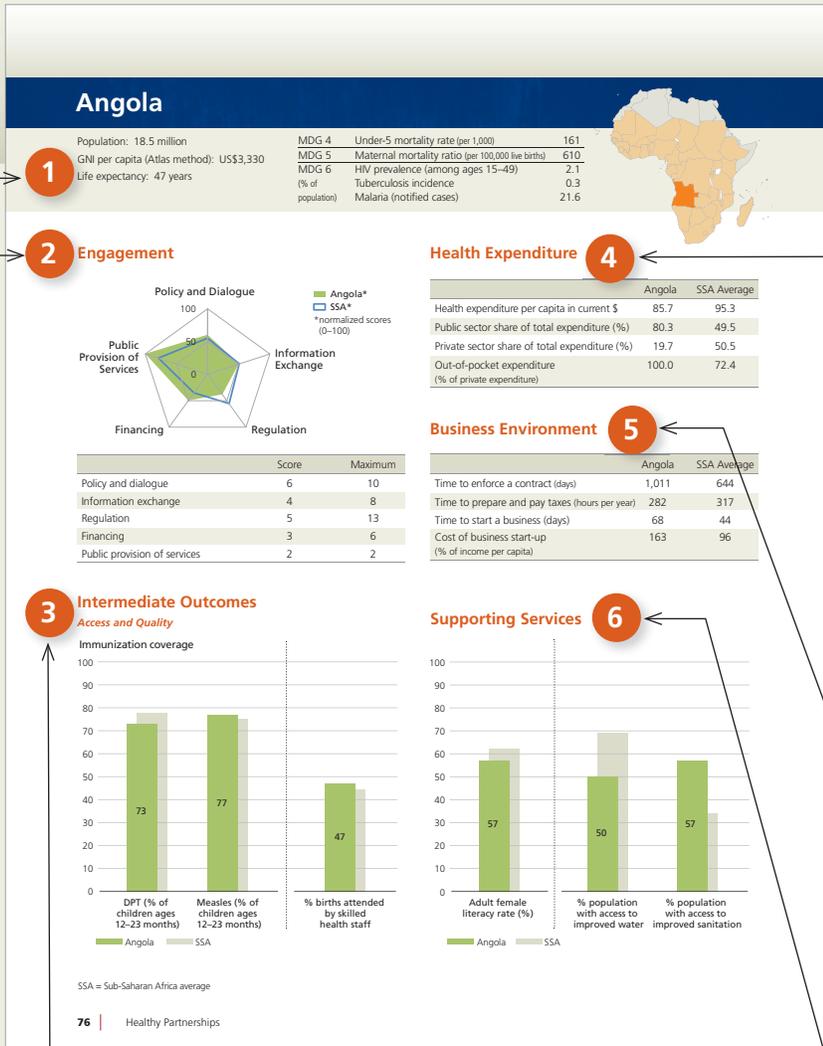
The banner provides basic information on the country and its high-level health outcomes. Total population and income per capita (as defined by the World Development Indicators) provide an indication of the (potential) size of the health market. Life expectancy and the measures for Millennium Development Goals (MDGs) 4, 5, and 6 are displayed to reflect the high-level health outcomes of the population. The MDGs are also the most prominent goals in terms of population health. Note that the standard indicator for MDG 6 reflecting diagnoses of the communicable diseases HIV, TB, and malaria has been transformed into percentage terms.

*Data sources:* World Development Indicators (WDI), 2010 (note that the data quoted in the WDI may in fact be a few years older than the WDI year); United Nations Statistics Division for notified cases of malaria.<sup>107</sup>

### 2. Engagement

The engagement data are the newly collected data discussed in detail in the Report. The normalized scores for each domain in a given country are presented in the pentagon spider figure for a representation of relative strengths and weaknesses of domains in a given country. Averages across the Sub-Saharan Africa countries are also represented in the pentagon graph (indicated by the blue line) for a comparison. It should be noted that the Sub-Saharan Africa average is calculated in this table and in subsequent tables for the 45 countries covered by the research, in each instance across all countries for which data is available.

*Data source:* Healthy Partnerships data (methodological details for each of the engagement indicators are in Appendix 4).



#### 4. Health expenditure

Data on the type of expenditure by the typical consumer/patient provides more detail on the health market: how much is currently being spent on each person (per capita spending on health) and who is spending it (the relative share of private and public in total expenditure on health). The high average share, of private spending coming from out-of-pocket payments shows the extent to which especially the poor population is vulnerable to potential financial impoverishment due to ill health. It is generally also an indication of the kind of funding that private providers have relied on most heavily.

*Data source: World Development Indicators, 2010.*

#### 5. Business environment

Selected measures from the World Bank's Doing Business indicators illustrate how easy or difficult it is to operate as a private company. Four measures that are most relevant to health providers are selected. Private health providers are typically required to register as private businesses, a process that can take considerable time and money. They also have to pay taxes and, occasionally, seek the enforcement of contracts. How easily these things are done for the private sector in general, therefore, affects private health providers as well.

*Data source: Doing Business 2011.*

### 3. Intermediate outcomes: Access and quality

For countries where data from the Demographic and Health Survey (DHS) are available, the snapshots provide measures of access and quality as the intermediate outcomes. The measures chosen for the snapshot are, again, only proxies. Appendix 2 provides a more comprehensive set of measures for intermediate outcomes. Access to health care is measured in terms of self-reported source of care for children with symptoms of acute respiratory infection (ARI). To proxy for the quality of care that is available in a country, the snapshots show the percentage of women who received all five of the basic prenatal services at some point during their pregnancy (blood pressure checks, blood tests, urine tests, weight check, and discussion of complications). Data on percentage of births that are attended by a skilled health staff (WDI data) are shown as an additional proxy for quality of available health services.

For countries where DHS data are not available, the snapshots report immunization coverage rates for diphtheria, pertussis, and tetanus (DPT) and measles as an imperfect proxy for the DHS access measures.

Note that averages for DHS data include only the 27 countries for which the relevant data are available.

*Data sources: World Development Indicators, 2010; Demographic and Health Surveys, year varies by country (see Table A1-1).*

### 6. Supporting services

Availability of basic services, such as water and electricity, significantly impact the cost of doing business for any private enterprise, especially private health providers. Measures of coverage for clean water and sanitation serve as proxies, in the absence of a similar measure for electricity. In addition, the availability of education has a significant impact on the customers of the private providers and, therefore, indirectly on private providers. As a proxy, we use female literacy, which is also strongly associated with positive health outcomes.

*Data source: World Development Indicators, 2010.*

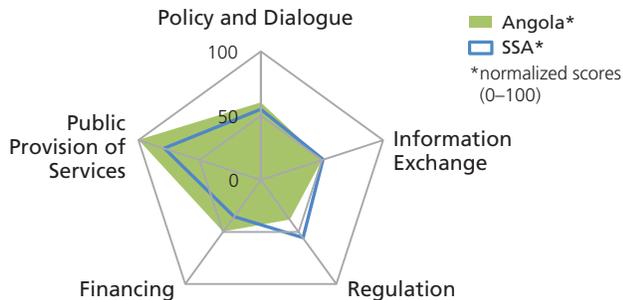
# Angola

Population: 18.5 million  
 GNI per capita (Atlas method): US\$3,330  
 Life expectancy: 47 years

MDG 4	Under-5 mortality rate (per 1,000)	161
MDG 5	Maternal mortality ratio (per 100,000 live births)	610
MDG 6	HIV prevalence (among ages 15–49)	2.1
	(% of population)	0.3
	Tuberculosis incidence	21.6
	Malaria (notified cases)	



## Engagement



Category	Score	Maximum
Policy and dialogue	6	10
Information exchange	4	8
Regulation	5	13
Financing	3	6
Public provision of services	2	2

## Health Expenditure

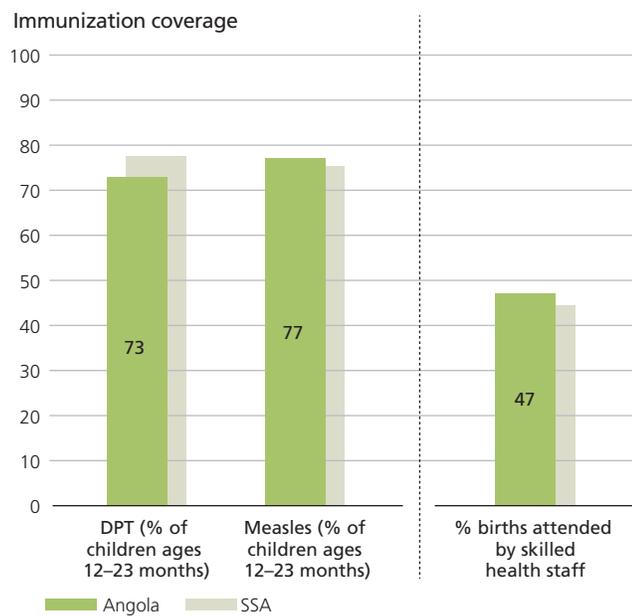
	Angola	SSA Average
Health expenditure per capita in current \$	85.7	95.3
Public sector share of total expenditure (%)	80.3	49.5
Private sector share of total expenditure (%)	19.7	50.5
Out-of-pocket expenditure (% of private expenditure)	100.0	72.4

## Business Environment

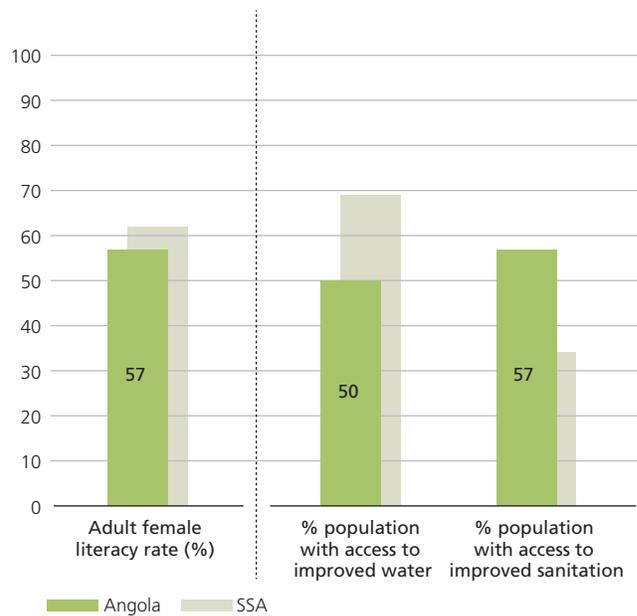
	Angola	SSA Average
Time to enforce a contract (days)	1,011	644
Time to prepare and pay taxes (hours per year)	282	317
Time to start a business (days)	68	44
Cost of business start-up (% of income per capita)	163	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

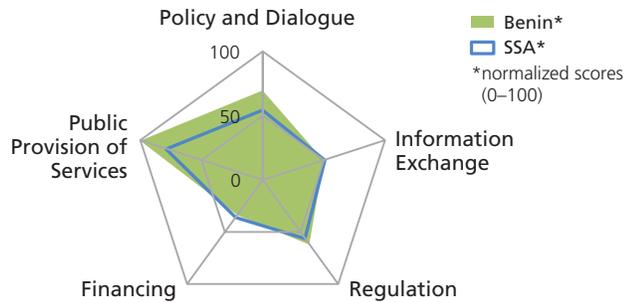
# Benin

Population: 8.9 million  
 GNI per capita (Atlas method): US\$700  
 Life expectancy: 61 years

MDG 4	Under-5 mortality rate (per 1,000)	118
MDG 5	Maternal mortality ratio (per 100,000 live births)	410
MDG 6	HIV prevalence (among ages 15–49)	1.2
	(% of population)	0.1
	Tuberculosis incidence	35.6
	Malaria (notified cases)	



## Engagement



	Score	Maximum
Policy and dialogue	7	10
Information exchange	4	8
Regulation	8	13
Financing	2	6
Public provision of services	2	2

## Health Expenditure

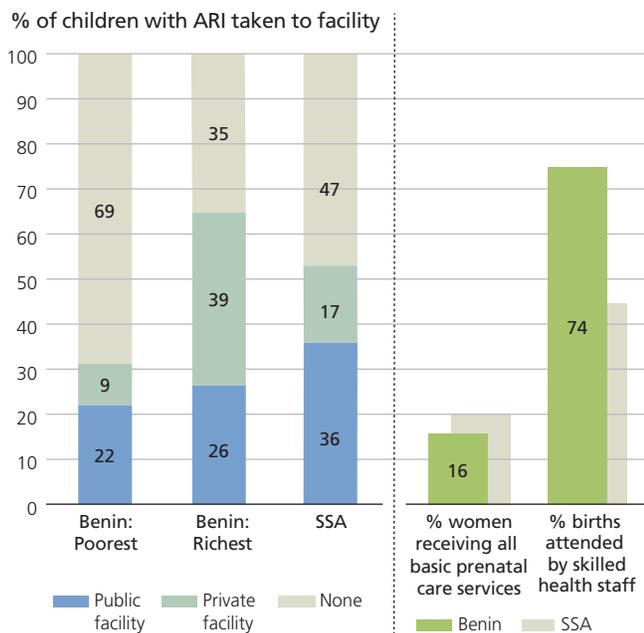
	Benin	SSA Average
Health expenditure per capita in current \$	31.9	95.3
Public sector share of total expenditure (%)	51.8	49.5
Private sector share of total expenditure (%)	48.2	50.5
Out-of-pocket expenditure (% of private expenditure)	94.9	72.4

## Business Environment

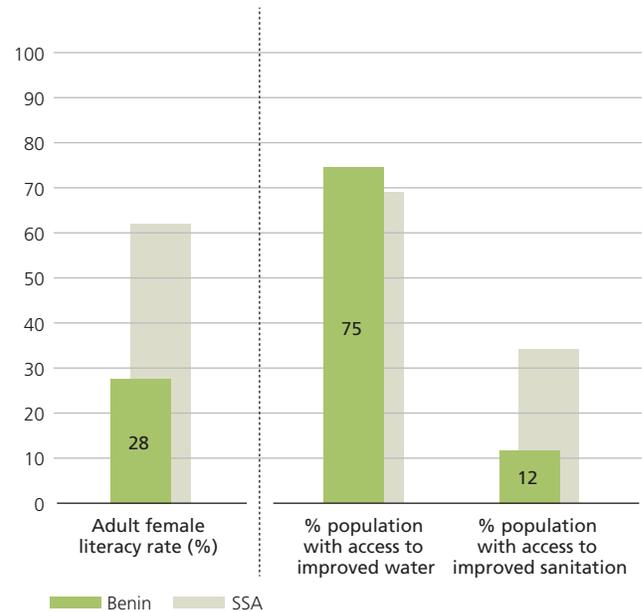
	Benin	SSA Average
Time to enforce a contract (days)	825	644
Time to prepare and pay taxes (hours per year)	270	317
Time to start a business (days)	31	44
Cost of business start-up (% of income per capita)	153	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

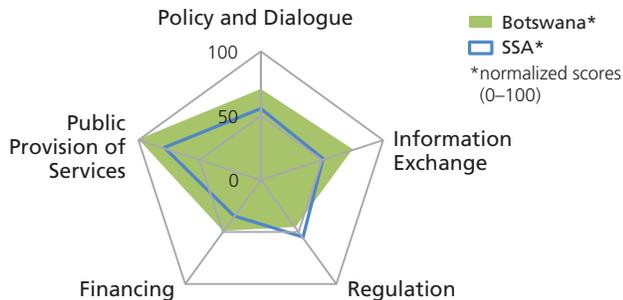
# Botswana

Population: 1.9 million  
 GNI per capita (Atlas method): US\$6,550  
 Life expectancy: 54 years

MDG 4	Under-5 mortality rate (per 1,000)	57
MDG 5	Maternal mortality ratio (per 100,000 live births)	190
MDG 6	HIV prevalence (among ages 15–49)	23.9
	(% of population)	0.7
	Tuberculosis incidence	0.6
	Malaria (notified cases)	0.6



## Engagement



	Score	Maximum
Policy and dialogue	7	10
Information exchange	6	8
Regulation	6	13
Financing	3	6
Public provision of services	2	2

## Health Expenditure

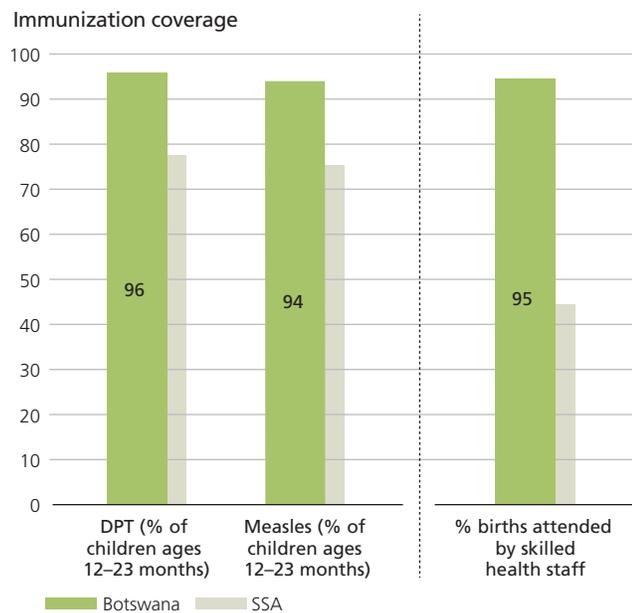
	Botswana	SSA Average
Health expenditure per capita in current \$	372.0	95.3
Public sector share of total expenditure (%)	74.6	49.5
Private sector share of total expenditure (%)	25.4	50.5
Out-of-pocket expenditure (% of private expenditure)	27.3	72.4

## Business Environment

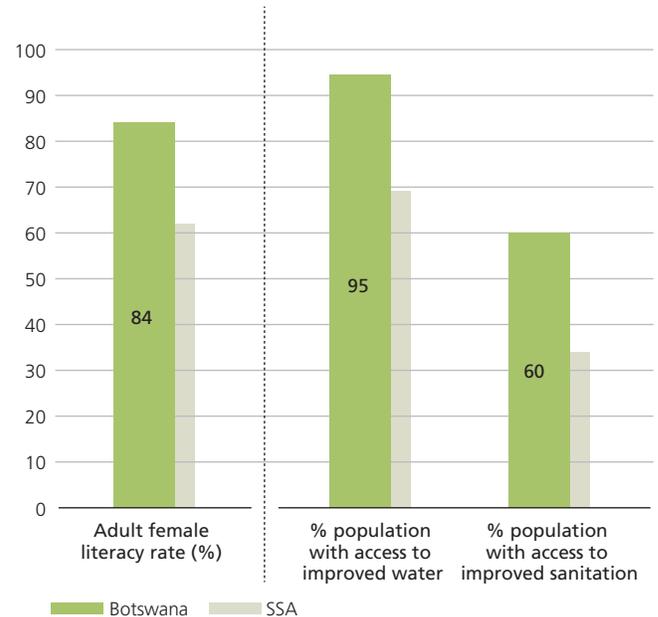
	Botswana	SSA Average
Time to enforce a contract (days)	625	644
Time to prepare and pay taxes (hours per year)	152	317
Time to start a business (days)	61	44
Cost of business start-up (% of income per capita)	2	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

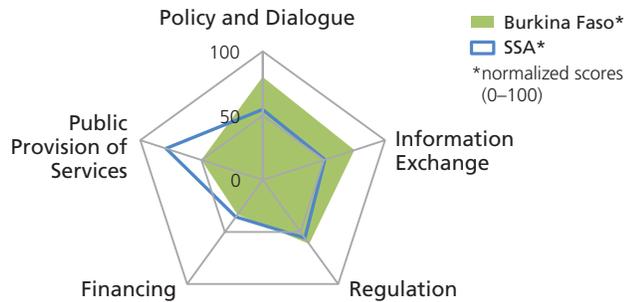
# Burkina Faso

Population: 15.8 million  
 GNI per capita (Atlas method): US\$480  
 Life expectancy: 53 years

MDG 4	Under-5 mortality rate (per 1,000)	166
MDG 5	Maternal mortality ratio (per 100,000 live births)	560
MDG 6	HIV prevalence (among ages 15–49)	1.6
	(% of population)	0.2
	Tuberculosis incidence	45.3
	Malaria (notified cases)	



## Engagement



	Score	Maximum
Policy and dialogue	8	10
Information exchange	6	8
Regulation	8	13
Financing	2	6
Public provision of services	1	2

## Health Expenditure

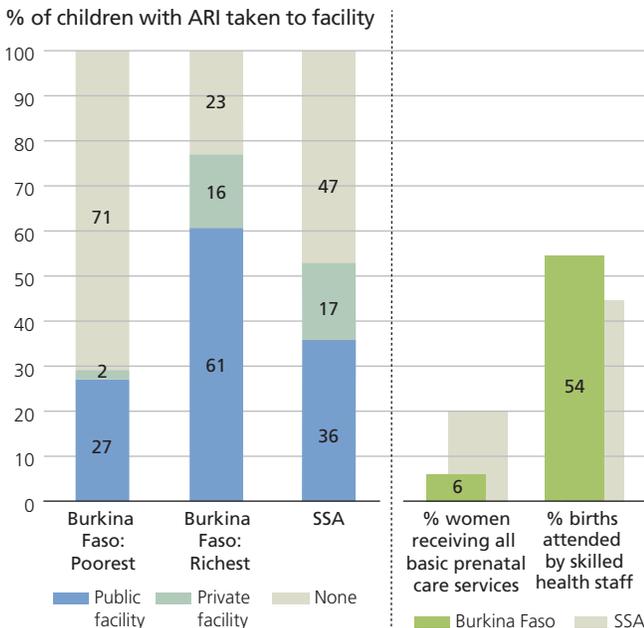
	Burkina Faso	SSA Average
Health expenditure per capita in current \$	29.3	95.3
Public sector share of total expenditure (%)	56.1	49.5
Private sector share of total expenditure (%)	43.9	50.5
Out-of-pocket expenditure (% of private expenditure)	91.3	72.4

## Business Environment

	Burkina Faso	SSA Average
Time to enforce a contract (days)	446	644
Time to prepare and pay taxes (hours per year)	270	317
Time to start a business (days)	14	44
Cost of business start-up (% of income per capita)	50	96

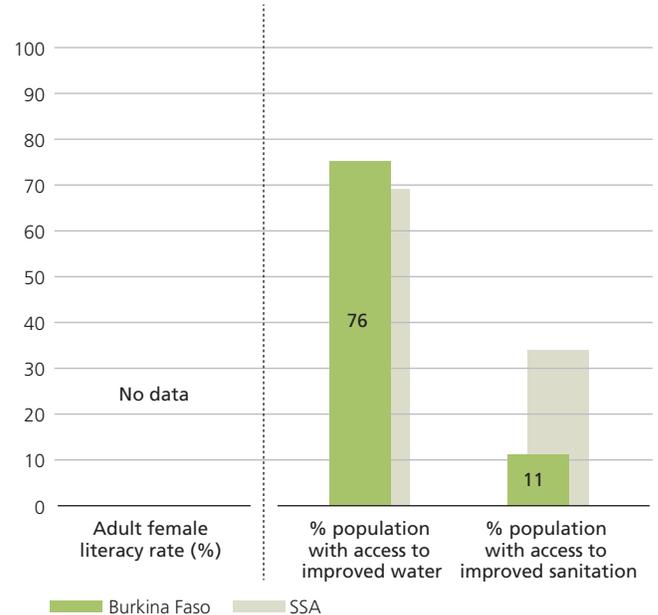
## Intermediate Outcomes

### Access and Quality



SSA = Sub-Saharan Africa average

## Supporting Services



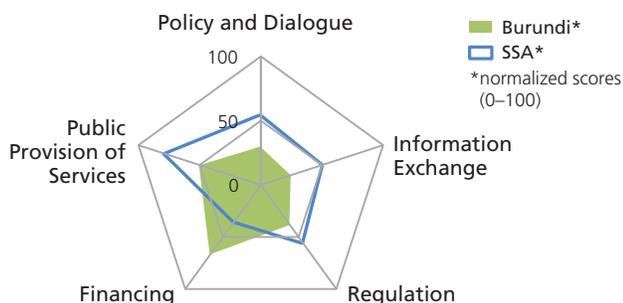
# Burundi

Population: 8.3 million  
 GNI per capita (Atlas method): US\$140  
 Life expectancy: 50 years

MDG 4	Under-5 mortality rate (per 1,000)	166
MDG 5	Maternal mortality ratio (per 100,000 live births)	970
MDG 6	HIV prevalence (among ages 15–49)	2.0
	(% of population)	0.4
	Tuberculosis incidence	48.5
	Malaria (notified cases)	



## Engagement



Category	Score	Maximum
Policy and dialogue	3	10
Information exchange	2	8
Regulation	5	13
Financing	4	6
Public provision of services	1	2

## Health Expenditure

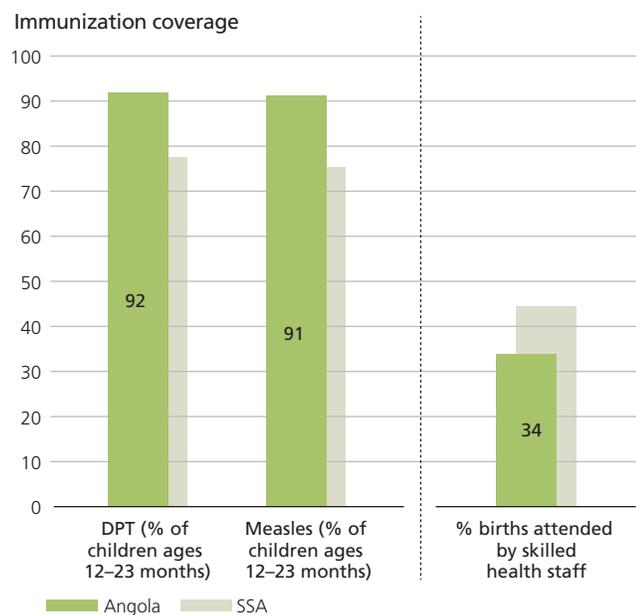
	Burundi	SSA Average
Health expenditure per capita in current \$	17.3	95.3
Public sector share of total expenditure (%)	37.7	49.5
Private sector share of total expenditure (%)	62.3	50.5
Out-of-pocket expenditure (% of private expenditure)	60.5	72.4

## Business Environment

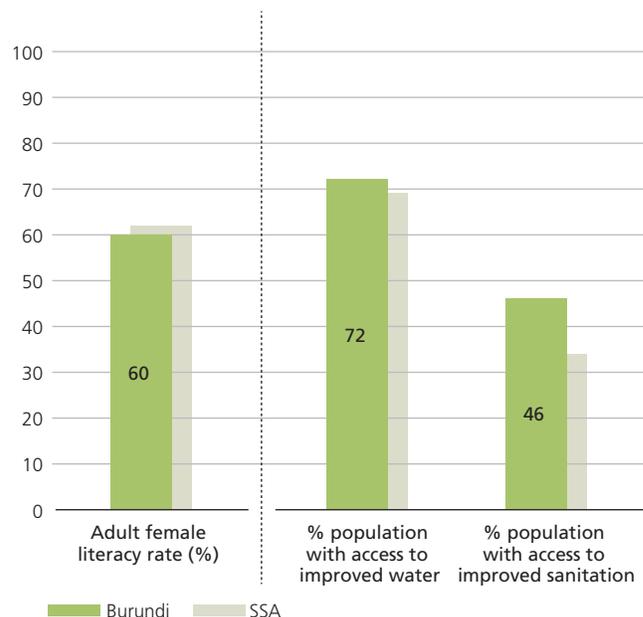
	Burundi	SSA Average
Time to enforce a contract (days)	832	644
Time to prepare and pay taxes (hours per year)	211	317
Time to start a business (days)	32	44
Cost of business start-up (% of income per capita)	129	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

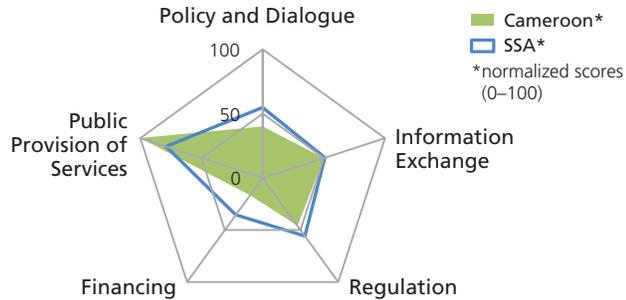
# Cameroon

Population: 19.5 million  
 GNI per capita (Atlas method): US\$1,140  
 Life expectancy: 51 years

MDG 4	Under-5 mortality rate (per 1,000)	154
MDG 5	Maternal mortality ratio (per 100,000 live births)	600
MDG 6	HIV prevalence (among ages 15–49)	5.1
	(% of population)	0.2
	Tuberculosis incidence	27.8
	Malaria (notified cases)	



## Engagement



	Score	Maximum
Policy and dialogue	4	10
Information exchange	4	8
Regulation	6	13
Financing	1	6
Public provision of services	2	2

## Health Expenditure

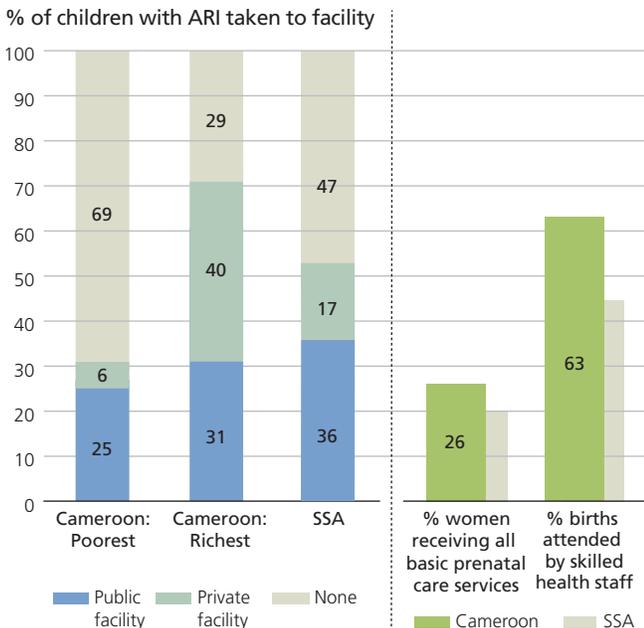
	Cameroon	SSA Average
Health expenditure per capita in current \$	54.3	95.3
Public sector share of total expenditure (%)	25.9	49.5
Private sector share of total expenditure (%)	74.1	50.5
Out-of-pocket expenditure (% of private expenditure)	94.5	72.4

## Business Environment

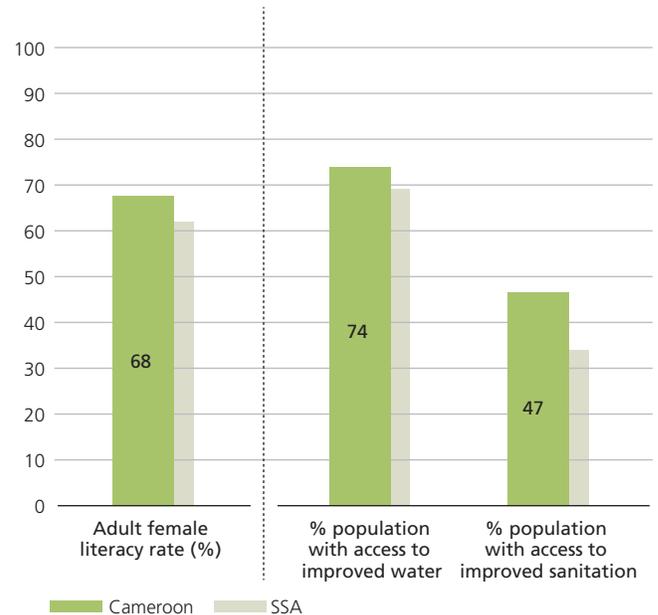
	Cameroon	SSA Average
Time to enforce a contract (days)	800	644
Time to prepare and pay taxes (hours per year)	654	317
Time to start a business (days)	19	44
Cost of business start-up (% of income per capita)	51	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

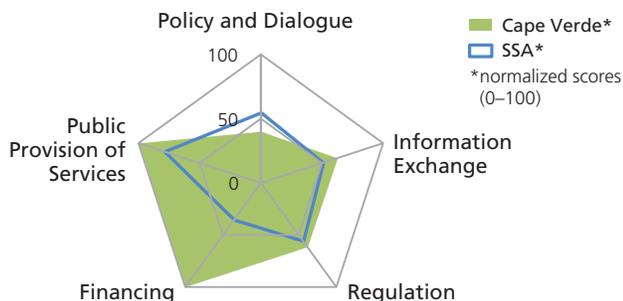
# Cape Verde

Population: .5 million  
 GNI per capita (Atlas method): US\$2,830  
 Life expectancy: 71 years

MDG 4	Under-5 mortality rate (per 1,000)	28
MDG 5	Maternal mortality ratio (per 100,000 live births)	94
MDG 6	HIV prevalence (among ages 15–49)	—
	(% of population)	0.2
	Tuberculosis incidence	0.02
	Malaria (notified cases)	0.02



## Engagement



	Score	Maximum
Policy and dialogue	4	10
Information exchange	5	8
Regulation	8	13
Financing	6	6
Public provision of services	2	2

## Health Expenditure

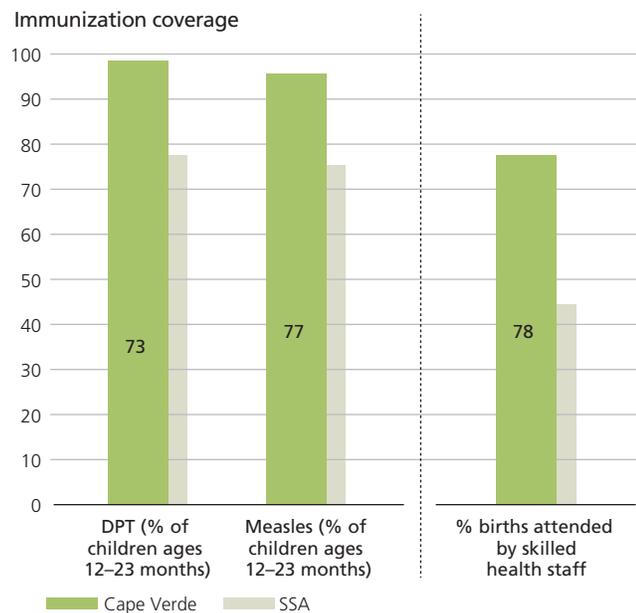
	Cape Verde	SSA Average
Health expenditure per capita in current \$	132.3	95.3
Public sector share of total expenditure (%)	74.6	49.5
Private sector share of total expenditure (%)	25.4	50.5
Out-of-pocket expenditure (% of private expenditure)	99.7	72.4

