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Leveraging Private Finance for Health

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C O N T E N T S

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P R O C E E D I N G S

THE SPEAKER: — as well, hearing about our presentations. I just thought I'd introduce the session on leveraging private finance for health with some very general comments. One of the things we found in our project is that when you talk to people about public health in the private sector, there are often a number of misconceptions and misunderstandings about, you know, what it means to work with the private sector; and specifically, even if you kind of get the importance of the private sector, how it is you interact with the private sector.

First of all, what do we mean by the private sector? There's often kind of a knee jerk reaction. With the private sector it conjures up images of big commercial multi-nationals, constant gardener pharmaceutical companies exploiting poor people in the third world.

And we try to remind people, first of all, the private sector encompasses a wide range of players, not just the manufacturers, but also very low level providers, the pharmacist, the chemist, the clinics, work place clinics, programs, NGO's, faith based clinics, even down to nurses and midwives operating at the community level. So when we talk about the private sector, it really encompasses all of this, and I think it's important to keep that in mind. The private sector is, by no means, one big monolith. So if you have social interests, why would you want to partner with the private sector? The most obvious thing is to increase the resources devoted to public health goals, and so we'll just ask the private sector to write a check, right. The other part that I think people increasingly are

recognizing is that it's — private sector offers a means to achieve at least a degree of sustainability that's typically not easy to achieve in the public sector programming.

Also, what is I think more surprising to people is that the private sector is often reaching people that are beyond the reach of the public sector, and this offers a means to get to these groups.

Finally, increasingly we're seeing, especially here in Africa, there's a massive problem of brain drain, and you have to address these issues both in the public and the private sector in order to stem the brain drain and keep human capacity where it's needed the most.

From the private sector side, again, one of the misconceptions we find is that the private sector is typically — is assumed to only be motivated by profit. In fact, many corporations, private providers, and small scale providers are also motivated by a desire to achieve a social mission, to be connected to wider organizations, and to increase their social standing, as well as business opportunities and profit motivation. From the consumer side, something important to keep in — why do people use the private sector if there's a public sector available? Well, private sector often offers the convenience, both in terms of proximity and shorter lines, and although technical quality is often hard to judge, clearly, there are often perceptions of higher quality in the private sector. Finally, in terms of privacy, and many places in the world, the private sector is the only option.

So this is all well and good, but then how do you actually work with the private sector if you are a donor, or if you wish to pursue social objectives? I'm putting up

kind of a list of different interventions, many of which my project, PSP1, is pursuing either documenting or actually trying to implement with a particular focus on reproductive health.

I begin with social marketing, which is one of the most successful ones, which has been very effective at bundling behavior change, communications, and product and service delivery in a fairly cost effective manner that leverages private sector commercial infrastructure.

We've also worked with provider networks managed both by non-governmental organizations and other groups. One of our panelists is going to be talking a bit about private networks. Pharmaceutical partnerships, which are a means of — these take the form — a couple of different forms. The most common way is in a market where there are a number of private sector providers, but there's clearly a need to create demand for the entire product class. Social investment can demand creation for the product class, and there's sort of a phenomenon of sort of raising all the boats at the same time, and this can be done in a way where private sector partners are kicking into the overall scheme, because they see their interest coming out of it, and yet the social investment is not directed toward any specific company or any specific brand, but they all are benefiting, and it's increasing use and access.

Obviously, corporations with social responsibility interests can be leveraged and directed in effective ways. Quality improvement is an issue that is recurring, and we are trying to find cost effective ways to promote this in the private sector.

Something we're calling base of the pyramid approaches, where a number of corporations around the world are looking at ways to generate profit amongst the poorest of the poor. We are currently in negotiations with Hindu Stan Lever (phonetic) in India, which has set up a rural shocti (phonetic) distribution system, which is almost based on kind of like a village Avon lady model, if you will, and we're negotiating with them to introduce health products, contraceptives, and other basic health products into the scheme to build on this distribution mechanism, which represents quite a long term vision and very substantial investment on their part.

We find increasingly that just simply working on regulatory issues makes a huge difference to the private sector. During a recent assessment in Zambia, for example, we found that one of the disincentives for nurses to stay in country and open their own businesses was that there was a requirement that they be supervised and managed by a doctor, even though there are very few doctors in Zambia.

And so we've been working with the Ministry of Health to rewrite a law that would create sort of a scope of practice to allow nurses to operate independently and encourage more nurses who want to set up their own businesses to do so.

Finally, health insurance is another area. We're going to be hearing about a very innovative example about that very shortly on a partnership in Nigeria. And contracting in and contracting out of services, whereby public sector systems will hire, essentially, individual providers or provider networks to work, to essentially offer the

public health services in a specific area or for a specific field, or contracting in, which we call sort of hiring private sector providers to work within the public sector infrastructure.

So this is just a very broad overview of sort of the range of things that can be done with the private sector in health. Let me introduce our first panelist, Jacques Van Der Gaag, who is the Professor of Development Economics at the University of Amsterdam, where he also serves as the Dean of Faculty of Economics and Business. He is also the Director of the Amsterdam Institute for International Development. He's previously worked with the World Bank and he's published widely in the area of health finance. Jacques.

MR. VAN DER GAAG: Thank you very much. And let me join the crowd over the past three days who have been thanking the Brookings Institution and Amanda and David for bringing us together on this exciting topic. This is the last session of a three day event and I have found it very interesting and stimulating, so I hope to come back many times.

My task really is very simple. I'm supposed to introduce the next speaker. But let me take advantage of standing here, giving a little bit of background. In my role in Amsterdam, after I left the World Bank, my role as Director of the Amsterdam Institute of International Development, I got in touch with a bunch of – with apology -- crazy, extremely motivated, can do professionals who are either in the medical school at the University of Amsterdam or in the shadow of the medical school, and I found out what they were doing, particularly in promoting the use of Aids drugs in Africa, and when I got to

learn them better, I found out that they were actually doing what I hoped that a lot of people would be doing, I hoped that 12 or 15 years ago, when I was still at the World Bank. Basically, they provide the simple answer to the question, why should you get involved or get interested in the private sector when you deal with these kinds of social issues, and the simple answer is, because they get things done. They don't worry about why it may not be the right approach, or how it fits into big frameworks, or I don't think they write strategy papers or other things, they just roll up their sleeves and get things done.

And I got enthused about what they were doing on a relatively small scale in Namibia and I convinced the Dutch government that it would be worthwhile to take a closer look at that and at the impact of that intervention, and so I got a small grant from the Dutch government to start evaluating that.

While that was happening, the same can do people got in touch with some pretty high level business people in the Netherlands and convinced them that what they really needed was a new foundation that would have the power to actually get money from wherever so that whatever this NGO was doing could be expanded in other countries.

The health insurance foundation, you will hear more about that. I was asked to come on the board, and for a very specific reason really. I have to basically hold everybody off, that is, everybody who asks the questions that we're used to, you know, is this sustainable, are you starting with the poorest of the poor, does it fit in the policy framework, all those. I do nothing but try to answer those questions. If I'm honest, the answer is, no, no, no, and no, but, of course, I make up stories, well, they just go on with

their work, that's how I see my role, and I enjoy it tremendously. To make a long story not so long story, because this is only the last two years, but make it a little shorter. We did convince the Minister of Development — Corporation of the Netherlands to promise \$100 million Euro as the first donation to the health insurance fund, so we're very excited about that.

Then basically Dave and I got back in touch around whatever David is trying to do, it fits in the scheme, and that's when I suggested, well, if you have this three day event and I have a great speaker for you, his name is Onno Schellekens, he is sitting there, he is the general manager of the NGO called PharmAccess, access to pharmaceuticals, and particularly Aids treatment drugs.

He has an MBA, he has made his money in the pharmaceutical sector, feels bad about that, and now starts to — I can tell you more about it later. And it's one of the driving forces about this, what I think a fantastic, exciting initiative that I'm delighted to be part of. Let's listen to Onno Schellekens.

MR. SCHELLEKENS: Okay. Thank you very much. Also, thank you very much for the Brookings Institute to have the possibility to give this presentation. We are a small NGO in the Netherlands, so it's, you know, in the U.S. with — and all the others, I think, for us, it's a great opportunity to have the possibility to present what we are doing. I'll try to give my presentation in two parts, basically three parts; one is a bit of background to where we're coming from and what we're doing. Then what we have noticed, some effects and observations in the last two to three years in Africa, because we're working only

on treatment in health delivery in Africa. And then some practical examples of what we're trying to do in a way forward, and one of the examples is the health insurance fund.

