Reference Guide for Development of Public Private Partnerships in the Health Sector for Countries in the SADC Region

Prepared by O’Hanlon Health Consulting, LLC
Barbara O’Hanlon
Joanne Bennett Jeffers
November 2013
Contact

SADC PPP Network
Plot 50676
Block B, First Floor
BIFM Fairgrounds Office Park
Gaborone, Botswana

O'Hanlon Health Consulting, LLC
5727 Moreland Street, NW
Washington, D.C. 20015
Office: +1.202.966.8233
Mobile:+1.202.841.4410
Mail: bohanlon@ohealthconsulting.com
Table of Contents

1. Introduction to Health PPPs
   1.1 Background
   1.2 Purpose of the H/PPP Reference Guide
   1.3 Rationale for Partnering with the Private Health Sector
   1.4 Basic Concepts for Health PPPs
   1.5 Range of Health PPPs in SADC

2. Process to Draft an H/PPP Framework to Implement H/PPP

   Step 1: Analyzing and Prioritizing Areas for H/PPP

   Step 2: Agreeing on a Framework for H/PPPs

   Step 3: Drafting an H/PPP Policy and/or Strategy

   Step 4: Establishing H/PPP Institutional Arrangements

   Step 5: Building the H/PPP Pipeline

3. Conclusion
# List of Acronyms and Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA</td>
<td>Contracting Authorities</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith Based Organizations</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GIZ</td>
<td>Deutsche Gesellschaft für Internationale Zusammenarbeit</td>
</tr>
<tr>
<td>GOM</td>
<td>Government of Malawi</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>H/PPD</td>
<td>Public private dialogue in health</td>
</tr>
<tr>
<td>H/PPP</td>
<td>Public private partnership in health</td>
</tr>
<tr>
<td>HRH</td>
<td>Human resources in health</td>
</tr>
<tr>
<td>ICT</td>
<td>Information Communication Technology</td>
</tr>
<tr>
<td>IDP</td>
<td>International Development Partners</td>
</tr>
<tr>
<td>IFC</td>
<td>International Finance Corporation</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MoF</td>
<td>Ministry of Finance</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MoHSW</td>
<td>Ministry of Health and Social Welfare</td>
</tr>
<tr>
<td>MST</td>
<td>Marie Stopes Tanzania</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non-government organizations</td>
</tr>
<tr>
<td>NHA</td>
<td>National Health Accounts</td>
</tr>
<tr>
<td>OECD</td>
<td>Organization for Economic Cooperation and Development</td>
</tr>
<tr>
<td>OPC</td>
<td>Office of the President and Cabinet</td>
</tr>
<tr>
<td>PFI</td>
<td>Private Finance Initiative</td>
</tr>
<tr>
<td>PFP</td>
<td>Private for-profit</td>
</tr>
<tr>
<td>PNFP</td>
<td>Private not-for-profit</td>
</tr>
<tr>
<td>PPP</td>
<td>Public Private Partnership</td>
</tr>
<tr>
<td>PPPPC</td>
<td>Public Private Partnership Commission</td>
</tr>
<tr>
<td>PSA</td>
<td>Private Sector Assessment</td>
</tr>
<tr>
<td>RAs</td>
<td>Regulatory Authorities</td>
</tr>
<tr>
<td>SADC</td>
<td>South African Development Community</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>THE</td>
<td>Total health expenditures</td>
</tr>
<tr>
<td>US</td>
<td>United States</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>VfM</td>
<td>Value for Money</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
List of Figures

Diagram 1.1 Private Health Sector Entities Organized by WHO Building Blocks
Diagram 1.2 Formal and Informal Private Sectors Actors in Health
Diagram 1.3 Tanzanian Health System Referral Pyramid
Diagram 1.4 Health Market Segmentation by Sector
Diagram 1.5 SADC Member States’ Definitions for PPPs
Diagram 1.6 Health PPP Models in Africa
Diagram 2.1 Steps to Develop an H/PPP Framework and Implement H/PPPs
Diagram 2.2 Stakeholder Overview and Areas of Influence in the Health Sector
Diagram 2.3 Stakeholder Groups’ Interests in H/PPPs
Diagram 2.4 Components of an H/PPP Framework for SADC Countries
Diagram 2.5 African PPP Units
Diagram 2.6 Roles and Responsibilities for H/PPPs in Tanzania
Diagram 2.7 Building Blocks to Develop H/PPP Unit Capacity
Diagram 2.8 Process to Draft an H/PPP Implementation Plan
Diagram 2.9 Defining the Strategic Direction for H/PPPs
Diagram 2.10 Definitions of H/PPP Models
Diagram 2.11 Health System Gaps Linked to H/PPP Models
Diagram 2.12 Potential Savings and Efficiency Gains from H/PPPs
Diagram 2.13 Risks and Benefits of PPPs in Health
Diagram 2.14 Health PPP Project Cycle

Table 1.1 Private Sector Contributions to Health in Africa
Table 2.1 Types of PPP Policies by Country
Table 2.2 Examples of Definitions of Health PPPs

Annex One: Data Sources for Analyzing and Prioritizing H/PPP Areas and Conducting PSAs in Health
Annex Two: Structure of an H/PPP Policy
Annex Three: Outline of an H/PPP Strategy
Annex Four: Examples of H/PPP Policy Vision or Goal Statements
Annex Five: Examples of H/PPP Policy Objectives
Annex Six: Example of Implementation Principles
Annex Seven: Malawi PPP Unit TORs
Annex Eight: Best Practices in H/PPP Capacity
Annex Nine: Range of H/PPP Models
I. INTRODUCTION TO HEALTH PPPS

1.1 BACKGROUND

Both the public and private sectors finance healthcare in every country. While the provision of healthcare is widely recognized as the responsibility of government, private capital and expertise are increasingly viewed as essential resources for increasing efficiency, expanding access to services and introducing innovative technologies. The challenge for governments, is finding the appropriate balance of public and private sector resources for both financing and managing health services as well as ensuring that those resources are used to achieve public health priorities. Public private partnerships (PPPs) in health are important mechanisms that governments can use to leverage private sector resources and expertise to achieve public health goals.

Over the last two decades, experience in developing and implementing PPPs in the health sector has grown. However, while many countries have used PPPs to finance energy, telecommunications, and transportation projects, to date, only 10% of all PPPs worldwide are in the health sector (PWC, 2011). The health sector differs from other sectors, and healthcare PPPs require a thorough understanding of the delicate balance between increasing value for money and advancing public health goals. For example, in infrastructure PPPs, the physical infrastructure is the desired end product, while in a hospital PPP, better health of the population using the hospital is the desired outcome. It is essential that government policymakers thoroughly assess the needs of the national health system; identify public health priorities; establish clear objectives for a health PPP; and conduct extensive due diligence to ensure that a PPP is the best arrangement for leveraging private sector resources and achieving a specific health goal.

Southern African Development Community (SADC) member countries are examining this growing experience and exploring how they can use health PPPs to leverage private sector resources and expertise more broadly and advance government goals of increasing efficiency in health spending. In the region, PPPs have been developed in key economic sectors such as energy, transportation and telecommunication, and health sector decision makers are asking how lessons learned from these experiences can be applied to PPPs in the health sector. The SADC Public Private Partnership (3P) Network - a regional incubator and center of PPP expertise, is spearheading these efforts. The SADC 3P Network recently commissioned a paper to examine SADC and Sub-Saharan African policy experience in supporting health PPPs and aims to disseminate its findings as part of its mandate to share best practices across Member States. In addition, the SADC 3P Network will use this reference guide as a tool to provide technical assistance and build government capacity to design and establish H/PPP frameworks that enable development and implementation of health PPPs.

1.2 PURPOSE OF THE H/PPP REFERENCE GUIDE

This reference guide aims to increase understanding of how PPPs can be used to achieve national public health goals; highlights the important role the private health sector plays in achieving these goals; and, guides policymakers through the process of designing a PPP Health Framework, including a H/PPP Policy or Strategy. The guide was developed after thorough review of 10 developing countries’ general and/or health PPP Acts, Laws and Policies; the Health PPP Policies of India; as well as those of several African countries.

The structure of the guide is based on the consultative process agreed upon and commonly used by SADC Member Countries. To set the stage, the introduction presents a rationale for partnering with the private
health sector and basic concepts that are used throughout the guide. This is followed by a presentation of the five-step process for developing a Health PPP Framework. Step 1: Analyzing and Prioritizing Areas for H/PPPs includes “tips” on best practices for organizing the due diligence required to prepare and inform a Health PPP Framework. Step 2: Agreeing on a Framework for H/PPPs describes strategies for building consensus among all stakeholders to support the H/PPP. Step 3: Drafting an H/PPP Policy or Strategy discusses the components of a Health PPP Policy and is supported by several Annexes containing illustrative language from the PPP Health Policies of a variety of SADC and Sub-Saharan countries. Step 4: Establishing H/PPP Institutional Arrangements discusses the institutional arrangements needed to spearhead an H/PPP Policy and implement H/PPP projects and presents several examples of H/PPP Units housed within SADC Ministries of Health. And, finally, Step 5 Building an H/PPP Pipeline focuses on strategies and processes used to implement H/PPP projects. The guide also presents the experience of the Malawi PPP Technical Working Group and the consultative process it used for the dialogue between the public and private sectors to design an H/PPP Strategy to illustrate the tasks required as well as the essential components of a comprehensive H/PPP Framework.

The guide is not intended to be exhaustive in its description of the many steps needed to put in place a sound H/PPP Framework in a SADC country. There are many tools and handbooks available and they are mentioned throughout the guide. Rather, the guide is intended to orient SADC country teams, comprised of both public and private sector stakeholders, on the process and approach needed to design an H/PPP Framework; provide lessons from other countries that are relevant to the SADC region; and, provide illustrative language from various country examples.

The H/PPP Framework Reference Guide:

- Makes the case for partnering with the private health sector;
- Proposes a participatory approach to design a policy framework and institutional arrangements to implement H/PPPs;
- Provides illustrative language from other policies for key components of an H/PPP framework;
- Presents the range of H/PPPs and their potential for advancing health goals and priorities;
- Offers tips and examples from other country experiences implementing H/PPPs.

1.3. RATIONALE FOR PARTNERING WITH THE PRIVATE HEALTH SECTOR

Ministries of Health in most SADC countries are confronting overwhelming health crises. The list of health priorities is well known: spread of HIV/AIDS, scourge of malaria, debilitating parasitic diseases, and, increasingly, chronic life-style diseases - such as cancer, diabetes and heart disease. Compounding these challenges is the poor state of the health systems in the region. Many SADC countries have made considerable progress in improving access and quality of health services, yet they are not on track to reach the Millennium Development Goals (MDGs) in health. To accelerate progress, several MoHs in the SADC region are reconsidering the role of the private sector in addressing public health goals. As presented in the International Finance Corporation’s seminal report – The Business of Health in Africa – the private health sector in Sub-Saharan Africa currently plays, and will continue to play, a vital role in financing and providing health services (IFC, 2007). Understanding the role the private sector is currently playing in national health systems and leveraging its entrepreneurial talents, vast resources and infrastructure is essential to addressing the health care needs of the populations of the SADC region.

The private health sector in SADC is engaged in a wide range of health activities

While policymakers often focus on the private sector role in healthcare delivery, the private health sector is active in all aspects of a health system (see Diagram 1.1). NGO Networks, Health Professional Associations and Business Councils engage the MoH on policy and planning issues. Academic Institutions, Think Tanks and Market Research Organizations as well as private Information Communication Technology firms play important roles in gathering health information. Albeit on a limited scale, private health insurance, community-based financing and micro-finance institutions are helping finance healthcare.

---

1 The discussion in the section is based on multiple private health sector assessments conducted by the IFC and USAID in Sub-Saharan African countries (Ghana, Kenya, Malawi, Namibia and Tanzania).
Private medical institutions and Faith Based Organization (FBO) training schools for different health cadres are stepping in to assist government medical colleges and teaching hospitals with the growing demand for education and training of healthcare professionals. And, increasingly, both the private-for-profit (PFP) and private-not-for-profit (PNFP) sectors are creating alternative supply chains to address chronic stock-outs and establishing lab networks to replace inadequate diagnostic equipment in public health facilities.

Diagram 1.1 Private Health Sector Entities Organized by WHO Building Blocks

The private health sector in SADC countries operates in the formal and informal sectors

The formal health sector includes a comprehensive range of professionals who are trained in healthcare provision, including physicians, nurse/midwives and clinical officers, and who provide services through small clinics and polyclinics and/or group practices that offer high-end, specialty care. The private sector also owns and manages a significant percentage of hospitals, from small maternity and nursing homes to large, modern hospitals in urban centers. In addition, private sector entities provide clinical support services such as diagnostics and laboratories. The private health sector also supports the entire medical supply chain including pharmaceutical entities such as international Research and Development Pharma Companies, importers, distributors, manufacturers and retail pharmacies.

Finally, there are two other private sector actors that play important roles financing healthcare. First, there are major employers and industries whose core business is not health but who provide healthcare services to their employees and the communities in which they operate through company-owned clinics and/or health insurance programs. Second, there is a small, but growing, number of private health insurance (medical aide) and micro-financing institutions that finance health services and medicines not only in the private sector but also in the public sector.
In addition to these formal providers, there are informal providers, including drug sellers, traditional healers and “quacks”. These informal providers pose a challenge for MoHs as their services are difficult to monitor and they do not always comply with quality and safety standards.

**The private health sector is active at all levels of the SADC countries’ health systems**

Diagram 1.3 illustrates the Tanzania Health System Referral Pyramid and shows that there are private health facilities at all levels – starting from village- and ward-level dispensaries and maternity homes to high-level specialty and referral hospitals at the regional and zonal levels. It is important to note that in the private sector, particularly the PFP sector, there are a few, highly qualified and skilled healthcare providers and facilities concentrated in urban centers while the majority of PFP providers are solo practitioners operating one-room offices or small clinics scattered throughout the country, especially in rural areas.

![Tanzanian Health System Referral Pyramid](image)

Source: Tanzania PSA, 2012

**PFP and PNFP health sectors’ roles are essential to achieving public health goals**

Diagram 1.4 shows the relative size of the public and private health sectors and the segments of the health care market they serve. The PFP sector, the smallest of the four groups, mainly serves urban, high- and middle-income population groups. The PFP health sector also provides services to lower income groups, including the poor, who pay out-of-pocket for services and drugs. In countries with dynamic private health sectors, such as Kenya, Ghana, Namibia, South Africa and Tanzania, the PFP sector has saturated the high-income consumer market segment. Consequently, the PFP sector is now pursuing strategies to go “down market” and provide products and services at more affordable prices to lower income groups with the expectation of making a profit through high volume. The diversity in size and scope as well as geographic distribution of the PFP health sector creates significant challenges for the MoH as it strives to partner with this key player in national health systems.

Two PNFP actors, non-governmental organizations (NGOs) and faith-based organizations (FBOs), serve the working poor and low-income population groups located in urban, peri-urban and rural areas. In SADC countries FBOs are typically larger and more active in rural areas than NGOs. They have facilities in both urban and rural areas, often in areas not served by the MoH. NGOs (also referred to as Community Service Organizations) play a critical role in not only the delivery of health services, but also, health promotion, community education and prevention.
In SADC Member Countries the MoH plays a leadership position as the largest provider of health care and also as steward of the health system – responsible for establishing priorities and ensuring performance. The MoH serves all income groups. However, several studies have shown that the middle and upper classes benefit disproportionately from the services provided by the MoH because they comprise the majority of users of publicly-funded equipment-intensive hospitals and tertiary care facilities which cater to the urban elite (Makinen, WHO Bulletin #78).

The SADC private sector’s contributions to many areas of the health sector is growing

The private health sector in Africa will grow substantially in some markets. Since 2001, Africa’s GDP as a whole has grown annually at five percent – faster than the global average of four percent. Consistent with global trends, as incomes rise, so does the demand for health care. The International Finance Corporation estimates that in 2007, the total value of the health market in Sub-Saharan Africa was approximately $16.7 billion US dollars and they expect this amount to double and reach $35 billion US dollars by 2016. Table 1.1 shows the different ways the private sector contributes to health in Africa.

Table 1.1 Private Sector Contributions to Health in Africa

<table>
<thead>
<tr>
<th>Area</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service delivery</td>
<td>The private health sector delivers approximately 50% of healthcare in Africa including care for the poor. It offers the best quality services – as well as the worst.</td>
</tr>
<tr>
<td>Financing</td>
<td>Around 60% of healthcare is financed by the private sector – mostly through out-of-pocket payments – highlighting the need for risk pooling mechanisms in the public, private and/or both sectors.</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>The private sector owns and manages approximately 50% of health facilities and specialized equipment in all levels of the health delivery system.</td>
</tr>
<tr>
<td>Pharmaceutical</td>
<td>The private health sector is the dominant force in the manufacturing and supply of medicines and other health products.</td>
</tr>
<tr>
<td>Human resources in health</td>
<td>The private health sector employs upwards of 75% of all health workers across all professions and produces skilled health workers.</td>
</tr>
<tr>
<td>HMIS</td>
<td>The private sector offers leading edge technology including e-health and ICT platforms.</td>
</tr>
</tbody>
</table>

Source: The Business of Health in Africa (IFC, 2007)

1.4. Basic Concepts for Health PPPs

Since PPPs are relatively new for the health sector in the SADC region, it is important to use common definitions for key terms as they apply to the health sector. It is also important to understand how PPPs in health are different from transaction (infrastructure) PPPs that have been formed in other development sectors. This section defines basic concepts and approaches for MoH and private sector policymakers to use as they begin to explore opportunities for potential H/PPPs; provides an overview of different H/PPP models; and presents examples of H/PPPs in SADC countries.

