Sustaining the Public Private Mix Model in the Private Health Sector in Ethiopia

Private Health Sector Project

The Private Health Sector in Ethiopia

The private sector is an important source of health care for people across geographies and income levels. In 2011, the World Bank noted that 52 percent of those in the bottom income quintile receive their care from the private sector, including both urban and rural populations (World Bank, 2011). In most countries, the public sector does not have sufficient resources or capacity to meet the health needs of all its citizens alone. Thus, providing universal access to high-quality health care requires that the public and private sectors work together to deliver health services and products to all population segments.

Cognizant of this and in order to meet the health care needs of the population, Ethiopia's draft Health Policy (FMOH, Health Policy, February 2017) calls for broader participation of the private sector and strengthening of public-private partnership. Over the last twenty five years, the private health sector in Ethiopia has grown exponentially.

The private sector is large and diverse, consisting of non-profit and for-profit formal and informal providers offering different levels of services. In 2016, there were more than 12,400 total health facilities and drug outlets/ pharmacies (FMOH, Health and Health Related Indicators 2016/17). The private sector is contributing significantly to building Ethiopia's health system in the areas of: health service delivery; training of the health workforce; manufacturing, importation, and distribution of medicines, supplies and equipment; and health care financing. Private health facilities are often reported as being better staffed and equipped, cleaner, and having significantly shorter waiting times than public facilities (PHSP|USAID, 2016).

As Ethiopia's economy grows and people acquire more financial resources, an increasing number of Ethiopians are seeking care at private facilities. While this growth can alleviate pressure on the public health system, there are a number of barriers in the enabling environment that are preventing the private sector from contributing to public health goals at its full capacity. A challenge for both the public and private sectors is that the private health sector is fragmented and does not have a representative body with the capacity to engage in policy, regulatory and partnership dialogues. Although the private health facilities are known to significantly contribute to the health coverage of particularly urban residents, their contribution in to the national goals and targets for communicable and non-communicable is not well known and acknowledged. The licensing and re-licensing requirements for health professionals and health facilities are similar for public and private health facilities; however, the regulatory agency is more strictly enforcing these requirements in private health facilities. Investment in the health sector other than pharmaceutical manufacturing is not a government priority. As a result, private facilities struggle to get loans from banks to initiate or expand existing health facilities. These challenges and others have required the continued support of USAID and its implementing partners.

The Evolution of USAID Support of the Private Health Sector

Since 2006, USAID has funded three rounds of projects to strengthen the private health sector's ability to contribute to the Ethiopian health system. These projects have focused on delivery of health care services for the prevention and treatment of diseases of public health importance. Project implementation can be divided into three phases:

- **Pilot phase (2006-2009):** Piloted the Public-Private Mix (PPM) model for TB/HIV in twenty facilities in two regions and demonstrated the potential of private health facilities. The PPM model seeks to leverage the capacity of the public and private sectors to increase collaboration and improve efficiency in the delivery of essential health services.
- **Scale up phase (2009-2015):** Expanded implementation of PPM TB/HIV in more than 350 facilities in seven regions of Ethiopia with the gradual integration of services for: comprehensive HIV (ART, PMTCT), family planning, sexually transmitted infections, and malaria. Actively supported the creation of an enabling policy environment for the private sector by working on issues such as regulation, public-private partnership, and financing.
- **Transition phase (2015-2020):** The current project expands the geographic scope of support to private health facilities to ten regions and added reproductive, maternal, newborn and child health (RMNCH) services. In addition to increasing the number of supported facilities to 900, the project emphasizes building the capacity of the private health sector associations, and strengthening government institutions for improved stewardship and sustainable support of the private sector.

Some of the achievements of the project in the past decade include:

- **Health service delivery:**
  - Introduced the public-private mix (PPM) model to engage private health facilities to provide quality assured and affordable services in TB, HIV/AIDS, STI, FP, and RMNCH in partnership with the public sector. This has included linking private health facilities with the Pharmaceuticals Fund and Supply Agency (PFSA) to create a stable supply of essential drugs and commodities. Thus far, the project has supported less than 2% of private clinics to provide clinical services in these priority health areas using the PPM implementation model.
  - Despite the small number of private health facilities participating (less than 2%) in PPM for TB prevention and care, these facilities contributed more than 10% of the national annual TB case notification. Moreover, the PPM-TB facilities on average identified and reported more than 60 patients with TB annually, which is more than two times the average number of TB cases reported by public health facilities.
  - Between October 2009 and September 2016 , project supported facilities have tested more than 1.5 million people for HIV and have identified a significantly higher proportion of people living with HIV than public health facilities. This may suggest that individuals at high risk for HIV prefer to be tested at private health facilities.
  - The private facilities participating in provision of TB, HIV, and malaria diagnostic services have been receiving regular External Quality Assessment (EQA) for sputum AFS, HIV testing and malaria parasite microscope. EQA reports by the regional labs prove that the quality of TB, HIV and malaria diagnostic services meet the national quality standards for these tests.
  - A national assessment found that that there is a substantial untapped capacity in the private sector to provide RMNCH services. The project is currently working to expand the PPM model to RMNCH services in private health facilities.
- **Health systems strengthening**
  - The private health sector projects have advocated for institutionalizing public-private partnership (PPP) and successfully established a case team and technical working group under the Directorate for Resource Mobilization and Partnership of FMOH. The projects have spearheaded the development and publication of a strategic framework and an implementation guideline for PPPs in health. The government has identified advanced tertiary health care, development of Human Resources for Health (HRH), pharmaceutical manufacturing, and PPM for diseases of public health

importance as the four priority thematic areas to partner with the private health sector. The projects have also seconded staff to help the FMOH translate the PPP guidelines into action.