Just what we are, we are a Dutch not for profit organization linked to the academic Medical Center of Amsterdam. The organization was founded by somebody I think here in the states, maybe you know him Uplanga (phonetic) he's one of the most well known people in the field of treatment. In Africa, I think he did the first moderate child transmission studies to WHO, and then came back to Amsterdam and founded this foundation, because in those days, everybody was treated in the west and nobody was treated in Africa.

And that was the main reason why he established this foundation. Brush (phonetic) immediately got a contract, and can you imagine five years ago, four years ago, a contract where we got money to prove that it was possible to do treatment in Africa, four years ago. He became Chairman of the International Aids Society, and then was also Chairman of the Bangkok Conference, and extended the organization with some other people. Wilford Hicks (phonetic) was the first managing director of the Global Fund. For an interim period, we have a CEO for big Dutch Bank. And our first customer, just say it also, customer, the first one to start treatment after Rush was somebody that had money and medical infrastructure, because that was the condition that we had to meet, and it was Heineken (phonetic) and Heineken got a lot of publicity, and they were the first that started, and then all the others came after that.

Today, we have moved a bit from HIV treatment to general health because, and I'll talk about it later. HIV treatment, as discussed at the Global Fund, is a financing way of discussing. But in terms of delivery, you cannot deliver HIV treatment without general health.

Back on what we're doing, we are doing work place programs for organizations that do have money and medical infrastructure. We're working for Heineken, Celetel the mobile operator that got purchased six months ago for 3.6 billion, I think. IFC made a lot of money.

We're doing capacity building for the government of Tanzania where we are upgrading and assessing all the hospitals. We are doing operational research through partly the University of Amsterdam and the Amsterdam Institute of International Development, and also with the academic center. We're doing a resistance monitoring program in 12 countries, the first one funded and still — and being really implemented. And then we come to the real stuff. We're doing donor funded HIV treatment programs, where we got a big grant, the care one from Russia I talked about, but we got a big grant in Namibia where we are working with four private health providers to launch a low cost basic health care package for people, including HIV Aids.

I talk about it a bit later because it's an interesting thing with risk organization the first one in Africa, can you believe it, on HIV Aids, and it's not because we are that great, it's more an example of the fact that this is not implemented right now.

And gradually we move to general health. We're working with Shell in Nigeria; they're going to outsource all their clinics to a local HMO. And we just got a 100 million grant for the health insurance fund, a sick fund for the Europeans.

This is just some capacity and what we're doing. There are hundreds of clinics implementing patient information systems in 146 clinics. And we are also doing, and I think that's for you Americans, I admire you, there's always criticism, but I think it's always also good to realize, you are thinking out of the box when it's related to HIV.

We got a grant from Pefpar (phonetic) the U.S. government program, to offer community based HIV treatment through military hospitals in Tanzania which is an interesting project. I'll don't talk about it now, but I think it's, for you, great. Some facts and observations, and here I just — before I go to the facts and observations, I just want to tell you something about a personal experience. My personal opinion is not that important, but the experience, I think, it shows what is going on in Africa.

Two years ago, we ended up with an organization in Nigeria that is working for these big multi-nationals. I think Alexander Pracker (phonetic) knows the organization, it's called Hygea.

Hygea is an HMO and established by a professor of medicine who is one of the first who got a PhD at Trinity College in 1948, went back to Nigeria, worked his whole life in the public health sector, established two universities, and then, when he retired seven or eight years ago, he said, well, I'm fed up with the fact that, published at Croy (phonetic)

80 percent of the hospitals in Nigeria don't have running water, I will start, according to the American model, a private health care system.

He did that. Wovensen (phonetic) came within a couple of months and visited it, and the IFC became immediately one of the funders of the organization. Two years later, they had Shell, Unilever, (inaudible), Guinness, Coca Cola, all kind of big companies as a customer, and these organizations are not paying for HIV Aids, because that's offered free of charge by the public sector, which cannot deliver. Then the IFC came back and said, well, you know, you have a polluted population and we are not willing to reinvest. Then I said, well, that is just a guy that was there, I thought, well, that's crazy, who am I, but I'll give it a try. We go to Difit (phonetic) and we asked him to get a fund to help this organization because they have thousands of people that need immediate treatment.

We went to the coordinating organization, which is Difit in Nigeria, and this organization said, well, sir, you — although your organization is run with a lady with a Harvard MBA, although you have your own background, et cetera, et cetera, et cetera, you cannot access donor money because you are for profit and you don't service the poor.

And that was a moment for me personally when I thought, this is just a communication problem, because if people like here at the Brookings or in the Netherlands or wherever know that this is going on, then things will change. It's a matter of getting to the right people.

My facts and observations, you should watch in the framework of what I just said here, because this is not one example, it happens everywhere in Africa. All these big companies and all countries in Africa, the situation is the same.

Just to start, I think, and here, you know more about it, I think, than I do, health systems have two parts, it is funding and it's the delivery. All the documents being published from the WHO, from the World Bank, even today, the health financing revisited, all those documents, they talk about funding, the choices, the frameworks, the purchasing of services, et cetera, et cetera, et cetera. Nobody talks about delivery. And delivery is, I think, very important to just make it into a framework, because this is what we're doing everywhere in Africa.

In order to get treatment or general health servicing done, you need two basic things. You need laboratory, you need medication, you need doctors, and a clinic, and then, really important, you also need an administrative system that can administrate those costs because you're working with groups.

And today, there is no funding at all available for this administrative part. It is completely neglected, everywhere. And medical accounting, anonymity, to register cost, to collect premiums, to pay providers, is essential to get something done.

And I think that this is just an important point to notice, because of the fact that this administration is not there, you get another problem, and I think it was widely discussed in the other two days, this is a clear example of what happens in Africa, more than 60 percent of the expenditures on health are out-of-pocket, made privately, and they

are not pooled through risk pooling mechanisms. Another fact, these kind of systems that we have everywhere in the West, risk pooling, third party administrators, then providers, and then servicing to the demand side, they have at each level, the word private can be applicable. Private doesn't mean private for everything, private can mean that you have public money, you use a third party administrator, or you use public hospitals, or private doctors servicing people. The word private is widely misused and misdefined, and I think that's an important thing, because public calls can be serviced through private providers.

This is, I think, also a really interesting one to say about my own slides — it's really interesting, it's a bit hilarious, but it's important to notice, this is the Global Fund expenditure, direct contracts, there is not one project on treatment and delivery approved by the Global Fund in Africa today for private providers, not one, not for third party administrators, not for clinics, not for laboratories, not for risk equalization, nothing, and I think that's important, because it has nothing to do with the fact that Geneva is bad, because I think it's a great organization, you can talk about — you can talk directly with them about it, it's because the CCM, the Country Coordinating Mechanisms, they don't approve private projects.

That's an important one. Another interesting one, and I'm sorry to say, I know that there are quite a few people of the World Bank here, but I would say also, the World Bank is doing some interesting things once in a while. They had this project, I don't know if you know, they had this project two years ago called TAP, Treatment Acceleration Program, focused on showing that it's possible to do treatment faster. They had three

models; one was for faith based, one was for NGO based, and one was for private sector based. We did the one for private sector based.

In Ghana, we went there with the World Bank, they just dropped us at the Ministry of Health, and the Ministry of Health said, well, you know, we're going to spend all the money of the World Bank for buying medication, and we exclude the private providers.

So the companies, we had a whole bunch of companies, the biggest employers of the country, Unilever, Heineken, (inaudible) others, the company said, well, if we cannot access that, then we don't pay, and we sent everybody to the public system, and the World Bank accepted this, they accepted this. We went to Debra Work (phonetic) and she was somebody really to say who helped us a lot. But the implementing team just let this happen. I think that is just really weird.

Another thing is, in Nigeria, also I think Alex, who is doing a lot there in Nigeria, and you too, this Hygea, the organization that I talked to you about before, 200 hospitals under contract, all these big employers, they wanted to set up an HIV treatment training center, they made a budget, \$250,000, two years later, not yet approved, which is also fundamental for the fact that the private sector raises red flags, I think. The third one, Namibia all big health care providers are there, all the big South Africans, Methealth, Metropolitan, all of them. Not one of them can access MAP money of the World Bank. And the last one, and I said before that I was a bit worried about it, but I just say it, the IFC,

who invested in these organizations, they have, I think, three investments in Africa in health, three.

The IFC invested in this HMO, and then later changed it to a loan and charges them today 23 percent. They cannot access the money, and this is just a weird thing, I think, from a private venture capital social development point of view.

The problem, the big problem is that if we look to the OECD (phonetic) model, that because of these failures and these non-addressed issues, group insurance, the starting point for health development in the west, is not enforced in Africa.

