Rapid Response Brief
MARCH 2020

What can research evidence tell us about:

Forming partnerships between Health Management Organisations and public health service providers

Key messages

- We did not find evidence indicating partnerships where public health facilities provided care on behalf of the private providers.
- It is crucial to define the goal of the partnership and operational areas of co-operation.
- Initial discussions for a partnership should include well defined incentives for each of the parties.
- The models for the partnership are dependent on common goals between the parties involved. The models include; operation and management contracts, co-location, contracting out, Alzira model, private-finance initiative, franchising and social impacts bonds.
- Factors for a successful partnership include; co-operation in developing options for working together, communication, working towards a common goal and capacity appraisal in the partnership.
- Challenges to the partnership including information sharing, management capacity, funding insecurity, incompatibility, differing priorities, corruption, mistrust and bureaucracies must be addressed.

Where did this Rapid Response come from?

This document was created in response to a specific question from a policymaker in Uganda in 2020.
It was prepared by the Center for Rapid Evidence Synthesis (ACRES), at the Uganda country node of the Regional East African Community Health (REACH) Policy Initiative.

+ Included:

- **Key findings** from research
- **Considerations about the relevance** of this research for health system decisions in Uganda

✕ Not included:

- Recommendations
- Detailed descriptions

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Summary

Background:

A private partner has built a health facility in a district in Uganda and intends to operate a Health Management Organization model of health care delivery. However, the facility is not enough to provide health care for all their potential clientele at the moment. As such, the private partner contacted the District Health Team and proposed a partnership with the public facilities in the district. It is in this regard that the District Health Team seeking for approaches to forming a successful partnership between the private and public health services providers.

Rapid Response Question: What are the different considerations for co-operation between a Health Management Organization and no-fee-for-service public health facilities to deliver health services to community members?

Findings:

Different motives lead parties into a partnership, and they must be clearly stated from the initiation of the discussions. Understanding the motivation behind the partnership helps shape the discussion and eases formulation of a common goal.

The factors for a successful private-public partnership for health include; co-operation for developing options for collaboration, setting up communication platforms for information sharing, developing and working towards a common goal and capacity appraisal for the management of the partnership from all parties involved. In addition, where possible, the franchised private providers should aggregate to enhance better interaction and engagement of the public sector.

The models for the partnership are dependent on their objectives. The models include; co-location, contracting out, franchising, Alzira, private-finance initiative and social impact bonds. These models can be adjusted and adapted according to context. However, even with the most appropriate model, there exist challenges to the partnership that warrant attention. These challenges include; inadequate information sharing, weaknesses in the management capacity, funding insecurity, mismatched organisational styles, having different priorities, corruption, lack of trust between partners and complicated bureaucracies.

Conclusions:

The model to be used for a private-public partnership highly depends on the common goal to be achieved. Clear communication channels must be established, and the partners must work together throughout the entire process aligning their priorities and identifying challenges.

How this Rapid Response was prepared

After clarifying the question asked, we searched for systematic reviews, local or national evidence from Uganda, and other relevant research. The methods used by the SURE Rapid Response Service to find, select and assess research evidence are described here: www.evipnet.org/sure/rr/methods

Background

A private partner has set up a private hospital in a district in Uganda to provide health services to the community members. The private partner intends to operate a Health Management Organization model of health care delivery to provide health care and financial protection to the residents. However, there is one major limitation to this plan; the private partner has only set up one health care facility at the moment, which is not sufficient to meet the needs of all the potential clientele. To overcome this challenge, the private partner proposes a partnership with the district health team whose tentative terms are to devise a way through which patients from the private partner's health facility will be referred to the public health facilities within the district, and vice-versa. This proposed arrangement, however, has its challenges; first, user fees were abolished in public health facilities, although some charge a fee-for-service in private wings, and as such they cannot prioritise patients from private facilities. Secondly, non-insured patients referred from public to private facility would potentially face financial implications such as transport costs and potential bills for services sought. These challenges led the district health team to explore different ways on how they can best approach the proposal tabled by the development partner to inform the decision they will take.

