



# Private Provider Networks: Bringing Order to Chaos

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### The "Chaos" of the Private Sector

- Independent, isolated providers
- Minimal regulation or oversight
- Provider associations, which by scope of practice advocate and train, have no authority over members
- Difficult to distinguish unlicensed providers from licensed providers
- Less access to technical updates, subsidized inputs or training in prevention strategies
- BUT: serving large segments of the population at all income levels



# Reasons for Creating Private Provider Networks

- Improving quality among private providers (training for skills, adding new services, improving business practices, etc.)
- **Diffusing innovations** (adding new products and services not widely used in private sector)
- Increasing access to specific products or services (expanding product or service delivery points)
- Improving market efficiency (shifting consumers to private sector, reducing unneeded subsidy, freeing public sector resources)
- Providing a new channel for health communications



# "Creating" Networks

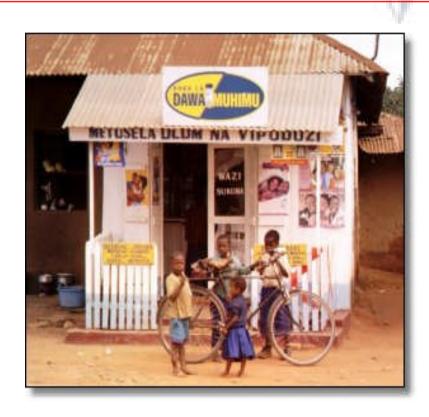
- Linking "spokes" to a "hub"
- Creating a network identity through a package of services
- Ensuring provider commitments
- Balancing the relationship
- Sustaining the "hub" function
  - Covering costs
  - Strengthening existing organizations
  - "BOOT" strategies



# Adding Value to the Private Providers

#### Hub functions:

- Pooled procurement
- Product supply
- Brand creation and promotion
- Training
- Quality monitoring
- Accreditation
- Advocacy
- Management support
- Financing





## Provider Contributions to the Network



#### Provider commitments:

- Paying fees for brand promotion, training, management
- Adherence to quality standards
- Reporting data
- Adherence to branding and management standards
- Offering preventive care services



# Balancing the Provider Network Relationship

#### **NETWORK BENEFITS**

- •reputation and brand
- •market penetration
- discounted supplies
- •training and technical assistance
- •grant funds and subsidies
- •access to credit
- •information management system
- •advocacy and fundraising



#### MEMBER OBLIGATIONS

- •adhere to quality standards
- •offer fixed services and prices
- •target a specific client group
- •pay fees or royalties to parent
- •participate in training
- •meet reporting requirements
- •participate in studies



#### **NETWORK VIABILITY**

- overall policy environment
- mission and vision
- institutional & business planning capacity
- sources of financing
- revenue and expenses
- quality assurance systems
- marketing strategies



# Entry Points to the Private Sector

- Training programs
- Provider associations
- Insurance/ health finance affiliation
- Franchise schemes



# **Training Programs**

- Focus on increasing knowledge and skills
- Branded or unbranded
- May involve provision of related products
- Obligations are minimal and loose
- Minimal commercial potential
- Short term period of engagement
- Lead organization typically a project or NGO
- Limited influence over providers



## **Provider Associations**

- Easy to find
- Limited resources
- Focus on training, advocacy
- Usually under resourced and dependent on membership fees
- Limited to a single scope of practice
- Institutionally and financially more sustainable than an NGO training program



# Insurance/Health Financing Schemes

- Quality monitoring/accreditation and fee payment mechanisms are built in
- Preventive care incentives may be built in
- Frequent contact between network "hub" and the spokes
- Limited opportunities given lack of health financing involving private providers



### Franchises

- Influence over providers is stronger because of formal agreements
- Franchise consider management systems
- Typically social franchises require more subsidy, so reach may be more limited
- Franchise brands may have more perceived value for providers



# Comparing the Network Models