Alex Brecker (phonetic) is working on it big time, I think, now in Nigeria, but still, it is not enforced. And then you get these kind of figures, World Health Organization, 2006, prepaid schemes, risk pooling, less than five percent.

The investment side, I think, is also just interesting to see. All the big investments, there are no investments in health in Africa today, and I think that's also quite an important thing to notice. The problem is, everywhere in Africa you can get a Heineken or a Coca Cola, but the distribution charges in Asia, around for two companies Tulic (phonetic) and Detel (phonetic) all pharmaceutical companies ship to Singapore, they do the distribution to seven countries, to every single pharmacy, and they do the collection for seven to twelve percent. In Africa, it's our single biggest cost, running up to 2,000 percent on landed cost. And there is no investment, nobody is copying, nobody is saying, to Tulic well, let's copy this, your model, we invested it and we tried to do the same thing in Africa.

I think, as a conclusion, interventions are very vertical, and they are approached from a money point of view and not from a delivery point of view. Delivery of services, as I said, is really seriously hampered, it's simply not there, and because it's not there, all kind of important issues like medical accounting, data, administrative capacity, actuarial data are simply not there, out-of-pocket expenses are still very, very, very high, and nobody is willing to pay for a service that doesn't exist. So if you don't address the issue of delivery of services, nobody is going to prepay for schemes.

I — five, okay. I want to say two things on examples that we're — what we're trying to do. One is, I think, in Nigeria — in Namibia, here you see an interesting slide. These different colors, they are health care providers. 20 percent of the population in Namibia is having health coverage, 80 percent not. We introduced a scheme where we focused on low income people, including HIV Aids, and we said we will fund it, and one year later, all providers are offering a low cost package, including HIV Aids, and they all agree now on a risk equalization fund, all together. So still we are channeling all that money and it's within the system.

Then some words on lessons learned, but I'll don't do that now. On the health insurance fund, because based on this whole approach, we launch this idea of the health insurance fund. It is chaired by somebody very well known in the Netherlands, he established the second largest life insurer in the world, grew a company of 100 million to 80 billion from a – is there and there is a board member of the Global Fund and some other people, and the CEO of the biggest Dutch private insurer.

What we're doing there is, we are setting up a scheme to reach out to low income people through private care providers, both from an accounting point of view and from a delivery point of view. They work against a fixed rate, and we have two target populations mentioned here; one is market women in Lagos and the other one is a community in Kwara state, one of the states in Nigeria.

The HMO is doing it for a profit of 1.4 percent of the total amount. Coverage of the package is \$28 in Kwara and \$48 in Lagos. It includes its primary care base, it includes HIV Aids, and it is administrated through this HMO, and they are responsible for everything. They are responsible for the delivery, they are responsible for the medical standards, they are responsible for the upgrading, everything. We are setting all the standards, because in Nigeria, right at this moment, there are no standards, and we are doing that also for the multi-nationals, so we're using the same kind of set, and we are working closely together with the government to use the same kind of standards as the national policy, which is going to take time, but we — there's a lot of interest from the government in Nigeria.

I just want to stop with the health outcomes, and I think that's also important. It's one of the big advantages, I think, of the approach. The advantage is that you have contractual output based eight schemes integrating everything, and we just know as example today how much we're going to do in the next five years, 2.1 million GP visits, 375,000 hospitalization days, 851,000 specialist days, et cetera, et cetera, et cetera. There is a thousand line data base with all the records on consumption, et cetera.

That is what I wanted to say. And I just wanted to stop where Jacques was starting, on the real difficult choices that you have to make once you are doing these kinds of programs. You do know that you don't have enough money; you have to make these choices. And if you exclude hospitalization and do only primary care, we notice that we could treat 20 percent more people. So these are tough choices, but they have to be made in order to deliver. The last thing, we are setting up also an investment fund, and we're talking to all kind of different financing agents. We think that by guaranteeing turnover, this 100 million, to these providers, we can raise investment capital maybe even of the most conservative financial institution in the Netherlands, the ABP, the second largest pension fund in the world. They just got a fixed return of 12 percent, and then they are funding the clinics in Kwara state I think that would be a break through. Thank you.

THE SPEAKER: Thank you very much, Onno. Our next speaker is Dr. Amy Tsui, who's the Director of the Bill and Melinda Gates Institute of population reproductive health at the Johns Hopkins School of Public Health. Her research focuses primarily on the effects of family planning and health service delivery models, on contraceptive fertility and sexual health outcomes. She's worked in a variety of countries. She also led the U.S. Aid funded evaluation project for a number of years. PSP1 has collaborated with Amy, we consider her a thought leader, particularly in the area of provider networks. A pleasure to have you here.

MS. TSUI: I'd like to thank the Brookings Institution and the organizers of this session. It's a pleasure to be here. And I actually think I'm slightly out of order

because my colleague, David Brichi (phonetic) probably should have been the opening act for this. But because I'm not an economist, so you'll see that right away. I had the opportunity to be asked to evaluate social franchising projects in three countries, and so these are results from the evaluation, and I will inform some of the issues that have already been raised both by Jacques and Onno. So I'm going to talk about the challenge of contraceptive service in commodity financing and share the concept of social franchising, share the findings and then some of the lessons learned.

There was, in 2001, an effort called — by the interim working group called Meeting the Reproductive Health Challenge, and it was formed because there was recognition that there was growing contraceptive demand, a growing client base, poor coordination of donor funding, and inadequate logistics capacity in developing countries to be able to move contraceptive commodities and condoms for HIV prevention.

The report took the roles of governments in developing countries, the international finance institutions, which is a nice word for the donors, and the private sector. And in the private sector role, one of their conclusions was, a key is market segmentation, and particularly in being pro-poor, which is what we've heard about already.

So this just gives you the scenario of the gap in future funding for contraceptive commodities relative to need. And you can see that the need goes up and then the expected level of resources is relatively flat. So one of the reports examine the financing options, and there were five, charging fees to public sector clients, community financing, which you heard a bit about, expanding the role of the private sector, and

contraceptive service delivery covering contraceptives under national health insurance, and then also establishing a contraceptive independent initiative fund, which is a bit like the funds you just heard about, and also the global vaccine initiative fund.

So social franchising, we actually see some of it here in the United States, but it's an attempt to use franchising methods to achieve social rather than financial goals, influencing service delivery systems of the private sector, similarly to the way social marketing has adapted traditional outlets for commodity sales.

And to remind us the definition of a franchise, it's when authorization is given to someone to sell or distribute a company's goods or services in a certain area, or it could be a business or a group of businesses that are established and operate under such an authorization.

And I wanted to — I don't think you need reminding, but there are many franchises that we live by these days, including Starbucks, I saw that was out there, but Singer sewing machines is the first franchise that was ever established. And the reason it was established is because no one would buy the sewing machines unless they learned to sew, so they had to set up these outlets to teach women to sew, mostly women, to sew. These days you can go to some of the pharmacies in the U.S., or the CVS Pharmacy, or Target stores, you'll see what's called a fractional franchise, which is these embedded health clinics. So there's something called a minute clinic, and their motto is, you're sick, we're quick. And one of the Indian franchises that I'll be talking about has a lot of similar dimensions, which is a fixed fee schedule and a delimited client population, that is, they

will not handle, obviously, highly expensive services that require a lot of curative care, and they will not take on risk populations like the very elderly or the very young, so they limit what they can financially manage.

The benefits of social franchising are many, and I've only listed here the ones for the franchisor or the franchisee, but there is also the client and the donor agency. But for the franchiser, generally there's a motivation of social responsibility, and also, they want to have a financially sustainable enterprise for the franchisor.

For the franchisee, also they're matched by a sense of social responsibility. They're looking for a proven business concept which has a well defined cost structure, and operations, and also the potential for increased revenue and profitability, as well as an enlarged paying client base. So we hear about loss leaders in many retail outlets, and this is one idea with the social franchising for primary health care. They were looking for an established brand, products, or service, and for improving their technical competence. For the customer, I thought I had — you can see these for the customer. In the interest of time, I'm not going to go over each one. Okay. The three models that we evaluated, one was in Pakistan, it operates in urban Pakistan, called Green Star. There were two in Northern India, in the state of Bihar which then, over the period of the project, divided into Bihar and Jharkhand.

And then the third was in Ethiopia, which operated in three regions that commanded 40 percent of the country's population, and that was called Birutesfsa.

(phonetic) And these franchises at the time were funded in whole or part by the Packard Foundation, which requested the evaluation.