## Business Environment

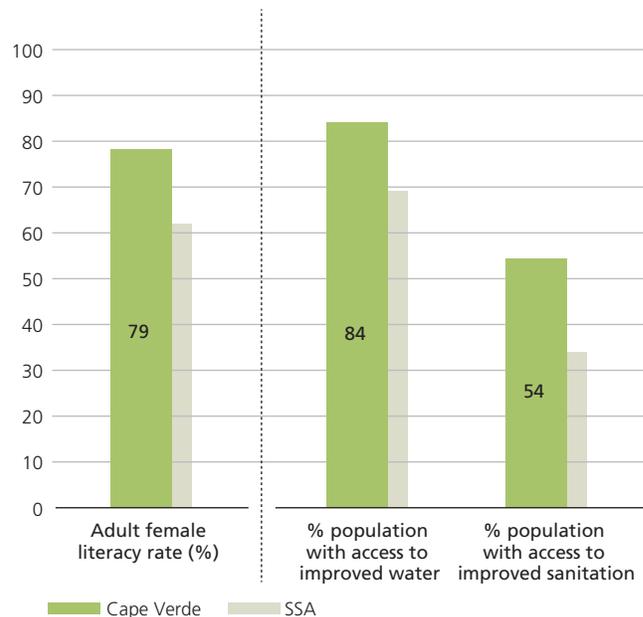
	Cape Verde	SSA Average
Time to enforce a contract (days)	425	644
Time to prepare and pay taxes (hours per year)	186	317
Time to start a business (days)	11	44
Cost of business start-up (% of income per capita)	19	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

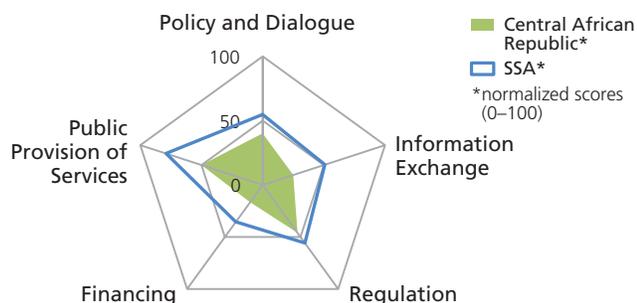
# Central African Republic



Population: 4.4 million  
 GNI per capita (Atlas method): US\$410  
 Life expectancy: 47 years

MDG 4	Under-5 mortality rate (per 1,000)	171
MDG 5	Maternal mortality (per 100,000 live births)	850
MDG 6	HIV prevalence ratio (among ages 15–49)	6.3
	(% of Tuberculosis incidence population)	0.3
	Malaria (notified cases)	35.8

## Engagement



	Score	Maximum
Policy and dialogue	4	10
Information exchange	2	8
Regulation	6	13
Financing	1	6
Public provision of services	1	2

## Health Expenditure

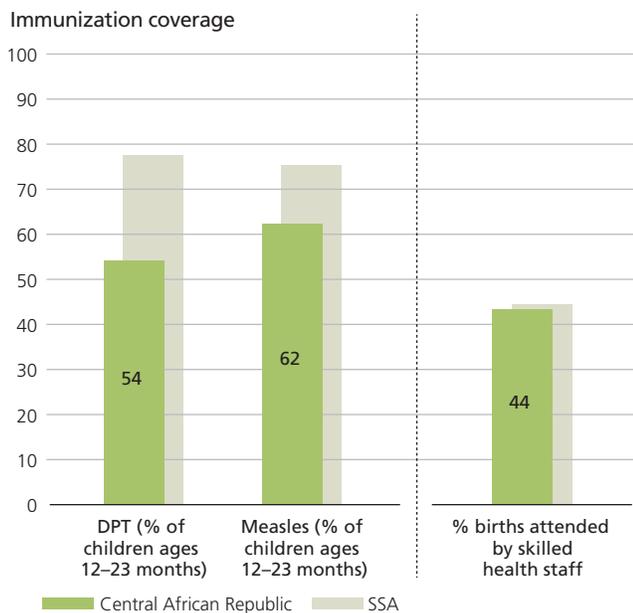
	C.A.R.	SSA Average
Health expenditure per capita in current \$	16.5	95.3
Public sector share of total expenditure (%)	34.7	49.5
Private sector share of total expenditure (%)	65.3	50.5
Out-of-pocket expenditure (% of private expenditure)	95.0	72.4

## Business Environment

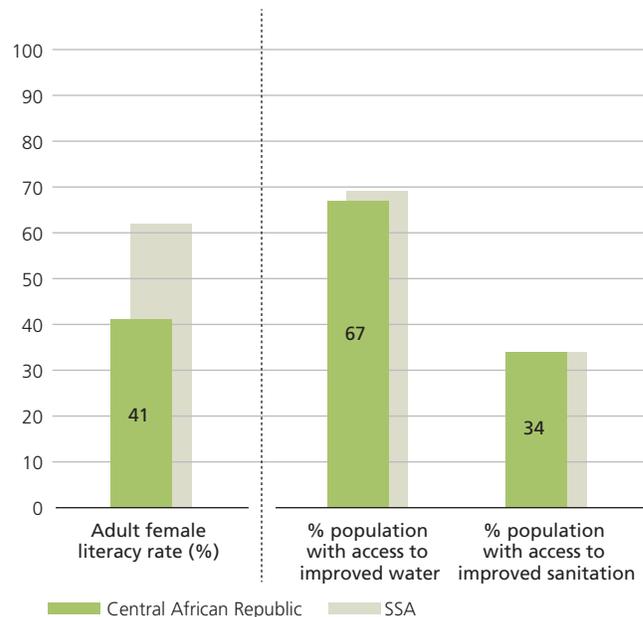
	C.A.R.	SSA Average
Time to enforce a contract (days)	660	644
Time to prepare and pay taxes (hours per year)	504	317
Time to start a business (days)	22	44
Cost of business start-up (% of income per capita)	228	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services

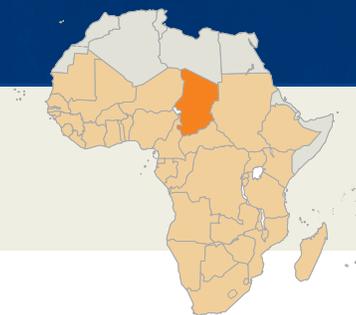


SSA = Sub-Saharan Africa average

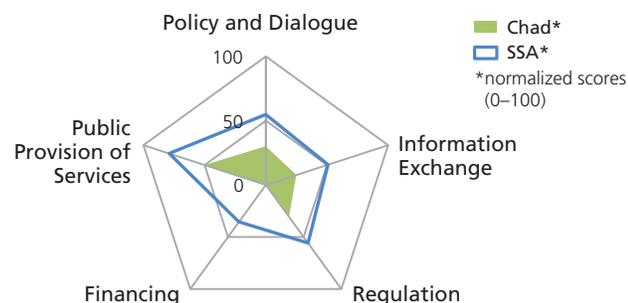
# Chad

Population: 11.2 million  
 GNI per capita (Atlas method): US\$540  
 Life expectancy: 49 years

MDG 4	Under-5 mortality rate (per 1,000)	209
MDG 5	Maternal mortality ratio (per 100,000 live births)	1,200
MDG 6	HIV prevalence (among ages 15–49)	3.5
	(% of population)	0.3
	Tuberculosis incidence	39.5
	Malaria (notified cases)	



## Engagement



	Score	Maximum
Policy and dialogue	3	10
Information exchange	2	8
Regulation	4	13
Financing	0	6
Public provision of services	1	2

## Health Expenditure

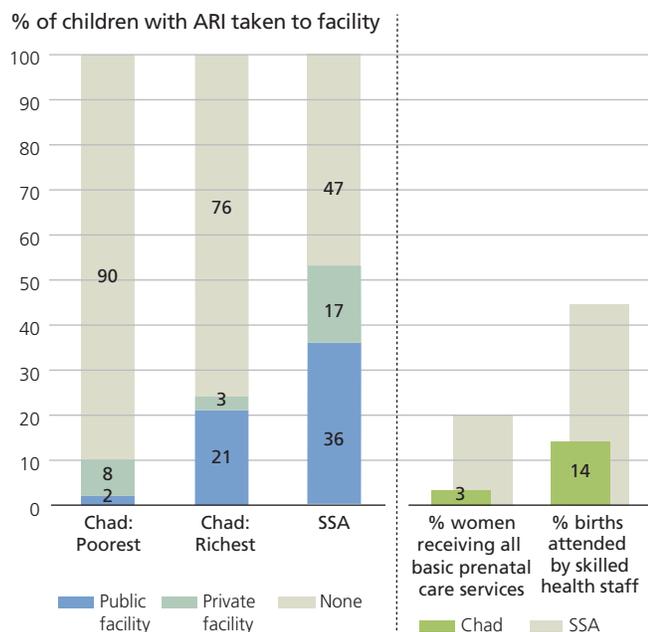
	Chad	SSA Average
Health expenditure per capita in current \$	31.7	95.3
Public sector share of total expenditure (%)	56.3	49.5
Private sector share of total expenditure (%)	43.7	50.5
Out-of-pocket expenditure (% of private expenditure)	96.2	72.4

## Business Environment

	Chad	SSA Average
Time to enforce a contract (days)	743	644
Time to prepare and pay taxes (hours per year)	732	317
Time to start a business (days)	75	44
Cost of business start-up (% of income per capita)	227	96

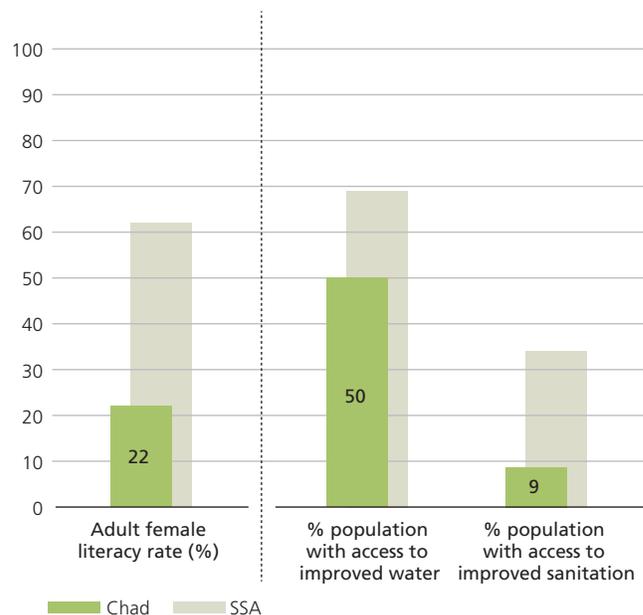
## Intermediate Outcomes

### Access and Quality



SSA = Sub-Saharan Africa average

## Supporting Services



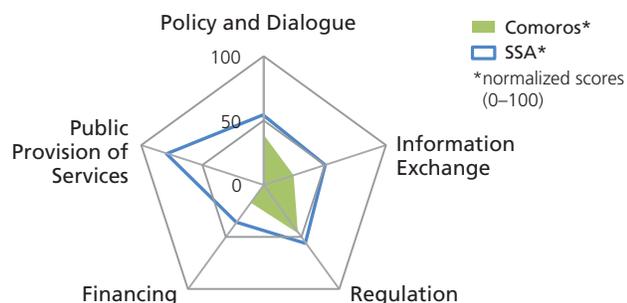
# Comoros

Population: .7 million  
 GNI per capita (Atlas method): US\$750  
 Life expectancy: 65 years

MDG 4	Under-5 mortality rate (per 1,000)	104
MDG 5	Maternal mortality ratio (per 100,000 live births)	340
MDG 6	HIV prevalence (among ages 15–49)	0.1
	(% of population)	0.0
	Tuberculosis incidence	0.0
	Malaria (notified cases)	24.6



## Engagement



	Score	Maximum
Policy and dialogue	4	10
Information exchange	2	8
Regulation	6	13
Financing	1	6
Public provision of services	0	2

## Health Expenditure

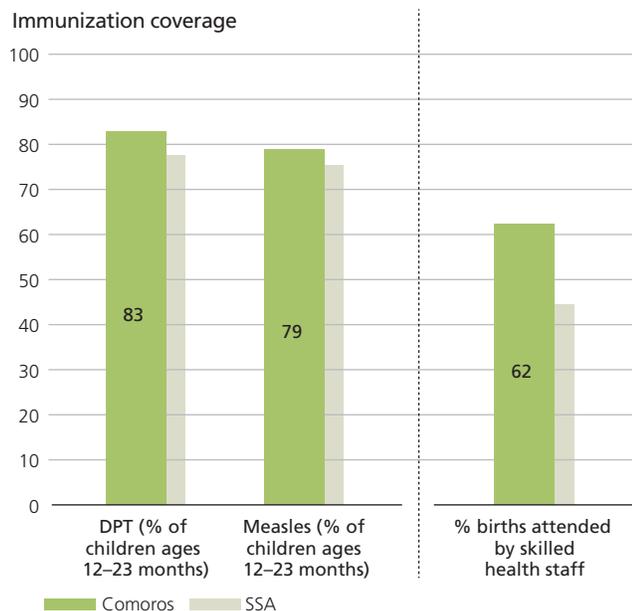
	Comoros	SSA Average
Health expenditure per capita in current \$	23.5	95.3
Public sector share of total expenditure (%)	57.2	49.5
Private sector share of total expenditure (%)	42.8	50.5
Out-of-pocket expenditure (% of private expenditure)	100.0	72.4

## Business Environment

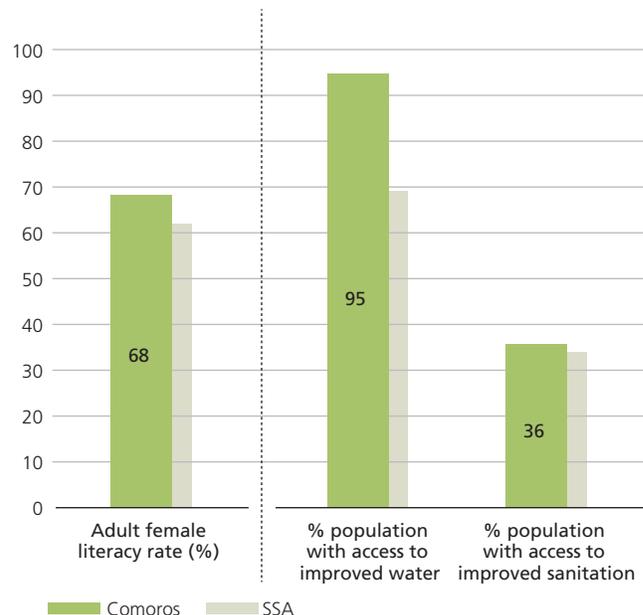
	Comoros	SSA Average
Time to enforce a contract (days)	506	644
Time to prepare and pay taxes (hours per year)	100	317
Time to start a business (days)	24	44
Cost of business start-up (% of income per capita)	177	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

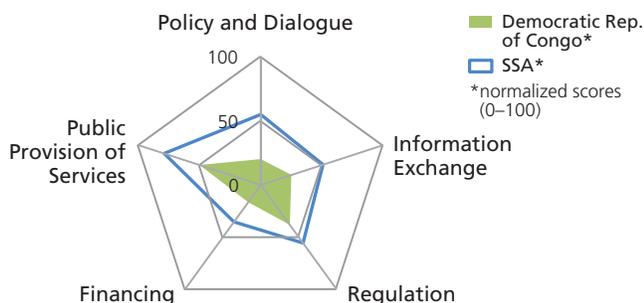
# Democratic Republic of Congo

Population: 66.0 million  
 GNI per capita (Atlas method): US\$150  
 Life expectancy: 48 years

MDG 4	Under-5 mortality rate (per 1,000)	199
MDG 5	Maternal mortality ratio (per 100,000 live births)	670
MDG 6	HIV prevalence (among ages 15–49)	—
	(% of population) Tuberculosis incidence	0.4
	Malaria (notified cases)	37.4



## Engagement



	Score	Maximum
Policy and dialogue	2	10
Information exchange	2	8
Regulation	5	13
Financing	1	6
Public provision of services	1	2

## Health Expenditure

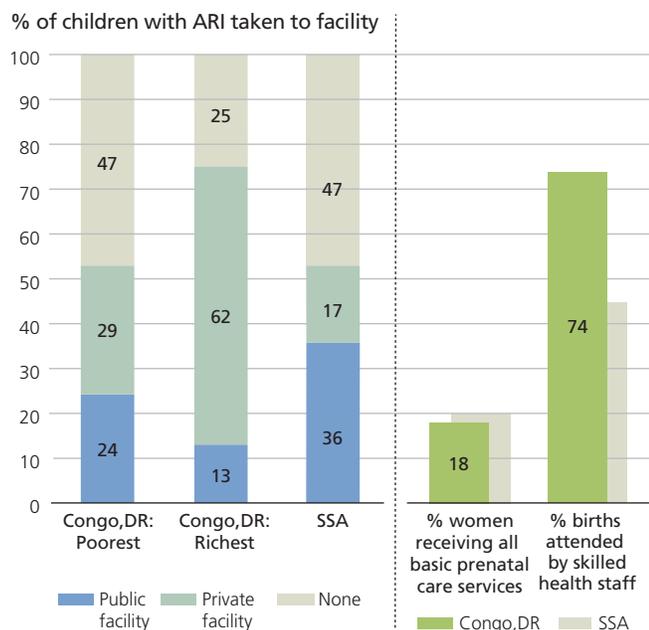
	Congo, DR	SSA Average
Health expenditure per capita in current \$	9.2	95.3
Public sector share of total expenditure (%)	20.8	49.5
Private sector share of total expenditure (%)	79.2	50.5
Out-of-pocket expenditure (% of private expenditure)	51.7	72.4

## Business Environment

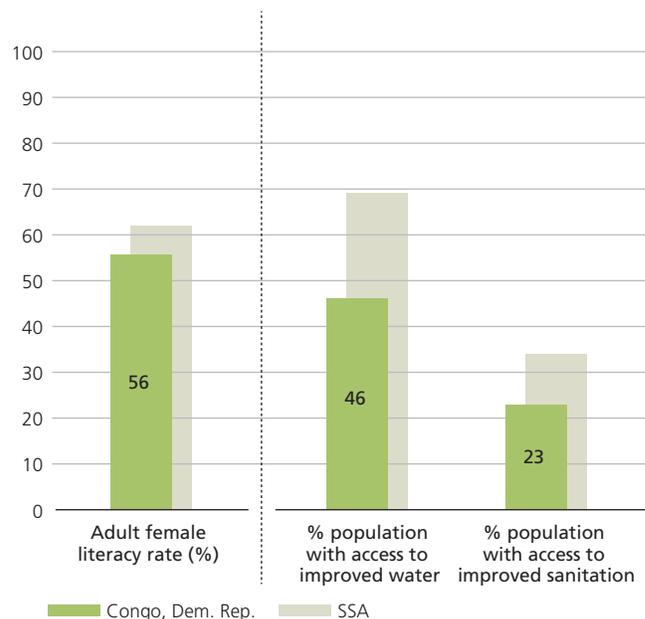
	Congo, DR	SSA Average
Time to enforce a contract (days)	625	644
Time to prepare and pay taxes (hours per year)	336	317
Time to start a business (days)	84	44
Cost of business start-up (% of income per capita)	735	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

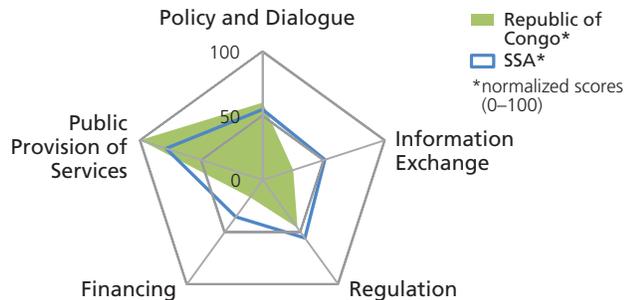
# Republic of Congo

Population: 3.7 million  
 GNI per capita (Atlas method): US\$1,980  
 Life expectancy: 54 years

MDG 4	Under-5 mortality rate (per 1,000)	128
MDG 5	Maternal mortality ratio (per 100,000 live births)	580
MDG 6	HIV prevalence (among ages 15–49)	3.5
	(% of population)	0.4
	Tuberculosis incidence	34.3
	Malaria (notified cases)	



## Engagement



Category	Score	Maximum
Policy and dialogue	6	10
Information exchange	2	8
Regulation	6	13
Financing	1	6
Public provision of services	2	2

## Health Expenditure

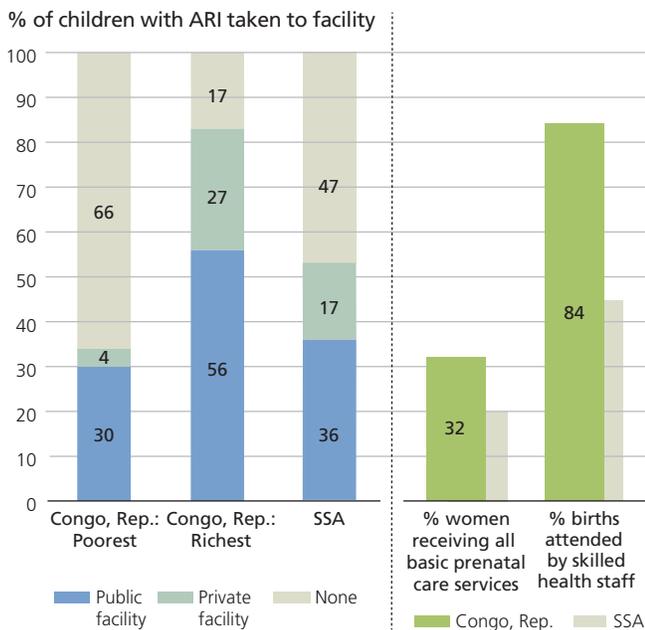
	Congo, Rep.	SSA Average
Health expenditure per capita in current \$	51.8	95.3
Public sector share of total expenditure (%)	70.4	49.5
Private sector share of total expenditure (%)	29.6	50.5
Out-of-pocket expenditure (% of private expenditure)	100.0	72.4

## Business Environment

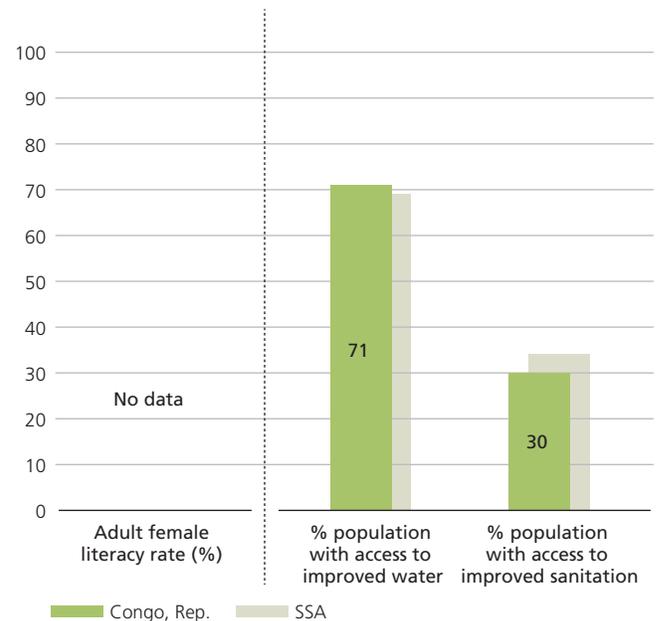
	Congo, Rep.	SSA Average
Time to enforce a contract (days)	560	644
Time to prepare and pay taxes (hours per year)	606	317
Time to start a business (days)	160	44
Cost of business start-up (% of income per capita)	111	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

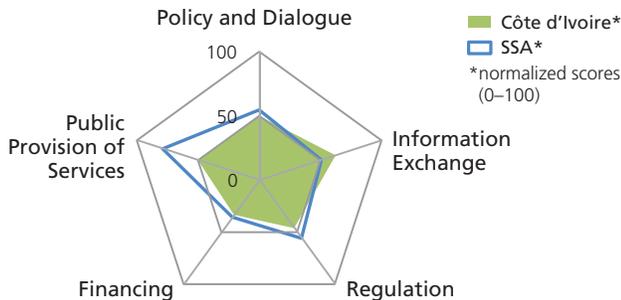
# Côte d'Ivoire

Population: 21.1 million  
 GNI per capita (Atlas method): US\$980  
 Life expectancy: 57 years

MDG 4	Under-5 mortality rate (per 1,000)	119
MDG 5	Maternal mortality ratio (per 100,000 live births)	470
MDG 6	HIV prevalence (among ages 15–49)	3.9
	(% of Tuberculosis incidence population)	0.4
	Malaria (notified cases)	36.5



## Engagement



Category	Score	Maximum
Policy and dialogue	5	10
Information exchange	5	8
Regulation	6	13
Financing	2	6
Public provision of services	1	2

## Health Expenditure

	Côte d'Ivoire	SSA Average
Health expenditure per capita in current \$	40.7	95.3
Public sector share of total expenditure (%)	24.0	49.5
Private sector share of total expenditure (%)	76.0	50.5
Out-of-pocket expenditure (% of private expenditure)	88.7	72.4

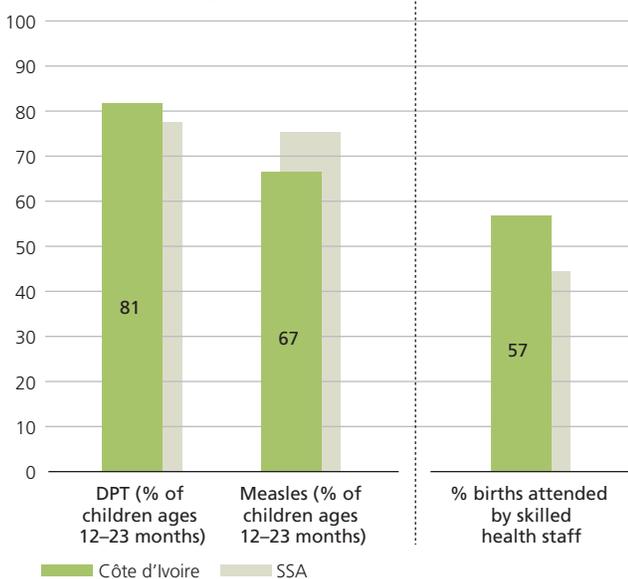
## Business Environment

	Côte d'Ivoire	SSA Average
Time to enforce a contract (days)	770	644
Time to prepare and pay taxes (hours per year)	270	317
Time to start a business (days)	40	44
Cost of business start-up (% of income per capita)	133	96

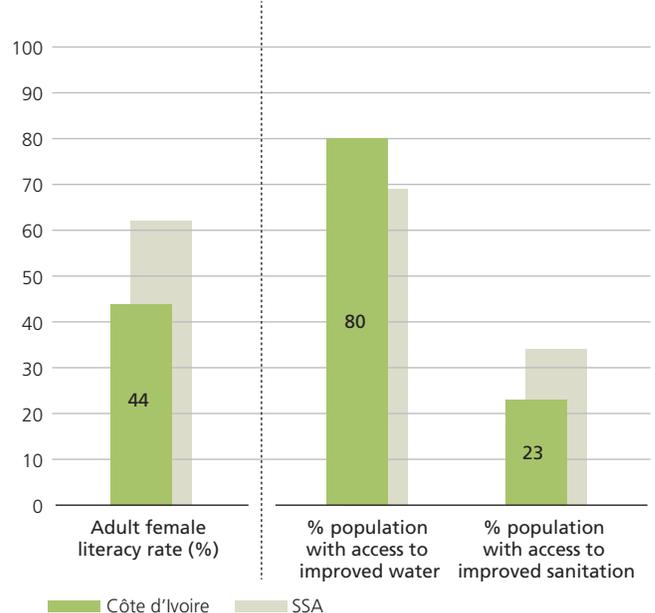
## Intermediate Outcomes

### Access and Quality

#### Immunization coverage



## Supporting Services



SSA = Sub-Saharan Africa average

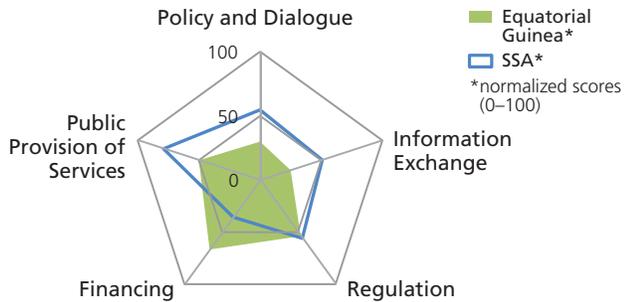
# Equatorial Guinea



Population: .7 million  
 GNI per capita (Atlas method): US\$14,980  
 Life expectancy: 50 years

MDG 4	Under-5 mortality rate (per 1,000)	145
MDG 5	Maternal mortality ratio (per 100,000 live births)	280
MDG 6	HIV prevalence (among ages 15–49)	3.4
	(% of population)	0.1
	Tuberculosis incidence	27.7
	Malaria (notified cases)	

## Engagement



	Score	Maximum
Policy and dialogue	3	10
Information exchange	2	8
Regulation	7	13
Financing	4	6
Public provision of services	1	2

## Health Expenditure

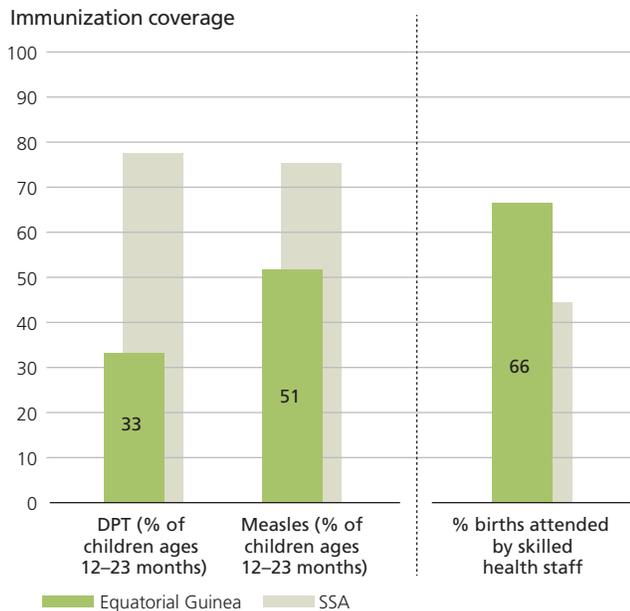
	Eq. Guinea	SSA Average
Health expenditure per capita in current \$	347.5	95.3
Public sector share of total expenditure (%)	80.4	49.5
Private sector share of total expenditure (%)	19.6	50.5
Out-of-pocket expenditure (% of private expenditure)	75.6	72.4

## Business Environment

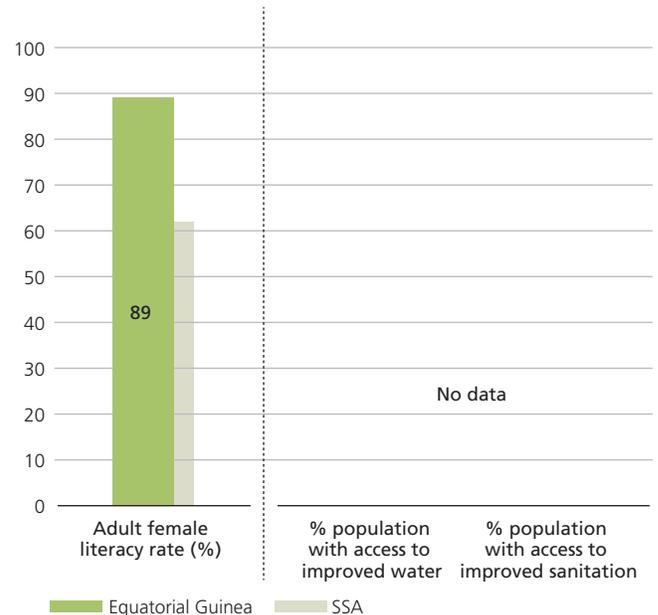
	Eq. Guinea	SSA Average
Time to enforce a contract (days)	553	644
Time to prepare and pay taxes (hours per year)	492	317
Time to start a business (days)	136	44
Cost of business start-up (% of income per capita)	104	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services

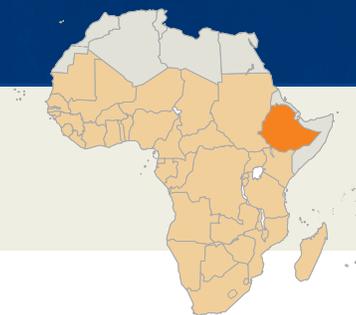


SSA = Sub-Saharan Africa average

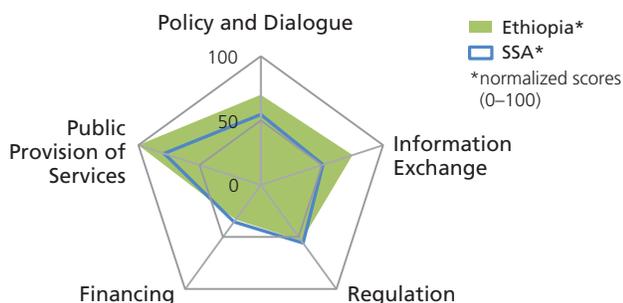
# Ethiopia

Population: 82.8 million  
 GNI per capita (Atlas method): US\$280  
 Life expectancy: 55 years

MDG 4	Under-5 mortality rate (per 1,000)	104
MDG 5	Maternal mortality ratio (per 100,000 live births)	470
MDG 6	HIV prevalence (among ages 15–49)	2.1
	(% of population)	0.4
	Tuberculosis incidence	11.5
	Malaria (notified cases)	



## Engagement



Category	Score	Maximum
Policy and dialogue	7	10
Information exchange	6	8
Regulation	7	13
Financing	2	6
Public provision of services	2	2

## Health Expenditure

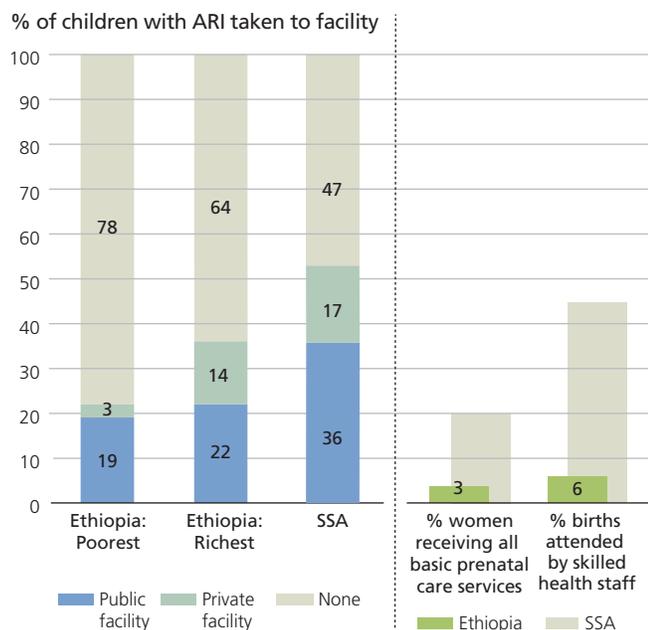
	Ethiopia	SSA Average
Health expenditure per capita in current \$	9.2	95.3
Public sector share of total expenditure (%)	58.1	49.5
Private sector share of total expenditure (%)	41.9	50.5
Out-of-pocket expenditure (% of private expenditure)	80.6	72.4

## Business Environment

	Ethiopia	SSA Average
Time to enforce a contract (days)	620	644
Time to prepare and pay taxes (hours per year)	198	317
Time to start a business (days)	9	44
Cost of business start-up (% of income per capita)	14	96