The continuum of public-private sector engagement in the health sector

Collaboration and coordination of the activities of the public and private health sectors occurs along a continuum and evolves in stages. Initially, the two sectors engage in public-private dialogue in which they begin to share ideas and concerns and build trust. This dialogue leads to public-private collaboration
where policymakers from both sectors work together to reform policies and collaborate on health priorities. Gradually, this collaboration evolves into informal partnerships where organizations form “gentlemen’s handshake” agreements to share resources and/or support one another in the implementation of defined activities. These informal partnerships then lead to formal Public Private Partnerships.

In a formal H/PPP the public sector becomes a contracting agent (CA) and enters into a formal agreement or contract with one or more private sector entities in which key features including payment structure, timeline, risk allocation and specification of outputs are defined. Through this agreement, the entities form a partnership united in the pursuit of a common public health objective. The World Health Organization (WHO) describes a public-private partnership in the health sector as a tool for “coordinating different stakeholders with the same goal to improve health for all”.

**Definitions of Public Private Partnerships in SADC Member Countries**

All PPPs in all sectors share the following characteristics:

- They are an arrangement between a government entity (central or sub-national) and a private sector entity or entities established for the purpose of providing an essential service or facility to the public;
- They are based on a formal contractual relationship that determines the rights, obligations and risks between the parties;
- Authority and oversight of performance is retained by the public sector;
- Risk is allocated fairly between the government and private sector partner, based on each entity’s ability to manage risk;
- Specification of outputs allows the private partners flexibility to propose the most efficient approach to implementing the project.
**Attributes of Sustainable PPPs**

Experience in PPP implementation shows that a supportive enabling environment with government commitment as well as the following attributes are needed to form successful and sustainable PPPs:

- Public and private sector partners trust one another and work together cooperatively;
- Both sectors share a common understanding of PPPs;
- Well trained and skilled government partners are in place to manage simple and complex PPPs;
- The Government is committed and supports PPPs through mechanisms such as government subsidies to reduce price shock; government investment to kick-start the market; and shared financial risk;
- The Government entity is empowered and authorized to enter into contractual relationships with the private sector;
- The Government is given the necessary tools, including technical skills, financial resources, and staff, to implement PPPs;
- The Government pays its bills on time.

Experience also shows that successful and sustainable PPPs share the following common traits:

- Roles, responsibilities and risks are agreed upon and clearly defined;
- Incentives and accountability are consistent in the partnership arrangement;
- Agreements are enforceable by law;
- The balance of power in the partnership is such that no one party has overwhelming authority.

**Which Definition to Use**

While it is difficult to arrive at a universal definition for PPPs in the health sector, all successful H/PPPs share the characteristics listed above. It is important for the wide range of stakeholder groups working in a health system -- global health practitioners, health economists, health system strengthening advocates, PPP specialists, transaction advisers, and representatives of the myriad private sector entities -- to recognize that there are different PPP definitions. The diversity of stakeholders and the wide range of their interests and perspectives can lead to disagreements and derail public private dialogue. It is critical that stakeholders recognize that it is not worth the time and effort to develop a universal definition, rather, the focus of dialogue needs to be on selecting the H/PPP model that best addresses the health goal, maximizes the strengths of each partner, and is best suited for the policy and legal context. H/PPP models should be problem/goal driven and directly address a health priority and/or health system gap.

1.5. **RANGE OF HEALTH PPPS IN SADC**

There are a variety of H/PPP models used in the health sector in the SADC region and Sub-Saharan Africa that differ from one another in their complexity and the amount of risk that is transferred to the private sector partner. The health sector is unique from other development sectors. Infrastructure sectors, such as roads, airports, electricity, telecommunication, etc., have well-established relationships between the government and PFP sector that have been formalized through complex contracts and transactions. The health sector, in contrast, has been slow to establish similar working relationships with the private sector, particularly the private for-profit health sector. The majority of H/PPP in the region are between the MoH and the PNFP sector, particularly FBOs and a few international NGOs. That being said, there is also an increasing, albeit small, number of H/PPPs, including infrastructure H/PPPs, with the PFP health sector.

---

2 Discussion from J. Janssen’s presentation at May 2013 Sandton Workshop, Johannesburg, South Africa.
In the health sector, partnerships can be informal or formal, depending on the type of arrangement under which the partners decide to work. There are many examples of “informal” PPPs in health (See Box) in the SADC region. These H/PPPs are ad hoc, often driven by personal relationships between a private and public healthcare provider to address an immediate need, and usually without formal documentation outlining the specifics of the arrangement. Although beneficial to both partners in the short-run, informal H/PPPs can become problematic as they depend upon the continued goodwill of the individuals who formed them and cannot be sustained. To be sustainable, these informal partnerships need to be formalized through contracts that specify the roles, responsibilities and rights of each partner.

Examples of Informal PPPs in Health in SADC

- In Tanzania, the MoHSW providers - particularly those in remote and rural areas - will ask the neighboring private sector provider to “lend” reagents and/or drugs when a public facility is experiencing stock-outs. The MoHSW restocks the private provider once they receive supplies from the Medical Store Department.
- In Uganda, the MoH donates supplies to private nurse/midwives working in areas without a public provider/facility and allows the nurse/midwife to deliver her clients’ babies in a public facility under the supervision of a doctor at no cost.
- With assistance from USAID, many MoHs in Sub-Saharan Africa, including Tanzania and South Africa, donate HIV test kits and ARTs to qualified private sector providers.
- In several countries, including Malawi and Tanzania, the MoH and FBO Association have staff sharing arrangements whereby a MoH staff person will work in an FBO facility or vice-versa.

Diagram 1.6 illustrates the formal H/PPP mechanisms used in the health sector in SADC and Sub-Saharan Africa. To date, the most frequently used H/PPP mechanisms have been those at the two opposite extremes – informal “gentlemen’s handshake” agreements and complex H/PPPs to build hospitals and other types of specialized health infrastructure.

There is a growing, albeit limited, experience in formal contractual arrangements between MoHSs and both PNFP and PFP entities in SADC (See Text Box). Although these H/PPP examples have yielded demonstrable health benefits (e.g. greater access, improved health outcomes, etc.) very few have gone to scale. Moreover, there is scant documentation of these H/PPP models and no central repository of tools and methodologies to document their experiences and enable others to develop similar models.
Examples of Formal H/PPPs in SADC

- There are three “classical” contracting arrangements (meaning not performance-based) in Cameroon, Chad and Tanzania with FBO hospitals. In Tanzania, the Lutheran Hospital informally served as the district reference hospital for 30 years and, in 2002, the MoHSW signed a contract with the Lutheran Hospital to recognize it as a Designated District Hospital that offers health services on behalf of the MoHSW.

- In 2005, Marie Stopes Tanzania (MST), an international NGO/Tanzania, began negotiations with MoHSW. In 2008 MST signed a service level agreement to deliver outreach services in public facilities (contract-in) and offer sexual and reproductive health services in MST’s clinics (contract-out). These contracts were between MST and 13 district local government authorities.

- South Africa has the most experience in health PPPs. Local- and provincial-level government hospitals outsource non-clinical services such as building and equipment maintenance, security, laundry and food services to private operators. Also, they outsource specialty care, radiology and pathology services with private provider networks and hospital companies as well as HIV and palliative care with NGO providers.

- In 2008, the government of Lesotho introduced in Maseru a PPP to construct, equip, finance and manage a 390 bed hospital and 3 referral clinics. With support from the IFC, the $120 million privately-financed project is one of the few hospital PPPs in the region where a private sector operator is responsible for all services.
2. Process to Draft an H/PPP Framework to Implement H/PPPs

While the process for developing a H/PPP Framework and a pipeline of H/PPPs (Diagram 2.1) appears to be linear, in fact, it is an iterative process.

Each country in the SADC region is at a different stage of development, or PPP maturity (Kopp-Mioni, 2012: p 19), and has already put in place one or several of the key components of an H/PPP policy framework --- the necessary institutional arrangements, technical capacity and required legal and regulatory regime. Regardless of the stage of PPP maturity in a country, the process the MoH uses to define how H/PPPs will be developed and implemented must be consultative. Experience to date has demonstrated that engaging key stakeholders throughout the process and undertaking thorough preparations to ensure reliable and timely data is available and technical capacity is reinforced with appropriate international expertise are essential to the development of successful H/PPPs (See Diagram 2.1).

As SADC countries move towards creating H/PPP frameworks, policies and/or strategies, they have the opportunity to identify and develop specific priority areas for H/PPPs through genuine consultation with both MoH leadership and private sector stakeholders.

Most PPP practitioners, whether in health or other development sectors, agree that pro-active engagement and stakeholder dialogue is a key driver for sustainable H/PPPs. Taking the time to bring together all the relevant stakeholder groups to specify priority areas for H/PPPs:
- **aligns private health sector activities to national health priorities** as private sector decision makers better understand MoH priorities and challenges;
- **promotes a common understanding** of the definitions and types of H/PPP mechanisms and builds consensus for selection of the mechanism best suited to achieve the health goal in the country context;
- fosters private sector buy-in and interest in partnering with the MoH;
- focuses MoH ideas for H/PPPs ensuring that projects are linked to identified health priorities and/or system gaps;
- encourages the private sector to propose H/PPP projects that align with national health priorities; and,
- offers the MoH the justification it may need to reject unsolicited proposals that are not aligned with H/PPP strategic areas.

The first step is to identify the relevant stakeholders to include in the H/PPP dialogue process (Diagram 2.2). The actors in the government sector are easily identified and well organized --while the MoH plays the key role, other government agencies, such as the Ministry of Finance’s PPP Unit / PPP Commission or the Office of the Prime Minister, also play critical roles. In addition, strategic stakeholders within the MoH, such as, for example, MoH Department Heads and Regional Health Officers, must be included to ensure needed support. Many SADC countries, Malawi and Tanzania for example, have devolved health services to regional and local government authorities requiring Local Government ministries’ participation in the H/PPP Policy design process. International donors are another group of key stakeholders that often provide resources to conduct analyses or support consensus building (O’Hanlon, forthcoming 2013). Key donors working in the private sector space in health in the region include GIZ, IFC, Italian Cooperation, USAID and the World Bank. Civil society groups, including NGOs, academic and health policy research organizations, also play critical roles as, for example, “watch dogs” to ensure the MoH fulfills its goals. The press and media also play pivotal roles in shaping public opinion to either support or oppose a MoH’s efforts to implement H/PPPs. Lastly, professional associations and labor unions representing public healthcare personnel are critical stakeholders to engage, as their support is needed to advance any MoH effort to work with the private health sector. The challenge for the MoH is collaborating with this highly fragmented, wide range of actors that have diverse and, at times, competing interests.

<table>
<thead>
<tr>
<th>Key Stakeholders in a Process to Develop the H/PPP Framework</th>
<th>Government Sector</th>
<th>Private Health Sector</th>
<th>International Donors in Health</th>
<th>Consumers / Civil Society</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office of the Prime Minister</td>
<td>MOH Officials</td>
<td>MOHs</td>
<td>World Bank / IFC</td>
<td></td>
</tr>
<tr>
<td>MOH Department Heads</td>
<td>MOH Regional Managers</td>
<td>MOH - USAID</td>
<td>DFID</td>
<td></td>
</tr>
<tr>
<td>MOH - Local Governments</td>
<td>MOH - GIZ</td>
<td>MOH - Bill Melinda Gates Foundation</td>
<td>MOH- WHO</td>
<td></td>
</tr>
<tr>
<td>MOH - WHO</td>
<td>MOH - “Think tank”</td>
<td>MOH - “Who is the best”</td>
<td>MOH - NGOs</td>
<td></td>
</tr>
<tr>
<td>MOH - Press and Media</td>
<td>MOH - Universities</td>
<td>MOH - Labor Unions</td>
<td>MOH - H/PPPs</td>
<td></td>
</tr>
</tbody>
</table>

- Authorize H/PPP policy and framework
- Govern H/PPPs through regulations and oversight
- Ensure health services and goods are affordable
- Implement H/PPP projects
- Increase access to health infrastructure and equipment
- Offer clinical and management expertise
- Deliver efficient, quality services at affordable prices
- Bring capital to health sector
- Technical assistance and capacity building
- Program support and financing
- Networking with international expertise
- Consensus and accountability on H/PPPs

The experience of the Government of the Republic of Zambia illustrates the wide range of key stakeholder groups outside the public sector that play important roles in all stages of development of a H/PPP...
Framework as well as the benefits of stakeholder engagement. The Zambian government started the PPP reform process by inviting the private sector to the table to drive the process. International donors then facilitated the process by providing resources for several rounds of meetings in which the public and private sectors sat together to discuss policy and regulatory reforms. Both the private sector and general public participated in key junctures of the process, reaching agreements and building consensus. Ultimately this process resulted in a collective effort for establishing an H/PPP scheme (Kopp-Mioni, 2012).

The text box below describes the Ministry of Health in Malawi’s commitment to a participatory public private dialogue process to develop an H/PPP strategy and describes how the MoH developed institutional arrangements and modified the process to fit the local policy setting.

Diagram 2.3 illustrates the expectations of key stakeholder groups with vested interests in H/PPPs. Ultimately the government, through the MoH, wants to obtain value for money while ensuring quality health services and medicines are delivered to the population. The government is also seeking to retain both public and private healthcare professionals by creating a vibrant domestic healthcare labor market that offers opportunities for professional advancement. The private health care sector in turn wants a stable business environment that provides opportunities for commercial growth with minimal risk. Ultimately, the goal of H/PPPs is to enable the MoH to deliver affordable, accessible, quality health care services and medicines, including to the poor. All H/PPP frameworks need to anticipate and address these stakeholder expectations.
Step 1: Analyzing and Prioritizing Areas for H/PPPs

Private Sector Assessments collect the timely and relevant information needed to understand the private sector and its role within a national health system.

Most SADC countries have little of the information on the size and scope of the private health sector that is needed to identify priority areas for H/PPPs. Information is limited because: i) the private health sector is reluctant to share information; ii) the private sector finds MoH reporting requirements cumbersome and time consuming; and, iii) the MoH does not share health data with the private sector. Moreover, donor-supported studies and population-based surveys do not always collect data on the private health sector. Recently, several donors (USAID, GIZ and IFC) have sponsored private sector assessments (PSAs) in health to address this knowledge gap.

PSAs answer the following questions:

<table>
<thead>
<tr>
<th>Who is the private sector?</th>
<th>Types and range of private sector entities engaged in health</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the private sector doing and for whom?</td>
<td>Type and range of private sector activities and clientele</td>
</tr>
<tr>
<td>Where do they render these services /activities?</td>
<td>Geographic areas</td>
</tr>
<tr>
<td>And at what price?</td>
<td>Prices charged, cost to deliver services, access to finance</td>
</tr>
</tbody>
</table>

PSAs provide:

- A “snap shot” of the private sector in particular health markets such as family planning, reproductive and maternal health, child health and HIV/AIDS;
- Accurate and reliable data on the scope, size and activities of the private sector in the overall health sector and in priority health areas; and,
- Actionable recommendations on policy reforms and system changes that would support the private sector and potential public-private partnerships.
PSA reports should be……

- **Broad and inclusive** incorporating relevant characteristics of a health system’s inputs and processes as they influence the private health sector;
- **Analytical** and based on a causal framework that links how health system inputs, processes and outputs impact the private health sector;
- **Relevant** by considering how policy reforms, system changes and market incentives can better harness and grow the private health sector; and,
- **Evidence-based**, making use of a wide-range of information on the private health sector combined with experience from other countries.

(Adapted from Berman and Bitran. 2011)

PSAs employ a range of methodologies including:

- **Literature Reviews**: search and review of published articles and data from the various international sources, as well as documents and datasets only available in country set the context;
- **Secondary Analyses**: secondary analyses of publicly available data sets and of population based surveys, such as the Demographic Health Survey or Living Standards Measurement Survey, provide trends and statistics describing demand for specific health services;
- **Stakeholder Interviews**: Key informant interviews fill in information gaps and map perceptions of stakeholders on the relationships between the public and private sectors and their attitudes towards H/PPPs;
- **Focus Group Discussions**: focus groups of private health providers and their clients shed light on the challenges private providers confront and the reasons why consumers seek healthcare in the private sector;
- **Private Provider Mapping**: if resources permit, PSAs conduct facility surveys to identify private providers in targeted regions, or country-wide and collect information on their facilities, including equipment, staffing, level of training, services delivered, and prices charged.

(See Annex One for Data Sources)

---

**Old data generated new data on the private health sector in Malawi**

The private sector assessment conducted secondary analyses of several data sets, including the Demographic Health Survey, National Health Accounts and MoH service statistics to quantify the size and scope of the private sector as well as consumer demand for private sector services. The preliminary analysis prompted more questions than answers and USAID supported additional data collection, including comprehensive mapping of all private facilities; development of a directory of all private health professionals; and an inventory of all equipment and infrastructure in the private sector.

