Malawi Private Sector Assessment

-Overview of the PSA
-Findings and Recommendations

Ilana Ron Levey and Dr. Nelson Gitonga

12 October 2011

SHOPS is funded by the U.S. Agency for International Development.
Abt Associates leads the project in collaboration with
Banyan Global
Jhpiego
Marie Stopes International
Monitor Group
O'Hanlon Health Consulting

Overview of the PSA and the Private Health Sector in Malawi

Overview of SHOPS Project

- **SHOPS**: **Strengthening Health Outcomes *through* the Private Sector**
- USAID-funded global health project awarded September 30, 2009
- Led by Abt Associates with five partners: Banyan Global, Jhpiego, Marie Stopes International, Monitor Group, O'Hanlon Health Consulting
- ***Purpose:*** Increase the role of the private sector in the sustainable provision and use of quality FP/RH, HIV/AIDS, child health & other health information, products, and services
- Focuses on strengthening a broad array of non-public actors including FBO, NGO, and private for-profit or commercial actors

Purpose: Private Health Sector Assessment

- **Overall**: Identify opportunities to strengthen and leverage the private health sector to fulfill MoH and USAID/Malawi national health objectives

- **Specific topics covered during the assessment**:
  - Policy environment for enabling the leveraging of the private health sector
  - NGO sustainability with an emphasis on CHAM
  - Service delivery in the private health sector
  - Health financing mechanisms to maximize the potential of the private health sector
  - Access to finance and credit for private providers
  - Potential to expand the commercial health sector in Malawi

Why Strengthen the Private Health Sector?

- Promote sustainability as donor resources decrease
- Build synergy and coordination between the public and private sectors to promote better health outcomes
- Not an effort to divert funding from the public sector

Key Concept: Public-Private Partnership

- Elements of successful PPP in health
  - Work together to achieve common objective (public health good)
  - Share risks and rewards
  - Aim to leverage comparative advantage and use effectively each partner's resources
  - Strengthen the ***entire*** health system

Assessment Methodology

- Conducted desk research and review (April-May 2011)
- Field work (May 23- June 3, 2011)
- Excellent participation and interest from interview respondents- THANK YOU!
- Opportunity to consolidate information about the private health sector in one document and merge both primary and secondary data

Stakeholders Interviewed

- Over 70 interviews with key stakeholders including:
  - **GoM** (Directorates of Planning, HTSS, Clinical Services, Preventative Services SWAP, FP/RH, and CMS)
  - All levels of **CHAM** (Secretariat, Proprietors, Training Institutions, Facilities)
  - Regulatory Bodies
  - NGOs
  - Donors including GIZ, JICA ,and UNICEF
  - USAID-funded partners
  - Commercial health providers
  - Commercial banks
  - Supply chain actors
  - Professional associations
  - Insurance and microfinance industry representatives

Opportune Moment to Conduct and Discuss the PSA

- **GoM HSSP:** "While acknowledging that the MoH is the major provider of health services, there are also other partners that are playing an important role in the provision of services, especially the private sector. …Currently, there are no structures, policy and guidelines to provide a framework under which the private sector can work with the public sector"
- **GHI Principle:** Leverage private sector engagement; "promote greater private sector involvement in improving health outcomes for Malawi" to focus on improving quality of care
- Interest in Leveraging the Private Health Sector from Key Donors including USAID and GIZ

Purpose of this Workshop

- **Consultation** not **Dissemination** workshop
- Use the findings of the PSA to spark public-private engagement and dialogue
- Determine country priorities for strengthening public-private cooperation
- Discuss concrete actions for strengthening the role of the private health sector in the overall health system
- Produce a roadmap to continue public-private interaction and engagement

Ground Rules

- Be active participants
- All opinions are valued, but please be respectful
- We only have one day together, so stay focused
- Pay attention to break times and please return to the workshop on time
- We hope that the workshop will be interesting, spirited, actionable, honest, thought-provoking and a new opportunity to engage in public-private dialogue