And so you can see the Green Star Network, which was in all the urban areas. There was, sorry, this is on a black background. There roughly are about 11,000 providers in that network, and there are four categories. There are male doctors, female doctors, there are lady health visitors, or the sort of paramedic, and then there are the pharmacists in the network. Here it is.

There is also another network that was funded by Difit and implemented by the futures group called The Key Network, so we pick up the effects of both of these. In Ethiopia, the network is called Birutesfsa (phonetic) which stands for ray of hope, and they implemented in three of the regions, Addis Ababa, Amhara, and Oromia regions. And they were relatively small. They just had started in 2001, when we began the evaluation. And by the end, they had only 120 in the networks. But they were linked to a number of other health providers in the area.

For the one in Northern India, you can see the population covered by Bihar and Jharkhand at the time was about 100 million — 110 million, it's I think maybe 120 million now. There are two networks, one was called Titley (phonetic) which engaged real medical practitioners, RMP's, and they're not qualified, they're called a quack, so to speak, they're unqualified doctors.

And they were authorized to dispense condoms and oral contraceptives, as well as provide rapid test services for pregnancy, blood sugar, and — well, sugar and urine.

They were designed to link to the other network, which is called Syria (phonetic). Oh, I should mention also that as part of Jonanee (phonetic) the franchising program, they wanted to improve the role of women in the provision of health care, so that RMP had to actually be a couple, so it was the RMP and his wife, so that his wife could counsel clients who are coming for reproductive health care.

And all of these networks paid a membership fee, an annual membership fee which fluctuated, which was an issue, because they weren't sure they could sustain demand and participation in the network. So the second network that Jonanee operated is called Syria, and this is the qualified doctor network. And they started out with 620, they've scaled back to about 300, so they're focusing on a strength of a cadre of about 300 now. And their annual franchise fee has now reached \$1,300. So all of these franchising programs provide training, and they provide commodities, and they provide advertising, and they provide monitoring and quality assurance, and often times delivery of product.

So our design was a pre-imposed test with a comparison group. These are non-equivalent. So the comparisons, although we did a full facility based sample of all kinds of health providers, government, both in the public and private sector, the logical comparison is between the private provider who joined the network and the private provider who did not join the network, who are the same. So you'll see some of these comparisons.

And we had the survey of the health facilities, providers, and of the clients. We also followed up the same providers, the same facilities who are in the sample in 2001 in 2004. So we have a — so this gives you an idea of the sample sizes.

In urban Pakistan, we started out with 993; in 2004, we had 1,120; so some of the 1,120 were the original — of the original 993. We refreshed the sample so that we've had cross sectional samples in both years, as well. So that's the only part that's a longitudinal sample. The staff, we could not follow up, nor could we follow up the clients. Okay. This gives you a sense of the distribution of the type of facility in each year, as well as the followed up sample, which is the third line for each country in the year. And you can see that there are variations here. One of the things we found, which surprised us, is, we thought three years from now, we'll find these health facilities because they're ecstatic, they're self-standing, they're not going to move, well, they're quite fluid, so that was something we didn't realize, was the rapid relocation of a lot of the health providers.

So we look at three outcomes here, and I'm only going to show you three, one of which is the — whether or not the client came for reproductive or child health care, because that was the original intent of the social franchising project, was to increase access to this type of care.

Another one is whether or not they came for general health care. And then a third is the equity issue, to what extent were the clients coming from the poorest segment. So this is the result from the panel regression looking at — for the three countries, the

effect of participating in a franchise network compared to not — to being seen by a facility that's not participating.

So for the first one in Ethiopia, the effect of being in the network meant that you would have 2.51 additional clients per month, I think this is, yeah, per month, more than the one who wasn't in the network, and that you would have almost seven family planning clients, more than somebody who wasn't in the network, and that you would have 1.2 more for reproductive health, and you would offer roughly .8 more services, reproductive health services if you were in the network. So for the unqualified doctors in India, you can see there was also a gain. And for the Sun Network, the qualified doctors, you can also see a gain there, as well as for Pakistan. Okay.

So we also, and this is where David Brichi's (phonetic) presentation will be relevant, also estimated the marginal — the additional value gained by the participation in the franchise by taking the estimated additional number of clients, and we did this here for the reproductive health clients for the three countries, and the number of franchise outlets, and then also taking the additional number of reproductive health clients, we calculated then the additional annual revenue of the clinic at the median fee that was estimated, and this would be for one year.

So in one year in Pakistan, the average clinic would have an additional income from reproductive health clients of about \$77. And in Ethiopia, it was only \$6. In large part, that was because it was a brand new network. And in Ethiopia, if you know a little bit about its history, at the time, it was just emerging out of a socialist period and there

was almost no private health sector, just charging for health care was discouraged. We looked at whether or not, for the clients, and this is using the client cross section, they were paying fees at the time of the visit. So the expectation is that what should be the rust colored or red colored bar, that that would go up between 2001 and 2004 for each pair of countries, and they do, except for India, they're still relatively high.

Obviously, if you're in the other private, most of them should be, I'm not sure why they're not 100 percent, but they should be very high in that regard. So the franchise clinics were seeing more paying clients in the cross section.

Then we did — and about the evaluation, the propensity score analysis to look at the three outcomes I mentioned. And here we get sort of more mixed results. This is between — so taking just the panel of the facilities and looking only at the outcomes for female clients and adjusting for everything there, you can see that if you look at the colored lines, the pair of colored lines, the solid line represents the franchise, and the dashed colored line of the same color represents the non-franchise clinic.

So in the case of whether or not a client was likely to come for reproductive and child health care, we saw a gain amongst the franchise clients in Pakistan and no gain for the other two countries. Relative to their comparison group, some of them did better, but most of them are about the same. So this is not overwhelming evidence that the franchise raised the number of clients coming for the type of care. However, we did find in two of the three countries that they did raise the number of clients coming for general health care. So that's the solid orange line going up, which compared to the dashed orange

line, is higher. They start out relatively the same place, but they end up in a bigger — with a bigger difference. The blue line went down, and the blue is in India. And then the green line for franchise clinics went up, but it stayed the same, it was flat for the comparison group.

The third outcome was whether or not, the equity issue, whether or not the clients were coming from the lowest income group. And we have females and males. The dashed lines represent the non-franchise between 2001 and 2004, and the solid represents the franchise clinics between 2001 and 2004. So you can see for India, there was a very large increase in serving the poor.

It didn't happen in Pakistan, okay. So the solid bars go down over time, and they don't start at the same point with the private sector, so there is a selection factor in terms of who participated in the network.

Overall, as I mentioned, they're sort of mixed, but we looked at a number of other outcomes, and the ones that are checked show significant results in the expected direction. And the question is, if these franchises are not improving equity, was it a mistake in policy or not? I give you — these results are just for Ethiopia. Again, the panel, and this is one respective of the franchisee, the provider, and asking them in 2001 and then 2004, do you think participating in the network improved client satisfaction, income, profit, product supply, product quality, services, range of services, and range of family planning methods. You can see they all went up.

So from the point of view of the franchisee, there is this gain, but from the point of view of — compared to other franchisers, we're not seeing the — always seeing the effects we expected.

So there are strong effects of franchise membership on the facility level client volume, and on the service, there were mixed effects on some of the client access measures. It was — I didn't show it, but it's weak with respect to quality. It may increase women's and men's use of franchise facilities for general health care. It does seem to reduce in some places the share of all clients who are poor, but it does increase in other places. And that suggests that there are revenue benefits for the health provider, especially the franchising health — franchisee.

So in some countries, for example, India, that would suggest that this is a relative efficient mechanism for financing health care to the rural poor, but on the other hand, it counters donor expectations when you aren't seeing the target service of interest being consumed at a higher level. So you're wondering whether you're enabling these low level providers to be gaining more income at the expense of losing out on the service that you originally were interested in. There are a number of other issues that came up. Pakistan, and these are apples and oranges in putting the three countries together. The Pakistan India networks are far larger. The India network, as I mentioned, oh, sorry, the Pakistan network, as I mentioned, 11,000, the India network, of which there were two, one had 20 to 30,000, and the other one had less than 1,000, and Ethiopia's was just about 100, so this is — they are quite different.

There is a challenge of supervision and maintenance from an implementation point of view. But one of the more interesting things we found for Pakistan and Ethiopia was that if there was not a significant budget in the franchising program for advertising, then the demand to go to those services went down, and so that's, I think, a lesson to be kept in mind.

And also, we compared their output with the output of the government clinics, and we found that the government clinics are monolithic. In these very low income places, the government, the public sector is the place to go.