---

**Once the role of the private health sector in the national health system is understood, public and private sector stakeholders convene to discuss and prioritize the supply side issues related to delivering health services and products in both sectors.**

In addition to understanding the private health sector, agreeing on health challenges and system gaps is essential to ensure that the H/PPP Policy and Implementation Plan addresses MoH priorities. To prepare for these discussions, participants should review key MoH strategy documents, such as Health Sector...
Strategic Plans, Sub-Sector Strategies (e.g. Human Resources for Health, Health Financing Strategies, etc.) and relevant annual plans and budgets to develop a thorough understanding of the health sector’s priorities and challenges. In addition, H/PPP staff should analyze MoH service delivery statistics and other studies to identify bottlenecks in the health system and quantify the magnitude and scope of the health challenges. Many of these resources are found in Annex One.

Stakeholders prioritize key areas for H/PPPs
Public and private sector stakeholders review a comprehensive list of health sector challenges and system gaps and then prioritize a “short-list”. The following criteria guide this selection process: i) is the issue aligned with MoH priorities; ii) does the private sector have capacity and expertise to address the service delivery challenge and/or health system gap; and, iii) will H/PPPs in this strategic area attract private sector participation and investment. The number of strategic areas on the short list should be realistic and manageable. In Malawi, the PPP-TWG agreed on five strategic areas for H/PPPs (See Text Box).

Current and potential roles the private sector does and will play in meeting consumer demand are determined
Public and private sector stakeholders analyze and discuss consumer health seeking behavior, including willingness and ability to pay for health services. Key data sources include the Demographic Health Survey and Living Measurement Survey (LMIS). In addition, MOH service statistics and other analyses, such as, for example, the facility mapping in Malawi and provider census in Ethiopia, offer a wealth of information on public and private sector capacity.

Stakeholders use data and answer the following questions:
- Who is the most prominent non-state provider? In what services? Where?
- Is there a sizeable (critical size) of private for-profit- or private-not-for-providers? If so, in what service?
- Can the private sector play a role in the agreed upon priority area(s)?
- What type of private provider is located in underserved areas?
- What services are they delivering?
- Is it possible for existing providers in underserved areas to add priority health services?

Five Strategic Directions for H/PPPs in Malawi

Consumer Demand for Private Services
Using DHS data from 2011, the PPP-TWG determined that the private sector - particularly the FBO sector – provided a significant percentage of maternity services in all three regions. The for-profit sector, in turn provided a very limited percentage of delivery care centered in Blantrye and Lilongwe across all income groups. The most startling result was how much the MoH subsidized deliveries among high-income groups, raising equity issues. The PPP-TWG agreed to explore strategies to encourage middle and high-income women to deliver with a private provider while using the freed-up resources to expand its service contracts with the FBO provider – CHAM – who have an extensive health network in underserved areas.
Step 2: Agreeing on a Framework for H/PPPs

*Step 2: Agree on a PPP Framework for Health*

H/PPP frameworks articulate the MoH’s core rationale for pursuing H/PPPs as well as the policies and procedures that need to be followed to implement them.

It is challenging to develop H/PPPs in an unstable policy environment; so, it is critical that a MoH establish a clear H/PPP framework. An H/PPP framework evolves over time, often in response to specific challenges facing an H/PPP program. This is particularly true for the health sectors in SADC countries that are only beginning to develop formal health PPPs. In the early stages of initiatives to implement H/PPPs, the emphasis of the H/PPP framework is on creating and promoting H/PPP opportunities, ensuring appropriate levels of fiscal risk, and strengthening the capacity of the MoH to design and manage H/PPPs. The framework focuses on efforts to develop institutional capacity, tools, and systems and build experience through development of less complex H/PPPs. As an H/PPP program matures as in South Africa, for example, the H/PPP Framework shifts to focus on strengthening management processes and systems for developing H/PPPs; managing public finances; improving performance; and delivering results.

Regardless of the level of PPP maturity of a country, all H/PPP frameworks share common elements, including an H/PPP policy, institutional arrangements, and legal/regulatory framework. Recently, the Ministers of Finance in SADC approved a PPP Framework (Diagram 2.4). Although this framework is designed for infrastructure PPPs, it is relevant for the health sector and provides a template for drafting H/PPP frameworks for the health sectors in SADC member countries.

![Diagram 2.4 Components of an H/PPP Framework for SADC Countries](Adapted from Kopp-Moni, 2012, p. 48)
The components of a PPP framework in health include:

- **H/PPP policy and/or strategy** — articulate the MoH’s intent to use H/PPPs to deliver public services and goods and describe the objectives, scope, and implementing principles for the H/PPP program. Furthermore, the H/PPP Policy and/or Strategy clarify the laws and regulations that set the rules and enable the MoH to enter into H/PPPs and regulate H/PPP programs. In many countries, overarching PPP legislation and policies authorize the MoH to implement H/PPPs. The MoH, however, must review the national legal and regulatory framework to ensure that all H/PPP policies and procedures are consistent and that any barriers limiting the scope of the private health sector are removed.

- **H/PPP institutional arrangements** — specify the organizational structures to identify, develop, appraise and manage H/PPPs, as well as, the governance processes to approve and oversee H/PPPs. A growing number of African countries have created a PPP Desk and/or PPP Unit within the MoH (O’Hanlon, 2013), including SADC Member States Malawi (in progress), Namibia (in progress) and Tanzania. Others SADC countries, namely Mauritius and South Africa, have seconded MoF PPP staff to the MoH. These countries, with the exception of South Africa, have yet to define roles and responsibilities and PPP processes.

- **H/PPP process** — lays out a transparent process by which the MOH identifies, appraises, procures and implements H/PPPs.

**Doing one’s “policy” homework in Malawi**

In Malawi, the Ministry of Health first created the PPP Node to spearhead the process to design an H/PPP Framework. One of the PPP Node’s first tasks entailed reviewing the current policy, legal and regulatory frameworks. Together with an outside consultant, the team cast a wide net and reviewed policies as diverse as the *Malawi Growth and Development Strategy II*, the *2011 National PPP Law and Act*, *Health Law* and most recent *Health Strategic Plan*. The team also dug into the details and studied the *Procurement and Disposition Act*, procurement guidelines, and MOH planning guidelines to identify existing procedures and practices that could serve as model for health PPPs. At the end of this exercise, the PPP Node proposed the approach (strategy instead of policy to ease approval and accelerate the process) and its components (see below).
Step 3: Drafting an H/PPP Policy and/or Strategy

This section presents common elements in an H/PPP Policy along with illustrative language for each (see Annexes Four to Six). Illustrative outlines for H/PPP Policies and/or H/PPP Strategies are included in Annexes Two and Three. The Malawi experience is presented to illustrate the process and provide an example of an H/PPP Strategy.

H/PPP policies and/or strategies enable MoHs to communicate to potential private sector partners its’ intention to use H/PPPs; priority areas for H/PPPs; and, how H/PPPs will be implemented.

An H/PPP policy or strategy typically includes:

- **PPP program objectives for the health sector**—why the MoH is pursuing a H/PPP program;
- **H/PPP program scope**—what types of projects will be pursued under the H/PPP policy;
- **Implementing principles**—how H/PPP projects will be implemented to ensure the H/PPP program meets its objectives;
- **Definition of H/PPP**—how a country will define what is and is not an H/PPP given its policy framework, and:
- **Scope of H/PPPs**—what type of H/PPP models, geographic and/or technical areas for H/PPPs and size in terms of minimum size or dollar value for H/PPP projects.

Many SADC countries have established PPP policies governing all economic sectors. As SADC Member Countries have developed PPP Policies, Ministries of Health have developed different legislative mechanisms for H/PPPs. There are a few African countries, such as Ethiopia, Ghana and Uganda that have PPP policies specific to health. Other countries, Malawi and Namibia, however, have chosen to draft a PPP Strategy for Health, as a strategy is easier to promulgate through the required approval process. SADC Member Countries and the types of policy they have developed are listed in Table 2.1. Most of these countries conducted consultative processes to develop the policies and/or strategies and the public and private sectors worked together to articulate the objectives for partnering; define the type of H/PPP models appropriate for the health sector; and agree on the principles guiding H/PPPs. In a few countries, such as Tanzania and Malawi, the MoHs are further along in the process and have drafted implementation plans to operationalize their H/PPP Strategies.

<table>
<thead>
<tr>
<th>Country</th>
<th>Type of PPP Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia</td>
<td>Draft PPPH Guidelines, 2009</td>
</tr>
<tr>
<td>Ghana</td>
<td>National PPP Policy (2011)</td>
</tr>
<tr>
<td>Madagascar</td>
<td>Une Politique Nationale De Contractualisation, 2007</td>
</tr>
<tr>
<td>Malawi</td>
<td>National Health PPP Strategy, 2013 (draft)</td>
</tr>
<tr>
<td>Malawi</td>
<td>National PPP Policy, 2011 / National PPP Act No. 27, 2011</td>
</tr>
<tr>
<td>Mauritius</td>
<td>The Investment Promotion Act, 2009</td>
</tr>
<tr>
<td>Mozambique</td>
<td>Anteproyecto Preliminary do Regulamento da Lei sobre PPPs e MegaProjectos, 2010</td>
</tr>
</tbody>
</table>
H/PPP Policy Goals vary and reflect national economic and health challenges, as well as, goals of the health sector.

The SADC Draft Regional Strategy states that PPP Policies in SADC countries have strategic (e.g. harnessing private capital, enabling more infrastructure investment) or operational (e.g. affordability and improvement in services) goals. Most SADC and Sub-Saharan countries’ H/PPP policies or strategies attempt to merge the two types of goals and focus on harnessing private sector contribution (strategic) in order to improve healthcare (operational). The challenge is to craft an H/PPP goal that harmonizes the country’s national H/PPP Policy and reflects national health priorities.

Examples of H/PPP Policy Goals are presented below and further details can be found in Annex Four.

- Uganda: “Universal access to affordable health care for all the population through an efficiently integrated public-private partnership in health”.
- Uttar Pradesh: “contribute to the strengthening of the health delivery system with capabilities and full participation of the private for-profit and not-for-profit health sectors to maximize the attainment of the health goals in rural and urban areas as envisioned by the Government of Uttar Pradesh”.
- Tanzania: “health service providers optimally use their comparative advantages to contribute to universally available, affordable, accessible, appropriate and effective health services in view of attaining the MDGs”.
- South Africa: “Facilitate and effect transformation of the health sector in the following key areas: 1) access to health services, 2) equity in health services, 3) quality of health services, and 4) black economic empowerment”.

Other examples include:
- “Harnessing private sector innovation and efficiency to deliver affordable, quality health services for all”;
- “Improve the health status of a country’s population by mobilizing private sector capital and investment”; 
- “Strengthen the health delivery system and improve performance (efficiency, effectiveness, cost savings)”; 
- “Align private health sector investment and activities to national health priorities”.

Specifying the priority areas (objectives) for H/PPP’s ensure they are aligned with the health sector’s overarching goals.

By specifying priority programmatic areas as well as H/PPP models the MoH signals to the private health sector the types of unsolicited proposals it might potentially fund. Clearly stated H/PPP programmatic
priority areas can also prove useful to the MoH as justification for rejection of unsolicited proposals that do not address stated priorities.

Examples of objectives in African and Indian H/PPP policies and strategies are limited. Annex Five includes additional country examples. Very few are specific and most focus on general health objectives, such as:

- “Build confidence and trust in the public and private health sectors”
- “Harness confidence and trust in the public and private sectors to attain National Health Policy Targets”
- “Promote and sustain equity, efficiency, accessibility and quality in healthcare through collaborative relationships between the public and private sectors”
- “Improve efficiency in allocation of existing public sector resources in health”
- “Align private health sector investment and activities to national health priorities”
- “Encourage a greater role of private sector in health”

Ethiopia and Malawi have articulated specific objectives on how to work with the private health sector as well as defined priority areas for H/PPPs.

---

**H/PPP Strategy Objectives in Malawi**

The overall goal of health PPPs is to leverage private sector capacity, expertise and investment to increase access to affordable quality healthcare services that contribute to the achievement of national health, social and economic goals.

---

**Priority Areas for H/PPPs (Ethiopia)**

**Health Care Delivery:**
- Disease prevention and control
- Curative and rehabilitative services
- Family Health
- Environmental Health and Hygiene
- Health Education

**Health Human Resources:**
- Basic training
- Transfer of skills and knowledge

**Health Information Systems:**
- Integrated HMIS
- Integrated HRH Info System

**Governance and Stewardship:**
- Leadership development
- Policy, planning and monitoring
- Quality assurance

**Outreach Services:**
- Diagnostics
- Health Referral Networks
- Health infrastructure development

**Health Products:**
- Pharma production
- Logistics
- Vaccines and technologies

**Health Human Resources:**
- Basic training
- Pre-service education

**Health Financing:**
- Social health insurance and community-based health insurance

---

Implementing principles - the guiding rules or code of conduct under which H/PPP projects will be implemented - are included in HIPP Polices and signal to the private sector the MoH’s commitment to fair and clearly-defined partnerships; set the standards against which those responsible for implementing PPPs will be held accountable; and present the regulations and processes that will govern H/IPPP implementation.

SADC member countries have recognized the need to adopt and formulate clear and transparent principles that present the government’s spirit and intent in developing PPPs in statements or laws that guide PPP implementation. Policymakers in the health sector have adopted many of these guiding principles, particularly VfM, affordability and openness, to guide H/PPP policies. In addition, they have added key health sector principles such as “equity”, “quality” and “health for all”. Common implementation principles guiding H/PPPs include:
- **Value for Money**: Achieving VfM criteria on H/PPP projects is paramount.
- **Risk Allocation**: The government strives to allocate risk optimally. Risks will be allocated to whoever is best able to manage them, taking into account public interest consideration.
- **Public Interest and Consumer Rights**: Consideration of public interest requires ensuring that procuring the project as a H/PPP is not contrary to the public interest.
- **Affordability**: Affordability is the cornerstone of all H/PPP projects. H/PPP options must be affordable - both to Government and the consumer - given that there are other priorities and commitments competing for scarce public and private health sector resources.
- **Accountability**: Contracting Authorities (CAs) are responsible for the delivery of their project outputs. Accountability cannot be transferred to the private sector.
- **Transparency**: Transparency and openness are important requirements of all government procurement and are equally important for H/PPPs.
- **Health for All**: “Be inclusive and gender sensitive” (Ethiopia)
- **Equity**: “The public sector partners will ensure the equitable allocation of resources for health in accordance with the needs of the population and according to the volume and quality of services rendered” (Tanzania)
- **Quality**: “Service provision by public and private providers shall focus on quality and efficiency to attain maximum benefits” (Uganda)

### Guiding Principles for H/PPPs in Malawi
- Secure trust between the public and private partners
- Establish parity of relationship between the public and private sector partners
- Strive to rationalize and complement services rather than duplicate them
- Nurture PPPs that increase access, improve quality and address equity in healthcare delivery
- Seek PPPs that reduce costs and improve overall efficiency in healthcare thereby reducing economic burden in the public sector
- Create space for private partners to earn a profit while working to achieve social objectives

Health sector decision makers have also included principles in their H/PPP policies to address two of the greatest barriers to PPPs in health (i) mistrust and suspicion between the sectors and (ii) the right of the private sector to earn a profit while delivering health services. Country examples are provided below and in more detail in Annex Six.
- “Secure trust between Public and Private Partners” and “Establish parity of relationship among the public and private sector” (Ethiopia)
- “Trust between the partner” and “Establish a relationship of equals” (Ethiopia) (Uganda) (Uttar Pradesh)
- “The identity and autonomy of each partner shall be accepted and respected” (Ethiopia) (Uganda) (Uttar Pradesh)
- “While ensuring that the social objective of the government is met, adequate space needs to be allowed to private partners for their returns” (Ethiopia)
- “Ensure social objective, create space for private partners for their returns. Profitability is not the motive, profit is a requirement” (Uttar Pradesh)
Definition of what an H/PPP is as well as what it is not can be included in a H/PPP policy/strategy so that local health stakeholders share a common understanding (see Table 2.2).

Malawi Definition of PPPs in the Health Sector

“A PPP in health is any formal collaboration between the public sector at any level (national and local governments) and the private sector (private for profit, not-for-profit and FBOs) with a clear agreement on shared objectives and risks to undertake activities that improve delivery of health services and products or address a health system constraint. In an H/PPP arrangement, the private sector party performs part or all of a government’s health service/product delivery and/or system functions while assuming associated risks for a specific time period. In return, the private sector receives benefits/financial remuneration according to the predefined performance criteria and risks.”

In some cases, the terms PPPs and privatization (divestiture) are used interchangeably, as for example, in the Malawi PPP Bill. This has resulted in confusion and association of PPPs with unpopular programs to privatize state companies by selling them outright. While an H/PPP might involve some privatization (e.g., contracting out) of services, a true H/PPP does not shift all public responsibility to the private sector.