Products from the PSA

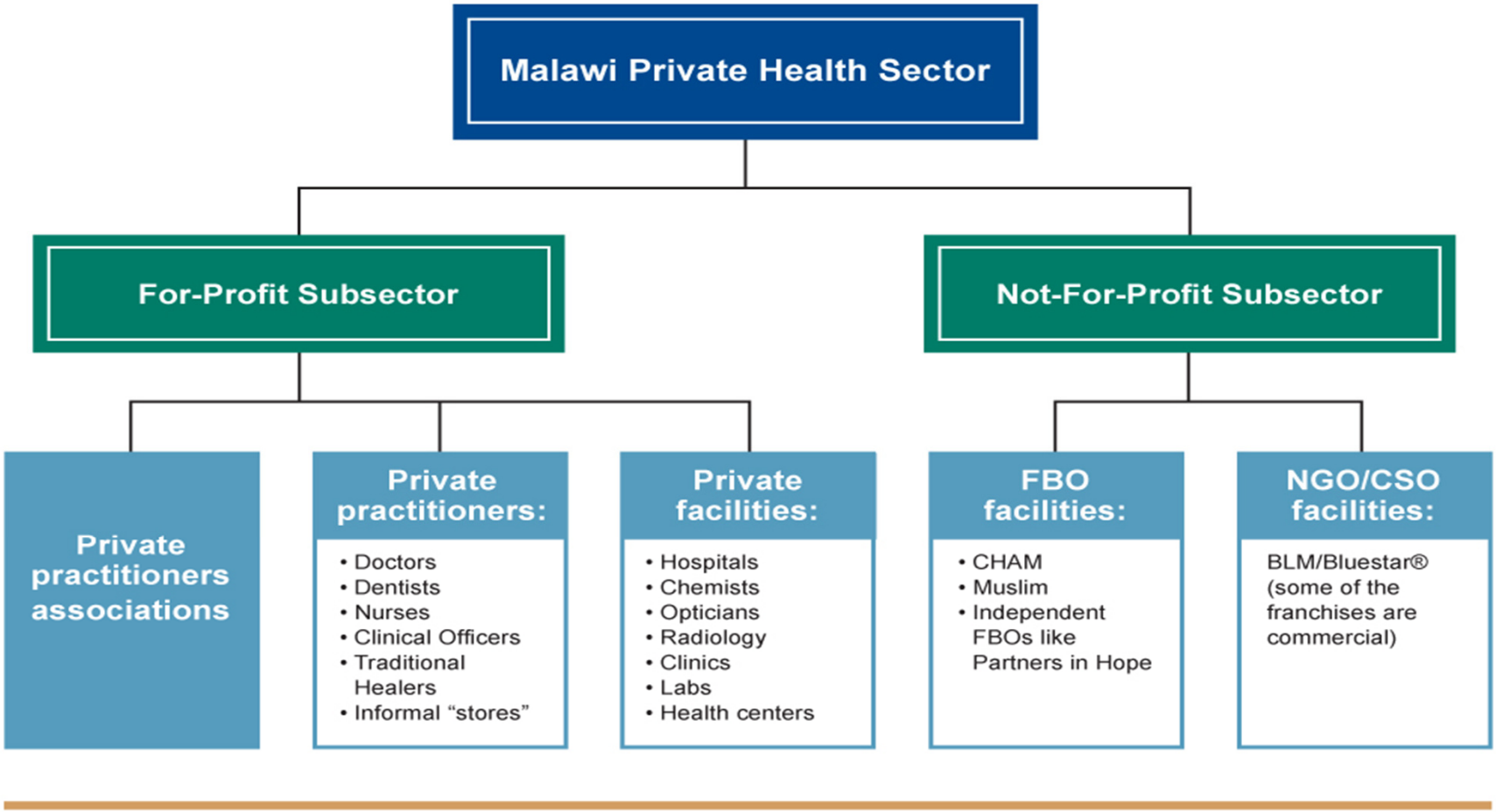
- You have all received today a summary document of the key PSA findings and recommendations

- Full report- including results of deliberations today- will be posted on **www.shopsproject.org**

Who is the Private Health Sector in Malawi?