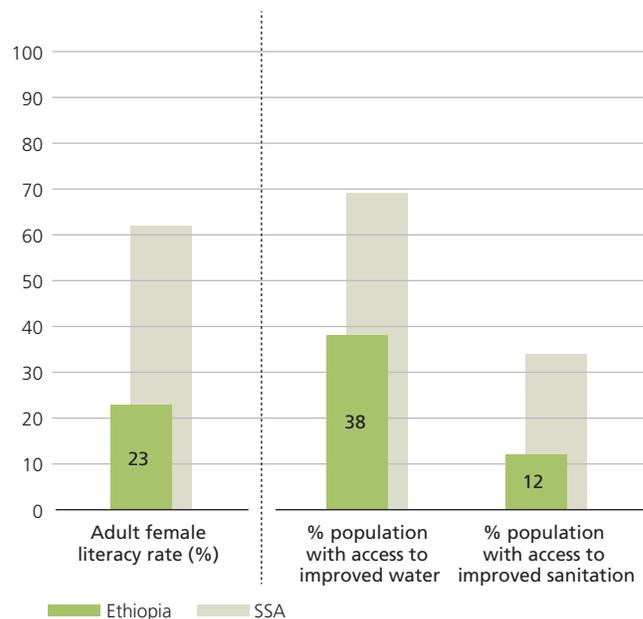
## Intermediate Outcomes

### Access and Quality



SSA = Sub-Saharan Africa average

## Supporting Services



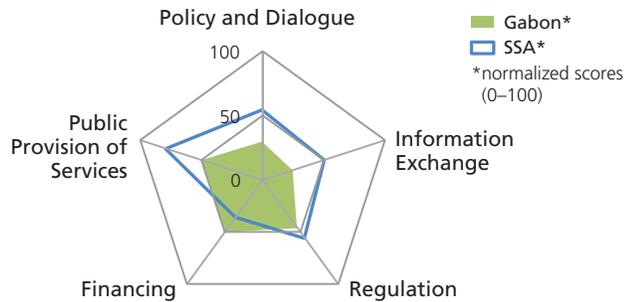
# Gabon

Population: 1.5 million  
 GNI per capita (Atlas method): US\$7,320  
 Life expectancy: 60 years

MDG 4	Under-5 mortality rate (per 1,000)	69
MDG 5	Maternal mortality ratio (per 100,000 live births)	260
MDG 6	HIV prevalence (among ages 15–49)	5.9
	(% of population)	0.5
	Tuberculosis incidence	29.5
	Malaria (notified cases)	29.5



## Engagement



	Score	Maximum
Policy and dialogue	3	10
Information exchange	2	8
Regulation	6	13
Financing	3	6
Public provision of services	1	2

## Health Expenditure

	Gabon	SSA Average
Health expenditure per capita in current \$	372.6	95.3
Public sector share of total expenditure (%)	64.5	49.5
Private sector share of total expenditure (%)	35.5	50.5
Out-of-pocket expenditure (% of private expenditure)	100.0	72.4

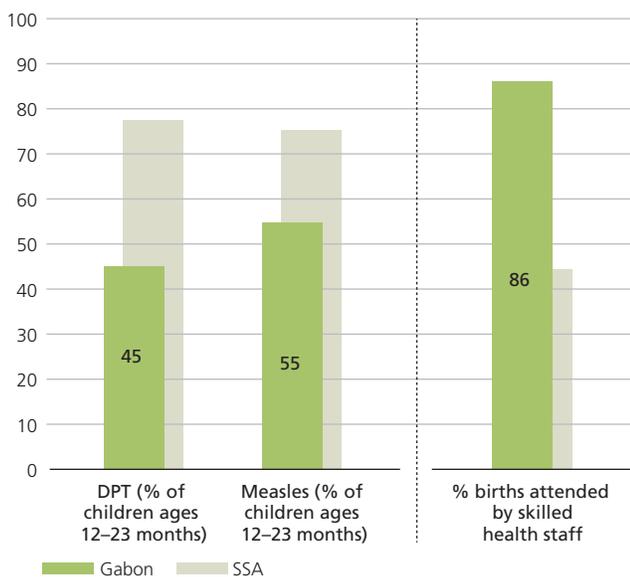
## Business Environment

	Gabon	SSA Average
Time to enforce a contract (days)	1,070	644
Time to prepare and pay taxes (hours per year)	488	317
Time to start a business (days)	58	44
Cost of business start-up (% of income per capita)	22	96

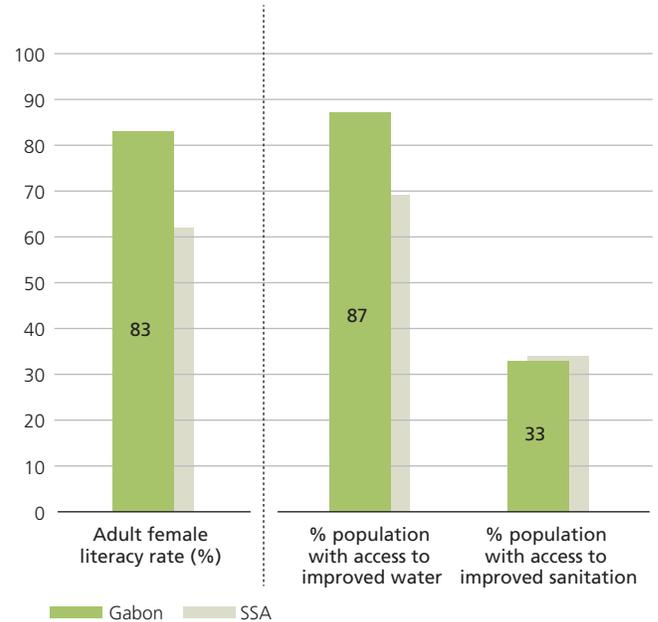
## Intermediate Outcomes

### Access and Quality

#### Immunization coverage



## Supporting Services



SSA = Sub-Saharan Africa average

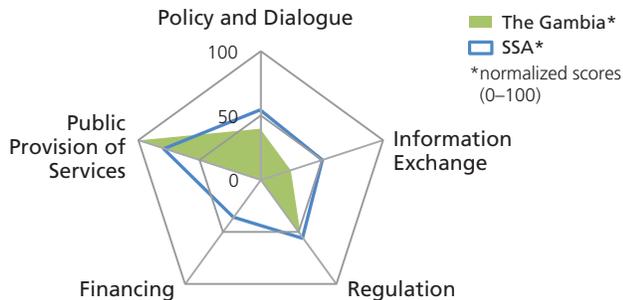
# The Gambia

Population: 1.7 million  
 GNI per capita (Atlas method): US\$400  
 Life expectancy: 56 years

MDG 4	Under-5 mortality rate (per 1,000)	103
MDG 5	Maternal mortality ratio (per 100,000 live births)	400
MDG 6	HIV prevalence (among ages 15–49)	0.9
	(% of Tuberculosis incidence population)	0.3
	Malaria (notified cases)	31.9



## Engagement



	Score	Maximum
Policy and dialogue	4	10
Information exchange	2	8
Regulation	7	13
Financing	0	6
Public provision of services	2	2

## Health Expenditure

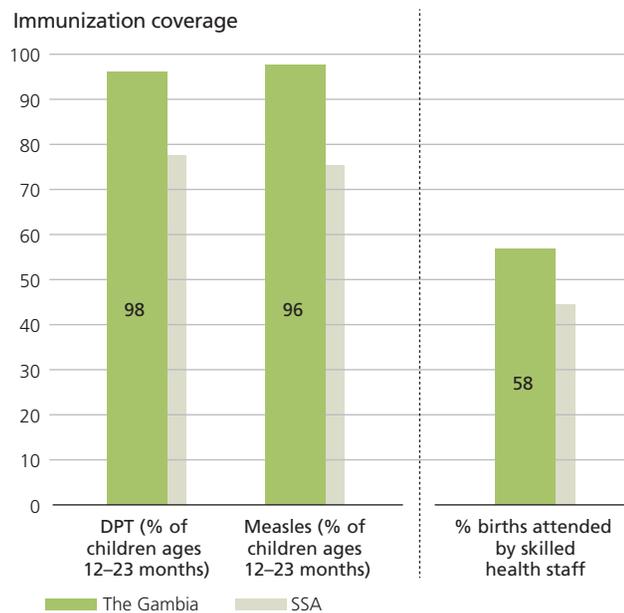
	The Gambia	SSA Average
Health expenditure per capita in current \$	21.9	95.3
Public sector share of total expenditure (%)	47.9	49.5
Private sector share of total expenditure (%)	52.1	50.5
Out-of-pocket expenditure (% of private expenditure)	48.4	72.4

## Business Environment

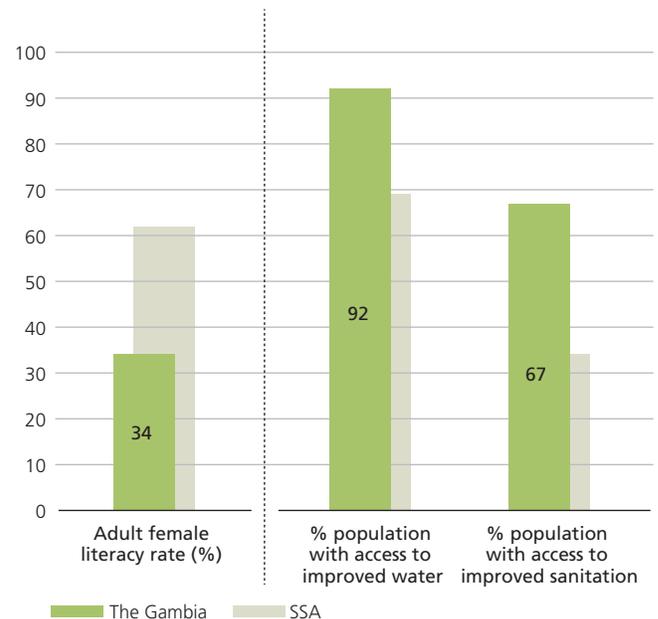
	The Gambia	SSA Average
Time to enforce a contract (days)	434	644
Time to prepare and pay taxes (hours per year)	376	317
Time to start a business (days)	27	44
Cost of business start-up (% of income per capita)	200	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

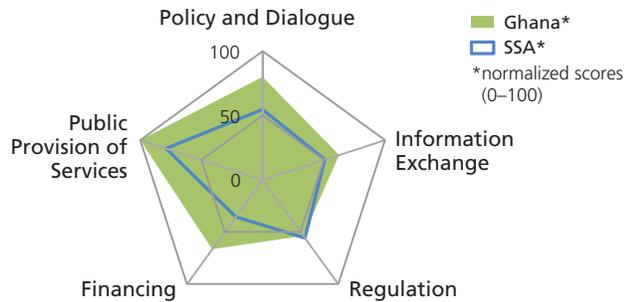
# Ghana

Population: 23.8 million  
 GNI per capita (Atlas method): US\$1,150  
 Life expectancy: 57 years

MDG 4	Under-5 mortality rate (per 1,000)	69
MDG 5	Maternal mortality ratio (per 100,000 live births)	350
MDG 6	HIV prevalence (among ages 15–49)	1.9
	(% of population)	0.2
	Tuberculosis incidence	31.2
	Malaria (notified cases)	



## Engagement



	Score	Maximum
Policy and dialogue	8	10
Information exchange	5	8
Regulation	7	13
Financing	4	6
Public provision of services	2	2

## Health Expenditure

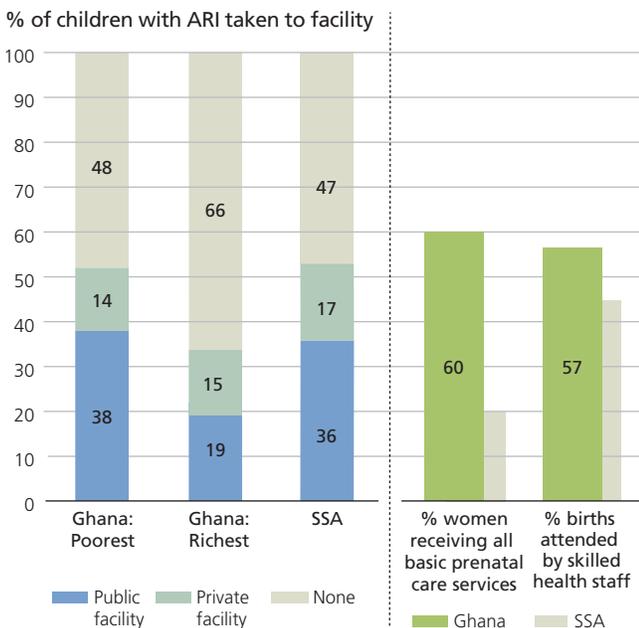
	Ghana	SSA Average
Health expenditure per capita in current \$	54.1	95.3
Public sector share of total expenditure (%)	51.6	49.5
Private sector share of total expenditure (%)	48.4	50.5
Out-of-pocket expenditure (% of private expenditure)	79.3	72.4

## Business Environment

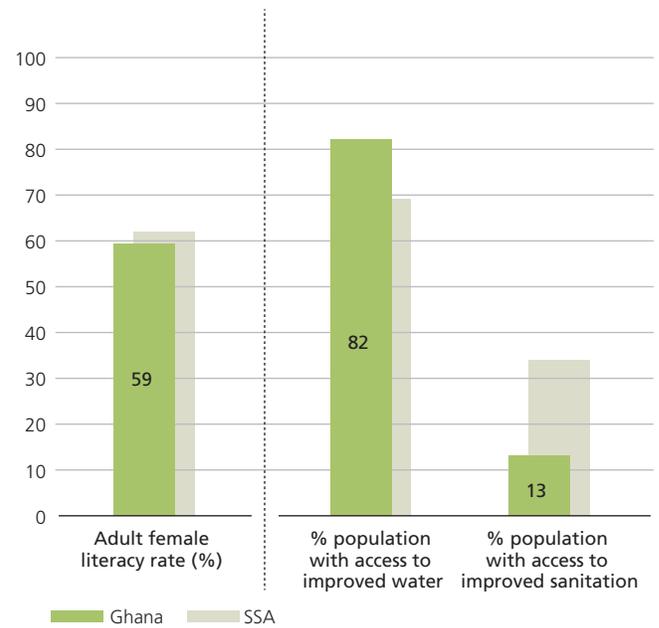
	Ghana	SSA Average
Time to enforce a contract (days)	487	644
Time to prepare and pay taxes (hours per year)	224	317
Time to start a business (days)	12	44
Cost of business start-up (% of income per capita)	20	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

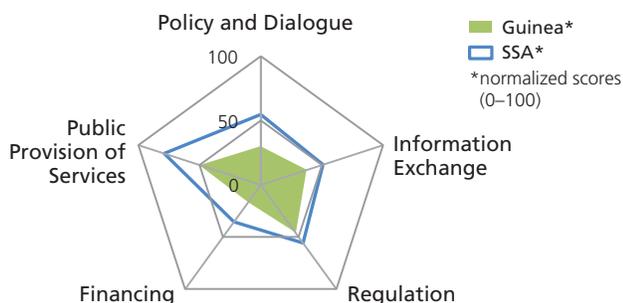
# Guinea

Population: 10.1 million  
 GNI per capita (Atlas method): US\$340  
 Life expectancy: 58 years

MDG 4	Under-5 mortality rate (per 1,000)	142
MDG 5	Maternal mortality ratio (per 100,000 live births)	680
MDG 6	HIV prevalence (among ages 15–49)	1.6
	(% of population)	0.3
	Tuberculosis incidence	40.6
	Malaria (notified cases)	



## Engagement



	Score	Maximum
Policy and dialogue	3	10
Information exchange	3	8
Regulation	6	13
Financing	1	6
Public provision of services	1	2

## Health Expenditure

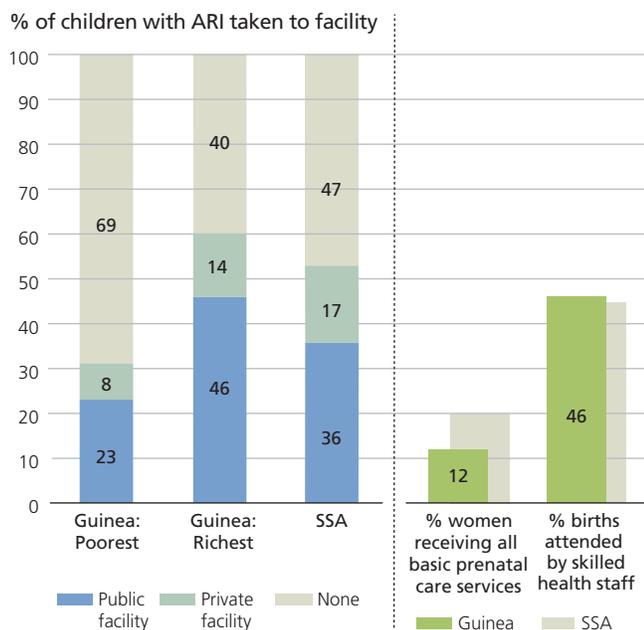
	Guinea	SSA Average
Health expenditure per capita in current \$	25.6	95.3
Public sector share of total expenditure (%)	11.0	49.5
Private sector share of total expenditure (%)	89.0	50.5
Out-of-pocket expenditure (% of private expenditure)	99.5	72.4

## Business Environment

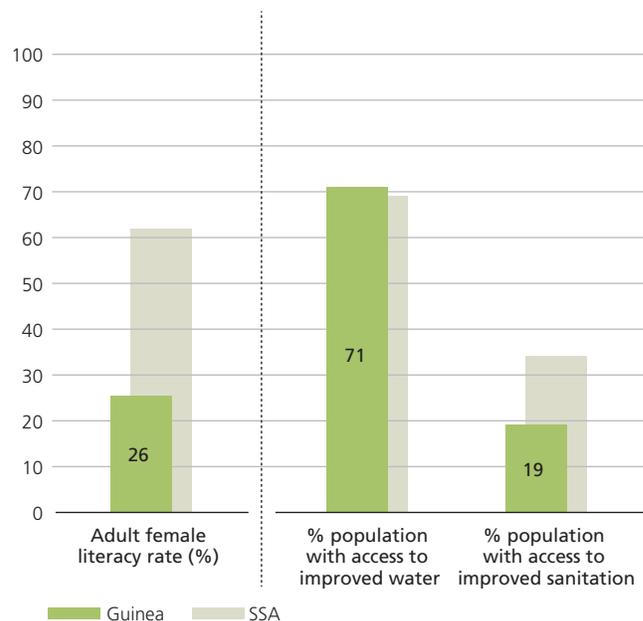
	Guinea	SSA Average
Time to enforce a contract (days)	276	644
Time to prepare and pay taxes (hours per year)	416	317
Time to start a business (days)	41	44
Cost of business start-up (% of income per capita)	147	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

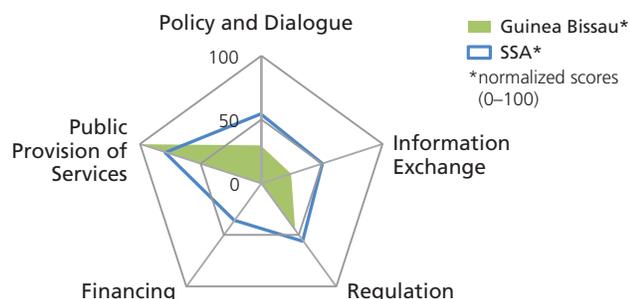
# Guinea-Bissau

Population: 1.6 million  
 GNI per capita (Atlas method): US\$460  
 Life expectancy: 48 years

MDG 4	Under-5 mortality rate (per 1,000)	193
MDG 5	Maternal mortality ratio (per 100,000 live births)	1,000
MDG 6	HIV prevalence (among ages 15–49)	1.8
	(% of population)	0.2
	Tuberculosis incidence	34.0
	Malaria (notified cases)	



## Engagement



	Score	Maximum
Policy and dialogue	3	10
Information exchange	2	8
Regulation	6	13
Financing	0	6
Public provision of services	2	2

## Health Expenditure

	Guinea-Bissau	SSA Average
Health expenditure per capita in current \$	15.5	95.3
Public sector share of total expenditure (%)	25.9	49.5
Private sector share of total expenditure (%)	74.1	50.5
Out-of-pocket expenditure (% of private expenditure)	55.7	72.4

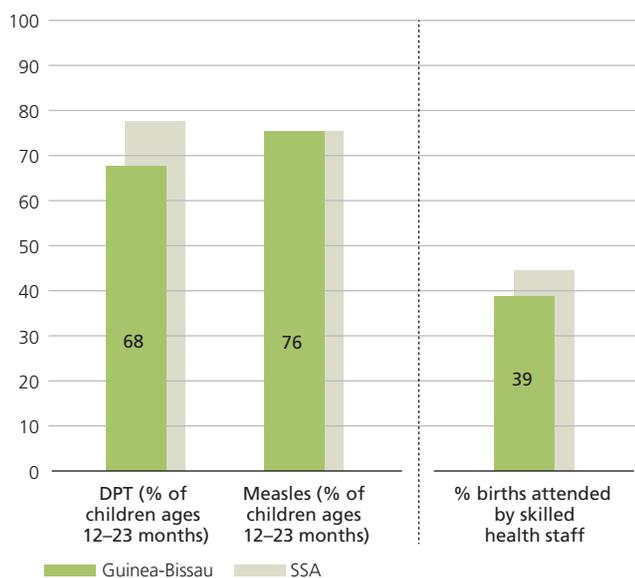
## Business Environment

	Guinea-Bissau	SSA Average
Time to enforce a contract (days)	1,140	644
Time to prepare and pay taxes (hours per year)	208	317
Time to start a business (days)	216	44
Cost of business start-up (% of income per capita)	183	96

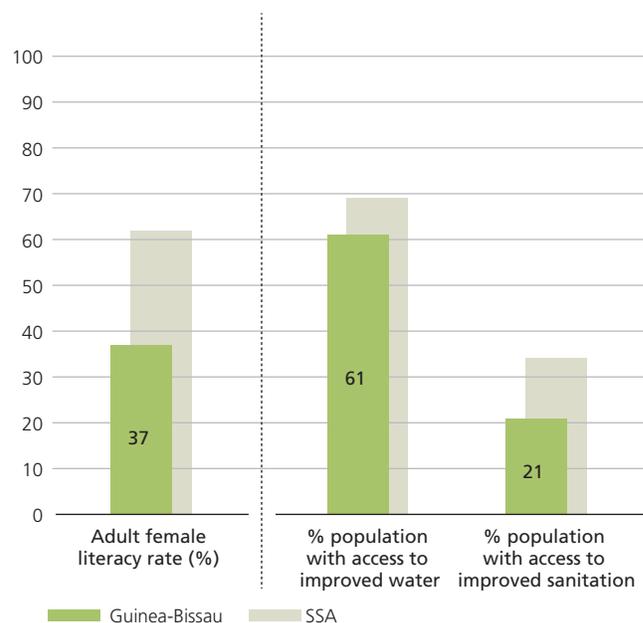
## Intermediate Outcomes

### Access and Quality

#### Immunization coverage



## Supporting Services



SSA = Sub-Saharan Africa average

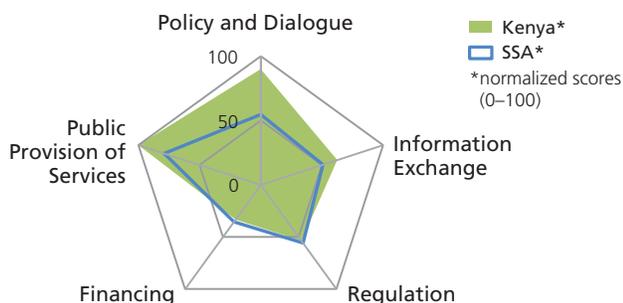
# Kenya

Population: 39.8 million  
 GNI per capita (Atlas method): US\$730  
 Life expectancy: 54 years

MDG 4	Under-5 mortality rate (per 1,000)	84
MDG 5	Maternal mortality ratio (per 100,000 live births)	530
MDG 6	HIV prevalence (among ages 15–49)	—
	(% of population)	0.3
	Tuberculosis incidence	30.3
	Malaria (notified cases)	30.3



## Engagement



	Score	Maximum
Policy and dialogue	9	10
Information exchange	5	8
Regulation	7	13
Financing	2	6
Public provision of services	2	2

## Health Expenditure

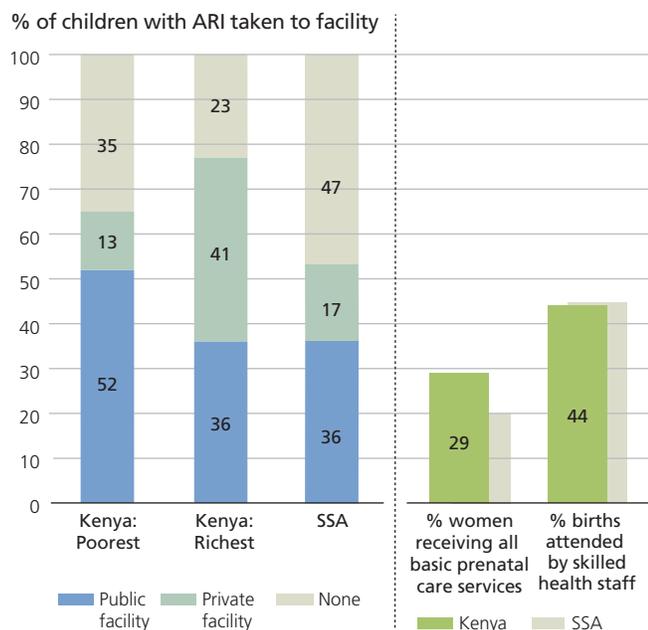
	Kenya	SSA Average
Health expenditure per capita in current \$	33.8	95.3
Public sector share of total expenditure (%)	42.0	49.5
Private sector share of total expenditure (%)	58.0	50.5
Out-of-pocket expenditure (% of private expenditure)	77.2	72.4

## Business Environment

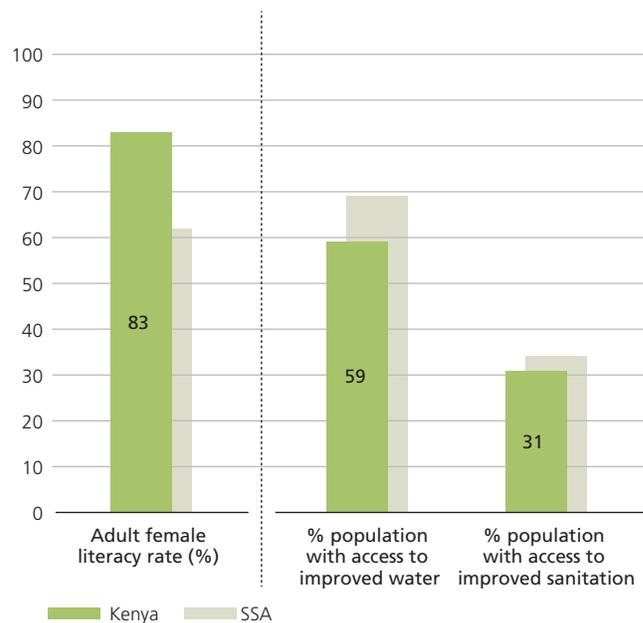
	Kenya	SSA Average
Time to enforce a contract (days)	465	644
Time to prepare and pay taxes (hours per year)	393	317
Time to start a business (days)	33	44
Cost of business start-up (% of income per capita)	38	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

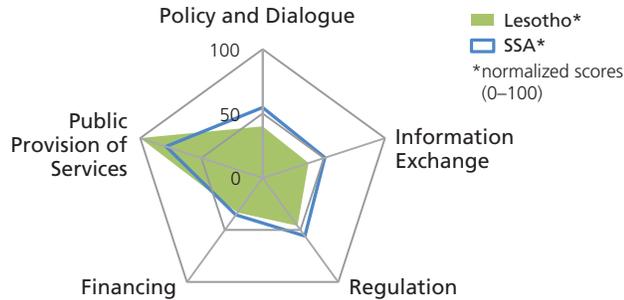
# Lesotho

Population: 2.1 million  
 GNI per capita (Atlas method): US\$1,010  
 Life expectancy: 45 years

MDG 4	Under-5 mortality rate (per 1,000)	84
MDG 5	Maternal mortality ratio (per 100,000 live births)	530
MDG 6	HIV prevalence (among ages 15–49)	23.2
	(% of population)	0.6
	Tuberculosis incidence	—
	Malaria (notified cases)	—



## Engagement



Category	Score	Maximum
Policy and dialogue	4	10
Information exchange	3	8
Regulation	6	13
Financing	2	6
Public provision of services	2	2

## Health Expenditure

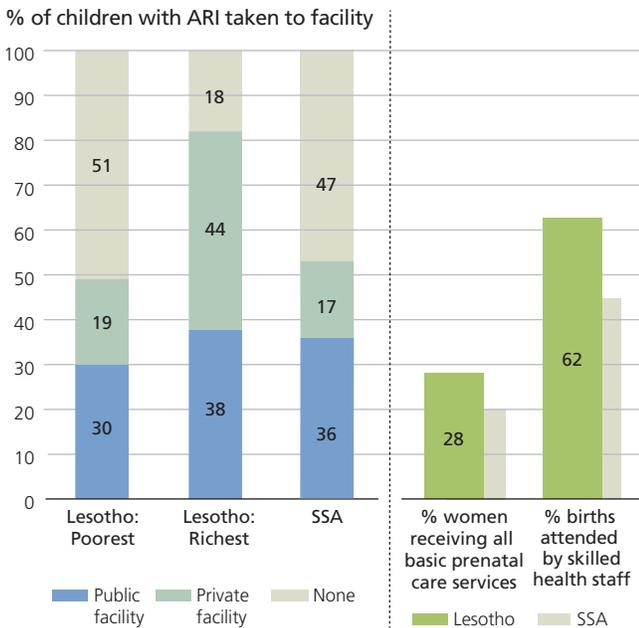
	Lesotho	SSA Average
Health expenditure per capita in current \$	51.1	95.3
Public sector share of total expenditure (%)	58.3	49.5
Private sector share of total expenditure (%)	41.7	50.5
Out-of-pocket expenditure (% of private expenditure)	68.9	72.4

## Business Environment

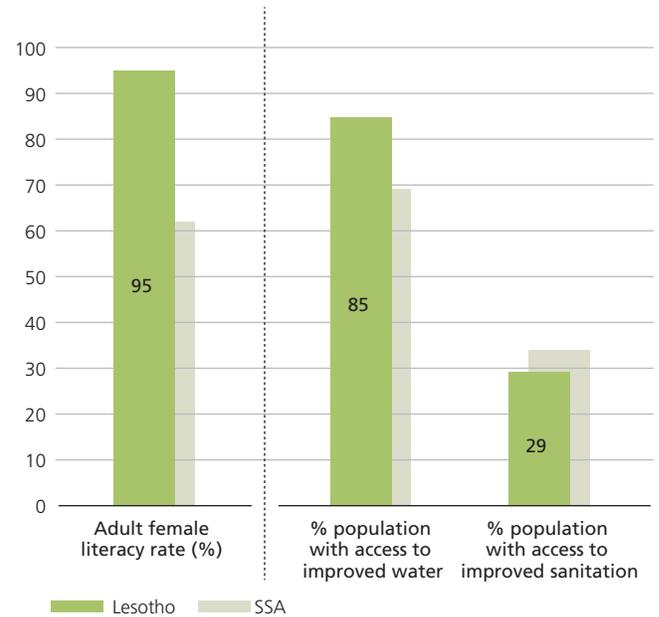
	Lesotho	SSA Average
Time to enforce a contract (days)	785	644
Time to prepare and pay taxes (hours per year)	324	317
Time to start a business (days)	40	44
Cost of business start-up (% of income per capita)	26	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

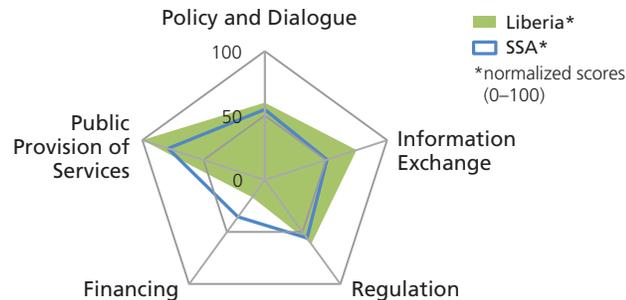
# Liberia

Population: 4.0 million  
 GNI per capita (Atlas method): US\$170  
 Life expectancy: 58 years

MDG 4	Under-5 mortality rate (per 1,000)	112
MDG 5	Maternal mortality ratio (per 100,000 live births)	990
MDG 6	HIV prevalence (among ages 15–49)	1.7
	(% of population)	0.3
	Tuberculosis incidence	30.0
	Malaria (notified cases)	



## Engagement



	Score	Maximum
Policy and dialogue	6	10
Information exchange	6	8
Regulation	8	13
Financing	1	6
Public provision of services	2	2

## Health Expenditure

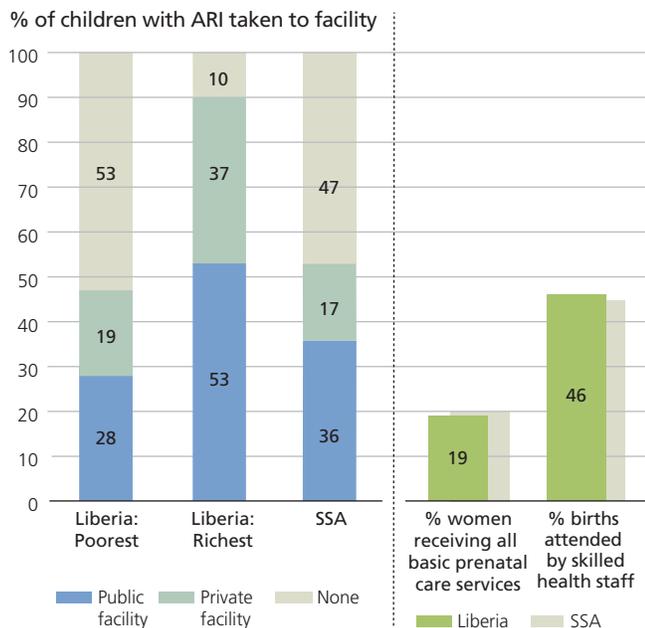
	Liberia	SSA Average
Health expenditure per capita in current \$	21.5	95.3
Public sector share of total expenditure (%)	26.2	49.5
Private sector share of total expenditure (%)	73.8	50.5
Out-of-pocket expenditure (% of private expenditure)	52.2	72.4

