Training on public-private contracting for HIV/AIDS or other health services²
January 2021
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(based on case study about country of Maryland)

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- These short interactive learning exercises use a fictitious case based on real experience They can be delivered as a UROHSODVolving role players and observers, or as a small group exercise, where teams read each scenario and discuss how the scenario might play out, noting key takeaways about each scenario on a flipchart that they can present to others. There are no right or wrong answers, and no single way to participate in this exercise. Everyone can participate, have fun and learn. This approach accommodate a range of learning and communication styles, and levels of technical knowledge
- Objectives:
  - Relate principles of public-private contracting to specific programming objectives (e.g., to sustain or strengthen HIV/AIDS response or decrease infant mortality)
  - Elicit thinking on how to find common ground among public and private actors for contracts. Focus should be on relationship building, dialogue and technical know-how for contracts.
  - Illustrate factors that affect outcomes in public-private contracting (e.g., contextual issues, stakeholder objectives.
  - Enable insights on potential stakeholder incentives/motivation for public-private (PP) contracting

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- **All training participants**: read the case and any related materials assigned
- **Facilitator**: moderates roleplays (start/stop, prompt when needed, ensures balanced conversation and conducive environment for learning), and facilitates discussion of results and lessons learned.
  - Ensure each roleplay complements and reinforces key messages on contracting across different stages of contracting lifecycle. Each UROHSODould build on the last, in succession.
  - Assign roles (role players, observers); can randomly or purposively assign participants, for example to combine peers, or to ensure a mix of perspectives here are many possibilities. It can be fun and instructive to have people play a role that is opposite their own (e.g., a ministry official might play the role of a healthcare provider).
  - Facilitate balanced, constructive discussion with role players, and then observers about outcome of each role play. Illustrative discussion questions (hand out in advance if desired):
    - Did the UROHSOGo as you expected? Why or why not? Did anything surprise you?[to role players]: How did you feel in your role?
    - What were the objectives of each role player? Did they accomplish their objectives? Why or why not?

        - What does this role-play illustrate about what works or does not work in contracting that you can apply?
    - Summarize main takeaways from the series of roleplays, e.g., Have groups of four identify, then post a takeaway for each phase of the contracting life cycle on the wall; review and consolidate takeaways from the group in plenary discussion
- **Role players:** One role player will represent the public sector purchaser (MoH), and one will represent a private sector provider
    - Read a short scenario and prepare to act out the role assigned
    - Take a few minutes to jot down ideas for how they plan to act out their role, and envision how they think dialogue will unfold between them and their counterpart.
    - Focus on articulating objectives and motivations during a role play. Do not worry about technical details. There are no right or wrong “answers” (have fun!).
    - Start role play by setting set the stage; summarize understanding of the hypothetical scenario, and discuss purpose of the meeting.
    - Over approximately five minutes, act out the scenario; attempt to meet certain objectives, in consultation with public/private counterpart.
    - Conclude the role play when prompted by facilitator
- **Observers:** Training participants who are not a role player are observers. They can provide their reactions to the role play from their perspective as an observer.

Training by SHOPS Plus for MoHW Botswana on public-private contracting—December 2020

Case: Public-private contracting to address challenges in national HIV response in the country of Manyland

Background: Manyland is a lower-middle income country of 25 million inhabitants and a founding member of the Federation of States for Equitable Well-Being. The Ministry of Health (MoH) in Manyland oversees publicly financed provision of essential services through the country's public health system. The public health system has been instrumental in improving health outcomes including for HIV/AIDS in recent decades. It is where most citizens obtain health care free, or nearly free, of charge. That said, the country is facing a looming challenge in its national HIV program. To date, the government has – with support from international donors – led the HIV response and concentrated on getting people living with HIV tested and on treatment in the public health system. The program has been largely successful -- nearly 85 percent of Manyland's estimated 4.2 million PLHIV know their status, with 92 percent of those who know their status on treatment and 89 percent of those on treatment achieving viral suppression. With this success, the MOH is looking for new strategies to fully achieve UNAIDS' 95-95-95 goals and is in the early stages of planning discussions with donor partners sustain their program. At the same time, it is looking to address challenges that have resulted from the success of its program, including: long wait times and congestion at public pharmacies, overburdened doctors and nurses at public health facilities, and long wait times for viral load tests that limit the ability of the government to monitor viral suppression in its patients.