Overview of the Private Health Sector

Figure 1: Private Health Sector Actors in Malawi



Source: USAID SHOPS Project led by Abt Associates (2011)

Service Provision in the Private Sector: CHAM

- Approximately 37% percent of services delivered by CHAM, particularly in rural and hard-to-staff areas of Malawi
- CHAM is largest non-profit in Malawi and provides services to about 4 million Malawians annually
- Employs approximately 7000 people, owns and manages 172 facilities including 20 major hospitals, 30 community hospitals, 10 training institutions, and 112 health centers
- Runs the majority of training institutions for healthcare workers in the country

Service Provision in the Private Sector: Other NGOs

- 3% of service provision in the country includes other, non-CHAM NGOs **AND** commercial providers
- BLM: operating in Malawi since 1987 and runs 31 static clinics and 364 community outreach sites
- FPAM: 4 clinics and approximately 70 staff
- Interesting, hybrid models:
  - Partners in Hope- Christian FBO with both private for-profit and public elements
  - Lighthouse Trust- public trust linked with Kamuzu Central Hospital; MOH Center of Excellence for HIV care but also receives donor funding like a NGO

Service Provision in the Private Sector: Commercial Providers

- Less than 3 percent of health care in the country
- Includes private hospitals, health centers, clinics, chemists, individual private practitioners, private laboratories, and drug “shops”
- Several professional associations but most service both public and private sector practitioners and are not specifically for the private sector; however, **National Paramedical Practitioners of Malawi** serves exclusively private paramedical practitioners including nurses and clinical officers

Size of the Private Health Sector

Health Professional Cadre	# of professionals licensed for private practice
Doctors (GP)	29
Doctors (Specialists)	22
Clinical Officers	51
Medical Assistants	97
Physiotherapists, Optometrists, etc.	12
Dentists	12
Lab Technicians	2
Pharmacists	80
Nurses	1464 (CHAM), 436 (PFP)
Health Facility Type	**# of facilities licensed for private practice**
Hospitals	17
Health Centre/Clinics	163
Laboratories	2
Pharmacies	80
Drug "Stores"	220
Others (Opticians, dentists, etc.)	46
Private Facility Ownership	
Owner	**# of facilities owned**
CHAM	172
BLM	55
Private for-profit and company facilities	127
Other NGO (e.g., Partners in Hope)	Approximately 10

Private Sector is a Growing Source of MCH and HIV Services

- 2004 MDHS: 58.7% of caregivers sought treatment for illnesses in a child under five from the private sector, compared to 41.3% from the public sector

- Growing number of private facilities providing ART: as of 2010, 59 private facilities were providing ART, treating 3.9% of total ART patients in Malawi

Cross-Cutting Themes from the PSA

Overall Themes

Opportune time to leverage and strengthen the private health sector because:

- Donor landscape is changing; possible withdrawal of funds from key donors affects service provision and raises interest in private health contributions
- Utilization of the private for-profit sector and NGO sector is growing
- Precedent since 2004 in utilizing contracting arrangements to leverage the private health sector (SLAs with CHAM)
- Can leverage existing USAID/Malawi investments in the private health sector including social marketing and piloting of SBM-R in CHAM
- Commercial bank interest in lending to the private health sector
- MoH openness to working with SHOPS and strengthening the private health sector; private sector champions identified

Overall Challenges

- Private commercial sector and NGOs are fragmented and weakly organized; private provider associations must be strengthened
- Knowledge about service provision, quality, registration, and location of the private commercial sector is limited; mapping is key
- CHAM is vital to service delivery but SLAs are contentious
- High levels of poverty erode demand for commercial health services
- Policy platform to guide public-private cooperation and contracting needs to be revitalized and strengthened

Policy & Regulatory Framework: Findings & Recommendations

Policy & Regulatory Framework Structure

1. Malawi Growth & Development Strategy (MDGS)

2. Malawi National Health Policy (in process)
   - Program of Work/Health Sector Strategic Plan (POW II/HSSP)

3. Program specific policies and strategies (e.g. RH, MCH, HIV/AIDS)

Policy & Regulatory Framework: Key Findings

- There is a good overall policy framework guiding the health sector:
  - Overall social development policy (MGDS), including health
  - The importance and role of the private sector is recognized
- There is no specific PPP policy and guidelines in the health sector
- There is a PPP TWG but does not meet regularly and private commercial sector representation is limited
- Incomplete representation of private sector in policy processes (formulation, dissemination and feedback)
  - CHAM sits on key TWGs and is a SWAP signatory but does not effectively engage in policy level development
  - Minimal commercial sector or NGO representation in policy fora

