



Partnerships with the Private Sector in Health

What the International Community Can Do to Strengthen Health Systems in Developing Countries

Final Report of the Private Sector Advisory Facility Working Group

April Harding, Chair

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Members of the working group participated in a personal capacity and on a voluntary basis. The report of the working group reflects a broad consensus among the members as individuals, though all members may not agree with every word in the report. This text does not necessarily represent, and should not be portrayed as representing, the views of any single working group member, the organizations with which the working group members are affiliated, the Center for Global Development, or the Center’s funders and board of directors, or any other organizations mentioned within.

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"It is becoming clearer every day that many countries will not be able to reach the health MDGs without bringing the private health sector into public health initiatives. The recommendations of this working group respond to country needs and demands and suggest a practical solution to making this happen."

Professor Eyitayo Lambo
CEO, International Management & Health
Consultants, Nigeria
Former Minister of Health, Federal Republic of
Nigeria

"The United Kingdom and a few other countries contract with Marie Stopes International (MSI) to deliver health services on their behalf to provide free or subsidized health services to many more people than they could on their own, and particularly among the poor and underserved. Yet such a formal partnership with governments is hard to achieve in developing countries. The private and not-for-profit health sector is too often perceived to be outside the health system, and thus is neglected by host governments and donors. With the type of support the advisory facility would provide to governments, I believe MSI, other health NGOs, and the private health sector could dramatically expand their reach and impact in developing countries, especially for poor people. I welcome this initiative."

Dana Hovig
CEO, Marie Stopes International

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Preface

Rarely visited when development agency representatives take to the field and often overlooked in official pronouncements about health priorities, health providers from the vast and diverse private sector play a role—often a key role—in delivering care. Private health care is not just the province of the wealthy; in many poor communities, private doctors (with varying degrees of training), drug sellers, and other service providers are the first line of response when people require care. Unfortunately, governments in most countries are unable to make the most of the potential of private health services or to mitigate the problems that occur in a largely unregulated environment. Despite unprecedented levels of interest by donors in improving health conditions in developing countries, very few sources of development assistance help to promote or improve the relationship between the public and private sectors.

The development community has paid scant attention to the private sector for decades. Policymakers consistently find far more donors who can help build and equip public diagnostic labs than can help establish an effective lab-accreditation program. Yet both are desperately needed.

Can and should the international community, particularly agencies active in providing development assistance for health, help developing-country governments deal with the private components of their health systems? To examine this question, the Center for Global Development hosted a working group from 2008 to 2009 made up of a diverse range of people with widely varying perspectives and backgrounds and long experience working in global health.

Members of the working group quickly agreed there is a need for such support. They conducted interviews with a broad range of stakeholders to ascertain the demand for such support and the nature of the support desired. The working group then developed a consensus recommendation: a call for the establishment of a new source of technical and implementation support to strengthen developing-country governments' capacity to work with their private health sectors. Recognizing the complex and crowded field of sources of support for health development assistance, they delved deeply into how to set up such a new mechanism. The recommendations have already gained significant support, including in the report issued by the Taskforce on Innovative International Financing for Health Systems chaired by Gordon Brown and Robert Zoellick.¹

¹ See "More Money for Health, and More Health for the Money," the final report of the Taskforce on Innovative International Financing for Health Systems, May 29, 2009.

The recommendations to establish a new source of support for developing countries should be quickly translated into actions—actions that unambiguously convey that donors are able to look at the real-world conditions of the health sector with clear eyes and respond to needs expressed by partner governments.

Ruth Levine
Vice President for Programs and Operations
Center for Global Development

Acknowledgments

The members of the working group provided the main inputs of this report. Meeting over a number of months, the group diligently hammered out a practical solution to a long-standing problem: how to provide support to developing countries in dealing effectively with the private components of their health systems. It was not an easy task, but was made easier by the dynamic and congenial personalities.

Thanks go to Roger England for his work on the demand survey, the findings of which formed an important platform for the thinking of the group, and to Lily Dorment for her participation and contributions to our last meeting.

Additionally, I thank Ruth Levine for the invaluable expertise that she brings in both chairing working groups at the Center for Global Development and understanding the global health environment.

Very special recognition goes to Barbara O'Hanlon, the facilitator of the working group, for brilliantly bringing this work together both during the meetings and in this report.

As always, I thank the team at the Center for Global Development for their support. Acknowledgment goes to Heather Haines for her assistance in planning the working group meetings, and Lawrence MacDonald, John Osterman, and the communications team for their support in publishing and positioning the report.

Finally, I would like to thank the Rockefeller Foundation and the Bill & Melinda Gates Foundation for intellectual contributions and financial support that facilitated this work.

April Harding
Visiting Fellow
Center for Global Development

Executive Summary

The private sector plays a significant role in delivering health care to people in developing countries. By some estimates, more than one-half of all health care—even to the poorest people—is provided by private doctors, other health workers, drug sellers, and other non-state actors. This reality creates problems and potential. By and large, developing-country health policy and donor-supported health programs fail to address the problems, or capture the potential of the private sector in health. Interest is growing, within the donor community and among policymakers in developing-country governments, to find ways to work with the private sector to accelerate progress toward high-priority health objectives. However, governments in many low- and middle-income countries lack the essential skills and tools (for example, public-private partnership guidelines) to do this effectively. Recognizing this constraint to health-system development, the Center for Global Development (CGD) convened a working group to design a practical way for donors and technical agencies to support successful public-private interactions, focusing on the design of an advisory facility.

Advisory facilities, which provide a range of technical support and knowledge-sharing services, have succeeded in other sectors, such as infrastructure development. For example, the Private Participation in Infrastructure Advisory Facility (PPIAF) housed at the World Bank helps government officials in developing countries involve the private sector in the provision of infrastructure services and facilities. The PPIAF offers strategic sector analysis, implementation support, and training and technical assistance in how to work with the private sector. With adaptation, the PPIAF model may serve well to bridge the capacity gap in the health sector.

But is there demand for such services? The working group confirmed strong interest in the types of services that could be provided by an advisory facility, expressed by a wide range of individuals in developing countries, from middle-income countries such as India, Brazil, and other Latin American countries to the poorest developing countries in Africa and Asia.

The working group, comprising experts from bilateral and multilateral organizations, foundations, consultants, the private sector, and academia, defined the aims and organizational structure of a global advisory facility. They determined that the advisory facility's main purpose should be to strengthen interested developing-country governments' capacity to collaborate with private practitioners and organizations to achieve public health objectives. The advisory facility will support developing-country clients by brokering knowledge, serving as an agent for change, providing strategic advice, and

offering technical and implementation support for engagement strategies² (for example, contracting, social franchising, and accreditation). Mobilizing experts and organizational partners, the advisory facility will provide a wide range of services targeted to assisting governments in developing countries to create, evaluate, or strengthen public-private partnerships in health. The advisory facility will have a strong field presence to better respond to demand in developing countries through a hub-and-spoke organizational structure with a central management unit located in a host organization in Washington, D.C., and field presence in regional hubs.

To ensure the quality of activities and maintain accountability to donors and clients, the working group proposes a three-pronged governance and management structure: a council to oversee management and operations; regional technical advisory boards to review regional strategies; and an operational unit to manage daily operations, financial operations, and technical activities. The working group estimated that launching the advisory facility will require approximately US\$3.5 million in start-up funds with an additional US\$16 million over four years to expand its operations and meet anticipated country demand.

The working group gave careful consideration to the question of the appropriate institutional setup for the advisory facility and has determined it best to build the advisory facility within an existing institution rather than add to the already overcrowded field of global health initiatives. It has concluded that the most promising host institution would be the World Bank–International Finance Corporation (IFC) on the basis of its related Health in Africa (HIA) initiative as well as its success with a similar advisory facility in the infrastructure sector (the Private Participation in Infrastructure Advisory Facility, discussed in box 4). The members recommend some modest modifications for HIA: harmonizing HIA and a global facility’s vision and mission by clearly specifying what success will look like; emphasizing transfer of capacity to developing-country experts and organizations as a guiding principle; and formalizing separation of investment-accelerating activities from policy, analysis, and implementation support in a global facility.

The working group members strongly believe that the creation of a global advisory facility established along the parameters outlined in this report will be responsive to expressed demand and will make a significant contribution to achieving public-health goals in developing countries. Furthermore, the working group members believe that housing the facility at the World Bank–IFC is the best approach. If, however, the World Bank–IFC decides not to host the facility, the working group proposes returning to the short list of other

² In this report, “private sector engagement” and “engagement strategies” refer to a range of policy tools, such as contracting, social franchising, or accreditation, that can be used to influence and collaborate with private-sector actors as productive counterparts in efforts to achieve sector goals.

possible host institutions, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Organization, and others.

Given the real momentum toward creating constructive partnerships between the public and private sectors, and the value of contributing to the broader discussions regarding health-system strengthening, there should be no backing away from the imperative to create a global facility to address the profound need for technical assistance on how to engage the private health sector.

About the Report and Working Group

The private health sector in developing countries is complex. It is Aravind Eye Care, providing high-quality cataract surgery to hundreds of thousands of poor people in India, subsidizing care for the indigent with payments from richer patients. It is Hygeia, a Nigerian health maintenance organization, providing high-quality insurance and health care coverage to a growing number of poor people under a government subsidy program. It is the private doctors in the Indian state of Gujarat, whose participation in a voucher program for poor women enabled a dramatic increase in attended deliveries and reduced maternal deaths. It is the contracted nongovernmental organizations (NGOs), faith-based and secular, that took over providing care in many areas of rural Afghanistan, dramatically increasing access to health care for people who had very little before their arrival. It is also drug sellers who are knowingly and unknowingly selling counterfeit malaria drugs throughout sub-Saharan Africa, and unqualified practitioners who miss the warning signs of serious illness in children or are unable to manage complications during pregnancy and delivery.

The private health sector presents many unparalleled opportunities to improve access to and coverage of services—services critically needed to reach the health-related Millennium Development Goals. It also necessitates intervention, typically by the state, to protect people by addressing the most serious shortcomings in the quality of care and health products. Health programs in most countries will only reach their objectives by engaging a range of private participants in the sector—to harness and expand the benefits they provide and, at the same time, to reduce harm. The need for such action has been clear for years, but effective policy interventions such as regulatory reform, contracting, risk-pooling, and policy dialogue, to name a few, have been few and far between. In most developing countries, the public and private sectors of the health system work separately, much to the detriment of the people who rely on them.