Snapshot: MoUs between MoH and HAM

- 150 of HAM's 180 facilities currently hold MoUs with the MoH to provide primary health services financed by the MoH, exclusive of HIV-related services.
- Each agreement stipulates which essential health services will be covered. Considerations include the HAM facility's capacity, proximity of the HAM facility to public facilities, available resources, and health priorities of Manyland
- Payments for services are fee-for-service, negotiated directly with each facility. Some HAM facilities receive other forms of financial support from the MoH such as salary subsidies or access to free commodities for covered services.

The MoH wishes to more fully engage Manyland's growing private health sector as one strategy it deploys to address these challenges. The private health sector in Manyland is small but growing. Historically private providers have served better off households, mostly employed in the formal economy. Most have private health coverage through medical aid (insurance) schemes, or they pay out-of-pocket for services often with minimal financial hardship. A main actor in Manyland's private health sector is The Health Association of Manyland (HAM), a group of 180 private health facilities located throughout the country. HAM's vision is to provide quality, sustainable health services for all people. HAM facilities provide 40 percent of health care services in the country and in some rural and hard to reach areas the proportion is higher. HAM finances its operations mostly from fee-for-service revenue, paid directly by clients or on their behalf by employers or medical aid schemes. HAM has also participated, with mixed results, in a public-private partnership to deliver family planning and reproductive health services and commodities to underserved populations. While its

members does offer high quality HIV services, HAM facilities tend to only serve those who can afford to pay for care – it has not been engaged by the national HIV program and only serves a small number of PLHIV. The MOH sees an opportunity to expand its partnership with HAM to include HIV services now. The additional human resources for health would help relieve some of the burden on the public sector facilities and the pharmacies that HAM operates could support more decentralized distribution of antiretroviral medicines (ARVs). Additionally, many HAM facilities have their own private laboratory network that could help with conducting viral load testing. Integrating HAM into the national HIV response would potentially help alleviate the pain points in the current response and free up public resources to concentrate on identifying the remaining PLHIV and initiating them on care and treatment. For its part, HAM wants to partner with the government through fair and sustainable contracts that would enable them to cover their costs of delivering the services.

The MoH wants to ensure that any patients who access HIV services in the private sector under the national response are able to do so without undue financial burdens. It also envisions that Manyland will implement a national health insurance scheme in the next five years that will serve as a major financing mechanism for health services that will purchase health services from public and private providers. As a result, the MoH is keen to build its capacity to set up and oversee contracts with private providers for provision of health services. This need is recently underscored by the COVID-19 pandemic and the desire to include public and private health providers in the response.

Contracting efforts so far: Recently, HAM signed a memorandum of understanding (MoU) with Manyland's MoH that outlined a new relationship. The MOU represents a substantial new commitment between the two parties to provide health services to beneficiaries of programs financed by the government. The MoU established a mechanism for designated HAM facilities to deliver essential health services in areas underserved by the public sector, free of charge to clients. In return, the government would pay HAM providers fee-for-service (FFS), based on a fee schedule for a list of services (the benefit package) that it would negotiate with each facility. These FFS payments would complement any other financial support the MoH provides sometimes to HAM, such as subsidies for health worker salaries and training, and free commodities for family planning and immunizations.

Based on this national-level MoU, the government initiated facility-level MoUs with a dozen HAM facilities in the north of the country, and expanded MoUs to facilities in other regions quickly thereafter. Although the MoUs are formal agreements, they are not legally binding contracts. Additionally, the MoUs do not detail important operational processes, such as how to revise the MoUs, or what a party can do if it is not satisfied with results under the MoU.