- The projects have actively supported FMHACA to develop a comprehensive set of health facilities standards for both public and private health facilities. The current project continues to support the regulatory authority in implementing these standards, and to build the capacity of inspectors to use technology in their assessments and determine inspection outcomes.

- **Strengthening the private health sector**
  - The projects have supported regional facility owners and providers to organize and form Facility Associations to give the private sector a platform for organization and a voice for contributing to key policy discussions. Seven regional Private Health Facility Associations (PHFA) and a National Association were created. These associations are still in their infancy, but are embraced by the government and have begun discussing some of the challenges faced by their members, like the health facility standards, with government stakeholders. The current project is providing technical and financial support to the associations to strengthen their capacity to support private health facilities in a sustainable fashion.
  - Access to financial resources has been major barrier for the private health sector to grow and meet the new health facility standards for infrastructure, equipment, and the number and mix of professionals set by FMHACA. Using the USAID Development Credit Authority (DCA) scheme, the projects have supported more than eighty facilities to access loans from banks to expand and upgrade their health services over the past four years . In order to increase lending to the private health sector, the projects have demonstrated the bankability of the health industry to banks, and built the capacity of bankers to evaluate loan applications from health facilities.

The Public and Private Sectors Are Not Yet Ready to Sustain the PPM Model of Health Care

- The partnership model for health service delivery in Ethiopia is designed so that the FMOH and its federal agencies shall provide overall leadership to the implementation of the partnership through the provision of policy guidance, implementation guidelines, and setting and implementing regulatory standards for licensing health facilities and professionals. To date, the FMOH has a written guideline for implementation of PPM-TB, but the implementation guidelines for other disease programs in private health facilities have not yet been developed. The absence of implementation guidelines impedes the start-up of PPM programs for comprehensive HIV/AIDS, Family Planning, STI and MNCH through private health facilities.
- The partnership model for health delivery expects the RHBs to fully integrate the private clinics participating in the partnership into their annual implementation and monitoring plans. They have to provide them regular supportive supervision, ensure uninterrupted supply of medicines and reagents, provide external quality assurances services, and scale-up involvement of more private health facilities in the service delivery. Although the RHBs are willing to include private providers in delivery of priority public health services, the regions do not have enough manpower and resources to provide the required level of support to the private providers.
- Through the three phases of USAID's private health sector projects, the following major tasks to grow and sustain the private health sector's contributions to health service delivery have been undertaken by the projects: health facility assessment and selection, training of health professionals, provision of registers, facilitating signing of MOU, linking to PFSA or another designated institution to access pharmaceutical supplies, monitoring performance, ensuring regular submission of performance reports to district health offices, ensuring quality through regular supportive supervision, clinical mentoring, laboratory EQA, and conducting program review workshops.

- The project has been vigilantly monitoring private health facilities to build the confidence of government authorities in the private sector's capacity to deliver high quality clinical services. Unlike the PPM TB program, the provision of HIV/AIDS, malaria, FP, and STI services is not supported by an FMOH endorsed implementation guideline. Moreover, the PFSA has not yet integrated private health facilities into the SOP for the national (Integrated Pharmaceutical Logistics System) IPLS, putting private facilities at persistent risk of interruption of supplies for the delivery of priority health services. Although there is an encouraging level of commitment at FMOH and RHBs on the PPM model, except for TB, the private facilities are not yet accounted for in the overall planning, implementation, and monitoring of the programs at the national and regional levels. A number of foundational policies required for the successful implementation of the PPM model across these other health areas are yet to be put in place at the FMOH and RHB levels.
- Given the status of the policies and public sector engagement mentioned above, the RHBs are not ready to assume full support and stewardship of the PPM model for engaging private health facilities. A rapid assessment was conducted a couple of years ago to assess the readiness of the RHBs to support private health facilities that participate in the PPM model of service delivery. This assessment showed that none of the RHBs had the attitudinal readiness or organizational capacity to support the private health facilities (PHSP|USAID, 2014). In addition, the National TB Program (NTP), has started allocating and disbursing a limited amount of funds from the Global Fund to scale up PPM-TB in the regions; however, the progress of enrolling private facilities to deliver TB services is not yet satisfactory due to the RHBs insufficient human resource capacity.
- Further, the PPM model was adopted from the WHO recommended PPM for TB prevention and care and social franchising models for increasing access to reproductive health services. These models recommend the participation of intermediary agents to facilitate partnership between the government system and the private health sector. It is recommended that the government play principally a stewardship role because the activities and level of vigilance required to successfully engage private health facilities are too demanding for the overburdened public health system. Currently, the FMOH and the RHB do not have the capacity to take on the support activities currently undertaken by the project, nor is it likely to make sense for the public sector to expend its scarce resources to support the private health facilities in this way in the future.
- At this moment, there no indigenous private organization ready to accept the transfer of and sustain support to the private health facilities. Currently, the private health facility associations, which are receiving technical and financial support from the project, are still new organizations and do not yet have the confidence of the FMOH and RHBs. They are being supported to participate in program implementation and policy advocacy. The project needs to continue to build their organizational, financial and technical capacity to implement key activities on behalf of their members and to win the trust of the RHBs before private health facility support is transitioned to them.

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