Prioritizing Private Sector Recommendations (completed example)

Private Sector Strategy	Impact	Note	Feasibility	Note	Prioritization
1. Lease inoperable MoH clinics to private NMW through its Association	Medium	Over 450 private NMW located in rural areas; will take time for NMW to convert facilities and to be trained in new scope so will not immediately translate into expanded MCH/PHC services.	High	No MoH opposition to leasing facilities. MoH has limited contracting capacity. NMW Association will be partner. NMWs will require training and certification but donors will finance training to update skills, equipment and clinic rehabilitation.	Medium priority – impact is moderate Quick win – private partner ready, donors will bring financing
2. Expand MCH services in rural areas through private NMW and link to MoH referral hospitals	High	Maternal/child health top priority; would immediately expand coverage to rural areas	Medium	MoH less supportive of contracting with private providers but NMW are located where need is greatest. NMW Association will facilitate PPP. MoH has limited contracting capacity–particularly in service delivery. Limited cost info in public and private sectors making it difficult to structure PPP.	High priority–fully aligned with MoH goals Quick win – can build on existing FBO partnership but will take time to build MoH contracting systems and capacity.
3. Contract out delivery of PHC services to FBOs in underserved geographic areas	High	Maternal/child health top priority; would immediately expand coverage to rural areas	Medium to High	MoH more comfortable partnering with FBOs, Currently has agreement with a small # of FBOs and has identified additional FBO partners in target areas. Limited cost info making it difficult to structure PPP.	High priority–fully aligned with MoH goals Prioritize–Can build on existing FBO partnerships. Will take time to build MoH contracting systems and capacity
4. Establish private lab capacity in 4 MoH hospitals in rural areas	Medium	Diagnostics–particularly in HIV/AIDs, ART compliance and malaria–weak. Will support quality of existing services but not directly expand them	Medium	MoH hospital directors reluctant to outsource lab and diagnostics but recognize labs not fully functional. Private lab network presented PPP. Limited MoH contracting capacity in this area–no cost info to price PPP proposal	Medium priority–High priority–fully aligned with MoH goals Prioritize–Have partner, will require time to build MoH support and capacity to price services and contract–out
5. Consolidate distribution & retailing of essential drugs and health products	High	Drug stock–outs in public clinics, high prices in private facilities, poor access in remote areas, key constraint to quality services.	Medium	Restructure market through policies to consolidate retail/distribution of drugs, requires regulatory changes and time for market to adapt.	High priority – supports MOH priority and addresses critical performance gap in health system. Prioritize – Needed. Initiate activities now to eventually affect reforms.

Prioritizing Private Sector Recommendations (completed example)

6. Establish local capacity to manufacture bed nets	Low	Malaria a MoH priority but donors continue to supply free bed nets, not urgent	Low to medium	Although manufacturing experience in regional, long lead time to establish capacity. No private partner identified/interested.	Low priority–not urgent De–prioritize–not feasible better to wait for opportunity
7. Contract out MoH hospital management	Medium	Hospitals consume large portion of public budget. Gained efficiencies would create more funds for priority services.	Low	Very strong opposition by current MoH management. Private health firms with experience but from outside country. No MoH capacity in contracting management services/operations.	Medium priority–would create savings that could be relocated to other MoH goals De–prioritize–will not get support from MoH hospital directors at this time
8. Restructure National Health Insurance Scheme	High	Number one strategy to address inequity in out–of–pocket spending, need to include out–patient services in benefits	Medium	NHIS leadership opposes reforms. Private sector resistant depending on type of reforms. Difficult organizational restructuring to implement reforms.	High priority–necessary condition to address inequity in health sector Long–term investment needed to build NHIS support, bring in private sector, implement reforms
9. Scale–up community based health insurance	High	Another strategy to address inequity in out–of–pocket spending.	Medium	CBHI exist in several counties. Some promising but uneven success. Hard to connect to broader risk pooling arrangements – so hard to make a systemic model to improve access/ financial protection. Donor will provide TA and funding to scale–up.	High priority–can begin to address economic barriers while reforming NHIS Prioritize–Can builds on existing programs to strengthen and scale–up.
10. Contract out non–clinical services in MoH hospitals	Low	Other more effective strategies to reduce hospital costs (see #7).	Medium	Hospital administrators do not oppose. Less risky to contract out non–clinical services. Some experience in contracting services under current procurement regulations.	Low–not as directly linked to other system gap priorities Quick win–No opposition. Several qualified private vendors exist in country. MoH has capacity in contracting non–clinical services. Can build MoH confidence and systems before embarking on more complicated contracts.

Prioritizing Private Sector Recommendations (completed example)

Based on fictitious SSA country with the following health objectives:

- Reduce maternal and child mortality
- Increase access to primary health care (PHC), particularly in underserved geographic areas
- Expand access to drugs and essential health products
- Remove economic barriers to health services, particularly by the poor
- Reduce hospital costs

Public and private stakeholders identified 10 potential solutions that are aligned with national priorities.