So whether these networks are franchises in the truest sense is not clear. The equity risk is not evenly shared between the franchiser and the franchisee. And as a result, the private provider's commitment is more fragile. Also, these networks, among the three, seem to do better when they were in the urban areas than in the rural areas, and that may be because of the paying customer. So thank you very much.

THE SPEAKER: Thank you, Amy. Our last panelist is David Brichi, who's a colleague of Amy's, as she mentioned. He's an Associate Professor, Population Family Health at Johns Hopkins, is also a health economist and a physician who's done some work as an Aids clinician and substance abuse. And he's doing research on economic evaluation of public health programs in low income population, and is lecturing on cost benefit analysis in program evaluation. David.

MR. BRICHI: Thank you, Jeff. I'm actually glad I get to follow the other two panelists. I think they really have done a lot of help for me. Onno said something very

important. He said it was important, I'm going to reiterate it so you hear how important it was. He said, and I'm close to quoting him, that he found that there was no funding for administrative systems in Africa, and it is completely neglected everywhere. And I'll be making that point again in my talk.

And I also want to echo some of the things that I took from Amy's talk. One thing she noticed in her final evaluation was that there was some disappointment because the donor wanted to improve reproductive health utilization, but a lot of other good things that we may care about happen, notably there was an increase in client satisfaction. Maybe the donor didn't really think that that was so important, but you know, I noticed, and I want to bring that out again in my talk. So I'm going to address market failure in private sector health care. Bringing the perspective of a health economist, and that's what you'll see in my talk, as health economists, we find that the role for public sector involvement depends upon a market failure, and why should the government intervene, we must locate the market failures.

And we all say that the two market failures are that the private health market will not take care of poor people. There's less profit in taking care of poor people, and there's plenty of profit in short changing quality. And this happens everywhere. It happens in every country and every health system, that you can't get providers to go where the poor are, and you can't just depend on them to supply quality without keeping a good eye on them, so that's the justification, access for the poor and quality from each and every provider.

So the solution for both problems is some sort of government intervention, some sort of regulation, and we really do need to get the regulators involved, which is why Onno's comment is that there's no funding for the administrative systems that can do the regulation to solve the market failure.

When we organize this week of sessions, especially the prior two days, it was about expansion, let's try to mobilize financing, let's get financing from the big, deep pockets of the world, let's get financing from here, from there, for the sake of expansion. Mobilizing additional resources for health is good, increasing health coverage, free up public subsidies so that the government can do what they really ought to be doing, which are reliably public goods. Sanitation, safety, public health, nobody is going to do that except the public sector, so why don't we free them up to do that, which is what we know they ought to be doing.

So, yeah, but I'm glad we had today and a week like the week we've had, because expanding a bad system isn't what we want to do. We have to be worried about improving the system and making sure that good things happen. And those two things, as we located the market failures are, the poor getting access and guaranteeing quality of care. So as we're expanding our financing, let's not forget about the big picture, which is the market failures that occur.

There are other talks throughout the week on forces of private finance. Onno had a list, just had a list, here's my list. Let's talk about patients. I know it's politically incorrect to even consider it, but ultimately, the person who benefits the most

from my medical care when I get sick is me, and the second most important person would be my family, and then maybe Amy, or maybe some of you care a little bit about me, but I am going to benefit most from my care, so I'm going to want to pay my insurance premium. I'm lucky enough to live in a place that has insurance, but if I'm in Africa, I'm going to pay my user fee or do what I have to do to get care because I am deeply insensitized. (phonetic) So patients are ultimately the biggest beneficiary, and they're going to end up doing most of the paying, as they're doing in the private sector each and every day in Africa, and they don't have the third party payers and sickness funds to do it right now.

So we would love to see those systems expand, we would love to see them, because what they do is, they institutionalize and systematize the cross subsidies that we'd like to see, the subsidies we want to see from the health to the sick, subsidies from the rich to the poor, that can happen when you build a third party payment system.

Philanthropists, we've gone through that earlier in the week, local NGO's, foreign NGO's, and providers get mentioned here, too, but at best, a provider, if it's a private provider, can, at best, just arrange an informal cross subsidy, charging their high end patients more and shaving off the fees or getting charity care at the lower end and that's about the best they can do.

So let's focus on expanding private finance, that's what today is about. And I'm going to talk about demand. I need you to understand that when I say demand, I mean not need, but not wish, but real demand with real people who can pay for what they want,

and what increases that sort of demand. The standard litany is low prices. Prices are the number one thing. And when we are talking about Africa, we're talking not always about the user fees, but definitely about the time and travel cost of access and care, and we can lower that by building facilities that are more convenient for our patients to reach.

Well, quality is a major reason. Onno cited it. If you ask a patient, why are you going to the private sector, they say, well, I perceive that there's better quality.

(tape interruption)

— and the private sectors got them. Other things happen. The private sector might have some cache and some social perception that it is a higher quality. So better quality will increase that amount of privately funded services.

Third party payment expansion is how the high income countries expanded their private funding of their health care. That's what happens. Insurance companies make patients see their doctors more because their end cost at the day of service is lessened.

But we've had bottlenecks in trying to expand third party systems in Africa. And there are a lot of them. I'm only citing one or two of them here. But clearly, administrative capacity has got to be mentioned as a reason that it's difficult to grow these systems.

But if we had a week, we could focus all on the development of insurance systems. There's emerging evidence that if you can price your product in insurance with a decent mark-up, so that your final price is close to the actuarial cost, you can sell your insurance product to poor people in Africa, in settings where you couldn't believe that it's

possible. So I wish we had another week or so to spend on expansion and insurance systems in developing countries, but we don't, and I'm going to not focus anymore on that.

I'm going to talk about the other two issues, prices and quality. Travel time has got to be mentioned. And so if we want to expand private demand for services, we can develop a system that builds small dispensaries within ten kilometers of most of the population.

A lot of governments have actually done this with their government system. They will put a little, you know, \$100 mud hut dispensary almost everywhere. It doesn't have a whole lot to offer, and the provider isn't there for half the year, but the capital is there, if you call it capital. It's there, and that's something.

Governments also work a lot on getting local providers to actually go there. They have a lot of vacancies in their system, but when they can, they will put somebody there to open up their government clinic. That's relevant for the private sector, as I'll come to in a minute, because of the very common practice of moonlighting, of those public system providers actually being private system providers on the side. And that system actually is de-rated in many circles; it's called leakage, and cheating, and all sorts of bad names, but under paying your health providers, the government health providers, is actually quite clever from an economic standpoint.

What it does, you know, you do that full knowing that your health provider can't support themselves on the government salary, knowing that they will moonlight and

be private providers. They will "leak drugs" from the public facilities to some private sector location. But think about the public problem.

The public sector's problem isn't paying for every unit of service, it's solving the problem of access. So by paying that provider just to go out to this rural place, they've solved the access problem, and now the patient, who's getting after hours care at a price, is solving their own problem of actually benefiting from the services that they need and paying for their own care.

So they got — the government gets that live body out to the periphery and solves the access problem, getting the workers out to where they're needed. So it's something that we should actually acknowledge, the government doing — accomplishing a whole lot, and we shouldn't find ways to shut down that type of moonlighting, because it will just cost way too much for the public sector to have to carry that load. I'm going to focus for the rest of my talk on quality, to build in Amy's talk on how I see these new business models contributing to the problem of improving quality. And as we improve quality, let's remember, we're also going to improve the ability of the private sector to offer cost recovery from the user. We can't ignore the private sector. Onno has reminded us just how much care they're providing. They are the elephant in the room and it's just amazing. I'm astonished how such a big service provider can be ignored by so many big donors.

So they're largely unregulated, they are entrepreneurs, some have formal training, some do not, some will work in the public sector part-time, and some are 100 percent private sector. They are businesses, not charities. They're not necessarily only

motivated by private incentives. They probably won't self-finance charity care for the poor, because they can't. There are competitive forces that would keep them from going all the way with, you know, cross subsidy. If they cross subsidize and their competitor doesn't, then they'll lose business.

The other problem is that so many parts of the developing world have homogenous poverty. It's not as though there really is an income radiant, everybody is poor, and there really isn't a deep pocket that you can cost recover, too, and so we really might not see them offering us a lot in the way of subsidization.

So let's go back to the problem. We know that individual providers, because of market failure, will systematically fail to provide access and quality. So the problem that we're missing, and what's missing in this typical picture, there's a health provider administering some polio vaccine or medication to a child, we see the patient, we see the provider, we see the parents, but what we don't see is a regulator, and as Onno said, there's really not been attention to those administrative systems that will keep an eye on those providers and make sure that quality happens.