Why does this situation prevail? Ideological perspectives on the role of government in providing and financing health services and, often, a lack of awareness of the extent and impact of the private sector, undoubtedly contribute. By and large, though, the biggest constraint is that policymakers and public officials in government agencies lack the technical know-how and management systems to engage the private health sector. Policies, such as those related to contracting or accreditation, that engage and influence the private sector are complex and challenging. They require specialized skills and new practices built on experiences in other countries and basic principles of economics, regulation, business, and other fields. The technical assistance available to

public officials in developing countries, however, typically offers little support and expertise on private-sector engagement.

The Center for Global Development convened a working group to examine the nature of this problem and identify the characteristics of a solution. The group was tasked with exploring practical and feasible ways for donors and technical agencies to support improvements in public-private interaction in developing countries as a means to accelerate the achievement of widely agreed-upon social objectives: reduced mortality and expanded and more equitable access to health services and essential medicines and products. The working group, whose work was supported by grants from the Bill & Melinda Gates Foundation and the Rockefeller Foundation, included a broad range of individuals with expertise in the public and private health sectors, acting on a voluntary basis and in their individual capacities, from bilateral and multilateral organizations, foundations, consultants, the private sector, and academia (see annex A for brief biographies). The working group met three times between August 2008 and April 2009.

This report presents the background context for the group's task, the rationale for framing the deliberations the way they did, and their specific recommendations for international donors and foundations.

Partnerships with the Private Sector in Health

In most countries, the government cannot fully meet the health needs of the people with public resources alone. While universal access to key health services such as family planning, maternal health care, and prevention of HIV/AIDS and other sexually transmitted infections is critical to achieving the United Nation's Millennium Development Goals,³ that access is far from becoming a reality. The private sector provides a complementary means to expand health services, products, and infrastructure (box 1). However, the private sector is not a replacement for effective public-sector action. In every setting, both sectors have roles to play in addressing the complex and difficult challenges faced by developing countries to expand access to high-priority health services to underserved populations.

Why Work with the Private Sector

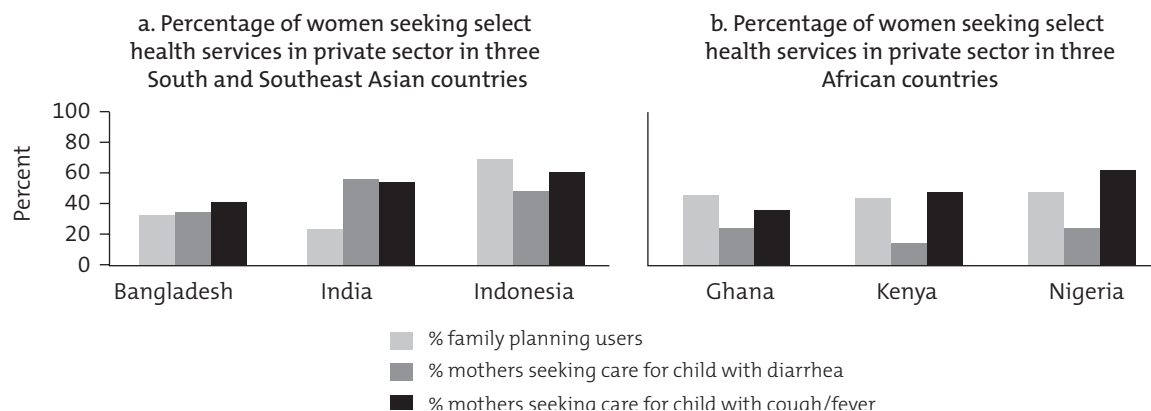
Developing-country governments have much to gain by engaging the private health sector for several reasons:

- **THE PRIVATE SECTOR ALREADY PLAYS A LARGE ROLE IN HEALTH CARE.** In Africa alone, nearly 50 percent of those who seek care outside the home go to a private provider (figure 1). About half of the US\$16.7 billion spent on health in sub-Saharan Africa in 2005 was spent in the private sector (World Bank, 2009).
- **PATIENTS OFTEN PREFER THE PRIVATE SECTOR.** Household decision-makers in developing countries often choose private providers because they respond more to patients' needs or preferences. People value the convenience, flexible payment plans, and ease of access to health care providers and drugs at private health services. They also value the

³ Adopted by world leaders following a UN summit in 2000, the goals aim to reduce poverty and improve quality of life. <http://www.un.org>.

Box 1. What Is the Private Health Sector?

The *private sector in health* includes for-profit (both informal and formal) and not-for-profit (NGOs, faith-based organizations, community-based organizations, and the like) entities as well as a range of for-profit financial institutions (banks, health insurance companies, and so forth).

Figure 1. Health Care Sought from Private Sector

Source: PSP-One 2006.

closer locations and more responsive services (Brugha and Zwi 1998; Mills et al. 2007; Hetzel et al. 2009).

- **THE PRIVATE SECTOR DELIVERS SERVICES TO THE POOR.** The private sector fills important gaps in health services and products to those underserved by the public sector. Across South Asia, for example, 80 percent of children from families in the lowest income quintile who seek care for respiratory illness use a private provider. In India, private health services accounted for 56.5 percent of utilization in the poorest households (Peters et al. 2002).
- **THE PRIVATE HEALTH SECTOR CAN INCREASE THE SCOPE AND SCALE OF SERVICES.** In many developing countries, the private sector owns and manages 40 to 50 percent or more of the country's health infrastructure and it is often the primary employer of health care professionals. Many of these services are located in remote and rural areas. The public sector can extend its reach by contracting with these providers or by undertaking quality-enhancing activities such as accreditation (box 2).
- **PRO-POOR STRATEGIES CAN WORK THROUGH PRIVATE-SECTOR ENGAGEMENT.** Public health services in developing countries often benefit better-off people more than the poor. Policy interventions, such as vouchers or insurance premium subsidies for poor people, can preferentially expand access for poor people to high-priority services or products.
- **ENABLING POLICY CHANGES CAN MOTIVATE INCREASED MANUFACTURING, DISTRIBUTION, AND RETAIL OF HIGH-PRIORITY HEALTH PRODUCTS.** In many countries, excessive and poorly designed regulatory and tax policies discourage investment in important

Box 2. Fighting Tuberculosis: A Successful Example of Public-Private Collaboration

The World Health Organization's Stop TB Strategy explicitly recognizes the private sector's role in stopping tuberculosis on the basis of several cases in which the private sector participated in national Directly Observed Treatment – Short-course (DOTS) programs. In Delhi and Hyderabad, India, the Public-Private Mix (PPM) DOTS program showed that DOTS treatment in the private sector is affordable and that the private sector reached more patients than the public (Floyd et al. 2006). In Bangladesh, the Damien Foundation trained more than 2,000 village doctors in DOTS, expanding coverage to 26 million people in rural Bangladesh (Salim et al. 2006).

subsectors. Strategic policy changes (for example, changing entry regulations or tax provisions) can provide incentives for expansion in these subsectors and increase access to and use of important health goods, including bed nets, diagnostic tests, medical equipment, and pharmaceuticals.

- PRIVATE-SECTOR INVESTMENT AND GROWTH OFTEN REQUIRES PUBLIC-SECTOR LINKS TO REACH PEOPLE IN LOWER-INCOME HOUSEHOLDS OR UNDERSERVED AREAS. Without contracting or insurance arrangements, or subsidies for poorer patients, much growth of the commercial private sector will occur in the subsectors primarily serving the better-off portions of the population (for example, urban hospitals).

Linking the Public and Private Sectors

The public sector can use a wide range of policy instruments to engage and create partnerships with the private sector in health (table 1). These interventions, which include contracting out, licensing and accreditation, social franchising, social marketing, and vouchers, have proven successful in advancing health priorities, including family planning, tuberculosis treatment, malaria prevention and treatment, and child and maternal health, as well as in reducing impoverishment through health care payment subsidies.

Taking advantage of the existence of the private sector to serve public health objectives is challenging. The barriers are both conceptual and operational, and include

- a lack of common definitions and disagreement over what role the private sector should play;

Table 1. Public-Private Interventions in Health Care Delivery

<i>Intervention</i>	<i>Description</i>
Contracting out	Governments contract with private providers (nonprofit and for-profit) to deliver health services.
Licensing and accreditation	Governments can extend licensing and accreditation systems to include provisions for private-sector providers.
Regulation	By updating and harmonizing laws, policies, regulations, and procedures, governments can authorize private provision of services and products by certain health professionals in specific settings.
Provider networks and franchises	Networks and franchises group health care providers under an umbrella structure or parent organization.
Public-private partnerships	Private providers and businesses join with governments, international organizations, or nonprofits to address social needs.
Social marketing programs	Use commercial marketing techniques to make subsidized products available more widely. The programs can distribute and promote products such as contraceptives, oral rehydration salts, and insecticide-treated bed nets.
Training and continuous education for private providers	A variety of training techniques—including direct training, long-distance learning, continuous medical education, and detailing—can improve the knowledge and skills of private health care providers.
Vouchers	Government can give vouchers to target populations to subsidize the price of health services and products, which makes them more affordable and more likely to be used.
Insurance	Government-funded insurance, commercial insurance, and community-based mutuelles pool financial risk across large population groups.

Sources: O'Hanlon 2009; Lagomarsino and Singh Kundra 2008.