## Business Environment

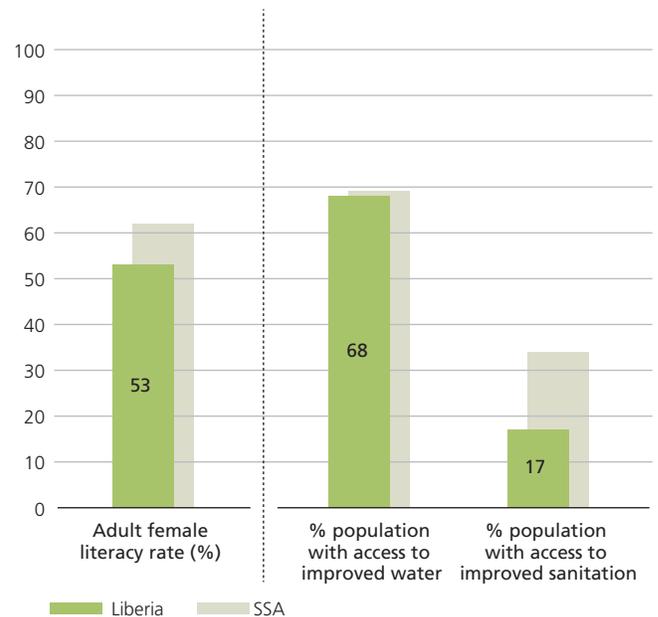
	Liberia	SSA Average
Time to enforce a contract (days)	1,280	644
Time to prepare and pay taxes (hours per year)	158	317
Time to start a business (days)	20	44
Cost of business start-up (% of income per capita)	55	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

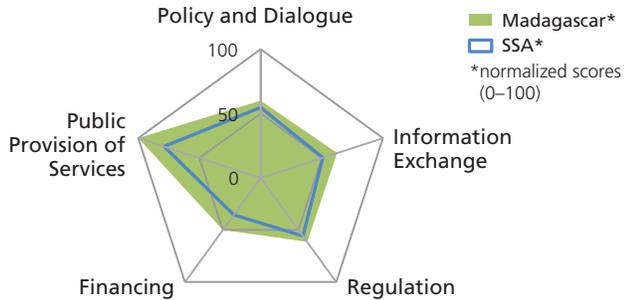
# Madagascar



Population: 19.6 million  
 GNI per capita (Atlas method): US\$420  
 Life expectancy: 60 years

MDG 4	Under-5 mortality rate (per 1,000)	58
MDG 5	Maternal mortality ratio (per 100,000 live births)	440
MDG 6	HIV prevalence (among ages 15–49)	0.1
	(% of tuberculosis incidence)	0.3
	(% of population)	3.7

## Engagement



Category	Score	Maximum
Policy and dialogue	6	10
Information exchange	5	8
Regulation	8	13
Financing	3	6
Public provision of services	2	2

## Health Expenditure

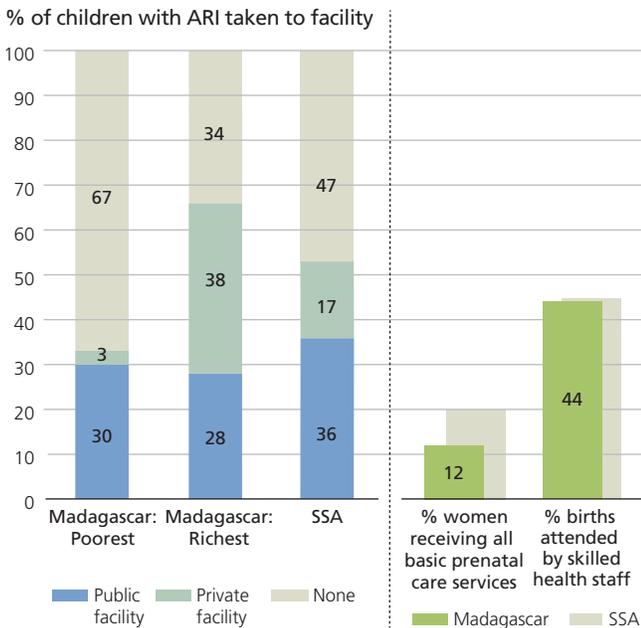
	Madagascar	SSA Average
Health expenditure per capita in current \$	16.3	95.3
Public sector share of total expenditure (%)	66.2	49.5
Private sector share of total expenditure (%)	33.8	50.5
Out-of-pocket expenditure (% of private expenditure)	67.9	72.4

## Business Environment

	Madagascar	SSA Average
Time to enforce a contract (days)	871	644
Time to prepare and pay taxes (hours per year)	201	317
Time to start a business (days)	7	44
Cost of business start-up (% of income per capita)	13	96

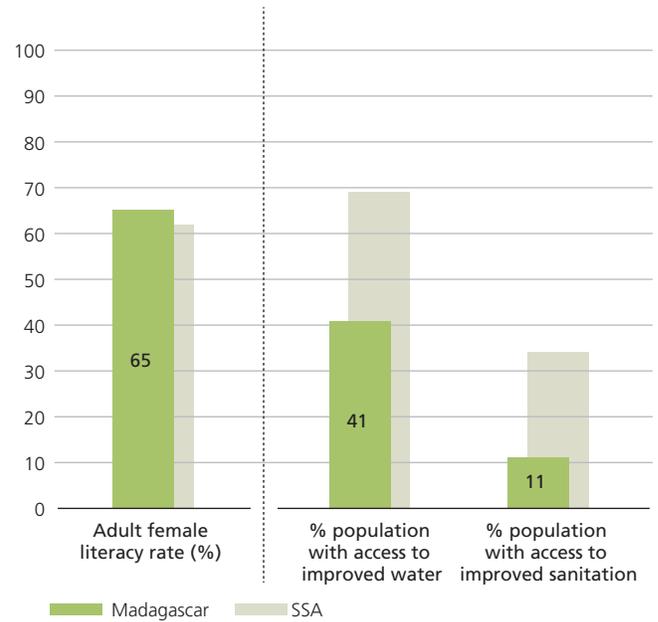
## Intermediate Outcomes

### Access and Quality



SSA = Sub-Saharan Africa average

## Supporting Services



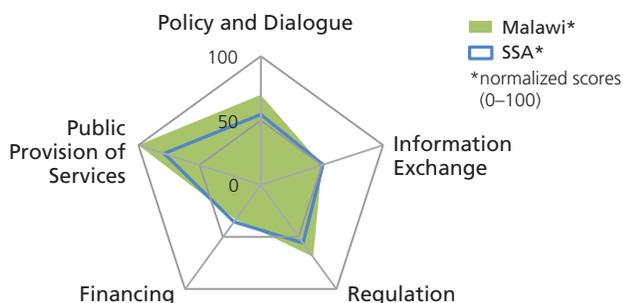
# Malawi

Population: 15.3 million  
 GNI per capita (Atlas method): US\$260  
 Life expectancy: 53 years

MDG 4	Under-5 mortality rate (per 1,000)	110
MDG 5	Maternal mortality ratio (per 100,000 live births)	510
MDG 6	HIV prevalence (among ages 15–49)	11.9
	(% of population)	0.3
	Tuberculosis incidence	33.8
	Malaria (notified cases)	



## Engagement



	Score	Maximum
Policy and dialogue	7	10
Information exchange	4	8
Regulation	9	13
Financing	2	6
Public provision of services	2	2

## Health Expenditure

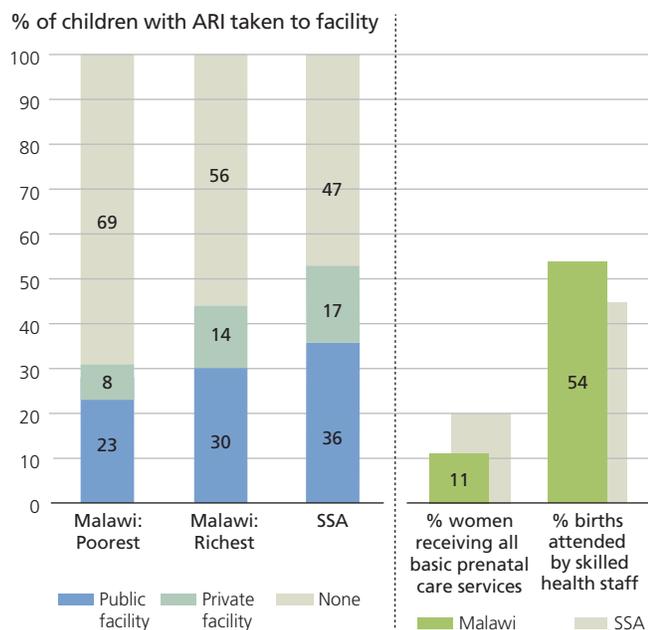
	Malawi	SSA Average
Health expenditure per capita in current \$	16.7	95.3
Public sector share of total expenditure (%)	59.7	49.5
Private sector share of total expenditure (%)	40.3	50.5
Out-of-pocket expenditure (% of private expenditure)	28.4	72.4

## Business Environment

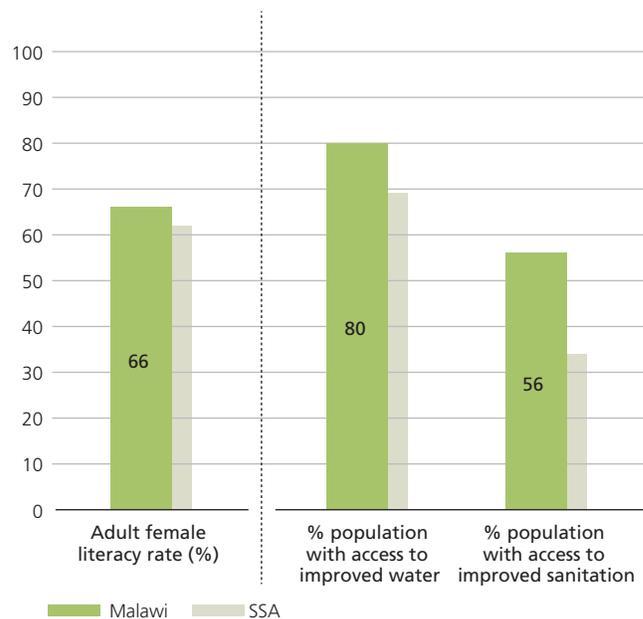
	Malawi	SSA Average
Time to enforce a contract (days)	312	644
Time to prepare and pay taxes (hours per year)	157	317
Time to start a business (days)	39	44
Cost of business start-up (% of income per capita)	108	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services

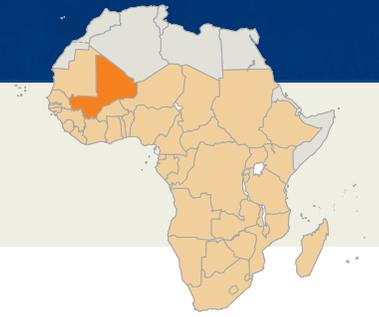


SSA = Sub-Saharan Africa average

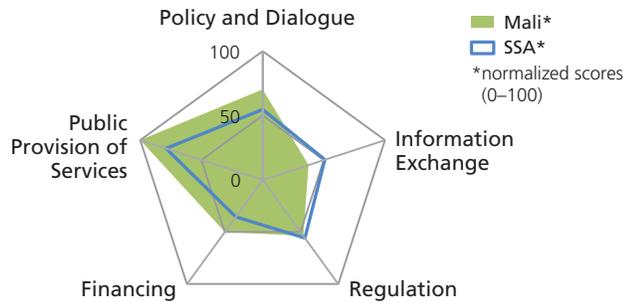
# Mali

Population: 13.0 million  
 GNI per capita (Atlas method): US\$610  
 Life expectancy: 48 years

MDG 4	Under-5 mortality rate (per 1,000)	191
MDG 5	Maternal mortality ratio (per 100,000 live births)	830
MDG 6	HIV prevalence (among ages 15–49)	1.5
	(% of population)	0.3
	Tuberculosis incidence	25.4
	Malaria (notified cases)	25.4



## Engagement



	Score	Maximum
Policy and dialogue	7	10
Information exchange	3	8
Regulation	7	13
Financing	3	6
Public provision of services	2	2

## Health Expenditure

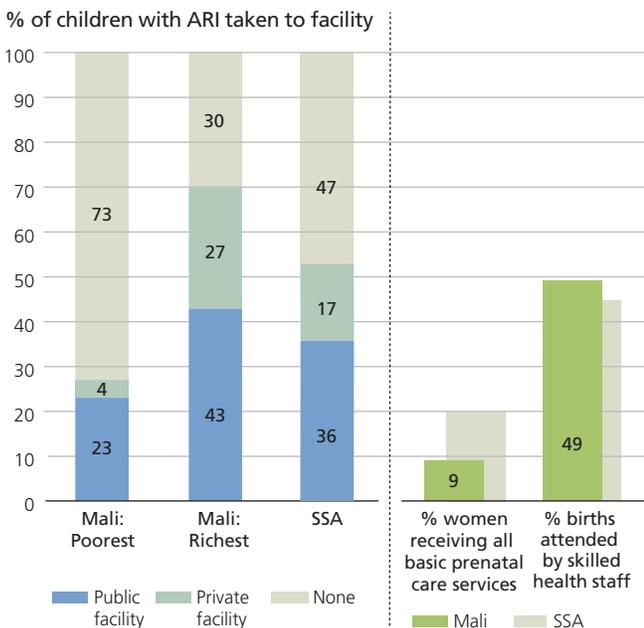
	Mali	SSA Average
Health expenditure per capita in current \$	34.3	95.3
Public sector share of total expenditure (%)	51.4	49.5
Private sector share of total expenditure (%)	48.6	50.5
Out-of-pocket expenditure (% of private expenditure)	99.5	72.4

## Business Environment

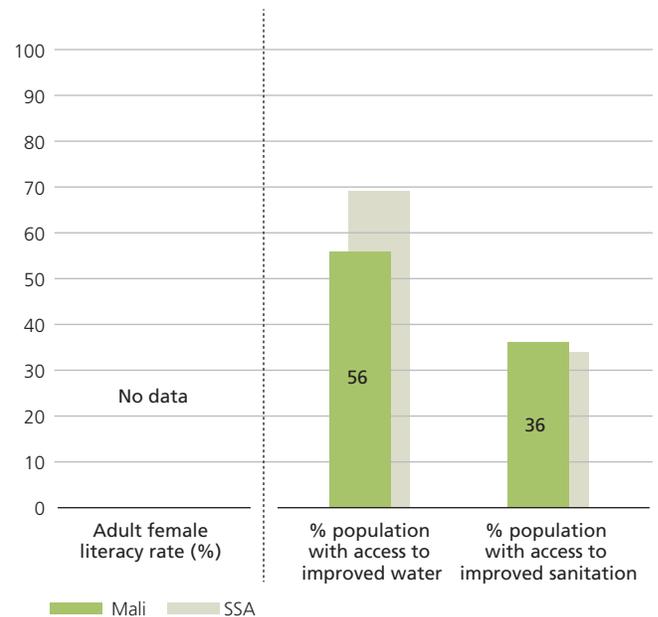
	Mali	SSA Average
Time to enforce a contract (days)	620	644
Time to prepare and pay taxes (hours per year)	270	317
Time to start a business (days)	8	44
Cost of business start-up (% of income per capita)	80	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services

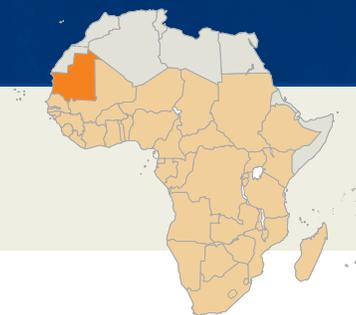


SSA = Sub-Saharan Africa average

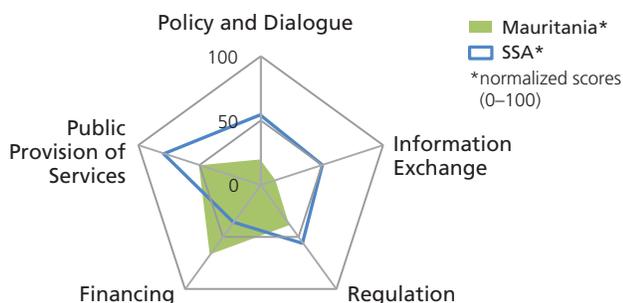
# Mauritania

Population: 3.3 million  
 GNI per capita (Atlas method): US\$980  
 Life expectancy: 57 years

MDG 4	Under-5 mortality rate (per 1,000)	117
MDG 5	Maternal mortality ratio (per 100,000 live births)	550
MDG 6	HIV prevalence (among ages 15–49)	0.8
	(% of population)	0.3
	Tuberculosis incidence	17.3
	Malaria (notified cases)	



## Engagement



	Score	Maximum
Policy and dialogue	2	10
Information exchange	1	8
Regulation	5	13
Financing	4	6
Public provision of services	1	2

## Health Expenditure

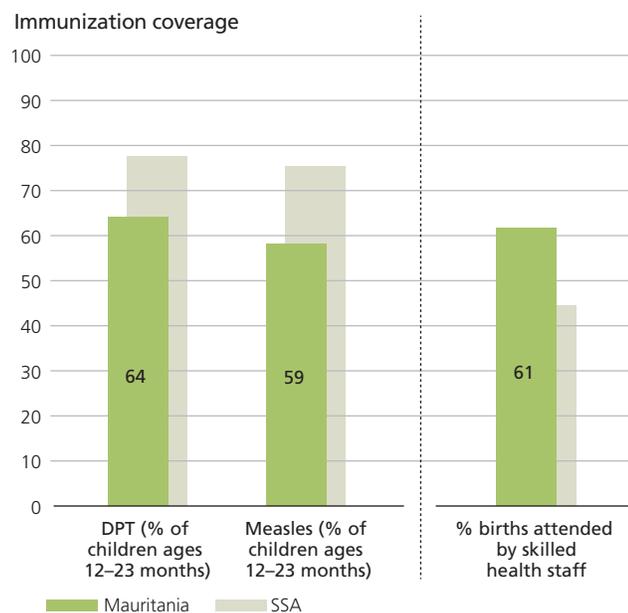
	Mauritania	SSA Average
Health expenditure per capita in current \$	21.7	95.3
Public sector share of total expenditure (%)	65.3	49.5
Private sector share of total expenditure (%)	34.7	50.5
Out-of-pocket expenditure (% of private expenditure)	100.0	72.4

## Business Environment

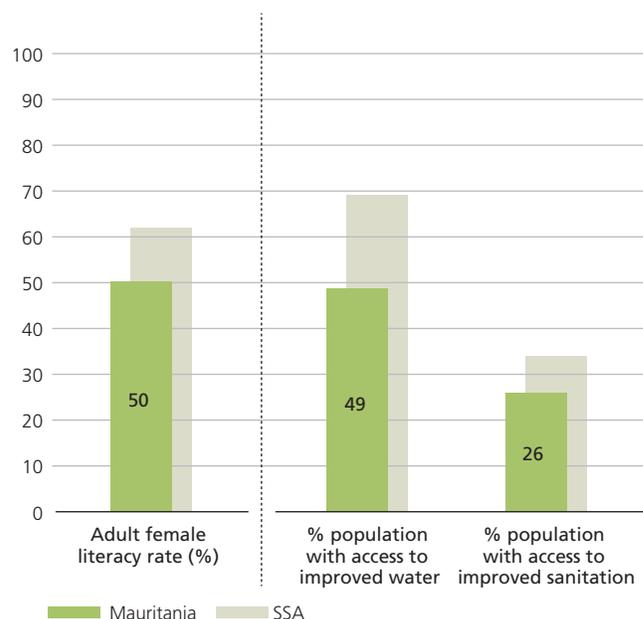
	Mauritania	SSA Average
Time to enforce a contract (days)	370	644
Time to prepare and pay taxes (hours per year)	696	317
Time to start a business (days)	19	44
Cost of business start-up (% of income per capita)	34	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

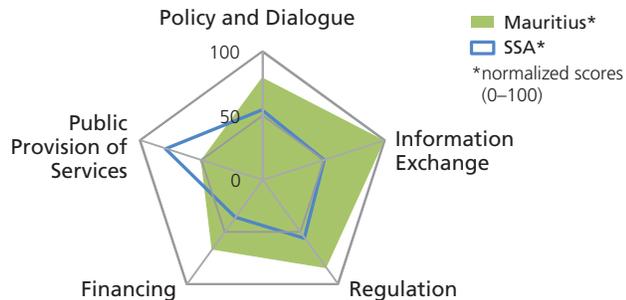
# Mauritius

Population: 1.3 million  
 GNI per capita (Atlas method): US\$6,720  
 Life expectancy: 73 years

MDG 4	Under-5 mortality rate (per 1,000)	17
MDG 5	Maternal mortality ratio (per 100,000 live births)	36
MDG 6	HIV prevalence (among ages 15–49)	1.7
	(% of population)	0.0
	Tuberculosis incidence	—
	Malaria (notified cases)	—



## Engagement



	Score	Maximum
Policy and dialogue	8	10
Information exchange	8	8
Regulation	11	13
Financing	4	6
Public provision of services	1	2

## Health Expenditure

	Mauritius	SSA Average
Health expenditure per capita in current \$	246.9	95.3
Public sector share of total expenditure (%)	49.0	49.5
Private sector share of total expenditure (%)	51.0	50.5
Out-of-pocket expenditure (% of private expenditure)	81.5	72.4

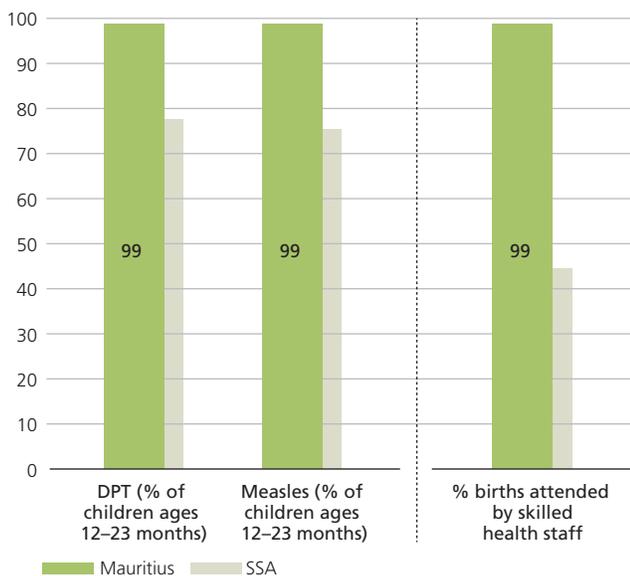
## Business Environment

	Mauritius	SSA Average
Time to enforce a contract (days)	645	644
Time to prepare and pay taxes (hours per year)	161	317
Time to start a business (days)	6	44
Cost of business start-up (% of income per capita)	4	96

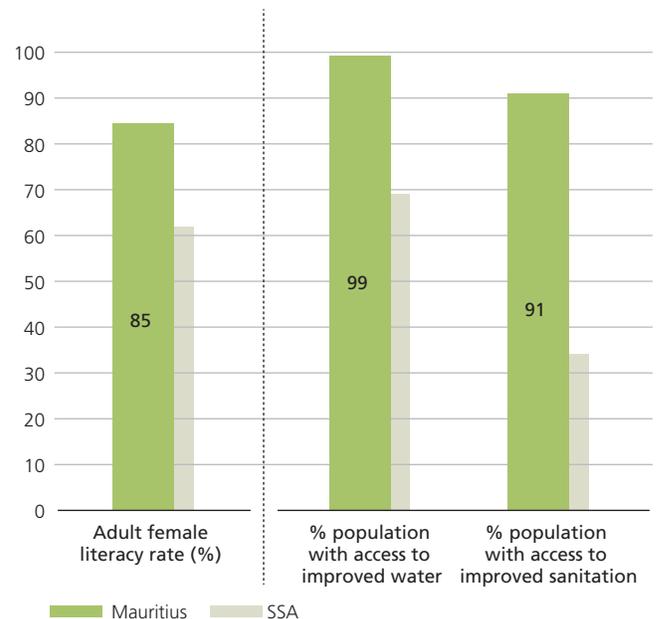
## Intermediate Outcomes

### Access and Quality

#### Immunization coverage



## Supporting Services



SSA = Sub-Saharan Africa average

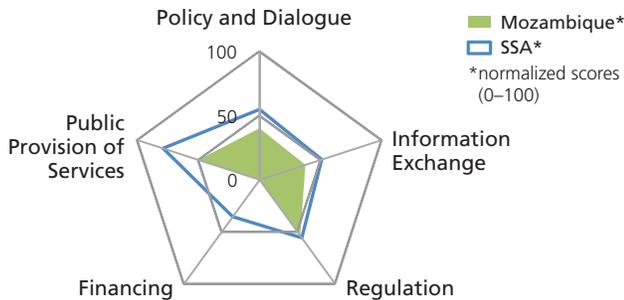
# Mozambique

Population: 22.9 million  
 GNI per capita (Atlas method): US\$380  
 Life expectancy: 48 years

MDG 4	Under-5 mortality rate (per 1,000)	142
MDG 5	Maternal mortality ratio (per 100,000 live births)	550
MDG 6	HIV prevalence (among ages 15–49)	12.5
	(% of population)	0.4
	Tuberculosis incidence	32.6
	Malaria (notified cases)	



## Engagement



Category	Score	Maximum
Policy and dialogue	4	10
Information exchange	3	8
Regulation	7	13
Financing	0	6
Public provision of services	1	2

## Health Expenditure

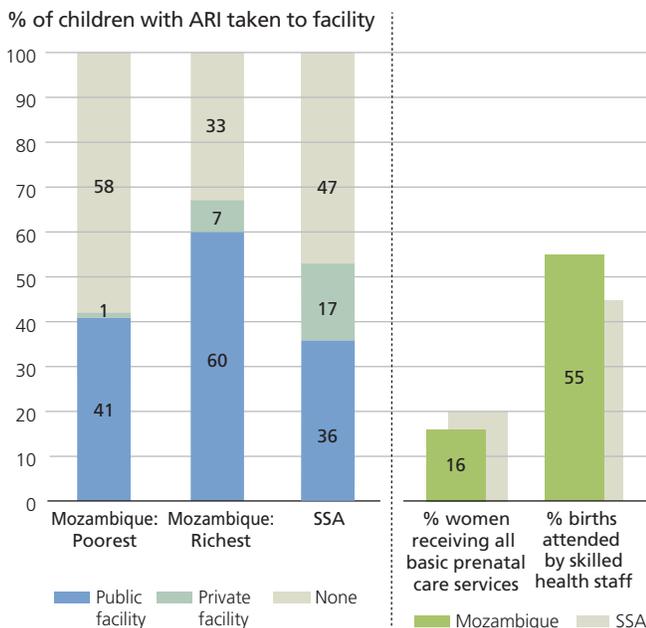
	Mozambique	SSA Average
Health expenditure per capita in current \$	18.1	95.3
Public sector share of total expenditure (%)	71.8	49.5
Private sector share of total expenditure (%)	28.2	50.5
Out-of-pocket expenditure (% of private expenditure)	42.1	72.4

## Business Environment

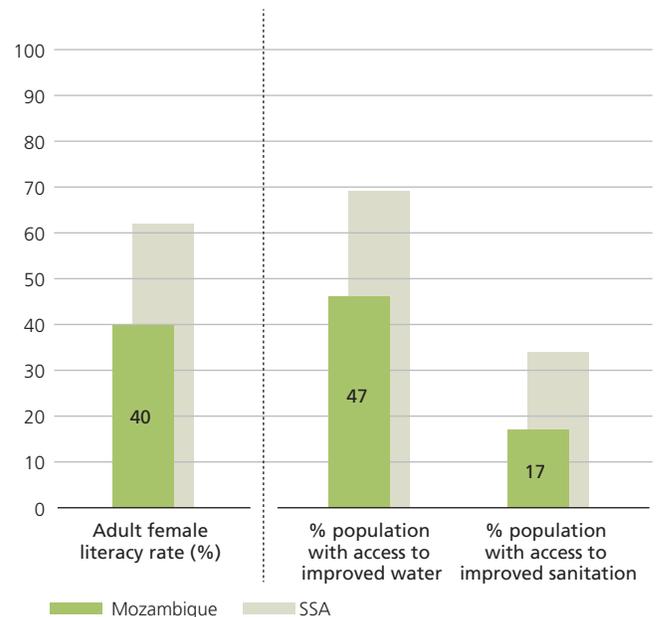
	Mozambique	SSA Average
Time to enforce a contract (days)	730	644
Time to prepare and pay taxes (hours per year)	230	317
Time to start a business (days)	13	44
Cost of business start-up (% of income per capita)	14	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

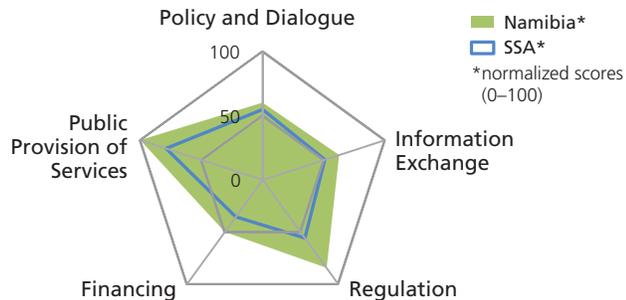
# Namibia

Population: 2.2 million  
 GNI per capita (Atlas method): US\$4,260  
 Life expectancy: 61 years

MDG 4	Under-5 mortality rate (per 1,000)	48
MDG 5	Maternal mortality ratio (per 100,000 live births)	180
MDG 6	HIV prevalence (among ages 15–49)	15.3
	(% of population)	0.8
	Tuberculosis incidence	0.8
	Malaria (notified cases)	4.6



## Engagement



Category	Score	Maximum
Policy and dialogue	6	10
Information exchange	5	8
Regulation	11	13
Financing	3	6
Public provision of services	2	2

## Health Expenditure

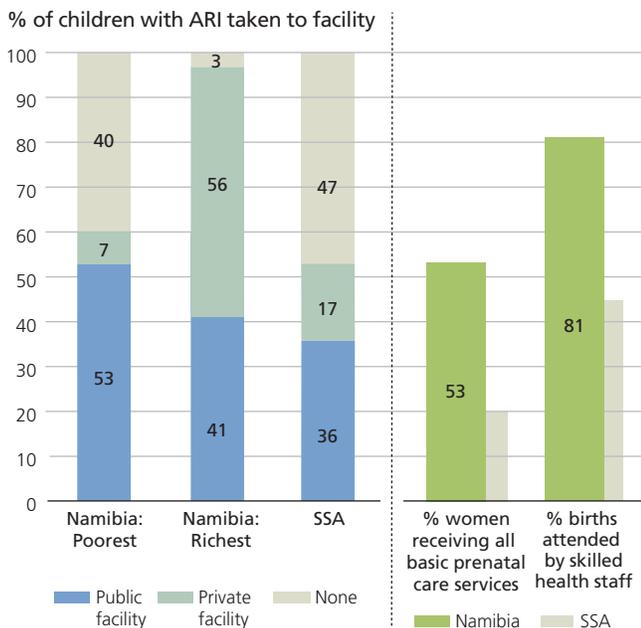
	Namibia	SSA Average
Health expenditure per capita in current \$	318.5	95.3
Public sector share of total expenditure (%)	42.1	49.5
Private sector share of total expenditure (%)	57.9	50.5
Out-of-pocket expenditure (% of private expenditure)	5.8	72.4

## Business Environment

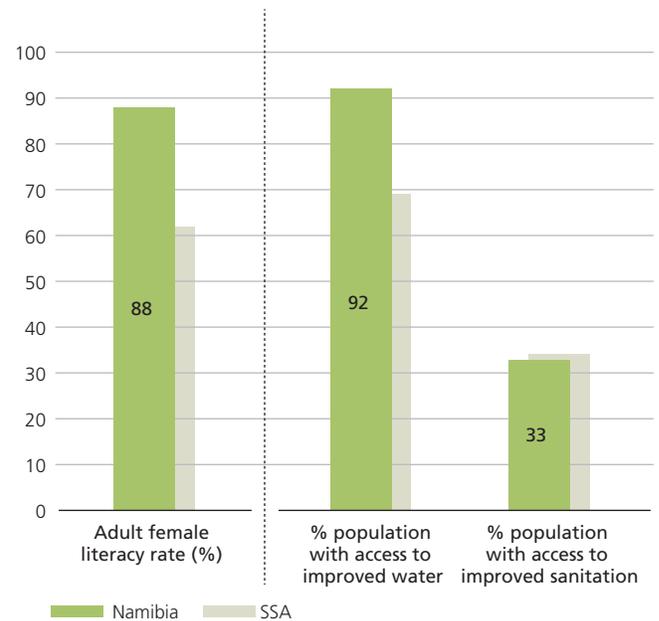
	Namibia	SSA Average
Time to enforce a contract (days)	270	644
Time to prepare and pay taxes (hours per year)	375	317
Time to start a business (days)	66	44
Cost of business start-up (% of income per capita)	19	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services

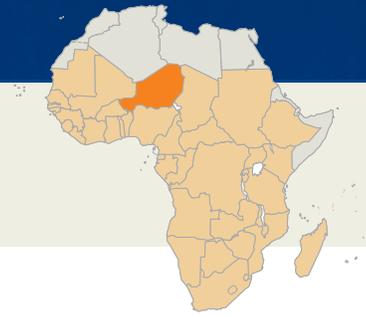


SSA = Sub-Saharan Africa average

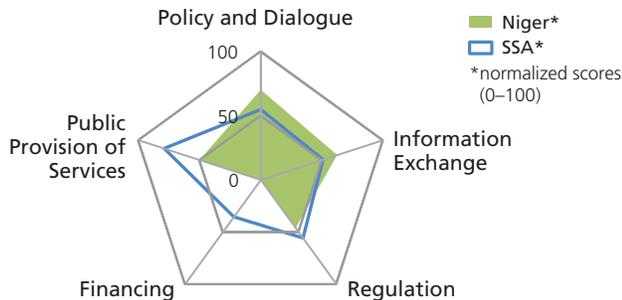
# Niger

Population: 15.3 million  
 GNI per capita (Atlas method): US\$330  
 Life expectancy: 51 years

MDG 4	Under-5 mortality rate (per 1,000)	160
MDG 5	Maternal mortality ratio (per 100,000 live births)	820
MDG 6	HIV prevalence (among ages 15–49)	0.8
	(% of population)	0.2
	Tuberculosis incidence	38.0
	Malaria (notified cases)	



## Engagement



	Score	Maximum
Policy and dialogue	7	10
Information exchange	5	8
Regulation	6	13
Financing	0	6
Public provision of services	1	2

## Health Expenditure

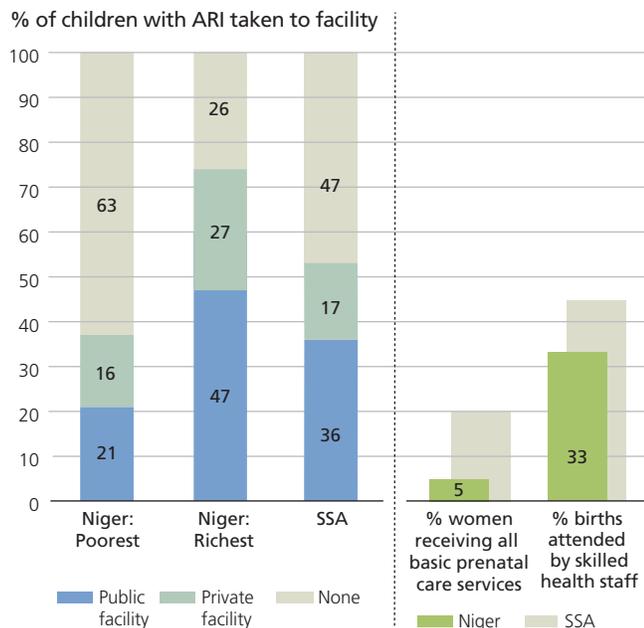
	Niger	SSA Average
Health expenditure per capita in current \$	16.4	95.3
Public sector share of total expenditure (%)	52.8	49.5
Private sector share of total expenditure (%)	47.2	50.5
Out-of-pocket expenditure (% of private expenditure)	96.4	72.4