We really do need to put our attention to financing, coordination above private providers, investing in this particular sort of human capital. That regulator can certainly watch the providers to make sure that access and quality are achieved. If there is output based aid, and access by the poor is one of the outputs you're contracting for, that type of a system would build it in.

What I'm going to talk about today is how a social franchising system can build in this type of regulation that makes sure that access and quality occur. We need to finance that somehow. And right now, the way we're financing that, or the way we're not financing that is, locating that type of regulation at the second level in my diagram.

The donor money and some public financing money comes from the bottom. The government finances a set of organizations, let's call them district health offices. The district health offices finance the care providers, and then they deliver medical services and quality to the patients. So that district health officer is the chief quality regulator, also the chief access regulator, and they just don't have time. They're also the chief public health officer in charge for that area, and it's just not going to happen. So this is your standard public system, bring in financing from the tax base and from donors, and lose track of that second level of administration and regulation, and get what we see today in the public sector. So we need that institutionalization of regulation and observation of our providers.

So in a franchise, we've all been to them. I mean I think most of you have purchased something from a franchise. They exist because the central office of a franchise has a real incentive in holding onto their trademark and maintaining the quality of the trademark.

McDonald's has been the most widely studied franchise in economics, and the reason they succeed is because they inspect their premises every three months by a district supervisor, who is making sure that that golden arches are scrubbed, the trash cans are emptied, making sure that the burgers are thoroughly cooked, they are really gung ho

on maintaining uniformity of their product, because they know if there's one bad burger, they can go the way of Jack in the Box.

For those of you who remember, Jack in the Box sold a bad burger up in the northwest, you don't see too many Jack in the Boxes anymore. They've got to keep inspection. So in the franchise health systems, there is a similar incentive to maintain the quality of the services, and there is a reason for those Titley Centers and Beratesfa Centers to get inspected every few months, to make sure that the providers are doing what they're supposed to continually. They'll inspect the records to make sure things are above board.

If that franchise wants to improve quality, it can do it, if it wants to improve access by the poor, it can do it. And so that's what can happen in a social franchise. And the model looks more like this, where we see some financing coming out from the left, from the donors; we also see some bubbling up from the customers, who are private paying patients, to the service providers.

But then that coordinating organization, the headquarters of McDonald's, Chicago, has to make sure that the service providers are doing the right thing. And you can see an arrow downward with the mark of Q for quality. So that's the model. I want to say a little bit more about the model.

I'm going to skip my results about the cost and quality of care. But I want to discuss about, you know, what could happen. Supposing there are trade-offs and it actually is going to cost us money to fund this administrative service that Onno talks about and I'm talking about. Something — it probably does cost some money to buy better quality for the

patients. Is that worth the donor's money? If it will lead to higher demand. What Amy was alluding to in the results from the Packard Evaluation was, the franchisees in that experiment had a rather low incentive to do what the regulator said. If the regulator said, look, you're not emptying the wastebaskets, they could say, so what, I don't need to do what you're asking me to do, go away, and there's nothing that that regulator could really do about it.

Unlike McDonald's, at any McDonald's, if you don't empty your trash cans, you lose your franchise, and there's going to be someone else who will take it, and you're out, and that matters a lot. These franchisees didn't have a whole lot of stake in staying in the franchise.

And as we go forward with social franchising, we can build a lot more incentivization, and what we're thinking of in the future in social franchising is actually to tie it to micro finance, to make that franchisee a debtor by giving them a micro finance loan to purchase some equipment so that they can't just walk away, that they're tied to that organization, they have to empty their trash cans, deliver safe and effective medical care.

So we need to go forward looking for those business models with teeth and incentivization. We need to be thinking about a future where we're financing that administrative function, because it will pay off in the long run. Our patients will get better care. We really don't want to expand the type of private care that happens in most of the world. We've got to improve it, and then my hypothesis is that the demand will materialize and offer better cost recovery from our patients, who are going to be getting a better

product. So in conclusion, one thing I mentioned at the outset was that the patient and their family had the most to gain from health services, and they're the logic, ultimate source of most of the revenue in the private sector.

But in the absence of insurance systems, revenue collection is socially inequitable and unable to guarantee quality, and that's really the problem to keep our eye on, don't lose sight of that.

So even health systems dominated by private insurance, even a system like a European system, I'd hate to put ours as an example, but our system definitely suffers from problems of quality and requires extensive regulation.

So the missing ingredient is regulation, and it has to occur above the level of the providers. The governments haven't really done this well. And business models of coordination modeled after McDonald's and other franchises really offer promise and deserve a second look. Thank you.

THE SPEAKER: We have about a half an hour for questions. Could I ask the other panelists to come join me on the stage and we'll take some questions? Go ahead.

MR. de FERRANTI: I'm David de Ferranti from here at Brookings. This is a question that is suggested by all the presentations. It's one I often ask because I always learn something new. And it was also suggested by a question that Phil Musgrove put yesterday at a mid-day session about the importance of doing experimentation. And I also want to invite Phil, who's got an announcement to make. But wait, my question.

We live in a time when there's a lot of discussion about output based aid, and so starting the story this way, when countries want to build infrastructure, roads, or whatever, they have concessions, there are goals, and there's an open bidding process, and whoever meets the goals gets the contract, et cetera.

Output based aid sort of extends that concept to other things, including water, and cases where it's perhaps not fully adequate or market return on the investment for the winning, or the bidders themselves, but that's built in by turning it around and saying, well, who will do the job for the minimum subsidy, so government is going to pay for results.

So the question is, in health, lots of people here have lots of experience, and it's always interesting, panelists, this is sort of a question for panelists and for audience, cases where the concept has been tried or could be tried, where for certain areas, maybe villages, maybe districts, the government says we're open for all comers who can meet certain objectives, maybe it's maintaining, maybe it's improving its outcomes, it's pretty tough to get to, but Bolivia did this on one project, outcomes, and who can do it for the least cost? And all comers are welcome whether they're private providers for profit, whether they're faith based, whether they're the government public health service itself. Maybe at the outset there's a very inclusive process so everybody can say what the measures of progress and the requirements are, concerns they may have about out-of-pocket payments or whatever, everybody gets to put their pitch in, the criteria are set, and

then somebody gets the job to do that. So my question to everybody is, your thoughts and any experiences you have on all of that.

MR. BRICHI: Well, I'll start. In output based aid, one of the difficulties, of course, is measuring that output, and particularly measuring the quality of that output. So a bidder could promise output and then not show you the quality and succeed, and that's really been a reason output based aid is often limited to services where quality isn't easy to measure. Vaccination is a pretty good example where it could be applied. If you could ensure cold chain every shot is worth the same as another and much more doable. But primary care is going to be tough.

THE SPEAKER: Well, I guess it depends, you know, how you define the outputs. I mean I think there are examples of contracting out schemes whereby it's not so much — either the output is not so much in terms of maintaining, you know, certain health status, but it's defining us for the geographical coverage area in which the private sector has successfully, and I don't know who it was. Our panelist at the global health conference — counsel gave a presentation, an experience in Cambodia, where they were able to do so in a way and maintain quality, but I think that has to do — more in terms of defining what was being delivered as covering a geographical area and providing all services within that.

MR. SCHELLEKENS: We did a project in Namibia I think it's interesting to note, as well, where we had two schemes, because doctors — I'm partly from a pharmaceutical industry, if you pay doctors rewards, they invent diseases that 20 years ago

didn't exist, you know, from depression to influenza, from hormone replacement to — and they put millions of people on treatments.

So we had this basic idea, and we thought what we do, we have two schemes, we have one with the basic package, on capitation, and the doctor takes a risk, and we have another scheme for HIV positive patients, to find them, and we give them a reward of \$10 to \$20 each. Within a week, the second category was full, within a week.

And with the first one, where we had a capitation model, they didn't find any HIV related patients. And the problem in this world is that we are talking so much about all these policy issues, quality, et cetera, et cetera, et cetera, but go to Lagos or go to Windhook (phonetic) go to all these other places. I mean we have to get things done, and build clinics, sign a contract, and then two years later, we start watching what the quality is. But if you don't do that, there is nothing, and you can't measure and regulate quality unless the clinic is there or the doctor is there, there's nothing to regulate. And I think that's — because I totally agree, of course, with the fact that it should be done. But first of all, we have to get the doctors there and make sure that they make a living.

MS. TSUI: I can only address the first part of it, which is whether or not the government would contract out this. In these three countries, the government was the single largest competitor with the private sector, and even though they were there to regulate and also provide the commodities, they resisted a lot of that.