<i>Expected results</i>	<i>Where it is happening</i>
Can expand private-sector coverage of particular services via public funding and may improve (through contract specification) the quality of care; can improve efficiency and quality through competition.	Afghanistan, Bangladesh, Cambodia, Guatemala, Haiti, Pakistan, Senegal, South Africa, most of central Europe
Can strengthen quality of private health services and help governments monitor the care that private providers offer.	Brazil, South Africa, Tanzania, Zambia
Can promote competition and organization (for example, multi-pharmacy chains) more conducive to quality or lower prices. Can increase private-sector contribution by removing obstacles and creating incentives that motivate the private sector to provide public health services and products.	Tanzania
Ensures standard quality and prices and encourages individual private providers to scale up their services.	Bangladesh, Benin, Cameroon, Ethiopia, Ghana, India, Kenya, Lesotho, Madagascar, Malawi, Mali, Pakistan, Philippines, Rwanda, Sierra Leone, South Africa, Swaziland, Togo, Vietnam, Zimbabwe
Leverages private-sector resources and expertise to deliver health products and services.	Brazil, Czech Rep., India, Lesotho, Mexico, Romania, South Africa, Republic of Yemen
Increases access to and use of essential health products.	Many countries, for family planning products and services and bed nets
Can improve private providers' knowledge, skills, and the quality of the care they provide in areas that address public health objectives.	India
Can increase consumer choice and make private-sector care more affordable through subsidies. Vouchers also create financial incentives to private providers to offer services and products they might not otherwise deliver. Can motivate quality improvement via provider eligibility requirements.	Ghana, India, Indonesia, Nicaragua, Tanzania
Can expand financial protection and ease burden on households paying out of pocket for health services. Insurance can reduce financial barriers to seeking health care, especially for preventive health services.	Colombia, Ghana, India, Mali, Namibia, Nigeria, Rwanda, Senegal

- mistrust, lack of communication, and negative attitudes toward the private sector, which often inhibit collaboration between the public and private sectors (Bennett et al. 2005);
- the reality and perception of tradeoffs between for-profit health care and access for the poor, and health care as a “public good”;
- a diverse and fragmented private sector, which makes finding a representative entity or group with whom to collaborate difficult⁴;
- scant information on who private providers are and what services they offer; and
- a lack of public-sector skills and expertise in developing and managing strategies to influence and collaborate with the private sectors.

This final challenge was the focus of the majority of the working group’s deliberations. Although evidence and experience are growing about how to work with the private health sector, many government agencies in developing countries lack the know-how and skills. Historically, the tasks of public health officials have not included competitive procurement and health-services contract management. Nor have most health officials had experience implementing or overseeing facility or professional accreditation in the private sector. Moreover, including private-sector actors in policy and planning, and managing meaningful interactions with the private health sector, require new skills and practices that are not taught in medical or public policy schools.

The technical support offered by the international donor community to developing-country governments has so far done little to address these skill gaps. Multilateral agencies active in health are staffed primarily by people with public health and clinical expertise. Bilateral agencies, with a few exceptions, tend to provide support in the context of health programs, which are usually implemented within the public system. Where bilateral agencies do possess expertise and support private-sector engagement, it often takes place outside the remit of public officials (for example, NGO-administered family planning programs). Because of historical patterns and the government-to-government nature of most aid programs, funders typically direct the majority of their funds to public-sector programs. In Africa, for example, National Health Accounts (NHA) data in 10 countries from 1997 to 2004 reveal that less than 5 percent of donor funds flow to actors outside the public sector: the majority of donor funds are directed to public-sector initiatives and, in a few cases, NGO activities. In many instances, donors’ decisions about what to support

⁴ The private health sector typically is characterized by a small number of large, high-quality private hospitals, clinics, and providers serving higher-income groups working alongside a larger number of small-scale private (and often informal) providers offering services to a wide range of income groups including the poor.

and how are made with little regard to what role private providers are already playing—often at the cost of undermining program performance, and sometimes at the expense of undermining the health system as a whole. The same NHA data show that the great influx of Global Fund money in 2003 and 2004 wiped out the nascent private-sector role in HIV/AIDS provision (Sulzbach, Wang, and O’Hanlon 2009).

The Working Group Task: Identify a Solution

In response to the need in developing countries for capacity building, CGD established a working group in August 2008 with a mandate to develop a charter for an agency or collaborative mechanism that could address this gap in skills and provide technical assistance to developing-country governments. The group conducted its work through regular teleconference calls, e-mail, and three in-person meetings.

Demand for Support?

A set of structured interviews was conducted to inform the group’s deliberations on the critical question of whether there was need and demand for support and, if so, what kind. Interviews were conducted with a diverse set of 36 respondents, including potential clients. The responses confirmed the need for, and interest in, technical assistance to better collaborate with the private sector. The interviews, carried out via e-mail and telephone in October and November 2008, elicited opinions on the formation of an international mechanism that could offer technical and financial support for developing countries to better engage the private sector for public benefit. In addition to identifying a number of barriers to engaging the private sector (box 3), the survey found that respondents believe that ministries of health in developing countries require a wide range of support to tap into the full potential of the private sector, including

- evidence supporting how the private health sector can address the challenges and issues confronting the public health sector;
- strategic advice on what the potential areas for public-private engagement are and what strategies are effective in mobilizing the private sector; and,
- technical assistance in strategy development and program design that will help developing-country governments implement public-private partnerships in health.

Moreover, the same public-sector officials asked for technical assistance in building political support to work with the private health sector among ministry of health staff, other government officials, and international donors.

Box 3. Developing-Country Policymakers Speak up on the Private Health Sector

In interviews commissioned by CGD, policymakers, and leaders in several ministries of health acknowledged the barriers to engaging the private sector:

- poor information on the private sector
- lack of capacity by government to work with the private sector
- resistance from ministry staff
- lack of political will
- no policy framework for private-sector engagement
- limited interest within the private sector to work with the public sector
- little support available for implementing new policies to include the private sector

The survey confirmed that there is demand from officials in a wide range of developing countries, including middle-income countries such as India, Brazil, and other Latin American countries, to the poorest developing countries, such as those in Africa. Working group members, from their own individual and organizational perspectives, further confirmed the global characteristic of demand for an advisory facility on private-sector interactions in health systems.

The Advisory Facility Concept

The concept of the entity or mechanism to encourage private-sector engagement rapidly focused on some form of an *advisory facility*. The working group examined the PPIAF in the World Bank and identified several characteristics that corresponded to the type of mechanism they envisioned for providing technical assistance for developing countries to engage the private sector in health (see box 4). The working group determined that the mechanism should be able to receive funds from multiple sources; provide technical support on an on-demand basis; focus on building public-sector capacity in developing countries; provide the type and range of technical assistance needed for the public sector to engage the private sector; build on an existing organization's structure, governance, financial management, and procedures; and leverage World Bank and IFC staff to establish contacts in key developing countries and to help generate awareness of available services.

Characteristics of a Global Private-Sector Advisory Facility

The working group forged agreement on the different components of a global advisory facility on the private sector in health. The consensus vision for the

Box 4. The PPIAF as a Model Mechanism for Helping Developing Countries Engage the Private Sector

The Private Participation in Infrastructure Advisory Facility (PPIAF), now supported by 15 donors, has successfully helped developing countries use the private sector to build infrastructure and provide services in the power, water, transport, and telecommunications sectors. PPIAF activities focus on five areas:

- Strategic analysis to identify promising approaches to bringing the private sector into key high-priority areas
- Direct support to elaborate and implement necessary policy or regulatory improvements
- Training and on-the-job support to help public officials develop the capacity to handle new tasks related to working with the private sector
- Technical assistance to support public officials to implement transactions unfamiliar in the local context
- Support to build consensus related to the implementation of private partnerships, policies, or strategies

The PPIAF is housed in the World Bank, which permits it to connect with developing-country governments through Bank staff. PPIAF management reports to its own board, however, ensuring that funds are spent in keeping with PPIAF priorities and criteria. With guidance from its board, PPIAF tracks the performance and effectiveness of its technical assistance activities.

PPIAF has 16 staff members; half are in Washington, D.C, and half are split among four regional offices. As of 2007, PPIAF had delivered 87 technical assistance grants and funded a total of 269 training workshops for governments, the private sector, and civil society since its inception in July 1999. In fiscal year 2007, PPIAF's operating budget was US\$19.5 million.

main features of a global advisory facility is described below (for a more in-depth discussion of these areas, refer to annexes B and C).

Vision and Mission

The global private-sector advisory facility's mission shall be to strengthen interested developing-country governments' capacity to work with the private health sector to achieve public health goals (see vision statement in box 5). These goals might include increasing access to high-priority health services, reducing maternal mortality, improving child survival, and others. Ideally, clients primarily will be government ministries or agencies in the poorest developing countries. However, the facility will also offer services to a limited

Box 5. The Advisory Facility's Vision

Helping improve the health of people in developing countries by strengthening health systems through better integration of the private health sector.

number of middle-income countries (representing approximately one-quarter of its total portfolio of technical assistance) because they provide a wealth of experience that can be adapted and applied to other client countries. Moreover, the total number of people living below the poverty line in middle-income countries exceeds that in low-income countries.

Available Services

The global private-sector advisory facility shall deliver the following support:

- knowledge brokerage to assemble information, tools, methodologies, and good and bad practices on strategies for developing-country governments to tap the full potential of public-private partnerships
- change agent to promote inclusion of the private sector in health by fostering dialogue between the public and private sectors and raising awareness of the facility
- strategic sector analysis to identify high-priority health areas and promising approaches for private-sector engagement
- technical assistance and implementation support to provide developing-country governments the capacity to design sustainable, country-specific, private-sector engagement strategies that will improve health and to help them implement specific policies and regulatory and institutional reforms

The group agreed that the facility should undertake knowledge management and operational research related to the topics on which it will provide analytical and technical support. Doing so will allow it to quickly integrate and share insights and lessons learned from its own work, and ensure that support within countries reflects the most up-to-date research.

Comparative Advantage

Group members took into account existing activities when they outlined the high value-adding areas upon which the facility should focus its efforts. Existing mechanisms to expand the private health sector's contribution to social objectives are limited to accelerating entry and growth of health care businesses by increasing access to funds for investment. The IFC and the European Bank for Reconstruction and Development, for example, increasingly invest in private health care organizations in the health sector. Such mechanisms typically cannot reach the small businesses that often make up most of the private health sector in developing countries (for example, clinics, pharmacies, laboratories). Nor can they help establish effective public funding or subsidy arrangements that can allow corporate hospitals and other service providers to serve lower-

income households. The advisory facility will be able to support engagement of the private sector in ways that can most directly reach the poor and achieve high-priority social objectives (refer to table 1). It will also provide support to enable policy changes that can complement such larger-scale transactions (for example, establishing service-purchasing agreements in conjunction with a public-private partnership for a new or upgraded hospital, as in Lesotho).

How the Global Advisory Facility Will Deliver Services

The working group agreed on several principles that will guide the global advisory facility's activities and manner of delivering services (box 6). Operating through expert consultants and partnerships with organizations that have wide-ranging experience in working with developing governments on private sector engagement, the advisory facility will provide the following types of technical assistance:

- Conduct private-sector assessments and offer recommendations for improving the role of the private sector.
- Collect data to analyze and better understand the private health sector.
- Establish and facilitate consultative forums to foster greater communication, cooperation, and collaboration between public and private stakeholders.
- Review policies and regulations and recommend policy actions to expand private-sector contributions to health-system performance, sustainability, and other goals.