## Business Environment

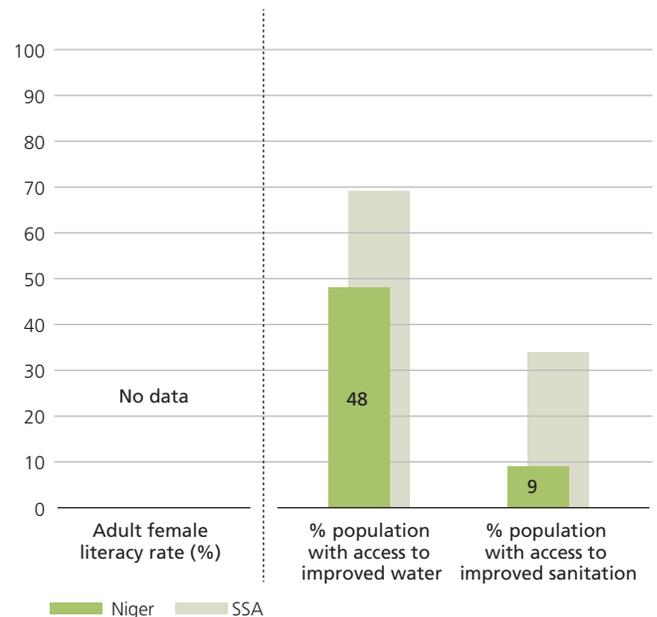
	Niger	SSA Average
Time to enforce a contract (days)	545	644
Time to prepare and pay taxes (hours per year)	270	317
Time to start a business (days)	17	44
Cost of business start-up (% of income per capita)	119	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services

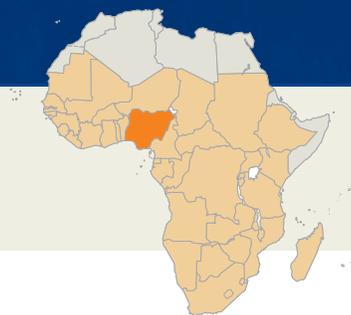


SSA = Sub-Saharan Africa average

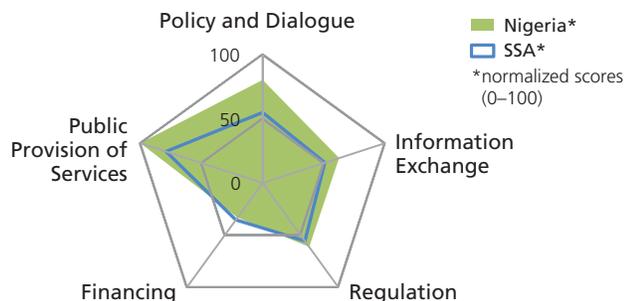
# Nigeria

Population: 154.7 million  
 GNI per capita (Atlas method): US\$1,170  
 Life expectancy: 48 years

MDG 4	Under-5 mortality rate (per 1,000)	138
MDG 5	Maternal mortality ratio (per 100,000 live births)	840
MDG 6	HIV prevalence (among ages 15–49)	3.1
	(% of population)	0.3
	Tuberculosis incidence	38.3
	Malaria (notified cases)	



## Engagement



Category	Score	Maximum
Policy and dialogue	8	10
Information exchange	5	8
Regulation	8	13
Financing	2	6
Public provision of services	2	2

## Health Expenditure

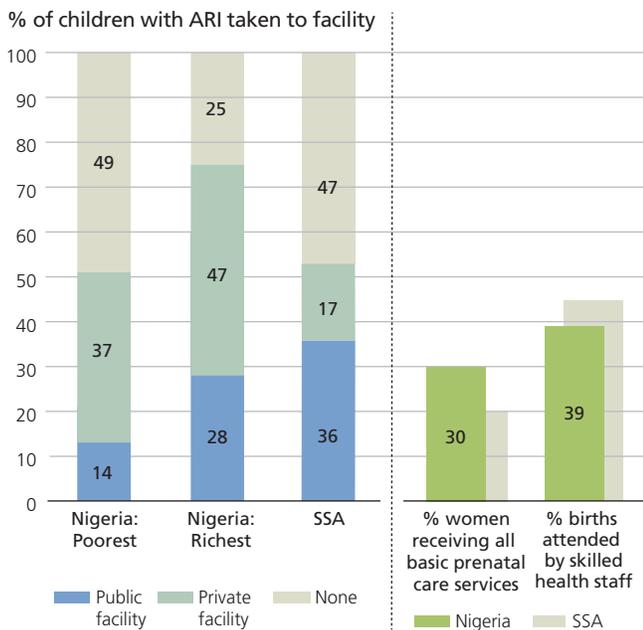
	Nigeria	SSA Average
Health expenditure per capita in current \$	74.2	95.3
Public sector share of total expenditure (%)	25.3	49.5
Private sector share of total expenditure (%)	74.7	50.5
Out-of-pocket expenditure (% of private expenditure)	95.9	72.4

## Business Environment

	Nigeria	SSA Average
Time to enforce a contract (days)	457	644
Time to prepare and pay taxes (hours per year)	938	317
Time to start a business (days)	31	44
Cost of business start-up (% of income per capita)	79	96

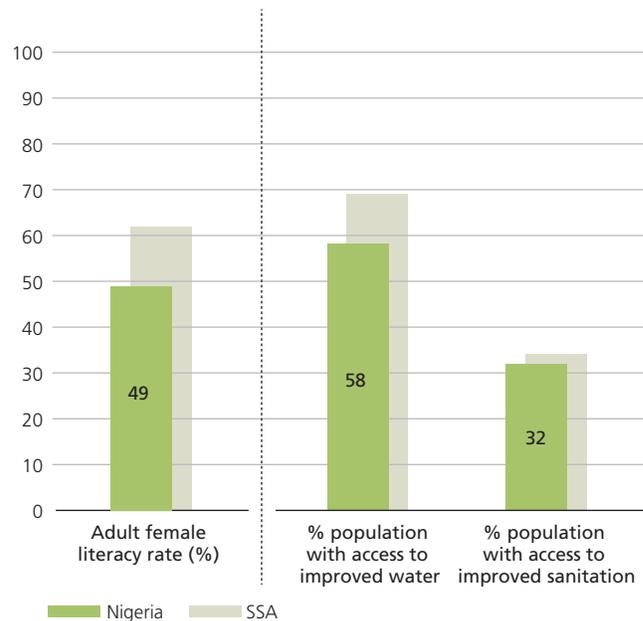
## Intermediate Outcomes

### Access and Quality



SSA = Sub-Saharan Africa average

## Supporting Services



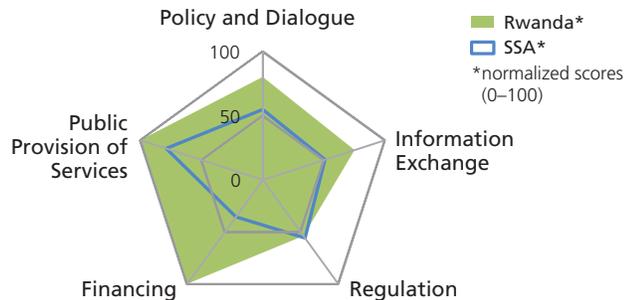
# Rwanda

Population: 10.0 million  
 GNI per capita (Atlas method): US\$410  
 Life expectancy: 50 years

MDG 4	Under-5 mortality rate (per 1,000)	111
MDG 5	Maternal mortality ratio (per 100,000 live births)	540
MDG 6	HIV prevalence (among ages 15–49)	2.8
	(% of population)	0.4
	Tuberculosis incidence	11.4
	Malaria (notified cases)	



## Engagement



	Score	Maximum
Policy and dialogue	8	10
Information exchange	6	8
Regulation	7	13
Financing	6	6
Public provision of services	2	2

## Health Expenditure

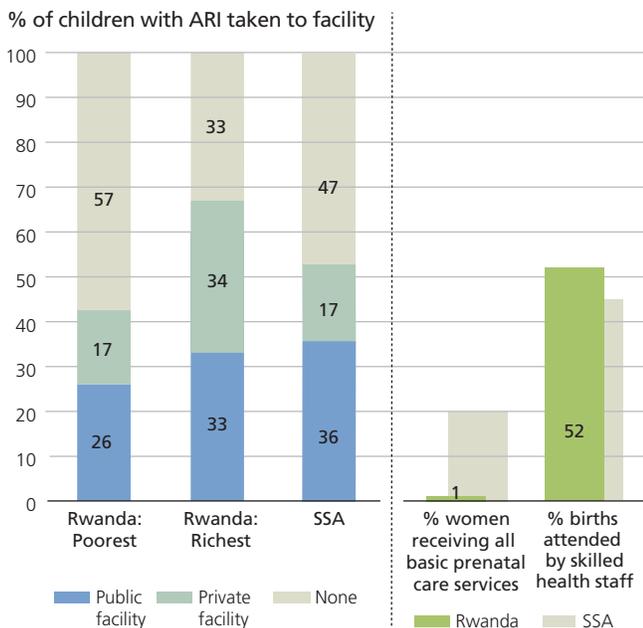
	Rwanda	SSA Average
Health expenditure per capita in current \$	37.2	95.3
Public sector share of total expenditure (%)	47.0	49.5
Private sector share of total expenditure (%)	53.0	50.5
Out-of-pocket expenditure (% of private expenditure)	44.4	72.4

## Business Environment

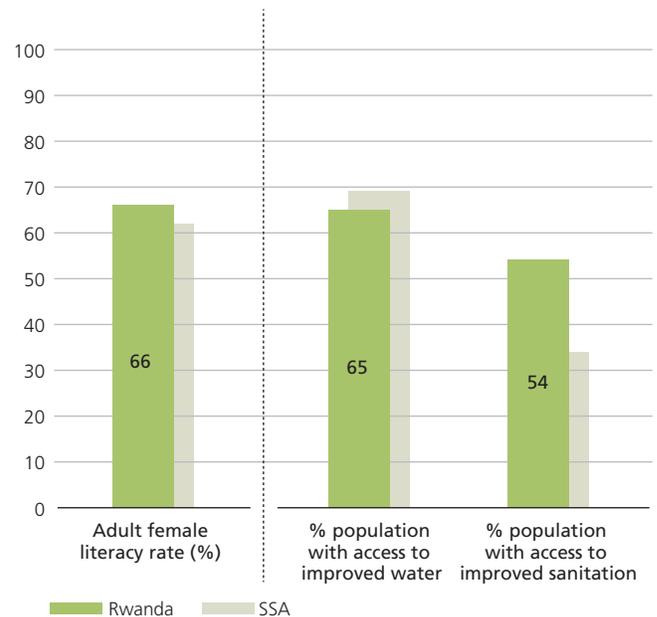
	Rwanda	SSA Average
Time to enforce a contract (days)	230	644
Time to prepare and pay taxes (hours per year)	148	317
Time to start a business (days)	3	44
Cost of business start-up (% of income per capita)	9	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

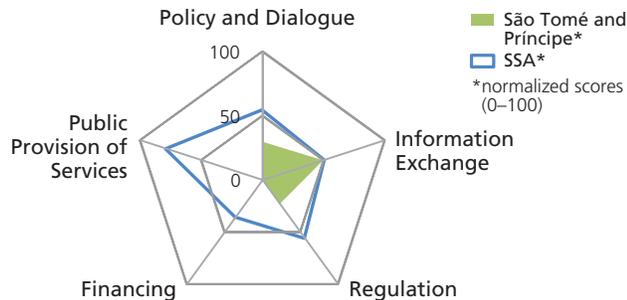
# São Tomé and Príncipe

Population: .2 million  
 GNI per capita (Atlas method): US\$1,020  
 Life expectancy: 66 years

MDG 4	Under-5 mortality rate (per 1,000)	78
MDG 5	Maternal mortality ratio (per 100,000 live births)	—
MDG 6	HIV prevalence (among ages 15–49)	—
(% of population)	Tuberculosis incidence	0.1
	Malaria (notified cases)	2.0



## Engagement



	Score	Maximum
Policy and dialogue	3	10
Information exchange	4	8
Regulation	3	13
Financing	0	6
Public provision of services	0	2

## Health Expenditure

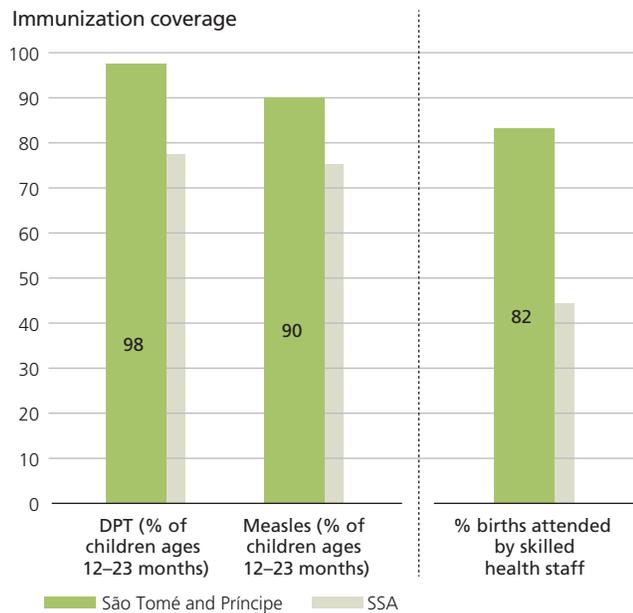
	São Tomé & Príncipe	SSA Average
Health expenditure per capita in current \$	102.7	95.3
Public sector share of total expenditure (%)	47.1	49.5
Private sector share of total expenditure (%)	52.9	50.5
Out-of-pocket expenditure (% of private expenditure)	58.9	72.4

## Business Environment

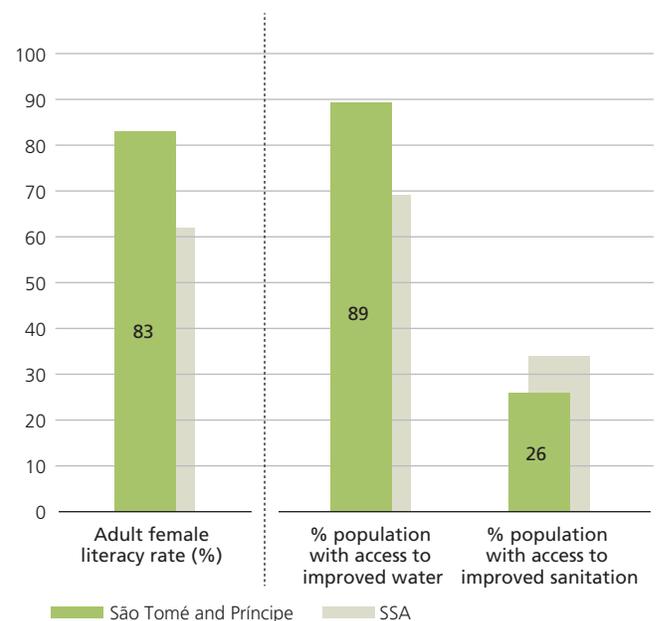
	São Tomé & Príncipe	SSA Average
Time to enforce a contract (days)	1,185	644
Time to prepare and pay taxes (hours per year)	424	317
Time to start a business (days)	144	44
Cost of business start-up (% of income per capita)	77	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

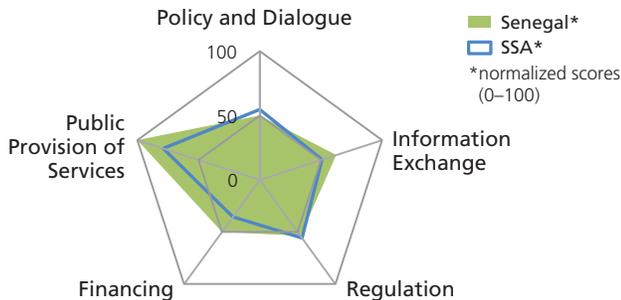
# Senegal

Population: 12.5 million  
 GNI per capita (Atlas method): US\$980  
 Life expectancy: 56 years

MDG 4	Under-5 mortality rate (per 1,000)	93
MDG 5	Maternal mortality ratio (per 100,000 live births)	410
MDG 6	HIV prevalence (among ages 15–49)	1.0
	(% of population)	0.3
	Tuberculosis incidence	7.1
	Malaria (notified cases)	



## Engagement



Category	Score	Maximum
Policy and dialogue	5	10
Information exchange	5	8
Regulation	7	13
Financing	3	6
Public provision of services	2	2

## Health Expenditure

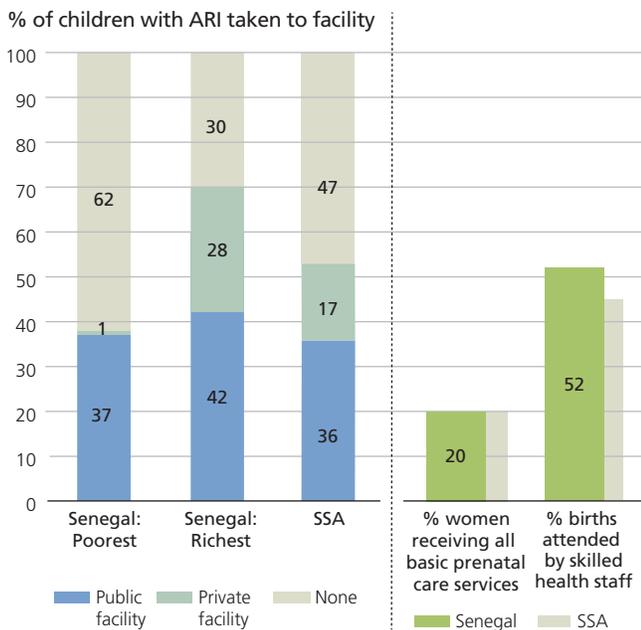
	Senegal	SSA Average
Health expenditure per capita in current \$	54.2	95.3
Public sector share of total expenditure (%)	56.0	49.5
Private sector share of total expenditure (%)	44.0	50.5
Out-of-pocket expenditure (% of private expenditure)	78.5	72.4

## Business Environment

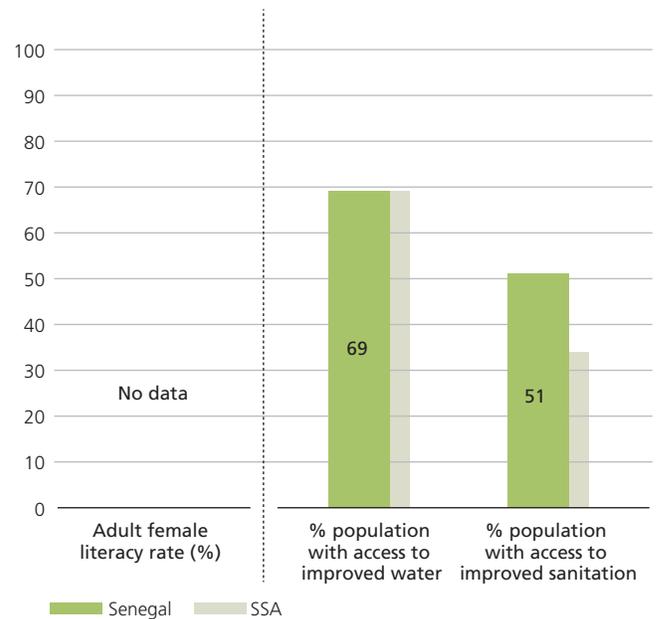
	Senegal	SSA Average
Time to enforce a contract (days)	780	644
Time to prepare and pay taxes (hours per year)	666	317
Time to start a business (days)	8	44
Cost of business start-up (% of income per capita)	63	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

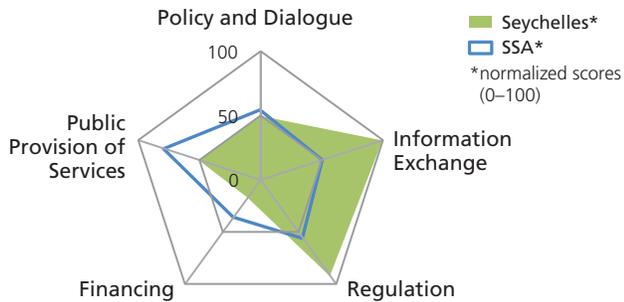
# Seychelles

Population: .1 million  
 GNI per capita (Atlas method): US\$10,530  
 Life expectancy: 73 years

MDG 4	Under-5 mortality rate (per 1,000)	12
MDG 5	Maternal mortality ratio (per 100,000 live births)	—
MDG 6	HIV prevalence (among ages 15–49)	—
(% of population)	Tuberculosis incidence	0.0
	Malaria (notified cases)	—



## Engagement



Category	Score	Maximum
Policy and dialogue	5	10
Information exchange	8	8
Regulation	12	13
Financing	1	6
Public provision of services	1	2

## Health Expenditure

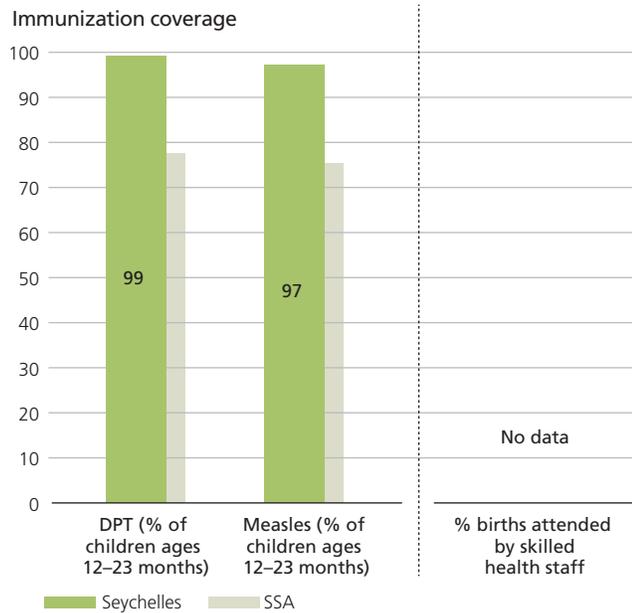
	Seychelles	SSA Average
Health expenditure per capita in current \$	564.0	95.3
Public sector share of total expenditure (%)	70.2	49.5
Private sector share of total expenditure (%)	29.8	50.5
Out-of-pocket expenditure (% of private expenditure)	62.5	72.4

## Business Environment

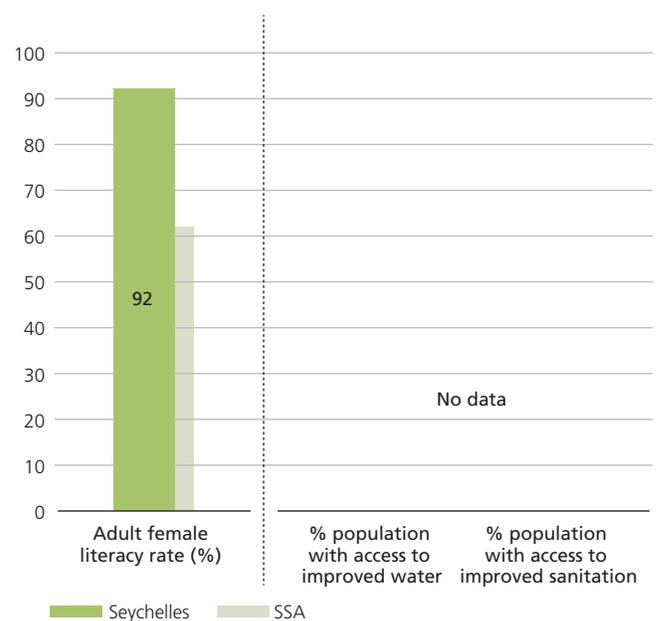
	Seychelles	SSA Average
Time to enforce a contract (days)	720	644
Time to prepare and pay taxes (hours per year)	76	317
Time to start a business (days)	39	44
Cost of business start-up (% of income per capita)	18	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

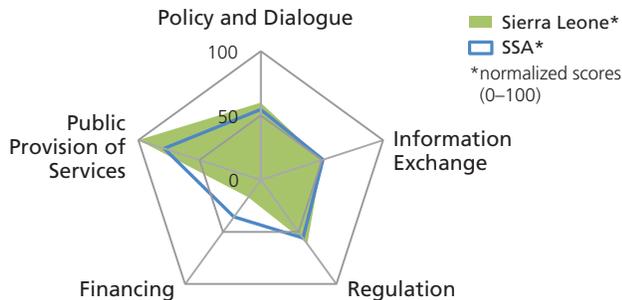
# Sierra Leone

Population: 5.7 million  
 GNI per capita (Atlas method): US\$320  
 Life expectancy: 48 years

MDG 4	Under-5 mortality rate (per 1,000)	192
MDG 5	Maternal mortality ratio (per 100,000 live births)	970
MDG 6	HIV prevalence (among ages 15–49)	1.7
	Tuberculosis incidence (% of population)	0.6
	Malaria (notified cases)	36.1



## Engagement



	Score	Maximum
Policy and dialogue	6	10
Information exchange	4	8
Regulation	8	13
Financing	1	6
Public provision of services	2	2

## Health Expenditure

	Sierra Leone	SSA Average
Health expenditure per capita in current \$	13.5	95.3
Public sector share of total expenditure (%)	31.3	49.5
Private sector share of total expenditure (%)	68.7	50.5
Out-of-pocket expenditure (% of private expenditure)	58.8	72.4

## Business Environment

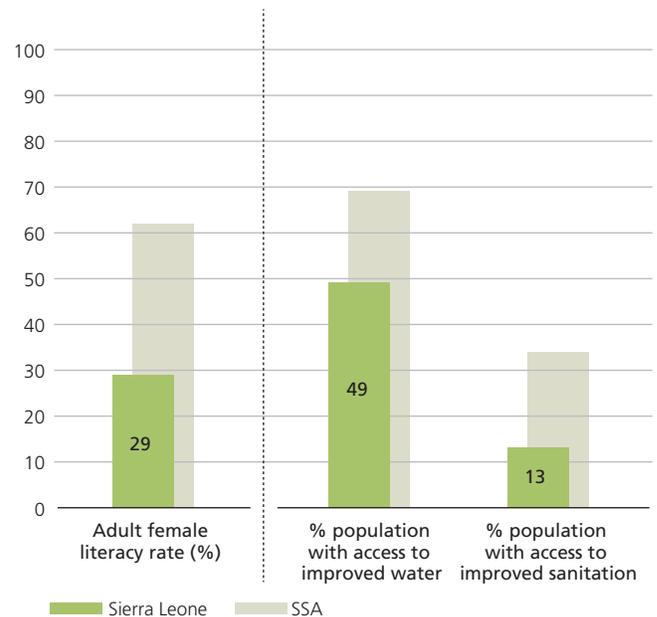
	Sierra Leone	SSA Average
Time to enforce a contract (days)	515	644
Time to prepare and pay taxes (hours per year)	357	317
Time to start a business (days)	12	44
Cost of business start-up (% of income per capita)	111	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

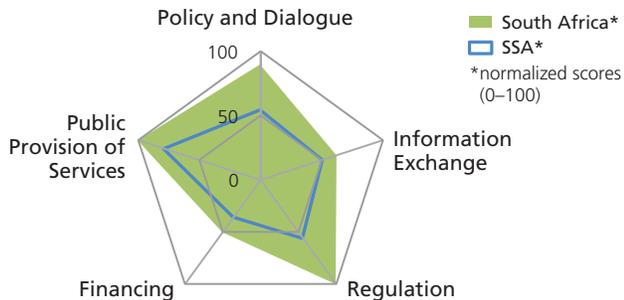
# South Africa

Population: 49.3 million  
 GNI per capita (Atlas method): US\$5,870  
 Life expectancy: 51 years

MDG 4	Under-5 mortality rate (per 1,000)	62
MDG 5	Maternal mortality ratio (per 100,000 live births)	410
MDG 6	HIV prevalence (among ages 15–49)	18.1
	(% of population)	1.0
	Tuberculosis incidence	1.0
	Malaria (notified cases)	0.1



## Engagement



	Score	Maximum
Policy and dialogue	9	10
Information exchange	5	8
Regulation	13	13
Financing	3	6
Public provision of services	2	2

## Health Expenditure

	South Africa	SSA Average
Health expenditure per capita in current \$	497.1	95.3
Public sector share of total expenditure (%)	41.4	49.5
Private sector share of total expenditure (%)	58.6	50.5
Out-of-pocket expenditure (% of private expenditure)	29.7	72.4

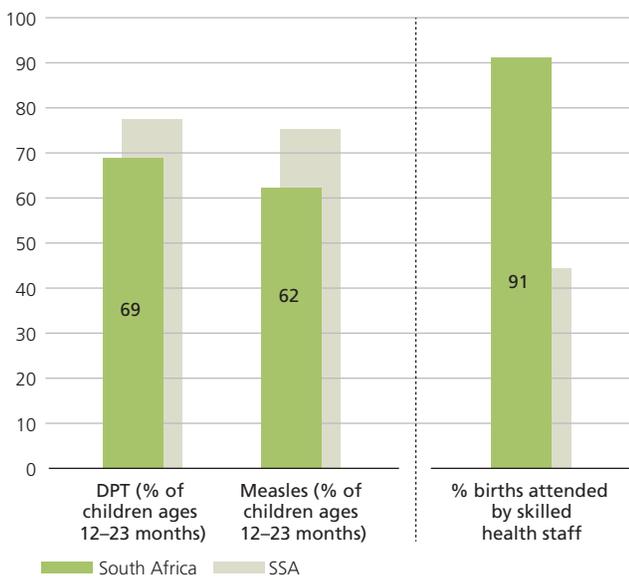
## Business Environment

	South Africa	SSA Average
Time to enforce a contract (days)	600	644
Time to prepare and pay taxes (hours per year)	200	317
Time to start a business (days)	22	44
Cost of business start-up (% of income per capita)	6	96

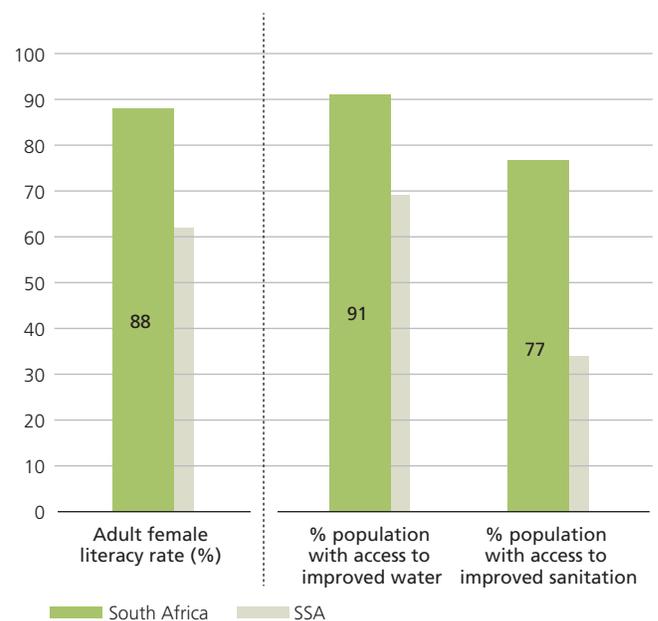
## Intermediate Outcomes

### Access and Quality

#### Immunization coverage



## Supporting Services



SSA = Sub-Saharan Africa average

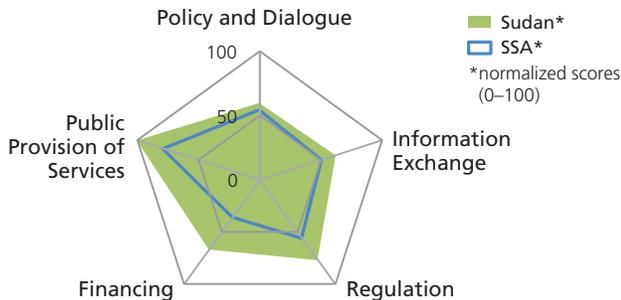
# Sudan

Population: 42.3 million  
 GNI per capita (Atlas method): US\$1,120  
 Life expectancy: 58 years

MDG 4	Under-5 mortality rate (per 1,000)	108
MDG 5	Maternal mortality ratio (per 100,000 live births)	750
MDG 6	HIV prevalence (among ages 15–49)	1.4
	(% of population)	0.1
	Tuberculosis incidence	12.8
	Malaria (notified cases)	



## Engagement



Category	Score	Maximum
Policy and dialogue	6	10
Information exchange	5	8
Regulation	10	13
Financing	4	6
Public provision of services	2	2

## Health Expenditure

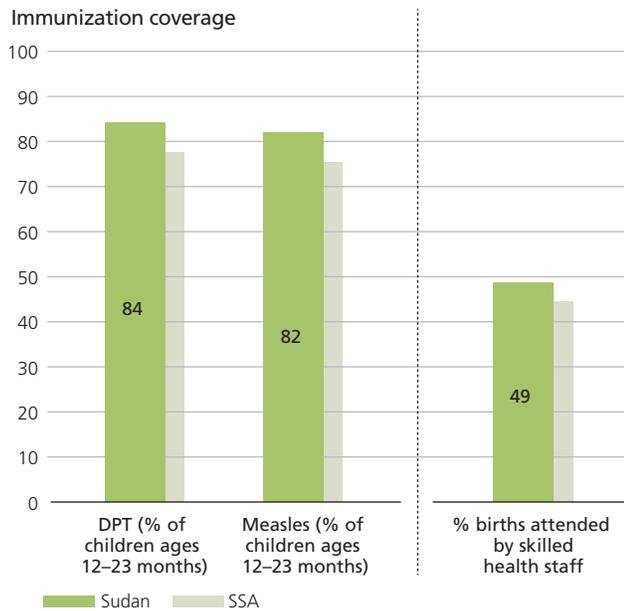
	Sudan	SSA Average
Health expenditure per capita in current \$	40.5	95.3
Public sector share of total expenditure (%)	36.8	49.5
Private sector share of total expenditure (%)	63.2	50.5
Out-of-pocket expenditure (% of private expenditure)	100.0	72.4

## Business Environment

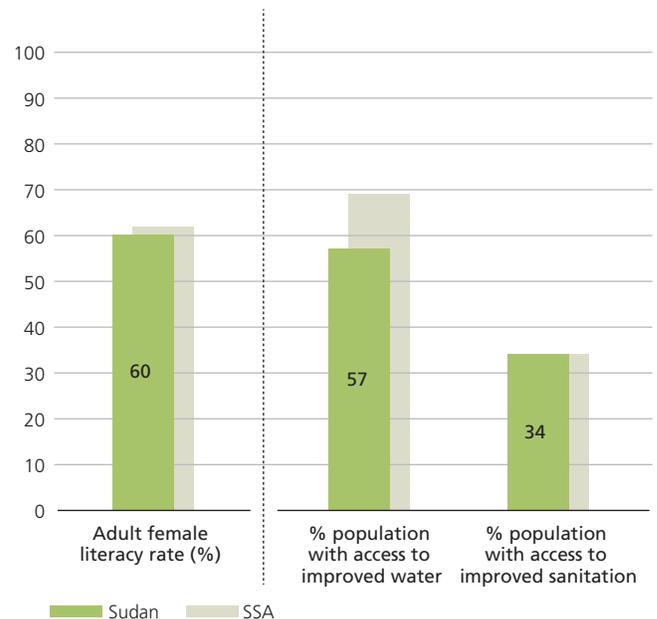
	Sudan	SSA Average
Time to enforce a contract (days)	810	644
Time to prepare and pay taxes (hours per year)	180	317
Time to start a business (days)	36	44
Cost of business start-up (% of income per capita)	34	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