And we have one part of our survey asking about the relationship between the private sector and the government over time, and invariably, if you look at it as a

mirror, the private sector said, we are being held back, and the government said, we're being very good to the private sector.

MR. CARROLL: Hi, I'm Tony Carroll with Manchester Trade and Consultant at Merck. And Timothy Evans, did he make it yesterday? No, okay. Well, he spoke last week on Capitol Hill, and he talked about the capacity shortages in health care professionals in Africa, intimating that this is the elephant in the room, that we're approaching less than 10 percent of what we need to do to maintain the training facilities that we're going to be required. Each of your systems, which are dramatic and wonderful and exciting, will, I guess, in theory, increase demand for health services. Isn't that the idea that you're going to get more people going to get health care because you're giving them realistic options of getting treatment? But that will also burden the system more. It will create more demands for new professionals to deliver that treatment.

Are any of you — I'm not saying that you're free riders on an existing system, but are you looking at ways to incorporate within your system or within your various perspectives an ongoing training mechanism that is above and beyond what's being provided right now instead? Because if you look at Tim Evans' work, you're seeing that not far down the road here, we're going to have a real collapse in health care provision in Africa, particularly because of the inability of maintaining the requirements and training personnel that we need, and you're going to even increase the needs for that.

MS. TSUI: I'll go first on that one. I absolutely agree with you. This is totally independent of what I was talking about. But at Hopkins, we have funds from the

Gates Foundation which we received in 1999 or 1998, and what we have now is a network of eight to nine universities, working with the public health portion of them, whether it's the community medicine department or the actual public health school. But this is pre-service training, this is to increase the number, the cadre of public health practitioners who would then have MPH's and go out. That's very different from the clinical side, which is also — which also needs to be strengthened.

MALE SPEAKER: I'll just comment on what I saw in Nigeria, which is the pool of training providers is not the constraint. There's a huge pool of training providers; the problem is, they don't have enough opportunities to put their skills to use, and the ones who want to stay in medicine will go serve in the UK or elsewhere.

I guess I'm a bit like Onno, where I sort of feel like let's solve one problem and then we'll worry about, if we start running out of trained providers, we'll cross that bridge when we come to it. But certainly, a lot of sub-Saharan Africa, the schools are turning out enough qualified providers, but they're not staying in the health care field, or if they are, they're barely scraping by.

I will say one of the things that we do see is, the providers that do start working in the private sector, they're cut off from training opportunities, again, because of the orientation of donors, especially in the HIV sector, to start — work entirely with the public sector. So you actually have private providers, for example, beginning to do ART, but they have no access to the training they need to deliver quality. So I would say, if anything, I would see a much greater need to connect the private sector providers with the

training opportunities that already exist, but which are unnecessarily focused exclusively on the public sector.

FEMALE SPEAKER: Well, I can't resist commenting on that. But something in David Brichi's presentation is important. He says, you know, let providers moonlight in the private sector so they make more money and they stay out in these hard to reach regions, and that's part of what this is about, trying to put more money into the system to make it more attractive for the human resources to stay. But anyhow, I had a question for Amy, and that was, you looked at — in one of your slides, you say that there was no substitution away from public care; can you talk about that a little bit?

MS. TSUI: Essentially, the total client volume increased, but the proportion of the client volume going to government versus private sector versus the non-profit didn't change.

FEMALE SPEAKER: So that was additional?

MS. TSUI: Yeah.

MALE SPEAKER: Okay. Question there?

ALEX : Alex Big (phonetic) at the World Bank. I think on the HR side, this is a really important issue. I mean there's an absolute and relative staff shortage in Africa. I mean there are some places, I agree, where there's been some shifts, but the solution is not putting out enough staff. I mean if you compare Africa to other regions of the world, the actual production is just way, way under the norm of what you'd find anywhere else.

And there's two constraints here; one of them is the fact that once you have staff that are trained, some of them go overseas, but actually, currently, there's probably more of an internal reallocation than there is an overseas reallocation. So when you get big money coming into an area like HIV Aids that are paying good salaries to doctors and other staff, what happens is, that sub-sector takes staff from the rest of the health system.

Now we're finding a share from each of the Aids to malaria, because that's becoming the sort of topic of the day, and what we're finding is that as the money in HIV is drying up, people are beginning to shift from the HIV area into the malaria area, and it's leaving the HIV area uncovered.

So it is pretty fanatic in the application and you don't find this in other regions of the world, where you have, say in Latin America, you've got (off mike) large numbers and sub Asia you have India (off mike). In Africa you don't actually have similar funding so this is a really critical problem and it has a range of financing because the reality is that if you actually work (off mike) and you put them on salary or have them go through private sector, you go way beyond the part where the project would be manageable in the system, so it's a pretty big challenge.

MR. MUSGROVE: I'm Phil Musgrove and I work for a publication called Health Affairs, and I would like to have manuscripts from you all because you bring some very interesting stuff which I think we should publish. Health Affairs has, for about 25 years, concentrated on publishing about the United States, with an occasional glance at the UK and Canada or Western Europe.

And we are now trying with some Gates financing to go global. And these kind of specific issues, these kind of specific experiences are exactly what we want to hear more about in the rest of the world. I'll be glad to give you all my card. And on the table out there are some brochures, some one-page flyers about the journal if you're not familiar with us already, here's a chance to find out. We'd like to add an observation outside of this advertisement, and that is —

FEMALE SPEAKER: What's your impact factor?

MR. MUSGROVE: It's large, we've got more than 10,000 subscribers, and it is the journal that everybody interested in policy in the United States already reads, way ahead of any other, so this bragging is on the flyer, you can read it there.

The observation is to connect a couple of things that were just said. David remarked that the incentives for using quality aren't high enough, that there's a market failure there. He didn't specifically say so, but it's been clear in your conversation. One reason you can get away with this is, the customer has a very hard time judging the quality. You can't tell when he's been cheated, particularly if he's been treated sweetly by a private provider. And another observation is, they're not having the training access. Well, often bad quality results, they're simply not knowing what to do. I mean sheer ignorance is a large part of the problem. If you fix that, you might still have some problems, people are shaving the quality, rushing things a bit, not being careful about it, for that, you've got to have some regulation oversight, it's true.

But when providers don't know what they're supposed to do, when they can't answer the half dozen key questions about how do you tell if somebody has gotten malaria, well, you can double their salaries and they'll be just as ignorant as before.

Health Affairs is right now looking at a batch of papers documenting just how wide spread this incapacity to do things right is. And that ought to be relatively easy to fix compared to the problem of getting people to move where you need them and getting them all the supplies they want and so on.

MR. HAMMED: Thank you. My name is Javed Hammed (phonetic) and I'm from IFC, and I found this presentation very interesting because we try to work with the private sector, and notwithstanding what Onno said about charging 23 percent interest rate, which I don't know whether it's exactly accurate or not, but still, the question that I have is that, you know, when you go and talk to the regulator, the policy maker in developing countries, or to donors, the reaction that you get is that the private sector will not be able to serve the poor, the private sector is only there to make a profit, and therefore, somehow, they should not be supported. I mean this is basically the reaction that you get.

On the other hand, we've heard from very interesting experiments that have been done in franchising and health insurance and things like that. I just want to — the question really is that, are you seeing more examples of the government being receptive to private sector solutions to the delivery of health services?

FEMALE SPEAKER: Deceptive?

MALE SPEAKER: Receptive; they may be deceptive, too.

MS. TSUI: I can say for Pakistan, where the ministry of population welfare has a social marketing division within it because it does all the commodities, that they are actually encouraging of it. On the other hand, I hear from the Janami (phonetic) implementers that they — they're constantly competing, you know, they're in a competitive stance with the government of India, and this has been going on for many years, so —

MALE SPEAKER: That's been our perception, as well. There is this sort of, you know, suspicion of the private sector, this feeling that somehow profit is evil and it should never have happened in the health field. The one maybe ray of hope that we've seen in a couple of places is for governments which are very concerned about meeting the millennium development goals and achieving certain targets, they're looking around and realizing that, you know, when they look at their own capacity, they're realizing there's absolutely no way they can do it with their infrastructure, and that somehow pulling in private sector providers may be a way to help them do it, if organizations or projects like ours can help them, in some cases, just sort of create a dialogue, in terms of knowing what the private GP's are doing in their areas and that kind of thing, and sort of we are seeing this as potentially an opportunity for us to kind of just make links between private sector providers and public sector providers.

Just getting their numbers is maybe, you know, a way to open the door for private sector providers to start working with the private providers.