Box 6. How the Global Advisory Facility Will Pursue Its Mission

The following principles would guide the activities of the advisory facility:

- **Strategic and selective.** Technical assistance should focus on policy support to the private sector where it will yield the greatest health impact, and address inequities in access to quality health services.
- **Complementary and collaborative.** Activities should foster creative partnerships that recognize the potential contribution of both public and private sectors.
- **Responsive.** Activities should be demand-driven, and respond quickly to a developing-country government by providing flexible, situation-specific technical support that meets its needs.
- **High-quality policy advice.** Technical assistance should address a client's most pressing health priorities and strengthen its capacity to implement strategies.
- **Leadership and knowledge.** The facility should be a credible information source and be committed to advancing the international development community's knowledge on private sector engagement in health.

- Explore potential for public-private partnerships in health and help to establish and facilitate these partnerships.
- Provide training in core policy areas supporting the private health sector, such as contracting out, voucher schemes, risk-pooling mechanisms, accreditation, and certification.
- Undertake operational research related to private-sector policies and practices.
- Create a knowledge clearinghouse on public-private interactions in health, good practice models, and examples.
- Assist in scaling up proven models and strategies to engage the private sector.
- Assist in negotiations involving complex contracts for health services or pioneering transactions with the private health sector.

Global Advisory Facility Implementation Model

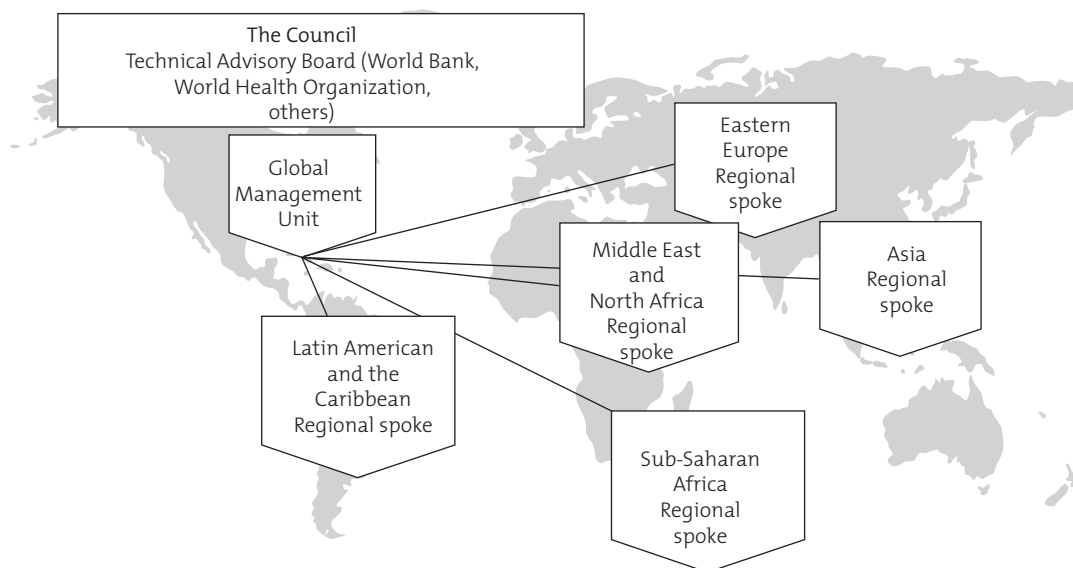
The advisory facility will have a strong field presence. To better respond to demand in developing countries, and to become familiar with regional priorities and policy challenges, the facility will have a hub-and-spoke organizational structure (see figure 2), with a central management unit located in a host organization and field presence at the regional level. At the outset, the facility will explore establishing one or two regional hubs, depending on demand.

In addition to helping countries identify and implement better policies, it is critical that the facility transfer private-sector engagement skills and expertise to the field. The regional hubs will serve as incubators to identify and grow capacity of professionals and organizations in the region to eventually provide the services offered by the global advisory facility.

Global Advisory Facility's Governance Structure

To ensure the quality of activities and maintain accountability to participating donors and clients, the following governance structure is proposed: a council to oversee management and operations; regional technical advisory boards; and an operational unit to manage daily operations, financial operations, and technical activities.

The council, composed of representatives from contributing donors (for example, bilateral and multilateral organizations and foundations), will oversee the global advisory facility's management and operations. To ensure a breadth of perspectives, the advisory facility will encourage developing-

Figure 2. Global Advisory Facility Hub-and-Spoke Model

country governments to participate in the council also. The council should meet annually to review the strategic direction of the facility's activities and achievements and to provide financial oversight.

The global advisory facility will be supported by regional technical advisory boards, to be established and convened as needed on the basis of work volume and distribution. Advisory boards will provide strategic advice and technical direction and will offer political support for the advisory facility in a specific region by reviewing and commenting on its regional strategy and by assessing whether its activities and achievements are in keeping with agreed-upon priorities and are within budget. Members of the technical advisory board will be selected for their expertise in private-sector engagement modalities and will serve in a voluntary capacity.

An operational unit, which should remain small, will be responsible for the advisory facility's daily operations, financial management, and, primarily, technical activities. Technical experts in policy instruments used to engage the private health sector (contracting, regulation, quality control, and so forth) and private-sector health care operation will be responsible for setting the facility's technical direction, ensuring the technical quality of the facility's products and services, and reviewing and synthesizing experiences and lessons of engaging the private health sector. Most country support should be contracted out and delivered by international and regional experts, whether individuals or organizations.

A New or “Build-On” Entity?

One of the toughest issues working group members considered was whether the advisory facility should be a new, stand-alone entity or one created within an existing institution working on related issues. All were conscious of how crowded and fragmented the global health field is. To resolve this issue, the group reviewed the strengths and weaknesses of four organizational models that have been used to establish and deliver similar types of support:

- Option A, “Subsidiary model”: A hosted subsidiary within a multilateral organization
- Option B, “Partnership model”: A hosted partnership within a multilateral organization
- Option C, “Contracting-out model”: A project managed by an existing NGO or private entity
- Option D, “Stand-alone model”: A newly created independent entity

The group concluded that it would be preferable to build the advisory facility from within an existing institution if a suitable hosting arrangement could be established. The analysis of the strengths and weaknesses and examples of each option are presented in annex D.

The group conducted a scoping exercise to identify all entities active on policies related to private health sector engagement—both to ensure the facility’s scope of work is appropriately defined (that is, not duplicating support that already exists for developing countries) and to assess potential hosting opportunities. The findings of the scoping exercise are presented in annex E.

The scoping exercise identified one initiative in particular with strong similarities to the envisaged advisory facility—the Health in Africa (HIA) initiative launched in 2008 by the World Bank and the IFC. At the end of the exercise, the working group concluded that the HIA initiative is the most promising foundation on which to build a global advisory facility. Members agreed that one global advisory facility should be created, which builds on the solid foundation and early successes of the HIA initiative. Having two distinct entities with such similar scope and purpose would only confuse developing-country counterparts and possibly duplicate efforts. Moreover, in response to requests from countries in other regions, HIA management is already exploring moving beyond sub-Saharan Africa, and creating the global facility would help bring about such a move. Also, the experience of the World Bank and IFC with establishing and operating the successful PPIAF indicated to the group their capability to undertake a similar initiative in the health sector.

Making the Global Facility a Reality

Financial Requirements to Launch the Global Advisory Facility

Ideally, the advisory facility will have a diverse funding base from foundations, bilateral and multilateral organizations, and developing-country governments. Launching the advisory facility will require approximately US\$3.5 million in start-up funds. The seed funds will cover the cost of recruiting four to six staff in the operational unit with the following responsibilities:

- Develop the technical approach, identify and adapt tools and methodologies to be used, and generate technical information.
- Develop and implement a business and operational plan for the global advisory facility.
- Mobilize demand for its services.
- Build management and operational systems to deliver services.
- Establish and convene the council and technical advisory board.

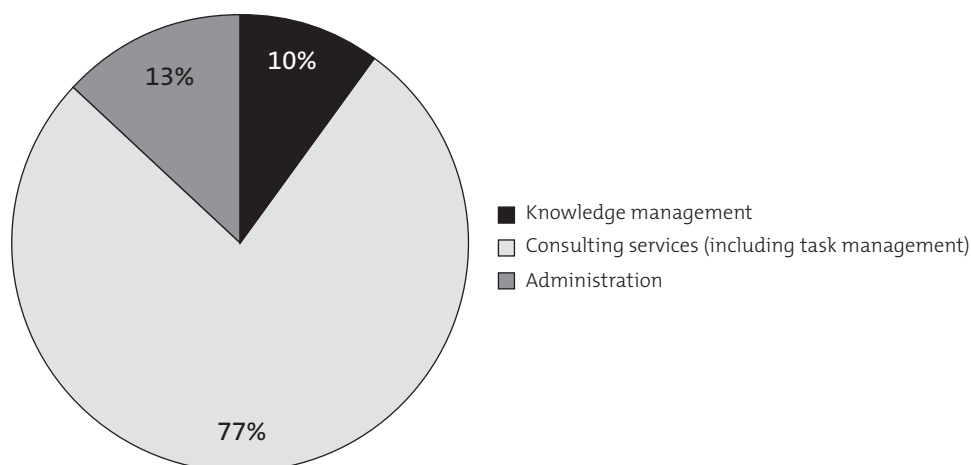
During the first year, a group of key stakeholders will work with the advisory facility staff to finalize its terms of reference, help generate client demand, and develop a strategy to host the advisory facility within an organization.

In addition, assuming the global advisory facility takes a business-development path similar to that of the PPIAF, it will need an estimated US\$16 million over four years to establish itself and launch country-support activities.

The proposed funding levels for start-up and for four years of operation are estimated on the basis of the budget parameters and average task cost for PPIAF (figure 3). With an estimated 16 country-support tasks per year at an average cost of US\$195,000 each, country support will cost US\$3.12 million per year. If facility knowledge management and administration costs are proportional to PPIAF costs (23 percent, see figure 3), they will require an estimated US\$920,000.

The funds will be used to consolidate the advisory facility's operational platform; open regional offices as needed; and vet, grow, and establish working relations with a diverse and qualified group of international consultants, organizations, and developing-country institutions to deliver its services. Also, the global advisory facility staff will build a website and reference library and convene and participate in technical meetings and workshops on private-sector engagement in health.

Figure 3. PPIAF Annual Budget by Categories
\$20 million per year



Source: Private Participation in Infrastructure Advisory Facility Annual Report 2008.