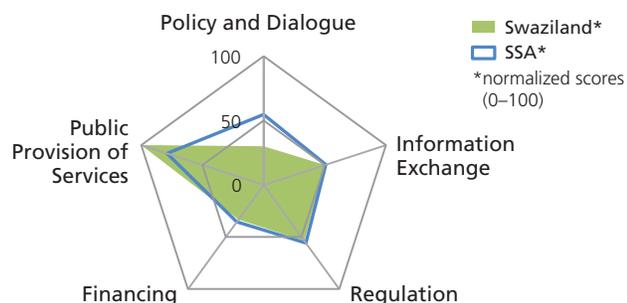
# Swaziland

Population: 1.2 million  
 GNI per capita (Atlas method): US\$2,560  
 Life expectancy: 46 years

MDG 4	Under-5 mortality rate (per 1,000)	73
MDG 5	Maternal mortality ratio (per 100,000 live births)	420
MDG 6	HIV prevalence (among ages 15–49)	26.1
	(% of population)	1.2
	Tuberculosis incidence	0.1
	Malaria (notified cases)	0.1



## Engagement



	Score	Maximum
Policy and dialogue	3	10
Information exchange	4	8
Regulation	7	13
Financing	2	6
Public provision of services	2	2

## Health Expenditure

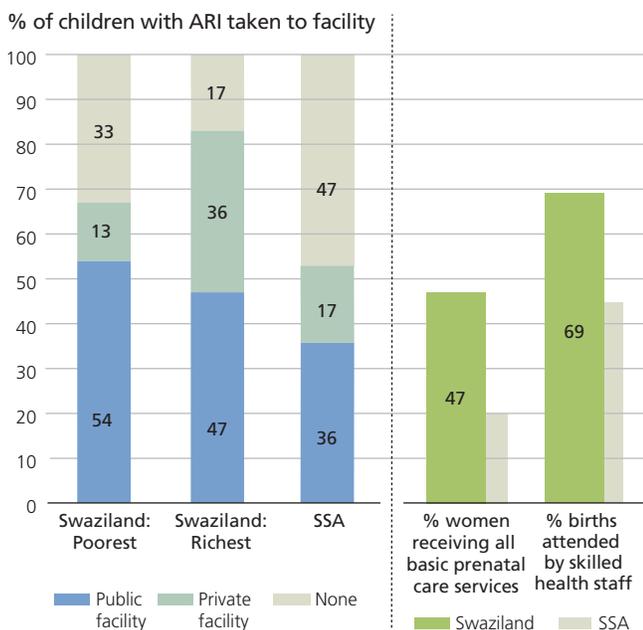
	Swaziland	SSA Average
Health expenditure per capita in current \$	151.1	95.3
Public sector share of total expenditure (%)	62.5	49.5
Private sector share of total expenditure (%)	37.5	50.5
Out-of-pocket expenditure (% of private expenditure)	42.3	72.4

## Business Environment

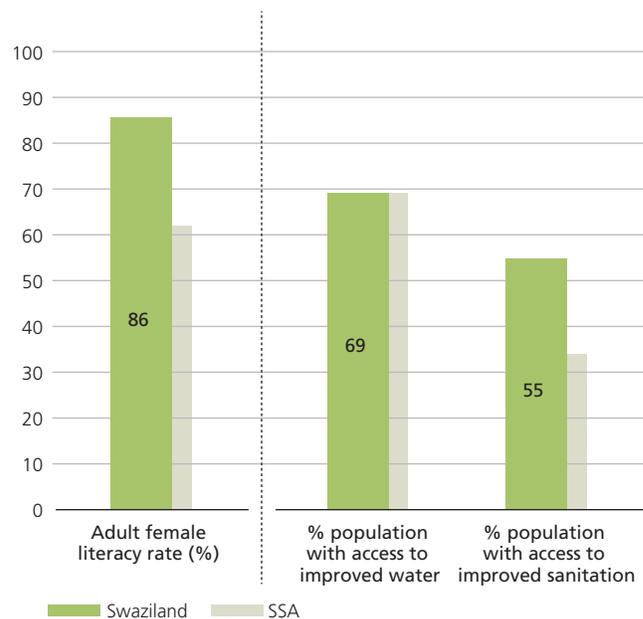
	Swaziland	SSA Average
Time to enforce a contract (days)	972	644
Time to prepare and pay taxes (hours per year)	104	317
Time to start a business (days)	56	44
Cost of business start-up (% of income per capita)	33	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

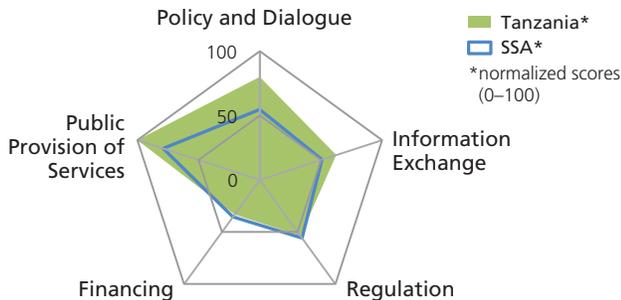
# Tanzania

Population: 43.7 million  
 GNI per capita (Atlas method): US\$460  
 Life expectancy: 56 years

MDG 4	Under-5 mortality rate (per 1,000)	108
MDG 5	Maternal mortality ratio (per 100,000 live births)	790
MDG 6	HIV prevalence (among ages 15–49)	6.2
	(% of population)	0.2
	Tuberculosis incidence	24.1
	Malaria (notified cases)	



## Engagement



	Score	Maximum
Policy and dialogue	8	10
Information exchange	5	8
Regulation	7	13
Financing	2	6
Public provision of services	2	2

## Health Expenditure

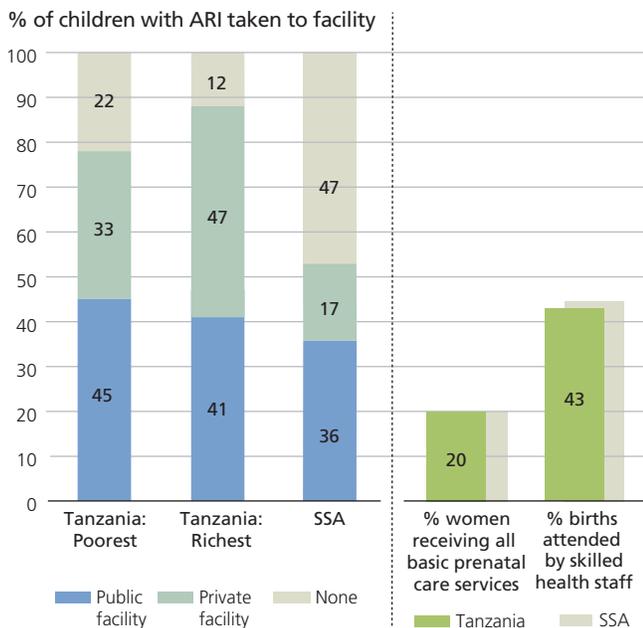
	Tanzania	SSA Average
Health expenditure per capita in current \$	21.7	95.3
Public sector share of total expenditure (%)	65.8	49.5
Private sector share of total expenditure (%)	34.2	50.5
Out-of-pocket expenditure (% of private expenditure)	75.0	72.4

## Business Environment

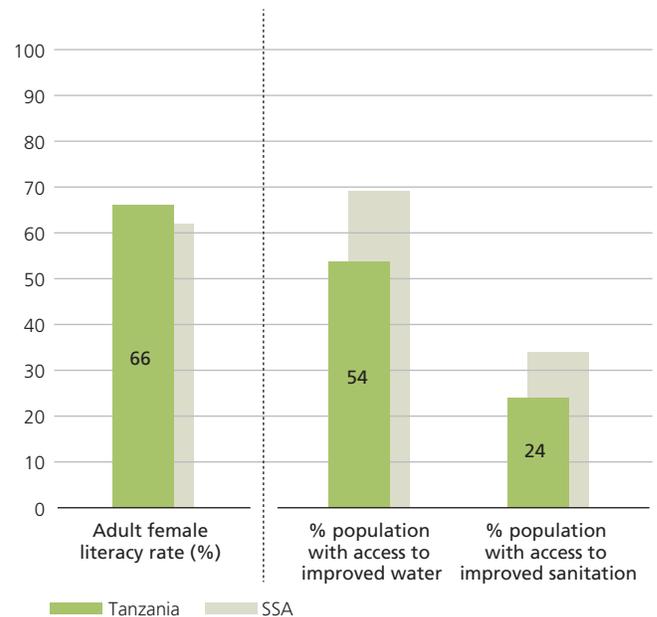
	Tanzania	SSA Average
Time to enforce a contract (days)	462	644
Time to prepare and pay taxes (hours per year)	172	317
Time to start a business (days)	29	44
Cost of business start-up (% of income per capita)	31	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

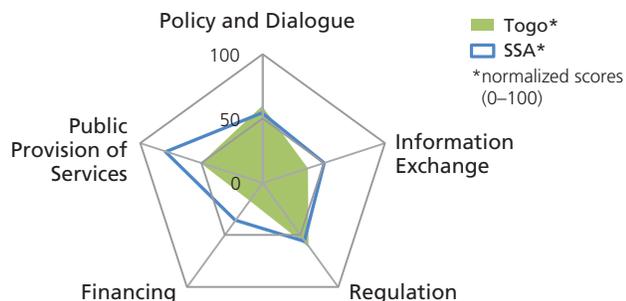
# Togo

Population: 6.6 million  
 GNI per capita (Atlas method): US\$410  
 Life expectancy: 63 years

MDG 4	Under-5 mortality rate (per 1,000)	98
MDG 5	Maternal mortality ratio (per 100,000 live births)	350
MDG 6	HIV prevalence (among ages 15–49)	3.3
	(% of population)	0.4
	Tuberculosis incidence	0.4
	Malaria (notified cases)	30.4



## Engagement



	Score	Maximum
Policy and dialogue	6	10
Information exchange	3	8
Regulation	8	13
Financing	1	6
Public provision of services	1	2

## Health Expenditure

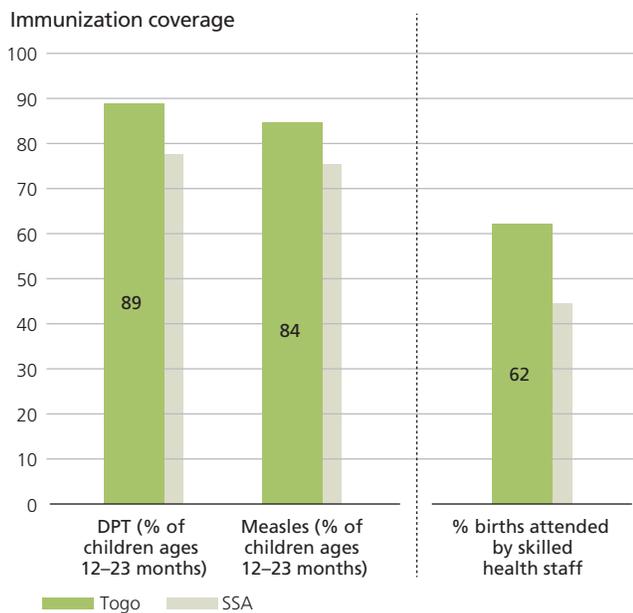
	Togo	SSA Average
Health expenditure per capita in current \$	32.9	95.3
Public sector share of total expenditure (%)	24.9	49.5
Private sector share of total expenditure (%)	75.1	50.5
Out-of-pocket expenditure (% of private expenditure)	84.2	72.4

## Business Environment

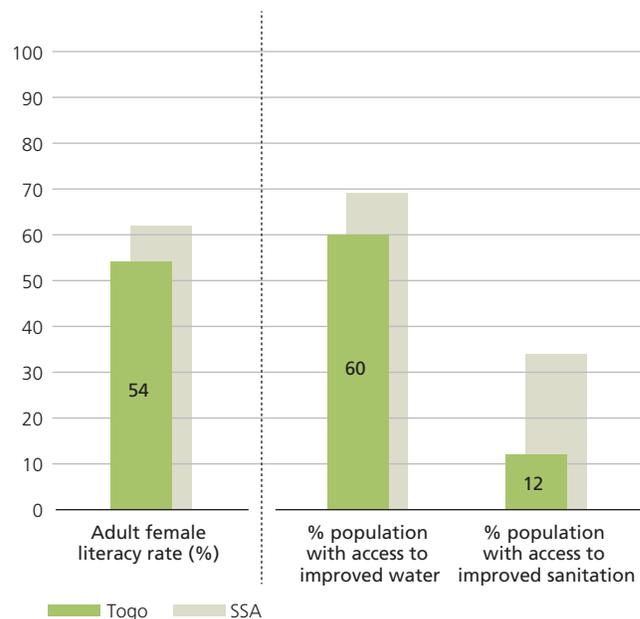
	Togo	SSA Average
Time to enforce a contract (days)	588	644
Time to prepare and pay taxes (hours per year)	270	317
Time to start a business (days)	75	44
Cost of business start-up (% of income per capita)	178	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

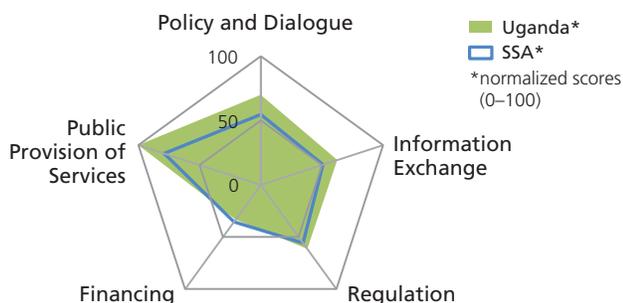
# Uganda

Population: 32.7 million  
 GNI per capita (Atlas method): US\$420  
 Life expectancy: 53 years

MDG 4	Under-5 mortality rate (per 1,000)	128
MDG 5	Maternal mortality ratio (per 100,000 live births)	430
MDG 6	HIV prevalence (among ages 15–49)	5.4
	(% of population)	0.3
	Tuberculosis incidence	0.3
	Malaria (notified cases)	36.2



## Engagement



	Score	Maximum
Policy and dialogue	7	10
Information exchange	5	8
Regulation	8	13
Financing	2	6
Public provision of services	2	2

## Health Expenditure

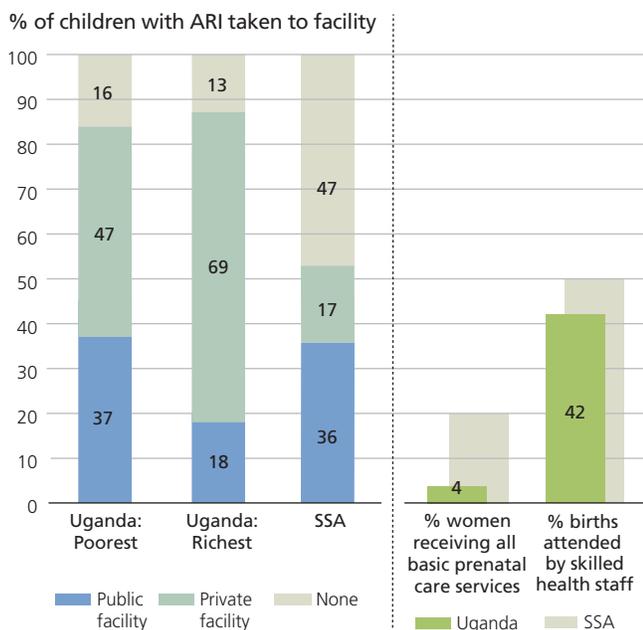
	Uganda	SSA Average
Health expenditure per capita in current \$	27.8	95.3
Public sector share of total expenditure (%)	26.2	49.5
Private sector share of total expenditure (%)	73.8	50.5
Out-of-pocket expenditure (% of private expenditure)	51.0	72.4

## Business Environment

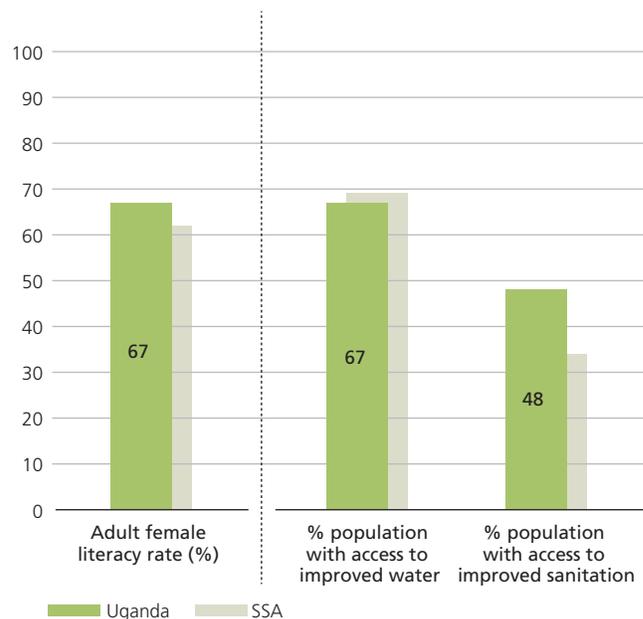
	Uganda	SSA Average
Time to enforce a contract (days)	490	644
Time to prepare and pay taxes (hours per year)	161	317
Time to start a business (days)	25	44
Cost of business start-up (% of income per capita)	94	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

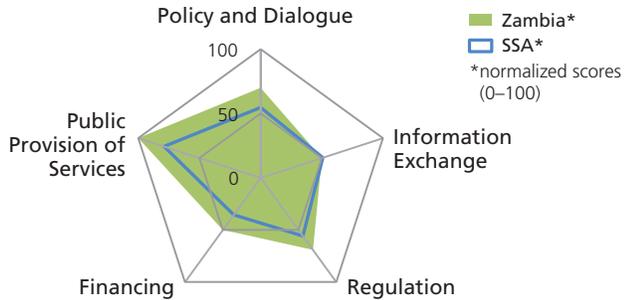
# Zambia

Population: 12.9 million  
 GNI per capita (Atlas method): US\$960  
 Life expectancy: 45 years

MDG 4	Under-5 mortality rate (per 1,000)	141
MDG 5	Maternal mortality ratio (per 100,000 live births)	470
MDG 6	HIV prevalence (among ages 15–49)	15.2
	(% of population)	0.5
	Tuberculosis incidence	13.5
	Malaria (notified cases)	13.5



## Engagement



	Score	Maximum
Policy and dialogue	7	10
Information exchange	4	8
Regulation	9	13
Financing	3	6
Public provision of services	2	2

## Health Expenditure

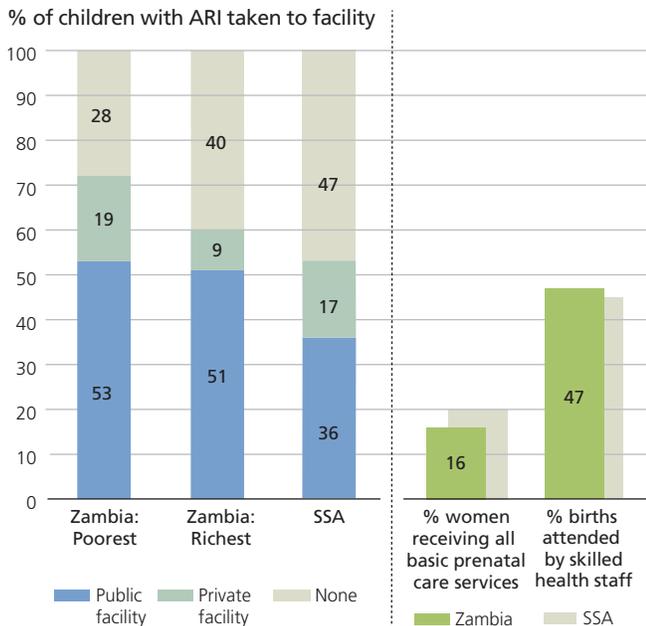
	Zambia	SSA Average
Health expenditure per capita in current \$	57.1	95.3
Public sector share of total expenditure (%)	57.7	49.5
Private sector share of total expenditure (%)	42.3	50.5
Out-of-pocket expenditure (% of private expenditure)	67.6	72.4

## Business Environment

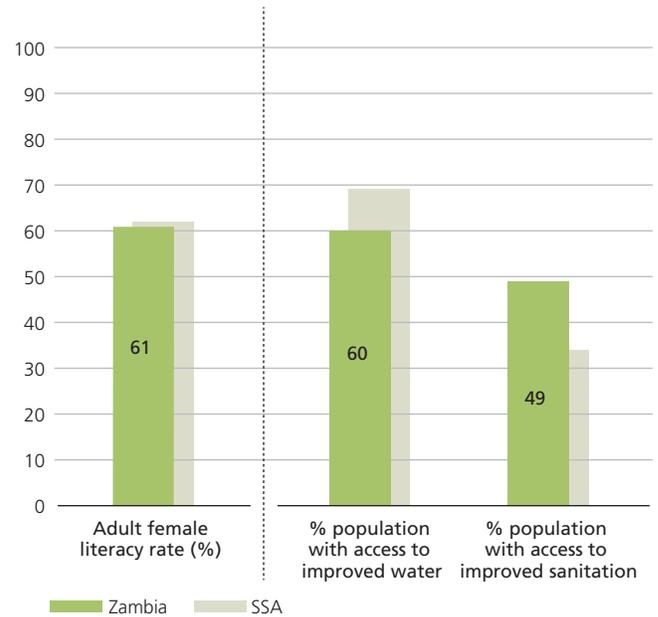
	Zambia	SSA Average
Time to enforce a contract (days)	471	644
Time to prepare and pay taxes (hours per year)	132	317
Time to start a business (days)	18	44
Cost of business start-up (% of income per capita)	28	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

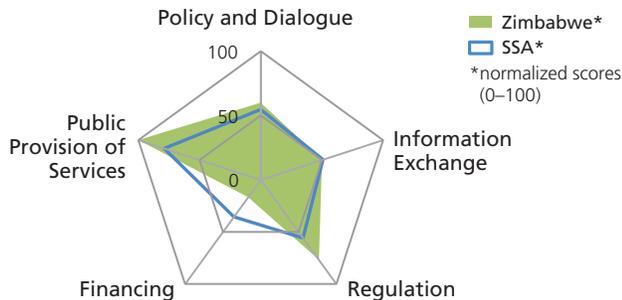
# Zimbabwe

Population: 12.5 million  
 GNI per capita (Atlas method): US\$ —  
 Life expectancy: 44 years

MDG 4	Under-5 mortality rate (per 1,000)	90
MDG 5	Maternal mortality ratio (per 100,000 live births)	790
MDG 6	HIV prevalence (among ages 15–49)	15.3
	(% of population)	0.8
	Tuberculosis incidence	7.5
	Malaria (notified cases)	



## Engagement



	Score	Maximum
Policy and dialogue	6	10
Information exchange	4	8
Regulation	10	13
Financing	1	6
Public provision of services	2	2

## Health Expenditure

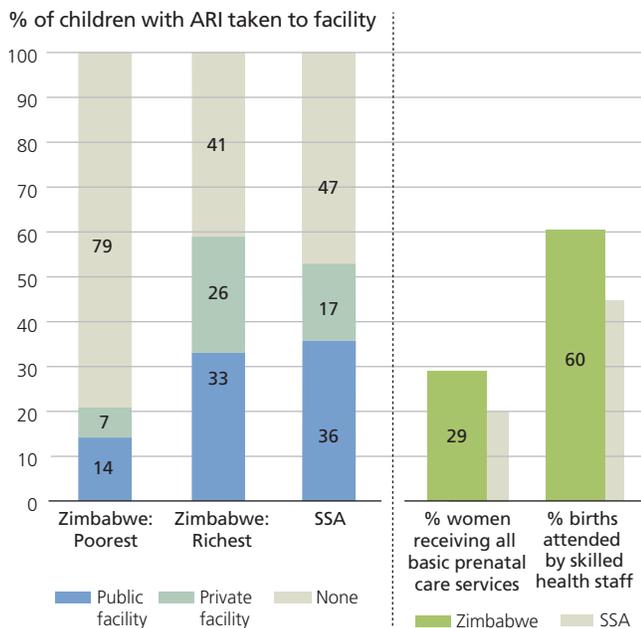
	Zimbabwe	SSA Average
Health expenditure per capita in current \$	78.6	95.3
Public sector share of total expenditure (%)	46.3	49.5
Private sector share of total expenditure (%)	53.7	50.5
Out-of-pocket expenditure (% of private expenditure)	50.4	72.4

## Business Environment

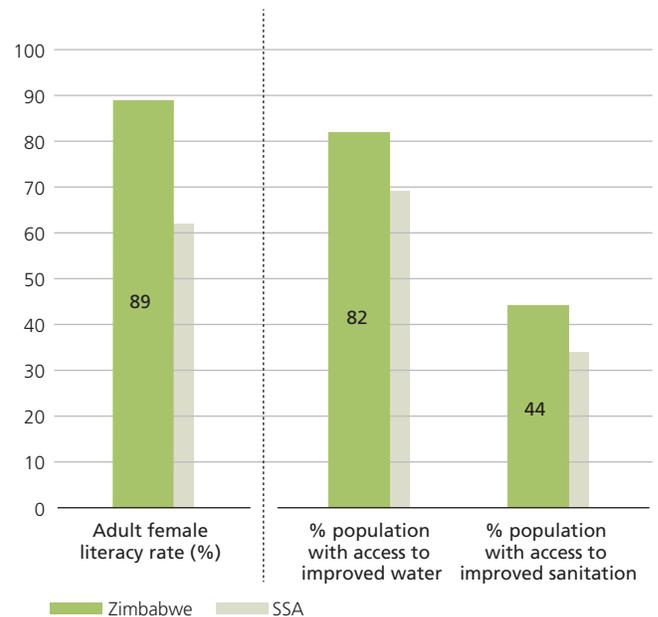
	Zimbabwe	SSA Average
Time to enforce a contract (days)	410	644
Time to prepare and pay taxes (hours per year)	242	317
Time to start a business (days)	90	44
Cost of business start-up (% of income per capita)	183	96

## Intermediate Outcomes

### Access and Quality



## Supporting Services



SSA = Sub-Saharan Africa average

**Table A1.1 Further Details on the Indicators<sup>a</sup> Used in the Snapshots Derived from Third-Party Sources**

Indicator	Year	Definition	Source
Population (millions)	2009	Total population is based on the de facto definition of population, which counts all residents regardless of legal status or citizenship, except for refugees not permanently settled in the country of asylum who are generally considered part of the population of their country of origin. The values shown are midyear estimates.	<i>World Development Indicators, World Bank<sup>b</sup></i>
GNI per capita, Atlas method (current US\$)	2008	GNI (formerly GNP) is the sum of value added by all resident producers, plus any product taxes (less subsidies) not included in the valuation of output, plus net receipts of primary income (compensation of employees and property income) from abroad.	<i>World Development Indicators, World Bank</i>
Life expectancy (years)	2008	Life expectancy at birth indicates the number of years a newborn infant would live if prevailing patterns of mortality at the time of its birth were to stay the same throughout its life.	<i>World Development Indicators, World Bank</i>
Under-5 mortality rate (per 1,000)	2009	Under-5 mortality rate is the probability per 1,000 that a newborn baby will die before reaching age 5, if subject to current age-specific mortality rates.	<i>World Development Indicators, World Bank</i>
Maternal mortality ratio (modeled estimate, per 100,000 live births)	2008	Maternal mortality ratio is the number of women who die during pregnancy and childbirth per 100,000 live births. The data are estimated with a regression model using information on fertility, birth attendants, and HIV prevalence.	<i>World Development Indicators, World Bank</i>
Prevalence of HIV, total (% of population ages 15–49)	2007	Prevalence of HIV refers to the percentage of people ages 15–49 who are infected with HIV.	<i>World Development Indicators, World Bank</i>
Incidence of tuberculosis (% of population)	2008	Incidence of tuberculosis is the estimated number of new pulmonary, smear positive, and extrapulmonary tuberculosis cases. The standard indicator is reported per 100,000 population, but is transformed into percentages for purposes of this report.	<i>World Development Indicators, World Bank</i>
Notified cases of malaria (% of population)	2008	Malaria incidence is expressed as the number of new cases reported by a Ministry of Health, adjusted to take into account (a) incompleteness in reporting systems; (b) patients seeking treatment in the private sector, self-medicating, or not seeking treatment at all; and (c) potential over-diagnosis through the lack of laboratory confirmation of cases. For some African countries, the quality of case reporting is considered insufficient, and estimates are derived from longitudinal studies of malaria incidence recorded in the published literature, with adjustments for population distribution and public health programs. The standard indicator is reported per 100,000 population, but is transformed into percentages for purposes of this report.	Millennium Development Goal Indicators, United Nations Statistics Division
Health expenditure per capita (current US\$)	2007	Total health expenditure is the sum of public and private health expenditures as a ratio of total population. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health, but it does not include provision of water and sanitation. Data are in current U.S. dollars.	<i>World Development Indicators, World Bank</i>
Public sector share of total health expenditure (percent)	2007	Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds.	<i>World Development Indicators, World Bank</i>
Private sector share of total health expenditure (percent)	2007	Private health expenditure includes direct household (out-of-pocket) spending, private insurance, charitable donations, and direct service payments by private corporations.	<i>World Development Indicators, World Bank</i>
Out-of-pocket health expenditure (% of private expenditure on health)	2007	Out-of-pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure.	<i>World Development Indicators, World Bank</i>
Time required to enforce a contract (days)	2010	Time required to enforce a contract is the number of calendar days from the filing of the lawsuit in court until the final determination and, in appropriate cases, payment. Indicators on enforcing contracts measure the efficiency of the judicial system in resolving a commercial dispute.	<i>Doing Business 2011</i>

**Table A1.1, continued**

Indicator	Year	Definition	Source
Time required to prepare and pay taxes (hours per year)	2010	Time it takes to prepare, file, and pay (or withhold) three major types of taxes—the corporate income tax, the value-added or sales tax, and labor taxes, including payroll taxes and social security contributions.	<i>Doing Business 2011</i>
Time required to start a business (days)	2010	Time required to start a business is the number of calendar days needed to complete the procedures to legally operate a business.	<i>Doing Business 2011</i>
Cost of business start-up procedures (% of income per capita)	2010	The cost includes all official fees and fees for legal or professional services if such services are required by law. Cost to register a business is normalized by presenting it as a percentage of GNI per capita.	<i>Doing Business 2011</i>
% children in poorest (richest) quintile with ARI only taken to public facility	Varies by country	Percentage of children under age 3 at the time of survey in poorest (richest) wealth quintile reporting fever/rapid breathing in the last 2 weeks taken only to a public health facility.	Demographic and Health Surveys <sup>c</sup>
% children in poorest (richest) quintile with ARI taken to private facility	Varies by country	Percentage of children under age 3 at the time of survey in poorest (richest) wealth quintile reporting fever/rapid breathing in the last 2 weeks taken to any private health facility (including pharmacies).	Demographic and Health Surveys
% children in poorest (richest) quintile with ARI not taken to any facility	Varies by country	Percentage of children under age 3 at the time of survey in poorest (richest) wealth quintile reporting fever/rapid breathing in the last 2 weeks not taken to any health facility.	Demographic and Health Surveys
% of women receiving all 5 basic services during prenatal care	Varies by country	Percentage of mothers giving birth in the 3 years prior to the time of survey who were checked for blood pressure, urine, and blood, and informed about complications during prenatal care.	Demographic and Health Surveys
Births attended by skilled health staff (% of total)	Varies by country	Births attended by skilled health staff are the percentage of deliveries attended by personnel trained to give the necessary supervision, care, and advice to women during pregnancy, labor, and the postpartum period; to conduct deliveries on their own; and to care for newborns. [Data for the latest available year between 2000 and 2009 presented for each country, average is the Sub-Saharan Africa average for 2009.]	<i>World Development Indicators</i> , World Bank
Immunization, DPT (% of children ages 12–23 months)	2009	Percentage of children ages 12–23 months who received three doses of vaccine against diphtheria, pertussis (or whooping cough), and tetanus (DPT) before 12 months or at any time before the relevant survey.	<i>World Development Indicators</i> , World Bank
Immunization, measles (% of children ages 12–23 months)	2009	Percentage of children ages 12–23 months who received one dose of measles vaccine before 12 months or at any time before the survey.	<i>World Development Indicators</i> , World Bank
Adult female literacy rate	2008	Adult female literacy rate is the percentage of women age 15 and above who can, with understanding, read and write a short, simple statement on their everyday life.	<i>World Development Indicators</i> , World Bank
% of population with access to improved water	2008	Percentage of the population with reasonable access to an adequate amount of water from an improved source, such as a household connection, public standpipe, borehole, protected well or spring, or rainwater collection. Unimproved sources include vendors, tanker trucks, and unprotected wells and springs. Reasonable access is defined as the availability of at least 20 liters per person per day from a source within 1 kilometer of the dwelling.	<i>World Development Indicators</i> , World Bank
% of population with access to improved sanitation	2008	Percentage of the population with at least adequate access to excreta disposal facilities that can effectively prevent human, animal, and insect contact with excreta. Improved facilities range from simple but protected pit latrines to flush toilets with a sewerage connection. To be effective, facilities must be correctly constructed and properly maintained.	<i>World Development Indicators</i> , World Bank

Note: GNI = gross national income, GNP = gross national product, ARI = acute respiratory infection.

a. The engagement indicator is discussed in the Report; conceptual underpinnings and methodological details are presented in Appendixes 3 and 4.

b. *World Development Indicators* is the primary World Bank collection of development indicators, compiled from officially recognized international sources. It presents the most current and accurate global development data available and includes national, regional, and global estimates. It is updated three times a year, and the indicators presented in this Report reflect the last update from December 2010.

c. The Demographic and Health Survey (DHS) provides nationally representative data on maternal and child health, family planning, and other health indicators. DHS survey data presented in this appendix were obtained from the latest available Standard DHS Survey year. Additional analysis on data presented here was carried out by the RAND project team. The countries and years included in the DHS analysis are Benin 2006, Burkina Faso 2003, Cameroon 2004, Chad 2004, Democratic Republic of Congo 2007, Republic of Congo 2005, Ethiopia 2005, Ghana 2008, Guinea 2005, Kenya 2008, Lesotho 2004, Liberia 2006, Madagascar 2008, Malawi 2004, Mali 2006, Mozambique 2003, Namibia 2006, Niger 2006, Nigeria 2008, Rwanda 2005, Senegal 2005, Sierra Leone 2008, Swaziland 2006, Tanzania 2004, Uganda 2006, Zambia 2007, and Zimbabwe 2005.