Policy & Regulatory Framework: Key Findings

- Regulatory boards in health (MCM, PMPB, NC) have large mandates but limited capacity to carry out mandate
  - Regulatory bodies extend to the private sector but a number of private actors, mainly in the informal sector, are poorly regulated
  - Regulatory boards face major financial and HR constraints
  - Re-licensing system is weak
  - Planned merger of the boards has created apprehension and uncertainty
  - Review of various outdated health laws has been slow
- Quality standards have been mainly infrastructural (health inputs) but moving to introduce process and outcome quality standards
  - Various MOH directorates also produce treatments guidelines and standards requiring harmonization with board standards
  - Some outdated Health Acts hinder enforcement of standards (e.g., small fines for breach of the law or standards)

Business Environment: Key Findings

- Barriers to entry for private practice
  - High # of public service years required to become licensed private practitioner
  - Private nurses and pharmacy tech have a limited scope of practice in the context of HR shortages
  - High capital requirements to meet infrastructural standards
- Strong, historic socio-political culture of ‘free’ provision of health care and suspicion of charging fees for health care
- Enabling environment for private sector role slowly emerging
  - Planned merger of regulatory boards and existing clear guidelines on dual practice
  - Mainstreaming the private sector and facilitating mutually beneficial “quick wins” for both the public and private sectors is necessary

Recommendation 1

Promote broad based public/private dialogue through a structured consultative process

- Support public-private dialogue process through a consultative, structured process to
  - Dispel myths and stereotypes and build trust and understanding
  - Foster a whole market approach in heath sector planning and service delivery through a consultative process.
  - Agree on public-private engagement process

- Public-private actors will work together through dialogue process to reach consensus on:
  - Strategy to reform and harmonize the regulatory framework
  - How to better involve diverse actors in health in policy/planning processes

Recommendation 2

Strengthen the policy and regulatory framework to support a greater private sector role in public health

- Develop a PPP policy in health including necessary guidelines and legal reforms to support policy objectives
- Strengthen and rationalize the regulatory framework to facilitate private health sector role and improve quality of *all* services – public and private alike
  - Review, harmonize and update the legal/ regulatory framework as per the road map of reforms
  - Build capacity of the regulatory boards (or new unified regulatory authority) to promote and enforce licensing, accreditation and quality standards across the health sector
  - Involve private sector associations in enforcing standards and quality among their members

Recommendation 3

Build MOH Capacity and Systems to Engage the Private Sector

- Strengthen the SWAp Secretariat and specifically the PPP TWG to carry out its mandate of promoting and overseeing PPPs in health. This may include:
  - Defining its mandate, assigning roles and responsibilities,
  - Funding the PPP TWG.
  - Ensuring CHAM, private for-profit and other non-state actors are involved and play their roles effectively in the PPP TWG.
-
- Assist the MOH to establish and operationalize a PPP Unit
  - Terms of references for the unit that maps out the purpose, mission and objectives, guiding principles, core functions, organization and structure, and operating budget.
  - Training of the PPP unit including study tours to other African countries with a PPP unit

Recommendation 3 continued

Build MOH capacity and system to engage the private sector

- Strengthen MOH contracting capacity through SLAs using relevant African experiences (e.g. South Africa, Tanzania). Tasks include:
  - Developing systems to procure and award contracts
  - Developing model service agreement contracts
  - Agreeing on transparent costing methodologies
  - Designing processes to track and assess impact/value of contracts
- Streamline and scale up existing PPPs as agreed between public and private sectors

Recommendation 4

Strengthen Private Sector Capacity to Dialogue and Partner with the Public Sector

- Facilitate stronger organization of the private health sector to more effectively engage the government
- Strengthen existing professional associations representing practitioners and facilities in the commercial sector
- Build the organizational capacity of CHAM to better execute its mandate and play a key role in partnering with the MOH
- Support creation of an alliance of all non-state actors in health to have a fairly unified voice, better engage the MOH, and leverage their potential and bargaining power