Incremental Approach

The private sector working group members endorsed establishing a global advisory facility from a base of the existing HIA initiative of the World Bank–IFC. This unique global advisory facility will add value beyond the HIA and other initiatives working with the private health sector by filling identified gaps in technical assistance, supporting activities that will be demand-driven, forging collaborative and responsive relations with developing-country clients through a strong field presence with a central and regional hub-and-spoke model, and transferring technical capacity to individuals and organizations in the regions where the global advisory facility works.

This approach was preferred for several reasons:

- It builds on an existing initiative that has activities similar to those proposed for a global facility.
- It reduces the possibility of confusing developing-country clients and duplicating efforts of similar initiatives.
- Creating the global advisory facility within an existing organization is more cost-effective—a criterion agreed upon by the working group members.

The working group recommends locating the advisory facility in the World Bank Group. Establishing the global advisory facility will involve extending the emphasis of HIA beyond Africa and making a few changes to the HIA model to reflect findings of the working group.

HIA Goes Global . . . With a Few Modifications

The existing HIA operational framework is similar, but not identical, to the ideal parameters identified by the working group. Table 2 contrasts the existing HIA model with the group's recommendations for the advisory facility model. The working group's recommended modifications follow:

- **Harmonize HIA's and the global facility's visions and missions by defining success.** The two initiatives have similar visions and mission statements, but with different emphases. Key concepts shared by both initiatives include mainstreaming the idea of private-sector engagement in all relevant aspects of public-sector policy and planning, providing quality technical assistance that is responsive to and adds value to public-sector efforts to work with the private sector, and encouraging private-sector engagement and public-private partnerships that contribute to increased access to quality health services for underserved populations. Drafting a clear statement of the global facility's definition of success that builds on the HIA experience, rather than spending more time to come up with new, consensus visions and mission statements, would help reconcile the small differences in wording.
- **Make transferring capacity to regional and local experts and organizations a guiding principle for the global facility.** One of the distinguishing characteristics of the global advisory facility would be its strong emphasis on building the capacity of individuals and organizations in the regions where it works to provide the range of services offered by the global facility. Initially, the global advisory facility will work through partners to offer the range of services while simultaneously working to identify individuals, organizations, and networks in the regions to which to transfer private-sector expertise and skills.
- **Formalize the decoupling of investment from policy and analysis.** The HIA initiative includes activities to expand access to equity and debt finance. Group members did not envision the global facility providing this type of support, although they agreed that accelerating access to equity and debt can contribute to high-priority health goals (for example, expanded service coverage or improved quality). Group members discussed the risk of real or perceived bias in policy advice—where there is an interest in improving the enabling environment and profitability of a particular sector or organization—and concurred that some separation of investment activities from policy and analysis would be appropriate. The HIA initiative already has established a separate and independent management structure for its equity finance activities; the working group supports this evolution and suggests formalizing this separation in the governance and management arrangements for the global facility.

Table 2. Analysis of the HIA Initiative and the Global Advisory Facility

Health in Africa initiative

Vision/Mission

HIA's mission is to increase access to quality health services and products in Africa and to improve financial protection against the impoverishing effects of illnesses by engaging the private health sector. HIA focuses on underserved population groups.

Purpose

- *Policy and analytics*: to improve knowledge, inform decisions, and benchmark performance. Outputs include flagship reports, country assessments, thematic studies, short policy briefs and technical articles, and policymaker toolkits.
- *Technical assistance*: country assessments in four countries and early private-sector projects in Ghana to accredit private providers and in Nigeria to implement National Health Insurance Scheme IT and reform business practices.
- *Equity vehicle*: multiple investors (IFC, DEG, Gates Foundation). Fund will be managed by Aureos. Basic terms include having initial funds available ranging from US\$100 million to US\$120 million. Expect to invest in 25–30 projects from around US\$50,000 to US\$5 million. Investments focused on lower-income population.
- *Debt vehicle*: HIA currently has a pipeline of US\$100 million with a target of US\$500 million over five years, with Eco-Bank identified as a partner for the regional financial-markets program and Ghana and Burkina Faso as potential countries. Ghana, Nigeria, Tanzania, and Zambia are first-phase countries.

Organizational structure

- Joint World Bank–IFC project (located in Investment Climate Advisory Services department).
- Headquarters in Nairobi with additional staff in Washington and Dakar.
- Activities contracted out to experts and implementing partners.
- Active in Africa only; has received requests for technical assistance from other regions.

Governance

- Governed under World Bank and IFC structures; the formation of an advisory board is now under discussion.

Advisory facility (proposed)

Vision

Helping improve the health of people in developing countries by strengthening health systems through better integration of the private health sector.

Mission

Strengthening interested developing-country governments' capacity to work with the private health sector.

Purpose

- *Knowledge brokerage*: assemble information, tools and methodologies, and good and bad practices on strategies for developing-country governments to tap the full potential of public-private partnerships.
- *Change agent*: promote inclusion of the private sector in health by fostering dialogue between the public and private sectors
- *Strategic sector analysis*: identify opportunities to expand the private sector's contribution to health-sector goals and strategies to address problems (for example, poor quality); develop strategic plans with governments to accelerate progress toward high-priority goals (for example, health services access for the poor and underserved; reduce maternal mortality) via private sector engagement.
- *Technical assistance and implementation support*: provide expertise and build developing-country government capacity to design sustainable private-sector engagement strategies that improve health outcomes and work with developing country governments to implement specific policies and regulatory and institutional reforms, and support the implementation of engagement strategies.
- *Does not have equity or debt vehicles.*

Organizational structure

- Hub-and-spoke organizational structure with a central management unit located in a host organization in Europe or the United States.
- Strong field presence in developing countries; could initially explore one or two regional hubs depending on country demand.

Governance

- A council will oversee the advisory facility's management and operations. The council will comprise representatives from contributing donors and the host institution.
- Multiple regional technical advisory boards will be responsible for providing strategic advice and technical direction.
- A management team will be responsible for the advisory facility's daily operations and financial management.

Going Global

Once the World Bank–IFC has agreed to advance the effort to establish a global advisory facility from the base of the existing HIA initiative, the following process to establish and launch the global facility should be undertaken:

- 1. Develop a strategy and plan to go global.** A core team will need to be assigned to plan and manage the incremental expansion of HIA to go global so that the advisory facility can be launched. The strategy will address how to complete several necessary tasks, including creating a global advisory facility organizational structure that responds to the working group’s recommendations yet fits into both HIA and the World Bank–IFC structure; mobilizing country demand for the facility; determining the terms of reference and staffing plan for the global facility’s management unit; establishing and convening the council and the initial technical advisory board; and identifying some of the initial technical and support activities. The core team should convene a small group of experts to provide input and guide the development of this strategy.
- 2. Secure additional donor funding.** Considerable interest exists among potential donors to provide initial funding to establish a global advisory facility. After Bank Group approval will be an opportune time to restart discussions with these potential funders to secure adequate funding to start the global advisory facility operations in one or two regions, depending on demand. The working group members could play a leadership role by promoting the facility with potential funders when helpful.
- 3. Promote the global facility.** Key to the global facility’s success will be the level of interest in and demand for its services. Initially, the core team will need to dedicate time and effort to increasing awareness of the global facility and promoting its services to developing-country governments. Working group members will also play a role in generating awareness and demand for support through their networks of contacts with developing-country counterparts.

If There Is No World Bank Approval

There is no guarantee that the working group’s recommendations to establish an advisory facility in the World Bank Group will be implemented. If the idea of growing and adapting HIA as outlined above is rejected, it will prove to be a major setback to the growing number of developing countries that have expressed an interest in and are ready to collaborate with the private health sector. These governments will lose time as they struggle to find an institution or donor that could respond to their technical assistance needs in a timely

fashion; they will miss opportunities and potential solutions to some of their pressing health challenges.

If this situation arises, the working group will have to reconvene and reexamine other potential host institutions. A process of soliciting proposals for hosting could potentially be launched at that time.

Conclusion

Working group members concluded their efforts with a shared sense of the importance of establishing an advisory facility as outlined here. Supporting such a facility could help developing countries use all available resources to meet their health-sector goals. Indeed, in many countries, such support may make the difference between success and failure of critical efforts to reduce maternal and child mortality and to bring infectious diseases like AIDS, malaria, and tuberculosis under control. Working group members confirmed their commitment to using the momentum created by the CGD working group to establish some means of providing this much-needed support to developing countries.

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Annex A: Working Group Members

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- Arnab Ghatak, Partner, Non-profit practice, McKinsey
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Daniella Ballou-Aares leads Dalberg's Health Practice and the firm's New York office. Ballou-Aares has spent more than 10 years as a management advisor in global development, designing innovative initiatives and financing mechanisms and advising organizations on strategic positioning and organizational change efforts. Ballou-Aares has unique expertise in the health and agricultural development sectors, with a particular emphasis on improving financing structures and supply chains in Africa. Ballou-Aares has recently supported the development of several financing mechanisms in the health sector, including the Affordable Medicines Facility for malaria (AMFm) and the Pledge Guarantee for Health. Ballou-Aares's clients include multilateral organizations, foundations, NGOs, and companies active in developing countries. Before Dalberg, Ballou-Aares worked for Bain & Company in the United States, the United Kingdom, and South Africa. Ballou-Aares was also a fellow with the International Rescue Committee in Liberia and is a term member at the Council on Foreign Relations. Ballou-Aares has an MBA from Harvard Business School, an MPA from the Kennedy School of Government, and a BS in Operations Research from Cornell University.

James Cercone is an economist and president of Sanigest Internacional, a health care management and consulting company with offices in Costa Rica, the United States, and Europe. Cercone developed his interests in health economics and health reform through engagements with the World Bank (from 1990 to 1994) and the government of Costa Rica (from 1994 to 1997). Cercone has more than 16 years' experience in the health sector, with particular emphasis in Latin America and transition countries. He is currently serving on the board of directors of the Latin America Association of Pre-Paid Health Insurance Plans (ALAMI). Cercone's experience covers more than 40 countries with a broad emphasis. He has worked extensively on the design, implementation, and evaluation of projects for the World Bank, the Inter-American Development Bank, the International Labour Organisation, and other development organizations. In the past five years, Cercone has also been involved in the start-up of several venture capital funds focusing on health-sector investments and has provided investment advice for clients around the world.