The rapid response brief, therefore, addresses the question; ***What are the different considerations for co-operation between Health Management Organizations and no-fee-for-service public health facilities to deliver health services to community members?***

Summary of findings

This Rapid Response Brief summarises evidence on motivation for private-public partnerships (PPP) in health services delivery, factors to a successful partnership, and models for the partnership.

The motivation for engagement in the PPP for health service delivery

There are various motives for partnership between the public and private sector. The public sector is often viewed from a socialist angle to provide health services to the citizens. In contrast, the private sector is prejudiced to be capitalist and primarily profit making[1]. Before forming a partnership, there is a need to define the incentives for each of the parties clearly. Based on the motivating factors, shared goals for the partnership can then be set [1]. A fundamental driving factor is the potential benefits that each party could derive from the partnership, for example, technical support, institutional infrastructure and the need for both parties to achieve their core mandates.

Factors for a successful PPP

The public-private sector partnership does not necessarily require co-operation in all aspects of their operations. They can as well share in just some critical areas, for example, information and data sharing, capacity development, cross-referrals, shared technology, and facilities such as laboratories and blood banks [2]. Forming the partnership is a lengthy process encompassing a range of activities

from research, to assessments, writing and presenting reports and frequent communication between the parties involved [1].

1. Co-operate in developing options for collaboration: The private partner should work hand in hand with the public facility in designing feasible options for their collaboration, getting a commitment from the public sector for the various options that arise. Working together enables the private provider to understand public sector policies and procedures[1].
2. Communication: Develop protocols for communication and interaction across sectors to make co-ordination easier and more efficient. The communication should not only be limited to formal structured ways but also informal, unstructured communication. The communication can range from sharing each other's concerns, successes, challenges and any additional information at the management level, to sharing patient information for the betterment of patient care [1, 3].
3. Working towards a common goal: A common goal and mutual understanding is crucial to a successful partnership between the public and private sector in delivering health services. Common goals and objectives eliminate any misconceptions that exist between the partners and create a mutual understanding of what each sector will offer[1, 3].
4. Capacity appraisal: For a successful partnership, there is a need for a prior realistic assessment of the public facilities' capacity to manage the engagement. This process enables the identification of different capacity development needs of public service providers and facilities and future planning for capacity development [2-4].
5. Aggregating private sector: In the event of many relatively small franchised private sector players, it would be more beneficial if they aggregated. Aggregation of franchised private providers facilitates interaction between the private sector and the public sector, which increases the probability of successfully reaching amicable terms of reference for the partnership [1].

Models for PPP for health services

The model chosen for the partnership will depend on the goal to be achieved. These models can be adjusted and adapted according to context. The description of the models depends on the role of either partners in the delivery or financing of services. Suggested models for the private-public partnership for health services provision can broadly be categorised into; infrastructure based models, discrete clinical services models and integrated private-public partnership models [4];

The infrastructure-based models; These are models that focus on infrastructure, financing, nonclinical services and clinical support services [4].

1. **Contracting out;** the public sector delegates a health-related responsibility to a private partner for a fee. Both parties sign a contract which clearly points out the type, quantity, quality and time-frame over which the services will be contracted out. In addition, public healthcare providers may be used to provide care in remote or rural locations on a part-time basis for the private provider [2, 5, 6]. Examples of contracting include; DBFO (design, build, finance, operate), BOO (build, own, operate), BOOT (build, own, operate, transfer), BOLB (buy, own, lease back), BOT (build, own transfer), Design-Build and Design-Build-Transfer [7, 8].
2. **Private-finance initiative (PFI);** in this model, the public facility contracts out different activities to the private partner. The activities that are contracted out include design and construction of facilities and provision non-clinical operations such as hygiene maintenance and provision of stationary [2, 5].

The discrete clinical services models; These models focus on clinical services where the private partner is contracted to deliver discrete clinical services [4].