Strengthening the Sustainability of CHAM

CHAM Sustainability Findings

- CHAM is a crucial health service delivery provider in Malawi (37% of services)
- CHAM is financially dependent on MOH (77 SLAs, staff salaries, access to free commodities & gov't scholarships)
- MOH is dependent on CHAM for its rural presence and pre-service education; major service delivery provider in rural areas
- Mutually dependent but tension in relationship currently
- CHAM and MOH are both multi-layered, decentralized organizations with major decisions at the district level
- CHAM is an umbrella organization with some facilities receiving more Church support than others
- CHAM Secretariat has gone through a major re-organization and currently has 12 vacancies

CHAM Sustainability Findings 2

- SLAs are contentious, but are a critical life-saving service delivery channel
  - Legitimate concerns from both parties about costs of SLAs
  - SLAs scaled up without full understanding of costs
  - New MOU under discussion, but MOH wants capitation structure and CHAM does not
- CHAM has limited contracts negotiation capacity, yet enters into both buying and selling contracts regularly
- CHAM Secretariat has a core funding issue, which limits the ability of the Secretariat to address weaknesses and perform many of its duties
- Contradictory perceptions of CHAM clinical quality

Strengthening the Sustainability of CHAM

- **Important as CHAM is the largest private sector actor**
- MOH-CHAM relationship serves as a model for how the MOH interacts with other private sector actors
- **Recommendation**: Focus on both CHAM facility-level sustainability and Secretariat's management capacity
- Roll-out business and management training to CHAM facilities and proprietors
- Structure and launch an independent Drug Supply Organization
- Improve HMIS and Monitoring and Evaluation to better understand quality of CHAM services
- Leadership & management training for performance culture (minimum standards for financial management, values-based management)

Recommendations to Strengthen CHAM

- **Improve CHAM Service Delivery**
- Expand SBM-R to more CHAM facilities
- Train CHAM providers on implants and IUD insertions
- Incorporate zinc into diarrhea treatment
- Distribute micronutrients through CHAM facilities

- **Improve Positive Perceptions of CHAM**
- Coach CHAM in strategic participation in the public-private dialogue, including TWGs and the MOU/SLAs
- Build contract negotiation skills
- Increase perception of CHAM Secretariat as being a valuable resource and advocate for CHAM facilities

Expanding the Commercial Sector

Overall Context

- Commercial health sector is relatively new and small
- Some evidence that the commercial sector has grown over the last three years but many providers are isolated and highly fragmented; strong source of data from PSI's work with commercial providers in social marketing
- Insufficient knowledge concerning the demand for commercial services (likely limited due to high levels of poverty)→ How is the market currently segmented?

Lessons from Social Marketing

- Currently, PSI works with 215 commercial health service providers outside the BlueStar network
- Socially markets condoms, water treatment kits, oral contraceptive pills, injectables and anti-malaria nets
- PSI works with these providers to sell its products but there may be an opportunity to develop a more formal network of commercial providers
- Appears to be more demand to purchase socially marketed products from commercial providers→ stock-outs, transportation costs, and distance

Social Franchises are One Way to Grow the Commercial Sector

- **Finding: Social franchises are an important model to expand quality service provision in the commercial sector but there are challenges in expansion.**
- Small private clinics join the franchise for an annual franchise fee of $65; receive branding, clinical training from BLM
- Important platform to expand FP service provision and potentially add other services
- BlueStar social franchise has recently consolidated and the # of clinics has decreased
- **Challenges:** Business and management skills of providers; perceptions of brand value; competition from free EHP services in CHAM and public facilities

Access to Finance Findings

- **Finding:** Private providers have limited access to financing and banks are only lending in a limited way
- **Finding:** Without access to financing, private health providers can have difficulty sustaining, expanding and adding essential health services
- **Finding:** Banks (Standard, Indebank, NBS, etc.) are interested in partnering with USAID to expand lending to the private health sector
- **Finding:** Interest rates are high. Base lending rate is 17.5 percent and commercial bank interest rates range from 22-25 percent

Access to Finance Recommendations

- Select most appropriate financial partners and develop a package of technical assistance to expand lending to BlueStar clinics and other private health care businesses. TA may include market research, loan product development, training, and referrals.
- Structure a Development Credit Authority (DCA) guarantee ($2 million) for the private health sector
- Include an access to finance component in business training and market linkages work