Scott Featherston is an investment officer at the IFC's Health and Education department, where he focuses principally on Africa and South Asia. Featherston led the IFC's recent work on health in Africa, including the report "The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives." Featherston has postgraduate degrees from the universities of Melbourne and Sydney in Australia and from Johns Hopkins University in the United States. He lectures part-time at the Johns Hopkins School of Advanced International Studies in Washington, D.C.

Arnab Ghatak is a principal in the New Jersey office of McKinsey & Company. He first joined the firm in 2000 with a degree in molecular biology from Princeton University, an MD from the University of Pennsylvania Medical School, and an MBA from the Wharton School, where he majored in health care. Since joining McKinsey, Ghatak has worked in the nonprofit and for-profit health arenas. In the nonprofit sphere, Ghatak has extensive experience with large multilateral technical institutions, governmental departments, and stand-alone NGOs. In the private sector, he has focused on business development and strategy for pharmaceutical, biotech, and medical device companies. Ghatak was a past fellow in McKinsey's Non-Profit Practice, specializing in global public health. His recent work includes strategic design for a leading global institution to support the development of health care in sub-Saharan Africa through financing investments; strategic design and implementation support for creation of a new multilateral fund focused on lowering drug prices and improving access in specific niches across HIV, tuberculosis, and malaria initiatives; and innovative strategic planning for key departments within a large multilateral technical public health institution.

Gargee Ghosh is a senior program officer at the Bill & Melinda Gates Foundation. She manages the foundation's portfolio of work in innovative financing for development, creating new and effective funding mechanisms to channel resources to health and development. In that capacity, and in her prior role at Gates in the Global Health Program, she has been involved in establishing the International Finance Facility for Immunization of the Global Alliance for Vaccines and Immunization, designing the Advance Market Commitment concept, supporting the pilot of a Global Fund Debt Conversion initiative, and, most recently, launching a double-bottom-line private equity fund for investment in health care for the poor in Africa. Before joining the Bill & Melinda Gates Foundation, Ghosh was a consultant with McKinsey & Company in New York and London working on health care and financial services projects. She was one of the first employees of the Center for Global Development's Global Health Policy Research Network, where she managed a portfolio of work on incentive mechanisms to stimulate product development. Ghosh has graduate degrees in economics from the University of Oxford and in international relations from the Georgetown University School of Foreign Service.

April Harding (chair) is an economist and health-systems specialist who joined the Center for Global Development from the Human Development department in the Latin America and Caribbean region of the World Bank. For the previous eight years, she led the Bank's work related to public policy in the private health sector. Harding also has done extensive research and operational work related to hospital reform and governance of health services in developing and transition countries. Before she shifted her focus to health systems, Harding worked for seven years on private-sector development in transition economies. This work included providing advice and technical assistance to governments in more than 13 countries. Before joining the World Bank, Harding was a research fellow in economic studies at the Brookings Institution. Harding is writing a book on how the most important global health programs (for example, programs related to malaria, tuberculosis, and child health) can be improved by increasing the private-sector contribution to program goals. Harding holds a doctoral degree from the University of Pennsylvania and has published widely on health policy and health systems in developing countries. She is the co-editor of two books, *Private Participation in Health Services* (World Bank 2004) and *Innovations in Health Service Delivery: The Corporatization of Public Hospitals* (World Bank 2003).

Ishrat Z. Husain is an economist working with the U.S. Agency for International Development (USAID) as senior advisor in public health in the Africa Bureau. She is responsible for the Reproductive Health, Human Capacity and Health Systems programs and specializes in multisectoral approaches to HIV/AIDS and health as well as in private-public partnership. She organized the first round table with the private sector on HIV/AIDS for USAID in the late 1990s and has been helping mobilize the private sector for HIV/AIDS and health through highly successful health sessions at the African Growth and Opportunities Act forum organized by the U.S. Department of State. Most recently, she organized the session on Private Investment Opportunities in Health and prepared a paper on business models in health. She was also responsible for helping the USAID missions in Nigeria and East Africa to develop private-public partnerships in health. Before joining USAID, Husain worked at the World Bank, starting in 1970, in technical and managerial capacities, including the management of multi-million-dollar population, health, and poverty operations. She has a doctorate in economics from India and had postdoctoral training at Princeton University.

Barry Kistnasamy is currently the executive director of the National Institute for Occupational Health in South Africa. He has 20 years' experience in public health policy and practice within South Africa and internationally. He spent 10 years as a senior manager in the public health and higher education sectors. He also has insight and knowledge of the nongovernmental and private, for-profit health sectors in South Africa. His experience encompasses strategic and operational planning, providing advice at a political and technical level, and the translation of policy into action. He has

worked with bilateral and multilateral agencies in South Africa and abroad (especially within Africa) and also is part of an extensive national and international health network through the public health academic community. He has an active interest in and is providing support for public-private interactions in the health sector as well as the provision of training in hospital management. He is a specialist in public health medicine and has had further training in health economics (York University–UK), occupational and environmental health (University of Michigan), and health leadership (Cambridge).

Danielle Kuczynski (program coordinator) joined the Center for Global Development in September 2007. Before joining CGD, Kuczynski worked in Tanzania with the University of Toronto’s HIV/AIDS Initiative–Africa as a knowledge network officer. In addition to other overseas experience, her work in the public sector includes a 2006 policy analyst post with the Ontario Ministry of Health Promotion. In 2005, Kuczynski completed an MS in international health policy at the London School of Economics and Political Science, where she wrote her dissertation on perceived barriers to antiretroviral adherence in South Africa. Additionally, she holds a BS with honors in psychology from the University of Western Ontario.

Ruth Levine is a health economist with more than 15 years’ experience working on health and family planning financing issues in East Africa, Latin America, the Middle East, and South Asia. Before joining CGD, Levine designed, supervised, and evaluated health-sector loans at the World Bank and the Inter-American Development Bank. From 1997 to 1999 she served as the adviser on the social sectors in the office of the executive vice president of the Inter-American Development Bank. Levine holds a doctoral degree from Johns Hopkins University, has published on health and family planning topics, and is the author or co-author of several books and reports, most recently *Start with a Girl: A New Agenda for Global Health* (CGD 2009), *Performance Incentives for Global Health: Potential and Pitfalls* (CGD 2009), and *Millions Saved: Proven Successes in Global Health* (CGD 2004), which has been on the required reading list at more than 33 schools and universities in the United States and abroad.

Dominic Montagu is an assistant professor of epidemiology and biostatistics and lead of the Health Systems Initiative at the Global Health Group of the University of California–San Francisco. His work is focused on private delivery of health services in developing countries and on market function for health services and health commodities. He holds master’s degrees in business administration and public health and a doctorate in public health from the University of California–Berkeley. He has worked extensively in Africa and Asia, primarily in Vietnam, where he was the country director for the American Friends Service Committee and country adviser for the Population Council.

Stefan Nachuk has been an associate director with the Rockefeller Foundation since February 2007. In this role, he concentrates on developing an initiative to

transform health systems globally, with specific components focused on strategic capacity building, leveraging the private sector, and developing eHealth platforms. This work centers on supporting a small number of countries, and on setting a global agenda. In addition, Nachuk also participates in a climate change adaptation initiative, with a special focus on developing models of climate resilience in selected cities within Thailand, India, Vietnam, and Indonesia. Before joining Rockefeller, Nachuk lived and worked in Southeast Asia for approximately 14 years, with a broad focus on decentralization, governance, and social development. Nachuk was a senior policy specialist with the World Bank in Indonesia from 2003 through 2006.

Barbara O’Hanlon (facilitator) is a recognized leader in international health policy and implementation with over 24 years’ experience providing policy-related technical assistance in 26 countries spanning Latin America, the Middle East, Africa, and the former Soviet Union. In the last seven years, her work has focused on mobilizing support for partnering with the private health sector. O’Hanlon’s policy expertise focuses on analysis to support policy design and evidence-based decision making, advocacy, and strategic communication to create favorable policy environments for key health issues; participatory and strategic planning to implement health policies at national and regional levels; and legal and regulatory analysis to identify policy constraints to service implementation. O’Hanlon has over nine years’ experience in senior management as a vice president and deputy director for two USAID-funded projects. After 15 years of increasing technical and management responsibility, O’Hanlon formed her own company to provide state-of-the-art technical assistance in health policy and management. O’Hanlon trained at UC–Berkeley in political science and Harvard’s Kennedy School for Public Policy.

Malcolm Pautz is currently with the Infrastructure Project Finance Division of Nedbank Capital in South Africa. Before joining Nedbank, he was a senior project advisor in the Ministry of Finance Public-Private Partnership (PPP) Unit in South Africa and was involved in the development and implementation of many health care PPPs. He was the senior project advisor for the planning and development of the Chris Hani Baragwanath Hospital Revitalization PPP project. Pautz has been asked to provide strategic input and comments by various organizations and parties involved in improving health outcomes in developing countries. Pautz has made a number of presentations to health care insurance providers, hospital management services, and pharmaceutical companies on projects involving public-private partnerships and interactions. Pautz is currently part of a technical advice subcommittee for the Centre for Development and Enterprise (CDE), based in South Africa, for a project titled CDE Project on Health Policy in South Africa and the Role of the Private Sector; he is involved, through his present employer, in the financing and advancement of social infrastructure, both locally in South Africa and throughout Africa. Pautz is also an executive board member for the South African Institution of Civil Engineering and is chairman of their Project Management Division.

Alexander S. Preker is the head of health investment policy and lead economist with the Investment Climate and Investment Generation department of the World Bank Group. Preker coordinated the team that prepared the World Bank's Sector Strategy for Health, Nutrition, and Population in 1997. While seconded to the World Health Organization (WHO) during 1999–2000, he was one of the co-authors of the *World Health Report 2000, Health Systems: Measuring Performance*, and subsequently served as a member of Working Group 3 of the WHO Commission on Macroeconomics and Health in 2001. In collaboration with UNICEF, the International Labor Organization, and several bilateral donors, he recently helped the WHO regional office in Brazzaville prepare a health financing strategy for the Africa Region and was on the recent Global Task Force on Scaling Up Education and Training for Health Workers. Preker has published extensively and is a member of the editorial committee for the World Bank's external operations publication department. He is adjunct associate professor in the Department of Health Policy & Management at Columbia University and the Wagner School of Public Policy at New York University. He is a member of the teaching faculty at UC–Berkeley and on the external advisory board for the London School of Economics Health Group. His training includes a PhD in economics from the London School of Economics and Political Science, a fellowship in medicine from University College London, a diploma in medical law and ethics from King's College London, and an MD from University of British Columbia/McGill.