<table>
<thead>
<tr>
<th>Country</th>
<th>Country Name</th>
<th>Reference</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia</td>
<td>Public-Private Partnership in Health Guideline</td>
<td>2009</td>
<td>“Collaborative and reciprocal, formal &amp; informal relationship between two or more parties with clear terms and conditions, clearly defined Partnership structures, and specified performance indicators, for the delivery of mutually agreed sets of health care services, that meet and satisfy the strategic attributes and concerns of Equity, access, quality, effectiveness, efficiency as well as sustainability in a stipulated time frame.” “Public-Private Partnership in Health (PPPH) is also about combining different skills and expertise in a framework of defined responsibilities, roles, accountability and transparency, to achieve a common goal that may be unattainable by independent action.”</td>
</tr>
<tr>
<td>Ghana</td>
<td>Republic of Ghana National PPP Policy</td>
<td>2011</td>
<td>“A PPP is a contractual arrangement between a public entity and private sector party, with a clear agreement on shared objectives for the provision of services and goods traditional provided by the public sector. Usually, in a PPP arrangement, the private sector party performs part or all of a government’s service delivery functions and assumes associated risks for a significant time period. In return, the private sector receives benefits/financial remuneration according to the predefined performance criteria.”</td>
</tr>
<tr>
<td>Tanzania</td>
<td>Tanzania Health Sector Strategic Plan</td>
<td>page 33</td>
<td>“Public Private Partnership in health can take a variety of forms with differing degrees of public and private responsibility and risk. They are characterized by sharing of common objectives, as well as risks and rewards, as might be defined in a contract or manifested through a different arrangement, so as to effectively deliver a service or facility to the public.”</td>
</tr>
<tr>
<td>Uganda</td>
<td>National Policy on PPPs in Health</td>
<td>2006</td>
<td>“The term PPP describes a spectrum of possible relationships between the public and private actors for integrated provision of services. The essential prerequisite is some degree of private participation in the delivery of traditionally public domain services.”</td>
</tr>
</tbody>
</table>

H/PPP Project Scopes can be used to limit H/PPPs to particular types of projects or H/PPP models; health areas; and/or dollar values thereby focusing efforts on projects that are most likely to achieve the MoH’s objectives and provide Value for Money (VfM).

In the H/PPP policy or strategy, the MoH may define the H/PPP scopes as limited to:
- **H/PPP Models:** An H/PPP policy can offer an operational definition of H/PPPs as well as prioritize the types of H/PPP models that are best suited to achieve the MoH’s objectives. The H/PPP policy may also outline the H/PPP models which are not to be included in the H/PPP framework.

- **H/PPP Areas:** An H/PPP policy may limit the technical areas for H/PPPs. For example, H/PPPs may be aligned to predetermined health priorities (e.g. reduction of maternal mortality, increased number of patients on ART, declines in the incidence of malaria, etc.) or health system gaps (e.g. improve the quality of diagnostics for malaria, HIV/AIDS, TB, lease inoperable public health facilities to private providers, extend distribution of drugs to rural areas, etc.).

- **H/PPP Size:** Many governments stipulate a minimum dollar value for H/PPP projects to be implemented. Some H/PPPs designed to address selected health priorities, may not reach the minimum value required of H/PPP projects – particularly when measured on a scale used for infrastructure PPPs, so H/PPP policies may exempt H/PPP projects valued under an established amount from appraisal and/or approval requirements required of larger H/PPPs and/or PPPs.

---

**Step 4: Establishing H/PPP Institutional Arrangements**

PPP Units are proliferating quickly throughout Sub-Saharan Africa, including in several SADC Member Countries -- Uganda and South Africa (2000), Benin and Ghana (2003), Senegal (2005), Ethiopia (2007), Nigeria (2007), Mozambique and Zambia (2008), Tanzania (2010), Rwanda (2010) and Kenya (2012) (Diagram 2.5). MOHs in both Malawi and Namibia are currently in the process of establishing PPP capacity.

While PPP units vary in size and scope, reflecting the broad range of functions they carry out, they all strive to inform and foster collaboration between the private and public sectors and support opportunities to form H/PPPs aiming to increase access to quality health services.³

This section focuses on the emerging experience of SADC MOHs in establishing institutional arrangements and PPP capacity in the health sector to

---

³ Most of the countries described here also have parallel economic growth PPP Units which are distinct from the health PPP Units, and are responsible for privatization or divestiture of large public enterprises and attracting and managing donor funds, loans and capital investments. Aside from the PPP Unit in South Africa, which merges all its PPP functions under one unit, the PPP Units for economic growth and capital investments typically have very distinct and separate functions, and are also housed in separate divisions of government. For more information see [www.fdi.net/spotlight/pppunits_sub.cfm?regnum=2&spid=9](http://www.fdi.net/spotlight/pppunits_sub.cfm?regnum=2&spid=9).
develop and implement H/PPP projects. PPP Units - also referred to as “desks” or “nodes” - play an important role for both the public and private health sectors. For the MoH, a PPP Unit is a point of coordination, quality control, accountability and information related to all H/PPPs. For private sector health stakeholders, a PPP Unit provides a clear point of contact and helps them to navigate the complex MoH system; establishes and enforces the “rules of engagement” for developing and implementing health PPPs and provides transparency and consistency.

**PPP Units make policy and seek to regulate, facilitate and strengthen public-private interactions with staff who are experts in both sectors; understand how a MoH operates and the risks and incentives needed to motivate the private health sector.**

The Terms of Reference of the PPP Unit of Malawi is included in Annex Seven and common responsibilities of PPP Units are included below:

- **Broker knowledge**: PPP Units play a critical role in assembling information and data that describe a country’s private health sector. In addition, the PPP Unit serves as the institutional memory on how best to work with the private sector by creating and collecting tools and methodologies, and documenting best/worst practices as well as strategies that the MoH can use to leverage the private sector and tap the full potential of H/PPPs.

- **Strategic advice**: The PPP Unit houses a government’s H/PPP expertise and provides technical support to different divisions within the MoH and other appropriate agencies to identify priority public health needs that can be addressed by the private sector; assess the private sector’s capacity; develop strategies for developing H/PPPs and recommend actions to leverage private health sector resources.

### Malawi PPP Node Roles and Responsibilities

The Ministry of Health approved the terms of references for the PPP Node. Its key functions are:

- Foster an enabling environment and markets
- Coordinate and collaborate with the private sector
- Offer strategic advice to MOH leadership on PPP opportunities
- Manage knowledge on the private sector and H/PPPs
- Support implementation of H/PPPs
- Build public and private capacity to implement H/PPPs

The PPP Node resides in the Department of Policy and Planning. The Central level PPP staff liaise with PPP Advisers at the decentralized level. To manage and supervise a virtual team dispersed throughout the country, the PPP Node plans to design several systems accessible from the regions. Also the PPP Node team will devolve skills and capacity to H/PPP Implementation teams, led by the Regional Health Officer and PPP Adviser.

- **Technical assistance**: PPP unit staff provide technical support and training to other MoH staff to i) harmonize legal and regulatory frameworks; ii) draft contracts and concessionary agreements for health services or facilities; iii) design programs that protect the poor; and iv) establish mechanisms to assure quality in the private sector. PPP Unit staff can also provide technical support for a) negotiating agreements, b) preparing and reviewing feasibility studies, c) structuring deals, and d) conducting proper due diligence to ensure appropriate risk transfer, affordability and value for money.

- **Implementation support**: PPP Unit staff collaborate with various MOH staff as they implement specific policies, regulatory and institutional reforms and support the design and start-up of H/PPPs. They also oversee projects by scrutinizing the quality, affordability, and feasibility of H/PPPs and monitoring their performance.
- **Evaluation support:** PPP Units may participate in cost and quality evaluations of H/PPPs. However, if the units were involved in initiating or renewing a particular H/PPP, it is best that they be recused from evaluating its performance and cost effectiveness. Instead, an independent auditor, or other group within the Ministries of Finance or Health should be utilized.

- **Capacity-building:** Lastly, PPP Units help build public sector capacity to identify, design and implement H/PPPs by developing toolkits, conducting training, standardizing practices and procedures, and developing case studies.

Institutional arrangements for developing and implementing H/PPPs differ from country to country and depend on existing institutional mandates and capacities as well as the priorities and needs of the H/PPP program. While there is no “right” or “wrong” way to set up the roles and responsibilities between government agencies, it is essential that institutional responsibilities for H/PPPs – that is, which entity will play what role at each step of the process are clearly defined in the H/PPP Framework.

### How H/PPPs work in Malawi

As the Contracting Authority, H/PPPs are “owned” by the MoH in Malawi. The MoH, through its PPP Node, generates H/PPP projects that are compliant with the PPP Commission’s guidelines on how to identify, appraise, structure and implement general PPPs. The PPP Adviser in the MoF offers to the MoH strategic advice, technical assistance but also approves certain H/PPPs that meet a threshold (still to be determined) of size, scope and value.

Within the MoH, the MoH Departments at the national level and the Regional/District Health Authorities play a central role in H/PPPs. These two groups are responsible for scoping H/PPP projects, leading the competitive process and managing implementation of the H/PPP project. The PPP Node plays a supporting role and helps the H/PPP Implementation Teams to: i) prepare the project, ii) select and manage technical specialist advisers when necessary; iii) ensure the project fits into the MOH’s H/PPP Strategy; iv) oversee the procurement process; and, v) monitor the H/PPP’s progress and performance. In essence, the MOH PPP Node plays an advisory, approval and quality assurance role throughout the project development process.

The generic responsibilities fundamental to a well-organized and functioning H/PPP system include:

- **Implementing H/PPPs:** The government needs to identify which government agency can be a “Contracting Authority” and be assigned specific responsibility for advancing the H/PPP project cycle -- from identifying potential H/PPPs; to appraising, structuring and drafting H/PPP project proposals; to competitively awarding H/PPP project contracts; and eventually, managing and monitoring H/PPP project implementation. These responsibilities are typically assigned to the government agency responsible for the sector and tasked with ensuring relevant assets or services are provided (WBI, 2012:p82). The types of government entities that can be “Contracting Authorities” responsible for implementing H/PPPs are defined in national H/PPP Law and/or Policy. Many SADC countries – Malawi, Namibia and Tanzania – have established or are in the process of establishing and building capacity of a PPP Unit within the health sector. The primary challenge for governments in designating
an appropriate implementing agency is ensuring that that agency has, or can access, the range of technical skills needed to implement and manage H/PPPs.

- **Approving H/PPPs:** Governments have rules for approving H/PPPs, particularly those that require major capital investments such as infrastructure H/PPPs. The regulations clearly lay out who can approve what level of project and at what juncture of the H/PPP process. Approvals are usually needed at several stages of the H/PPP project development process— for example at the H/PPP concept, business case and final contract stages. Having several decision points in the process when weak H/PPP projects can be eliminated saves scarce planning resources.

Jurisdictions vary as to which entity must approve a H/PPP. Some countries have established tiers in which large capital investments require Cabinet-level approval; lesser-valued projects require MOF approval; and smaller projects, especially those with a health and/or system impact that require no capital investment, require only MoH approval.

- **Regulating the H/PPP process:** In successful H/PPP programs, one government agency is responsible for making sure that all government agencies follow appropriate procedures; that all relevant agencies are involved in the process; and that the final decision-makers have the information they need. This responsibility is often given to a central agency that already exercises cross-government coordination and control functions (WBI, 2012: 85), such as the Ministry of Finance or the Planning Department.

Roles and Responsibilities in Implementing H/PPPs in Tanzania

Tanzania, like Malawi, has a devolved health system in which decision-making resides at the county level. The Ministry of Health and Social Welfare clearly prescribes a participatory and inclusive annual budgeting process that includes all stakeholders. Through this process, the County Health Management Team, supported by a PPP Focal person, identifies H/PPP opportunities and starts the process outlined in the H/PPP Project Guidelines (in draft) to develop and implement the H/PPP pipeline (see Diagram 2.6).

Diagram 2.6 Roles and Responsibilities for H/PPPs in Tanzania

Developing H/PPP capacity requires significant investment to support staffing and equipping a PPP Unit; training MoH staff at central and regional levels; hiring outside H/PPP experts to design an efficient H/PPP process and develop necessary operating systems; and using H/PPP advisors and specialists on a regular basis to help the PPP Unit perform its functions as it develops its’ own capacity.

The United Nations Economic Commission in Europe (UNECE) Guidebook outlines the strategic areas needed to build H/PPP institutional skills and capacity within a MoH (UNECE Guidebook, 2008). Experience shows that an H/PPP Unit does not have to be large; in fact large units can undermine the government’s intent for increased efficiencies. Governments can build the necessary capacities in a combined approach that establishes new institutions and trains public officials while at the same time uses external expertise. Unfortunately, few SADC MoHs have allocated sufficient funds to the new H/PPP Units, resulting in many implementation challenges. International donors, and organizations such as the
SADC 3P Network can provide much needed support by fielding technical expertise; facilitating sharing of experiences and best practices; and developing tools and other training resources (Annex 8).

Other innovative strategies for augmenting limited H/PPP experience in the health sector include (i) forming inter-departmental committees that include appropriate representatives from the sector ministry and the ministries of finance and planning, as well as other legal representatives; (ii) involving staff of dedicated PPP Units that are tasked with supporting Contract Authorities in line ministries – both Mauritius and South Africa have dedicated PPP Units; and (iii) embedding or seconding PPP Unit staff to line ministries help carry out H/PPP implementation functions.

**Teaming MoH PPP staff with appropriate outside experts** — including transaction advisers; lawyers; financial analysts; financiers; and economists — from the beginning of the HIPPP Framework design process through the first and possibly second round of using the operating systems to identify, negotiate and implement HIPPPs is the best way to build HIPPP capacity.

These specialists can be procured as a team or recruited individually and play an important role in creating and maintaining momentum, developing strategies, performing analyses of different H/PPP options and supporting the bidding and negotiation process. It is best to include these advisers in the early stages of the design of the H/PPP Framework and team them with appropriate MoH staff thereby allowing them to assist in laying a solid foundation for HIPPPs and training MoH staff in new roles and responsibilities based on the new policies, institutional structures and operating systems. If outside technical assistance is not available during the preparatory stages, then it is critical that MoH staff receive training in H/PPP design; contract negotiation and management; and financial analysis and due diligence as early in the process as possible.

**Step 5. Building the H/PPP Pipeline**

An HIPPP implementation plan to initiate and implement HIPPPs aligned to a SADC’s country’s national health goals and partnership objectives is an important planning tool that monitors the progress of SADC member countries in (i) reaching agreement on strategic areas for HIPPPs; (ii) articulating private sector and market-based objectives; and (iii) proposing a range of HIPPP projects and models for consideration.
An effective H/PPP Implementation Plan also sets targets (e.g. number of H/PPP projects, types of H/PPP models, etc.) and the milestones required to reach them. Once again, to increase buy-in, ensure interests of both sectors are met, and increase the likelihood of success of H/PPPs, all key stakeholders who will be implementing H/PPP projects must be involved in a consultative process to develop this H/PPP implementation plan. Moreover, the deliberations should be data-driven, permitting the participants to discuss and weigh options based on accurate information. Diagram 2.8 lays out the steps and analyses needed to draft an informed H/PPP Implementation Plan.

![Diagram 2.8 Process to Draft an H/PPP Implementation Plan](image)

Following a simple planning process (Diagram 2.9), participants articulate the private sector objective for each priority area, define the multiple strategies to achieve the objective, scope out possible private sector partners and identify possible H/PPP approaches.

![Diagram 2.9 Defining the Strategic Direction for H/PPPs](image)

Questions to guide the process include:

- What type of H/PPPs does the MOH currently use? For what type of health activity? With what type of providers?
- Can they use the same type of H/PPP arrangement? With more of the same type of provider? With a new type of provider?
- Are there other types of PPPs beyond health services that will address one of the “top” five priorities? With what type of provider? Using what type of PPP mechanism?
- Does the H/PPP project make the health services more accessible? More affordable to consumers?
- How strongly does the H/PPP project support and contribute to the MOH’s national health goals?
- Is the H/PPP project feasible both in terms of MOH capacity to manage it and the private sector capacity to implement it?
- How sustainable is the H/PPP project? Does it create savings, value for money, and/or efficiencies for the MOH?
- Is the H/PPP project culturally and politically acceptable to consumers? MOH leadership? Other government officials?

By specifying the strategic areas as well as the types of H/PPP models, the MoH signals to international and local private sector entities its objectives and interests and indicates to them the types of projects that it will potentially fund.
There are a range of H/PPP models used in the health sector in SADC and Sub-Saharan Africa that differ from one another in their complexity and the amount of risk that is transferred to the private sector partner.

Diagram 2.10 provides definitions for the types of H/PPP models and Annex Nine offers an overview of the full range of H/PPP projects and the types of H/PPP models used to implement them.

Before selecting a specific H/PPP model, it is critical to first ask “what is the problem we are trying to solve?” In the health sector, the problems can be categorized as health needs and/or system gaps. Keep in mind that a PPP is an instrument - a means to an end – and that the process by which the
instrument is developed and implemented is what matters. Diagram 2.11 offers examples of H/PPP models that can strengthen the overall health system.

For example, the MoH can more easily outsource or contract for specialty services (e.g. oncology, cardiology, etc.) that often reside in the private health sector instead of developing capacity within the MoH. Similarly, the MoH can benefit from private sector experience in management practices by contracting private sector healthcare administrators to manage public hospitals and/or public provider networks. And the MoH can lease from and contract private companies to maintain expensive medical equipment as a mechanism to improve efficiencies.