Key Findings: Healthcare Financing Landscape and Indicators

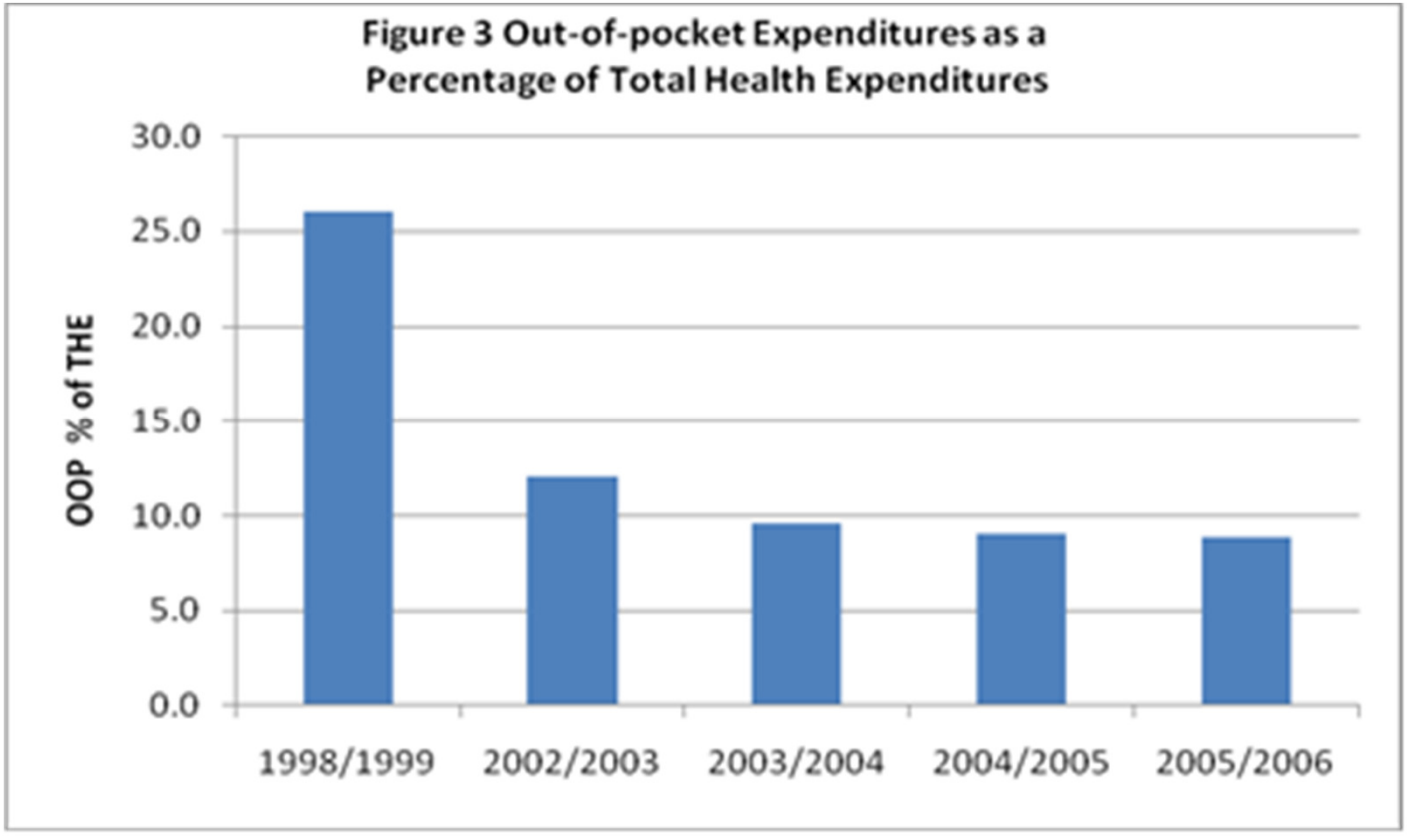
- Low per capita spending on health compared to region average
  - Per capita spending was $ 25 (2005/6) compared to an average of $ 37 in SSA countries
  - WHO recommends per capita spending of $54 to achieve MDGs
- Increasing dependence on donor sources to finance health
  - Percentage of THE from donors was high and increasing - 60.7% in 2005/6 compared to 2004/5
  - Large inflows in programs such as PEPFAR
- Increasing proportion of THE from private sources
  - Private sources contributed 18.6% of THE in 2005/6 compared to 14.2% in 2004/5
- Decreasing proportion of THE from government
  - Percentage of THE from government was 21.6% in 2005/6 compared to 24.5% in 2004/5
  - However health spending as % of GDP was high at 9.7% compared to 5.7% for the SSA region