Julian Schweitzer is the director of the Health, Nutrition, and Population department of the World Bank. Immediately prior to his current appointment, Schweitzer was the director of the human development sector in the South Asia Region of the World Bank. During his career in the Bank, he has also worked in the Middle East and North Africa, Latin America, and the transition economies of Europe, managing operations in health, education, and social protection. He has also worked as the operations director in the Bank's East Asia and Pacific region and as the Bank's country director based in the Russian Federation. While working in the South Asia Region, he focused on developing sector-wide approaches to mobilizing external financing effectively in support of a single-country health strategy. Schweitzer restructured and strengthened the Bank's regional HIV/AIDS engagement with clients and external partners while also strengthening the Bank's advisory and financial role. He has extensive operational and management experience with health and development issues in different parts of the world. His health sector interests include health finance and health-system strengthening. Before joining the Bank, Schweitzer worked in the public and private sectors in the United Kingdom and India. He holds a PhD from the University of London and has authored numerous articles and essays on economic and human development.

Guy Stallworthy is senior program officer of strategic business planning at the Bill & Melinda Gates Foundation. Stallworthy came to the foundation with 25 years' experience in a variety of health and development program roles in the NGO sector. He joined the foundation in January 2007 after working for 11 years in social marketing with Population Services International (PSI); during

this time he spent five years as country director of the Burma/Myanmar program. Stallworthy has dedicated a large part of his career to developing and applying innovative strategies that engage the private sector to deliver high-quality and pro-poor health services in developing countries, especially for HIV/AIDS, malaria, tuberculosis, and family planning. As an executive director for PSI-Europe, Stallworthy directed special projects for UNAIDS and Roll Back Malaria in addition to leading PSI's engagement in the Microbicide Development Program funded by the UK Department for International Development and organization-wide initiatives on sustainability and poverty-focused programming. Stallworthy has professional experience in more than 25 countries in Africa, Asia, and Latin America, including long-term assignments in Bangladesh, Chad, the Dominican Republic, Bolivia, and Burma/Myanmar. Stallworthy holds a master's of health sciences and a master's in international affairs and economics from Johns Hopkins University.

Hope Sukin is the senior health advisor for the Africa Bureau of USAID and leads the Africa Bureau Health Team. She provides strategic and technical guidance to the 25 USAID missions in Africa that manage and implement health programs. Her technical specialties include nutrition, maternal and child health, HIV/AIDS, and health-system strengthening. She also represents USAID as one of the deputy principals to the President's Emergency Plan for AIDS Relief. She has directly provided technical support to countries across Africa including Benin, Ethiopia, Ghana, Guinea, Mali, Malawi, Mozambique, Nigeria, Senegal, Tanzania, Zambia, Zimbabwe, and others. Sukin has an MPH from the University of Michigan and a BA from the University of Pennsylvania. She received the Mike White Memorial Award in 1996 for developing new programs and partnerships to improve health care in Africa.

Jurrien Toonen is a public health specialist focusing on health-system development, institutional development, health reforms, aid effectiveness, service-delivery models, health financing, and monitoring and evaluation. He has 25 years' experience in public health at the interface between policy development and implementation. He is coordinator of the health system group in the Royal Tropical Institute (KIT in Amsterdam). Before this, he held long-term positions in Bolivia (five years) for an NGO at the operational level, and in Mali (four years) supporting the public sector at the intermediate level. For four years, he has been the team leader for KIT's support to a private-sector organization in Bangladesh and vice chair of the task force of the Dutch private medical equipment industry for overseas development assistance. He has experience in health insurance and has participated in various evaluations of private-sector interventions. He is now based in Accra, Ghana.

Gerver Torres works for the Gallup Organization developing a new product, the World Poll. His main focus is in Latin America. He is a director of Leadership and Vision, an NGO established in 1995 to enhance and promote better leadership in Latin America. He has been a consultant for the World Bank, the

Inter-American Development Bank, the Latin American Economic System, and the United Nations on different economic and social issues including private-sector participation in the social sectors. He served as director of the International Monetary Fund representing Spain, Mexico, Central America, and República Bolivariana de Venezuela. He has served as minister of the Venezuelan Investment Fund, professor of economics at the Universidad Central de Venezuela, and editor of *El Diario de Caracas*, a national daily newspaper in Venezuela. He has published several books and many different articles on economic and social topics including, *Un sueño para Venezuela* (2000); *Municipal Privatization* (World Bank 1998); “The Third Wave of Privatization: Privatization of Social Services in Developing Countries,” (World Bank 1996); *¿Quiénes ganan? ¿Quiénes pierden? La privatización en Venezuela* (1994).

Jim Tulloch, of Adelaide University, has worked on developing-country health for more than 30 years in more than 50 countries, including Bangladesh (1975–77) in maternal and child health clinics and later the smallpox eradication program; Papua New Guinea (1981–82) in malaria research; Timor-Leste (2000–01) as head of the health sector in the UN Transitional Administration and manager of a multidonor World Bank–administered health project; and Cambodia (2002–05) as the WHO Country Representative. From 1990 to 1999, he was director of diarrhoeal and acute respiratory disease control and then director of child and adolescent health and development at WHO headquarters and oversaw the development of the WHO/UNICEF strategy for integrated management of childhood illness. Since 2005 he has been the principal health advisor at the Australian Agency for International Development.

Juan Pablo Uribe was the executive director of Fundación Santa Fe de Bogotá in Bogotá, Colombia, while participating in the working group.⁵ He also held the position of corporate manager director at the same organization. His other experience in Colombia includes serving as vice minister of health for the Colombian Ministry of Health from 1998 to 1999, national director of public health at the ministry in 1994, and technical coordinator and head of the health arena for the Fundación Corona–Bogotá, Colombia, from 1995 to 1998 and from 1999 to 2000. Uribe was also an assistant professor of preventive medicine at Pontificia Universidad Javeriana Medical School–Bogotá, Colombia, from 1994 to 2000. Uribe holds a medical degree from Pontificia Universidad Javeriana and master’s degrees in both public health and public administration from the University of Michigan. Uribe is a board member for various organizations, both public and private, and a consultant and expert invited to speak nationally and internationally.

⁵ In June 2009, Uribe began a new position as sector manager for health, nutrition and population at the World Bank.

Annex B: Key Concepts for a Private-Sector Advisory Facility

Each of the working group members brought a different perspective on the private health sector. Given the diverse composition of its members, the working group began its task by defining important concepts to reach a common starting point in designing an effective facility.

Definition of the private sector

As in any deliberation on the role of the private sector in health, the working group members used their common understanding to develop a working definition of the private sector. Initially, the working group members focused on individuals and organizations operating in the health sector and drew on other examples. The IFC's new Health in Africa initiative, for instance, is also concerned with investment opportunities for the private health sector and therefore works with non-health-related entities, including banks and insurance companies. Taking into account this broader scope, the working group expanded its definition to also include these important stakeholders. "Private sector in health" is the term that the working group decided to use to describe this diverse group of stakeholders.

Operational definition of technical assistance

Another key concept was technical assistance. The donors, as well as the consulting groups who contract and provide technical assistance, had different ideas about what technical assistance is. As a group, the members reached a common understanding of this term (see box 7).

Description of the facility's clients

The principal clients will be developing-country governments. But while ministries of health are clear and natural partners, group members agreed that focusing on them would be too limited. In fact, there are cases in which other public-sector agencies, such as ministries of planning and ministries of finance, are equally involved in engaging the private sector in health. Consequently, the client category was expanded to include a wider range of

Box 7. What Is Technical Assistance?

Advisory and consulting services spanning from policy design to implementation; includes strategic thinking, problem solving, and knowledge sharing.

government agencies. Initially, the facility will focus on developing countries where there is a strong interest in working with the private sector and a greater likelihood of impact (box 8).

Additionally, the working group members discussed whether to include other stakeholders. Although the facility's focus will be how to work with the private sector, the working group members decided that the private sector should participate in, but not be the focus of, the facility's activities—for example, the private sector should be involved in public-private dialogue, but not be the “client.”

Box 8. Who Is the Client?

Appropriate government ministries or agencies in countries eligible for assistance are those classified as developing and transition countries by the Development Assistance Committee of the Organisation for Economic Co-operation and Development.

Annex C: Discussion and Design of Key Components for a Global Private Sector Advisory Facility

The working group members identified four core roles for the facility by examining the range of activities that it will perform: (1) knowledge broker, (2) change agent, (3) strategic adviser, and (4) technical and implementation-support adviser (box 9). Group members agreed that one of the distinguishing features of the facility should be the intent to transfer the capacity to conduct these four functions to local and regional organizations. As a result, the functions below consider activities in anticipation of this eventual transfer of capacity and roles.

1. *Neutral knowledge broker.* Meeting participants acknowledged that this could be an enormous task and consume the facility staff. Therefore, they agreed that all knowledge-brokering activities will be limited to the topics and issues related to the technical areas of strategic advice offered to country clients. The activities include the following:
 - Assemble existing information about working with the private sector.
 - Encourage other groups building evidence and research to include the private sector.
 - Include lessons on both successes and failures as part of knowledge building.
 - Expand collection and analysis of basic information about private-sector activities in countries.
 - Develop tools and methodologies that can be used across countries and regions.
 - Develop training approaches that can be integrated into other regional organizations' capacity, thereby building local or regional organizations' capacity to assume strategic advice and technical assistance roles.
 - Integrate the private sector into other training and capacity-building activities.
2. *Change agent.* There was discussion about whether being a change agent is an appropriate role for a facility. However, most agreed that

Box 9. What Are the Functions of the Facility?

Knowledge broker Assemble information, tools, and methodologies, and good and bad practices on strategies governments can use to tap the full potential of public-private partnerships.

Change agent Promote inclusion of the private sector in health by fostering dialogue between the public and private sectors and raising awareness of the facility.

Strategic advice Analyze public-sector strengths and private-sector capacity, framing strategies that will take full advantage of private-sector involvement and recommend actions to better integrate the private sector's contribution.