## APPENDIX 2—Data tables

**Table A2.1: Selected Sub-Saharan African Indicators**

Country	Banner information			Millennium Development Goals					Engagement			
	Population (in '000s) (2009)	GNI per capita, Atlas method (current US\$) (2008)	Life expectancy, years (2008)	Under-5 mortality rate (per 1,000) (2009)	Maternal mortality ratio (modeled estimate, per 100,000 live births) (2008)	Prevalence of HIV, total (% of population ages 15–49) (2007)	Incidence of tuberculosis (as % of population) (2008)	Notified cases of malaria (as % of population) (2008)	Policy and Dialogue Score: Max 10 (2010)	Information Exchange Score: Max 8 (2010)	Regulation Score: Max 13 (2010)	Financing Score: Max 6 (2010)
Angola	18,498	3,330	47	161	610	2.1	0.3	21.6	6	4	5	3
Benin	8,935	700	61	118	410	1.2	0.1	35.6	7	4	8	2
Botswana	1,950	6,550	54	57	190	23.9	0.7	0.6	7	6	6	3
Burkina Faso	15,757	480	53	166	560	1.6	0.2	45.3	8	6	8	2
Burundi	8,303	140	50	166	970	2.0	0.4	48.5	3	2	5	4
Cameroon	19,522	1,140	51	154	600	5.1	0.2	27.8	4	4	6	1
Cape Verde	506	2,830	71	28	94	—	0.2	0.0	4	5	8	6
Central African Republic	4,422	410	47	171	850	6.3	0.3	35.8	4	2	6	1
Chad	11,206	540	49	209	1,200	3.5	0.3	39.5	3	2	4	0
Comoros	659	750	65	104	340	0.1	0.0	24.6	4	2	6	1
Congo, Dem. Rep.	66,020	150	48	199	670	—	0.4	37.4	2	2	5	1
Congo, Rep.	3,683	1,980	54	128	580	3.5	0.4	34.3	6	2	6	1
Côte d'Ivoire	21,075	980	57	119	470	3.9	0.4	36.5	5	5	6	2
Equatorial Guinea	676	14,980	50	145	280	3.4	0.1	27.7	3	2	7	4
Ethiopia	82,825	280	55	104	470	2.1	0.4	11.5	7	6	7	2
Gabon	1,475	7,320	60	69	260	5.9	0.5	29.5	3	2	6	3
Gambia, The	1,705	400	56	103	400	0.9	0.3	31.9	4	2	7	0
Ghana	23,837	1,150	57	69	350	1.9	0.2	31.2	8	5	7	4
Guinea	10,069	340	58	142	680	1.6	0.3	40.6	3	3	6	1
Guinea-Bissau	1,611	460	48	193	1,000	1.8	0.2	34.0	3	2	6	0
Kenya	39,802	730	54	84	530	—	0.3	30.3	9	5	7	2
Lesotho	2,067	1,010	45	84	530	23.2	0.6	—	4	3	6	2
Liberia	3,955	170	58	112	990	1.7	0.3	30.0	6	6	8	1
Madagascar	19,625	420	60	58	440	0.1	0.3	3.7	6	5	8	3
Malawi	15,263	260	53	110	510	11.9	0.3	33.8	7	4	9	2
Mali	13,010	610	48	191	830	1.5	0.3	25.4	7	3	7	3
Mauritania	3,291	980	57	117	550	0.8	0.3	17.3	2	1	5	4
Mauritius	1,275	6,720	73	17	36	1.7	0.0	—	8	8	11	4
Mozambique	22,894	380	48	142	550	12.5	0.4	32.6	4	3	7	0
Namibia	2,171	4,260	61	48	180	15.3	0.8	4.6	6	5	11	3
Niger	15,290	330	51	160	820	0.8	0.2	38.0	7	5	6	0
Nigeria	154,729	1,170	48	138	840	3.1	0.3	38.3	8	5	8	2
Rwanda	9,998	410	50	111	540	2.8	0.4	11.4	8	6	7	6
São Tomé and Príncipe	163	1,020	66	78	—	—	0.1	2.0	3	4	3	0
Senegal	12,534	980	56	93	410	1.0	0.3	7.1	5	5	7	3
Seychelles	88	10,530	73	12	—	—	0.0	—	5	8	12	1
Sierra Leone	5,696	320	48	192	970	1.7	0.6	36.1	6	4	8	1
South Africa	49,320	5,870	51	62	410	18.1	1.0	0.1	9	5	13	3
Sudan	42,272	1,120	58	108	750	1.4	0.1	12.8	6	5	10	4
Swaziland	1,185	2,560	46	73	420	26.1	1.2	0.1	3	4	7	2
Tanzania	43,739	460	56	108	790	6.2	0.2	24.1	8	5	7	2
Togo	6,619	410	63	98	350	3.3	0.4	30.4	6	3	8	1
Uganda	32,710	420	53	128	430	5.4	0.3	36.2	7	5	8	2
Zambia	12,935	960	45	141	470	15.2	0.5	13.5	7	4	9	3
Zimbabwe	12,523	—	44	90	790	15.3	0.8	7.5	6	4	10	1
Average	18,353	1,934	55	115	536	6.0	0.4	24.5	5	4	7	2

	Public Provision of Services Score: max 2 (2010)	Public sector governance CPIA quality of public administration rating (1 = low to 6 = high) (2009)	Health expenditure				Business environment				Supporting services		
			Health expenditure per capita (current US\$) (2007)	Public sector share of total health expenditure (%) (2007)	Private sector share of total health expenditure (%) (2007)	Out-of-pocket health expenditure (% of private expenditure on health) (2007)	Time required to enforce a contract (days) (2010)	Time required to prepare and pay taxes (hours per year) (2010)	Time required to start a business (days) (2010)	Cost of business start-up procedures (% of income per capita) (2010)	Adult female literacy rate (2008)	% of population with access to improved water (2008)	% of population with access to improved sanitation (2008)
	2	2.5	85.7	80.3	19.7	100.0	1,011	282	68	163	57.0	50	57
	2	3	31.9	51.8	48.2	94.9	825	270	31	152.6	28.1	75	12
	2	—	372.0	74.6	25.4	27.3	625	152	61	2.2	83.5	95	60
	1	3.5	29.3	56.1	43.9	91.3	446	270	14	49.8	—	76	11
	1	2.5	17.3	37.7	62.3	60.5	832	211	32	129.3	59.9	72	46
	2	3	54.3	25.9	74.1	94.5	800	654	19	51.2	67.8	74	47
	2	4	132.3	74.6	25.4	99.7	425	186	11	18.5	79.3	84	54
	1	2.5	16.5	34.7	65.3	95.0	660	504	22	228.4	41.1	67	34
	1	2.5	31.7	56.3	43.7	96.2	743	732	75	226.9	21.9	50	9
	0	2.5	23.5	57.2	42.8	100.0	506	100	24	176.5	67.8	95	36
	1	2	9.2	20.8	79.2	51.7	625	336	84	735.1	56.1	46	23
	2	2.5	51.8	70.4	29.6	100.0	560	606	160	111.4	—	71	30
	1	2	40.7	24.0	76.0	88.7	770	270	40	133	44.3	80	23
	1	—	347.5	80.4	19.6	75.6	553	492	136	104.3	89.1	—	—
	2	3.5	9.2	58.1	41.9	80.6	620	198	9	14.1	22.8	38	12
	1	—	372.6	64.5	35.5	100.0	1,070	488	58	21.9	83.2	87	33
	2	3	21.9	47.9	52.1	48.4	434	376	27	199.6	34.3	92	67
	2	3.5	54.1	51.6	48.4	79.3	487	224	12	20.3	59.3	82	13
	1	3	25.6	11.0	89.0	99.5	276	416	41	146.6	26.4	71	19
	2	2.5	15.5	25.9	74.1	55.7	1,140	208	216	183.3	36.5	61	21
	2	3.5	33.8	42.0	58.0	77.2	465	393	33	38.3	82.8	59	31
	2	3	51.1	58.3	41.7	68.9	785	324	40	26	95.1	85	29
	2	2.5	21.5	26.2	73.8	52.2	1,280	158	20	54.6	53.0	68	17
	2	3.5	16.3	66.2	33.8	67.9	871	201	7	12.9	65.3	41	11
	2	3.5	16.7	59.7	40.3	28.4	312	157	39	108.4	65.8	80	56
	2	3	34.3	51.4	48.6	99.5	620	270	8	79.7	—	56	36
	1	3	21.7	65.3	34.7	100.0	370	696	19	33.6	49.5	49	26
	1	—	246.9	49.0	51.0	81.5	645	161	6	3.8	84.8	99	91
	1	3	18.1	71.8	28.2	42.1	730	230	13	13.9	40.1	47	17
	2	—	318.5	42.1	57.9	5.8	270	375	66	18.5	87.7	92	33
	1	3	16.4	52.8	47.2	96.4	545	270	17	118.6	—	48	9
	2	3	74.2	25.3	74.7	95.9	457	938	31	78.9	48.8	58	32
	2	3.5	37.2	47.0	53.0	44.4	230	148	3	8.8	66.1	65	54
	0	3	102.7	47.1	52.9	58.9	1,185	424	144	77.3	83.3	89	26
	2	3.5	54.2	56.0	44.0	78.5	780	666	8	63.1	—	69	51
	1	—	564.0	70.2	29.8	62.5	720	76	39	17.5	92.3	—	—
	2	3	13.5	31.3	68.7	58.8	515	357	12	110.7	28.9	49	13
	2	—	497.1	41.4	58.6	29.7	600	200	22	6	88.1	91	77
	2	2.5	40.5	36.8	63.2	100.0	810	180	36	33.6	59.6	57	34
	2	—	151.1	62.5	37.5	42.3	972	104	56	33	85.6	69	55
	2	3.5	21.7	65.8	34.2	75.0	462	172	29	30.9	66.3	54	24
	1	2	32.9	24.9	75.1	84.2	588	270	75	178.1	53.7	60	12
	2	3	27.8	26.2	73.8	51.0	490	161	25	94.4	66.8	67	48
	2	3	57.1	57.7	42.3	67.6	471	132	18	27.9	61.0	60	49
	2	1.5	78.6	46.3	53.7	50.4	410	242	90	182.8	88.8	82	44
	2	2.9	95.3	49.5	50.5	72.4	644	317	44	96	61.8	69	34

continued

Table A2.1, (continued)

Country	Health care access and quality									
	DPT Immunization (% of children ages 12–23 months) (2009)	Measles Immunization (% of children ages 12–23 months) (2009)	PUBLIC—% of children in poorest quintile with ARI only taken to public facility	PRIVATE—% of children in poorest quintile with ARI taken to private facility (2003–2008)*	NONE—% of children in poorest quintile with ARI not taken to any facility (2003–2008)*	PUBLIC—children in richest quintile with ARI only taken to public facility (2003–2008)*	PRIVATE—% of children in richest quintile with ARI taken to private facility (2003–2008)*	NONE—% of children in richest quintile with ARI not taken to any facility (2003–2008)*	% of women receiving all 5 basic services during prenatal care (2003–2008)*	Births attended by skilled health staff (% of total) (2000–2009)*
Angola	73	77	—	—	—	—	—	—	—	47.3
Benin	83	72	22	9	69	26	39	35	16.0	74
Botswana	96	94	—	—	—	—	—	—	—	94.6
Burkina Faso	82	75	27	2	71	61	16	23	5.8	53.5
Burundi	92	91	—	—	—	—	—	—	—	33.6
Cameroon	80	74	25	6	69	31	40	29	25.7	63
Cape Verde	99	96	—	—	—	—	—	—	—	77.5
Central African Republic	54	62	—	—	—	—	—	—	—	43.7
Chad	23	23	2	8	90	21	3	76	3.3	14.4
Comoros	83	79	—	—	—	—	—	—	—	61.8
Congo, Dem. Rep.	77	76	24	29	47	13	62	25	18.2	74
Congo, Rep.	91	76	30	4	66	56	27	17	32.0	83.4
Côte d'Ivoire	81	67	—	—	—	—	—	—	—	56.8
Equatorial Guinea	33	51	—	—	—	—	—	—	—	64.6
Ethiopia	79	75	19	3	78	22	14	64	2.8	5.7
Gabon	45	55	—	—	—	—	—	—	—	85.5
Gambia, The	98	96	—	—	—	—	—	—	—	56.8
Ghana	94	93	38	14	48	66	15	19	60.0	57.1
Guinea	57	51	23	8	69	46	14	40	12.4	46.1
Guinea-Bissau	68	76	—	—	—	—	—	—	—	38.8
Kenya	75	74	52	13	35	36	41	23	28.8	43.8
Lesotho	83	85	30	19	51	38	44	18	28.4	61.5
Liberia	64	64	28	19	53	53	37	10	18.7	46.3
Madagascar	78	64	30	3	67	28	38	34	12.4	43.9
Malawi	93	92	23	8	69	30	14	56	11.2	53.6
Mali	74	71	23	4	73	43	27	30	9.1	49
Mauritania	64	59	—	—	—	—	—	—	—	60.9
Mauritius	99	99	—	—	—	—	—	—	—	99.2
Mozambique	76	77	41	1	58	60	7	33	16.0	55.3
Namibia	83	76	53	7	40	41	56	3	53.1	81.4
Niger	70	73	21	16	63	47	27	26	5.1	32.9
Nigeria	42	41	14	37	49	28	47	25	29.6	38.9
Rwanda	97	92	26	17	57	33	34	33	0.8	52.1
São Tomé and Príncipe	98	90	—	—	—	—	—	—	—	81.7
Senegal	86	79	37	1	62	42	28	30	20.1	51.9
Seychelles	99	97	—	—	—	—	—	—	—	—
Sierra Leone	75	71	35	8	57	32	30	38	25.5	42.4
South Africa	69	62	—	—	—	—	—	—	—	91.2
Sudan	84	82	—	—	—	—	—	—	—	49.2
Swaziland	95	95	54	13	33	47	36	17	46.6	69
Tanzania	85	91	45	33	22	41	47	12	20.2	43.4
Togo	89	84	—	—	—	—	—	—	—	62
Uganda	64	68	37	47	16	18	69	13	4.2	41.9
Zambia	81	85	53	19	28	51	9	40	15.5	46.5
Zimbabwe	73	76	14	7	79	33	26	41	29.1	60.2
Average	77.4	75.69	30	13	57	39	31	30	20.39	44.4

Note: — = data not available.

\* data refer to the most recent year available during the period specified in the column heading.

The data tables restate the data from the snapshots and expand the indicator set with additional measures. The additional measures are from the Demographic and Health Survey (DHS) and from the World Bank's Country Policy and Institutional Assessment (CPIA).

To provide a more comprehensive and more complete picture of the contributions of the private health sector, we offer additional DHS measures in table A2.2. The details regarding the additional DHS measures are discussed in table A2.3.

**Table A2.2: Selected Indicators from Demographic and Health Survey Data**

Country	Knowledge of modern health care services		Use of modern health care services			Barriers to access		Overall private sector market share		
	% currently married women with knowledge of modern contraception	% mothers with knowledge of ORS	% currently married women with unmet need for contraception	% of births taking place in health facility	% children with ARI taken to health facility	% women reporting distance to health facility as problem for access	% women reporting cost as problem for access	Women obtaining modern contraception from private medical sector source, as % total users	Births taking place in private health facility as % of births in any facility	Children under 3 years with acute respiratory infection taken to private facility as % of total taken to any facility
Benin	90.1	70.7	29.9	80.1	41.7	—	—	34.7	17.9	36.4
Burkina Faso	90.4	66.7	28.8	38.9	39.4	46.4	63.0	13.8	1.8	11.8
Cameroon	88.5	54.9	20.2	60.0	50.3	38.7	65.6	25.0	30.6	41.0
Chad	48.6	64.5	19.1	13.6	8.7	—	—	12.8	13.9	28.5
Congo, Dem. Rep.	76.7	78.0	24.4	72.0	59.0	40.4	75.6	58.4	29.4	59.8
Congo, Rep.	96.3	54.3	16.2	82.6	57.0	—	—	26.4	9.8	24.1
Ethiopia	87.4	45.8	33.8	5.8	22.4	67.7	75.6	16.9	8.4	25.3
Ghana	97.8	89.6	35.3	58.0	63.8	25.9	45.1	47.1	17.0	27.7
Guinea	92.6	88.9	21.2	31.3	47.1	55.0	73.3	19.3	5.2	19.1
Kenya	96.2	78.7	25.6	43.4	66.4	—	—	35.9	25.5	34.7
Lesotho	98.1	88.1	31.0	52.4	61.6	27.5	39.1	15.4	25.6	38.9
Liberia	86.7	91.0	35.6	39.9	68.6	48.6	53.6	30.5	26.3	40.6
Madagascar	95.0	40.5	18.9	34.8	45.4	20.6	27.0	19.6	7.7	32.4
Malawi	98.6	93.9	27.6	56.8	36.7	59.9	61.5	3.3	27.2	23.8
Mali	75.0	65.3	31.2	47.3	40.2	38.4	52.5	36.9	5.6	16.8
Mozambique	90.4	86.9	18.4	49.1	58.4	51.6	57.1	10.7	0.4	3.2
Namibia	99.0	90.3	20.6	81.4	68.3	41.5	38.9	10.1	5.5	17.7
Niger	68.3	78.4	15.8	18.6	48.5	51.1	64.9	24.1	2.3	42.3
Nigeria	76.2	65.0	16.9	35.4	61.3	24.4	30.4	56.7	42.9	65.1
Rwanda	97.5	86.4	37.9	29.3	47.9	40.0	70.8	14.1	4.9	42.8
Senegal	93.1	64.4	31.6	63.6	53.9	36.2	53.3	21.9	6.5	23.9
Sierra Leone	66.2	90.8	27.6	24.8	51.6	52.9	80.0	38.9	10.9	25.8
Swaziland	99.9	98.0	23.8	75.1	77.1	24.5	25.2	30.5	41.0	32.8
Tanzania	97.4	95.5	21.8	47.5	87.5	37.6	39.9	15.5	20.5	45.6
Uganda	96.9	86.1	40.6	42.4	81.9	54.5	65.2	51.7	28.2	66.4
Zambia	98.7	94.3	26.5	47.7	68.0	40.8	33.6	16.5	10.2	18.2
Zimbabwe	99.2	—	12.0	66.7	27.5	41.3	57.8	22.1	18.2	24.0
Average	89.1	76.3	25.9	48.1	52.4	42.0	54.3	25.8	16.1	31.6

Disparities in access to private health care												Quality of care			
Women obtaining modern contraception from private medical sector source as % of total users				Births in private facility as % of total births in facility				Children under 3 years with acute respiratory infection taken to private facility as % of total taken to any facility				% of women informed of side effects of current method as % of contraceptive users	% of women receiving all 5 basic services during prenatal care	Neonatal mortality rate in facilities (% of births): Public	Neonatal mortality rate in facilities (% of births): Private
Urban	Rural	Poorest	Richest	Urban	Rural	Poorest	Richest	Urban	Rural	Poorest	Richest				
45.6	16.5	16.7	52.0	25.1	13.5	12.7	30.9	50.0	28.1	30.3	59.6	49.0	16.0	2.2	2.1
20.3	4.7	2.1	20.1	5.1	0.5	0.0	4.8	22.7	8.6	6.2	20.7	63.0	5.8	2.0	0.0
26.8	18.4	14.7	28.7	31.5	29.2	29.1	28.8	51.5	26.5	19.4	56.7	44.0	25.7	2.0	2.0
14.5	6.4	0.0	14.5	7.6	25.8	47.6	6.5	15.4	42.3	83.4	11.4	—	3.3	1.6	2.4
60.4	54.4	43.0	69.4	46.0	13.8	9.5	56.9	72.6	50.0	54.7	82.4	40.0	18.2	2.4	2.2
31.7	15.4	7.2	37.1	13.1	6.1	6.6	9.2	22.1	27.4	10.9	32.3	—	32.0	3.1	1.9
24.0	13.1	0.1	21.6	5.9	11.9	15.3	5.8	42.4	23.2	14.3	39.5	34.0	2.8	5.1	0.0
53.9	40.3	30.2	52.6	20.8	12.4	7.4	24.4	22.4	31.4	27.1	18.9	49.0	60.0	2.8	0.6
21.2	15.3	6.8	19.9	9.5	1.2	0.0	13.2	14.8	20.7	26.6	23.2	51.0	12.4	3.4	4.3
45.8	31.7	16.2	47.0	31.1	22.7	11.6	36.9	45.8	32.2	20.4	53.0	45.0	28.8	3.8	5.1
16.4	14.9	3.4	19.8	20.6	27.1	20.9	26.1	45.9	37.9	38.6	54.0	—	28.4	2.4	2.9
33.3	25.3	17.4	43.3	30.2	21.8	17.3	39.2	39.4	41.0	40.5	41.0	—	18.7	1.8	2.8
41.2	14.4	5.4	42.0	19.5	5.0	0.9	19.3	63.7	24.6	9.9	57.5	45.0	12.4	2.3	1.1
3.3	3.4	2.9	3.3	21.8	28.5	21.0	30.6	15.8	24.7	24.8	31.0	69.0	11.2	1.7	1.7
49.0	17.1	18.2	48.2	5.3	5.7	8.6	6.3	35.2	6.0	13.6	38.6	42.0	9.1	2.7	3.7
13.9	3.9	4.2	15.5	0.5	0.4	0.5	0.8	6.8	0.8	1.4	10.1	58.0	16.0	2.3	0.0
15.2	2.9	0.0	26.6	9.3	2.1	0.3	21.2	30.8	10.7	11.8	58.2	45.0	53.1	2.0	0.4
32.7	13.6	8.2	30.9	3.5	0.5	2.7	3.5	35.7	44.0	44.1	36.6	36.0	5.1	2.3	0.0
56.3	57.3	51.8	55.6	48.4	37.2	35.4	53.2	68.5	63.6	72.4	62.7	42.0	29.6	3.3	3.7
29.9	7.6	4.4	23.2	10.9	2.7	4.2	8.6	55.0	39.4	40.0	50.9	53.0	0.8	2.9	0.0
25.4	12.4	5.2	32.0	9.0	3.8	0.9	17.1	33.0	13.9	3.6	40.4	49.0	20.1	2.0	2.8
45.7	22.9	18.9	45.2	20.7	3.7	4.6	31.5	46.9	20.8	18.2	48.6	—	25.5	2.8	5.0
41.2	25.4	19.8	43.4	50.6	37.4	39.1	47.2	47.1	30.8	18.9	43.4	49.0	46.6	2.0	0.5
25.3	7.2	6.9	26.1	12.2	24.7	21.8	16.3	46.6	45.4	42.1	53.6	64.0	20.2	2.4	3.5
56.8	49.4	37.7	58.3	26.3	28.7	22.6	31.6	71.4	65.9	56.4	79.4	50.0	4.2	2.1	1.6
23.6	8.6	4.5	27.6	5.2	15.5	17.4	7.9	9.6	22.3	26.1	14.5	67.0	15.5	2.9	3.2
40.2	9.2	4.7	44.5	13.2	21.5	23.4	21.2	47.2	13.8	33.9	43.9	45.0	29.1	2.1	0.6
32.7	18.4	13.0	35.1	18.6	14.5	14.1	22.2	38.9	28.7	29.2	43.0	47.3	20.4	2.6	2.0

Note: — = data not available.

**Table A2.3 Definitions for Country Policy and Institutional Assessment<sup>a</sup> and Demographic and Health Survey Indicators<sup>b</sup> Presented in Table A2.2**

Indicator	Definition
CPIA quality of public administration rating (1=low to 6=high)	Extent to which civilian central government staff is structured to design and implement government policy and deliver services effectively
% currently married women with knowledge of modern contraception	Percentage of currently married women at time of survey who report knowing any modern method of contraception
% mothers with knowledge of ORS	Percentage of mothers of children under age 3 at the time of survey who report knowing about ORS as a treatment for diarrhea
% currently married women with unmet need for contraception	Percentage of currently married women at time of survey who are assumed to be fecund but are not using contraception and (a) have unmet need for spacing (want to wait >2 years for next birth, unsure if or when to have next birth, or are experiencing/have recently had mistimed pregnancy) or (b) have unmet need for limiting (do not want more children and are experiencing or have recently had unwanted pregnancy)
% of births taking place in health facility	Percentage of deliveries up to 3 years prior to the time of survey taking place in any health facility
% children with ARI taken to health facility	Percentage of children under age 3 at the time of survey in poorest wealth quintile reporting fever/rapid breathing in the last 2 weeks and taken to any health facility (including pharmacies)
% women reporting distance to health facility as problem for access	Percentage of women of reproductive age reporting "distance to a health facility" as a problem when obtaining care for self
% women reporting cost as problem for access	Percentage of women of reproductive age reporting "cost" as a problem when obtaining care for self
Women obtaining modern contraception from private medical sector source as % total users	Percentage of women of reproductive age reporting currently using modern contraceptive methods (including pills, IUD, injectables, female sterilization, or implants) who obtain their method from private medical sector (including pharmacies)
Women obtaining modern contraception from private medical sector source as % total users (urban, rural, poorest, richest)	Percentage of women of reproductive age reporting currently using modern contraceptive methods who obtain their method from private medical sector (including pharmacies); expressed by location of residence and wealth quintile
Births taking place in private health facility as % of births in any facility	Number of deliveries up to 3 years prior to the time of survey taking place in any private health facility as a percentage of the total number of deliveries up to 3 years prior to the time of survey taking place in any health facility
Births in private facility as % of total births in facility (urban, rural, poorest, richest)	Number of deliveries up to 3 years prior to the time of survey taking place in any private health facility as a percentage of the total number of deliveries up to 3 years prior to the time of survey taking place in any health facility; expressed by location of residence and wealth quintile
Children under age 3 with acute respiratory infection taken to private facility as % of total taken to any facility	Number of children under age 3 at the time of survey reporting fever/rapid breathing in the last 2 weeks taken to any private health facility (including pharmacies) as a percentage of the number of children under age 3 at the time of survey reporting fever/rapid breathing in the last 2 weeks taken to any facility
Children under age 3 with acute respiratory infection taken to private facility as % of total taken to any facility (urban, rural, poorest, richest)	Number of children under age 3 at the time of survey reporting fever/rapid breathing in the last 2 weeks taken to any private health facility (including pharmacies) as a percentage of the number of children under age 3 at the time of survey reporting fever/rapid breathing in the last 2 weeks taken to any facility; expressed by location of residence and wealth quintile
% women informed of side effects of current method as % of contraceptive users	Percentage of women of reproductive age reporting currently using modern contraceptive methods who report being informed about side effects
% of women receiving all 5 basic services during prenatal care	Table A1.1
Neonatal mortality rate in facilities (% births); public	Number of deliveries in any public facility with reported deaths under 1 week from birth as a percentage of total deliveries in any public facility
Neonatal mortality rate in facilities (% births); private	Number of deliveries in any private facility with reported deaths under 1 week from birth as a percentage of total deliveries in any private facility

Note: ARI = acute respiratory infection, IUD = intrauterine device, ORS = oral rehydration salts.

- a. The World Bank's Country Policy and Institutional Assessment (CPIA) rates countries against a set of 16 criteria grouped in 4 clusters: economic management; structural policies; policies for social inclusion and equity; and public sector management and institutions. The rating ranges from 1 = low to 6 = high. We include the ratings for the quality of public administration criteria from the 2009 CPIA as an additional measure of the operating environment for private health providers.
- b. The Demographic and Health Survey (DHS) provides nationally representative data on maternal and child health, family planning, and other health indicators. DHS survey data presented in this appendix were obtained from the latest available Standard DHS Survey year. Additional analysis on data presented here was carried out by the RAND project team. The countries and years included in the DHS analysis are Angola 2006, Benin 2006, Burkina Faso 2003, Cameroon 2004, Chad 2004, Democratic Republic of Congo 2007, Republic of Congo 2005, Ethiopia 2005, Ghana 2008, Guinea 2005, Kenya 2008, Lesotho 2004, Liberia 2006, Madagascar 2008, Malawi 2004, Mali 2006, Mozambique 2003, Namibia 2006, Niger 2006, Nigeria 2008, Rwanda 2005, Senegal 2005, Sierra Leone 2008, Swaziland 2006, Tanzania 2004, Uganda 2006, Zambia 2007, and Zimbabwe 2005.

## APPENDIX 3—Conceptual background on engagement framework

This appendix provides further detail and the conceptual background on the engagement framework introduced in the Report. The framework grew out of an extensive consultative development process of more than two years. Please refer to the background paper available at [www.wbginvestmentclimate.org/health](http://www.wbginvestmentclimate.org/health) for a discussion of the development process itself, and of the alternative frameworks that were considered but ultimately discarded in favor of the one presented here.

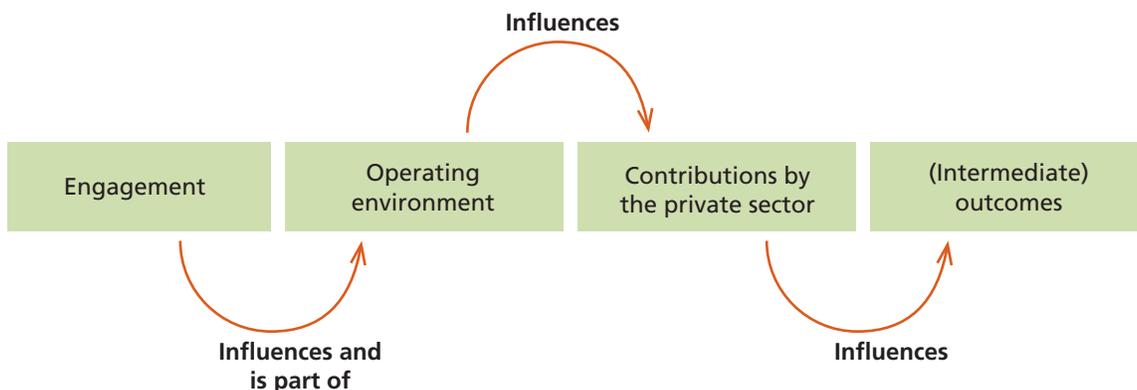
The starting point for both the Report and the framework is the understanding that the operating environment is a constraint to greater contributions of the private health sector to health systems performance. This understanding grew out of the findings of the earlier International Financial Corporation report, “The Business of Health in Africa,” and was confirmed by the increased attention of national governments and

international partners to the operating environment of the private health sector.<sup>108</sup>

The fact that a constraint (the operating environment) to better contributions by the private health sector was identified matters, because if such contributions could be improved, health systems performance would improve as well, which in turn would improve the ultimate outcomes (for example, people’s health). This logical framework was discussed in the Report, but is considered here in slightly more detail and is presented schematically in figure A3.1.

This Report’s focus on public-private engagement, therefore, is based on the understanding that it is through engagement that major elements of the inappropriate operating environment for private providers can be identified and improved. Such improvements in the operating environment, in turn, will relieve one of the key constraints to enhancing the contributions of the

Figure A3.1 Simplified Logic Model for Private Health Sector Contributions to Health Outcomes



private health sector and to improving health systems overall.

This model is a crude simplification and adaptation of the more comprehensive logical model that is typically used for the health sector, such as the one depicted in figure A3.2. The essence of it, however, is the same.

Figure A3.2 is also a schematic representation of the underlying theory: engagement can impact health sector characteristics and, therefore, the private health sector’s contribution to the health system overall. This, in turn, will impact those things we really care about—health outcomes and protection from financial risk.

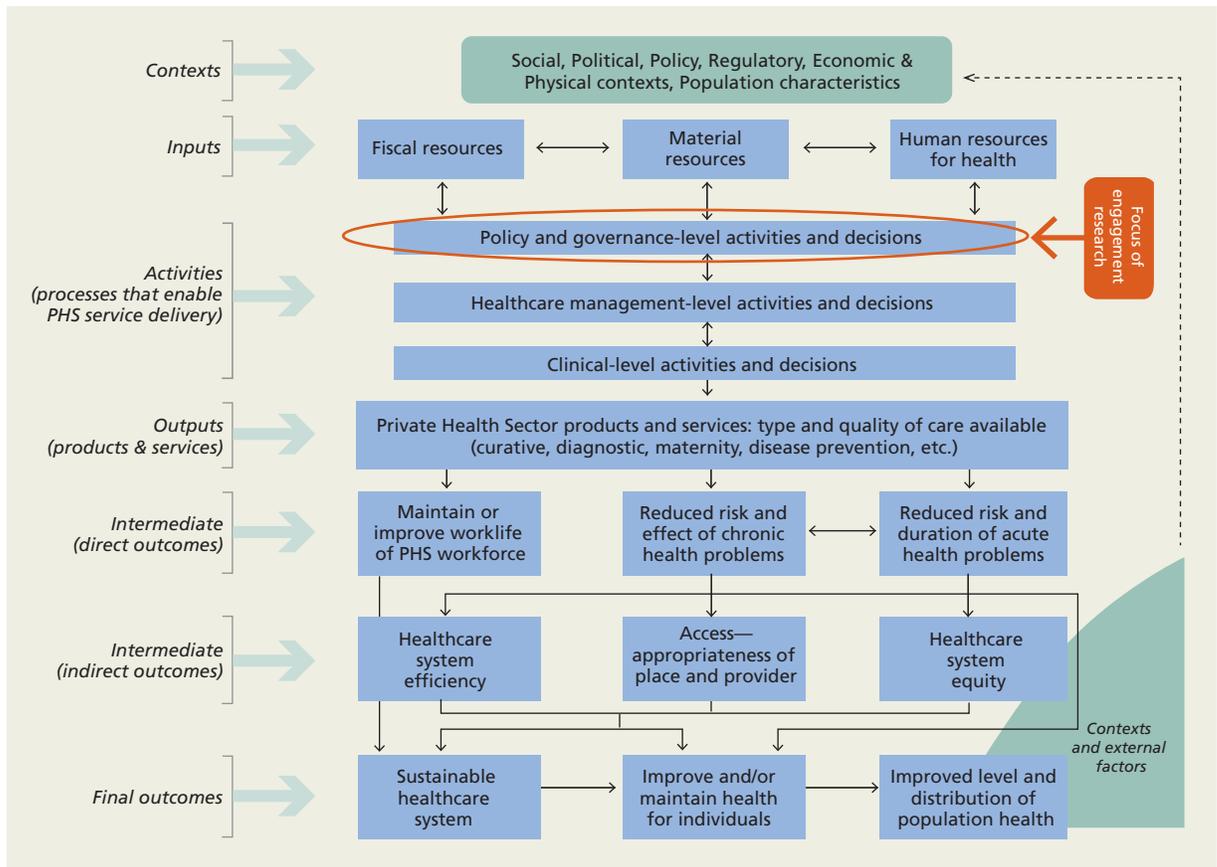
### Setting the context—Engagement as a part of stewardship

Engagement with the private health sector is part of the broader concept of stewardship, or overall

government responsibility for the health sector. The World Health Organization’s *World Health Report 2000* describes stewardship as involving oversight of “the entire health system” (p. 123), private as well as public. Key elements of this government responsibility—usually through a health ministry—include strategic planning, regulating, monitoring and evaluating, and setting and enforcing the rules and incentives that define the environment and guide the behavior of health system players.