There is increasing evidence demonstrating that H/PPPs focusing on health care delivery offer greater savings and efficiencies. A PwC study revealed that contracting the private sector for clinical and non-clinical services and the provision of medicines and medical equipment yield greater savings and efficiencies (See Diagram 2.12) than infrastructure H/PPPs. Also, private finance initiatives (PFI) that combine public financing of health infrastructure with privately operated delivery of services, as has been done in Brazil and Lesotho, are promising H/PPP models. In contrast, infrastructure H/PPPs have yielded much lower efficiency gains and savings. Studies on hospital PPPs in the United Kingdom and Australia concluded that efficiencies resulting from involving the private sector in only infrastructure H/PPPs (e.g. design-build) with “facility availability” were too low to make up for the higher cost of capital and management. Also, the United Kingdom experience in hospital PPPs concluded that a fairly limited amount of risks (related to cost escalation, etc.) was transferred to the private health sector making it infrastructure PPPs a poor use of public funds.

As with the introduction of a new way of “doing business” and delivering health services, the MoH must carefully weigh all risks and benefits of H/PPPs before proceeding (Diagram 2.13).

Benefits of H/PPPs. Two of the primary reasons MoHs in Sub-Saharan Africa are interested in partnering with the private health sector are to attract private sector capital to the health sector and expand access to health services and products.
Attract capital: H/PPPs can attract private capital investment to supplement public resources or free them for other public needs. H/PPPs also reduce reliance on donor funds. The private health sector is self-sustaining, requiring no donor or government funds to operate. When the private sector earns a profit, it not only covers its current costs but can, if the agreement is so designed, invest profit in improving quality, expanding health services or both.

Access and Efficiencies: There is evidence that the private health sector can deliver health services and products at an affordable cost with comparable and even better health outcomes than those in the public sector. H/PPPs can also create efficiencies across the health sector by rationalizing the use of existing resources in public and private sectors such as health staff and infrastructure.

Innovation. The private health sector in Africa leads the sector in adopting new technologies, innovative management approaches and improved healthcare operations. In addition to introducing state-of-art medical equipment, other examples of new technologies the private health sector can bring into the health system include ICT platforms for hospital, clinics and pharmacy chains; electronic medical records; and e-health technologies.

Expand and retain the pool of human resources in health. One of the key constraints to improving health systems in Sub-Sahara Africa is the “brain drain”. Encouraging private sector growth is one strategy to retain health professionals as it increases business opportunities in country. Moreover, the private health sector increases access to newer technologies and creates wider career opportunities for health professionals.

Build Capacity. The private health sector brings skills, particularly in specialty areas like diagnostics, cancer, chronic diseases, and surgery that can be shared with public sector counterparts. By partnering, the public sector can extend its reach by increasing the number of service delivery points.
through private providers who have their own infrastructure and state-of-the-art medical equipment as well as increasing the number of skilled health personnel in the country.

**Risks of H/PPPs.** There are however, also risks associated with H/PPPs.

- **High transaction costs.** MoHs have an existing procurement process to purchase goods and services. The costs of designing an H/PPP process as well as creating in-house H/PPP management capacity will, in the short-run, be more costly for the public sector than using the traditional procurement system.

- **Lack of funds.** Another risk is insufficient public funds to finance H/PPPs. There is a common misperception among African MoHs that the private sector will bring its own financing to deliver health services, particularly to hard-to-reach population groups. Experience has shown however, that even FBOs, with a social mission like that of the public sector, require reimbursement to cover operating costs. Many MoHs have notoriously poor payment records making headlines in local newspapers. It is important to ensure that as an H/PPP project is developed funds are allocated to support it throughout the anticipated life of project and once the H/PPP contract is awarded all future payment commitments are included in the MoH budget and expenditure plans.

- **Potential higher financial costs.** At times, MoHs take on too much financial risk in large infrastructure and long-term service delivery contracts and fail to anticipate all contingencies over the lengthy timeframes of the projects. This lack of fiscal clarity can lead MoHs to over-estimate the value for money of an H/PPP. In addition, MoHs can be pressured by political leaders to invest in a large H/PPP infrastructure project to construct, for example, a new hospital, in order to gain political support when the H/PPP project is not in fact the best use of public funds.

- **Poor planning and project selection.** H/PPPs are a new “way of doing business” for MoHs. Only a few, like South Africa, have experience and capacity to identify, select and manage “good” H/PPPs. Forming and managing H/PPPs requires MoH managers to take on additional work and acquire new skills, such as feasibility analyses, contract design and private sector engagement. In addition to new skills, MoHs also need to develop policies and procedures; standardized systems to conduct due diligence and capacity to manage H/PPP projects properly – skills many MoHs in the region lack.

- **Lack of transparency and competition.** The process for identifying and selecting H/PPP projects is ad hoc and reactive. MoHs are besieged with multiple proposals without a disciplined, analytical process and the necessary skills to identify and select sound H/PPPs, creating the potential for corruption and collusion. Furthermore implementing a transparent competitive process is difficult and even more challenging when the MoH lacks the staff and skills to compete, structure and manage H/PPPs well.

*By standardizing and documenting the H/PPP project cycle, a MoH will be able to improve timeliness, facilitate planning, and ensure equal access to information and transparency in its approach to H/PPPs.*

Diagram 2.14 illustrates a common approach to identify, design, structure and implement H/PPPs (WBI, 2011) based on international best practices in other economic sectors. While Diagram 2.14 illustrates the H/PPP

---

**Starting with an H/PPP inventory - the Case of Malawi**

The PPP Node recognized they were not start from zero when implementing H/PPPs. Indeed, the MoH had several service delivery contracts with the CHAM. The MoH decided to conduct an inventory of both informal and formal PPPs to better understand the full range of PPP mechanisms it currently employs and the variety of private sector partners. Also, the H/PPP inventory would serve as a baseline and initial catalog of H/PPP projects in the MOH pipeline. The MoH (still underway) is working in partnership with the District Health Management Teams and local private sector groups to identify all ongoing H/PPPs. The type of H/PPPs can range from dialogue and public-private interactions (e.g. through planning, information and resource sharing) to service contracts and infrastructure H/PPPs. At the conclusion of this task, the MoH plan to have a more accurate record on the number, size (scope, total value, geographic coverage), types of projects (service delivery, HR production, etc.), geographic location, range of private partners and H/PPP mechanisms (MOUs, contract, lease, etc.).
Project Cycle with a linear graphic, in fact, the H/PPP Project cycle is an iterative process with progressively more rigorous, intensive and expensive analyses at each successive stage culminating in the final outcome of an H/PPP project contract and/or agreement which has been evaluated; judged to be in the public interest and to be a solid project concept that can be transformed into a successful H/PPP project; and, most importantly, deemed worthy of MOH investment.

![Diagram 2.14 Health PPP Project Cycle](image)

**Stage One: Originate, Screen and Prioritize H/PPP ideas**

- **Originate**: In the case of Malawi, the MoH elected to take a strategic, top-down approach to identify and originate H/PPP project ideas. The strategic directions in the H/PPP Strategy define the priority areas appropriate for H/PPP projects. The MoH, through its PPP Unit, needs to share these priorities not only with its own staff, particularly at the decentralized levels, but also with the private health sector groups. The MoH also needs to reinforce these priorities and continuously communicate its intent to partner with the private sector. It can use annual and district level planning and policymaking processes to originate H/PPP ideas. Participatory planning and inclusive policymaking, as in the case of Uganda and Tanzania, encourages FBO, NGO and private-for-profit partners to propose innovative
ideas for H/PPPs. These processes, however, are not sufficient to generate sufficient private sector response. Best practices underscore the need for MoHs to also actively promote and market select H/PPP projects to raise awareness, and generate interest.

- **Screen**: A MoH will receive various project ideas—many of which may not be suitable for an H/PPP. The MoH screens— with all the available information— to assess whether the proposed H/PPP project addresses the MoH’s strategic directions. If so, then the PPP Unit will screen the “feasibility” of the H/PPP proposal. Screening factors include: i) health/system impact; ii) legal barriers; iii) technical feasibility; iv) scale of project relative to the cost and risk; v) opportunities to transfer risk; and vi) private sector capacity and potential interest.

- **Prioritize**: Given limited MoH resources, the PPP Unit will also prioritize among the identified H/PPP potential proposals. Criteria to prioritize H/PPP proposals include: i) project readiness and stage of preparation; ii) responsiveness to health sector goals and consumer needs and iii) high “implementability” with a greater likelihood of success.

The H/PPP proposals that survive Stage One become an H/PPP project concept and are added to the MoH’s H/PPP pipeline. The H/PPP pipeline includes all MoH H/PPPs in each of their different stages of the H/PPP Project cycle.

**Stage Two: Appraise and Structure H/PPP Projects**

- **Appraise**: At this point in the process, the PPP Unit appraises the H/PPP concept to determine if it is worthwhile for the MoH to develop it into an H/PPP project. Using different analytical approaches, a PPP Unit measures the H/PPP concept against the following criteria: i) Is the project technically feasible? ii) Can the project costs be justified? iii) Is the H/PPP opportunity commercially attractive to the private health sector? iv) Will the H/PPP project deliver more value for money if implemented as an H/PPP compared to conventional contracting? v) Is the project fiscally responsible? vi) Are there sufficient public funds to finance the H/PPP over the proposed life of the project?

- **Structure**: Based on the appraisal, the PPP Unit then structures the H/PPP project, allocating responsibilities, rights and risks to each partner in the agreement. Allocation and risk transfer is the key feature in an H/PPP project that distinguishes it from traditional procurement arrangements. The defined partnership structure becomes the foundation for the contract. The structure outlines the commercial terms of the H/PPP — required outputs, responsibilities and risks borne by each party; processes for monitoring performance; conditions and terms of payment to the private provider; and processes for modification and/or termination of the agreement.

At the end of this stage, the PPP Unit presents the H/PPP project to MoH leadership, and/or the appropriate Ministry Contracting Agency (depending on origination and project size) for approval before committing additional MoH resources to drafting a contract, managing a bid process and awarding the contract.

**Stage Three: Design and Tender of H/PPP Contract**

- **Design**: The contract is the foundation for the partnership, defining the relationship between the partners, their respective rights and responsibilities, allocation of risks, relevant legal authorities and provisions for change and/or termination of the arrangement. A “PPP contract” refers to the contractual document(s) governing the relationship between the public and private partners in the H/PPP. In some cases, there may be several contracts depending on the level of complexity and size of H/PPP project.

- **Market and tender the H/PPP Project**: In the procurement stage (often referred to as “transaction” stage), the MoH selects the private partner to implement the H/PPP project. The MoH’s aim is to select the most competent private sector entity or consortium that can demonstrate a sound
technical solution to the proposed H/PPP project goal and objectives while delivering VfM to the MoH and its health consumers. To ensure a fair, transparent and efficient procurement process, the MoH will select the appropriate private sector partner through a competitive selection process.

To facilitate a competitive procurement process, the MoH’s PPP Unit will: i) design a procurement strategy including the process and criteria which will be used to select the private partner; ii) market the forthcoming H/PPP project to potential bidders; iii) identify potential bidders through an “Expression of Interest” prequalification process in which potential bidders are short-listed; iv) manage the bidding process, including preparing and issuing the Request for Proposal (RFP); v) interact with bidders to respond to questions as they prepare proposals; and vi) evaluate bids to select the winning bidder.

In most instances, the MoH PPP Unit is responsible for signing off on the selected bidder. Required approvals of the procurement award are dependent upon the size and complexity of the H/PPP project. Large, complex contracts may require MoF approval. The PPP Unit and regional health management teams and/or PPP focal persons at the regional levels may be conveyed authority to approve smaller H/PPP contracts. Once approved, the PPP Unit will execute the contract, ensuring the final agreement meets all the conditions outlined in the proposal and achieves financial close and that all procedures are in place to monitor performance.

Stage Four: Manage implementation of the H/PPP Project

- **Manage:** To ensure successful implementation of all its H/PPPs, it is imperative for the MoH to allocate sufficient funds to staff the PPP Unit at the central level as well as PPP focal persons at the regional/decentralized level. It also requires investment of staff time and resources at other relevant units of the MoH that will have responsibilities for the H/PPPs at different stages in the H/PPP Project cycle. Finally, clear lines of authority and communication are essential to enable the PPP Unit to liaise with and ensure management oversight of individual H/PPP projects.

- **Monitor:** The PPP Unit’s management focus of its entire portfolio of H/PPP projects is to ensure achievement of defined outputs and contractor performance. The private partner will be required to provide regular updates and financial reports as defined in the contract. Best practices stress the need for the PPP Unit to engage with its contractors on a regular basis and provide feedback through one-on-one meetings, regular reports and site visits and fiscal audits.

- **Evaluate:** The PPP Unit, in collaboration with its private sector partners, may conduct periodic evaluations on a select number of H/PPPs to ensure they are achieving the H/PPP policy’s goals and objectives and to share lessons on what works, does not work and needs to be strengthened.
SADC Member States are facing significant challenges in addressing the healthcare needs of their populations. To meet this growing demand for healthcare products and services and achieve national public health goals, governments must leverage the resources and expertise of the private health sector. Public private partnerships are important mechanisms that governments can use to accomplish this. SADC Member Countries have agreed upon definitions of H/PPPs and a consultative process for designing an H/PPP Framework and developing and managing a pipeline of H/PPP projects. This Reference Guide presents public and private health sector stakeholders an overview of these definitions and this process.

The reference guide:

- Makes the case for partnering with the private health sector and discusses how to identify the current and future potential roles the private health sector is and can play in SADC Member States’ national health systems;
- Proposes a participatory approach to design a H/PPP policy framework and establish the institutional arrangements and technical capacity needed to develop and manage successful H/PPPs;
- Presents the processes; key components; and illustrative language for developing H/PPP policies and/or strategies;
- Describes the range of H/PPP models and their potential for addressing health challenges and filling health system gaps; and, finally,
- Offers tips, experiences, and examples from SADC Member Countries, as well as other countries, for developing and implementing a pipeline of H/PPPs to address national health priorities.

The reference guide is not exhaustive, but, is intended as a resource to guide private and public sector policymakers; direct them to additional resources; and enable them to mobilize the resources of the private health sector to meet the growing demand for healthcare in the SADC region.
Bibliography

Centre for Health Policy, School of Public Health, University of Witwatersrand and Health Policy Unit, London School of Hygiene and Tropical Medicine. 2004 March. Public-Private Interactions in the South African Health Sector: Experience and Perspectives from National, Provincial and Local Levels. Haroon Wadee, Lucy Gilson, Duane Blaauw, Ermin Erasmus and Anne Mills


### Annex One: Data Sources for Analyzing and Prioritizing H/PPP Areas and for Conducting PSAs in Health

<table>
<thead>
<tr>
<th>Information Sources for Literature Review</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDLINE</strong></td>
</tr>
<tr>
<td><strong>POPLINE</strong></td>
</tr>
<tr>
<td><strong>Health System data base</strong></td>
</tr>
<tr>
<td><strong>Office of the Prime Minister</strong></td>
</tr>
<tr>
<td><strong>Household surveys</strong></td>
</tr>
<tr>
<td><strong>National health accounts</strong></td>
</tr>
<tr>
<td><strong>Demographic Health Surveys (DHS)</strong></td>
</tr>
<tr>
<td><strong>Several countries also complete Service Provision Assessments (SPAs)</strong></td>
</tr>
<tr>
<td><strong>National Health Accounts (NHA)</strong></td>
</tr>
</tbody>
</table>
### Information Objectives by Target Audiences in Public Sector

#### Ministry of Health

<table>
<thead>
<tr>
<th>Interview Objectives</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>- To get perspective on the long-term strategies to address health challenges</td>
<td>- MoH leadership: Minister of Health, Permanent Secretary, Deputy Permanent Secretary</td>
</tr>
<tr>
<td>- To learn about MoH policy/plans to work with the private (NGO, FBO, and for-profit) sectors</td>
<td>- Director of Policy, Planning and HRD (strategic plan and/or policy guidance on working with the private health sector)</td>
</tr>
<tr>
<td>- To measure openness towards private sector</td>
<td>- Director of Human Resources and General Services (focus on human resources for health, or the regulatory body internal to the MoH that can provide policies, health acts, laws related to private health sector)</td>
</tr>
<tr>
<td>- To identify current partnerships with private sector in HIV/AIDS and/or other health areas</td>
<td>- Director of Tertiary Health Care &amp; Clinical Support Services (pharmaceutical services; medical laboratory services)</td>
</tr>
<tr>
<td>- To identify possible barriers for public sector to engage/transact with the private sector</td>
<td>- Director of Primary Health Care Services (potential linkages between HIV/AIDS and MCH, FP)</td>
</tr>
</tbody>
</table>

#### Other Ministries

<table>
<thead>
<tr>
<th>Interview Objectives</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>- To get perspective on the long-term strategies to address health challenges</td>
<td>- Ministry of Social Welfare (Gender Equality and Child Welfare)</td>
</tr>
<tr>
<td>- To learn the extent to which the Ministries engage with the private (NGO, FBO and for-profit) sector</td>
<td>- Ministry of Labor</td>
</tr>
<tr>
<td>- To measure openness towards private sector</td>
<td>- Ministry of Finance</td>
</tr>
<tr>
<td>- To measure openness towards cross-Ministry collaboration with the private sector (e.g., Ministry of Labor working with MOH &amp; private sector)</td>
<td>- Ministry of Trade and Industry</td>
</tr>
<tr>
<td>- To identify any barriers for public sector to engage/transact with the private sector</td>
<td></td>
</tr>
</tbody>
</table>