MALE SPEAKER: I think yesterday there was an interesting presentation on developments in the French speaking part of Africa, and the French are, I think, well,

they have a long history of an ethnistic kind of system. But they were saying yesterday, the people in Paris, the policy makers, that they, at least this is what I thought they were saying, really that's an important — that the least developed countries, that they very much need also this private sector involvement, and that the French government would pay much more attention and would fund schemes based on that direction. So — and I think there you see quite a movement, also in countries like Rwanda, Burundi — in Kenya the whole thing was stopped because some organizations tried to launch a nation-wide social tax based system, and in the end, it was stopped mainly because the private sector just said it's too early, you're going to destroy more than what you're going to collect.

MALE SPEAKER: There's a story from Uganda, I think answers this. It's not the private sector, but the NGO sector has — the small NGO hospitals have suffered cut-backs from their donor base in the last four or five years, and they were politically tied to parliamentarians in Uganda and able to get government subsidies to keep them afloat, they saying this wonderful hospital serving your voters will go belly up unless you rescue us. And so they've been rescued by the government and the NGO's.

I wanted to also react to Phil's comment, that there is incapacity for which the obvious band-aid would be a training program. And just to caution you as editor, when you see these as the ending of these papers, the experience of one shot training programs is very poor. You can go with your one shot IMCI training, show up 12 months later and there's nothing there, which is why we must institutionalize those follow-up supervisory visits after each training.

FEMALE SPEAKER: If I could just add also, I think there's a norming now that's going on with private sector involvement. I mean there's more and more attention certainly to the involvement of the private sector, and I think the Gates Foundation is looking into franchising at outlets for HIV therapy, and the WHO, as well. So perhaps as the donor agencies lead by example, then maybe the governments will lower their resistance.

MR. GRIFFIN: Charlie Griffin with the World Bank. First, on the contracting, the rate profit or the great contractor is Ben Lovensen (phonetic) Cambodia thing when he was at the ABP, and at the World Bank, he's actually engineered the contracting of services for seven or nine provinces in Afghanistan, where the World Bank is financing the contracts for the whole provincial health services being done by an NGO, and that's being evaluated.

It helped that the deputy minister was the hospital administrator from Fairfax, Virginia when he was trying to sell that. But I had a question for the panel, which is, there's a huge pressure now, at least for the last five years, again, on the multi-lateral institutions to do away with people paying for anything for health services.

But everything you talked about today was based on either the current behavior of paying or trying to make paying more efficient, or somehow it's all based on people paying for things. How do you respond to the very large group of people who think this is immoral, it is against human rights, and it shouldn't be allowed?

MALE SPEAKER: Well, my feeling is, as soon as Jeff Sax (phonetic) can come up with the 10 billion that it will take to, you know, treat malaria throughout Africa, then I say let's go for it. Until then, I think it still makes sense to require some system of payments.

It's an issue, you know, these trains are coming up, and you know, it's almost a conflicting trend. It's true, in some realm, we talk more about private sector; at the same time, there's these ground swell thanks to Sachs and Bono and Angelina Jolie that somehow it's evil.

I don't know, I guess we have to wage some other kind of public campaign. My mantra is, everybody has to get paid. You can't sustain things if people aren't getting paid, and in the private sector, they get paid with profit, and it's not evil, it's just how they get paid. I don't know what to say, but it is definitely an issue for us.

FEMALE SPEAKER: I would reject the assumption that making a payment system work better forestalls the day that we can live without it. I really don't think we're entrenching it, having seen many systems make a very rapid transition from a fee for service payment patient pay system to socialized insurance. So by saving lives today, making them pay for something that's actually going to help them, we're not forestalling that, we just have to remember to keep working for that goal. It's the matter of people dying today from a broken system, and I don't see a conflict there.

MALE SPEAKER: We are working only with group contracts, because otherwise, we cannot calculate the cost. And there — we do the collection on the group

level, so you can think of banks, and in the case of micro insurance, you can think of employers, you can think of all kind of groups, because otherwise, if the cost of collection is more than what you collect, you are already basically bankrupt. So that's what we try to enforce as much as possible.

FEMALE SPEAKER: For the systems that I was showing, I think those were set up to segment the market and to enable those who could pay to pay and to have those systems become more sustainable than the resources, obviously, that are needed for the pool would be there, and I think it would then be immoral to charge the poor, the poorest of the poor when they need the care that much more.

MALE SPEAKER: Could I have a shot at that question also? It comes back to this fear and hatred of the private sector, which I think is very common among public health folks. It isn't something that Jeff Saxe invented it goes back at least 24 years since I joined the (inaudible) discovering just how strong this was.

You hear people say things like health is not a business, that's right. And my counter to that, and maybe this is a way to start getting people to think a little bit more straight-lined, this notion of the kind of campaign you've got to develop. Just to say, okay, is it possible to live to a ripe old age without ever seeing a doctor, is it possible, not that most of us will, just possible, and people will think and say, well, yeah, I guess you could, and I will say, is it possible to live to a ripe old age without eating, and of course, they'll have to say no, and then I'll say, well, you don't seem to get quite so livid about the fact that we sell food, charge people for it, and occasionally even make a profit on it, what's the

problem here, and I think the problem is not the relative necessity, because you can live, and a lot of people do live without ever seeing a doctor, it's the risk that you suddenly are told by somebody that you can't live on rice and beans anymore, you've got to have caviar and champagne, it's the catastrophic cost involved.

You can cover that and charge people for what they can afford, for a lot of the basic and relatively cheap stuff, then you're okay. And then to come back to something that David said, about how governments are too sometimes clever by under paying people, I think they're also very clever sometimes to throw a lot of money at hospitals, not because they do it well, but because the hospital is where you go when you've got to face something catastrophically costly, and subsidizing that and making you pay for the cheap stuff is perfectly sensible. Never mind the argument; you should cover everything with subsidies and basic stuff first. In fact, that's completely backwards. It's saying anybody who needs something expensive, sorry, we're going to kiss you goodbye right here and now.

MR. CHAKO: I'm Sindy Chako (phonetic) from New Info Solutions. I have a question on the connection between your 100 million Euro grant and how you link to the private equity investors. In the sense, does that 100 million grant serve as the capital base and collateral on which you raise other money? Is the other money for working capital? And how were you — I mean, first of all, it's congratulations on convincing the Dutch Ministry of Foreign Affairs to put that kind of resources, it is, obviously, not easy. So, you know, why not give us a few tips on how you manage that?

MALE SPEAKER: I mean what we are doing basically, what we are trying to do is, using models that are very common also in the private sector, in other sectors. If Shell has an option to drill for oil either in the North Sea or in Nigeria, Niger Delta, they have different discount factors, and they calculate the risks, and then they say the net present value of the project is this, and the other option is that.

So what we're doing on raising private equity is, we're guaranteeing the turnover, then we're going to state, and we're looking there what the discount factor of money is using by others, and then we calculate that back in the premium with a depreciation period of five to six years. And thereby, using a method like this, because we're using hard currency, we can reduce substantially the cost of capital, and theoretically, but that is the next step, we are going to convince the pension fund to fund those clinics, because they have a guaranteed income, and they know that they will get a return, so they're — you can just simply calculate it.

The question, back to what you were saying, what we have been saying to the government is, back to the same mechanism, how is it possible on one hand that there are billions, billions available to get people serviced in health, and on the other hand, there are no investments. And we said to them, look at a company like Seltel, everybody thought that there was a willingness to pay, there was no willingness to pay for pre-paid or for mobile telephone, and everybody thought that the supply side, it was impossible to get it up and running, and look to the success, so — and how everybody was wrong.

And I think it's with this item, it's exactly the same thing. Why can you not copy the same kind of principals? Why are people not willing to pay for health, whereas everywhere in the world they pay for health. The problem is the capacity and to being able to administrate it between the real cost and the cost that they need for a basic package, but that is a matter of administration, so that was how we thought this whole thing, but it was difficult, I tell you.

MALE SPEAKER: We've reached the end of our time. So I want to thank our moderator, thank our whole panel, and thank everyone who has been involved. We've had three rich days with different perspectives over the President of Ireland, the current Minister of Health from Mexico, current head of UNAIDS, et cetera, GAVI and so on, and we thank everyone who's contributed to this. And I can't resist with one last comment, which is a content comment.

This last discussion we were having about how to convince people to be able to speak to each other around these things, I think is a major challenge. And having wandered away from the health field for some years and now coming back, I'm struck by how this linguistic divide is more severe in health, even though it's also severe in other sectors.

And I guess I would propose that all parts of that process need to reach out to the other. So even though I find very convincing what was said today, the job of convincing other people remains a huge challenge, which we should take on. We should

not assume they're going to come to us, we're going to have to find the language to go to them. So thank you everybody very much.

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