Key Findings: HCF Landscape and Indicators continued

- Decreasing out of pocket spending (OOP)
  - OOP was 49.1% of total private spending in 2005/6 down from 63.8% in 2004/5. SLAs with CHAM and free donor financed essential services have contributed to this reduction
  - Per capita OOP had remained low and stable between 2003 and 2005 at between $ 1.82 and $ 1.81 (about 11.5% of THE).
- Despite focus on EHP, most of the healthcare spending is in hospitals for both private sources and government (64% of public expenditure on health)
- The private sector was an important financing agent of health funds – 30% of THE was channeled through the private sector in 2005/6
- Lack of an overall national healthcare financing policy and strategy to guide the country and all actors towards common goals of an efficient and equitable HCF system

Key Findings: HCF Indicators – OOP Trends

Source: Health financing in Malawi: Evidence from National Health Accounts



Key Findings: Risk Pooling Mechanisms for Health Insurance

- There is no specific health insurance law or regulatory authority
- There is no public risk pooling mechanism such as a Social Health Insurance Scheme
  - HSSP has a section on alternative healthcare financing and there is an intention to develop a SHI scheme.
- Private health insurance is small and nascent in Malawi (3.7% of THE in 2005/6) but growing
  - Main players are Medical Aid Organizations such as MASM and formal insurance companies such as NICO
  - MFIs & CHAM have shown keen interest in developing low cost private health insurance in partnership with the above insurance providers
  - Other innovative financing mechanisms such as vouchers are being considered

Key Findings: Risk Pooling Mechanisms for Health Insurance continued

- The development of private health insurance and other risk pooling mechanisms is constrained by several factors
  - Low demand due to high poverty levels and lack of awareness
  - Lack of institutional capacity – to design, deploy and manage viable health insurance products and services and to manage necessary partnership with other organizations and health providers
  - Few and poorly distributed health providers
  - Policy and regulatory gaps
  - Lack of reliable market information
- A number of private insurance schemes are open to improving their depth of cover by including priority health services such as HIV/AIDS and FP

Recommendations

- Develop a national healthcare financing policy and strategy to guide the development of a sustainable and equitable healthcare financing system in Malawi
  - The policy should include the key elements of revenue generation, pooling mechanisms and purchasing of health benefits for the covered population
  - Consider alternative and innovative healthcare financing models which are sensitive to the country's context

- Review and strengthen health insurance regulatory framework to promote sustainable growth of the sector
  - Support development of a health insurance law
  - Decide who will regulate health insurance and build their capacity to do so.

Recommendations

- Build consensus on the future development of a SHI scheme that has clear roles for the private sector both in financing and provision of services
  - The SHI development process should be inclusive and participatory
  - The private sector is important to the success of a SHI scheme as healthcare service providers, insurers, scheme administrators, providers of health commodities, trainers of health workers and tax payers.
  - Malawi can learn from the successes and failures of other African countries in SHI
- Provide TA to current HCF initiatives in the areas of market research, product development and piloting - with an emphasis on innovative low-cost health financing models
  - MFIs, MAOs, CHAM and some DPs are working on health micro-insurance, community insurance, voucher schemes, and provider-based plans
  - Support strengthening of existing provider networks (CHAM, BlueStar, etc.) and link them to above financing mechanisms

.

Thank you!

Questions or Comments?

USAID
FROM THE AMERICAN PEOPLE

SHOPS
Strengthening Health Outcomes *through* the Private Sector

For more information, please contact Ilana Ron Levey at Ilana_Ron@Abtassoc.com

www.shopsproject.org

Abt

SHOPS is funded by the U.S. Agency for International Development.
Abt Associates leads the project in collaboration with
Banyan Global
Jhpiego
Marie Stopes International
Monitor Group
O'Hanlon Health Consulting