#### Other Government Officials

<table>
<thead>
<tr>
<th>Interview Objectives</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>- To get perspective on the long-term strategies to address health challenges issues</td>
<td>- Parliamentarians or government officials who are active in and familiar with key health issues such as FP/RH, maternal and child health, and HIV/AIDS issues</td>
</tr>
<tr>
<td>- To learn about government policies/plans to work with the private (NGO, FBO and for-profit) sectors</td>
<td>- Regional bodies, e.g., ECSA</td>
</tr>
<tr>
<td>- To measure openness towards private sector</td>
<td></td>
</tr>
</tbody>
</table>

### Information Objectives by Target Audiences in Private Sector

#### Commercial Health Sector

<table>
<thead>
<tr>
<th>Interview Objectives</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>- To learn if the private sector is aware of government strategies and long-term plans to address key health challenges</td>
<td>- Directors of physician, pharmacist, nurse and laboratory professional associations</td>
</tr>
<tr>
<td>- To measure willingness to work on public health issues and what could be their potential contribution</td>
<td>- Key private sector practitioners</td>
</tr>
<tr>
<td>- To identify possible barriers to partnering with the public sector and/or barriers to a greater role in public health areas</td>
<td>- Key private sector hospital and/or clinic owners</td>
</tr>
<tr>
<td>- To measure openness to working with public sector</td>
<td>- Key lab owners</td>
</tr>
<tr>
<td></td>
<td>- Owners of pharmacy chains</td>
</tr>
<tr>
<td></td>
<td>- Key leaders in the pharmaceutical sector</td>
</tr>
<tr>
<td></td>
<td>- Owners/directors of pharmaceutical manufacturing companies</td>
</tr>
<tr>
<td></td>
<td>- Owner/directors of health product distribution companies</td>
</tr>
<tr>
<td>Non-government and Faith Based Sectors</td>
<td>Interview Objectives</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>• To learn if the private sector is aware of government strategies and long-term plans to address key health challenges</td>
<td>• To gauge receptivity to partnering with the private commercial sector</td>
</tr>
<tr>
<td>• To identify current partnerships with the private sector or public sector to address public health issues</td>
<td></td>
</tr>
<tr>
<td>• To gauge receptivity to partnering with the private commercial sector</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Insurance Industry</th>
<th>Interview Objectives</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To ascertain the current status of the health insurance market</td>
<td>• To explore prospects for expanding coverage to low- and middle-income populations</td>
<td>• Private insurers (2 or 3)</td>
</tr>
<tr>
<td>• To understand why uptake has been marginal on low-cost private insurance programs, and identify strategies for improving uptake</td>
<td></td>
<td>• Insurer’s umbrella organizations, e.g. Namibia’s Association of Medical Aids Funds (NAMAF)</td>
</tr>
<tr>
<td>• To explore prospects for expanding coverage to low- and middle-income populations</td>
<td></td>
<td>• Agencies regulating medical schemes, e.g. Namibia’s NAMFISA (regulates medical schemes)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Industry (Particularly relevant for HIV/AIDS)</th>
<th>Interview Objectives</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To provide an update on industry practices and policies related</td>
<td>• To measure openness to working with public sector and NGO/FBO sectors</td>
<td>• Organizations representing formally employed workers (e.g. Employers Federation, National Union of Workers)</td>
</tr>
<tr>
<td>• To identify current partnerships with NGO/FBO or public sector to address HIV/AIDS</td>
<td></td>
<td>• Associations representing businesses (Business Coalition on AIDS) or industries employing a large percentage of population (Tourism, Financing, Hospitality, Mining, Agriculture)</td>
</tr>
<tr>
<td>• To identify possible barriers to the private sector partnering with public sector and/or barriers to greater role in HIV/AIDS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annex Two: Structure of an H/PPP Policy

PREAMBLE

i. Pressing health needs and system gaps in a country’s health sector
ii. Rationale for PPPs in a country

PART I. GENERAL PROVISIONS OF A PUBLIC-PRIVATE PARTNERSHIP POLICY IN HEALTH (Policy Framework)

1.1. Purpose of H/PPP Strategy
1.2. Guiding principles
1.3. Definitions and key concepts
1.4. Priorities for H/PPPs

PART II. IMPLEMENTATION FRAMEWORK (Institutional coordination and responsibilities)

2.1 Public/Governmental administrative bodies: rights and responsibilities
2.2 Private Partner: rights and responsibilities
2.3 Consumers: rights and responsibilities

PART III. IDENTIFICATION OF PROJECTS AND AWARD PROCESS FOR PPPs IN HEALTH (PPP Process)

3.1 Forms of partnership
3.2 Contracting Authority
3.3 Financial rights and obligations of partners
3.4 Process
3.5 Instruments
Annex Three: Outline of an H/PPP Strategy

Part One: Health PPP Framework and Vision

1. Situation Analysis
   1.1. Challenges in the Malawi Health Sector
   1.2. Strategies to Address these Challenges
   1.3. Overview of the Private Health Sector

2. Policy and Regulatory Foundation for H/PPPs

3. Rationale for Partnering with the Private Sector

4. Strategic Framework for PPPs in Health
   4.1. Vision for PPPs in Health
   4.2. Strategy for PPPs in Health Goals and Objectives
   4.3. Values Guiding the H/PPP Strategy
   4.4. Definition for H/PPPs
   4.5. Types of H/PPPs

Part Two: Institutional Arrangements for H/PPPs

1. Government Agencies Involved In H/PPPs

2. H/PPP Capacity in the MOH
   2.1 PPP-Technical Working Group
   2.2 PPP Node
   2.3 H/PPP Implementation Teams
   2.4 Role of Outside Experts

3. Private Sector Role in H/PPPs

Part Three: Strategic Plan for Implementing PPPs in Health

1. Strategic Priorities for H/PPPs

2. Strategic Directions for H/PPPs

3. Potential H/PPPs

4. H/PPP Pipeline

5. Implementation Milestones
## Annex Four: Examples of H/PPP Policy Vision or Goal Statements

<table>
<thead>
<tr>
<th>Country</th>
<th>Reference</th>
<th>H/PPP Vision-Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia</td>
<td>Draft H/PPPH Guidelines, 2009 (page 10)</td>
<td>The overall objective of H/PPP is to contribute towards the reduction of Morbidity, Mortality, and Disability and to improve the health status of the Ethiopian people through provision of a comprehensive package of preventive, rehabilitative and curative service. The purpose of which is to contribute and advance the generation of a healthy, able and productive population that will contribute further to the socio-economic development of the country.</td>
</tr>
<tr>
<td>India (Uttar Pradesh)</td>
<td>Policy Framework for PPP in the Health Sector (page 8)</td>
<td>The overall objective of H/PPP is to contribute to the strengthening of the health delivery systems in the state of Uttar Pradesh with capabilities and full participation of the private for-profit and not-for-profit health sectors to maximize the attainment of the health goals in rural and urban areas as envisioned by the Government of Uttar Pradesh.</td>
</tr>
<tr>
<td>Madagascar</td>
<td>Une Politique Nationale De Contractualisation: Guide Pour Son Elaboration Et Son Suivi, 2007 (page 35)</td>
<td>La politique contractuelle dans le secteur de la santé au Tchad a pour objectif de s’assurer que les arrangements contractuels établis entre les acteurs de la santé contribuent à améliorer la performance du système de santé et s’inscrivent dans le respect de la Politique nationale de santé et de ses principes d’équité.</td>
</tr>
<tr>
<td>Malawi</td>
<td>National Health PPP Strategy, 2013 (draft)</td>
<td>The overall goal of health PPPs is to leverage private sector capacity and investment to increase access to quality and cost effective health services that contribute to the sustainable achievement of national health, social and economic goals.</td>
</tr>
<tr>
<td>Nigeria</td>
<td>National Policy on Public Private Partnership for Health in Nigeria, November, 2005 (page 10).</td>
<td>Governments (Federal, State and Local) share the obligation to ensure an enabling environment for the entire spectrum of (public and private) health provision. This obligation goes side by side with the parallel responsibility for ensuring that all people are protected from harmful health practices, and have rights as consumers of health services.</td>
</tr>
<tr>
<td>Senegal</td>
<td>Une Politique Nationale De Contractualisation au Sénégal, 2004 (page 10)</td>
<td>La politique de contractualisation dans le secteur de la santé au Sénégal a pour objectif de s’assurer que les arrangements contractuels établis entre les acteurs de la santé se font dans le respect de la Politique nationale de santé et de ses principes d’équité et contribuent à améliorer la performance du système de santé.</td>
</tr>
<tr>
<td>South Africa</td>
<td>The Charter of the Public and Private Health Sectors</td>
<td>Facilitate and effect transformation of the health sector in the following key areas: 1) access to health services, 2) equity in health services, 3) quality of health services, and 4) Black economic empowerment. It is essential to ensure the sustainability and efficiency of the health sector in order to achieve the transformation goals for each of these areas.</td>
</tr>
<tr>
<td>Tanzania</td>
<td>H/PPP Strategic Plan 2009-2014</td>
<td>Strategic Plan’s vision, in line with national health policies, to ensure that all categories of health service providers in Tanzania optimally use their comparative advantages to contribute to universally available, affordable, accessible, appropriate and effective health services in view of attaining the MDGs.</td>
</tr>
<tr>
<td>Uganda</td>
<td>National Policy on Public Private Partnerships in Health, 2012</td>
<td>Universal access to affordable health care for all the population of Uganda through an efficiently integrated public-private partnership in health.</td>
</tr>
</tbody>
</table>
### Annex Five: Examples of H/PPP Policy Objectives

<table>
<thead>
<tr>
<th>Country</th>
<th>Reference</th>
<th>H/PPP Policy Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia</td>
<td>Draft H/PPP Guidelines, 2009 (page 10)</td>
<td>The specific objectives are focused towards the improvement and achievement of the following outcomes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Availing and providing promotive, preventive, basic curative and rehabilitative health Services for all segments of the Population utilizing the decentralized and democratized Health Systems, H/PPP values and strategies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Improvement in physical access and equity in the distribution of health service facilities through increased Public-Private led and sponsored construction, up-grading, renovation and scaling–up of services on the ground.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Improved quality of health care services through effective coordination, and technical application; resource allocation, managerial follow-up, peer evaluation, corrective inputs and or intervention of the Public-Private Partnership interface.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Building the Human Resource and institutional Capacity by mobilizing and optimally utilizing every available technical and non-technical capacity of the Public-Private Partnership framework</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Introducing and availing demand-based Pharmaceutical products, medical equipment, other logistical tools and supplies for both the Public and Private Provider health facilities so as to cater the health service needs of the general Population.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Providing cost-effective Health care service to the population in need, by minimizing wastages, utilizing rationalized approach in combining and making optimum use of the Public and Private sector resources, expertise, time, and health facilities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Assess the need for and Create enabling environment for the Private not-and for profit Sector participation in health Research and Development.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Develop further the Health Management information Systems (HMIS), Human Resource Information &amp; Management System (HRMIS), Monitoring and Evaluation (M&amp;E) to incrementally incorporate core indicators/ attributes and aspects of H/PPP.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Develop further the Capacity Building and enhancement of Human Resource for health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Specify and enhance duly the Roles and responsibilities of the Public sector and Private sector- for Profit, not-for profit, &amp; clients.</td>
</tr>
<tr>
<td>India (Uttar Pradesh)</td>
<td>Policy Framework for PPP in the Health Sector (page 8)</td>
<td>- Improve accessibility to healthcare services in rural and urban slum areas</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Address the equity concerns by targeting healthcare services for the poor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Improving the quality of health care services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Improve efficiency in allocation of existing public sector resources in health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Mobilize additional resources for strengthening the health sector</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Strengthen the existing public health management and service delivery systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Ensure optimal utilization of public investment and infrastructure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Enhance community ownership in health care programs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Promote healthcare education and skill development institutions</td>
</tr>
<tr>
<td>Country</td>
<td>Reference</td>
<td>H/PPP Policy Objectives</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Malawi       | Malawi National Health PPP Strategy, 2013 (draft)                          | • Improve access to health services and products, particularly to underserved population groups  
• Create cost savings for the MoH and improve efficiency of health services  
• Align private health sector investment and activities to national health priorities  
• Encourage a greater role of private sector in health  
• Foster complementarity and coordination of resources in health sector                                                                                                                                                                                                                           |
| Nigeria      | National Policy on Public Private Partnership for Health in Nigeria, November, 2005 (page 10 – 11) | The primary objectives of the National Public Private Partnership Policy in Health shall be to:  
• Build confidence and trust in the public and private health sectors.  
• Harness confidence and trust in the public and private sectors for the attainment of Millennium Development Goals, and other National Health Policy Targets.  
• Promote and sustain equity, efficiency, accessibility and quality in health care provisioning through the collaborative relationships between the public and private sectors.  
Other objectives are to:  
• Identify areas of need in which collaborations and partnerships are desired on long and short-term basis  
• Develop the regulatory framework for public and private interactions and collaborations in health care delivery in the country  
• Facilitate universal access to a Minimum Health Package  
• Support capacity building across the public and private sectors in health care provisioning  
• Contribute to the sustainability of the overall health system  
• Build the National Health Management Information System (NHMIS)  
• Underscore the contribution/roles of each of the sectors/partners in the partnership to health care delivery |
# Annex Six: Example of Implementation Principles