This Report’s focus on government engagement with the private health sector does not suggest that other stewardship functions are less important in reaching health targets. Rather, the focus on engagement is motivated by the fact that relatively little attention has been paid to how governments are engaging the private sector at the systems level. Given the poor performance of many health systems in Africa, and the large size

**Figure A3.2 Logic Model for Private Health Sector Contributions to Health Outcomes**



Source: Adapted from Watson, Broemeling, and Wong 2009.  
Note: PHS = private health sector.

of the private health sector, a closer look at how engagement is currently carried out, and how it might be improved, is especially important.

### **The shifting stewardship role in Africa**

In recent years, the way in which governments have been carrying out their stewardship functions has been shifting significantly. As the capacity of nonstate oversight mechanisms within the private health delivery system grows, the mechanics of transactions between public and private sectors become institutionalized and the role of government increasingly emphasizes strategy and the ongoing review and adjustment of rules to ensure efficient and fair functioning of the market, equitable distribution, and acceptable levels of quality. Two important trends are underway in different countries in the Africa region:

- The separation of stewardship functions such as policy and strategy from the management of publicly provided services
- The separation of stewardship functions from the financing functions such as revenue generation, risk pooling, and purchasing.

In Organisation for Economic Co-Operation and Development countries, the experience has been an evolution from the direct provision of care to a more nuanced balance. In Africa, the same evolution has also been happening, at different speeds in different countries. But the continental trend is unmistakable. Ghana provides the clearest example of this evolution: in 1997, the country created the Ghana Health Services (GHS), separating the provision of care (now under GHS) from the policy functions of the Ministry of Health. In 2004, Ghana went further and separated the bulk of financing and risk pooling from policy, creating the Ghana National Health Insurance Scheme and giving it a degree of autonomy from both governmental delivery, in the form of the GHS, and governmental policy, in the form of the Ministry of Health. Similar changes are occurring in other countries across Africa, such as Namibia, Nigeria, Rwanda, and Uganda.

It is in this context of the evolving roles in the ministries, or in observations that their neighboring country ministries are evolving, that policy makers are asking for support. A central challenge for them and, therefore, for this Report is that private health sector engagement requires not only the point of view of health and health systems, but also the point of view of private sector development and a careful consideration of the business environment.

### **Building the analytic framework for engagement**

The project team set out to create a conceptual framework capable of measuring and enabling comparison of how governments are engaging the private health sector in each country. Engagement was defined as the deliberate, systematic collaboration of the government and the private health sector according to national health priorities, beyond individual interventions and programs. The engagement framework is based on the classic role of the state and the policy instruments that governments can use to influence the private health sector, as adapted by Harding and Preker (2003). Engagement, therefore, is broken down into five domains, each of which is bidirectional to and from the private health sector, and each interacts with the others:

- Policy and dialogue
- Information exchange
- Regulation
- Financing
- Public provision of services.

Each of the domains represents a key aspect of government engagement with the private health sector. Although it is not a specific policy instrument, the policy and dialogue domain measures the underlying policy framework for, and dialogue with, the private health sector. The other domains cover the range of policy instruments that governments can use to engage the private health sector—information exchange, regulation, financing, and public provision of services.

### Defining the constructs to be measured

The operating environment for private health providers is best understood as consisting of three interrelated elements:

- The health side, affecting all operators in the health sector
- The private sector side, to which all private companies in any sector are subject
- Elements of the operating environment that are unique to the private health sector, that is, specific issues in the operating environment that affect private businesses engaging in health service delivery.

Table A3.1 delineates areas specific to the private health sector, and the more general areas from the private sector and health system perspectives. The dark green areas are the areas of focus for the framework, and those shaded in light green are secondary areas of focus, given their overall importance to public-private collaboration.

What follows is a brief discussion of each of the domains. Background is provided for the key constructs in each domain, as is an explanation of how they link to the measures discussed in Section 2 of the Report.

### Policy and Dialogue

Policy and dialogue is the starting point for measuring government engagement with the private health sector; it underlines and summarizes government intentions for the use of the other policy instruments. Given the frequent mistrust and suspicion between the government and private providers in many countries, establishing an underlying policy framework for the private health sector can help lay the foundation for practical engagement by framing the intention for the relationship as one of collaboration rather than competition. The existence of a functioning dialogue mechanism with the private providers shows that the government is aware of their presence, takes them into account, and views

**Table A3.1 Domain Matrix for Indicator Development**

	Private sector	Private health sector		Health	
Policy and dialogue	Overall policy, inclusion, and attitude of government toward private sector	Specific policy and private health sector dialogue		Degree of government ownership of its role as steward of the whole health system	
Information exchange	Less applicable to private sector; information related to registration and accreditation under "regulation"	Specific information exchange for private health sector	Full inclusion of the private sector in the information system	Quality of overall health information management system	
Regulation	Regulatory burden on private sector (e.g., ease of entry)	Applicability of general regulatory burden for private health service providers	Regulatory framework specific for private health sector	Equal treatment in terms of quality restrictions, inspections, etc.	Capacity of the government to exercise oversight role generally for the public sector
Financing	Use of private providers for the delivery of public services in other sectors (education, infrastructure, water, etc.)	Public money flowing to the private health sector for the delivery of services		Government capacity in decentralized financing and availability or strength of risk-pooling mechanisms	
Public provision of services	Provision of basic services for private sector operations, such as electricity, water, education	Public provision of services to crowd out private providers (e.g. due to perceived lack of quality)	Full inclusion of the private sector in the distribution of public goods (e.g., vaccination programs)	Coverage and quality of services provided through the public health system	

Source: "Healthy Partnerships" data, 2010.

■ Primary areas of focus  
■ Secondary areas of focus

them as a partner to improve overall health systems performance. Taken together, policy and dialogue presents the overall context for the private health sector across the region.

In light of the fact that the government's stewardship role toward public and private health sector providers can be significantly different, the domain focuses on policy and dialogue specific to the private health sector. The key construct here, therefore, is finding out the intention and action of the government toward the private health sector. The policy and dialogue domain captures both overall intentions toward, and current level of government engagement with, the private health sector by measuring two things:

- The existence of a private health sector policy framework and its implementation
- The presence of a dialogue mechanism between the government and the private health sector, as well as actual levels of dialogue.

### ***Information Exchange***

A key ingredient of engagement is the government having accurate information on the private health sector. In practical terms, this requires the development of an information exchange between the government and the private health sector so that important data about the scale and scope of private providers can be collected by the government and then used in a strategic manner to ensure private health care is used as efficiently as possible to further overall health goals. Indeed, having more systematic information about health markets is a key first step in any reform. This is especially pertinent if the private health sector is providing a large amount of care in a country, as it does in much of the Africa region.

Unlike the other domains, however, information exchange is not something that needs to be done specifically for the private health sector. The government, as the steward of the entire health system, needs to have basic information on all the health service facilities, regardless of whether they are public or private, for appropriate planning and action. Moreover, government must inform private practitioners and facilities of changing regulations, infectious disease outbreaks, new treatment protocols, and other information relevant to their

operations or delivery of care. In such cases, the critical factor is not the creation of systems specific to the private health sector that parallel those in the public sector; rather, the critical factor is that the government is fully including the private health sector in the various information functions it has under its jurisdiction.

The key construct for the information exchange domain, therefore, is whether the private health sector is included in the governments' information systems. This includes whether there is a flow of basic information between the government and private providers both in terms general information on the operating environment and for the health information management system. Private sector participation in national disease surveillance programs, a critical function of a Ministry of Health, is also measured. Information collection, dissemination, and management, with the full inclusion of the private providers, should be part of the government's overall strategy for the health sector as a key element of ensuring the outcomes intended.

### ***Regulation***

Most governments in the region view their role vis-à-vis the private health sector primarily as that of regulators. Thus, their penchant for turning to regulation—setting rules to direct, prescribe, or otherwise influence the actions of private providers—to solve problems is often strong. The use of regulation, among other public interventions, is usually justified, in economic terms, by the intent to correct a market failure. Evidence from other country contexts suggests, however, that engagement of the private health sector is almost always designed with an overemphasis on regulation. Often these regulations prescribe unrealistic requirements for registration, licensing, use of medical equipment, or the type of professional who can provide particular services. These inappropriate rules are often mitigated by almost universally poor enforcement, which is considered one of the primary reasons for the poor quality of services offered by private providers.<sup>109</sup>

Part of the trouble with delivering effective regulation is the lack of consensus on what constitutes "good" regulation outside of a particular context. Very little has been published about the

successes and failures of government attempts to implement regulatory frameworks to ensure that the private sector is delivering what it is supposed to. What has been examined mostly concerns evaluations of government efforts to regulate private pharmacies and does not specifically address service delivery.<sup>110</sup> Indeed, the criteria for good regulation are quite general. A regulatory framework is considered good if it is targeted, proportional, coherent, consistent, and transparent<sup>111</sup>—in other words, if the rules are understandable, if they address the problem they are meant to correct, if they do not contradict other rules, if they establish a clear framework for what happens if they are not followed, and if the severity of the rules' intervention matches the severity of the problem. The challenge in measuring regulation, therefore, is to define constructs that unequivocally (that is, independent of the country context) have a positive impact on the functioning of the health system.

The key constructs for the regulation domain are three simple, but core, aspects of the regulatory function that should be carried out by the government.

The first construct is the proper registration and recording of new entrants into the market. While the team collected data on the registration process itself (in terms of steps and time), such a construct does not lend itself for inclusion in a measure of engagement. It is not clear whether lower entry barriers increase access (positive) or lower the quality standards for new entrants into the market (negative). Irrespective of the barrier to entry, however, new entrants into the market should be officially registered. Hence, the cross-country comparison focused on attainment of this threshold, not on the process of registration, by looking at the quality of private-provider registry in each country.

The second construct is the existence of a quality regulatory framework. This is measured by the existence of rules covering the very basic regulatory functions—for opening a private facility, similar rules for public and private clinics, and rules in place for inspecting a private clinic. Of course, such rules should be defined according to a local context, taking enforcement capacity into account.

But without any coherence in the approach to quality regulation, the engagement with the private health sector cannot be deemed to be complete. An important subconstruct here is the scope of the regulatory framework and whether a given country's regulatory framework includes the most important providers of health services. The importance of traditional medicine in most countries in the Africa region suggests that their inclusion in the regulatory framework may be a useful proxy.

The third construct is the effective enforcement of regulation. Enforcing basic regulations, as mentioned, is a key component of government engagement. This not only includes carrying out frequent inspections of private facilities, but also ensuring that enabling services are there to follow regulations, such as allowing private sector participation in continuing medical education opportunities. The level of enforcement capacity varies widely from country to country, so any potential regulations must be aligned with the ability to enforce them.

### *Financing*

Financial incentives are a main motivator of the private sector and are central to effective public-private engagement. Strategic government financing of private providers can create mutually beneficial arrangements that improve the efficiency of available public funds while taking advantage of capacities in the private health sector. However, government financing of the private health sector is contentious in terms of the overall benefit to the health system. This is especially the case in countries where the public system provides much of the care and where the private health sector is small. Where the private sector provides a substantial proportion of care, however, the assessment of financing as an instrument provides some measure of how the governments are taking advantage of the capacities of the private sector.

The key construct in the financing domain is whether public funds are being channeled to the private health sector. This can take the form of government contracting of private providers to perform particular services. Strategic purchasing allows governments to use limited resources on

the most needed services, without due regard for who is providing those services. It also refers to financial incentives for capital investments or operating costs (for example, tax exemptions) that can lower the operating costs for private facilities.

An important area of financing is the role of government in promoting a mechanism for risk pooling and sustainable financing for the health system. Engagement with the private health sector is, then, also about fostering the expansion of coverage and depth of health insurance and making the private health sector accessible to enrollees.

### ***Public Provision of Services***

Direct government production of health care inputs and health services has an impact on the operating environment for the private health sector. The intentional inclusion of the private health sector in the use of public resources enhances the ability of the for-profit providers to operate, and contributes to better health performance overall. Through strategic allocation of resources, governments can use public production to complement, crowd out, or build a supporting environment for private health care markets.

For example, even though it is not directed at the private health sector, reliable and affordable infrastructure services are critical for private sector development and economic growth. For health services businesses, access to electricity, water, and sewerage facilities are core technical inputs. Efficient government production of these services has a tangible benefit in terms of the operating environment for private providers. In other areas, government services may have less of a benefit to the private health sector, but a greater overall health benefit.

Measuring public production, therefore, focuses on whether the government is using its own

production of health care inputs and services to promote and encourage collaboration between the public and private sector. The key construct is whether the private sector is explicitly included in government programs that can and should be open to all qualified providers, regardless of what sector they come from. An example of this is private sector participation in government or government-sanctioned vaccine programs. This measure also considers private sector involvement in government health system processes, such as the referral system in place for transferring patients from the private to the public sector and vice-versa.

### **Challenges in defining an optimal level of engagement**

The goal of the Report is to promote an optimal level of engagement, not only in terms of more or less engagement, but also in terms of quality engagement. Defining good engagement would enable direct assessment of country performance by measuring the distance between the observed level of engagement and the optimal level. However, the empirical basis for defining what constitutes an optimal level of engagement does not currently exist. Accordingly, the focus of the domains discussed is on those elements of engagement where some consensus exists that they are necessary. Since effective engagement is very low in many African health systems, the elements are defined to cover only the basics of engagement. In other words, without most of these elements in place, it will be difficult for governments to engage with the private health sector in a way that fosters improved access, quality, and efficiency in health service delivery. The challenge moving forward will be to continually refine the engagement framework and to make further progress in defining the optimal level of engagement.

## APPENDIX 4—Methodology for data collection

### Data collection, analysis, and validation

Data were collected for 45 countries between February and July 2010. The only countries in the African region of the World Bank not covered in the Report are Eritrea and Somalia.

#### Data source and collection

The primary method of data collection was confidential face-to-face interviews with key respondents during a one week in-country visit. An “ideal” key respondent list was created. The respondent list (box A4.1) covers a cross-section of the key stakeholders in the public and private sector, including from the Ministry of Health, regulators, for-profit and not-for profit private providers, and independent experts. The purpose of the list was to ensure as much standardization as possible across countries and to serve as a guide for planning the schedule for in-country interviews.

#### BOX A4.1

##### Respondent List

In each country, key respondents include:

- Two to four independent experts: donor representatives, former officials, academia
- Two to five officials from the Ministry of Health, Director of Planning, Health Information Management Unit, Inspectorate, Office of Standards and Regulation, and the Public-Private Partnership unit
- One to four officials from regulatory boards
- One state- or district-level Health Officer
- Two to six representatives of the private health sector, which includes representatives of the appropriate professional or private facility associations and owners of prominent private facilities, not the for-profit sector.

Source: “Healthy Partnerships” data, 2010.

The minimum number of interviews was designated at 8 per country; the team completed interviews with over 750 respondents for an average of 16 respondents per country.

In-country data collection was reinforced by desk research performed before and during the in-country visit, particularly in terms of collecting and verifying the de jure indicators.

A standardized set of in-depth interview guidelines covering each of the domains was used to collect the data. During the two rounds of pilot testing, less-relevant questions were dropped in order to keep the guidelines as concise as possible. The questions in the guidelines took on different forms; the de jure indicators asked whether a particular policy or regulation exists as a matter of fact; de facto questions asked respondents to evaluate, on a categorical scale, a particular aspect of engagement in practice.

The scores across the domains and the assessment of engagement more generally apply primarily to the urban centers, since that is where the data collection and interviews took place (capital city and largest economic center, where applicable). The degree and nature of the engagement in rural areas was not separately assessed. The indicators across the domains likely represent an upper bound on the quality and intensity of engagement that is seen throughout the country. The same urban bias is found in other policy measures, such as the Doing Business indicators. It should be noted that the measures for Nigeria and Sudan represent a special case of this limitation, due to the fact that in both countries most governmental authority toward the private health sector is exercised at the state level. Therefore, for several measures in Nigeria and Sudan the assessment had to be made at the level of Lagos and Khartoum State, respectively, rather than at the national level.

### Data coding

Once the data collection was finalized, the team coded a subset of the collected data into quantitative form. The data were primarily coded in binary form (1 or 0). Five de facto indicators were coded on a categorical scale (1 to 4) to allow for more nuanced answers across countries, and for assigning a higher score to engagement in practice. A set of coding principles was developed for each of the indicators to guide assessor coding.

### Data validation

To ensure accuracy of the coded data, the Health in Africa team engaged in two major rounds of data validation.

First, the team completed an initial verification by reviewing the coded data by comparing the coding with the raw data file containing the interviews conducted in each country.

Second, two country experts (usually independent experts) analyzed the team’s assessment by filling out a document containing the coded data for the country and the coding principles. Any inconsistencies were clarified by e-mail and telephone with experts from the relevant country.

### Coding principles

Table A4.1 lists the principle behind the coding for each element.

**Table A4.1 The Principle Behind the Coding of Each Element**

Domain	Indicator	Coding principle (unless otherwise noted, coding is binary [1/0])
Policy and dialogue	A policy exists for engaging with the private health sector on paper.	The government has a stand-alone policy toward the private health sector or the private health sector is included in the Ministry of Health’s main and current health sector policy or strategic plan. The policy or plan must make more than a passing mention of the private health sector; it should include, at a minimum, a definition of the role of the private health sector and identify possible areas of collaboration.
	There is de facto implementation of the engagement policy with the private health sector.	The government is implementing, in practice, the engagement policy with the private health sector; scored on a 1–4 scale as follows: 4 – comprehensive implementation of the policy 3 – solid implementation of engagement components with significant room for improvement 2 – low day-to-day engagement, or engagement limited to subsectors or individual disease programs 1 – very little, if any, implementation of an engagement policy.  Note: Day-to-day implementation of engagement is also possible in the absence of an explicit engagement policy. Selective engagement with key players is sufficient only in cases where further engagement is not currently feasible (e.g., conflict-afflicted countries).
	There is a formal dialogue mechanism with the private sector (de jure).	There is a formal or official mechanism for dialogue between the Ministry of Health and the private health sector. This can include a specialized forum, regularly scheduled meetings, joint committees, or other forums where the private health sector is deliberately invited to participate. The existence of a dialogue mechanism that is limited to a disease-specific program, such as Global Fund-mandated dialogues for HIV/AIDS, does not count.
	There is dialogue with the private health sector, in practice (de facto).	There is an active dialogue taking place between the Ministry of Health and the private health sector through one of the forums mentioned above or through an alternative forum outside of disease-specific dialogue arrangements.  Aggregated responses from key informants were scored on a 1–4 scale as follows: 4 – strong, comprehensive, and ongoing dialogue with the full private health sector 3 – ongoing dialogue with the private health sector with significant room for improvement 2 – ongoing dialogue restricted to subsectors or disease areas 1 – Very low level of dialogue or no ongoing dialogue.  Note that the coding does NOT refer to the quality of the dialogue or to the outcomes it produces (such aspects would be found under implementation of engagement) but, rather, to whether it is currently taking place.

*continued*

**Table A4.1, (continued)**

Domain	Indicator	Coding principle (unless otherwise noted, coding is binary [1/0])
Information exchange	There is a functioning exchange of health-specific information between the Ministry of Health and the private health sector.	<p>There are information flows, in practice, between the Ministry of Health and the private health sector. This includes vital statistics and other service statistics (which flow both ways) and other relevant information from the government to the private health sector (e.g., updated treatment guidelines and changes in regulation, and so forth).</p> <p>Aggregated responses from key informants were scored on a 1–4 scale as follows:            4 – strong, comprehensive information exchange with the full private health sector            3 – ongoing information exchange with the private health sector, with significant room for improvement            2 – information exchange restricted to subsectors or disease areas            1 – very low or no ongoing exchange of information.</p>
	The private health sector is required to provide health-related information to the Ministry of Health.	The Ministry of Health requires that private health sector clinics provide health status vital statistics (e.g., births and deaths) or health services utilization data information on a regular basis. The requirement is explicitly mandated by law or regulation and is beyond (a) information reported as part of the national disease surveillance program and (b) requirements arising from participation in disease-specific programs such as HIV or TB programs.
	Information from the private health sector is reaching the Ministry of Health as intended.	Private health sector clinics are sending the required information to the Ministry of Health on a regular and timely basis and the Ministry of Health is receiving this information, coded as a “1” or “yes” if at least two-thirds of the private health sector respondents indicate that they (and/or others like them) are providing information with positive corroboration from the Ministry of Health.
	The private health sector is included in the Ministry of Health’s disease surveillance program.	The Ministry of Health (or a designated body) includes the private health sector in the country’s national disease surveillance program, as defined by the government. Not all of the private health sector needs to be involved as long as the government does not exclude private health sector facilities from the surveillance program.
	The private health sector receives disease surveillance updates from the Ministry of Health.	The Ministry of Health sends prompt disease surveillance updates to the private health sector, at the very least, in cases of emergency. The private health sector receives such updates in a timely manner.
Regulation	Quality of private health sector providers’ registry	<p>An assessment of the regulator’s knowledge about private health sector providers is taken. Aggregated responses on the quality of the registry (i.e., the list of private health sector providers) coded on a 1–4 scale are as follows:</p> <p>4 – There is an updated, comprehensive registry of private health sector providers currently operating. A positive assessment is reserved only for countries where the quality of the registry implies good implementation of registration and maintenance of the registry; where there are few informal providers.            3 – A registry of private health sector providers exists and is being used (i.e., updated at least once a year). Despite being used, the registry is not complete or fully representative of the private health sector.            2 – A registry of private sector providers exists, but it is not being used or updated in any practical way.            1 – A registry of private sector providers could not be readily produced by the registrar or designated body.</p>
	The quality of regulation is good.	The laws and regulations that govern the private health sector are deemed to be of good quality. Coding is based on respondent answers to the question, and a positive assessment is restricted to countries where there is a consensus among respondents that the laws and regulations are appropriate and reasonable. It does not explicitly take into account whether such laws and regulations are actively enforced.
	Regulation is enforced as intended.	The Ministry of Health (or a designated body) generally enforces laws and regulations toward private health sector clinics. Coding is based on respondent answers to the question, and a positive assessment is restricted to countries where there is a consensus among respondents that the laws and regulations are enforced as written.
	There are standardized rules to open a private health sector clinic.	There is a clear set of rules that outline the requirements and steps necessary to open and officially register a private health sector clinic.

*continued*

**Table A4.1, (continued)**

Domain	Indicator	Coding principle (unless otherwise noted, coding is binary [1/0])
Regulation, <i>continued</i>	There is an inspection regime on paper for private health sector clinics.	The Ministry of Health (or a designated body) has procedures for inspecting private health sector clinics on paper. Coding is independent of whether the inspections are actually carried out.
	The inspection regime is carried out, in practice, for private health sector clinics.	The Ministry of Health (or designated body) carries out the inspection as intended. No judgment is made regarding the level of detail or quality of the inspection. Coding is based on a consensus among respondents.
	The quality control process or inspection regime, on paper, is the same for private and public health sector providers.	There is no institutionalized difference in terms of the way the private and public health sectors are inspected, coded as a 1 by default except when there is an undue distinction in the inspection process and in the requirements for the public and private providers based on ownership. Specific rule or cited evidence for such a distinction, and appropriate corroboration among respondents, is needed for a 0 coding.
	There are continuing medical education (CME) requirements for professional license renewal.	Medical doctors have to fulfill a CME requirement to maintain their professional license. Evidence of enforcement of this requirement is needed. The existence of a CME requirement that is not linked to the renewal of professional license does not count.
	Ministry of Health trainings or other CME opportunities are open to private health sector professionals.	Ministry of Health trainings, workshops, or other CME opportunities for public sector health professionals are open to private professionals. This also includes where they have to pay to participate. This is determined by respondent answers; evidence of participation is necessary.
	There is a policy on, and engagement of, traditional medicine practitioners.	There is a policy, unit, or program in the Ministry of Health (or a designated, health-specific body) responsible for engaging with traditional medicine practitioners or their representatives. The existence of any of these is sufficient.
Financing	The government uses contracts with the private health sector.	The government is purchasing specific clinical services from the private health sector. This includes contracts with individual medical practitioners. Price agreements between the private health sector and government health insurance organizations do not count. Subcontracting by public hospitals to private hospitals to provide services for which they are responsible and remunerated with public funds count as contracts.
	There are financial incentives available to private health sector operators.	The government offers financial incentives to the private health sector, including but not limited to tax breaks, tax credits, import duty reductions, and value-added tax exemptions. The incentives have to be specific to the private health sector; in other words, incentives that are available to all private sector businesses do not count. Evidence of implementation of the incentive scheme is required. If the incentive exists in theory, but it is never accessed by the private health sector, it does not count.
	Overall population covered by health insurance.	The approximate percentage of citizens covered by either public or private health insurance, including community health insurance schemes, that would reimburse for treatment received in a private facility, is indicated by respondent answers: 4 – more than 50% 3 – more than 20% 2 – more than 10% 1 – less than 10% 0 – no insurance.
Public provision of services	The private health sector receives vaccines, medicines, or similar items from the Ministry of Health or from a government-sanctioned donor program.	The government provides vaccines or medicines to the private health sector for distribution to the general population. The private health sector may or may not be permitted to charge a consulting/service fee.
	There is a public-private referral process.	There is a process in place to refer patients from the private sector to the public sector (or vice versa) for further treatment when required. It does not have to be a strictly formal process, as long as there is a method to facilitate the movement of patients. Patients moving from private to public or vice versa through self-referral do not count as part of the referral process.

## APPENDIX 5—Scoping the private health care market

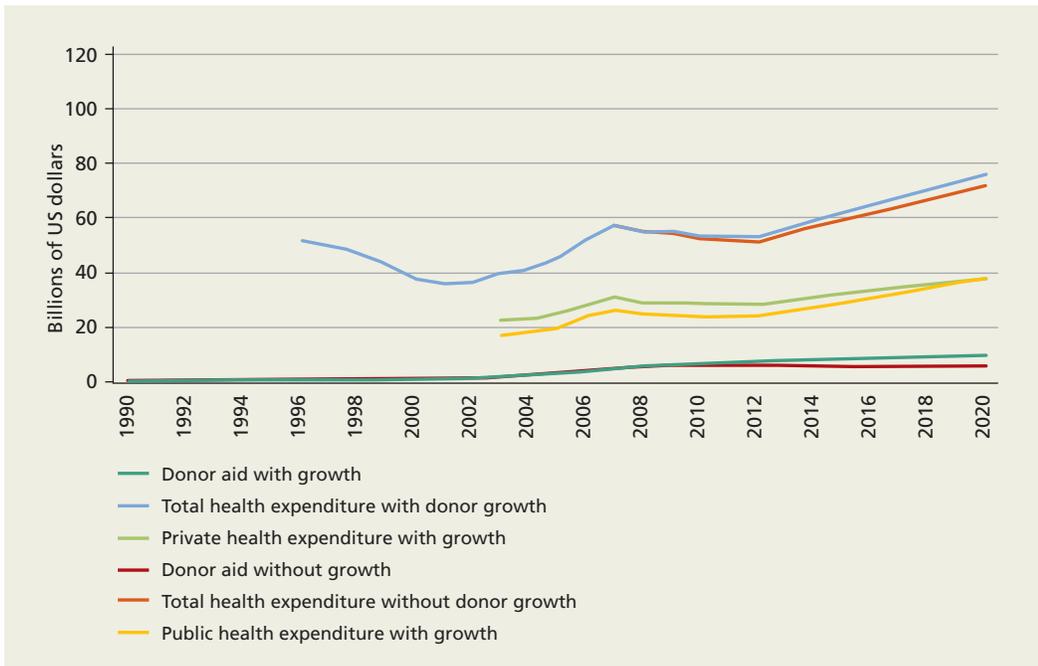
The size and growth of a country's economy largely determines the size of the health sector. It also influences the relative share of public and private spending on health services. A large share of the population of low-income countries often lives in the rural areas and works in the informal sector. This limits the effective taxation capacity of their governments. In middle- and upper-income countries, larger segments of the population work in urban settings and the formal employment sectors. This makes it relatively easy to tax workers at the source and to design a health care system financed by government or payroll taxes. In most low-income countries, the formal urban employment sector is small relative to the population in rural areas and in informal employment.

Based on data from official National Health Accounts, total health spending on health care in Sub-Saharan Africa was US\$68 billion in 2008, of which 45 percent was spent in the public sector and 55 percent was spent in the private sector. During 2001–06, Africa experienced remarkable economic growth (approximately 5 percent), and the relative share of public spending on health care increased annually by 1 percent, while the relative share of private spending on health care decreased annually by 1 percent. These trends are consistent with historical trends observed in other regions going through rapid growth. We use some basic back-of-the-envelope calculations to project

how the overall size and the relative public/private share could possibly develop in the coming years (figure A5.1). While these calculations remain incomplete, they do indicate where generally observed trends will lead African health care markets.

These projections have significant implications for public sector engagement with the private sector and for private sector development during the next decade or two. For example, there will be more money spent on the health care sector and a steady shift in relative spending from out-of-pocket private spending to collective, publicly mandated spending. Additional public spending, however, does not have to be spent only in the public sector. Governments often have little control over how the current funding envelope is spent because of pressures from the wage bill and existing public service delivery obligations. But with good planning, future growth in public spending could (and should) be spent on services provided by public or private providers, whichever is most effective at delivery. A shift away from out-of-pocket spending to more risk pooling, for example, through public financing, is likely and a welcome prospect. Adept governments will take best possible advantage of the public and private capacities currently in the system that can best contribute to public health goals.

**Figure A5.1 Africa: Spending on Health, by Source**



Source: "Healthy Partnerships" analysis and projection based on WDI data, 2010.

## Notes

1. WHO 2010a; IFC 2008; Lagomarsino, Nachuk, and Kundra 2009.
2. Data obtained from Demographic and Health Surveys (DHS); latest available year included. RAND analysis. For a complete list of countries and years included in the RAND DHS analysis, see Appendix 2.
3. Data obtained from DHS; latest available year included. RAND analysis.
4. IFC 2008.
5. Data obtained from sum of all Population-Weighted Sub-Saharan Africa Demographic and Health Surveys conducted after 2000. Analysis by Dominic Montagu, 2010. For a complete list of countries and years included in the DHS analysis, see [www.ps4h.org/globalhealthdata](http://www.ps4h.org/globalhealthdata).
6. See Section 1 for details on use of health care services by wealth quintiles.
7. Davoodi, Tiongson, and Asawanuchit 2010.
8. See literature review in Section 1, under Observation 3, of main report.
9. World Bank, World Development Indicators database, December 2010; WHO, Global Health Observatory Database, February 2011.
10. IFC 2008.
11. Reinikka and Svensson 2010.
12. WHO 2010b.
13. IFC 2008.
14. This analysis borrows from other health systems measures that have been developed; for instance, the WHO framework for health systems performance assessment, and the World Bank control knobs framework.
15. WHO 2010a.
16. Lagomarsino, Nachuk, and Kundra 2009.
17. WHO 2008a.
18. IFC 2008; Jütting 2002; Hozumi et al. 2009.
19. WHO 2007a.
20. WHO 2005.
21. WHO, various years, World Health Statistics.
22. WHO 2010d.
23. UNICEF 2010.
24. World Bank, World Development Indicators database, December 2010.
25. World Bank, World Development Indicators database, December 2010.
26. WHO, various years, World Health Statistics.
27. World Bank, World Development Indicators, December 2010.
28. Data obtained from DHS surveys; latest available year included. RAND analysis.
29. Ibid.
30. World Bank, World Development Indicators database, December 2010.
31. Data obtained from DHS surveys; latest available year included. RAND analysis.
32. Ibid.
33. Ibid.
34. World Bank, World Development Indicators database, December 2010.
35. Data obtained from DHS surveys; latest available year included. RAND analysis.
36. Ibid.
37. Ibid.
38. Ibid.
39. Ibid.
40. Ibid.
41. Ibid.
42. World Bank, World Development Indicators database, December 2010.
43. IFC 2008.
44. Data obtained from DHS surveys; latest available year included. RAND analysis.
45. Marek et al. 2005.
46. Data obtained from DHS surveys; latest available year included. RAND analysis.
47. Klemick, Leonard and Masatu 2008.
48. Klemick, Leonard and Masatu 2008; Leonard 2007.
49. Leonard 2007.
50. Leonard 2004.
51. "Healthy Partnerships" data, 2010.
52. WHO 2002.
53. IFC 2008.
54. Kadiri, Arije and Salako 1999; Isnard et al. 2004.
55. Wall, et al. 2004.
56. Barnes et al. 2010.
57. Results for Development, no date.
58. IFC 2008.
59. Hongoro and Kumaranayake 2000.
60. IFC 2008.
61. Brugha and Zwi 1998; Sauerborn 2001; Zwi, Brugha, and Smith 2001; Chakraborty and Frick 2002; Kamat 2001; Gilson et al. 2007.
62. Das, Hammer, and Leonard 2008.

63. Yoong et al. 2010.
64. Mills et al. 2002; Dahlgren and Whitehead 2007; Oxfam International 2009.
65. WHO 2010b.
66. WHO 2008c.
67. Results for Development Institute, no date.
68. Berman 1998; Harding and Preker 2003.
69. Patouillard, Goodman, and Hanson 2007.
70. Davoodi, Tiongson, and Asawanuchit 2010.
71. Castro-Leal et al. 2000.
72. "Healthy Partnerships" data, 2010.
73. Harding, forthcoming.
74. McLaughlin, van Olst, and Whelan 2010.
75. Stover and Ross 2010; Antarsh 2004; Winikoff and Sullivan 1997; Daniel and Rivera 2003.
76. Van Dalen and Reijer 2006.
77. Stanback, Mbonye and Bekiita 2007.
78. WHO 2007b.
79. Prata et al. 2005; Prata et al. 2009; Pagel et al. 2009.
80. Pagel et al. 2009; Sutherland et al. 2010.
81. Bradley et al. 2007; Prata et al. 2009; Sutherland and Bishai 2009; Sutherland et al. 2010.
82. Koblinsky 2003.
83. Madhvan et al. 2010.
84. For instance, Loevinsohn 2008.
85. Loevinsohn and Harding 2005.
86. Basinga et al. 2010.
87. "Healthy Partnerships" data, 2010.
88. Tangcharoensathien et al. 2008; Shaw 2003.
89. The Joint Commission 2010.
90. Rosenthal 2000.
91. Ensor and Weinzierl 2007; Hanson and Berman 1998; Hanson et al. 2008.
92. Hozumi et al. 2009.
93. Das and Teng 2004.
94. Fousekis and Shortle 1995.
95. "Healthy Partnerships" data, 2010.
96. Bennett et al. 2005; Bowles 2008.
97. Ferrinho et al. 2004; Jan et al. 2005.
98. Batley 2006.
99. Batley 2006.
100. Transparency International 2006.
101. Reinikka and Svensson 2010.
102. Logie, Rowson, and Ndagije 2008; Peters et al. 2009.
103. World Bank 2010.
104. "Health in Africa" initiative support of policy reforms in several countries, including Burkina Faso, Congo, Ghana, Kenya, Mali, and Uganda.
105. WHO 2007a.
106. Mathers et al. 2005.
107. United Nations Statistics Division, Millennium Development Goals Indicators database, January 2011.
108. WHO 2010a; IFC 2008; Lagomarsino, Nachuk, and Kundra 2009.
109. Yazbeck and Peters 2003.
110. Goodman et al. 2007; Smith 2009; Wijesinghe, Jayakody, and De A Seneviratne 2007.
111. Haskins 2000; Kirkpatrick and Parker 2004.

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