1. **Operation and management contracts:** A private provider is contracted to run a specialised service on behalf of the public provider [4].
2. **Co-location;** this is a partnership whereby part of the public facility's premises is allocated to the private provider. The premises can be allocated for an incentive to the public health service provider, for example, payment and infrastructural management. Such an arrangement favours patients at the public facility who might need and can afford private care services, but as well a revenue generation opportunity for the facility [2].
3. **Social Impact bonds;** the private sector provides an upfront capital investment and implements a service of activity agreed upon with the public sector. If the private sector achieves the set outcomes and outputs of the service, the public sector refunds the capital investment of the private sector with interests [9, 10].
4. **Franchising:** In this model, the public authority contracts out a private provider to manage an already existing health facility. The public authority maintains a supervisory function over the operations of the contracted private provider [7].

Integrated Private-Public-Partnership model; This model incorporates infrastructure, financing, clinical services, clinical support services and nonclinical services[4].

1. **Alzira model;** this involves a contractual arrangement between public and a private partner focusing on the construction of facilities and provision of both non-clinical and clinical services including primary care provision for a defined population in return for payment. Medical providers are paid a set fee per patient regardless of the treatment provided to the patient [2, 7].

Potential Challenges of PPP for health services delivery

1. Lack of information sharing: This has effects both at the managerial and patient level of the engagement. At the managerial level, the lack of information sharing creates mistrust between the two parties, while at the patient level, it affects effective patient management and follow up [3].
2. Management Capacity: Weaknesses in a management capacity on either end of the partnership can lead to a failure of executing and fulfilling the expected roles from either partner [11].
3. Funding: Funding insecurity which stems from the failure to raise or pool funds and purchase services could lead to a breakdown of health service delivery from either the public or private sector provider [3].
4. Incompatibility: Mismatched organisational styles which are especially applicable in settings where a private provider follows a fee-for-service model of health services delivery while a public provider offers a no-fee-for-service health service delivery model. There is a need for prior planning and agreement on how the two models could be merged to provide health services to the community efficiently[1].
5. Different priorities: It is expected that most private health care service providers are profit-making while public providers are not. Naturally, the difference in priorities can complicate engagement between private and public health service providers [3].
6. Corruption: This impedes successful engagement between the private and public sectors, especially where a lot of funds are lost during the partnership [3].

7. Trust: Lack of trust between the partners involved can offset the relationship. Pre-conceived ideas that the public sector is "socially minded" whereas the private sector is "commercially minded" could hinder their collaboration[1].
8. Bureaucracies: Co-ordination across sectors may be slow and inefficient due to multiple bureaucracies interacting[1].

Conclusion

The motivation behind the partnership has to be spelt out by both parties at the start to ensure priorities are well aligned. It is crucial to co-operate in the development of the partnership, identifying challenges and developing communication channels, both formal and informal, as measures to ensure a successful collaboration between the private and public sectors. The model followed in the partnership is highly dependent on the common goal to be achieved.

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What is a Rapid Response?

Rapid Responses address the needs of policymakers and managers for research evidence that has been appraised and contextualised in a matter of hours or days, if it is going to be of value to them. The Responses address questions about arrangements for organising, financing and governing health systems, and strategies for implementing changes.

What is ACRES?

ACRES – The Center for Rapid Evidence Synthesis (ACRES) is a center of excellence at Makerere University- in delivering timely evidence, building capacity and improving the understanding the effective, efficient and sustainable use of the rapid evidence syntheses for policy making in Africa. ACRES builds on and supports the Evidence-Informed Policy Network **(EVIPNet) in** Africa and the Regional East African Community Health **(REACH)** Policy Initiative (see back page). ACRES is funded by the Hewlett and Flora foundation. http://bit.do/eNQG6

ACRES' collaborators:

Regional East African Community Health Policy Initiative

EVIPnet

Glossary

of terms used in this report:

www.evipnet.org/sure/rr/glossary

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Conflicts of interest
None known.

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