Relationship at a crossroads: Six years later, 150 HAM facilities have MoUs with the Manyland MoH – some of these were on paper but others were more informal, verbal agreements. However, persistent and growing challenges threatened the relationship between HAM and the MoH. Both parties debated whether they should terminate, or renew the agreements, perhaps after renegotiating the terms. As part of its efforts to engage the private sector in the national HIV response, the government also wants to consider adding additional HIV related services and including new HIV commodities such as test kits and ARVs.

Manyland's Minister of Health and the President of the HAM stepped in, recognizing the importance of the partnership for both parties, and for the citizens of Manyland. Not only did the Minister and HAM's President want the partnership to continue, they wanted it to expand and prosper. They saw the MoUs as a mechanism for the country to advance toward universal health coverage and to improve access to primary health care for citizens, the majority of whom face financial and geographic barriers. They felt the relationship was an important stepping stone to enable the MoH and HAM to partner more extensively in public-private purchasing arrangements in the future, such as when a national health insurance scheme might start up, or to support the current COVID-19 response.

To proceed, they formed the MoH/HAM Partnership Task Force, comprised of equal numbers of representatives from MoH and HAM. They tasked members to strengthen the MoUs and underlying relationships between the MoH and HAM.

Roleplay: Description of Roles and Tasks

Case: Public-private contracting to deliver health services in the country of Manyland

Role A: Director of Health Services, Manyland MoH

- As Director of Health Services, you report to the report to the Chief of the Health Service Delivery Directorate at Manyland's MoH. You oversee the MoUs with 150 HAM facilities. The Chief, with approval of the Minister of Health appointed you as a member of the MOH/HAM Partnership Task Force.
- Today, the Chief asked you, to assess how the MoUs are performing. She wants you to highlight current challenges and to recommend how the MoH, working with HAM, can to address these challenges.
- The Chief wants to present preliminary recommendations to the Minister at next month's cabinet meeting. Therefore, you plan to launch a quick assessment of the situation.
- You reach out to your colleague on the MoH/HAM Partnership Task Force, HAM Senior Manager of Operations to set up a series of meetings.

Role B: Senior Manager of Operations, HAM Secretariat

- Your career began as a primary care physician, first at a public health center, and later at a HAM facility in the South Region. After 10 years of clinical practice, you transitioned to management. You remain passionate about providing high quality, affordable health care to all.
- You currently oversee operations of HAM are a member of HAM's senior management team. You are responsible for the MoUs held between 150 HAM facilities and the MoH to deliver health services to citizens on behalf of the government. You also sit on the MoH/HAM Partnership Task Force, at the request of the HAM President.
- You just received a request to meet the Director of Health Services from the MoH and a fellow member of the MoH/HAM Partnership Task Force. Your colleague wants to discuss performance of the MoUs.
- You see these meetings as a good time to surface important issues. HAM has become increasingly dissatisfied with the way the MoUs are working on the ground, especially in the East Region. You are keen to report to the President of HAM what you are doing to improve things for HAM facilities in the East Region, and throughout the country. The President wants to reassure members of the association that the MoUs are worth keeping.

Roleplay #1

Case: Public-private contracting to deliver health services in the country of Manyland

The number of HAM facilities with MoUs, either written or verbal, to provide services to government clients had grown considerably and showed promise. Early challenges to select HAM facilities for MOUs and to set up an initial MOU included:

- The MoH had not purchased services from HAM before, and HAM had not worked with the MoH in this way. Often, one side did not know who their counterpart was, or how to contact that person.
- HAM documentation about capabilities of network facilities was incomplete and out of date. HAM could only provide limited information to the MoH about key information such as:
    - Location of HAM facilities, and what and how many services they could deliver
    - The quality of care and administrative systems at HAM facilities
    - Number of clients in HAM facility catchment areas
- The process and criteria used to select HAM facilities to contract with the MoH was not well documented and appeared subjective. Some HAM facilities that appeared to be overlooked and were without an MOU, but no one knew why.
- The MoH usually issued accreditation (quality assurance) and other guidelines without consultation of HAM counterparts. Some of the requirements were not well understood by MoH district staff or personnel at HAM. Some thought the requirements did not align with standards of care in the community, and added cost without necessarily improving quality.
- HAM needed to invest in quality improvements to meet MoH quality standards at ten of its facilities as a prerequisite to executing a MOU with those facilities. This caused delays.
- It became time consuming and increasingly complex to negotiate a unique benefit package and payment terms for each MOU. The MoH and HAM started with a list of all potential covered services and a “starting” fee for those services to include in each MOU. It tailored that list of services and fees based on what services the facility offered and its current charges (user fees). The result was that the benefit packages were mostly the same across all MOUs, but could include minor differences. This approach was manageable with the first 10-20 MOUs. Now with 150 MOUs, it was another story to keep up with so many similar yet unique benefit packages and fee schedules. It was daunting to think about adding still more MOUs to the portfolio.
- Most HAM facilities have capacity to serve more clients. HAM was committed to expand access to services in partnership with the MoH. Yet it was difficult to estimate the financial impact of the MOUs. How many clients would visit HAM facilities, and for what services? How adequate was the MOH funding to pay for anticipated services?
- So far, the parties were using a rudimentary approach to measure and reflect costs as an input to negotiate the fee schedule. HAM felt that the amounts negotiated in the fee schedules appeared to cover direct costs of labor and supplies for some but not all services. For example, payments for child health appeared to be more generous than payments for family planning or snakebites.

Conduct roleplay followed by discussion…

Roleplay #2

Case: Public-private contracting to deliver health services in the country of Manyland

As the MoH and HAM scaled up MoUs at HAM facilities, changes became more evident at the point of care:

- The MoH Public-Private Partnership Desk was supposed to help administer the MoUs but was overwhelmed, whereas HAM had only a basic secretariat function and it mostly relied on individual facilities to manage their MoUs with the MoH.
- More clients began seeking care at HAM facilities now that user fees no longer applied. MoH clients now represented more than 50% of HAM's patients.
- Waiting times for clients increased and provider morale suffered as patient volumes rose, straining limited resources. Some facilities turned away clients when commodities ran out.
- Many staff at HAM were unaware that user fees did not apply to government clients, and continued to ask them to pay at time of service. Community opinion of HAM, normally very positive, soured. HAM providers became unhappy when patients complained.
- Billing procedures set forth by the MoUs were new to HAM. Staff did not know how to prepare invoices. This created delays to get them submitted to the MoH, and errors were common.
- The MoUs also instituted new reporting requirements, such as submitting additional client demographic information. After several billing cycles passed, HAM's accountant learned that the MoH that had pended payments to HAM until reporting was complete, per MoH protocol.

HAM representatives who were not familiar with the MoUs tried to meet with the MoH to resolve current challenges, and to reinforce things that were working well. They learned that MoH managers who negotiated the MoUs turned over "live MoUs" to staff of the Public-Private Partnership Desk to oversee. In one region, MoH officials refused to meet the HAM facility managers, saying they were not at the same level. Everyone lost time trying to determine who was responsible for what. Meanwhile, tension rose as cash flow dwindled at HAM. Some at HAM wondered if HAM should terminate the MoUs.

After several meetings to assess reporting needs and requirements, everyone came to understand that complying with the reporting protocol was feasible for HAM. HAM could even see benefits of capturing the additional data, but it needed time to revise its data collection procedures first. In addition, to prepare the reports quarterly, HAM would need to hire four data analysts. Alternatively, HAM could hire just one additional analyst if the MoH would agree that HAM could submit several existing data elements that could serve as a reasonable proxy for one of the new indicators. Either way, HAM did not see the benefit of providing these reports more often than twice per year. More frequently than that seemed too short a period to measure real change.