<table>
<thead>
<tr>
<th>Country</th>
<th>Reference</th>
<th>H/PPP Implementation Principles</th>
</tr>
</thead>
</table>
| Ethiopia | Draft PPPH Guidelines, 2009 (page 10) | • Secure trust between Public and Private Partners  
• Establish parity of relationship among the public and private sector  
• Nurture the Public-Private Partnerships  
• Sustain collaboration among partners  
• Be inclusive and gender sensitive  
• Create enabling environment for H/PPP  
• Ensure social objective, create space for private partners for their returns. Profitability is not the motive, profit is a requirement. |
| India (Uttar Pradesh) | Policy Framework for PPP in the Health Sector | • **Trust between the partners**: Mutual trust and respect is essential in any partnership. Both the government and the private partners will join hands in offering to the communities at large what is their essential right – right to quality health care.  
• **Establish a relationship of equals**: Partnerships thrive on the principle of equality and equity. The partnership design and the contract framework will ensure that the private partners are treated as equals in the mission of transforming health care and true partners in progress.  
• **Accept that private partners may face the same challenges and realities as the government, the only difference being the former may know how to address it better and have the flexibility to respond faster**: Believe that the private sector will be joining hands with the Government in its mission with the right intention. The path may be fretted with innumerable challenges and issues. The private partner will attempt to address them with positive intent and there may be short comings in process or some gap between the actions planned and the way they materialize on ground. Partners will be honest to themselves in handling the situation and sensitive and mature enough to resolve the issues amicably and arrive at a consensus.  
• **While ensuring that the social objective of the government is met, adequate space needs to be allowed to private partners for their returns. Profitability is not the motive, profit is a requirement.** While entering in partnership with the private sector Government is conscious that quality, efficiency and effectiveness have costs. Market economy therefore demands ventures need to be designed in a way that adequate revenue generation is allowed and also to recover the investment costs to sustain. The financing model and the concession period will reflect this consciousness.  
• **Partnerships needs to be nurtured**: Partnerships need sensitive nurturing like any other relationship. Initial hand holding and the role of an interface between the public and the private partners will be essential and available to see to it that these partnerships mature and become the foundation of the public health system in Uttar Pradesh. |
<p>| Madagascar | Une Politique Nationale De Contractualisation: Guide Pour Son Elaboration Et Son Suivi 2007 (page 35) | Afin d’harmoniser la pratique de la contractualisation, il est recommandé de se referer une structure-type d’un contrat. |</p>
<table>
<thead>
<tr>
<th>Country</th>
<th>Reference</th>
<th>H/PPP Implementation Principles</th>
</tr>
</thead>
</table>
| Malawi   | National PPP Policy in Health, 2013 (draft)                                | • Secure trust between the public and private sector partners  
• Establish parity of relationships between the public and private sectors  
• Strive to rationalize and complement services rather than duplicate them  
• Nurture PPPs that increase access, improve quality and address equity in healthcare delivery  
• Seek PPPs that reduce costs and improve overall efficiency in healthcare thereby reducing economic burden in the public sector  
• Create space for private partners to earn a profit while working to achieve social objectives                                                                                                                                                                                                 |
| Nigeria  | National Policy on Public Private Partnership for Health in Nigeria, November, 2005. | • Governments (Federal, State and Local) share the obligation to ensure an enabling environment for the entire spectrum of (public and private) health provision. This obligation goes side by side with the parallel responsibility for ensuring that all people are protected from harmful health practices, and have rights as consumers of health services.  
• A “public private partnership” is a collaborative relationship between the public and private sectors aimed at harnessing (and optimizing the use of all available resources, knowledge, and facilities required to promote efficient, effective, affordable, accessible, equitable and sustainable health care for all people in Nigeria.  
• Effective partnerships among private sector institutions, civil society organizations, and governments will allow fulfillment of their social expectations without compromising core missions.  
• All formal (contractual) partnerships shall be based on written agreements specifying the purpose, duration, and exit arrangements.  
• Partnership agreements shall clearly state the rights and obligations of all stakeholders. Such rights and obligations shall be enforceable.  
• Best practices shall be encouraged/rewarded based on potential to improve upon the quality of care provided.  
• While for-profit institutions have a right (or an obligation) to make a profit, this has to be balanced against the equally important considerations of ensuring safety quality, and equity.  
• PPP shall be recognized as a long-time process which requires perseverance, regular attention, and maintenance.  
• There shall be ongoing communication/interaction on health issues by all stakeholders in the public and private sectors. As part of such interactions and consultation, private sector organizations shall have opportunities to contribute towards the planning and implementation of policy.  
• There shall be decentralization of powers by government and acceptance of the expanded role of the private sector and the community.  
• Part of the wider governmental obligations will include provision of basic amenities such as water supply, environmental sanitation, power supply.  
• 2.2 In keeping with these principles, all compendia of regulations, codes of ethics, guidelines and other documentation pertaining to PPP shall be freely available to those in the public and private sectors, and also to consumers of  
• Health care, through annual publication, websites, and other media. |
<table>
<thead>
<tr>
<th>Country</th>
<th>Reference</th>
<th>H/PPP Implementation Principles</th>
</tr>
</thead>
</table>
| Senegal | Une Politique Nationale De Contractualisation au Sénégal, 2004 (page 10) | - l’État est le garant de l’intérêt général. A ce titre, le Ministère de la Santé, soucieux de garantir l’accès de l’ensemble de la population à des services de santé de qualité, doit être en mesure de s’assurer que tous les arrangements contractuels respectent cet objectif de la Politique nationale de santé.  
- La politique de contractualisation garantit la qualité des prestations et l’équité dans l’offre de service.  
- La politique de contractualisation affirme que la contractualisation est un outil de la politique de santé qui doit contribuer à l’amélioration des performances du système de santé;  
- La politique de contractualisation dans le secteur de la santé affirme que la contractualisation est un outil permettant d’établir des relations durables et solides entre des acteurs œuvrant dans le domaine de la santé et qu’elle ne signifie aucunement un désengagement de la part de l’État ni une quelconque volonté de privatisation de la santé;  
- La politique de contractualisation rappelle que la contractualisation concerne tous les acteurs œuvrant dans le domaine de la santé:  
  - l’État et ses démembrements, les populations, les institutions de financement, les organisations de la société civile, le secteur privé lucratif ou non lucratif, les partenaires au développement. Il est du devoir de l’État de veiller au respect de ce principe. Ainsi, tous les acteurs doivent se sentir concernés par cette politique et l’État doit les y aider;  
  - La politique de contractualisation, en définissant un cadre propice et incitatif à la contractualisation, veut favoriser l’expression de la compétence de tous les acteurs du secteur de la santé, notamment le secteur privé et la société civile. Néanmoins, le respect de la mission de service public demeure un élément fondamental de la politique de contractualisation. Ces principes fondamentaux se recoupent avec les principes directeurs de la mise en œuvre de la Stratégie de Réduction de la Pauvreté (SRP), à savoir la proximité, l’équité, le faire-faire, la transparence, la participation, la complémentarité et la synergie;  
  - La politique de contractualisation affirme que la contractualisation doit être fondée sur le respect mutuel dans les relations contractuelles entre les acteurs quels qu’ils soient. Ainsi, même dans les cas où il est fait appel à la concurrence et à la compétition pour assurer une prestation de services de santé, il est important que les acteurs évitent autant que possible les situations conflictuelles et privilégient les solutions négociées. De même, si l’État est indéniablement un partenaire particulier du fait de son statut, il doit toujours s’efforcer à ce que son partenaire apporte la meilleure prestation possible pour la population;  
  - La politique de contractualisation affirme que la contractualisation doit sauvegarder les intérêts des populations et leur implication dans le fonctionnement des services de santé. Ainsi, les mécanismes de participation des populations qui ont été progressivement mis en place ne doivent pas être remis en cause par la contractualisation;  
  - La politique de contractualisation réaffirme la liberté des acteurs à contracter. Pour autant, s’agissant du domaine de la santé et plus particulièrement de la santé publique, l’État doit veiller à ce que cette liberté contractuelle ne puisse pas s’exprimer au détriment de l’intérêt des populations;  
  - La politique de contractualisation rappelle que les relations contractuelles doivent s’établir entre des acteurs qui disposent de la capacité juridique à signer des contrats. Néanmoins, des formes de contractualisation interne peuvent être développées pour autant que leur spécificité soit clairement établie. |
<table>
<thead>
<tr>
<th>Country</th>
<th>Reference</th>
<th>H/PPP Implementation Principles</th>
</tr>
</thead>
</table>
| South Africa | The Charter of the Public and Private Health Sectors                       | Implementation of the Health Charter will be a process that allows for experimentation and discovery and must be flexible enough to allow for changes and adjustments to be made to strategies as new variables come to light and existing variables change.  
3.5.1 The Parties agree that a mechanism to monitor the implementation of the Charter be established and to enable the public and private sectors to work together towards the common goals outlined in this Charter.  
3.5.2 The eligibility of stakeholders that do not implement the Charter for state contracts and contracts with other parties to the Charter would be reduced or precluded altogether depending on the circumstances.  
3.5.3 The National Department of Health undertakes, in collaboration with the National Treasury, to develop a practical framework for PPIs.  |
| Tanzania     | National Public Private Partnership Policy, 2009 (page 14)                 | • Overall responsibility for health policy formulation and for the health status of the population is maintained by the government who will consult and seek consensus with the partners in all cases of common concern.  
• National policies will guide the provision of health services to the population at different service delivery levels while plans and operations of the private health sector will support the available national policies and strategies and be integrated into respective plans.  
• The Government and private sector partners will support the available national policies and strategies and be integrated into respective plans.  
• The distinct identity and autonomy of each partner will be respected.  
• The public sector partners will ensure the equitable allocation of resources for health in accordance with the needs of the population and according to the volume and quality of services rendered.  
• Inputs, outputs and outcomes relating to achievement of available health strategies’ goals and objectives will be agreed, reported by and shared among the partners in an accountable and transparent manner.  
• Each of the partners brings some sort of resource (material or immaterial) to the partnership. In addition to straightforward material resources other resources may also be leveraged.  
• Partnership implies mutual shared responsibility for the outcomes of its activities. In other words, the risk for the provision of a service is shared between the public and private entities and is not the sole responsibility of one or the other.  
• Partnerships follow the principles of fair play.  |
| Uganda       | National Policy on Public Private Partnerships in Health, 2012 (page 16)   | • Government and private sector partners will ensure the equitable allocation of resources for health in accordance with the needs of the population.  
• Service provision by public and private providers shall focus on quality and efficiency to attain maximum benefits.  
• Government and private sector partners will ensure the equitable allocation of resources for health in accordance with the needs of the population.  
• Government and private sector partners shall strive to rationalise and complement services rather than duplicating them.  
• The identity and autonomy of each partner shall be accepted and respected.  
• Infrastructures, financial and human resources available by the sectors shall be utilized in an efficient and coordinated way to maintain the scope and extent of the health services to the population.  |
Annex Seven: Malawi PPP Unit TORs

Terms of Reference for Public-Private Partnership Node in the Ministry of Health

JANUARY, 2013
TABLE OF CONTENTS

1. Key Concepts And Terms
2. Policy and Legal Framework
3. Purpose
4. Objectives
5. Vision Statement
6. Mission Statement
7. Guiding Principles
8. Core Functions
9. Linkages
10. Budget

ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA</td>
<td>Contracting Authority</td>
</tr>
<tr>
<td>ETC</td>
<td>Et cetera</td>
</tr>
<tr>
<td>H/PPP</td>
<td>Health public-private partnerships</td>
</tr>
<tr>
<td>MoF</td>
<td>Ministry of Finance</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>OPC</td>
<td>Office of the President and Cabinet</td>
</tr>
<tr>
<td>PPP</td>
<td>Public-private partnership</td>
</tr>
<tr>
<td>PPC</td>
<td>Public-private partnership Commission</td>
</tr>
<tr>
<td>PPP-TWG</td>
<td>Public-Private Partnership Technical Working Group</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>VfM</td>
<td>Value for money</td>
</tr>
</tbody>
</table>
1. BRIEF BACKGROUND

The Malawi ministry of health is charged with raising the level of health status of all Malawians by reducing the level and incidence of illnesses in the country and also reducing the occurrence of premature deaths. One of the strategies that the ministry has been employing to achieve its goal is to engage with the private sector, including entering into partnerships with the private sector to deliver health related services. An example of the public private engagement is the service level agreements between the ministry and Christian Health Association of Malawi. Based on the Malawi Health Sector Strategic Plan (2011-2016), the ministry of health intends to continue and enhance the public private engagements.

Although public private engagements are valued in the Malawi health sector, their design and implementation has been generally lacking in quality. The Malawi private sector assessment commissioned by USAID Malawi in May 2011 revealed some gaps in the way the ministry relates to the private sector. The report recommended the strengthening of the public private partnerships in the country. In addition, the public partnership policy framework of the government of Malawi, recognized health as one of the areas that PPPs need to be enhanced. In order to achieve enhanced PPPs in the MoH, it was agreed that PPP capacity be established in the ministry and that a special desk/unit be established where this capacity could reside in. It is for this reason that the terms of reference for the PPP unit were developed.

2. KEY CONCEPTS AND TERMS

Establishment of Public-Private Partnership capacity is a critical step for the Malawian Ministry of Health (MoH) thereby enabling the MoH to govern the non-state actors and to manage its interactions and partnerships with the private sector. The MoH in Malawi, in close collaboration with other stakeholders, has agreed to create this capacity in a PPP Node. The private health sector is defined as both not-for-profit and for-profit entities engaged in a health related activity. The private health sector will also include the private non-health actors that have interests to further health in Malawi.

3. POLICY AND LEGAL FRAMEWORK

In recognition of the role of PPPs in social and economic development, Malawi has developed a National PPP Policy and PPP Act that creates and encourages all sectors, including health, to develop a PPP Policy, strategy and guidelines as well as the institutional structures, like the MoH Public-Private Partnership Node, by which to implement PPPs. Below is an overview of some of the key sections supporting the Ministry’s efforts to design a PPP Strategy for Health as well as some form of organizational capacity and arrangement within the MoH.

a) National PPP Policy: Any MOH initiative to formulate a PPP Strategy in Health and a PPP Unit to implement it is anchored by the National PPP Policy. This National PPP Policy outlines the government’s
intent to engage the private sector in a variety of areas, including health, and outlines its framework for PPPs. Any MOH PPP Strategy should be framed by the same principles and institutional arrangements.

b) PPP Act: The PPP Act fully embraces the concepts of the National PPP Policy and provides a legal basis by which government and private sector can partner to provide infrastructure and services. The Act empowers the Ministry of Health and regional authorities to design, implement and monitor PPPs using appropriate mechanisms identified by the MOH, under the guidance of the PPP Commission. The recent approval of the PPP Act creates the opportunity for the MOH to develop its own Health PPP Strategy, design PPP Guidelines, and establish a PPP Unit with capacity to enter into PPPs at the national and regional levels.

4. PURPOSE

The main purpose of establishing Public-Private Partnership (PPP) Node within the MoH is to create an enabling environment for accessible, affordable, quality health services and products through cost-effective and innovative PPPs in health. The mandate for the newly founded PPP Unit is to ensure that PPP arrangements conform to the MoH’s national health priorities, Public-Private Partnerships law, Strategy, and Guidelines.

5. OBJECTIVES

The following are the specific objectives for the PPP Node
a) To strengthen MoH capacity at the national- and district-levels to effectively govern and regulate public private partnerships
b) To promote an enabling environment that fosters opportunities to partner with the private health sector
c) To drive PPPs opportunities by identifying prospects for partnerships that yield value for all stakeholders
d) To institutionalize MoH skills and competence to partner with the private health sector

6. VISION STATEMENT

Affordable and quality health care promoted through efficient public private partnerships based on best practices.

7. MISSION STATEMENT

Become a dynamic and sustainable center of excellence for PPPs in health.

8. GUIDING PRINCIPLES

The PPP Node subscribes to a philosophy that partnerships maximize the comparative advantage of the public and private health actors so as to improve the health of all Malawians who are not receiving adequate health services. In this approach, the private sector’s role as efficient innovator, efficient provider and efficient financer of healthcare contributes to and complements the government’s role as the steward of the health sector and agent of the poor.

The central principles outlined below guide the PPP Node’s work with its constituencies both in and outside the health sector:

a) Accountability and transparency: Openness and honesty are preconditions to build the trust needed for partnerships. On one hand, the PPP Node works with its partners to ensure the PPP outputs and outcomes help attain Malawi’s national health goals and priorities while on the other hand, the Node strives to communicate regularly on PPP progress, share lessons and innovations emanating from the partnerships.
b) **Fairness:** The PPP Node strives to be fair minded in designing, monitoring and evaluating the partnership. This entails sharing the risks – joint investments in the health partnerships, providing capital, personnel, and equipment to strengthen accessibility, quality and efficiency of the health system. It also requires sharing the rewards - while ensuring that the government meets its social objectives (value-for-money; care for the poor; an efficient, quality health system). The private sector also needs to be allowed to recoup its direct and indirect costs and/or earn a profit to sustain its on-going enterprises.

c) **Inclusiveness:** The MoH recognizes that Malawi’s health sector comprises multiple actors ranging from the multiple government ministries, to varied private sector actors, to individual Malawian health consumers. In response to the mixed health system, the PPP Node attempts to include all relevant stakeholders through a variety of mechanisms to inform, engage, consult and partner with them.

d) **Professionalism:** The PPP Node is dedicated to bringing sound business practices and management innovations used in both the public and private sectors to its work in PPPs in health. The PPP Node uses best practices to facilitate greater interaction between the public and private sectors; applies state-of-the-art health finance and economics to its decision-making; relies on sound business practices to design feasible PPPs; and, focuses on achieving results.

e) **Integrity:** The PPP Node, aware of its responsibility to be accountable and transparent in all its activities, is committed to the highest standards of integrity in developing and promoting PPP’s in health. The Node will uphold all the relevant and applicable government requirements and standards on integrity and openness in order to build ownership and confidence in the PPP process.

f) **Passion:** The PPP Node staff share a passion for genuine dialogue, greater coordination, and strategic health PPPs collaboration with MoH staff and private sector stakeholders actors. This enthusiasm for health PPPs stems from experience in partnerships strengthening health systems and improving equity, access and quality of healthcare.

### 9. CORE FUNCTIONS

The Ministry, through the PPP Node, plays a critical role as **steward of the entire health sector** and helps guide and govern health actors by:

a) **Identifying and analyzing projects to include in the list of PPP health projects**

   The PPP Node works collaboratively with different MoH departments and provides technical assistance to MoH staff at national and county levels to:
   - Identify PPP opportunities
   - Conduct due diligence and oversight ensuring risk transfer, affordability and value of money
   - Assist in complex negotiations and structure of PPPs
   - Facilitates start-up of PPPs

b) **Brokering knowledge (knowledge management)**

   The PPP Node assembles and analyzes information and data to describe Malawi’s public/private mix in health. In addition, the Unit serves as the MoH’s institutional memory by documenting, disseminating, reinforcing and archiving policies, strategies and approaches on how the government can best work with the private health sector. The PPP Node is responsible for:
   - Creating a data-base of past and current PPPs which entails identifying, validating and monitoring the status of all PPPs in health
• Receiving, synthesizing and sharing information on existing and new PPP opportunities both local and overseas
• Developing and collecting tools and methodologies used to implement PPPs
• Documenting and sharing lessons learnt and best and worst practices on health PPPs
• Archiving all policies, guidelines and standards related to PPPs in health

In addition, the PPP Node actively disseminates information with different departments within MoH, with other government departments and with non-state stakeholders. Types of information include:
• Synthesis of policies, guidelines and standards
• Policy changes relevant to private provision of healthcare
• News stories of successes and failures in health PPPs
• PPP opportunities
• Archiving of policies
• Health sector and markets analysis
• Analysis of national budget implications on health PPPs
• Best practices on PPPs in health from other countries

c) Marketing and promoting PPPs
The PPP Node shall promote and market PPPs in health in conjunction with other relevant stakeholders. Marketing is an ongoing function of the PPP Node and takes a variety of forms.
• Raising awareness on the benefits of and opportunities for PPPs in health to build MoH support for the PPP Node and its activities
• Marketing its services to MoH management staff at the national and district level, promptly responding to call for assistance from districts
• Sharing lessons and best practices on health PPPs through multiple channels (e.g. webpages, quarterly letter, workshops, etc)
• Marketing and promoting partnerships through constant communication and active engagement with the full range of private sector actors

d) Offering strategic advice
The PPP Node will analyze the public sector’s strengths and private sector’s capacity; frames strategies that will take full advantage of private sector involvement; and, recommends actions to better integrate the private sector’s contribution into the overall Malawian health sector. Tasks include:
• Assessing changes in the health market and relative contribution of each sector to the health system
• Promoting and ensuring PPPs are aligned with Malawi’s national health priorities as outlined in the Health Sector Strategic Plan (2011-2016)
• Raising awareness on budget issues related to PPPs in health
• Appraising PPP opportunities for different MoH departments and districts in terms of their feasibility, fairness, value and health impact
• Provide guidance to the MoH/PPP TWG on whether to approve or decline PPP opportunities