Technical assistance and Implementation support Provide expertise and build a government's capacity to design sustainable public-private partnerships that improve health outcomes. Work with governments to implement specific policies and regulatory and institutional reforms, and to support the design and start-up of public-private partnerships.

given the deep-seated suspicion and mistrust toward the private sector, the facility will have to play some promotion and advocacy role to raise awareness and foster dialogue between all the relevant stakeholders. Change-agent activities will include the following:

- Advocate for inclusion of the private sector where relevant, by working with both the public and private sectors.
 - Champion and promote the mainstreaming of the private sector, potentially through creation of units or institutions in-country.
 - Raise awareness of the respective roles of the public and private sectors in partnerships for health.
3. *Strategic adviser.* All group members consider strategic advisory and technical support (see below) to be the facility's core functions. Activities will include the following:
- Conduct stakeholder analysis to identify all relevant actors, existing networks, and organizations, and effective mechanisms to bridge the two worlds together.
 - Conduct private-sector assessments to identify opportunities for public-private collaboration toward high-priority sector goals.
 - Make recommendations on types of public-private engagement.
 - Identify key actors and suggest processes to initiate public-private dialogue.

- Design frameworks and systems for public-private interaction.
 - Help the private sector align with public-sector goals.
 - Make matches between types of strategic advisers needed and experts available to correspond to the need.
 - Identify local and regional capacity to assist with strategic advice and implementation support and design strategies—such as partnering with organizations to provide strategic advice or training in key technical areas—to build institutional capacity.
4. *Provider of implementation support and technical assistance.* Working group members agreed on the need to partner with the facility's clients to build the clients' capacity in relevant skill areas required by developing-country governments so they can effectively work with the private sector in health. Additionally, they agreed that facility staff will provide technical assistance as the clients are learning how to implement the recommendations offered in the strategic advice. But all agreed that technical assistance will extend only to a limited point, after which the developing countries can hire consulting firms to either provide assistance or actually implement the recommendation (for example, a country could hire a firm or individual consultants to implement training programs, perhaps at the subnational level). Finally, the facility will need to have clear entrance and exit strategies for its interactions with client governments to prevent being carried too far into the implementation phase of projects.

Annex D: Organizational Structure and Institutional Home

The working group conducted a cost-benefit analysis of different organizational structures. This analysis, building on an organizational framework developed by working group member Daniella Ballou-Aares, presented four types of organizational models used by organizations working in the development field (see box 10 and table 3).

Group members identified several key management and organizational characteristics appropriate for the envisaged facility:

- independent, but housed within an existing organization with the opportunity to spin off to become an independent organization (for example, PROvention, the Alliance for Health Systems, the Council on Health Research for Development, the Global Development Network)
- funded by multiple donors from start-up phase with, ideally, developing-country representatives brought on as board members and potential funders
- offers a combination of “free” strategic advice and technical assistance with some buy-in from developing countries
- requires a light board or governance structure that offers flexibility and the ability to adapt to field demand
- ensures independence to have credibility with developing-country clients and private-sector partners
- looks to create capacity within regional organizations that could eventually, with time and support from the facility, assume the facility’s role

After much discussion, group members converged on Option A: Subsidiary model.

Box 10. Four Options for Organizational Structure

Option A, “Subsidiary model”: Hosted subsidiary within a multilateral organization

Option B, “Partnership model”: Hosted partnership within a multilateral organization

Option C, “Contracting-out model”: Project managed by existing NGO or private entity

Option D, “Stand-alone model”: Newly created independent entity

Table 3. Comparison of Organizational Models

<i>Components</i>	<i>Option A “Subsidiary model”</i>	<i>Option B “Partnership model”</i>
Organization structure	Entity embedded in a multilateral organization	Partnership embedded in a multilateral organization
Governance	Reports to own board; has its own management structure	Secretariat composed of staff from partners; reports to own board and has its own management structure
Administration	Funds its own staff; shares administrative infrastructure with host	Partnership funds its own staff; shares administrative structure with host infrastructure
Funding requirements	Realize cost-sharing in infrastructure and possibly staff; requires donor commitment for shorter time period for implementation	Realizes cost-sharing in infrastructure and possibly staff; requires donor commitment for shorter time period for implementation
Pros and Cons	<p>Pros: Leverages existing capacity and operations of host organization; legitimacy linked to host organization</p> <p>Cons: Assumes organizational culture of host entity; possible inefficiencies linked to large bureaucracy; low to moderate independence depending on host</p>	<p>Pros: Legitimacy linked to members in partnership</p> <p>Cons: Partnerships are difficult to manage; challenging to reconcile different organizations’ expectations; possible inefficiencies linked to large bureaucracy; weak coordination capability</p>
Examples	Private Participation in Infrastructure Advisory Facility (PPIAF), HLSP	Roll Back Malaria, Stop TB, Reproductive Health Supplies Coalition

Source: Adapted from Dalberg “Four Options Can Be Considered for Start-Up and Management of New Initiatives in the Interna

<i>Option C</i> <i>“Contracting-out model”</i>	<i>Option D</i> <i>“Stand-alone model”</i>
Project or contract managed by an existing NGO or private firm	Distinct entity created as an independent not-for-profit or for-profit organization
Project managed by existing NGO or private firm managers; reports to “client”	Reports to its own board; has its own board
Project employs staff and expertise of existing NGO or private firm; shares administrative	Creates new management systems and administrative infrastructure
Requires donor commitment for set time period (5–10 yrs) to fund; donors provide funds in annual allotments	Requires donor commitment to forward fund start-up costs and initial 2–3yrs budget for implementation
<p>Pros: Leverages private entity’s expertise and staff; manage as a contract for services; high independence; more flexibility; potentially lower operational costs</p> <p>Cons: Does not have same influence and access to client as a multilateral organization</p>	<p>Pros: More independence and flexibility; allows for branding</p> <p>Cons: Huge start-up costs; higher operating costs; lag time to start up and staff up; risk of unknown with new entity</p>
USAID contracting PSP-One; Rockefeller contracting Results for Development	International Initiative for Impact Evaluation, AfriStat

ational System” and Evaluation Gap Working Group (2006).

Annex E: Create a New Entity or Build On an Existing One?

Group members were conscious of how crowded and fragmented the existing global health space is. They weighed seriously the need for a new entity against what might be possible with incremental changes to existing sources of technical support (for example, the WHO, the World Bank, various bilateral resource centers). On the basis of the analysis below, the working group decided to explore how the IFC's Health in Africa initiative could be expanded to have a global focus.

Facility's niche

Members were also concerned that the facility's activities should be defined in a way that will avoid overlapping with others working in the space. Hence, they conducted a gap analysis to identify organizations and projects carrying out related technical activities with developing-country governments. The purpose of this analysis was two-fold:

1. demonstrate potential overlap as well as gaps in technical assistance that define the facility niche and focus, and
2. determine the facility's comparative advantage.

Table 4 provides an overview of different activities being carried out by existing projects and organizations, broken down by the key functions proposed for the facility. These organizations range from time-limited entities like USAID's *PSP-One* project, to longer-term initiatives housed in foundations or multilateral organizations, to available support of local and international consulting firms.

Relative to other global health areas (for example, HIV/AIDS, malaria control), there are very few actors operating in this space. There is the USAID-funded project that performs many of the proposed functions of the facility, but only in the subsectors of family planning and HIV/AIDSs. The Rockefeller Foundation has taken a leadership role in fostering global dialogue with donors and the WHO using their sponsored research. And both *PSP-One* and the Rockefeller Foundation implement private-sector-related activities in developing countries: *PSP-One* is in over 36 countries with a focus in Africa; Rockefeller will invest in three to five African and South Asian countries.

There are a few investment actors, such as the Overseas Private Investment Corporation (OPIC) and other Latin American equity firms, offering equity or risk guarantees to private firms or investors working in health.⁶

The IFC's HIA initiative is the most similar in scope to the proposed facility. Realizing this prompted further analysis of how the two entities could best be coordinated or merged.

⁶ OPIC is a U.S. government entity that promotes investment by U.S. companies abroad through the allocation of risk guarantees.

Table 4. Organizations Working on Activities to Strengthen Private Sector Engagement in Health

	<i>Private Sector Program PSP-One^a (for family planning and HIV/AIDS)</i>	<i>Rockefeller Foundation</i>
	First order of the umbrella Private Sector Program (PSP) of USAID, a five-year, time-limited project focused on promoting and expanding private-sector programming	Foundation providing grants and other support in a number of high-priority areas, including harnessing the private sector as an entry point into health-system transformation in developing countries, with a focus on sub-Saharan Africa and South-east Asia
<i>Function</i>		
Knowledge broker	<ul style="list-style-type: none"> • Conducts research • Writes briefs • Holds meetings and workshops • Hosts website 	<ul style="list-style-type: none"> • Sponsors studies • Intends to <ul style="list-style-type: none"> – facilitate South-South learning – provide intermediate funding – track mechanisms
Change agent	<ul style="list-style-type: none"> • Conducts mainstreaming activities to raise awareness and promote working with private sector 	<ul style="list-style-type: none"> • Fosters global dialogue with the WHO, donors, and governments • Creates a network hub
Strategic adviser	<ul style="list-style-type: none"> • Conducts private-sector assessments • Designs strategy (how to) • Fosters dialogue 	<ul style="list-style-type: none"> • Will invest in 3 to 5 places in Africa and South Asia
Provider of implementation support and technical assistance	<ul style="list-style-type: none"> • Learns while doing • Builds capacity • Strengthens dialogue 	

a. The current USAID-funded project has been renamed Strengthening Health Outcomes through Private Sector. The activities listed here are continuing under the new contract.

<i>IFC</i>	<i>OPIC</i>
<p>Applied strategy for improving health care in Africa by engaging the private sector, including financial support, advice on regulations and reforms, and assessment of the financial climate in countries and across the continent</p>	<p>Independent U.S. government agency that mobilizes and facilitates investment of U.S. private capital and skills in the economic and social development of less-developed countries and areas, and countries in transition from nonmarket to market economies</p>
<ul style="list-style-type: none"> • Creates local learning related to strategic advice • Maps private sector • Develops business-environment indicators • Fosters dialogue on policy environment • Produced the “Business of Investing in Health in Africa”; will proceed with follow-on activities <p>In Africa:</p> <ul style="list-style-type: none"> • Provides technical assistance and strategic advice on policy environment • Designs private-assessment strategies • Conducts analysis of business environment • Provides advice to business sector • Offers debt and equity to firms • Provides technical assistance to firms to improve business practices 	<ul style="list-style-type: none"> • Offers equity to firms

PARTNERSHIPS WITH THE PRIVATE SECTOR IN HEALTH

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in Developing Countries

Final Report of the Private Sector Advisory Facility Working Group

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ISBN 978-1-933286-45-7

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