Conduct roleplay followed by discussion…

Roleplay #3

Case: Public-private contracting to deliver health services in the country of Manyland

After several years, the relationship between the MoH and HAM enduring by sometimes shaky. Both HAM and the MoH felt encouraged by progress to negotiate and operationalize so many MOUs, but there were growing tensions especially around payment and billing and as utilization increased. Both parties, especially HAM, also felt concerned that the MoUs are not legally binding. The MoH could not obligate HAM to guarantee it would serve government clients, but HAM had little recourse if the government failed to pay on time or at all. Additionally, no one knew how to adapt the MoUs, and there was no schedule to do so. There was limited documentation of processes, e.g., for accreditation or dispute resolution. Now with 150 MOUs that contained similar but not identical benefit packages and fees, the MoH and HAM found themselves spending considerable time to process claims and payments. Surely, this invited more errors.

The MoH continued to view HAM as an important and cost-effective extension of the public health system. The collaboration with HAM improved access for the population, most of whom are poor and living in hard-to-reach areas. Rising MoH concerns included:

- The MOUs specified that HAM facilities should submit invoices to the MoH monthly. However, most HAM facilities submitted invoices in a batch every few months.
- Some invoices from HAM were inaccurate – worse yet, the MOH suspected that some might even be fraudulent.
- The MoH was supposed to pay HAM within 60 days of receiving an “approved” invoice. No one was sure what that meant. Lengthy audits of invoices often ensued, adding costs and extra work for all.
- The government lacked a reliable source of dedicated funds to pay for services provided by HAM. The money always ran out before new funding arrived. In response, the MoH regularly delayed payments to HAM, sometimes by six months or more, or paid them partially.

For its part, HAM felt the partnership with MOU was valuable for HAM and for citizens facing barriers to access services. HAM noted that:

- The MoH planned to introduce case rates for maternity care (to replace unbundled FFS payments). This was a new concept for HAM, affecting its highest volume service. Proposed case rates would pay a single fixed amount for a delivery and the standard package of antenatal care, regardless of whether the delivery was normal or cesarean or whether a client received some or all visits recommended for antenatal care.
- MoH payments came late. This negatively affected HAM facility cash flow and operations. Some facilities wondered if the agreements were worth continuing. Some HAM facilities decided to stop delivering covered services until they were paid amounts owed in arrears. HAM noted that the billing process instituted by the MoH was cumbersome and labor-intensive.
- FFS payment rates had been set based on a simple costing analysis done 5-7 years earlier. Since then, costs at HAM facilities had risen faster than the general rate of inflation.

Conduct roleplay followed by discussion…

Illustrative discussion questions (use at end of each roleplay)

Case: Public-private contracting to deliver health services in the country of Manyland

General: On communication, relationships (all roleplays)

1. How did the dialogue between stakeholders develop? What did you notice about this discussion?
2. Describe the objectives and interests of each stakeholder. How similar (or different) were they?
3. To what extent did stakeholders find common ground and agreement? How did they identify and respond to differences?
4. What factors helped/hindered stakeholders to address their objectives, and why? How could they improve communication?

General: on contracting lifecycle (all roleplays)

5. Which stage(s) of the contracting lifecycle does this scenario match?

Roleplay #1 additional questions

6. What information would be useful for the MoH to obtain about HAM and the operating context to improve its planning, and how would it use the information?
7. How could HAM assess its capacity to work under a MoU with the MoH? What external and internal data might be useful?
8. What structures and way of working would facilitate the initial evaluation of the MOUs and support their design?
9. How should the MOH and HAM design the list of covered services and the fee schedule for those services? Discuss the approach, the information and other inputs needed.

Roleplay #2 additional questions

10. How has HAM performed so far in implementation of the MoUs? How has the MoH performed?
11. What are the issues both parties need to tackle?
12. What steps could HAM and the MoH take together and separately to improve implementation of the MoUs?
13. What performance indicators are of common interest to HAM and the MOH and should tracked? Which indicators may be relevant to one but not the other party?

Roleplay #3 additional questions

14. Name several issues around billing and payment that stakeholders need to address. Why are these important? How could they address them?
15. Is the MOU structure sufficient? What are pros and cons?
16. What kind of information would HAM and the government need to revise the terms of payment? How might they approach analyzing this information and implementing changes in payment mechanisms or in the rates?
17. How would should the MoH monitor performance of itself and HAM on claims adjudication??
18. What should HAM and the MoH do to strengthen monitoring and reporting?