The PPP Node also has an important role in advising other government ministries’ policy and program impact on the health sector and MoH’s ability to partner with the private sector. Tasks in this area include:
• Sensitizing and liaising with Ministry of Finance, PPP Commission (PPPC) and other relevant Ministries (Industry, Economic Planning and Development, Commerce, Customs, etc.) on MoH’s PPP Strategy
• Analyzing other government ministries’ policies and procedures to identify barriers that impact the health sector and offering recommendations on how to harmonize them with MoH objectives vis-a-vis PPPs
e) **Fostering an enabling policy framework**

The PPP Node shall support PPPs in consultation with other sections in department of Planning and Policy using relevant legal and regulatory frameworks. As the MoH’s experts in health PPPs, the PPP Node works closely with relevant departments to:

- Engage non-state actors in designing and formulating policies and guidelines that directly impact the private health sector
- Map different stakeholders groups in the health sector with regular updates to understand changes in the market place, and changes in private sector attitudes and perspectives in partnering with the public sector
- Establish a comprehensive policy framework for the health sector that supports the National PPP Law including a Policy for Health PPPs, Strategy for Health PPPs, and Guidelines for Health PPPs
- Make available through multiple channels to relevant non-state actors a synthesis of laws, policies and guidelines
- Revise and update periodically laws, policies and guidelines governing PPPs in health

f) **Coordinating and collaborating with the private sector and public sector**

To maintain trust and transparency with all health stakeholders, the PPP Node plays a coordination role both within the government on all PPPs in health and between the private sector groups. Key tasks include:

- Ensuring all stakeholders-public and private alike-have the same relevant information
- Clarifying roles and responsibilities between public and private sectors in achieving national health goals
- Liaising with other government agencies (e.g. Ministry of Finance, Industry, Commerce, Economic planning and development, justice, Office of the President and Cabinet, Office of the Director of Public Procurement etc. and/or representing the MoH in policy forums related to PPPs
- Coordinating with non-state stakeholders to ensure active participation in government fora on PPPs and in policy processes directly influencing the private sector

g) **Supporting implementation of health PPPs**

The PPP Node works collaboratively with different MoH departments and provides technical assistance to MoH staff at national and district levels to:

- Implement specific policies, regulatory and institutional reforms related to the private sector
- Conduct due diligence and oversight ensuring risk transfer, affordability and value of money
- Assist in complex negotiations
- Structure and start-up of appropriate PPPs and
- Support implementation and monitoring of district level PPPs using appropriate channels and institutions

h) **Capacity Building**

The PPP Node also has a role in building private sector capacity to interact with the public sector and assists them to:

- Understand the roles, structures of the MoH (Navigating MoH)
- Utilize the services offered by the PPP Node
- Better understand the policy processes and policies governing the private sector
- Update the private sector with new MoH information or initiatives relevant to PPPs
- Identify appropriate opportunities for PPPs in health

The Node will also provide technical expertise and skills transfer including on how to

- Engage and work with the private sector
- Harmonize legal and regulatory frameworks
- Draft contracts and concessionary agreements for health services, facilities and/or equipment
- Design risk pooling that covers the poor
- Establish mechanisms to assure quality in the private sector
- Evaluate cost-effectiveness and/or impact of PPPs
i) Building the evidence to support PPPs
The PPP Node assists the MoH to monitor and evaluate the impact of the wide range of health PPPs. Tasks include:
- Tracking PPP opportunities, design, and negotiation
- Conducting due diligence in the design phase of deals to ensure conformity to MoH priorities and compliance with policy and guidelines during implementation
- Monitoring progress on implementation of PPPs
- Evaluating cost, quality and impact of PPPs in health
- Sharing results of PPP evaluations with public and private sector stakeholders

10. PPP Node’s Relationships and Linkages

a) PPP Node’s Relationship within the MoH at the Central Level
The PPP Node resides within the Ministry of Health’s Department of Policy and Planning (See Figure 2). The PPP Node reports directly to the Head of Policy and Planning Department. The PPP Node serves as the technical and operational arm of the PPP-TWG. On a quarterly basis, the PPP Node presents recommendations on new PPPs as well as provides update on the status of existing PPPs to the PPP-TWG and MoH leadership. In these meetings, the MoH leaderships and PPP-TWG approves and/or declines PPPs as well as recommends how to improve implementation of struggling PPPs. The MoH leadership is ultimately responsible for the decisions and achievements of the H/PPP Strategy while the PPP Node is responsible for the day-to-day operations of all the partnerships.

To fulfill the PPP Node’s mandate, the Node is comprised of a multi-disciplinary team that covers the diverse skills required to engage and partner with the private health sector. A professional with expertise in one of the core PPP skills areas leads the Node and is at the Deputy Director level. Skill areas include: health and health management; law and policy; health finance; business management and administration; negotiation and contracting; monitoring evaluation; and, communication.

b) Organizational Structure
The following is the proposed minimum requirements for the PPP Node
- Deputy Director (PPP)
- Health Planning
- Finance/Economics
- Procurement/Contracts Specialist
- Monitoring and Evaluation Expert

Figure 3 offers an overview of the PPP Node’s organizational structure. These skills reside among the different PPP Advisers. In the short-term, the PPP Node will leverage existing MoH staff and/or outside experts on a part-time basis with these prerequisite skills while building the PPP Node team. In the long-term, the PPP team will contain most of the skills needed and hire, on an as need basis, specialized expertise fully staff these positions (Other skill areas to consider later on: engineers, investment bankers, project financiers, etc.). Personnel in the PPP Node will receive the necessary training and skills to become a premier institute with the skills required to handle the expected tasks. Moreover, the PPP Node will be supported by an Administrative Assistant and Head of communications.
To facilitate the team’s effectiveness and performance, one of the PPP Node’s first tasks is to design a Systems Manual that outlines the functioning protocols, reporting mechanisms and clear terms of reference for each staff. The PPP Node’s administration system shall include a comprehensive project tracking system to assist the PPP Node monitor and manage H/PPPs. The project data base will also be an important source of information on H/PPPs and shall be accessed by many MoH divisions and private sector parties via the MoH website.

c) PPP Unit’s Relationship within the MoH at the Regional Level

In Malawi, the District Health Management Team will be the primary contracting agent for PPPs health. Creating H/PPP Implementation Teams offers a central point of accountability and management in a decentralized health system. The H/PPP Implementation Team is responsible for identifying H/PPP opportunities, scoping potential private sector partners, leading the procurement process and awarding the H/PPP. Once the H/PPP is established, the H/PPP Implementation Team monitors and reports on the H/PPP progress, performs financial management and accounting and troubleshoots and helps solves implementation issues with the private sector partner.

The PPP Node, therefore, plays a supporting role and assists the H/PPP Implementation Teams: i) prepare the project, ii) where necessary, select and manage specialist advisers, iii) ensure the project fits into the overall PPP policy, iv) oversee the procurement process, and v) monitor the H/PPP’s progress and performance. In essence, a PPP Node plays an approval and quality assurance role throughout the project development process. The PPP Node also builds and transfers PPP capacity to the Districts and will create mechanisms and provide training to help the H/PPP Implementation Team follow the guidelines and rules.

d) PPP Unit’s Relationship with other Government Agencies

The PPP Policy and Act outlines the key institutional relationships between the MoH/PPP Node and other government agencies involved in PPPs. Figure 5 illustrates these functional relationships. The Malawi PPP Policy and Act clearly outline the roles and responsibilities between the MoH/PPP Unit, the Office of the President and Cabinet (OPC), the Ministry of Finance and PPP Commission. They are:

- **OPC** provides broad policy leadership and overall directions of the PPP Framework and PPP Commission and ensure timely enactment of legislative instruments.

- **PPP Commission** is the implementation Agency for PPPs on behalf of the Government of Malawi. The PPPC is the driver of the PPP policy framework and will assist government agencies, such as the MoH, to carefully plan, prepare and appraise PPP projects before procurement.
Ministry of Finance (PPP Monitoring and Evaluation Unit) ensures overall coordination of the review, screening and approval process for PPPs in all sector of government. The MoF primary function is to assess financial risk and exposure to protect the interest of the public.

Figure 5. PPP Unit’s Linkages to other Government Agencies

II. BUDGET

The PPP Node is primarily funded through a budget line from MoH. Development partners will also contribute to the PPP Node by funding the cost of additional staff and specialized expertise as well as other direct costs (communication, promotion, consultation, etc) not covered initially by the MoH budget. International Donors can also provide technical assistance and build the Unit’s capacity and skills in this new domain. By the end of the first year, the Node shall be staffed to the required minimum, at the very least. The Node can hire short-term expertise when required, utilizing both donor and departmental resources for this purpose.
Annex Eight: Best Practices in Building H/PPP Capacity

The UNECE Guidebook states that “governments can build the necessary capacities in a combined approach which establishes new institutions and trains public officials while at the same time uses external expertise”. The following describes best practices in building capacity in a PPP Unit.

**Establish an H/PPP Unit:** It takes time for government agencies to switch overnight from the status quo – that is, publically provided services through government assets – to designing new procurement systems that require the MoH to manage a network of new partners to deliver health services. Concentrating the new skills into a unit or task force helps accelerate the transition as well as facilitate capacity building. The H/PPP Unit’s TOR is an important document, signaling to both MoH staff and the private health sector how the MoH will implement PPPs. The MoH will also need to allocate funds and other resources in order to staff and equip the PPP Unit and to fund it activities to perform the tasks outlined in the TORs.

**Map the H/PPP process:** To date, many of the service delivery PPPs in health are ad hoc, relationship-based and informal agreements between the public and private partners. For a MOH to implement H/PPPs at scale, MoHs will have to move towards a formal, standardized process that ensures consistency and compliance with the government’s national H/PPP policy and other laws. Therefore a critical step is to design and map a PPP process that is specific to the health sector and conforms to the national PPP framework. Having a uniform PPP process encourages efficiency and transparency, saves time as the public sector uses standard contracts and procedures and reduces private sector costs as they learn the new rules and procedures (WBI: PPIAF: PPP Guidebook Version 1).

**Design the systems:** Once the H/PPP process has been defined, the MOH H/PPP Unit needs systems and tools to operationalize the process. The systems support key functions such as i) identifying and prioritizing health H/PPP projects, ii) encouraging competition through a transparent bidding process, iii) conducting due diligence on all H/PPP proposals, iv) ensuring the most effective use of government resources, v) implementing a standard and consistent bidding process, and vi) monitoring performance and evaluating value for money. In addition, the H/PPP Unit will have to develop standard tools and instruments supporting the systems and procedures such as H/PPP guidelines, H/PPP process handbooks, procurement / tender procedures, standard contract templates, and consistent project appraisal and costing approaches.

**Prime the market:** To build the H/PPP pipeline, a H/PPP Unit will have to engage the private sector. The H/PPP unit often starts “priming the market” by communicating and liaising with key private sector groups, such as trade and professional associations and major provider networks, to inform them about the MoH H/PPP Strategy and the H/PPP Unit’s roles and responsibilities. Communication activities require H/PPP Unit staff to spend considerable time outside the MoH attending private sector events, such as meetings and conferences, as well as organizing “meet and greets” between MoH leadership and the private sector. Relationships develop over time, starting with sharing information and advancing to H/PPP dialogue in which the H/PPP Unit actively discusses and solicits private sector input and advice on technical and financial issues related to H/PPPs. In addition to engaging the private sector, the H/PPP Unit also plays an important interlocutor role by updating MoH leadership and colleagues on key findings about private sector attitudes on what is happening in the health sector and on private sector capacity to respond to specific MoH H/PPP proposals.

**Build the H/PPP pipeline:** Another key role of an H/PPP Unit is to develop and competently manage the preparation and implementation of H/PPP projects – a task called “building the H/PPP pipeline”. While a MoH may
already be engaged in health PPPs, it may not have a centralized system to track new as well as monitor existing H/PPPs. To create such a system, the MoH must first conduct an inventory of current H/PPPs that identifies the full range of H/PPPs; describes the H/PPP project goals and objective; and categorizes the different H/PPP mechanisms used (e.g. MOU, service contract, lease, etc.). The inventory serves multiple purposes: 1) creates a data-base for the pipeline, 2) informs what systems are needed, and 3) identifies the required templates (e.g. standard contracts, agreements, etc.). After this initial stage, the H/PPP Unit can then create a system to “build” the pipeline that seeks new H/PPP proposals. Many proposals will be needed as few will actually result in a formal H/PPP project.

**Develop needed skills:** Many of the skills required to partner with the private health sector are not found in MoHs therefore governments, often with donor support, will not only have to invest in building systems but also in developing the needed skills. There are many options for acquiring the required skills: i) send MOH staff to training workshops offered by outside vendors and/or donors, ii) develop and conduct, with donor support and outside expertise, in-country training workshops, iii) conduct study tours to countries with more “mature” health PPP programs and capacity, iv) network and partner with other African governments learning the same skills, and v) “learn-by-doing” H/PPPs by teaming staff with outside experts.

Successful examples in developing new skills include a combination of these options as well as an incremental approach (WBIL: PPIAF: PPP Guidebook). Typically, MoHs first invest in creating and training a core team including key staff from other MoH departments in addition to the H/PPP Unit staff. It is important to develop a training approach that is based on international best practices, uses appropriate teaching methods such as case studies and “on-the-job” training and includes country-specific experts on H/PPPs. There should also be some mechanism for the core team to be informed of new knowledge and practices for managing H/PPPs. While the core team is building their skills and knowledge, the MoH can carry out a modified approach to transfer required skills to MoH department staff and regional health management who will then become the PPP Implementation teams.

**Leverage outside expertise:** Even countries with long H/PPP experience do not have all the necessary in-house expertise and skills required to develop H/PPP projects. All countries, developed and developing alike, engage outside experts – whether they are an expert located in another government agency or outside expert with specialized skills to perform a specific task. The extent and nature of external advisory support required changes as the country and the MoH PPP Unit gain experience. Experts include transaction advisers and/or specialists such as lawyers, financial analysts, financiers, economists, sociologists. These experts can be hired as a team or recruited individually. Hiring outside experts can serve many purposes. In addition to fulfilling a specific technical task in the H/PPP process, outside experts can “fill-in” while MoH staff are gaining new skills and experience, create momentum and progress by processing PPP proposals quickly, and build MOH capacity at the H/PPP Unit and H/PPP Implementation Team levels. To maximize the experience with an outside adviser, the MoH should bring the PPP expert into the PPP process early and pair him or her with government counterparts. Ideally the PPP expert will continue to support the PPP Unit through the award and implementation of the H/PPP contract.

**References on PPP Units**

- World Bank Sustainable Development Department in East Asia & Pacific (2007). *PPP Units: Lessons for their Design and Use in Infrastructure.* World Bank, PPIAF. This report provides a comprehensive assessment of the effectiveness of PPP units in developed and developing countries.
- Burger (2006) *The Dedicated PP Unit of the South African Treasury.* This paper provides a review of the South African PPP Unit and its programs.

**Skill Areas for PPP Implementation Teams**

- Describes the policy framework authorizing health PPPs.
- Explains the PPP Unit’s roles and responsibilities.
- Establishes working relationships with regional PPP Implementation Teams.
- Trains participants to design a health PPP addressing a local health priority and/or system gap.

---

67
# Annex Nine: Range of H/PPP Models

<table>
<thead>
<tr>
<th>Area</th>
<th>Clinical Services</th>
<th>Non-Clinical Support Services</th>
<th>Clinical Support Services</th>
<th>HRH Education and Training</th>
<th>Facility/ Hospital Management</th>
<th>Medicines and Medical Equipment</th>
<th>Health Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laundry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Billing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialized</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radio-therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lab analysis</strong></td>
<td>Lab analysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostics tests</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical equipment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance</td>
<td>Open donor sponsored training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contract for services</strong></td>
<td>MOUs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contract for services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Service Level Agreements</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MOUs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Resource sharing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(subsidized inputs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Staff sharing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MOU</strong></td>
<td><strong>MOU</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contract for services</strong></td>
<td><strong>Contract for services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Subsidized inputs</strong></td>
<td><strong>Subsidized inputs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff sharing</td>
<td><strong>Staff sharing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Equipment sharing</strong></td>
<td><strong>Equipment sharing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management</td>
<td>Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contracts</strong></td>
<td>Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Co-location</strong></td>
<td>Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Leasing</strong></td>
<td>Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contract for services</strong></td>
<td><strong>Contract for services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lease contracts</strong></td>
<td><strong>Lease contracts</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Capital financing</strong></td>
<td><strong>Capital financing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Build-Operate-Transfer</strong></td>
<td><strong>Build-Operate-Transfer</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Increase Access | Improve Equity | Decrease Costs | Improve Efficiency

- Contract for services
- MOUs
- Service Level Agreements
- MOUs
- Resource sharing (subsidized inputs)
- Staff sharing
- MOU
- Contract for services
- Capital financing
- Management Contracts
- Co-location
- Leasing
- Contract for services
- Lease contracts
- Capital financing

- Detailed design
- Building construction
- Medical equipment
- Capital financing